Caithness Initial Agreement – Appendix SC02
Current Service Model

This Appendix provides details for current services and an indication of potential future location and arrangements. Services are arranged from preventative work (green) to crisis and/ or acute services (red). This should make it easier to demonstrate where there are opportunities to strengthen approaches and services and in turn opportunities for investment.

Table 1: Blue - Statutory Services

The Highland Council	Since integration in 2012, health and social care in the Highland region has been formally integrated with NHS Highland the designated lead agency for the delivery of adult services across health and social care, and Highland Council the lead agency for children's services.
Current Location:	Caithness House, Wick
Potential future location:	No change to physical location. Services will work together in a more integrated way through Multi-Disciplinary Team membership for relevant staff and close involvement with the Single Point of Access.

Table 2: Green - Preventative/ early intervention

Health Improvement/ Smoking Cessation Service:	Smoking cessation clinics are held in GP surgeries, Caithness General Hospital, Dunbar Hospital (Outpatients), schools and workplaces (by invitation). Referrals are received from GPs, ward staff, midwives and Consultants; people can also self-refer into the service. Smoking Cessation Advice and support is available 09:00 to 17:00, Tuesday to Friday. There are occasional evening group sessions and health improvement activities, such as walking groups, have been set up supporting Community Partnership outputs. Alcohol Brief Interventions are also undertaken within this service.
Current Location:	Dunbar Hospital, Thurso (Clinics delivered in various outpatient and community settings throughout Caithness and North Sutherland).
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Third Sector:	There is an active Third Sector in Caithness with many organisations having a close working relationship with NHS Highland. A well-attended and proactive quarterly Health Improvement Forum, organised by Caithness Voluntary Group and Chaired by NHS Highland, has helped to build and maintain partnership working across the Third and Statutory sectors. It regularly hosts a community health showcase to raise awareness of the organisations and projects that are active in Caithness and to improve uptake of their services. Several organisations are funded by NHS Highland (both locally and on a pan-Highland basis), with a recent renewal of contracts providing organisations with greater stability. Caithness Mental Health Support Group (Stepping Stones, Thurso & The Haven, Wick) Hearing & Sight Care (contract pending) Samaritans (Caithness)

	Dunbeath & District Health & Wellbeing Hub Let's Get On With It Together (LGOWIT) Befrienders Highland
Current Location:	Each organisation operates from their own premises.
Potential Future Location:	Community space will be available at each of the Hubs to foster closer working, provide hot desking facilities for Third Sector organisations and provide opportunities for people to easily access different groups and services. Some organisations (e.g. Caithness Mental Health Support Group (The Haven Wick) are considering moving to the Hubs.

Table 3: Yellow - Early Intervention

Caithness is served by seven GP practices:

GP Practice:	Practice Type:	Current Location:	Dispensing Practice?	Proposed change?	List size (as of 01/01/2020)
	East Caithness:				
Dunbeath Health Centre	17J	Dunbeath Health Centre	Yes	N/A	631
Lybster Medical Practice	2C (since 2004)	Lybster Health Centre	Yes	N/A	1,127
The Pearson Practice	17J	Wick Health Centre, Martha Terrace	No	Final location to be agreed by Practice.	2,221
Riverview Medical Practice	2C (since 2014)	Wick Health Centre, Martha Terrace	No	Final location to be agreed by Practice.	7,446
	West Caithness:				
Riverbank Medical Practice	2C (since 2012)	Riverbank Medical Practice	No	Final location to be agreed by Practice.	5,480
Thurso & Halkirk Medical Practice	17J	2 x sites: Princes Street, Thurso & Halkirk Health Centre	Yes (Halkirk Surgery part-dispensing)	Final location to be agreed by Practice.	6,059
	East & West Caithness:				
Canisbay & Castletown Group Practice	17J	2 x sites: Canisbay & Castletown	Yes	Improvements to be made to both practices to facilitate additional requirements under new GMS contract.	2,877
				TOTAL PATIENTS	**25,841**

A **2C practice** is a 'salaried' practice that is run by the local NHS Board.
A **17J practice** is a 'General Medical Services' practice that has a standard, nationally negotiated contract.

All GP Practices work closely with NHS Highland and as a cluster to meet the requirements of the new GP contract. As part of this, First Contact Physiotherapists have been recruited and are working across all practices in Caithness. A First Contact Mental Health Practitioner has been recruited to work with the three 2C practices in Caithness and plans are underway to roll out Community Links Workers to all Caithness practices. However, like Primary Care throughout the United Kingdom, practices are facing significant challenges.

- Workforce pressures – GPs & Advanced Nurse Practitioners (experienced practice staff). There remains a reliance on Locum GPs and bank staff to meet the demands of the practices. Recruitment is challenging with many recruitment rounds resulting in no appointments. However, there has been some recent success with Riverbank Medical Practice, Thurso successfully recruiting 2 x WTE GPs starting in August & September 2020. One is a locum GP taking up a permanent appointment and the second is a local GP moving to a different practice (thus creating a vacancy elsewhere).
- Accommodation pressures – all practices are facing significant accommodation pressures, with not enough space for all staff to fulfil the requirements of the GP contract.
- Sustainability of practices – three of the seven practices are salaried practices, run by NHS Highland. Due to the demands of Primary Care and the afore mentioned pressures, there are concerns that in the future, circumstances may result in more of the practices handing back contracts to NHS Highland.

Dental Service:	The population of Caithness are provided with Primary Care Dental Services through a combination of Independent contractor (General Dental Practitioners) and Public Dental Services The services are complementary with the Public Dental Service (PDS) focusing on patients with additional needs who cannot be seen in General Dental Practice. There are 5 General Dental Practitioner (GDP) practices in Caithness - two in Wick and three in Thurso. Each practice has GDPs who contract with NHS Highland to provide NHS General Dental Services. There is a comprehensive Oral Health Improvement Service in Caithness, delivering preventative dental programmes, including: Childsmile – oral health improvement for children Smile4Life – oral care for homeless people Caring for Smiles – oral health improvement, training and support for older adults and those who care for them.
Current Location:	Dunbar Hospital, Thurso & Public Dental service, Lochshell, Wick.
Potential Future Location:	Oral Health Improvement staff co-located at Thurso & Wick Hubs. Dental Staff will remain in their current locations (surgeries & Public Dental Service).

Speech and Language Service:	The local element of this service transferred to Care and Learning within Highland Council and any requirements for inpatients within Caithness General Hospital are provided by a visiting service from the Raigmore team. The focus of the service locally is on prevention, as well as improving health and wellbeing.
Current Location:	The Highland Council, Caithness House, Wick, with clinics being delivered from Highland Council & NHS Highland Premises (at

	present Caithness General Hospital and Dunbar Hospital Outpatient Departments).
Potential Future Location:	TBC

NHS Near Me	NHS Near was first trialled in Caithness in 2018, with GP Near Me (Primary Care version) trialled in Riverview Medical Practice, Wick shortly afterwards. Prior to the COVID-19 pandemic, clinical uptake of NHS Near Me was slow. However, out of necessity, usage has rapidly accelerated with both clinicians and patients positive about the ability to safely access essential services. All GP surgeries are actively using GP Near Me and this has proved vital in maintaining patient care throughout 2020. Looking to the future, NHS Near Me will be crucial to the remobilisation of NHS services.
Current Location:	Delivered from Caithness General Hospital, Dunbar Hospital and available remotely via technology.
Potential Future Location:	Expanded use within Caithness General Hospital, Thurso & Wick Care Hubs and GP practices. Increased use expected within the community through personal technology.

Table 4: Pale Orange - Emerging Need

Community Adult Health services are delivered by Integrated Teams, encompassing all community-based health and social care services. These are arranged along geographical lines with the East Caithness Integrated Team based in Wick, and the West Caithness Integrated Team in Thurso. Neither team is co-located, with staff working from several bases. Measures have been put in place to help foster a greater sense of integrated working, including weekly Multi-Disciplinary Team meetings to discuss cases. Looking to the future, staff will be based at each of the new Hubs and this is currently being trialled in West Caithness with a temporary move for all community staff to William Smith House (as of May 2020).

Adult Social Care:	Adult Social Care encompasses support work, home care, care homes, day care and respite services in the community for older adults and adults with a learning disability. NHS Highland Adult Social Care works in partnership with Third Sector and Independent organisations to help people achieve their outcomes.
Current Location:	Various locations – staff not co-located
Potential Future Location:	Thurso & Wick Hubs

Community Nursing:	The Community Nursing Team provides a community nursing service for patients requiring a clinical intervention who are unable to leave their home. The service is provided from 08:00hrs to 17:00hrs seven days a week with an on call out of hours provision for end of life care which is on an informal basis. Staff are involved in the weekly Integrated Team Multi-Disciplinary Meetings.
Current Location:	Thurso – Davidson's Lane (until April 2020); William Smith House (April 2020 – temporary arrangement); Wick – Wick Medical Centre
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Dietetic Service:	The Dietetics Service is a community service but also covers hospital inpatients and paediatrics offering nutritional advice and

	support to those with complex diabetes, Irritable Bowel Syndrome and malnutrition.
Current Location:	Davidson's Lane (until April 2020); Dunbar (April 2020 – temporary arrangement)
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Occupational Therapy:	Occupational Therapy (OT) offers a wide range of services to in-patients, out-patients and those in the community. The remit of OT is to enable people to maintain their independence and/or reach their maximum level of potential in activities of daily living, through specialist assessment and treatment programmes. They work as part of the Integrated Team to prevent admissions to hospital and are integral in keeping people in the community, as well as managing safe discharge home following admission.
Current Location:	Various locations – staff are not co-located but are based on the West in William Smith House (since April 2020, previously Davidson's Lane) Those based in WSH predominantly deliver community-based interventions while those delivering hospital-based interventions are based in Caithness General in Wick
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Physiotherapy Service:	The Caithness Physiotherapy Service sits within Caithness General Hospital and Dunbar Hospital. The Physiotherapy Service provides: inpatient and outpatient support; physiotherapy outreach to the community (provided by hospital-based Physiotherapists); patient rehabilitation (including cardiac, pulmonary and vestibular); and pelvic health clinics. Advanced Practitioner Physiotherapists are now based within Primary Care, providing a triage service, referring patients to the Physiotherapy Service and working with musculoskeletal patients. This development is still in the early stages of implementation, but it is hoped that the outcome will be that patients are seen by the right professional at the right time, with an anticipated reduction in the number of referrals to the musculoskeletal and outpatient services. Pelvic health clinics are run once weekly in Dunbar hospital, Caithness General and Riverview Practice Wick. Patients can self-refer to the service and referrals are also accepted from GPs, Consultants, nurses and midwives.
Current Location:	Staff located at Caithness General Hospital, Wick and Dunbar Hospital, Thurso.
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Podiatry Service:	Podiatry services are provided to patients requiring assessment and treatment of conditions of the lower limb including nail surgery.
Current Location:	Various locations – staff not co-located
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Social Work Service:	The role of the social work team is to support individuals and their families through difficult times, assessing those who may require a service. They also provide a statutory service and protect vulnerable adults in the community to safeguard them from harm. The Social Work team is comprised of registered social workers and forms part of the integrated team, attending multi-disciplinary

	meetings with ward staff at Caithness General Hospital to ensure safe and appropriate discharges for their clients. The social workers also: provide information relating to Self-Directed Support (SDS); organise Adults with Incapacity meetings when appropriate; act as Welfare Guardian on behalf of the Chief Social Work Officer (CSWO); liaise with other agencies to protect adults under Adult Support and Protection legislation; and present applications for Long Term Care, Respite and SDS. The social work team is available Monday to Friday from 9:00am to 5:00pm. However, there is an out of hours service that provides weekend cover and 5:00pm to 9:00am from Monday to Friday.
Current Location:	Thurso – Davidson's Lane (until April 2020); William Smith House (April 2020 – temporary arrangement); Wick – Wick Health Centre
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Services not working as part of the Integrated Teams:

Care at Home:	There are two areas of service within Care at Home, both aimed at helping people to remain independent in their own home: the mainstream Care at Home team and the Enablement Service. The Care at Home service is provided by in-house NHS staff, in conjunction with four independent sector providers: Birchwood Highland; Carr Gomm; Eildon; and Pulteneytown People's Project. The service is provided according to the assessed need of the individual service user and reviewed regularly to detect any changes in need promptly and to ensure that the right support is being provided. The Care at Home team delivers a range of services including personal care, assistance with meals, medication management and assistance, continence management, assistance with mobility, all of which help the service users retain their independence at home for as long as possible and prevent hospital admissions. The Enablement Service facilitates an early discharge from hospital for those who are medically fit but require some additional assistance at home to regain independence. It also offers an intervention service for those in the community who may be struggling to prevent hospital admission. This service operates seven days a week, 365 days a year between 8am and 2pm and 5pm to 10pm.
Current Location:	Thurso – Davidson's Lane (until April 2020); William Smith House (April 2020 – temporary arrangement); Wick – Pulteney House Care Home.
Potential Future Location:	Staff to be co-located at Thurso & Wick Hubs

Cardiac Rehabilitation/ Heart Failure Service:	The local Cardiac Rehabilitation Service is delivered locally by the Cardiac Rehabilitation Nurse and Cardiac Physiotherapist. The service aims to provide the patient and their family with the knowledge and skills to self-manage, by facilitating psychological and physical recovery and educating them on ways to reduce risk and further events. The Heart Failure Service is delivered locally by a part-time Heart Failure Nurse and aims to support and educate patients and carers living with heart failure in Caithness.

Current Location:	Two staff members covering the whole county. The service is delivered from Outpatients at the Dunbar Hospital, Thurso & Caithness General Hospital, Wick.
Potential Future Location:	Staff located, and service delivered in the community (e.g. local leisure centre) and at Thurso & Wick Hubs.

Day Care Services:	Day Care facilities (34 places) for older adults are provided at Couthie Corner and Bayview Care Home, Thurso. Day Care facilities (15 spaces) for adults with learning difficulties (aged 18 to 65) are provided at Thor House, Thurso. The Laurandy Centre, situated in Wick Airport Industrial Estate, is a Care Inspectorate registered Day Care Centre, providing week-day support for up to twenty-four older people per day. The Laurandy Centre is a Third Sector partner, funded by NHS Highland, with regular reviews in place to ensure the resources are being fully utilised to support service users with the greatest need. The Dunbeath and District Health & Wellbeing Hub delivers flexible community based inter-generational services. It promotes community cohesion and social integration to reduce user's isolation and dependency on statutory services. The centre provides meals, activities, a good neighbour scheme and social integration. The service is part funded by NHS Highland and is reviewed regularly by NHS Highland.
Current Location:	Each service is located in its own premises.
Potential Future Location:	All services are involved in the redesign of Adult Health & Social Care and we are working in partnership to develop and implement processes to enable remote/ virtual Multi-Disciplinary working regardless of where staff and/ or the service is based. • Couthie Corner/ Bayview – Thurso Hub • Thor House – Thurso Hub • Laurandy Centre – Current premises or Wick Hub (awaiting final decision from Laurandy Centre) • Dunbeath & District Health & Wellbeing Hub – remaining in the current premises.

Out of Hours/ Urgent Care:	The Caithness Out Of Hours (OOH) service is provided by Ash Locums 18:00 – 08:00, seven days a week. The weekend service is provided 08.00 – 18:00 by local GPs as sessional locums. The evening OOH GP is based in Wick and the Primary Care Emergency Centre (PCEC) is in Caithness General Hospital. The Dunbar Hospital has a PCEC which is nurse led and caters for the West Caithness population. However, this is temporarily closed due to the ongoing COVID-19 situation and staff redeployment to support this. The existing OOH service will move to a multi-disciplinary model which, until the completion of the North (Sutherland) Coast Redesign, will cover the North Coast of Sutherland as far as Tongue. This service will work out of the Dunbar Hub and will be staffed by Advanced Nurse Practitioners (ANPs) with clinical support from the OOH GP based in Wick. The development of the Dunbar ANP service will support the development of the 24/7 responder model and provide medical cover for the community and palliative care beds in the care hubs.

	The new model of service will be fully integrated including input from GPs, Allied Health Professionals and nursing staff and will be supplemented by paramedics and unscheduled care nurses.
Current Location:	Caithness General Hospital Dunbar Hospital, Thurso (limited hours currently due to covid)
Potential Future Location:	Thurso Hub (North Sutherland to be delivered from Tongue)

Stroke Service:	This service is jointly funded by Chest, Heart and Stroke Scotland (CHSS) and NHS Highland and the role of the posts is reviewed on an annual basis as part of the Service Level Agreement. CHSS also provide quarterly feedback at the Stroke Clinical Network meetings which meets quarterly. The CHSS stroke nurse follows up all patients referred to the service with a new stroke or Transient Ischemic Attack (TIA) diagnosis. Referral sources are from both inpatient and outpatient services, primary care and self-referrals are also acceptable.
Current Location:	Caithness General Hospital
Potential Future Location:	Staff to be co-located at Thurso & Wick Hubs.

Table 5: Dark Orange - Developing Need

Care Homes:	NHS Highland provides residential care across two sites; Bayview House (Thurso) which has 23 beds, one of which is a permanent respite bed; and Pulteney House (Wick) with 18 beds, again one of which is a permanent respite bed. Looking towards the future, dual registration (residential and nursing) has been sought for both homes and it is anticipated that they would move to the new Care Hubs in both Wick & Thurso. The private sector provides nursing care in three nursing care homes in Caithness: Pentland View (Thurso); Riverside (Wick) and Seaview (Wick). Pentland View and Seaview are owned and run by Barchester Healthcare and are registered for 50 and 42 clients respectively. Both have availability for shared rooms. Riverside can accommodate 44 service users.
Current Location:	NHS Highland residential care homes: Bayview, Thurso Pulteney House, Wick
Potential Future Location:	Thurso & Wicks Hubs (NHS Highland homes only)

Community Hospital - Dunbar Hospital, Thurso	Dunbar Community Hospital is a six-bed, nurse led unit. These beds cater for patients requiring palliative care, post-operative care and general nursing care. Medical cover is provided in-hours by Thurso & Halkirk Medical Practice and by local and agency GPs during the Out of Hours period. In addition to this, there is a 24/7 nurse led Minor Injuries/ Minor Ailments service on site (currently suspended due to COVID-19), as well as a Primary Care Emergency Centre, receiving referrals from the Highland Hub of HS24/ Out of Ours. Located on the same site are: Community Mental Health Team; Community Midwifery clinics; Outpatients (Consultant led clinics and NHS Near Me); Physiotherapy; Podiatry; and Vocational Support.
Current Location:	Dunbar Hospital, Thurso
Potential Future Location:	Beds and on-site services co-located in Thurso Hub

Community Hospital – Town & County Hospital, Wick	Town & County Hospital, Wick is a nine bed, nurse led unit. Included in the bed capacity are two palliative care suites with medical cover for the hospital provided through a combination of

	consultants at Caithness General Hospital and the Out of Hours service.
Current Location:	Town & County Hospital, Wick
Potential Future Location:	Wick Hub

Mental Health Service (Adults):	The Community Mental Health Team (CMHT) is a multi-disciplinary team providing community-based support for adults of all ages experiencing moderate to severe mental health concerns or for any adult concerned about their use of substances. The four distinct service areas are general adult; older adult; alcohol and drug recovery services; and psychological services; which includes cognitive behavioral therapy and guided self-help. Several Third Sector organisations provide local support for people with mental health concerns. Caithness Mental Health Support Group is a registered charity commissioned by NHS Highland to provide support for people with mental health conditions. The facilities are based in the Haven, Wick and Stepping Stones, Thurso, employing 20 staff across both sites. Birchwood Highland is also a registered charity commissioned by NHS Highland to provide support workers to increase individuals' capacity to live independently and to feel fully included in the community.
Current Location:	Wick Town & County Hospital (Relocated from Caithness General to Harmsworth Unit, Town & County, Wick in April 2020 due to COVID-19) and the Old Outpatient building, Dunbar Hospital, Thurso.
Potential Future Location:	Staff co-located at Thurso & Wick Hubs.

Scottish Fire & Rescue Service (SFRS):	There are currently four Retained Duty Fire Stations in Caithness (Dunbeath, John O'Groats, Thurso & Wick) and one Community Response Unit, based in Lybster. Caithness crews work in partnership with other organisations to respond to incidents (Intervention & Protection role), as well as in a preventative with the aim of eliminating all types of incidents. Right Call for a Fall, a partnership between NHS Highland, Scottish Ambulance Service (SAS) and Scottish Fire & Rescue Service (SFRS), is being piloted in Caithness. SAS integrated pathways for falls and frailty aim to enable people to remain at home with the required community support and follow-up for (1) recovery, (2) rehabilitation, and (3) prevention of further falls, when it is safe and appropriate to do so. Non-injured fallers are referred to SFRS with trained staff attending appropriate calls, with follow up community support is organised (if appropriate).
Current Location:	Various Fire Stations throughout Caithness.
Potential Future Location:	Dunbeath – no change John O'Groats – no change Thurso – co-located at Thurso Hub (to be determined at OBC) Wick – co-located at Wick Hub (to be determined at OBC)

Table 6: Red - Increased Need

Acute Services – Caithness General Hospital:	Caithness General is a modern, well-equipped Rural General Hospital with facilities and services including: • Ambulatory Care Unit – providing renal dialysis, medical infusions and IV chemotherapy; • Acute Emergency Care Unit;

	• Midwife Led Community Midwifery Unit (3 beds); • Day-case Unit • Diagnostics (X-ray, Ultrasound, and CT); • Emergency Department; • General surgery; • General medicine; • High Dependency Unit; • Inpatients (42 beds, inclusive of 3 High Dependency beds)* • Laboratory; • NHS Near Me; • Outpatients; • Palliative Care; • Pharmacy; • Theatre suite (two operating theatres) The hospital provides consultant-led acute and rehabilitation inpatient care, but there is no on-site paediatric service. * This figure is based on the configuration of beds in non-COVID times.
Current Location:	Caithness General Hospital, Wick
Potential Future Location:	No change

Acute Services – Raigmore (and elsewhere):	Raigmore Hospital, Inverness (c. 100 miles south of Wick), is the only District General Hospital in Highland. It provides acute health services for the Highland population, with close links to hospitals in Aberdeen, Edinburgh and Glasgow who provide additional, specialist services such as neurosurgery and cardiothoracic surgery.
Current Location:	Raigmore Hospital, Inverness
Potential Future Location:	No change

Scottish Ambulance Service (SAS):	The Scottish Ambulance Service has bases in Thurso & Wick, providing emergency cover for Caithness and part of North & East Sutherland. The existing Ambulance Stations are no longer suitable for the level of service that is being provided in Caithness, with staffing levels having increased significantly at both sites. There is a requirement to move to larger premises that are fit for purpose and co-located with NHS Highland at the Caithness General and Dunbar Hospital sites.
Current Location:	Thurso Ambulance Station & Wick Ambulance Station
Potential Future Location:	Thurso – co-located at Thurso Hub Wick – co-located at Caithness General Hospital

Caithness Initial Agreement – Appendix SC03
Description of Services and Activity Data

1. Contents

2. Introduction

This document sets out details of all existing adult health and care services in Caithness. The is broken down into a number of sections with management and professional leads identified. Within each section there is a brief description of the services provided, data illustrating activity and demand and/or details of the current challenges faced.

3. Acute Assessment Unit

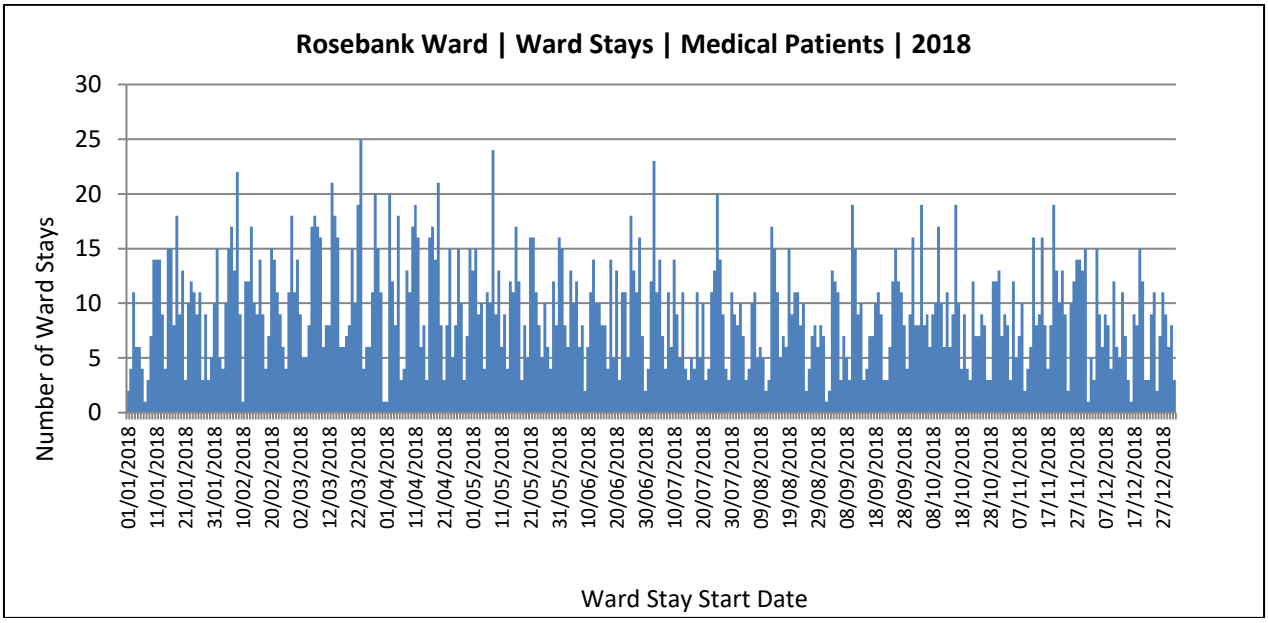
During the initial phase of the redesign of Caithness General (2015), an Acute Assessment Unit (AAU) model was introduced within the Rosebank ward. The purpose of the unit is to provide an assessment service for direct GP referrals, with the aim of reducing admissions and length of stay.

Challenges:

- Variable patient flow, caused by increased admissions and delayed discharges, can often result in pressure on the Rosebank Ward, directly impacting on the functions of the AAU.

Data:

Figure 1: Variable Patient Flow through Rosebank Ward



Data Source: Ward Stay Cube (TrakCare PMS)

Figure 2: Weekly Elective Admissions to Caithness General Hospital 2018

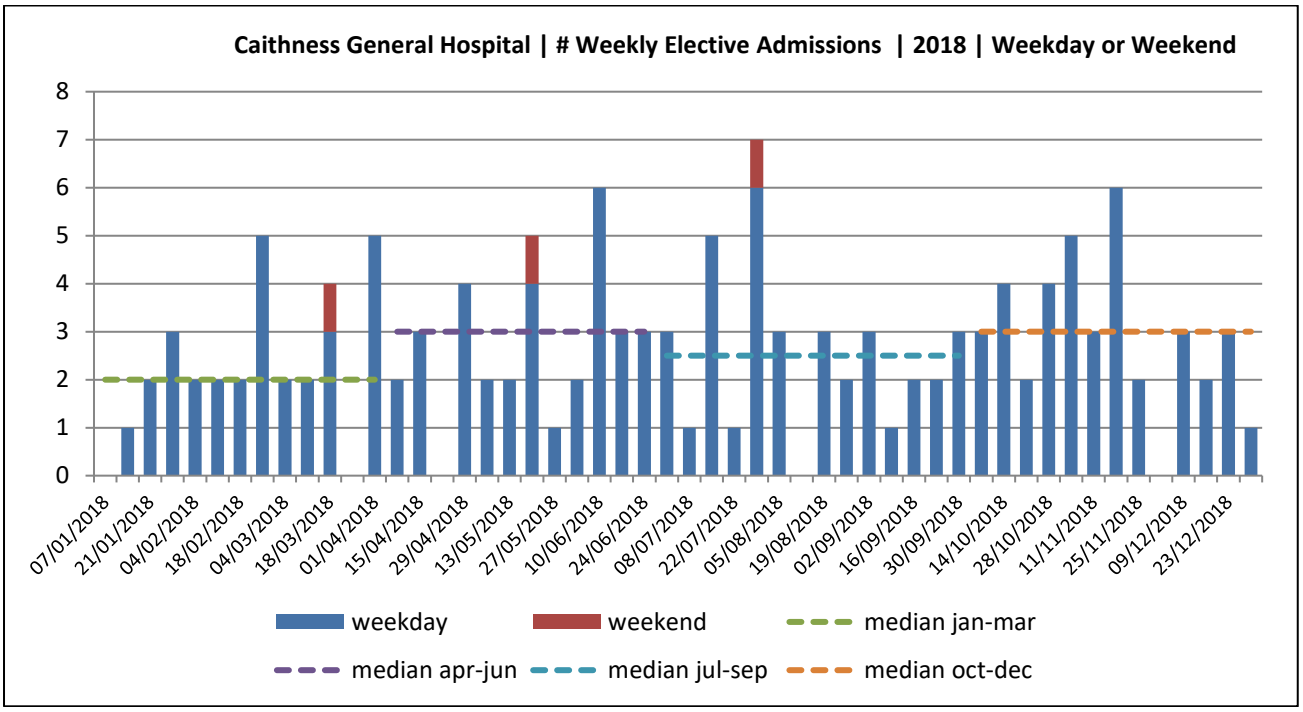
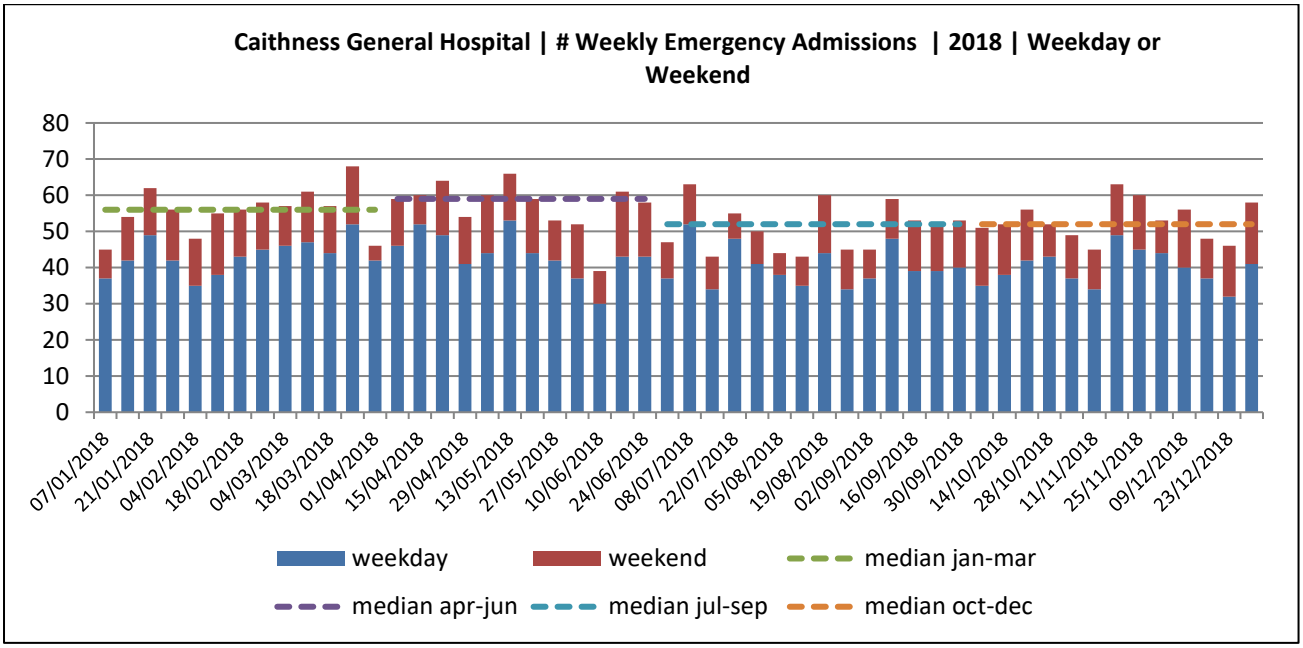


Figure 3: Weekly Emergency Admissions to Caithness General Hospital 2018



Delayed Discharges

Caithness General Delayed Discharges in 2018
Total Delayed Discharge Patients: 52

Table 1: Caithness General Hospital Discharges - 2018

Delay Category	Total DD Days 2018	*% of Total*
Community Care Arrangements (Care Home)	624	*43.64%*
Community Care Arrangements (Home)	534	*37.34%*
Complex Needs: Adults With Incapacity Act	272	*19.02%*
Total	**1430**	***100.00%***

Delay Reason	Total DD Days 2018	*% of Total*
Awaiting completion of social care arrangements - In order to live in their own home – awaiting social support (non-availability of services)	501	*35.03%*
Complex Needs	272	*19.02%*
Adults with Incapacity Act	*272*	*19.02%*
Awaiting place availability in Nursing Home (not NHS funded)	264	*18.46%*
Awaiting place availability in Independent Residential Home	186	*13.01%*
Awaiting place availability in Local Authority Residential Home	174	*12.17%*
Awaiting completion of social care arrangements - In order to live in their own home – awaiting procurement/delivery of equipment/adaptations fitted	18	*1.26%*
Awaiting completion of social care arrangements - Specialist Housing provision (including sheltered housing and homeless patients)	15	*1.05%*
Total	**1430**	***100.00%***

4. Administrative Services

The Administration Team provides a confidential support service to all management levels and nursing staff across all departments. Their duties include being the Single Point of Access for patients contacting the integrated teams, maintaining waiting lists and ensuring clinic appointments and patient letters are progressed.

The Administration Team monitors the community equipment store which is off site, liaising with the portering staff and community nursing staff to arrange the delivery/collection of equipment for patients in the community and ordering new stock when required.

A Cash Office and banking facility for patients travel, safe keeping of patient funds and hotel services income is also provided by a member of the team at Caithness General Hospital.

Challenges:

- The administration staff, who support the community and mental health teams, are located in various facilities across the county, are often isolated and would benefit from being co located within the integrated care teams to improve communication, stream line administration services and provide equity of service.

5. Adult Social Care

NHS Highland delivers a range of Adult Social Work and Social Care services across the Highland Council area. Care and support can be provided for adults aged over 16 who are assessed as having a care or support need and who require assistance.

Adult Social Care encompasses support work, home care, care homes, day care and respite services in the community for older adults and adults with a learning disability. NHS Highland Adult Social Care works in partnership with Third Sector and Independent organizations to help people achieve their outcomes. For example, this may be to help someone continue to live in their own home.

Challenges:

- At this time, there is difficulty in providing a sustainable, reliable resource to enable people to stay in their own home for as long as possible longer or move from acute care to a more homely environment, resulting in people being delayed in hospital or moving into a care home earlier than required.
- There are also challenges around long-term care and support for the families and carers of adults with learning disabilities. At present, the majority of care for these individuals rests with the families themselves and there are concerns over the long-term sustainability of this.
- There is a requirement for carers to receive respite in accordance with their assessed need. Due to a scarcity of traditional respite care, traditional long term care and a pan-Highland demand for these services, this can be difficult to deliver to everyone who requires it.

Self-Directed Support (SDS)

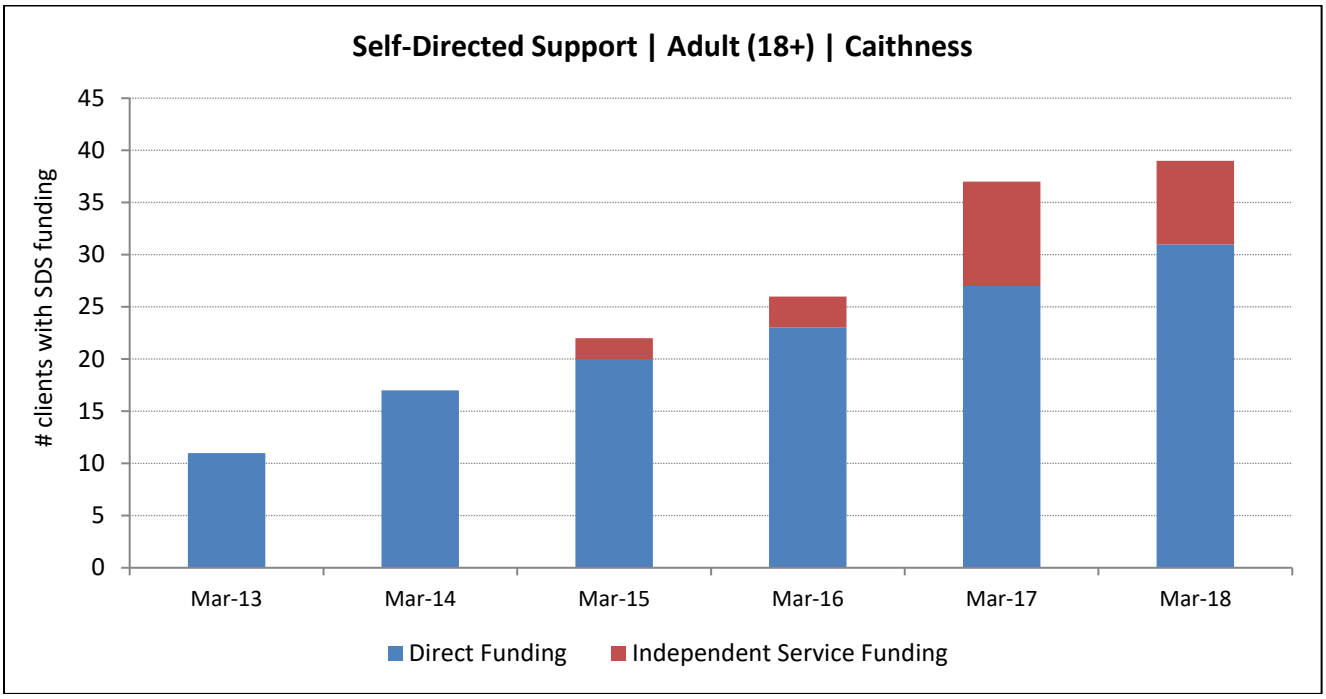
Table 4 shows the number of clients with funding from Self Directed Support (SDS). This is presented by those who appoint their own staff (Direct Funding) and those who use an independent organisation to organise their staff (Independent Service Funding). A supplementary table indicates the approximate split between East and West.

Figure 4 demonstrates a sustained increase in uptake of SDS from March 2013 onwards.

Table 2: Self Directed Support - Adults (18+) Caithness

	31/03/2013	31/03/2014	31/03/2015	31/03/2016	31/03/2017	31/03/2018
Direct Funding	11	17	20	23	27	31
Independent Service Funding	0	0	2	3	10	8
		East	West			
% split East/ (at 31/03/2018)		38%	62%			

Figure 4: Self-Directed Support - Adult (18+) Caithness



6. Ambulatory Care Unit

The Ambulatory Care Unit was introduced as part of the initial Caithness General Hospital redesign and provides renal, medical infusion and IV chemotherapy services.

Challenges:

- Renal: Currently, 11 out of our 12 dialysis spaces are full. As a result, the facility is operating close to capacity and with an expected increase of patients in the first half of this year, could lead to delays to treatment or patients having to travel out with Caithness. Any increase in dialysis spaces (allowing the unit to treat 15 patients per week) would require additional staffing.
- Chemotherapy: There are currently 4 trained staff; a sustainable service requires a minimum of 5 staff members and work is undergoing to address this shortfall.
- Medical Infusions: Medical Infusions are currently carried out one day per week, utilising empty dialysis spaces for additional treatments when necessary. However, the increase in dialysis activity has limited this recently.
  An additional challenge has been when Haematology patients have required more than one infusion per week. Due to limited capacity to deal with this, has placed additional pressures on the service and a long term solution is yet to be identified.
- Side Room: The unit currently only has one side room and at times this is insufficient to meet demand. However, there is work currently underway which will provide a second side

Figure 5: Number of Ward Stays in Ambulatory Care Unit 2018

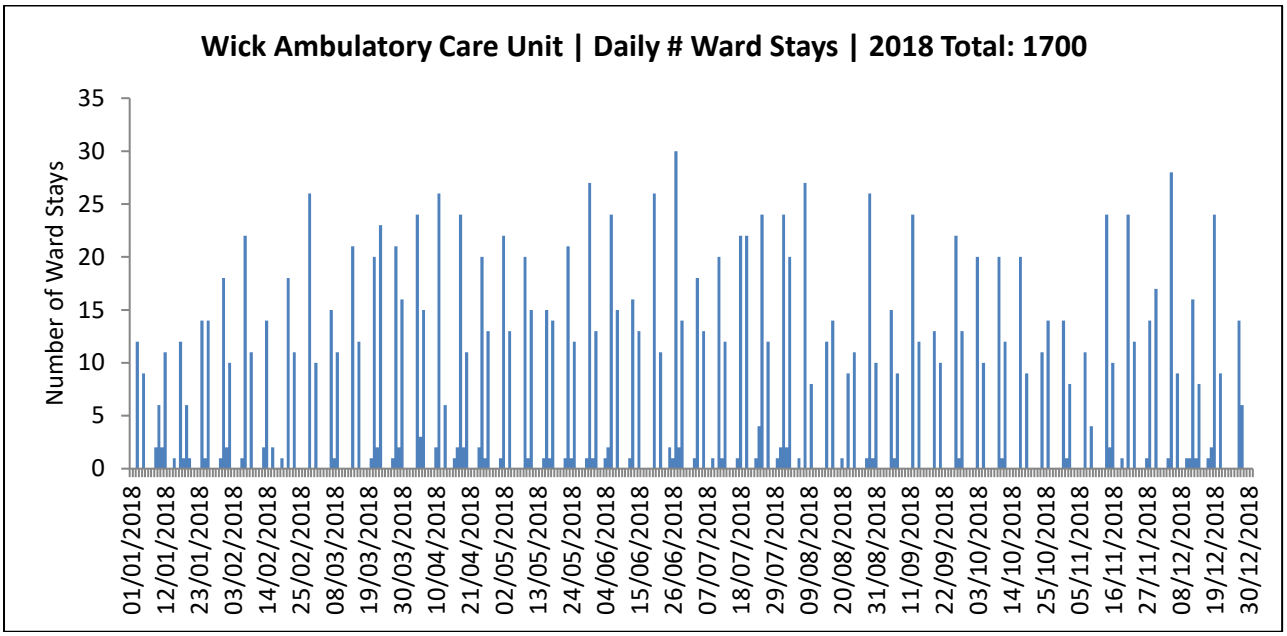


Figure 6: Number of Ambulatory Care Unit Stays by Age Group, 2018

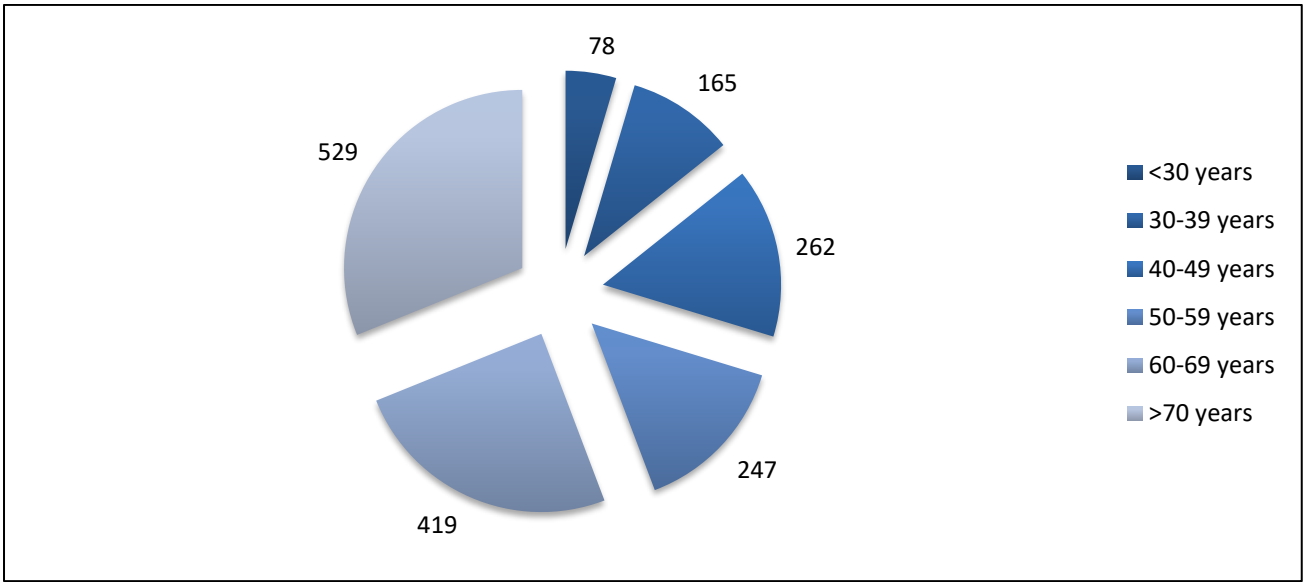


Table 3: Ambulatory Care Unit Activities, 2016 - 2018

Number of Chemo/Infusions/Venesection/Blood Transfusion/Immunotherapy Day Cases

	2016	*%*	**2017**	*%*	**2018**	*%*
Chemotherapy_Neoplasm	436	*42%*	365	*39%*	435	*41%*
Infusion	413	*40%*	428	*46%*	484	*45%*
Venesection	99	*10%*	110	*12%*	95	*9%*
Blood Transfusion	57	*6%*	28	*3%*	59	*5%*
Subcutaneous Chemotherapy	19	*2%*		*0%*		*0%*
Immunotherapy	3	*0%*		*0%*		*0%*
Total	**1027**	***100%***	**931**	***100%***	**1073**	***100%***

Table 4: Age Profile of Cases, 2016 - 2018

	2016	%	2017	%	2018	%
0-64	620	*57%*	608	*62%*	637	*55%*
65-74	247	*23%*	228	*23%*	324	*28%*
75-84	195	*18%*	120	*12%*	182	*16%*
85+	28	*3%*	17	*2%*	13	*1%*
Total	**1090**	***100%***	**973**	***100%***	**1156**	***100%***

7. Cardiac Rehabilitation Service

The local Cardiac Rehabilitation Service is delivered locally by the Cardiac Rehabilitation Nurse and Cardiac Physiotherapist. The service aims to provide the patient and their family with the knowledge and skills to self-manage, by facilitating psychological and physical recovery and educating them on ways to reduce risk and further events.

The Cardiac Nurse initially contacts the patient by telephone and they then attend a joint nurse/physiotherapy clinic for their initial assessment. The number of reviews thereafter depends on the patient and their needs. All patients appropriate for the Cardiac Rehab classes are invited to attend. These are run weekly with help from Physiotherapy Support workers from Highlife Highland premises in both Wick and Thurso. All patients then have a review one year post initial referral.

The patients we provide care for ranges from those with established cardiovascular disease, which have had a cardiac event, to those who have been deemed at high risk of a cardiac event.

Referrals are usually received from the Cardiac Rehabilitation Service in Raigmore, from other hospitals, and occasionally GP's.

<u>Challenges;</u>

- There have been challenges for the service, as there is no local lead (the lead is currently based in Raigmore). Both staff members are also overseen by different managers. Despite this, they work well together and are providing a coordinated service within Caithness.
- The Cardiac Nurse works part-time (22.5 hours per week) and delivers both a Cardiac Rehabilitation and Heart Failure Service within this limited amount of time. This presents challenges due to the increased level of demand on the service, as well as challenges for both members of staff when they are off on annual leave or sick leave. There is currently no way of providing cover and whilst patients can contact the Cardiac Rehabilitation Service in Raigmore, there is no one in Caithness delivering the service. In order to ensure long-term sustainability for the service, staffing levels need to be looked at again and increased. One solution would be to separate the two services (Cardiac Rehabilitation and Heart Failure) and have a WTE post for each. By developing these as multi-skilled posts, cover for each service could be provided if/ when necessary.
- At present, there is no Phase 4 (Physiotherapy) available locally through Highlife Highland.
- There are significant challenges when accessing suitable clinical space – this is something that needs to be addressed to enable the clinical service to be delivered.

Table 7 shows a breakdown of the referrals to the service throughout 2018, as well as the number of people who engaged with the service, either through one-to-one assessment or through exercise classes. The up-take is consistently high; this is a reflection of the time taken to engage with patients upon initial referral and that way that both members of staff work together.

Table 5: Referrals to Cardiac Rehabilitation Service

Age:	Total No. of Referrals:	Did not engage:	1:1 assessment only	Attended classes:	% of uptake:
30-34	1	0	0	1	100%
35-39	1	1	0	0	0%
40-44	3	0	1	2	100%
45-49	4	0	0	4	100%
50-54	8	4	2	2	50%
55-59	10	1	3	6	90%
60-64	8	0	2	6	100%
65-69	8	2	0	6	75%
70-74	10	0	7	3	100%
75-79	6	1	2	3	83%
80-84	13	3	6	4	77%
85-89	6	2	2	2	67%
90-94	1	0	1	0	100%
TOTAL:	**79**	**14**	**26**	**39**	**82%**

8. Care and Learning (formerly known as Children's Services)

Care and Learning is hosted by Highland Council and is primarily a community led service. The acute element of the service is provided by visiting Consultants in Paediatric Medicine from Raigmore Hospital. Multi disciplinary clinics are run locally, supported by the Consultant Paediatricians and the Paediatric Allied Health Professionals in Highland Council as required. These clinics are currently run within the old Medical Centre building at Caithness General Hospital; these could be provided within Caithness General Hospital if increased outpatient clinic facilities were available.

The Care and Learning Team is located within Highland Council offices at Caithness House, Market Square, Wick. Health Visiting and School Nursing services use clinic space which is available at Caithness House, with additional clinics continuing to be held at health centre locations throughout Caithness.

Figure 7: Number of Planned (Attended and Did Not Attend) Acute and Community Paediatric Appointments in Caithness Locations

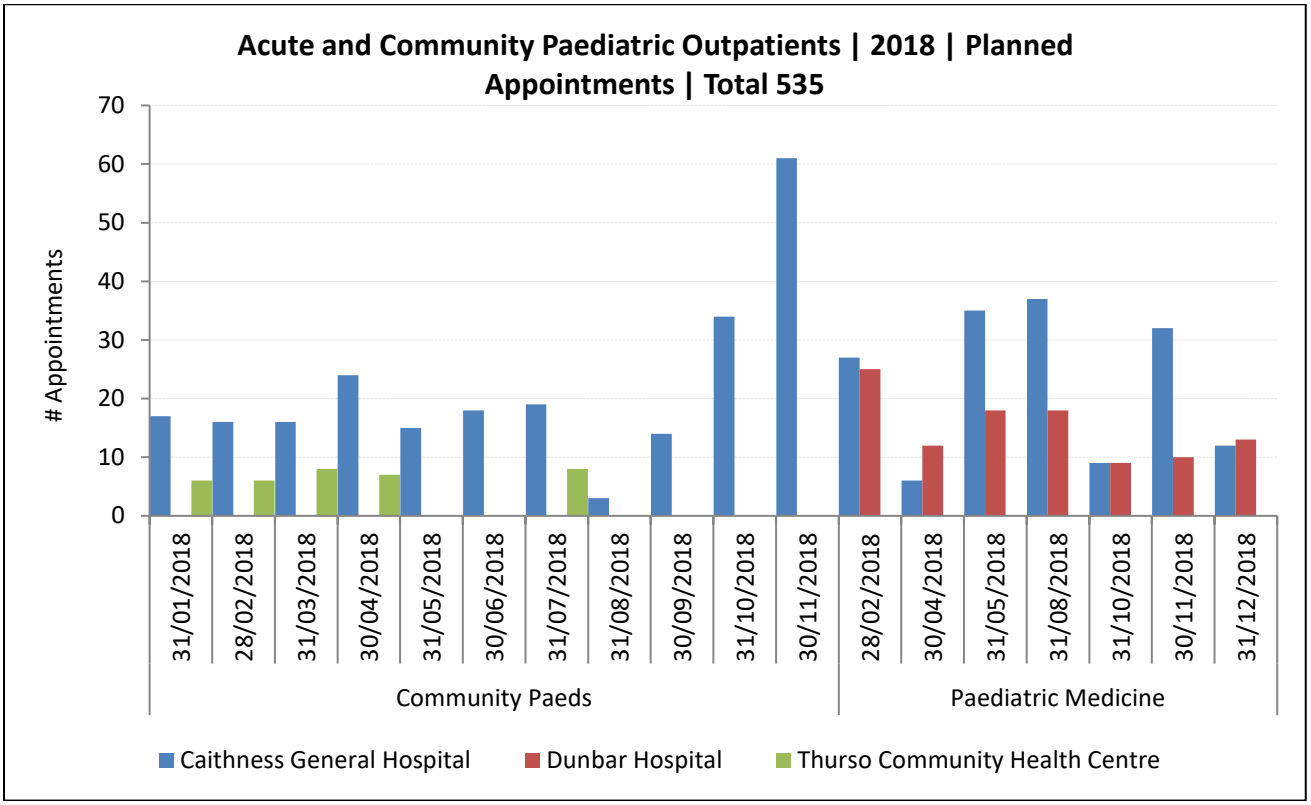
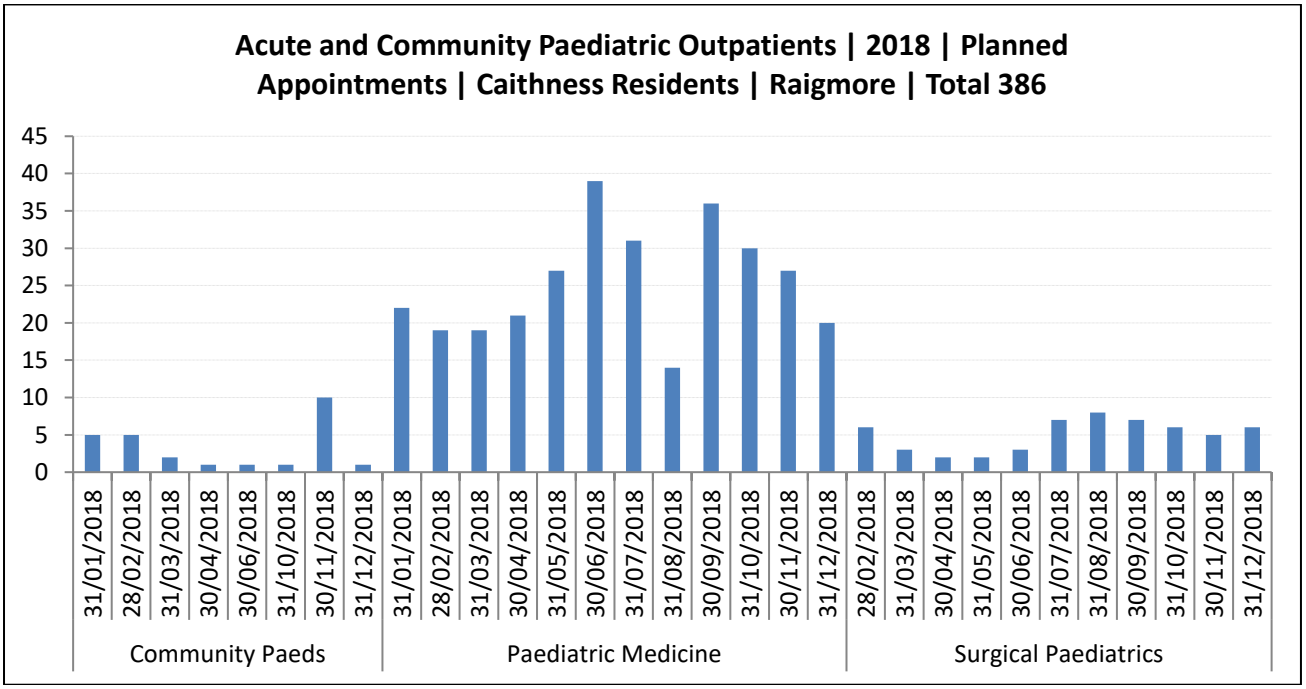


Figure 8: Number of Planned (Attended and Did Not Attend) Acute and Community Paediatric Appointments in Raigmore



9. Care at Home Services

There are two areas of service within Care at Home, both aimed at helping people to remain independent in their own home: the mainstream Care at Home team and the Enablement Service. The main staff groups are: Care at Home Officers; Care at Home Workers/Senior Health and Social Care Support Workers; Care at Home Coordinators; and Administration staff. The Care at Home service is 'split' into two areas - East and West Caithness.

The Care at Home service is provided by in-house NHS staff, in conjunction with four independent sector providers: Birchwood Highland; Carr Gomm; Eildon; and Pulteneytown People's Project. The service is provided according to the assessed need of the individual service user and reviewed regularly to detect any changes in need promptly and to ensure that the right support is being provided. The Care at Home team delivers a range of services including personal care, assistance with meals, medication management and assistance, continence management, assistance with mobility, all of which help the service users retain their independence at home for as long as possible and prevent hospital admissions. These services are delivered to a wide range of service users, from those who require very little assistance, to those with complex care needs requiring two staff, four times per day.

The Enablement Service facilitates an early discharge from hospital for those who are medically fit, but require some additional assistance at home to regain independence. It also offers an intervention service for those in the community who may be struggling in order to prevent hospital admission. This service operates seven days a week, 365 days a year between 8am and 2pm and 5pm to 10pm and the staff work closely as part of a Multi-Disciplinary Team. The Care at Home Officers and Manager attend regular hospital Multi-Disciplinary Team and Ward round meetings to identify suitable patients. An assessment is carried out by an Allied Health Professional and a programme of outcome focused activities, usually delivered over six weeks, is arranged to help the individual regain their independence at home. The service is reviewed on a weekly basis and adjusted if necessary. If anyone has been unable to return to being independent and ongoing support is required, then appropriate Care at Home (mainstream) services would take over.

Telecare services are also available to support people to remain at home independently. This is the use of technology and sensors to provide support and assistance, at a distance. It allows people the freedom to live their life, safe in the knowledge that help can be summoned quickly if needed. It may be provided alongside Care at Home services.

<u>Challenges:</u>

- Recruitment – Due to the number of independent care providers operating in Caithness, it can be difficult to recruit and retain staff, as there is significant competition for a small pool of people.
- Capacity – The Care at Home service is currently struggling to keep up with the demands on the service. This is due to: budget pressures; an increase in referrals; and people living longer with multiple co-morbidities and complex needs. Without significant changes, this is unlikely to change in the future.
- Training – All Care at Home staff are now required to register with the Scottish Social Services Council and complete an SVQ3 in Social Services and Healthcare. Due to a large work force and restricted availability of training locally, it can be challenging in ensuring that all staff have time to complete mandatory training, in addition to personal development opportunities. The challenge is two-fold – covering shifts so that staff can attend training and meeting the cost of the additional shift cover within an already stretched budget.
- As with other services, staff sickness can be an issue; however this is closely monitored and managed through the NHS Highland Promoting Attendance policy.

Care At Home (NHS)

Tables 8 and 9 are based on a snapshot of the Care At Home service as at 24th March 2019. This shows that over Caithness as a whole 32% of clients have been receiving this service for a year or less, 24% for 2 or less years, 12% for 3 or fewer years, and 32% for more than 3 years. These figures are also broken down by East/West Caithness. The reasons for the higher numbers of people receiving longer term support in East Caithness is unknown, although there is speculation that this could be linked to East Caithness having a more settled population than in West Caithness (Dounreay effect).

Table 6: Number of Care at Home Clients (on 24th March 2019) by length of support and location

Area	<12 months	13-24 months	25-36 months	37+ months
East Caithness	42	35	14	57
West Caithness	47	31	19	33
Total	**89**	**66**	**33**	**90**

Table 7: Percentage of Care at Home Clients (on 24th March 2019) by length of support and location

Area	<12 months	13-24 months	25-36 months	37+ months
East Caithness	28%	24%	9%	39%
West Caithness	36%	24%	15%	25%
Total	32%	24%	12%	32%

Table 10 gives a breakdown of the same information by Client Category and Area, indicating that West Caithness has a lower percentage of clients than East Caithness with “problems arising from infirmity due to age", and a higher percentage of clients with “physical disability” than East Caithness. As mentioned above, this may be related to a greater proportion of Clients in East Caithness receiving longer-term care; it is expected that people would become increasingly frail the longer they are in receipt of Care at Home services. Table 11, in contrast to Table 10, indicates a similar age-breakdown for both East and West Caithness for Clients of the Care At Home service.

Table 8: Client Category and Location

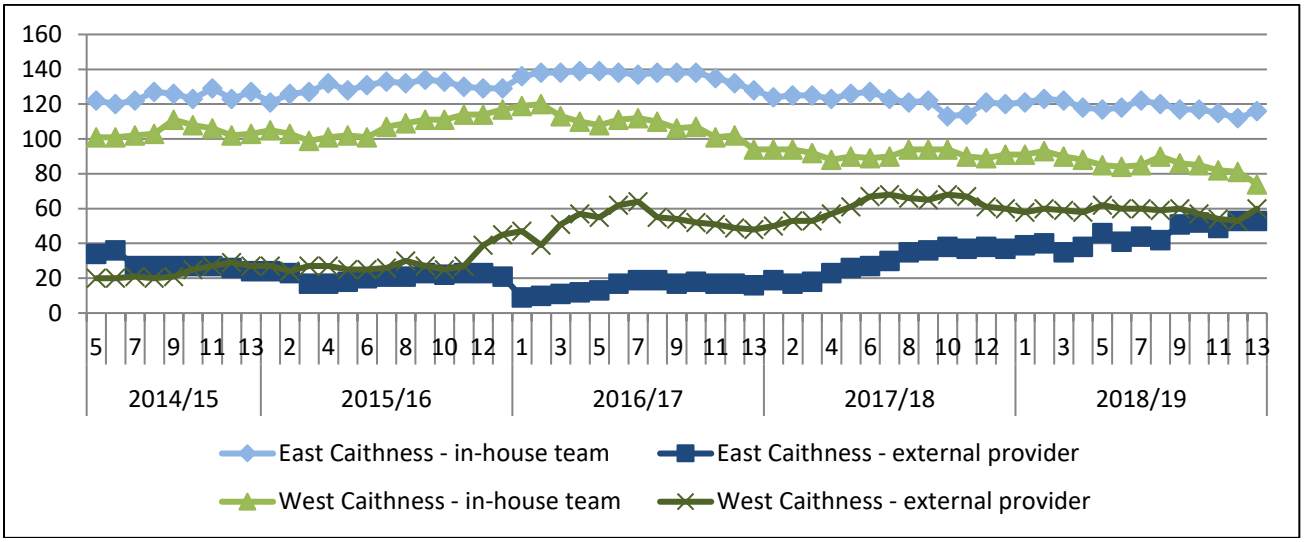
Area Client Category	**Number of Clients**	**%**
East Caithness	**148**	***53.2%***
dementia	25	*17%*
LD_MentalHealth_Other	22	*15%*
physical disability	16	*11%*
problems arising from infirmity due to age	85	*57%*
West Caithness	**130**	***46.8%***
dementia	32	*25%*
LD_MentalHealth_Other	19	*15%*
physical disability	32	*25%*

problems arising from infirmity due to age	47	*36%*
Total	**278**	*100%*

Table 9: Client Age and Location

Area Age-band	**Number of Clients**	**%**
East Caithness	**148**	***53.2%***
85+	59	*40%*
75-84	55	*37%*
65-74	22	*15%*
<65	12	*8%*
West Caithness	**130**	***46.8%***
85+	56	*43%*
75-84	59	*45%*
65-74	11	*9%*
<65	4	*3%*
Total	278	*100%*

Figure 9: Caithness Care at Home Clients - In-house and External Providers

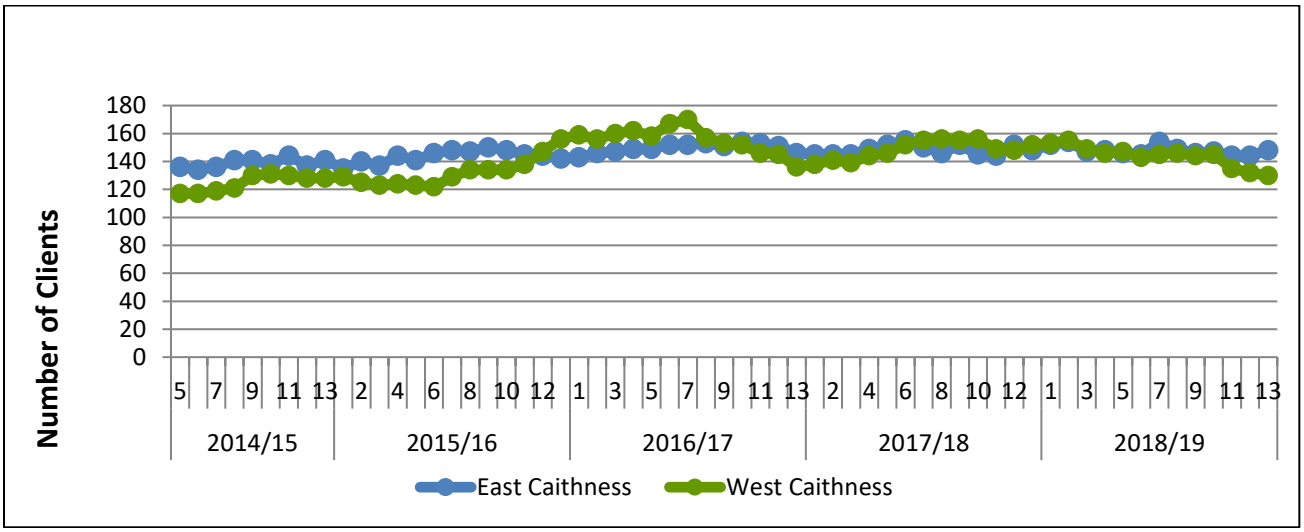


Data Source: Highland Council Social Care

Figure 9 indicates the number of clients receiving Care At Home for each 4-week period from April 2013 to March 2019. This is also broken down by East/West Caithness and In-house or External providers.

Figure 10 shows very little change in the overall number of clients receiving Care At Home over the 5 year period.

Figure 10: Caithness Care at Home Clients - All Providers

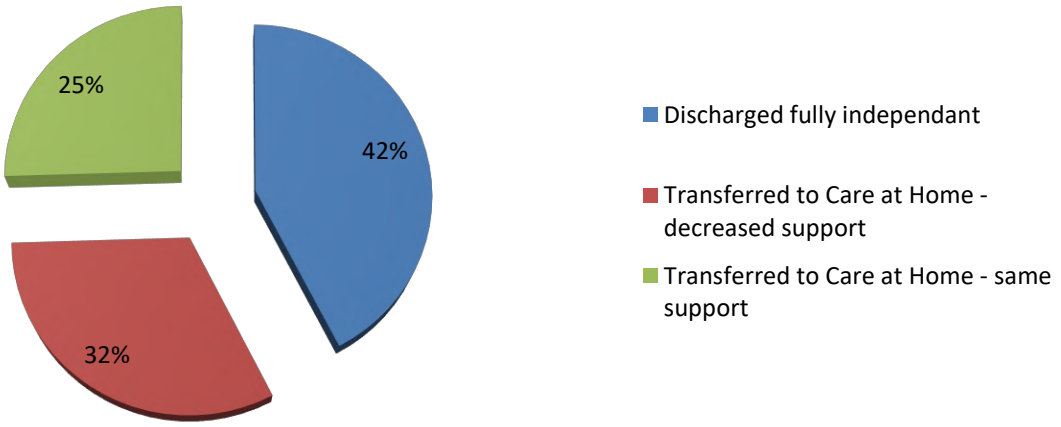


Data Source: Highland Council Social Care

Enablement Service – 2018

In 2018, there were 121 referrals to the Enablement Service, of which 15 (12%) were unsuitable referrals or did not engage with the service. 106 Service Users successfully completed the pathway; – a breakdown of the outcome following completion of Enablement can be seen in Figure 11.

Figure 11: Outcome of Enablement Service 2018



Data Source: Care at Home, North Area.

10. Care Home (Residential & Nursing)

Residential and Nursing Care homes provide accommodation, meals and personal care. The difference in nursing home care is that the team on duty will always include at least one qualified nurse (the number will depend on the number of residents) and can therefore cater for people with a medical condition who require nursing attention.

Residential care homes can call in medical support from local GPs, out of hours, community nurses etc. Assessment of needs will determine the most appropriate setting for people.

NHS Highland provides residential care across two sites; Bayview House (Thurso) which has 23 beds, one of which is a permanent respite bed; and Pulteney House (Wick) with 18 beds, again one of which is a permanent respite bed. Both care homes would benefit from rooms of a suitable size to support the equipment required for bariatric patients attending for respite care.

The private sector provides nursing care in three nursing care homes in Caithness: Pentland View (Thurso); Riverside (Wick) and Seaview (Wick). Pentland View and Seaview are owned and run by Barchester Healthcare and are registered for 50 and 42 clients respectively. Both have availability for shared rooms. Riverside can accommodate 44 service users. Achvarasdal Residential Home, run by Crossreach, Church of Scotland was registered for 28 residents but was closed in June 2018.

Challenges:

- Bayview:
    - The existing building is no longer fit for purpose and the layout over three floors, creates significant issues for both staff and residents. This includes restrictions on the people who can be accepted due to the danger of people accessing the stairwells as a result of confusion or dementia. The layout also requires additional staff to ensure the safety and welfare of all residents.
    - A lack of space for dining and storage has a significant impact on the physical environment, with some residents having to eat in an overflow area and equipment being stored in staff and residents' sitting areas.
    - Some Day Care areas are accessed via the residents living area which does not create a very homely atmosphere. The residential home areas should not be a thoroughfare for other services.

- Pulteney House:
    - Staffing – There are ongoing issues recruiting to the post of Domestic Assistant, resulting in issues when substantive staff are on leave/ off sick. A staff bank would help to address this issue.

Table 10: Number of Residents in Caithness Care Homes in 2018 (NHS Highland)

In-House Residents	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Bayview House	38	39	40	40	40	42	42	42	41	39	35	38
Pulteney House	25	25	25	24	25	24	22	22	21	21	22	22
Melvich	4	4	4	4	4	4	3	3	3	3	4	4
Total	67	68	69	68	69	70	67	67	65	64	61	63

Table 11: Number of Residents in Caithness Care Homes in 2018 (Independent Sector Care Homes)

Independent Sector Residents	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Achvarasdal	12	12	11	10	10	3	0	0	0	0	0	0
Pentland View	49	47	46	49	49	48	46	47	46	46	47	44
Riverside House	36	36	35	36	36	37	40	36	36	38	34	37
Seaview House	35	36	37	37	38	36	38	37	37	37	38	38
Total	132	131	129	132	133	124	124	120	119	121	119	119

Table 12: Number of Independent Sector Respite Placements (2018)

Independent Sector Respite	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Dec
Achvarasdal		4									
Pentland View		1							1		1
Riverside House	1	3	2	1	1		2	2	2	2	1
Seaview House		1		1	1	1	1			1	
Total	**1**	**9**	**2**	**2**	**2**	**1**	**3**	**2**	**3**	**3**	**2**

Data source: Highland Health & Social Care

11. Community Hospitals (Dunbar Hospital, Thurso & Town & County Hospital, Wick)

In addition to inpatient services at Caithness General Hospital, Wick, Caithness is also served by two community hospitals – the Dunbar Hospital, Thurso and the Town & County Hospital, Wick.

Dunbar Community Hospital is a six-bed, nurse led unit. These beds cater for patients requiring palliative care, post-operative care and general nursing care. Medical cover is provided in-hours by Thurso & Halkirk Medical Practice and by local and agency GPs during the Out of Hours period.

In addition to this, there is a 24/7 nurse led Minor Injuries/ Minor Ailments service on site, as well as a Primary Care Emergency Centre, receiving referrals from the Highland Hub of HS24/ Out of Ours. Located on the same site are: Community Mental Health Team; Community Midwifery clinics; Outpatients (Consultant led clinics and NHS Near Me); Physiotherapy; Podiatry; and Vocational Support.

Town & County Hospital, Wick is a six-bed, nurse led unit. Included in the six-bed capacity are two palliative care suites with medical cover for the hospital provided through a combination of consultants at Caithness General Hospital and the Out of Hours service.

Occupancy Rates:

Table 13: Bed Occupancy rates based on national rules - 2018 & 2019

	Year	Local Bed Occupancy		
		Occupied Beds	% Occupied	Average LOS
North & West Operational Unit	2018	3604.2	71.2%	38.8
	2019	3491	82.3%	46.5

	Year	Local Bed Occupancy		
		Occupied Beds	% Occupied	Average LOS
Dunbar Hospital, Thurso	2018	1505.2	71.1%	32.0
	2019	1652.4	82.2%	47.2
Town & County Hospital, Wick	2018	2099	71.3%	45.6
	2019	1836.6	82.4%	46.0

Delayed Discharges:

- Dunbar Hospital - Total Delayed Discharge Patients, 2018: 10

Table 14: Dunbar Hospital Delayed Discharges - 2018

Delay Category	**Total DD Days 2018**	***% of Total***
Community Care Arrangements (Care Home)	367	*48.80%*
Community Care Arrangements (Home)	49	*6.52%*
Complex Needs	336	*44.68%*
Total	**752**	***100.00%***
Delay Reason	Total DD Days 2018	*% of Total*
Complex Needs	336	*44.68%*
Adults with Incapacity Act	*336*	*44.68%*
Awaiting place availability in Local Authority Residential Home	201	*26.73%*
Awaiting place availability in Independent Residential Home	136	*18.09%*
Awaiting completion of social care arrangements - In order to live in their own home – awaiting social support (non-availability of services)	49	*6.52%*
Awaiting place availability in Nursing Home (not NHS funded)	30	*3.99%*
Total	**752**	***100.00%***

- Town & County Hospital - Total Delayed Discharge Patients, 2018: <10

Table 15: Town & County Hospital Delayed Discharges - 2018

Delay Category	**Total DD Days 2018**	***% of Total***
Community Care Arrangements (Care Home)	194	*13.99%*
Community Care Arrangements (Home)	224	*16.15%*
Complex Needs	969	*69.86%*
Total	**1387**	***100.00%***

Delay Reason	**Total DD Days 2018**	***% of Total***
Complex Needs	969	*69.86%*
Adults with Incapacity Act	*969*	*69.86%*
Awaiting completion of social care arrangements - In order to live in their own home – awaiting social support (non-availability of services)	184	*13.27%*

Delay Reason	Total DD Days 2018	*% of Total*
Awaiting place availability in Nursing Home (not NHS funded)	163	*11.75%*
Awaiting completion of social care arrangements - Specialist Housing provision (including sheltered housing and homeless patients)	40	*2.88%*
Awaiting place availability in Independent Residential Home	31	*2.24%*
Total	**1387**	***100.00%***

12. Community Midwifery Unit (CMU)

The role of the Community Midwifery Unit (CMU) is to provide person-centred, safe, effective, efficient, equitable and timely care to women and their babies throughout the antenatal, intrapartum and postnatal period.

Care and health improvement work is delivered in a range of settings through home visiting and midwife led clinics held in Caithness General Hospital and the Dunbar Hospital outpatient department.

The core service is provided by a team of midwives, maternity healthcare support workers and maternity care assistants. The on call obstetric consultants based at Raigmore provide 24/7 advice and support by telephone and VC. They also provide weekly on site or NHS Near Me antenatal clinics. The service runs 24/7 and manages planned workload as well as triage and assessment for all unscheduled maternity cases from within the Caithness and North Sutherland area.

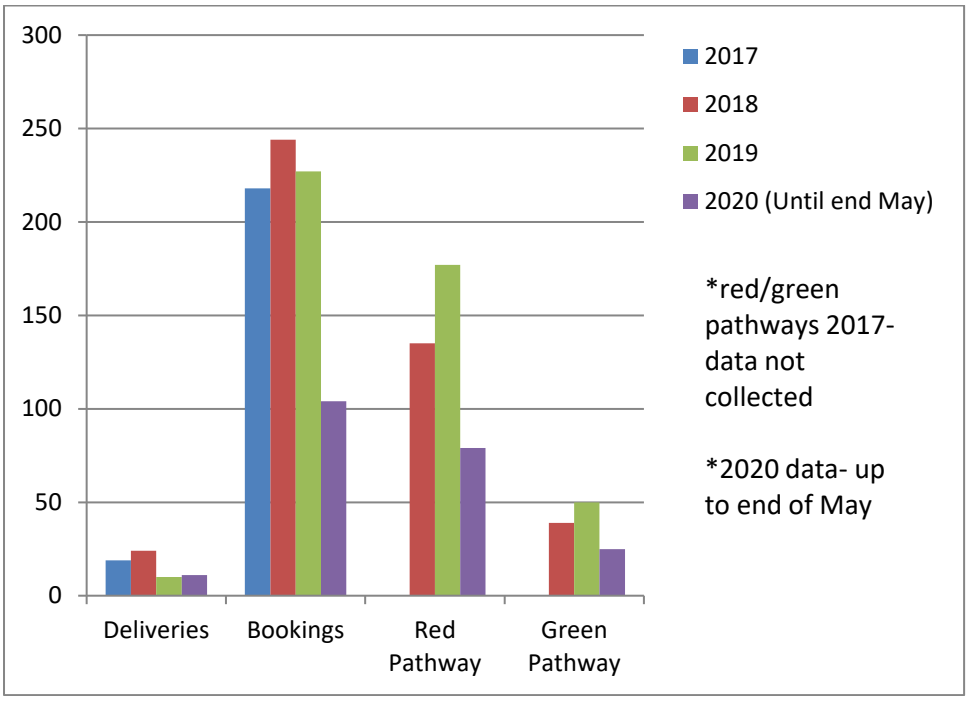
Women booked for a planned caesarean section and any emergency patients are transferred to Raigmore Hospital.

Challenges:

- Current facilities could be better utilised within Caithness General Hospital and do not meet standard for CMU functioning. The unit does not have: a Labour, Delivery and Post Natal room (LDP); direct access into the unit; family parking facilities; on site clinic provision; antenatal scanning, infant feeding facility, bereavement/family room or dedicated parent education facility.
- There are ongoing issues with the Scottish Ambulance Service around the transport of pregnant women to Raigmore Hospital. There are limited numbers of ambulances available and transfers to Raigmore Hospital result in ambulances being unavailable for use within Caithness for a considerable length of time.

Figure 12 details the caseload of the Community Midwives, broken down by pathway for the years 2017, 2018, 2019 & 2020. Patients booked on the red pathway are those who medically require maternity team care due to health conditions or pregnancy complications; most Caithness patients on this pathway will deliver at Raigmore Hospital. Patients booked on the green pathway are typically healthy women with uncomplicated pregnancies are able to deliver at Caithness General Hospital/ at home should their pregnancy and labour remain uncomplicated and they choose to do so.

Figure 12: Caithness Midwifery Caseload



Data Source: Caithness Community Maternity Unit

13. Community Nursing Services

The Community Nursing Team provides a community nursing service for patients requiring a clinical intervention who are unable to leave their home.

The services provided include:

- Assessment co-ordination and management of complex, chronic and acute nursing needs;
- Holistic wound assessment and management;
- Acute and chronic disease management;
- Palliative care for those who are terminally ill;
- Technical nursing interventions, e.g. syringe drivers, central lines, intravenous drugs;
- Bereavement support;
- Promotion of continence and management of incontinence;
- Assessment for nursing equipment;
- Health promotion for individuals, carers and communities;
- Nurse prescribing;
- Nursing procedures: e.g. ear care, injections, immunisations and vaccinations.

The service is provided from 08:00hrs to 17:00hrs seven days a week with an on call out of hours provision for end of life care which is on an informal basis.

Challenges:

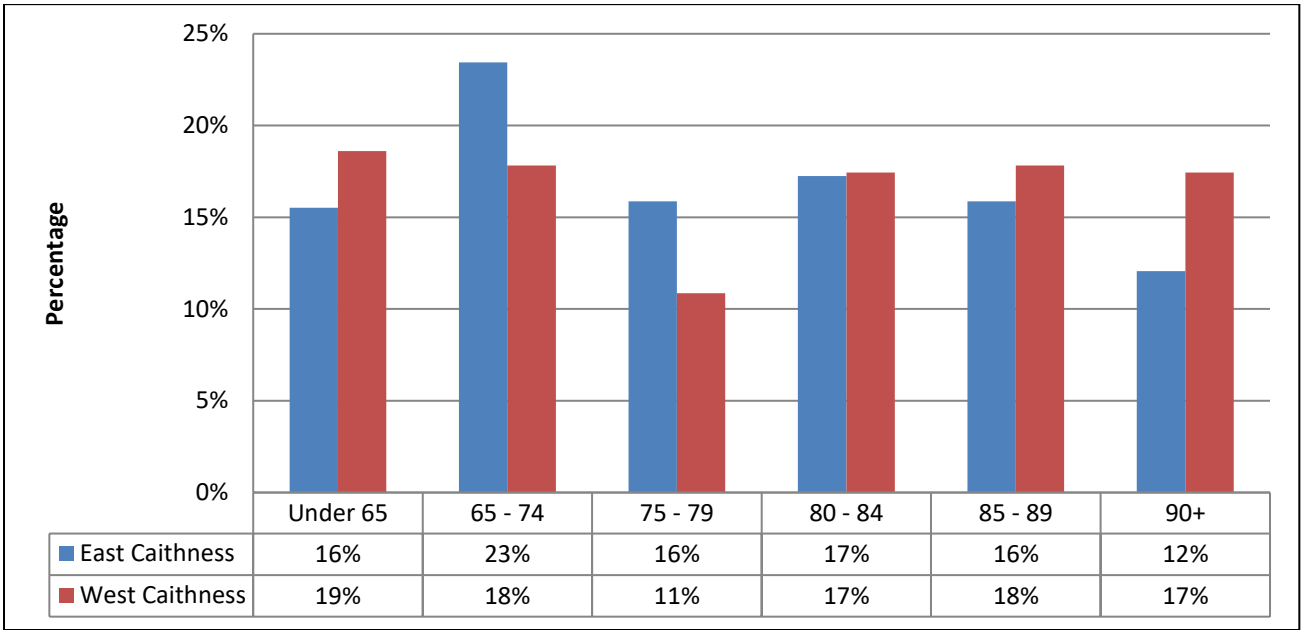
- The service is experiencing significant staffing pressures, including staff on maternity leave, long-term sickness and unfilled posts. The result is that this has placed existing staff under pressure to maintain the existing service. The long-term viability of the service requires an increase in staff, both substantive posts and bank staff.
- The service is seeing a gradual increase in the complexity of patient needs on their caseloads. Patients often require more frequent, intensive interventions such as IV antibiotics at home, taking up more staff resources. With a view to moving more patient care

to the community, as mentioned before, additional staffing will be required to allow this to happen.

Community Nursing Services currently have no electronic patient records; they are solely reliant on a paper-based system. As a result, it has been difficult to access reliable data to gauge demand on the service. However, all six teams (East Caithness: Pulteney; Lybster & Dunbeath; and Wick, Watten & Canisbay. West Caithness: Princes Street; Riverbank; and Rural) conducted an audit of their caseload on a day in 2019. All of the data below is drawn from these audits.

Figure 13 shows a comparison of the caseloads in East and West Caithness by age range. East Caithness has a greater proportion of patients aged 79 and below (55%), whilst 52% of the West Caithness caseload is aged over 80.

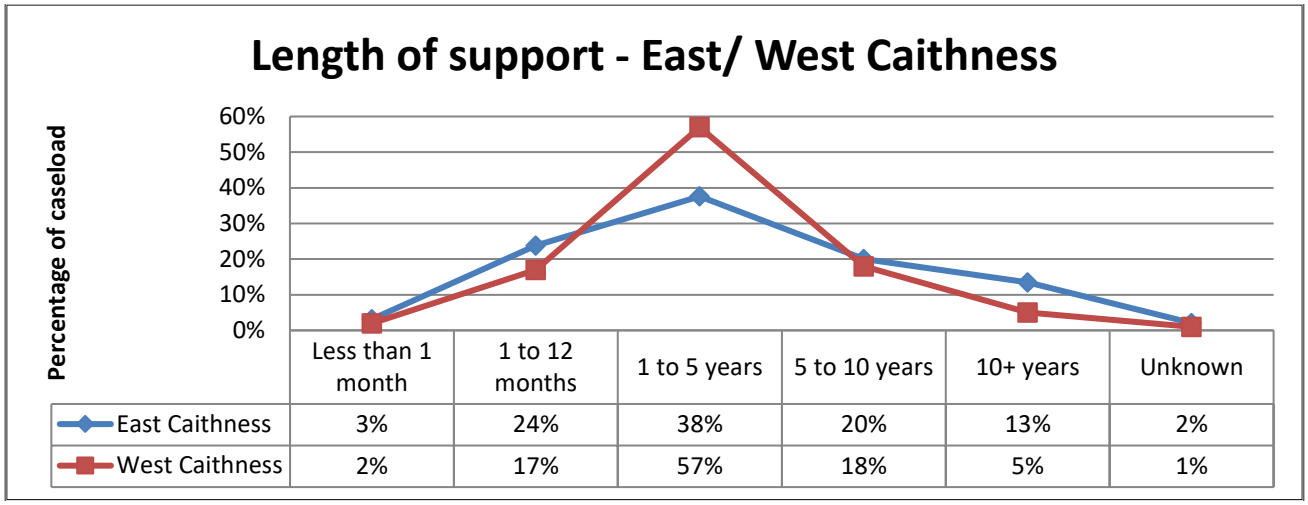
Figure 13: Comparison of Community Nursing Caseloads in Caithness (Age Range - %)



	Under 65	65 - 74	75 - 79	80 - 84	85 - 89	90+
East Caithness	16%	23%	16%	17%	16%	12%
West Caithness	19%	18%	11%	17%	18%	17%

Figure 14 shows a breakdown of the length of support in both East and West Caithness. This shows that many patients are receiving Community Nursing care long term, with 43% of East Caithness patients being supported for more than 5 years and 57% of West Caithness patients being supported for between 1 and 5 years.

Figure 14: Comparison of the Length of Community Nursing Support for Patients in Caithness



	Less than 1 month	1 to 12 months	1 to 5 years	5 to 10 years	10+ years	Unknown
East Caithness	3%	24%	38%	20%	13%	2%
West Caithness	2%	17%	57%	18%	5%	1%

Figure 15 gives a breakdown of patient's conditions; with 43% of all patients being supported due to a Urinary condition.

Figure 15: Patient Conditions - Caithness Community Nursing

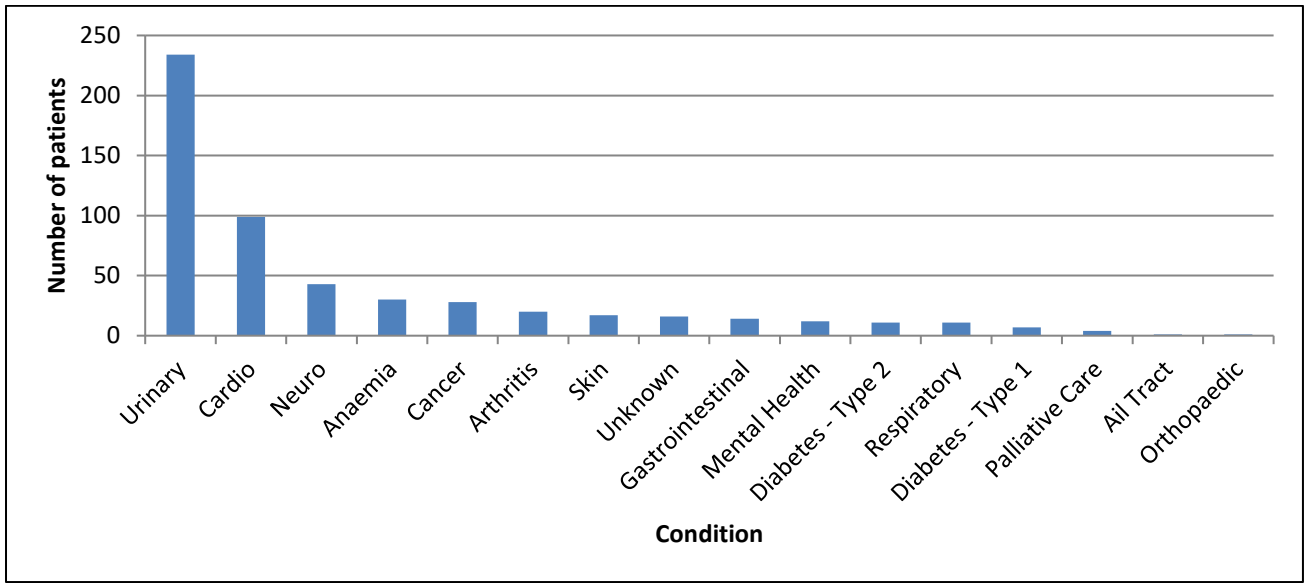


Figure 16 shows the range of interventions provided by the Community Nursing Teams. It is unsurprising that given the number of patients with a Urinary condition that this relates to the high levels of intervention for bladder or bowel care.

Figure 16: Community Nursing Interventions

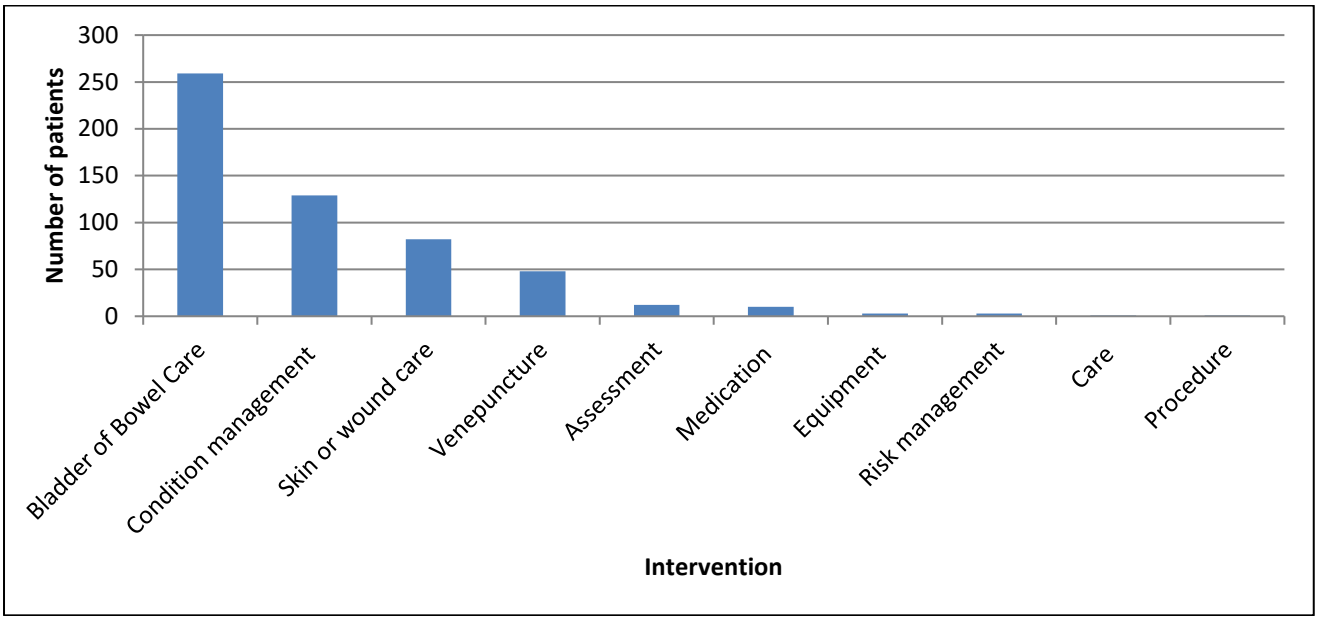
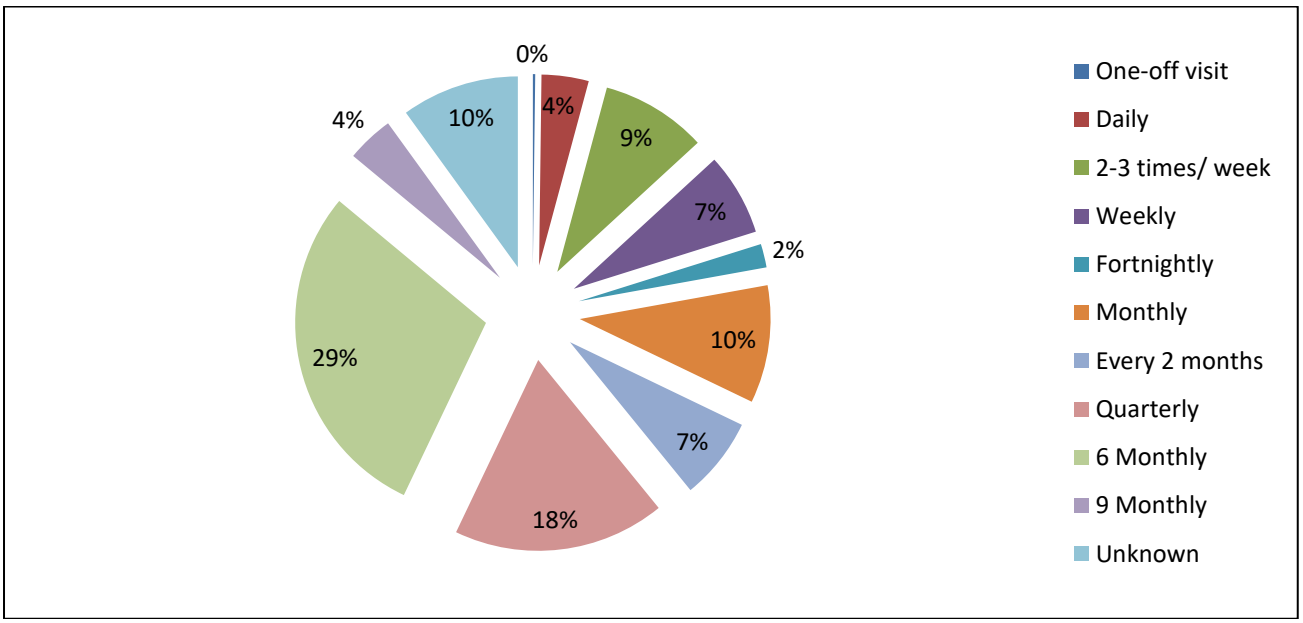


Figure 17: Frequency of Community Nursing Contact with Patients



Data Source: Caithness Community Nursing

14. Day Care Services

Day Care facilities (34 places) for older adults are provided at Couthie Corner and Bayview Care Home, Thurso. Day Care facilities (15 spaces) for adults with learning difficulties (aged 18 to 65) are provided at Thor House, Thurso.

The Laurandy Centre, situated in Wick Airport Industrial Estate, is a Care Inspectorate registered Day Care Centre, providing week-day support for up to twenty-four older people per day. The Laurandy Centre is a Third Sector partner, funded by NHS Highland, with regular reviews in place to ensure the resources are being fully utilised to support service users with the greatest need.

The Dunbeath and District Health & Wellbeing Hub delivers flexible community based inter-generational services. It promotes community cohesion and social integration to reduce user's isolation and dependency on statutory services. The centre provides meals, activities, a good neighbour scheme and social integration. The service is part funded by NHS Highland and is reviewed regularly by NHS Highland.

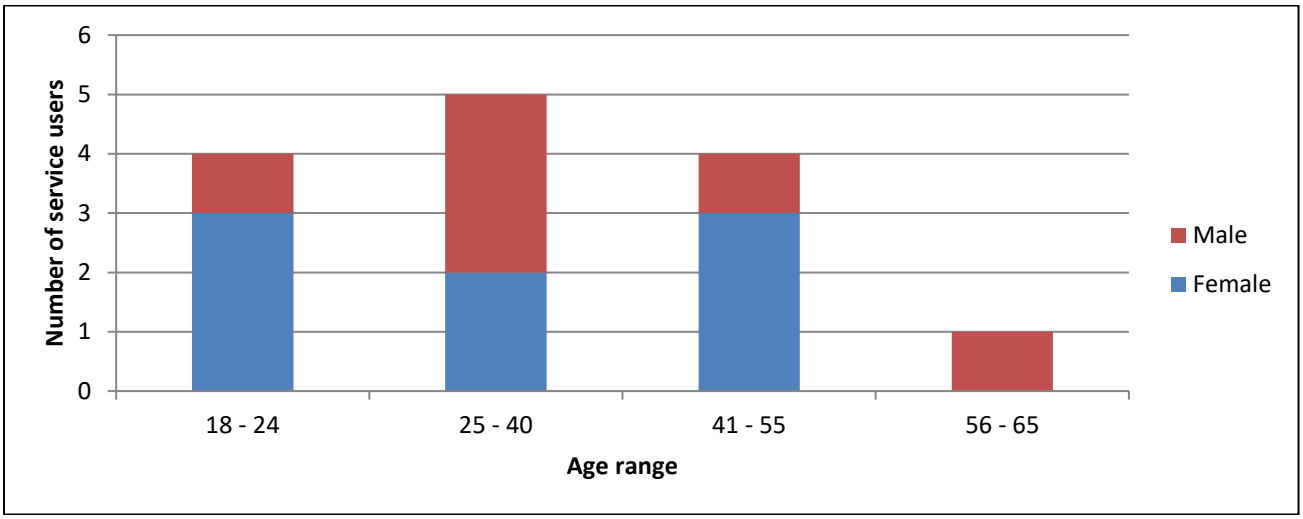
Thor House:

Challenges:

- The current building is not fit for purpose to provide the required service. Numbers are limited due to space constraints; the waiting list is full and social work is no longer able to refer new service users as a result. Children, who are transitioning to Adult Services, are also unable to access the service and due to the remote and rural nature of Caithness, there are few other suitable services to offer support.
- The current building is owned by the Highland Council and shared with their Children's Short Stay Service. Any necessary improvements have to be authorized and carried out by the Highland Council, which can lead to delays.
- Activities are limited due to a lack of space and there is no quiet room where someone can go to calm down or relax.

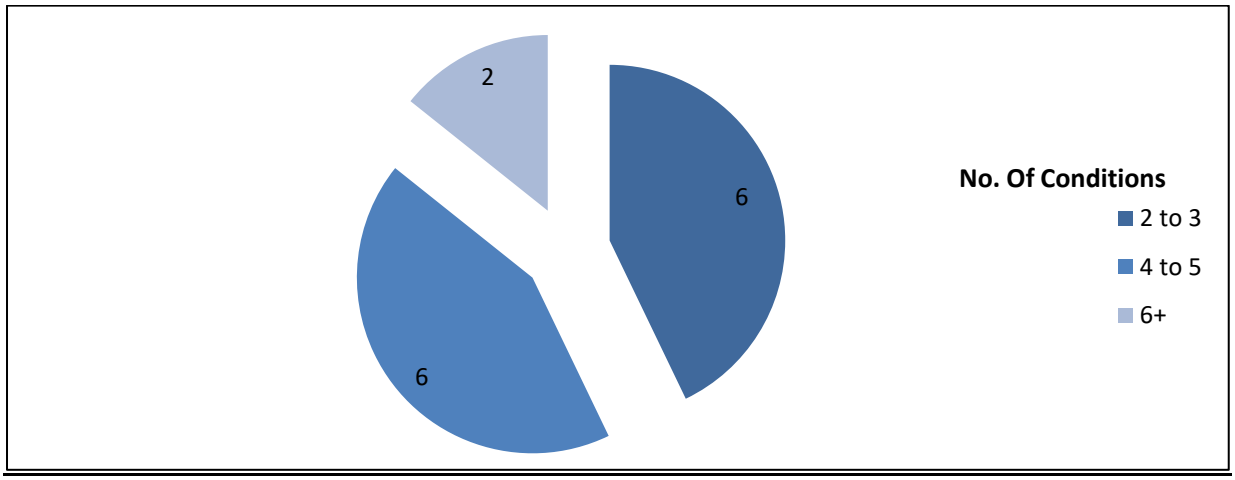
Thor House is registered for fifteen service users and is at currently operating at capacity (fourteen) due to the number of service users with complex needs. It is important to note that the majority of the service users have been supported by Thor House for many years, as there is no other form of support for people with severe Learning Disabilities in the Far North of Scotland. Several have transitioned from Children's Services and may continue to receive support until they are 65 years old. As such, service users can be supported for a considerable length of time, resulting in new spaces opening up infrequently. Out of the fourteen people currently support, nine continue to live at home with their parents/ carers and attend for Carer Breaks. Five live in their own accommodation and receive intensive support from Key Community Supports.

Figure 18: Number of Service Users - by Age and Gender



All service users have complex needs, with 100% experiencing communication difficulties, 43% of whom are non-verbal. Figure 19 below shows the percentage of service users living with multiple conditions.

Figure 19: Number of Conditions Experienced by Service Users



Data Source: Thor House, Day Care (Adults with Learning Difficulties)

Bayview/ Couthie Corner:

Challenges:

- The current Day Care facilities are unsuitable for the current and future needs of the service. The Day Care facility currently operates from the Bayview Care Home, with the service utilizing space over two floors, making it difficult for people with mobility problems. As the space is shared, there is inadequate room to deliver all the desired services and also limited room for storage. This is particularly challenging given an increase in the number of people requiring hoists and mobility aids meaning that more room is required. High levels of noise and poor lighting can make the environment difficult for people with hearing and sight impairments, as well as those with dementia.
- People are transported to the Day Care via staff cars and a dedicated mini-bus service. Transport can be difficult for people with dementia and complex needs and a more sustainable way of helping people to access the service is required. The car-parking area is

small and can be particularly busy at the beginning and end of the Day Care, making it unsafe for certain people.

- Recruitment of suitable staff is an ongoing problem within day care, with fewer numbers of skilled candidates applying for roles. Should a solution to this problem not be found, the result will be a shortage of skilled staff to run the service. Closer partnership working with the North Highland College may help tackle this.

Table 16: Bayview Day Centre Usage - 3rd January to 31st December 2018

Available Places	6,780
Occupied Places	5,453 (80%)
Emergency Admissions	2: - One person in for one day care day while husband attended Hospital appointment in Inverness; - One gentleman in day care for two week period while wife recuperating from ill health and living with daughter at this side of county for short period.
Falls	0
No of Referrals	29 (3 did not take up a place and 1 not suitable)
Left the service	29
New Attendees	25

Data Source: Bayview Day Care Statistics

Laurandy Day Centre:

Challenges & Future:

- There is an increasing demand to provide 7 day a week day care to enable people to remain in the community for longer and to provide greater support for their carers. Laurandy would be prepared to offer this service, either through extending the opening hours of the Laurandy Centre or utilizing staff registered to provide a Care at Home service to visit the most frail service users at weekends. There would be a cost implication to this.
- There are plans to create a Quiet Room, particularly as the Laurandy Centre is seeing an increase in the frailty of people referred. There is a need for a quiet space for people to use should they not be well. There is also a need for a trolley/ bed to be purchased for use in the Treatment Room and the Quiet Room (if necessary). This would enable NHS staff to carry out a wider range of procedures with Day Centre service users.
- Looking to the future, the Laurandy Day Centre is keen to be an equal partner in the new Adult Health and Social Care Model being designed and implemented in Caithness. They are also keen to explore including the Day Centre service in the Wick Hub.

Table 17: Laurandy Day Centre Usage - 1st October 2018 to 31st March 2019

Available Places:	3120
Allocated Places:	2813 (90%)

Occupied Places:	2554 (81%)
Reasons for non-attendance:	
Health	142
Respite	13
Holiday	29
Choice	16
Hospital admission	36
Transport	5
Domestic/ Home matters	2
Appointment	12
Weather	1
Left service:	6
Reasons for leaving the service:	
Hospital admission	2
Care Home admission	3
Choice	1
Referrals:	20
New attendee	10
Emergency admission	9
Unsuitable referral	1

Data Source: Laurandy Day Centre Statistics.

15. Dental Services

The population of Caithness are provided with Primary Care Dental Services through a combination of:

- Independent contractor (General Dental Practitioners) and;
- Public Dental Services

The services are complementary with the Public Dental Service (PDS) focusing on patients with additional needs who cannot be seen in General Dental Practice.

There are 5 General Dental Practitioner (GDP) practices in Caithness - two in Wick and three in Thurso. Each practice has GDPs who contract with NHS Highland to provide NHS General Dental Services. As of January 2019, NHS Highland contracted with a total of 12 GDPs to provide services in the Caithness area.

GDPs provide primary care dental services for all patient groups and participate in the Integrated Out of Hours Service with PDS colleagues.

The Public Dental Service provides the following service to the community:

- Dental treatment and advice for identified priority group patients including care provided under sedation and General Anaesthetic, also domiciliary dental visits;
- Emergency care for patients not registered with a Dentist;
- The delivery of national oral health improvement programmes e.g. Childsmile and Caring for Smiles (older adults);
- Local and national epidemiology programmes.

The Public Dental Service has two clinics in Caithness – Lochshell Dental Clinic and Caithness General Hospital.

Key developments moving forward are:

- Improving Access to Orthodontic Services;
- Improving access to Primary Care Minor Oral Surgery Services;
- Improving accessibility to Public Dental Service in West Caithness;
- Public Dental Service co-location within the proposed Care Hubs/ Care Village;
- Sustaining recruitment and retention of staff.

Table 18: Dental Services - Caithness Patient Registration Profile

Location:	GDP Registrations (as at 30/09/2018)			PDS Registrations (as at January 2019)		
	Child:	**Adult:**	**TOTAL:**	**Child:**	**Adult:**	**TOTAL:**
Thurso	1,943	9,390	11,333	0	0	0
Wick	2,273	6,465	8,738	376	1,140	1,516
TOTAL:	4,216	15,855	20,071	376	1,140	1,516

Figure 20: Referrals (%) to the Public Dental Service - January to December 2018

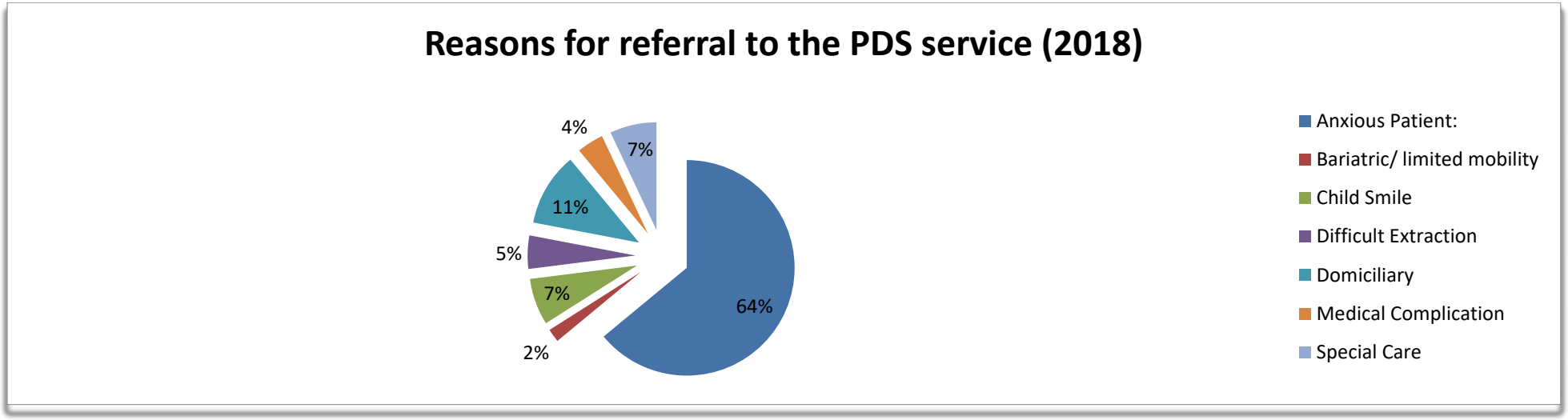


Table 19: Reasons for Referral to the Public Dental Service – January to December 2018

Reason for Referral:	**Anxious Patient:**	**Bariatric/ limited mobility**	**Child Smile**	**Difficult Extraction**	**Domiciliary**	**Medical Complication**	**Special Care**	**TOTAL:**
Number of patients:	105	3	11	8	18	6	11	162
% of total:	64%	2%	7%	5%	11%	4%	7%	100%

Data Source: Dental Services

16. Dietetic Services

The Dietetics Service is a community service but also covers hospital inpatients and paediatrics offering nutritional advice and support to those with complex diabetes, Irritable Bowel Syndrome and malnutrition. Presently, the Caithness dietetics team is made up from 1.0 WTE Band 7 Professional Lead and a 0.5 WTE Band 6. There is also a 0.6 WTE Band 6 based in Sutherland.

The Dietitians based in Caithness provide a cradle to grave service, covering Caithness and the North Coast area as far as Tongue. The Band 7 post provides professional leadership to the Dietitians, in addition to a clinical caseload. There is no Support Worker for Dietetics and presently there is no designated administration support. There is some support from medical records staff and the cash officer who complete the clinic letter dictations.

Caithness dietetics is currently working on a reduced referral criteria to manage the case load. Dietetic clinics are held in both Wick and Thurso – two per week in each locality. A Dietitian also attends the Multi-Disciplinary Team (MDT) Consultant led clinics for Diabetes – Adults (Face to Face clinics only) and Paediatrics. At present there is no capacity to see patients on the wards at Caithness General Hospital unless for urgent enteric feeding and staff are unable to attend ward MDT meetings due to workload pressures and the time that the meetings are held.

Challenges:

- Room availability and clinic space – there have been ongoing difficulties in obtaining room bookings in both Wick and Thurso. There is also no suitable NHS space in Thurso from which to deliver group work.
- Administrative Support – there has been no administrative support for dietetics since October 2018. The Dietitians now have to undertake all administration duties except dictation. This is equating to approximately 2 days per week to cover the basic requirements, thus reducing the clinical capacity of the service.
- Case Load Management: Due to ongoing pressure on the Dietetics service, there is limited capacity to meet all the demands of the service. This includes: limited capacity to see patients on the wards (support is provided, when necessary, via telephone); no capacity to deliver Health Promotion work; no capacity to attend Multi-Disciplinary Team meetings. Even with working on the reduced referral criteria the wait time for non urgent referrals is approximately 5 months. Urgent referrals are seen within 1-2 months.
- Clinic Bookings: Numerous requests have been submitted to eHealth to have TrakCare (PMS) implemented across Dietetics in Highland. At present the only Dietitians across NHSH who *do not* have their clinics on TrakCare are Caithness, Wester Ross and Lochaber.

Table 20: Total Dietetics Caseload (Caithness) on 1st March 2019

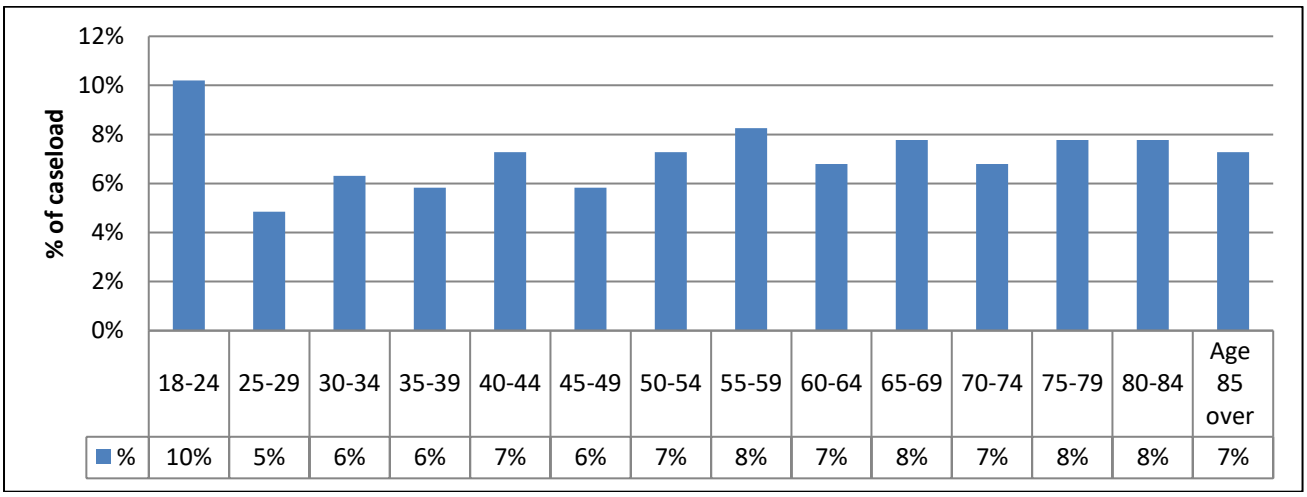
Overview – 2019 (as of 1st March 2019)	**Number:**
Current Caseload:	
Adults:	206 (74% of total caseload)
Paediatrics:	71 (26% of total caseload)
TOTAL:	277
Awaiting admission to caseload:	
Adults:	25
Paediatrics:	11
TOTAL:	36
Discharged:	
Adults:	38
Paediatrics:	6
TOTAL:	44

Data Source: Dietetics Service, Caithness

Adult Service:

Figure 21 shows the age range of the adult caseload. 52% of patients aged between 18 and 24 are supported due to a diagnosis of Type 1 Diabetes. This trend continues through the younger age ranges and support gradually shifts as people age to receiving support for nutrition.

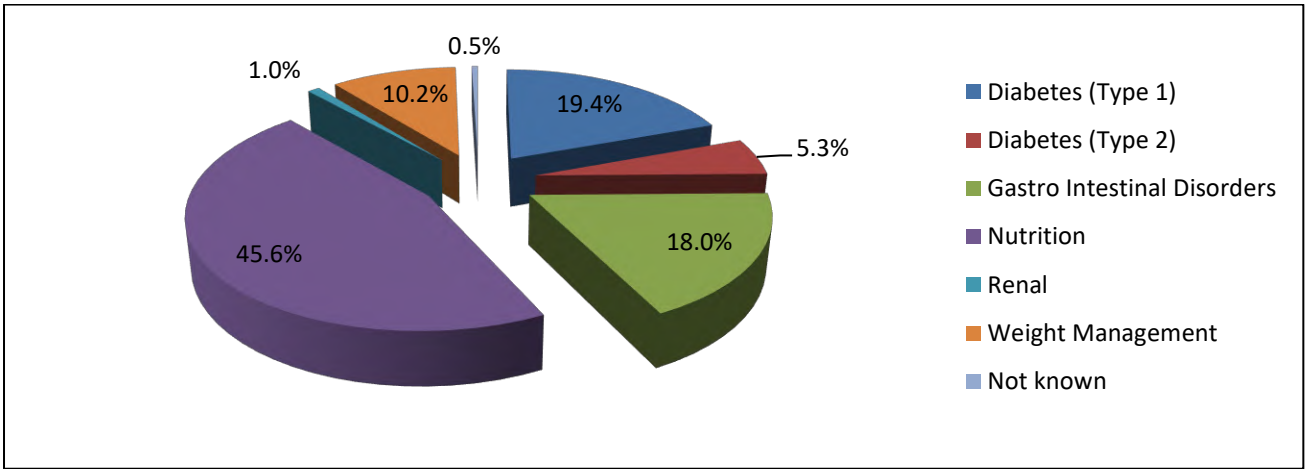
Figure 21: Adult Dietetics (Caithness) Caseload - Age Range



Data Source: Dietetics Service, Caithness

Figure 22 shows a breakdown of the conditions that Adult patients are being treated for. Over 45% of dietetic intervention is for Nutrition support, with 66% of patients in this category aged over 65 (100% of patients over 85 have been referred for Nutrition support). 18% of patients receive support for Gastro Intestinal Disorders, something which used to be managed by specialist teams based in Raigmore. This, combined with the complexity of conditions that many older patients are facing, is placing pressure on the Dietetics service.

Figure 22: Adult Dietetics Caseload - Condition

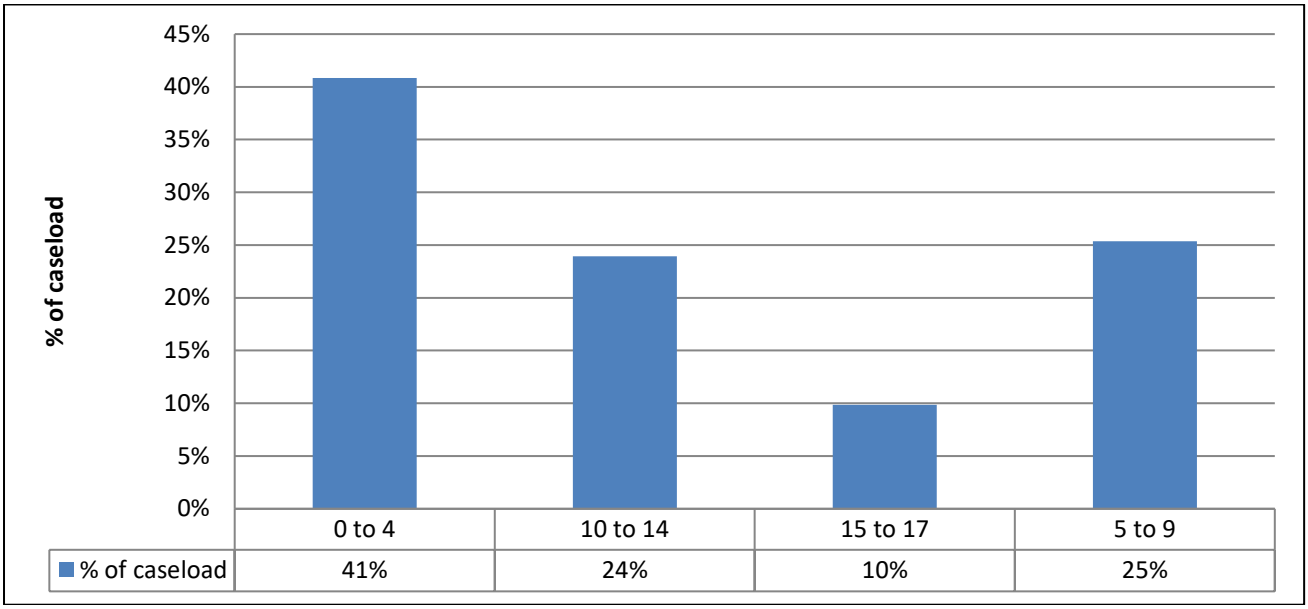


Data Source: Dietetics Service, Caithness

Paediatric Service:

Figure 23 gives a breakdown of the percentage of patients in each age range. The largest proportion of patients are aged 4 and under and 97% of patients in this age range have been referred for support with allergies and/or food intolerance.

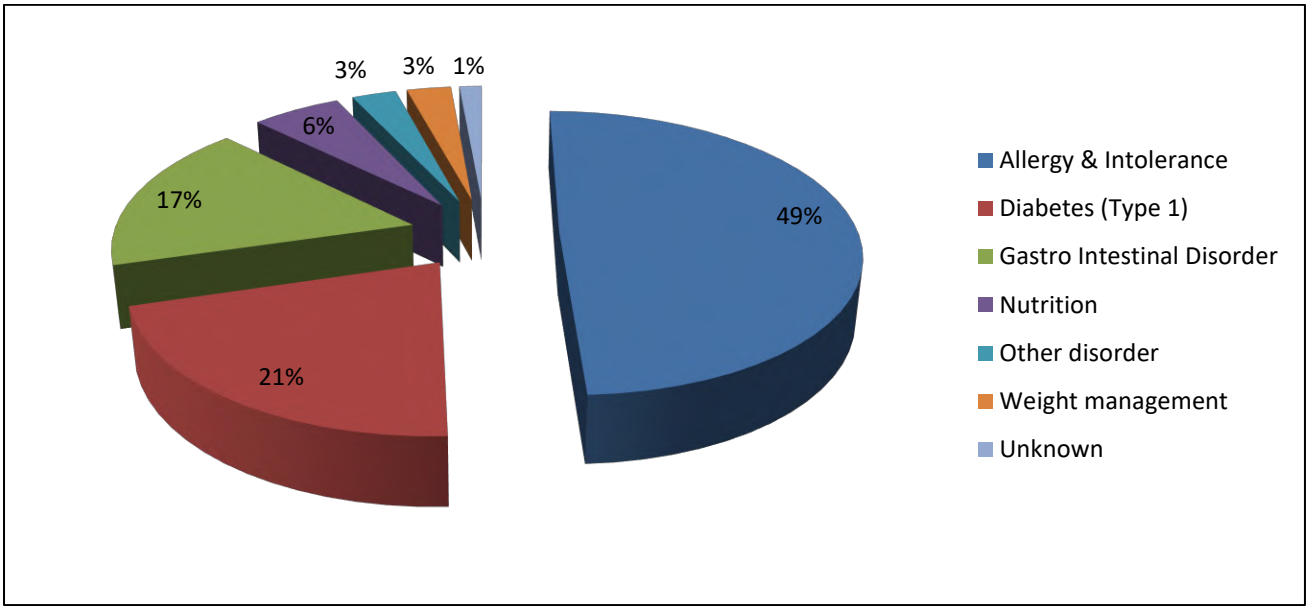
Figure 23: Age range of Paediatric Caseload



Data Source: Dietetics Service, Caithness

Figure 24 shows a breakdown of the conditions that Paediatric patients being supported with. The majority of patients under 9 (74%) are referred for support with allergies and intolerances, something which, until recently, was managed by a specialist team based in Raigmore. 21% of patients are referred for support following a diagnosis of Type 1 diabetes; 87% of these patients are aged between 10 and 17.

Figure 24: Paediatric Conditions



Data Source: Dietetics Service, Caithness

17. Emergency Department

The Emergency Department, Caithness General Hospital provides a 24 hour service for the initial evaluation, diagnosis, and treatment of any patient requiring urgent medical, surgical, obstetric, gynaecological or psychiatric care. The ED team also supports the resuscitation team within Caithness General Hospital and their colleagues in other areas of the hospital.

Challenges:

- The Emergency Department is cramped with a dysfunctional waiting area and insufficient treatment areas to cater for the increase in demand on the department. This has a consequent impact on the departments' ability to achieve the Scottish Government's four hour waiting target, reducing patient flow and placing staff under pressure. The insufficient waiting areas and treatment space affects patient privacy and dignity and also impacts on patient flow, causing delays in the assessment and treatment. In addition there is no WC within the department for patients/staff and current space does not meet recommended standards.
- The current sluice facilities require urgent upgrading and improving.
- The current staff base is inadequate, is not fit for purpose and is not compliant. At present, the Senior Charge Nurse Office doubles up as a staff coffee room and there are insufficient PCs for staff.
- The current reception area does not provide a 24/7 service and does not have sufficient workspace for the staff who have a dual role of reception support and clinical coding. The lack of 24/7 cover has a significant impact on patient flow and places staff under pressure.

Figures 25 and 26 indicate the trend in Emergency Department attendances at Caithness General Hospital since 2011. Figure 27 shows compliance with the 4 hour waiting time target.

Figure 25: Emergency Department Attendances since 2011 (Caithness Residents)

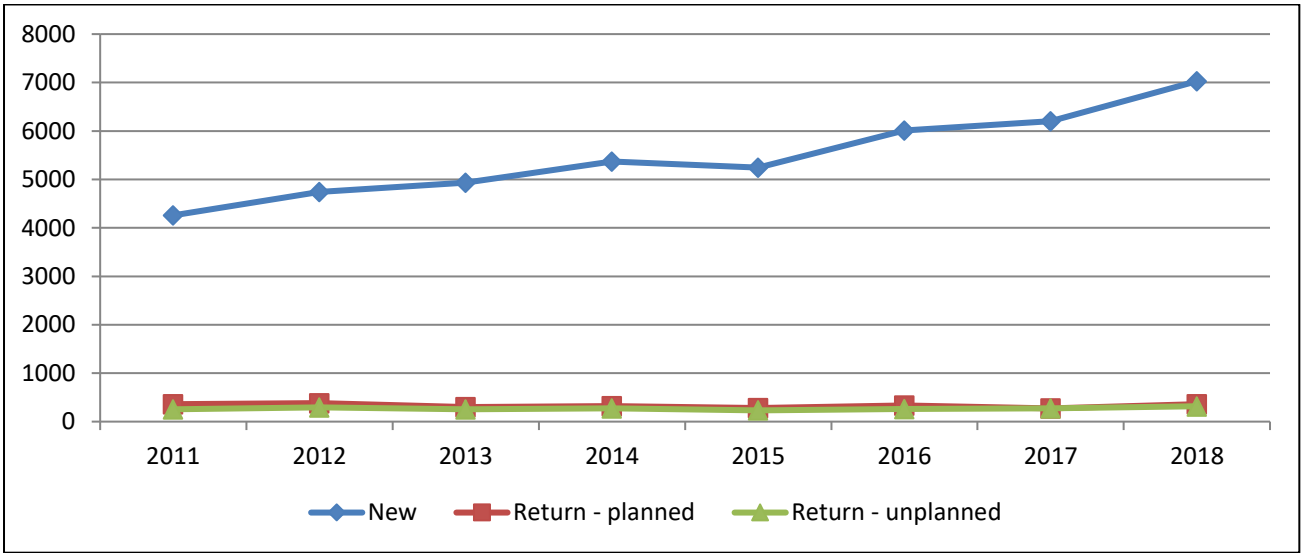
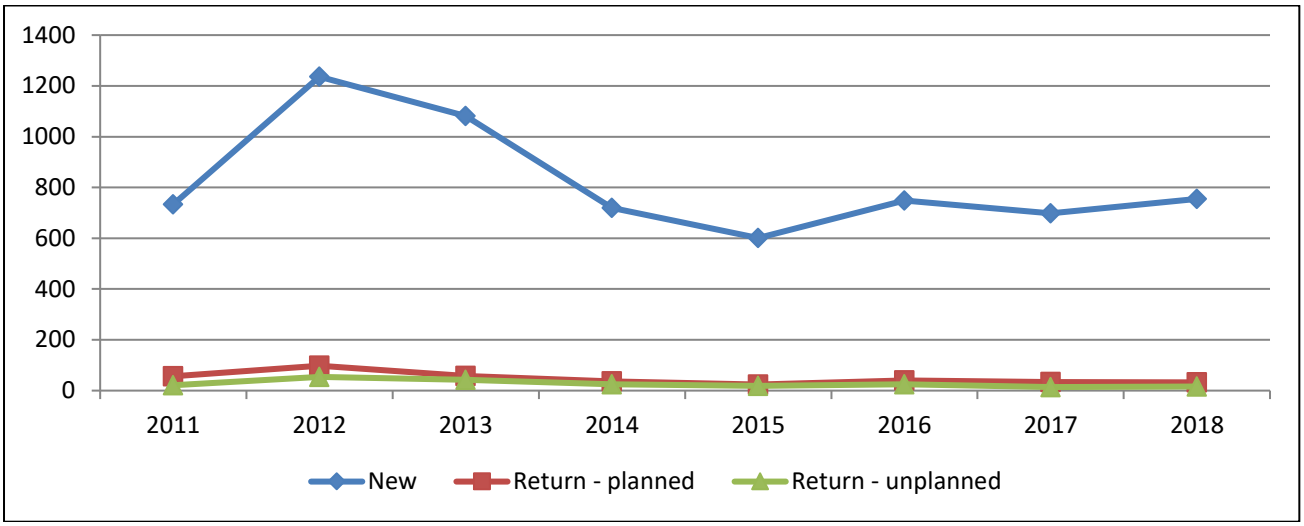
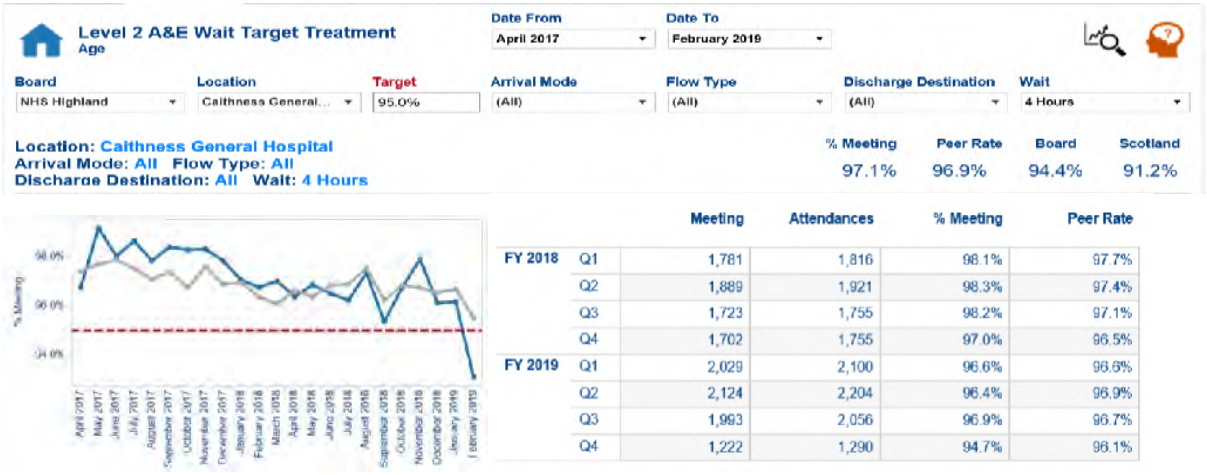


Figure 26: Emergency Department Attendances since 2011 (Non-Caithness Residents)



Data Source: ISD ACaDMe A+E Datamart

Figure 27: Emergency Department Compliance with 4-Hour Waiting Time Target



		Meeting	Attendances	% Meeting	Peer Rate
FY 2018	Q1	1,781	1,816	98.1%	97.7%
	Q2	1,889	1,921	98.3%	97.4%
	Q3	1,723	1,755	98.2%	97.1%
	Q4	1,702	1,755	97.0%	96.5%
FY 2019	Q1	2,029	2,100	96.6%	96.6%
	Q2	2,124	2,204	96.4%	96.9%
	Q3	1,993	2,056	96.9%	96.7%
	Q4	1,222	1,290	94.7%	96.1%

Data Source: Discovery

18. Estates Services

In Caithness, Estates Services employs nineteen people, all of whom are based at Caithness General Hospital. Four of the posts are Highland-wide posts, with all maintenance management and strategic Estates planning for NHS Highland controlled from Wick. The remainder of the Caithness based posts covers all facilities in Caithness, Sutherland and Easter Ross.

Challenges:

- NHS Highland operates from a number of buildings across the county, some owned by NHS Highland, while others are leased. The condition of some of the buildings mean that we need to look at what services can be provided from them now and in the near future.
- Staffing levels are currently what they should be. Consideration will need to be given to ongoing workforce planning to maintain an appropriate balance of skills and experience within the team, particularly given that several members of staff may retire within the next five to ten years.

- The Estates Service continues to remain largely within budget. However, budgets continue to decrease, whilst maintenance and repair demands increase.

19. Health Centres / GP Services

Around 90% of local NHS services that people use are what is termed as primary care e.g. provided from GP practice, dentistry or pharmacies.

There are seven GP Practices in Caithness, two in Thurso (Riverbank and Thurso and Halkirk Medical Practice (Princes Street)); two in Wick (Pearson Practice and Riverview). The others are Castletown & Canisbay, Lybster and Dunbeath.

Most GPs work as independent businesses with a contract with the Scottish Government. However, NHS boards have taken on the responsibility for some GP practices and these are termed as "salaried practices". Riverview, Riverbank and Lybster practices are run by NHS Highland as salaried practices.

Challenges:

- Ongoing recruitment and retention of GPs is continuing to put a strain on front-line primary care services, resulting in increased use of locums. This adds to the cost of providing services and can lead to an unavoidable lack of continuity of care for patients.

Data:

Table 20.details Caithness Primary Care practice list sizes by age range (as of 1st July 2019).

Table 21 Caithness Primary Care - Practice List Sizes (1st July 2019)

	Practice Type	Dispensing Practice?	Practice size (01/07/2019)	List size by age	0-4	%	5-14	%	15-24	%	25-44	%	45-64	%	65-74	%	75-84	%	85+	%
Canisbay & Castletown Joint Practice	17J	Yes	2,875		90	3%	304	11%	260	9%	537	19%	906	32%	467	16%	235	8%	76	3%
Dunbeath Surgery	17J	Yes	615		21	3%	46	7%	34	6%	87	14%	214	35%	126	20%	70	11%	17	3%
Lybster Medical Practice	2C	Yes	1,142		32	3%	117	10%	92	8%	185	16%	392	34%	198	17%	101	9%	25	2%
Riverbank Surgery	2C	No	5,491		261	5%	553	10%	486	9%	1,258	23%	1,598	29%	674	12%	492	9%	169	3%
Riverview Medical Practice	2C	No	7,482		357	5%	889	12%	804	11%	1,770	24%	2,148	29%	845	11%	510	7%	159	2%
The Pearson Practice	17J	No	2,211		112	5%	199	9%	214	10%	522	24%	686	31%	261	12%	165	7%	52	2%
Thurso & Halkirk Medical Practice	17J	Yes	6,095		275	5%	651	11%	607	10%	1,491	24%	1,856	30%	643	11%	416	7%	156	3%

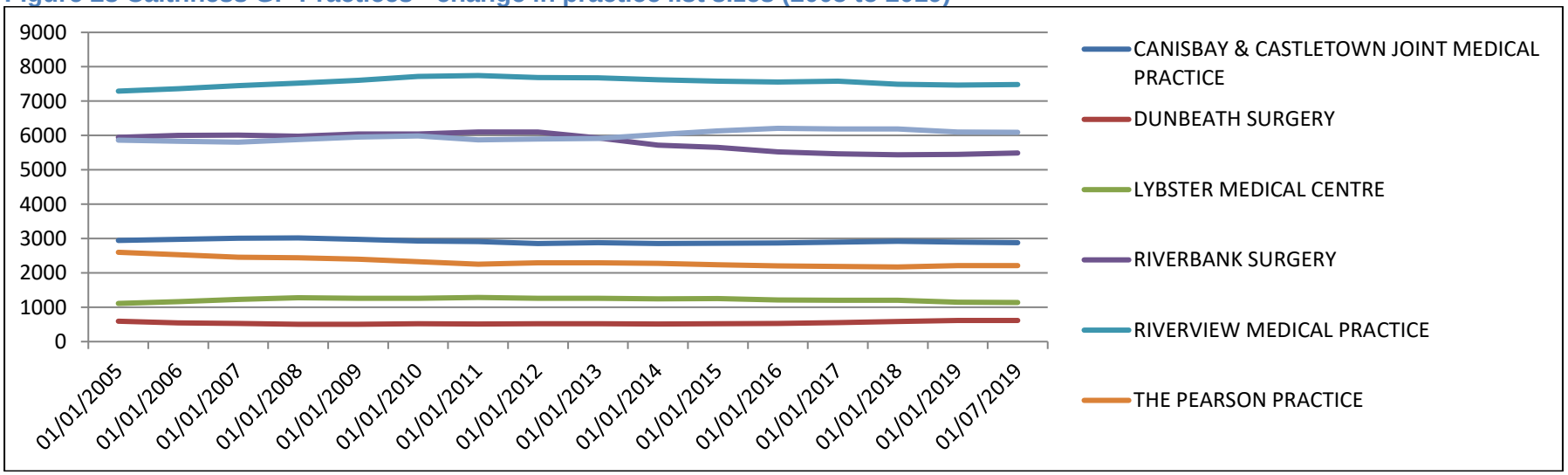
Data Source: ISD – GP Workforce and Practice Population: Practice Populations by gender and age group, 1st July 2019

Table 21 and Figure 28 evidence the change in Caithness Primary Care practice list sizes between 2005 and 2019.

Table 22 Caithness Primary Care - change in practice list sizes (2005 to 2019)

GP Practice	List size – 2005 (as at 1st January)	List size – 2019 (as at 1st July)	Difference (numerical)	% increase/ decrease
Canisbay & Castletown Joint Practice	2,943	2,875	-68	-2.3%
Dunbeath Surgery	595	615	20	3.4%
Lybster Medical Centre	1,111	1,142	31	2.8%
Riverbank Surgery	5,947	5,491	-456	-7.7%
Riverview Medical Practice	7,291	7,482	191	2.6%
The Pearson Practice	2,600	2,211	-389	-15.0%
Thurso & Halkirk Medical Practice	5,865	6,095	230	3.9%
Combined Caithness Practice Population	***26,352***	***25,911***	***-441***	***-1.7%***

Figure 28 Caithness GP Practices - change in practice list sizes (2005 to 2019)



Data Source: ISD GP Workforce and Practice Population: Historic List sizes (July 2019)

20. Health Improvement Advisor/Smoking Cessation Advisor

Smoking cessation clinics are held in GP surgeries, Caithness General Hospital, Dunbar Hospital (Outpatients), schools and workplaces (by invitation). Referrals are received from GPs, ward staff, midwives and Consultants although people can also self refer into the service.

Smoking Cessation Advice and support is available 09:00 to 17:00, Tuesday to Friday. Out with these times, support is available nationally through 'Quit Your Way Scotland', run by NHS 24. There are occasional evening group sessions and health improvement activities, such as walking groups, have been set up supporting Community Partnership outputs. Alcohol Brief Interventions are also undertaken within this service.

Having facilities within a community hub for group sessions and health improvement activities would make it easier for people to access the services and advice available.

No current or anticipated challenges have been identified.

The Scottish Government's vision is to have a 'smoke-free' Scotland by 2034. Previous HEAT targets have been replaced with a Local Delivery Standard of embedding and sustaining successful smoke quits for people residing in the 40% most deprived parts of Scotland. The most recent report (2017/18) shows a 'quit rate' of 22.1% at the three month follow up stage in the most deprived areas. This is against a target of 27%. Table 25 below shows that the 'quit rate' for Smoking Cessations Service (Caithness) was 51%.

Between 1st January and 31st December 2018, 165 referrals were received, with 67 having a quit date during this period. Please note that due to the way this data is recorded, quit dates may include repeat attempts for the same client.

Table 23 Age of clients referred to Smoking Cessation Service

	Number	Percentage
Under 16	0	0%
16-17	1	1%
18-24	9	5%
35-34	24	15%
35-44	30	18%
45-59	67	41%
60+	34	21%
Total:	165	100%

Table 24 Referral source

	Number	Percentage
Community	2	1%
GP	28	17%
Hospital	14	8%
Mental Health	6	4%
Midwife	13	8%
Pharmacist	2	1%
Practice Nurse	36	22%
Self-referral	59	36%

	Number	Percentage
Other	5	3%
Total:	165	100%

Table 25 Success rates at One Month Follow-up

Whether client smoked in the previous two weeks (self reported)	Male	Female	Total	%
Yes	2	1	3	4%
No	29	27	56	84%*
Lost to follow up	1	5	6	9%
Unknown	1	1	2	3%
	33	34	67	100%

***** 67% of these were confirmed by Carbon Monoxide testing

Table 26 Success rates at Three Month Follow-up

Whether client smoked since one month follow-up (self reported)	Male	Female	Total	%
Yes - between 1 & 5 cigarettes in total	0	0	0	0%
Yes - more than 5 cigarettes	2	4	6	9%
No	20	14	34	51%
Lost to follow up	1	5	6	9%
Unknown	10	11	21	31%
	33	34	67	100%

Data Source: NHS Smoking Cessation System

21. Heart Failure Service

The Heart failure Service is delivered locally by a part-time Heart Failure Nurse and aims to support and educate patients and carers living with heart failure in Caithness. Heart Failure accounts for around 5% of all unscheduled hospital admissions and is associated with a long length of stay (on average, 12 days). The Heart Failure Nurse is a key role in delivering physical and psychological therapies and the relationship with the patient is often a long-term one as heart failure is a complex, long-term syndrome. The key components of the service are:

- Regular contact with patients to detect deterioration of condition;
- Continued adjustment and maximum possible use of drug therapy;
- Teaching patients to monitor their weight and to detect early signs of salt and water retention;
- Teaching patients to adjust their medication according to symptoms (or making this adjustment for them);
- Monitoring blood chemistry and giving dietary advice;
- Encouraging drug and diet compliance;
- Acting as an intermediary between the patient and other health care professionals in both a GP and hospital setting;
- Providing education and training for other health care professionals (e.g. District Nurses and Practice Nurses) involving the care of patients with heart failure.

Challenges:

- The key challenge for the service is one of sustainability. The service is solely delivered by one part-time member of staff who also co-delivers the Cardiac Rehabilitation Service. Due to this, there is no cover for the staff member should they be off work on annual leave or sick leave. Patients are able to contact the Heart Failure Service in Raigmore should the local heart failure nurse be unavailable. There has also been a substantial increase in referrals to the service, having increased by 118% in the past year. In order for the service to remain viable, a WTE post needs to be created, possibly linked to the Cardiac Rehabilitation post so that staff members could cover each service should the need arise.
- At present, there are no staff members trained in Caithness to be able to perform Echocardiograms and staff have to travel from Inverness to carry out this test.

Table 27 Heart Failure Service - Referrals and Uptake (2018)

Age:	Total No. of Referrals:	Engaged with service	Did not engage	Unsuitable Referrals	% of uptake:
55-59	1	1	0	0	100%
60-64	0	0	0	0	N/A
65-69	2	2	0	0	100%
70-74	5	1	2 (1 died before being seen)	2	33%
75-79	7	2	0	5	100%
80-84	8	7	0	1	100%
85-89	5	5	0	0	100%
90-94	0	0	0	0	N/A
95-99	1	0	0	1	N/A
TOTAL:	**29**	**18**	**2**	**9**	**90%***

*Uptake was calculated by dividing the uptake by the number of suitable referrals.

Data Source: Mary Richard, Heart Failure & Cardiac Support Nurse

22. Hotel Services

Hotel Services includes: the provision of domestic services; laundry services for Caithness General Hospital, Dunbar Hospital and Town & County Hospital; catering services for patients and staff; and portering services.

Domestic services are provided to all NHS Highland premises in Caithness and Sutherland, ensuring a professional cleaning service to support patient flow; reduce the risk of healthcare associated infections; and comply with national cleaning specifications.

The portering staff are responsible for: the movement of patients throughout the hospital; collection and distribution of stores; waste management; mortuary duties; collection and distribution of linen; transport of food between Caithness General Hospital and Town and County Hospital; fortnightly transport service to Sutherland; community equipment delivery and collection; and a porter service to Town & Country and Dunbar Hospitals.

The department also manages the CABs booking system for the pool cars at Caithness General Hospital, including car maintenance requests, in addition to managing accommodation requirements for visiting staff. This includes the booking and invoicing, maintenance of properties, furniture and fittings, cleaning and laundry provision.

Challenges:

- Recruitment challenges exist across all disciplines, with the most challenging being cooks. This is not expected to improve.
- There are challenges around maintaining services in hospitals with low inpatient numbers (Dunbar Hospital and Town & County Hospital) while following NHS policy and remaining within budget.
- There is a lack of decontamination areas to clean equipment in all hospitals.
- Significant challenges exist within Caithness General Hospital:
    - Caithness General Hospital catering department is too large and costly to maintain and clean.
    - Waste storage facilities are inappropriate, particularly in relation to the storage of electrical waste.
    - The contaminated linen area requires larger entry and exit points.
    - The stores area is too small and this has become more challenging since Hotel Services was required to handle all stores for local NHSH Care Homes.

23. Human Resources Department

The Human Resources (HR) department based at Caithness General Hospital is part of the wider NHS Highland HR function and provides local Employment Services to the North Area. The team administers NHS Highland procedures to enable the efficient and effective delivery of recruitment and selection processes. The medical staffing function also supports recruitment of medical staff to the Area, including GP recruitment for salaried practices. Additionally the team supports management in delivery of the junior and senior medical rotas at Caithness General Hospital. There is also a Postgraduate Administrative function carried out in relation to supporting junior doctors who rotate from Aberdeen to Caithness General Hospital, and this role ensures that smooth transition for those doctors in training.

Challenges:

- The local HR department continues to provide local support as summarised above. There are challenges in recruiting the necessary skill-mix across disciplines, with consideration of alternative recruitment methods to progress with employing the preferred workforce.

24. Inpatients – Bignold Ward (Post Acute and Rehabilitation)

Bignold ward, Caithness General Hospital, is a 21 bed inpatient ward for post acute and rehabilitation patients (reduced from 22 beds in 2021). It caters for surgical, medical and rehabilitation step down inpatients from Rosebank wing and other hospitals within NHS Highland area. The ward also provides end of life care as required.

The nursing team works alongside the multidisciplinary team to provide rehabilitation and arrange social care in the community and long term care placements.

Challenges:

- Staffing – there are ongoing difficulties filling vacant nursing posts, resulting in a reliance on bank staff and the goodwill of substantive post holders to work additional hours. This is unsustainable in the long-term.
- Delayed discharges – the main challenge within Bignold is a lack of flow and delayed discharges, impacting on the whole hospital. The main reason is that there is an apparent lack of home care to support patients requiring three to four times a day care at home. There is also a shortage of beds for long term care, resulting in patients staying in hospital for longer than they need to.

NB: Turnover = average ward admissions per bed per day

Table 28 Bignold Ward – Occupancy Rates

Bignold	2015	2016	2017	2018	2019
# Beds/Day	21	19	23	22	22
# Ward Stays	5265	2678	1869	1449	360
Total Length of Stay	5464	5475	7552	7140	7985
Occupancy	71.3%	78.7%	90.0%	88.9%	99.9%
Turnover	0.6869	0.3851	0.2226	0.1804	0.1818

25. Inpatients – Rosebank Ward

Rosebank Ward, Caithness General Hospital, is a 17-bed inpatient ward and 3 High Dependency Bed Unit receiving all medical and surgical acute admissions and GP referrals.

Challenges:

- Rosebank Ward faces significant challenges around bed availability in the ward; the main reason for this is due to a lack of available beds in the Bignold Ward for patients to 'step down' to. This in turn places the ward under pressure resulting in a lack of patient flow and prevents patients being moved from Accident and Emergency in a timely manner.

NB: Turnover = average ward admissions per bed per day

Table 29 Rosebank - Occupancy Rates

Rosebank	2015	2016	2017	2018	2019
# Beds/Day	20	17	17	17	17
# Ward Stays	2550	2709	5254	4904	1233
Total Length of Stay	3187	2638	3984	4091	4765
Occupancy	43.7%	42.4%	64.2%	65.9%	88.9%
Turnover	0.3493	0.4354	0.8467	0.7903	0.8059

26. Integrated Teams

Caithness has two "Integrated Teams" which include community nursing, community mental health, learning disabilities, physiotherapy, podiatry, occupational therapy, and social work. The teams are split along geographical lines with the East Caithness Integrated Team based in Wick and the West Caithness Integrated Team based in Thurso.

The specific services within the teams are covered elsewhere in the document.

27. Laboratory Services

The laboratory service provides a 24/7 service to Caithness General Hospital and an in-hour service to GP practices.

Challenges:

- The recruitment and retention of staff is a significant challenge: there are currently three locum biomedical scientists employed to cover vacancies and maternity leave.
- The on call system is onerous and compensatory rest impacts on the in-hours service. Staff participating in the on call rota are required to be competent in all elements of the laboratory service e.g. biochemistry, haematology and transfusion. A one in four rota is required to cover the existing service. However, due to staffing, this often drops to one in two, which impacts on

the in-hours service as staff are required to take compensatory rest. The introduction of Point of Care Testing service (POCT) will greatly reduce the number of call outs.

- The footprint/layout of the laboratory department is restrictive and impedes the flow/efficiency within the department.

Data:

Table 30 Rural General Hospital - Laboratory Services outputs (2017-2018)*

*No data is available from the ISD Cost Book for the Western Isles Hospital

Hospital	Clinical Chemistry				Haematology				Total Expenditure
	Expenditure	Tests	Cost per Test		Expenditure	Specimens	Cost per Specimen		
	£000		£	Group Index	£000		£	Group Index	£000
Balfour Hospital, NHS Orkney	600	285,459	2.10	256	219	28,486	7.70	141	1,024
Belford Hospital, NHS Highland	273	260,743	1.05	128	201	188,829	1.06	20	474
Caithness General Hospital, NHS Highland	360	50,173	7.17	875	417	31,564	13.20	242	776
Gilbert Bain Hospital, NHS Shetland	596	107,112	5.56	679	533	29,851	17.84	327	1,437
Lorn and Islands, NHS Highland	776	-	-	-	510	-	-	-	1,680

Data Source: ISD Cost Book – Laboratory Services 2017-18 (R130)

28. Medical Record Department

The Medical Records Department provides services across several sites in Caithness, primarily Caithness General Hospital, the Dunbar Hospital and the Old Medical Centre, Wick. The team manages the administration of the patient journey from initial referral to appointment booking, clinic preparation, reception, waiting list and inpatient stay. The department also provides accurate clinical coding following discharge, to support NHS Highland Information systems. This in turn supports local clinical and business decision-making and feeds the national database.

Challenges:

- Access to medical records is required 24/7 and records are currently filed in several storage areas due to restrictions in space. The anticipated area required to allow all records to be stored together is approximately 120 m^2 (current – 103 m^2). It is essential that this area is adjacent to the telephonist / receptionist in the main reception area of Caithness General Hospital. In addition, the alarm panels (fire, gases etc) need to be located here.
- Due to the uncertainty of future plans, planning staffing and work can be challenging.

29. Adult Mental Health Services

The Community Mental Health Team (CMHT) is a multi disciplinary team providing community based support for adults of all ages experiencing moderate to severe mental health concerns or for any adult concerned about their use of substances. The four distinct service areas are general adult; older adult; alcohol and drug recovery services; and psychological services; which includes cognitive behavioral therapy and guided self help.

The CMHT is available Monday to Friday from 9:00am until 5:00pm, with a local on-call service on Wednesdays and Thursdays from 5:00pm until 9:00am for place of safety and escort service to New Craigs Hospital, Inverness. Out with these times, the service is provided by the Mental Health Assessment Team at New Craigs Hospital, who also provides Caithness with weekend provision. The Caithness and Sutherland Drug and Alcohol Recovery Service run a drop-in service in Caithness General Hospital every Monday evening between 18:00 and 20:00 (excluding first Monday in month and Bank Holidays).

A number of Third Sector organisations provide local support for people with mental health concerns. Caithness Mental Health Support Group is a registered charity commissioned by NHS Highland to provide support for people with mental health conditions. The facilities are based in the Haven, Wick and Stepping Stones, Thurso, employing 20 staff across both sites. Birchwood Highland is also a registered charity commissioned by NHS Highland to provide support workers to increase individuals' capacity to live independently and to feel fully included in the community.

Challenges:

- The CMHT is based in the Old Medical Centre, Caithness General Hospital, Wick and the Old Outpatient building, Dunbar Hospital, Thurso. Both buildings are old, unfit for purpose and lack adequate and sufficient clinical space and related facilities. Treatment is frequently delivered in a group setting in addition to or instead of 1:1 intervention. There is no dedicated appropriate space readily available to undertake clinical groups resulting in frequent additional costs of hiring venues. In addition the buildings are not suitable for wheelchair users. Due to the layout of the buildings and the nature of some of the work, there are concerns about staff and patient safety and this is something that must be addressed when planning for the future.
- There are no current vacancies within the team. However, there are concerns about the increasing demands of the service on staff and ongoing challenges in recruiting into a specialised area when vacancies do arise. A more sustainable model of care and staffing is required in order to mitigate this.

- Increasing demands from the Scottish Government can be difficult to deliver, particularly in a remote and rural setting and without access to technology which enables easy collection and analysis of both baseline and outcome measures.
- There is a requirement to manage expectations from: patients; their families; GPs; other health professionals. This can be challenging, particularly given the significant year-on-year increase in demand on all services with limited staff and budgets. There are limited local services available for people experiencing milder symptoms of mental illness or acute distress.
- There is evidenced need for preventative work focusing on mental health improvement, health inequalities and problem drug and alcohol use. The CMHT are well placed to deliver this. However, due to the aforementioned demands on the service, this is not possible and the priority focus remains on treatment rather than prevention.
- Some services, particularly the personality disorder service, are unavailable in Caithness and people have to travel to Inverness to access these. Public transport is inadequate and people are unable to travel to Inverness, access treatment and return within the one day, unless they have access to a car.

Figure 29: Caithness Adult Mental Health Service - Referrals (2018-19)

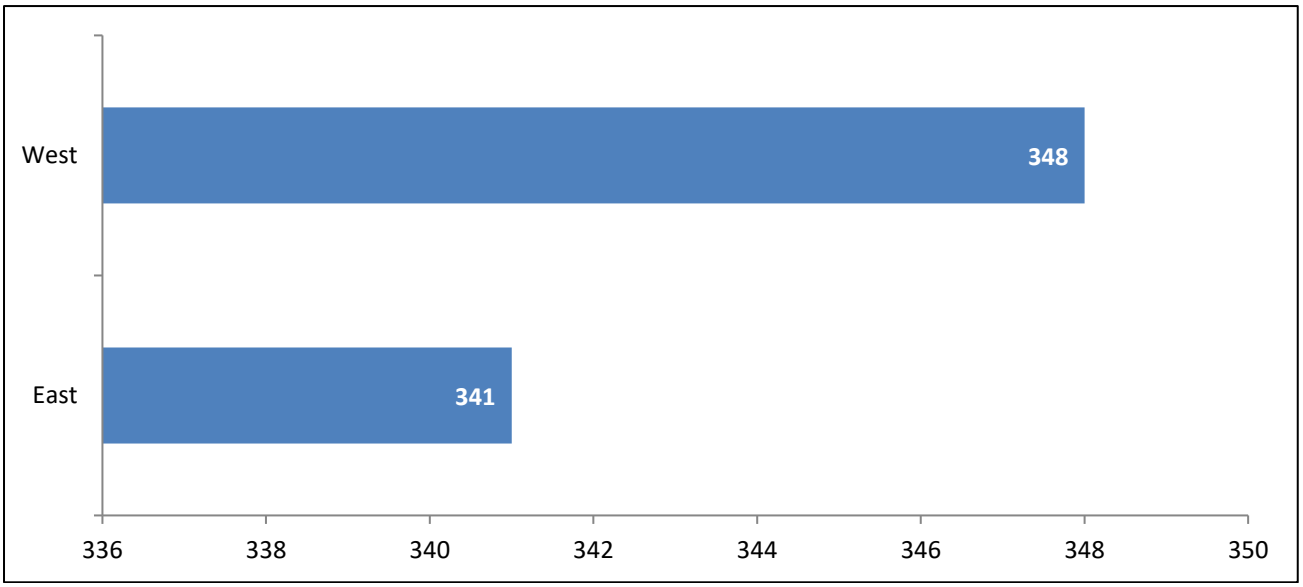


Figure 30: Adult Mental Health Service – Service Demand (2016 to 2019)

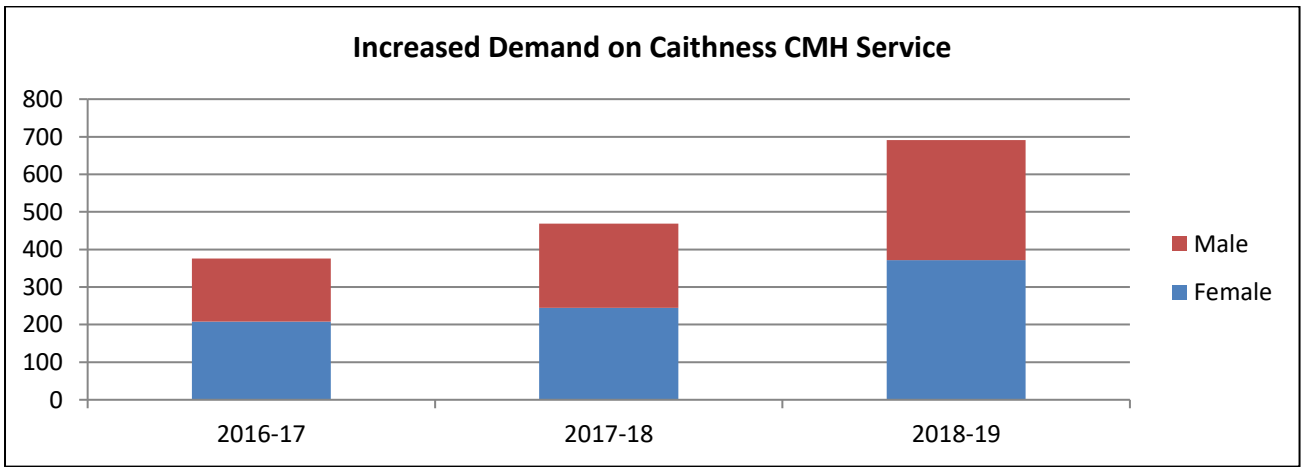


Figure 31: Adult Mental Health Service - Initial Referral Reason, 2018 - 2019

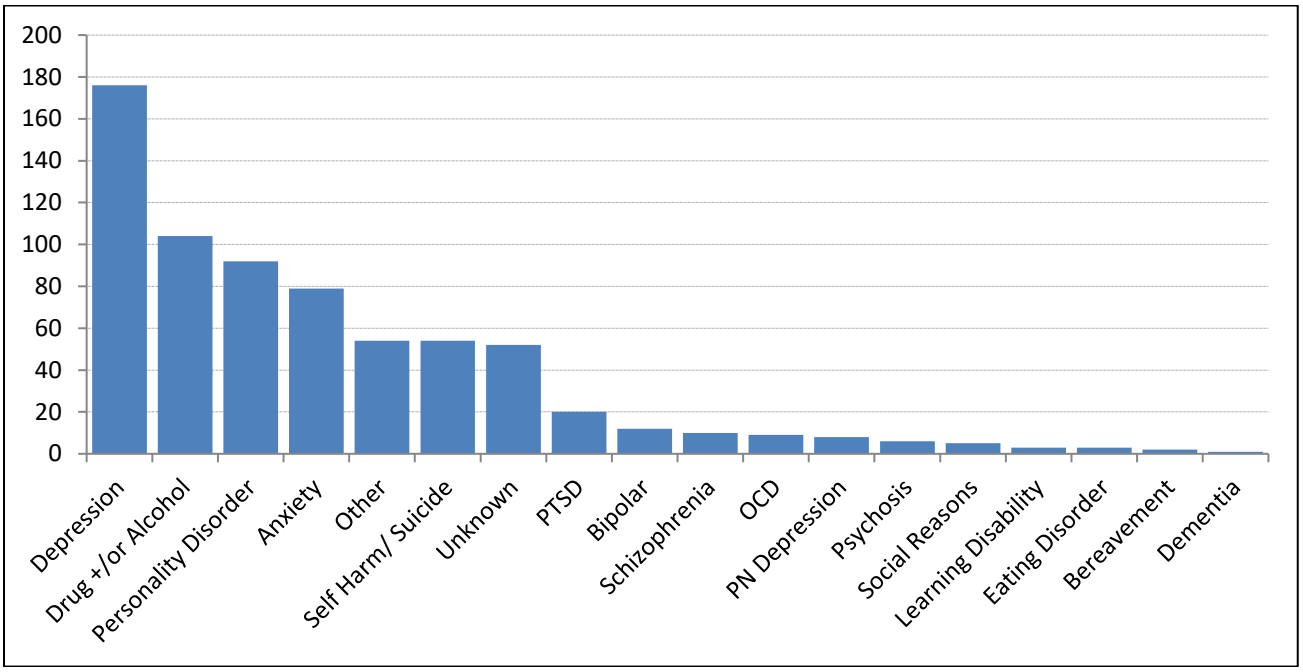
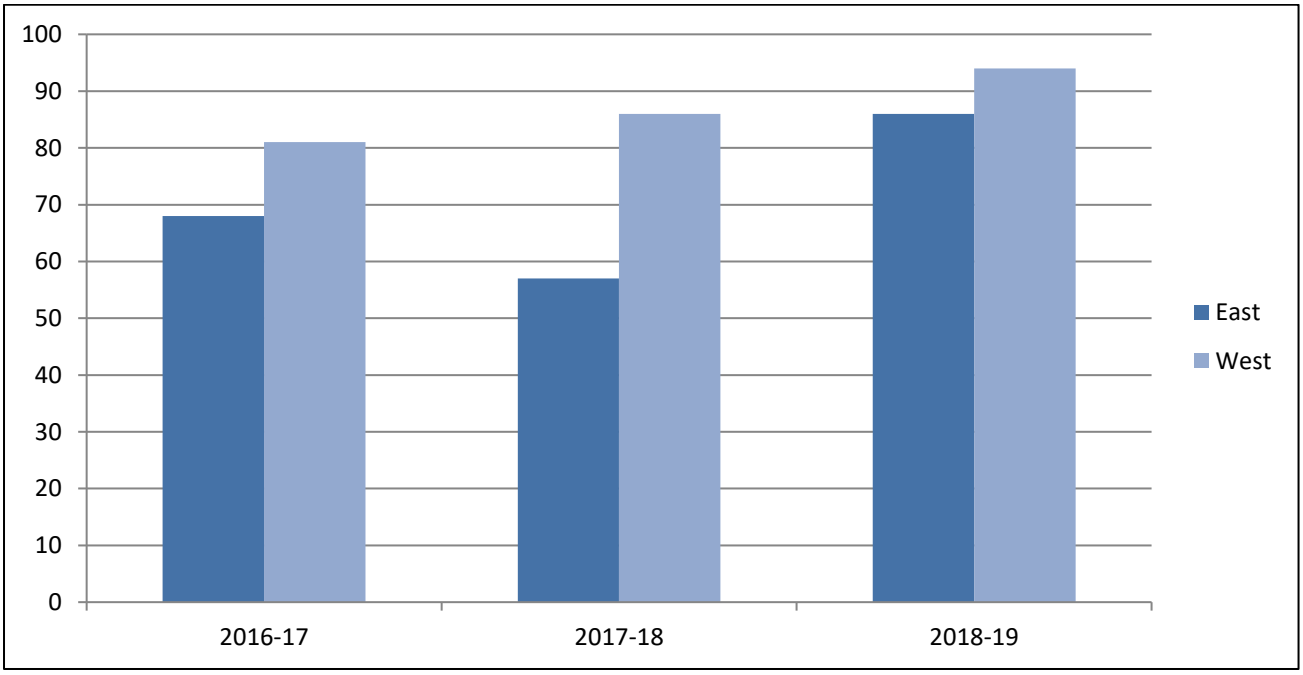


Figure 32: Adult Mental Health Service – Older Adult Demand



Data Source: Community Mental Health Team

30. Mortuary Services

There is a requirement to provide 24/7 mortuary services for Caithness General Hospital, Police Scotland and post mortem transfers, holding bodies if there are delays in funeral arrangements. Mortuary facilities/fridge, powered trolley and a viewing area are available.

Challenges:

- The current equipment was installed thirty-two years ago, comprising six fridge spaces. The fridge cabinet does not meet modern mortuary standards and is no longer fit for purpose. Additional challenges include:
    - No bariatric storage facility;
    - No freezer capacity;
    - Inappropriate waiting area and viewing room;
    - No CCTV;
    - No electronic computing system;
    - No Mortuary Attendant staff.

- Further work is required to realign the body removal entry/ exit from its current location beside the main store area. This is inappropriate and does not provide the necessary privacy.

Due to a lack of a suitable database/ tracking system for the mortuary, there is only very basic data available, which records the number of patients whose bodies have been stored in the mortuary. There is insufficient information available to work out the 'occupancy rate' of the mortuary (i.e. how many spaces are utilized on a daily basis). Moving forward, this is something that will need to be developed enable effective planning and to give an accurate record of the demand for the service.

Table 31: Number of Mortuary Spaces utilised per month (June 2018 to June 2019)

Month	June 2018	July 2018	Aug. 2018	Sept. 2018	Oct. 2018	Nov. 2018	Dec. 2018	Jan. 2019	Feb. 2019	March 2019	April 2019	May 2019	June 2019
Number	19	7	14	6	7	10	10	18	8	3	3	4	3

Data source: Hotel Services

31. Occupational Therapy Services

Occupational Therapy (OT) offers a wide range of services to in-patients, out-patients and those in the community. The remit of OT is to enable people to maintain their independence and/or reach their maximum level of potential in activities of daily living, through specialist assessment and treatment programmes. They work as part of the Integrated Team to prevent admissions to hospital and are integral in keeping people in the community, as well as managing safe discharge home following admission.

Occupational Therapists are specialists in assessing and treating people with a variety of conditions including: elderly care; stroke; musculoskeletal problems; long term conditions; and palliative treatment. The OT service also provides a specialist service for:

- housing adaptations and provision of essential equipment;
- hand therapy and splinting;
- enabling (reablement) service both in hospital and community.

Challenges:

- As the culture of care changes and the emphasis on anticipatory care is enhanced, it is expected to be more challenging to meet those needs whilst continuing to provide the

services we currently offer. Demand for existing services is not expected to reduce and the remote and rural setting adds to the challenge of meeting demand and expectations.

- Flexible working patterns would allow for a greater spread of service and realistic care – this is challenging at present.
- There are significant challenges with electronic patient record systems (Care First) within Community OT services. Care First is primarily a Social Work system that was migrated across following integration of NHS & Highland Council Adult Services. This system does not 'communicate' with the rest of the Integrated Team or hospital systems and as a result, patient records are incomplete. This can cause significant issues with workload (e.g. unnecessary work being carried out when a Community OT patient has been admitted to hospital) and patient care (e.g. clinical staff are unaware of the patient's complete care and/or medical record).
  There are also issues with Care First Licenses; due to cost implications, not all community staff are granted access to the system, with the burden of updating patient records becoming the responsibility of the senior member of staff. This is not a good use of staff time or budget.

Data:
Table 31 shows a breakdown of referrals and first appointments (Hospital Occupational Therapy) between October 2016 and October 2017. Due to a change of recording, there is no electronic data available after October 2017.

Table 32: Hospital Based Occupational Therapy Referrals and First Appointments (October 2016 to October 2017)

No. of referrals	Oct. 2016	Nov. 2016	Dec. 2016	Jan. 2017	Feb. 2017	Mar. 2017	Apr. 2017	May 2017	June 2017	July 2017	Aug. 2017	Sept. 2017	Oct. 2017	TOTAL:
Adult	30	31	41	31	39	27	35	34	39	28	31	34	33	**433**
Child	-	-	-	1	-	-	-	-	-	1	-	-	-	**2**
TOTAL:	30	31	41	32	39	27	35	34	39	29	31	34	33	**435**
No. of first appointments														
Adult	32	27	43	33	37	26	34	37	39	29	32	34	32	**435**
Child	-	-	-	1	-	-	-	-	-	1	-	-	-	**2**
TOTAL:	**32**	**27**	**43**	**34**	**37**	**26**	**34**	**37**	**39**	**30**	**32**	**34**	**32**	**437**

Data Source: AWT, NHS Highland

Table 33: Overview of West Caithness Community Occupational Therapy Caseload (as of 29th July 2019)

	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 & over	Not known	TOTAL:
Current caseload:	3	3	3	2	3	4	6	7	12	9	9	10	18	23	0	**112**
Awaiting admission to caseload:	1	2	1	0	2	4	2	4	2	2	6	4	5	6	0	**41**
Discharged:	1	0	1	4	4	3	6	9	8	11	11	7	26	22	1	**114**
TOTAL:	**5**	**5**	**5**	**6**	**9**	**11**	**14**	**20**	**22**	**22**	**26**	**21**	**49**	**51**	**1**	**267**

Data Source: West Caithness Community Occupational Therapy Team

Table 34: Overview of the East Caithness Community Occupational Therapy Caseload (as of 28th August 2019).*

*Discharges are calculated on the number of patients who have been discharged from the caseload between the 1st January 2019 and 28th August 2019.

	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 & over	TOTAL:
Current caseload:	0	2	3	3	0	1	3	4	4	1	8	8	6	4	47
Awaiting admission to caseload:	0	0	1	2	1	1	1	4	0	2	2	4	5	2	25
Discharged:	1	0	1	1	2	4	3	2	6	5	12	6	12	10	65
TOTAL:	1	2	5	6	3	6	7	10	10	8	22	18	23	16	137

Data Source: East Caithness Community Occupational Therapy Team

32. Out of Hours Service

The Caithness Out Of Hours (OOH) service is provided by Ash Locums 18.00 – 8.00 seven days a week. The weekend service is provided 8.00 – 18.00 by local GPs as sessional locums. The evening OOH GP is based in Wick and the Primary Care Emergency Centre (PCEC) is in Caithness General Hospital. The Dunbar Hospital has a PCEC which is nurse led and caters for the West Caithness population.

The existing OOH service will move to a multi-disciplinary model which covers the North Coast area as far as Tongue in the near future, following extensive co-design with the community. This service will work out of the Dunbar Hub and will be staffed by Advanced Nurse Practitioners (ANPs) with clinical support from the OOH GP based in Wick. The development of the Dunbar ANP service will support the development of the 24/7 responder model and provide medical cover for the community and palliative care beds in the care hubs.

The new model of service will be fully integrated including input from GPs, Allied Health Professionals and nursing staff and will be supplemented by paramedics and unscheduled care nurses.

Challenges:

- Key challenges relate to our ability to recruit, train and retain advanced nursing and paramedical staff within the timescales required. We must balance the difficulties relating to low activity and antisocial working, and design mixed roles that work across daytime and out of hours settings and across organisational boundaries.

Figure 33: OOH Primary Care - Activity (January 2014 to March 2019)

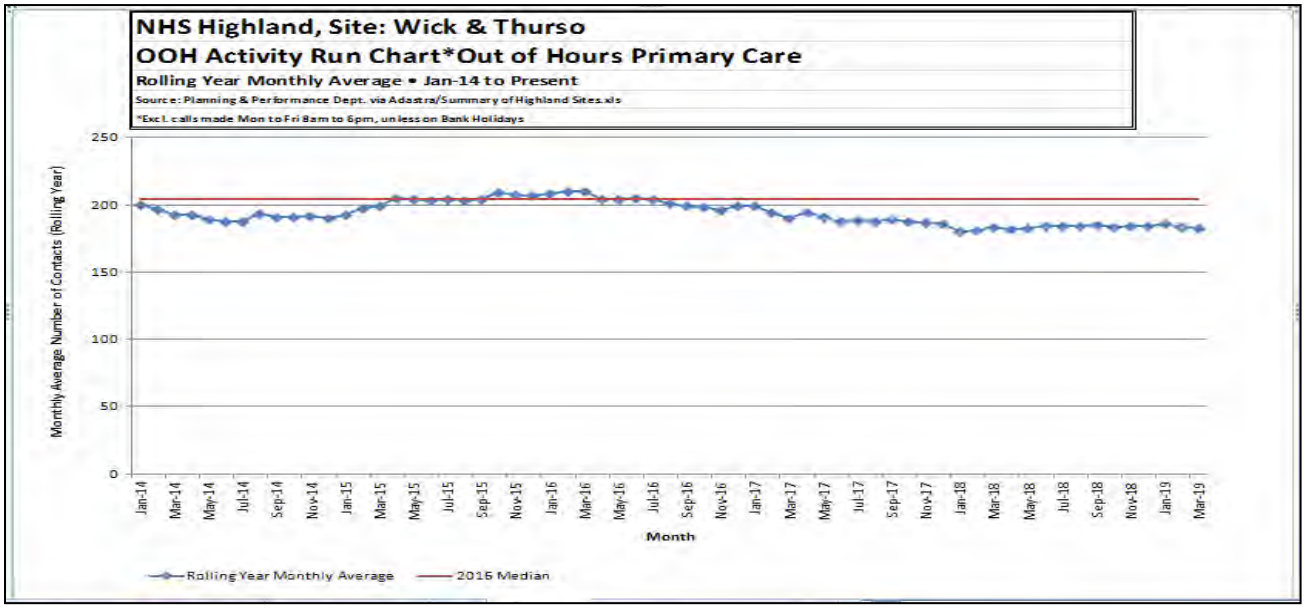


Figure 34: OOH Emergency Department/ Minor Injuries Unit Activity (January 2014 to March 2019)

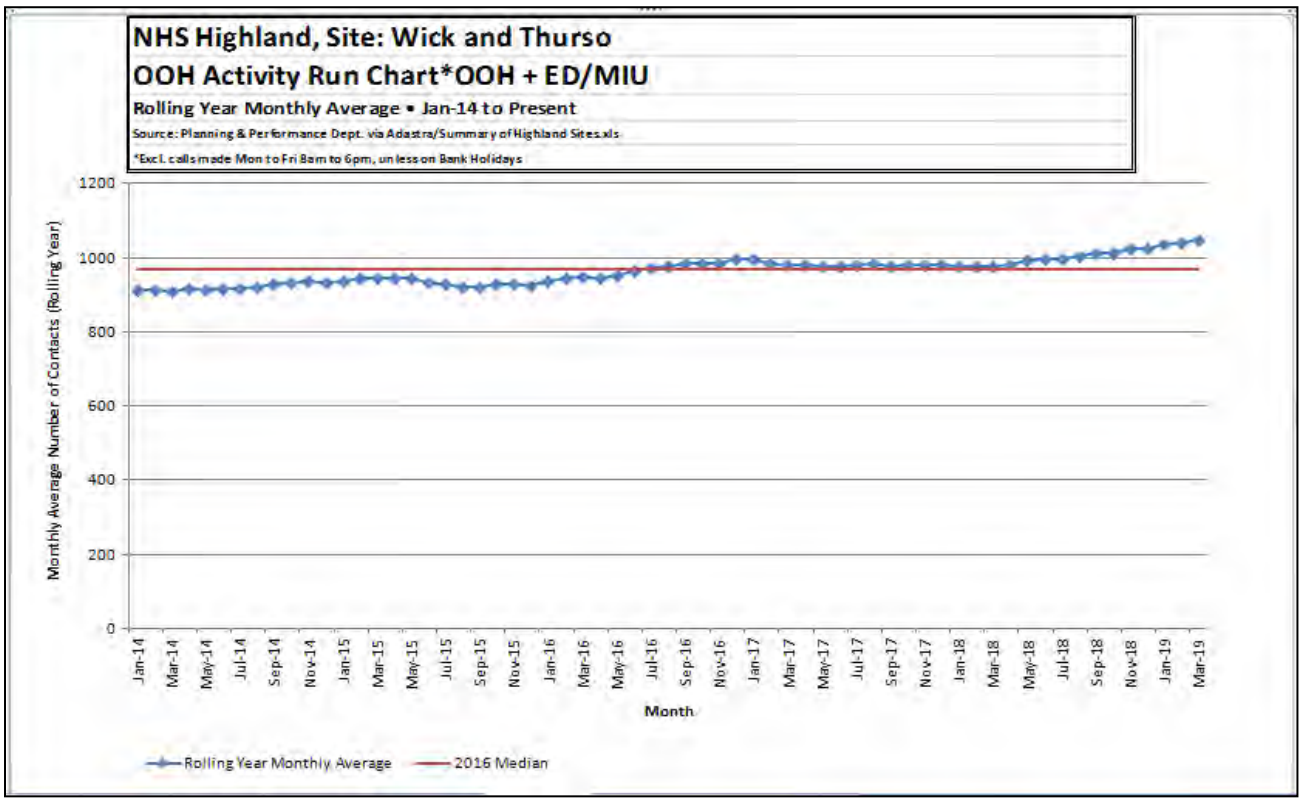
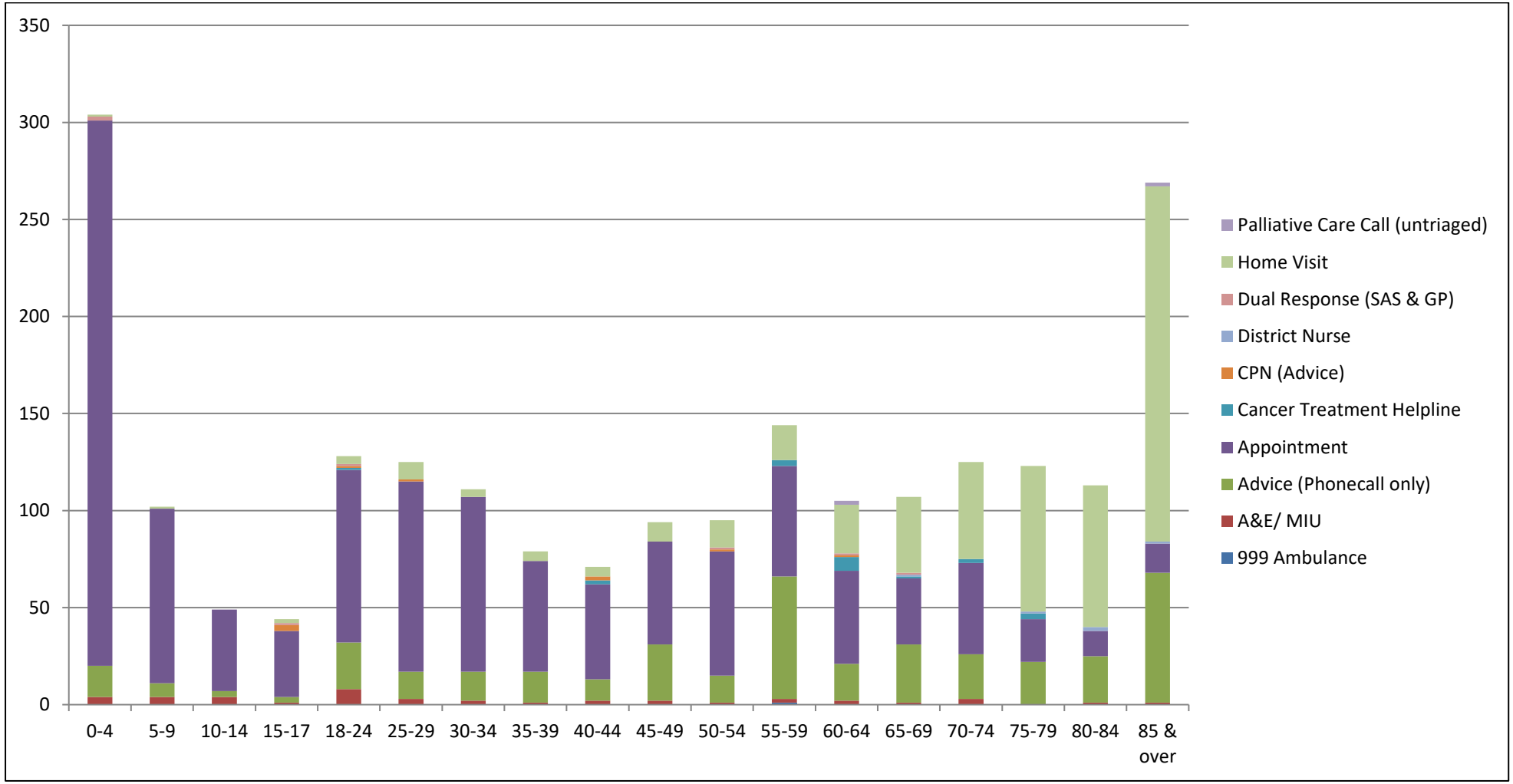


Table 35: Breakdown of Caithness OOH Contacts by Location - April 2018 to March 2019

	Thurso	Wick	Total
999 Ambulance	1	0	1
A&E/MIU	30	12	42
Advice	106	294	400
Appointment	552	631	1183
Cancer Treatment Helpline	11	8	19
CPN (Advice)	1	8	9
District Nurse	3	2	5
Dual Response (SAS & GP)	0	7	7
Home Visit	150	368	518
Palliative Care Call (Un-triaged)	2	2	4
Total:	**856**	**1332**	**2188**

Figure 35: Age Range and Type of Contact - Out of Hours contacts (1st April 2018 and 31st March 2019)



33. Outpatients Department

The Outpatients Department, Caithness General Hospital provides a five day a week service, Monday to Friday with evening sessions for family planning and sexual health clinics. There are five consulting rooms and an audiology room within the department which offers a wide range of outpatient services, treatment and procedures either by medical, nursing or Allied Health Professional staff.

The Outpatients Department, Dunbar Hospital, Thurso provides a five day a week service, Monday to Friday. There are four consulting rooms and one treatment room within the department, providing a wide range of outpatient services.

Challenges:

- The current space (Caithness General Hospital) is no longer fit for purpose and the consulting rooms do not meet modern healthcare standards.
- There is no capacity to accommodate the visiting consultant clinics resulting in an increase in the number of people travelling out with the area.
- Near Me Clinics have been successfully introduced within Caithness General Hospital and will be further developed within the Caithness Redesign Program. The Outpatients Department requires to be relocated to the vicinity of the NHS Near Me clinic rooms to enable the redesign of the emergency department and allow an increase in the number of consulting rooms to accommodate the increased demand.

Figure 36: Outpatient Appointments (excludes NHS Near Me) - Caithness Residents - Locations out with Caithness/ Sutherland

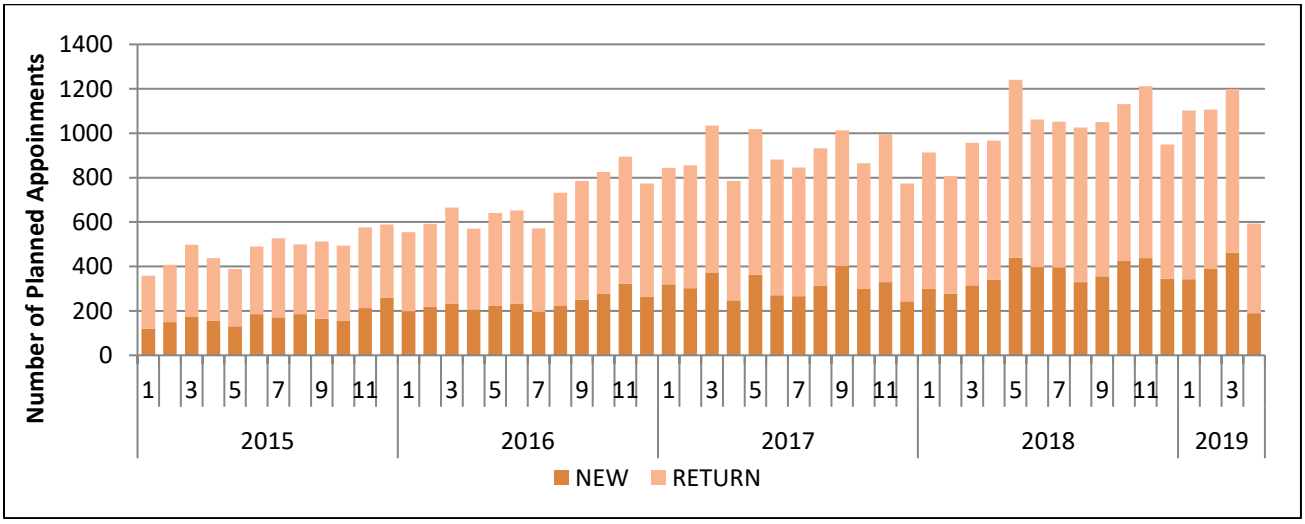


Figure 37: Outpatient Appointments (excludes NHS Near Me) - Caithness Residents - Caithness/ Sutherland Locations

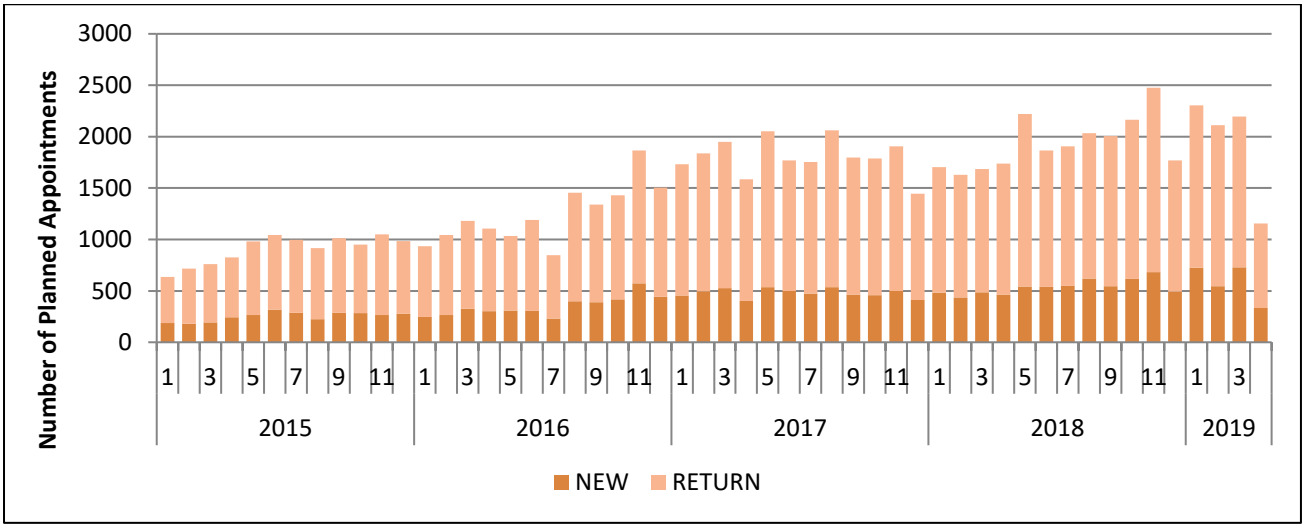


Figure 38: NHS Near Me Appointments - Caithness Residents

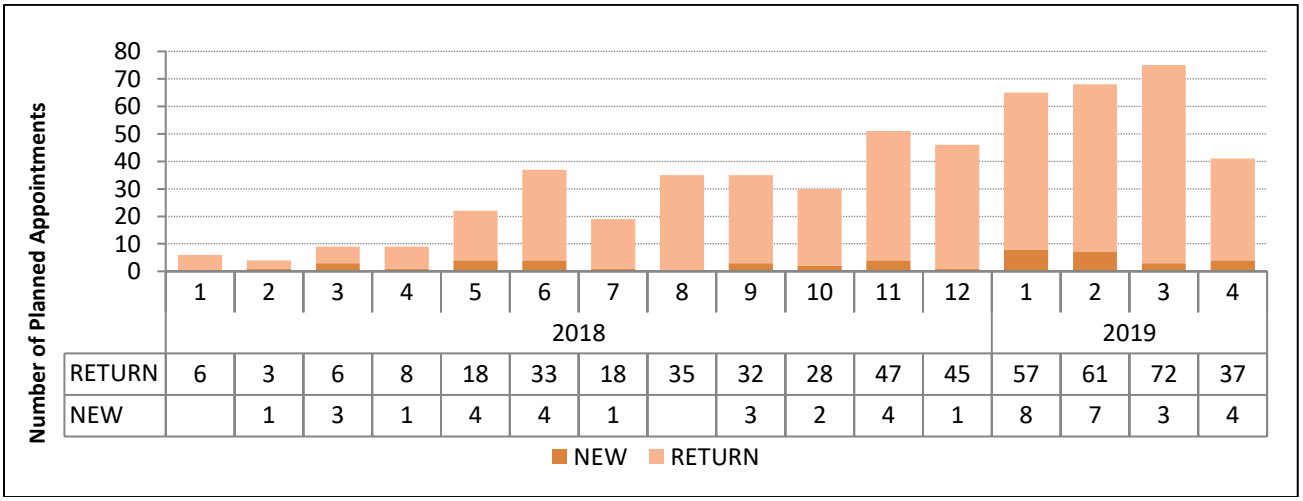


Table 36: NHS Near Me - by Speciality and Type

Clinician Type	Outpatient Speciality	Total Appointments
Consultant	Haematology	150
	Respiratory Medicine	93
	Rehab Medicine	42
	Gastroenterology	19
	Oncology	18
	General Psychiatry	11
	Community Paediatrics	10
	Neurology	7
	Renal Medicine Nephrology	7
	Medical	5
	Obstetrics Antenatal	5
	Colorectal	3
	Dermatology	3

Clinician Type	Outpatient Speciality	Total Appointments
	Diabetes	2
Consultant Total:		**375**
Psychologist	Psychological Services	8
	Clinical Psychology	1
Psychologist Total:		**9**
Registered Nurse	Respiratory Medicine	46
	Sleep Apnoea	45
	Cardiology	20
	Gastroenterology	18
	Dermatology	17
	Rheumatology	16
	Haematology	5
	Medical	1
Registered Nurse Total:		**168**
TOTAL:		**552**

Table 37: Top 15 (93%) Specialities seeing Patients in Caithness/ Sutherland Locations in 2018

Outpatient Specialty	2018	%
Physiotherapy	5349	23.10%
Chiropody	4379	18.90%
General Surgery	2313	10.00%
Orthopaedics	1761	7.60%
Surgical Endoscopy	828	3.60%
General Psychiatry	821	3.50%
Ophthalmology	818	3.50%
Orthoptics	723	3.10%
Psychiatry Of Old Age	677	2.90%
Gynaecology	667	2.90%
Obstetrics Antenatal	645	2.80%
Medical	591	2.50%
Chronic Pain	571	2.50%
Oncology	497	2.10%
Ear Nose and Throat	310	1.30%

Table 38: Top 15 (68%) Specialities seeing Patients out with Caithness/ Sutherland locations in 2018 (excludes NHS Near Me)

Outpatient_Specialty	2018	%
Ophthalmology	1165	9.40%
Orthopaedics	1026	8.30%
Dermatology	723	5.80%
Ear Nose and Throat	716	5.80%
Rheumatology	546	4.40%
Haematology	538	4.40%
Orthodontic	506	4.10%

Outpatient_Specialty	2018	%
Oral and Maxillofacial Surgery	445	3.60%
Oncology	428	3.50%
Urology	419	3.40%
Breast General Surgery	409	3.30%
Gastroenterology	391	3.20%
Cardiology	370	3.00%
Neurology	362	2.90%
Chronic Pain	321	2.60%

34. Chronic Pain Management Service

The Chronic Pain Service is hosted by North and West Operational Unit, providing a service to all of North Highland. Currently there is provision of out-patient clinics and theatre procedures weekly in Caithness General Hospital.

Challenges:

- Demand continues to grow, resulting in increased waiting times and greater pressure on the service. With limited additional resources available, it is unlikely that this will change. Specialist input will continue to be delivered from Raigmore, Inverness.

Figure 39: Chronic Pain Outpatient Appointments - Caithness/ Sutherland Locations (2015 to 2019)

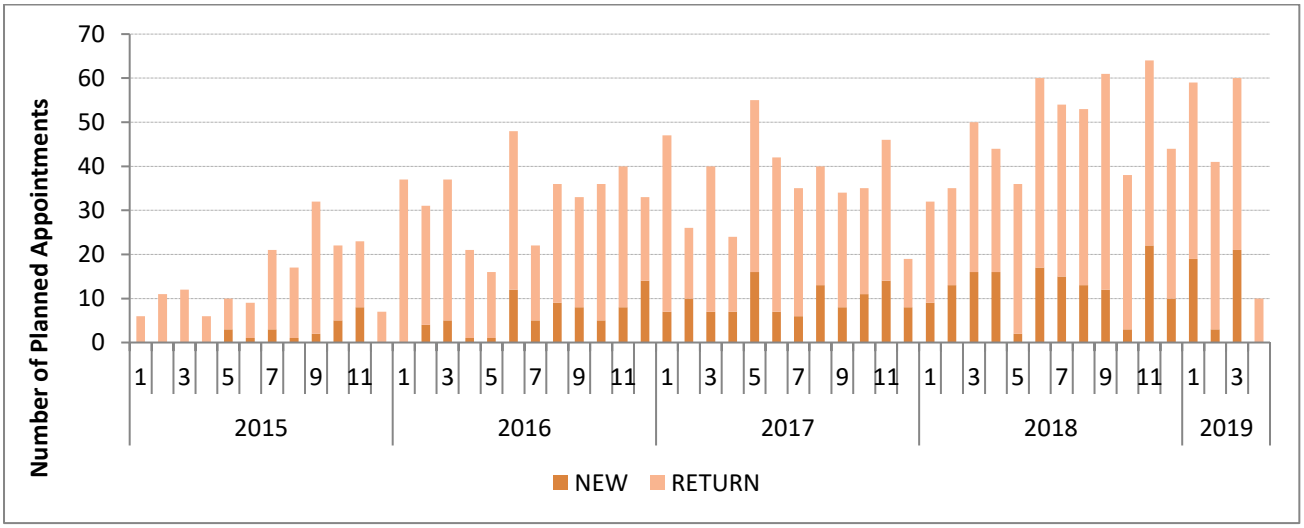
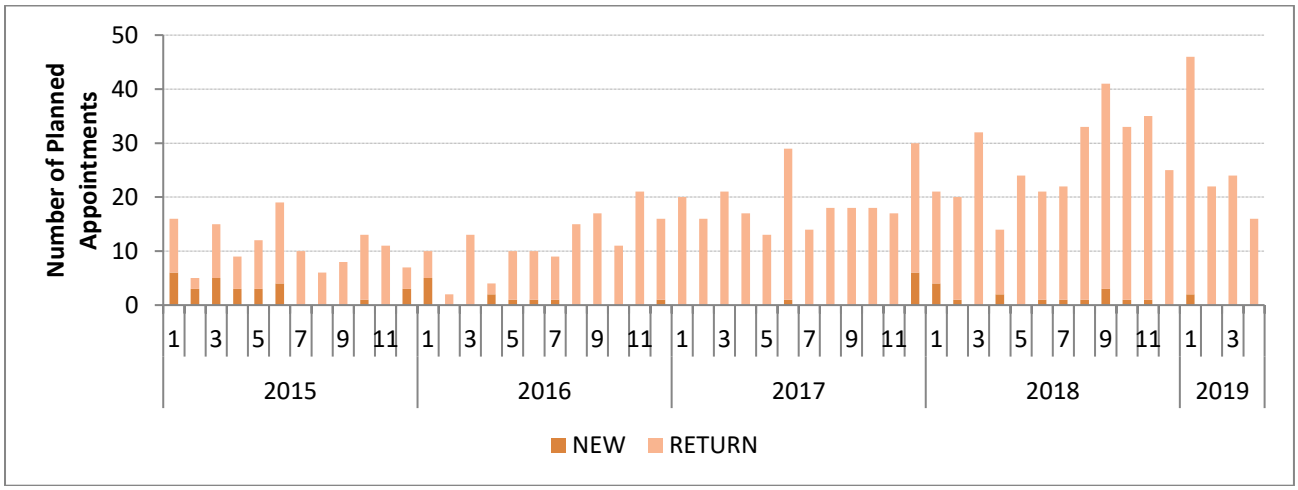


Figure 40: Chronic Pain Outpatient Appointments - Locations Out with Caithness/ Sutherland



35. Palliative and End of Life Care

Palliative Care is a person-centred approach which aims to improve the quality of life for people (children and adults), and their families, who are facing problems which are associated with life-threatening illness. Palliative care prevents and relieves suffering through early identification, assessment and treatment of pain and other problems whether physical, psychological or spiritual. It uses a team based approach; supporting people to live as actively as possible during their illness which includes addressing practical needs and where required providing bereavement counseling.

End of Life Care aims to address the medical, social, emotional, spiritual and accommodation needs of people who are in their last year of life. It is provided by a range of health and social care services and covers a range of disease specific interventions.

Palliative and end of life care in Caithness is provided at home and across a range of health and social care settings including care homes and hospitals.

The patient's GP will lead on documenting an anticipatory care plan to support all those involved in his or her care. Community nursing teams also identify palliative patients on their caseload and seek to ensure anticipatory care plans are in place. Community nursing teams provide an 'on call' service for patients deemed to be in the last 48 hours of life.

In the patient's own home, family members, carers or other networks of support, play the most important role where they are able to do so. Professional support is mainly by primary care teams with the patient's GP acting as the lead.

Palliative and end of life care within a residential and nursing home setting is provided by the staff in conjunction with the GP, community nursing team and others as and when required.

Caithness General, Dunbar and Wick Town and County Hospitals look after palliative and end of life care patients. Patients and their families will be made aware of the options for care out with the acute hospital environment, if appropriate, and the levels of support they will receive.

The local Macmillan team provides specialist nursing to those patients on cancer treatment as well as palliative care services. The team comprises of the Advanced Practitioner who leads the service, a Macmillan nurse and two part time Macmillan carers. In addition Marie Curie is contracted by NHS Highland to provide support to patients overnight. This can be provided either by a trained nurse or by a health care support worker. Locally, support may be provided for two to three nights in any week.

Challenges:

- There are key challenges in relation to social care provision within the community and ensuring that patient's wishes to remain at home can be met. This is particularly difficult within a remote and rural setting, especially in more rural parts of Caithness away from the main towns of Wick and Thurso.

NB: Turnover = average ward admissions per bed per day

Table 39: Dunbar Hospital Palliative Care - 2015 to 2019

	2015	2016	2017	2018	2019
# Beds/Day	1	1	1	1.8	2
# Ward Stays	28	23	16	18	7
Total Length of Stay	179	216	106	514	83
Occupancy	49.0%	59.0%	29.0%	78.2%	46.1%

	2015	2016	2017	2018	2019
Turnover	0.076712	0.062842	0.043836	0.027397	0.038889

Table 40: Newton Palliative Care - 2015 to 2019

Newton Palliative Care	2015	2016	2017	2018	2019
# Beds/Day	2	2	2	2	2
# Ward Stays	26	48	50	56	19
Total Length of Stay	463	489	382	459	77
Occupancy	63.4%	66.8%	52.3%	62.9%	42.8%
Turnover	0.035616	0.065574	0.068493	0.076712	0.105556

36. Pharmacy Services

Currently, the pharmacy department at Caithness General Hospital provides pharmaceutical care across five sites in both Caithness and Sutherland. The department also acts as a distribution point for the Cold Chain and provides a supply service to numerous GPs, podiatrists, physiotherapists and community/school nursing staff. The department's main role is to provide and develop integrated patient focused pharmaceutical care to meet the present and anticipated needs of the population in NHS Highland in accordance with local health plan and national strategies.

Clinical involvement has increased dramatically over recent years with involvement in Scottish Patient Safety Programme (SPSP) medicines reconciliation; greater involvement in discharge planning; supporting medical staff in the timely completion of Immediate Discharge Letters (IDL) to include full medicines reconciliation on admission and discharge; and medication reviews to meet needs of patient with high risk medications, polypharmacy and falls risk. The team also supports antimicrobial stewardship with input into daily empirical audits and wider point prevalence antimicrobial audits.

Table 41: Rural General Hospital Services, Drug Expenditure (2017 - 2018)

Hospital	Drug Expenditure £000	Net Hospital Running Costs £000	% of Net Hospital Running Costs
Totals or averages (NHS Highland)	**19,036**	**305,926**	**6.2**
Balfour Hospital, NHS Orkney	568	21,431	2.7
Belford Hospital, NHS Highland	743	13,168	5.6
Caithness General Hospital, NHS Highland	762	16,004	4.8
Gilbert Bain Hospital, NHS Shetland	528	21,395	2.5
Lorn and Islands, NHS Highland	1,098	17,262	6.4
Western Isles Hospital, NHS Western Isles	239	31,771	0.8

Table 42: Caithness Hospitals - Drug Expenditure (2017 – 2018)

Hospital	Drug Expenditure £000	Net Hospital Running Costs £000	% of Net Hospital Running Costs
Totals or averages (NHS Highland)	**19,036**	**305,926**	**6.2**
Caithness General Hospital, NHS Highland	762	16,004	4.8
Dunbar Hospital, Thurso	5	1,250	0.4

Hospital	Drug Expenditure £000	Net Hospital Running Costs £000	% of Net Hospital Running Costs
Town & County Hospital, Wick	22	2,482	0.9

Data Source: ISD Cost Book – Pharmaceutical Services 2017-18 (R610)

37. Physiotherapy Services

The Caithness Physiotherapy Service sits within Caithness General Hospital and Dunbar Hospital. The Physiotherapy Service provides: inpatient and outpatient support; physiotherapy outreach to the community (provided by hospital based Physiotherapists); patient rehabilitation (including cardiac, pulmonary and vestibular); and pelvic health clinics.

The Physiotherapy Department provides services to all wards and outpatient departments at Caithness General Hospital and the Dunbar Hospital. An open referral system operates within the wards. Physiotherapy treatment is provided in the ward areas and in the physiotherapy department.

The outpatient department receives referrals from GP's, Consultants, Physiotherapists, other Health Professionals and public self referral is via the Musculoskeletal Advice and Triage Service (MATS), part of NHS24. The services provided include: musculoskeletal and general outpatient clinics, pulmonary and cardiac assessment and rehabilitation classes, falls / OTAGO / balance assessments and classes, in addition to chronic pain management.

Advanced Practitioner Physiotherapists are now based within Primary Care, providing a triage service, referring patients to the Physiotherapy Service and working with musculoskeletal patients. This development is still in the early stages of implementation, but it is hoped that the outcome will be that patients are seen by the right professional at the right time, with an anticipated reduction in the number of referrals to the musculoskeletal and outpatient services.

Pelvic health clinics clinic are run once weekly in Dunbar hospital, Caithness General and Riverview Practice Wick. Patients can self refer to the service and referrals are also accepted from GPs, Consultants, nurses and midwives.

<u>Challenges:</u>

- The most significant challenge faced by the Physiotherapy Service is chronic understaffing in all areas. Demands on the service have grown in recent years due to an aging population, particularly with reablement assessments, falls prevention and Accident and Emergency cover; staffing levels have not increased in line with the demand. Turnover of patients on the Rosebank Ward is high, leading to increased demands (and expectations) on the domiciliary service, rehabilitation service (all areas) and the expectation of a rapid response service. As such, staff are under considerable pressure, are required to provide cover for numerous physiotherapy disciplines and patient waiting times are high across the county. The model is unsustainable and must be addressed in order to provide a sustainable service in the future.
- The Physiotherapy Department at Caithness General Hospital does not meet requirements for a modern physiotherapy department. Currently, patients in the waiting area are able to hear consultations taking place in nearby cubicles. This requires redesign to allow for patient confidentiality, as well as more cubicles to deal with the increase in patients being seen.

Figure 41: Net Referrals for North Physiotherapy Services

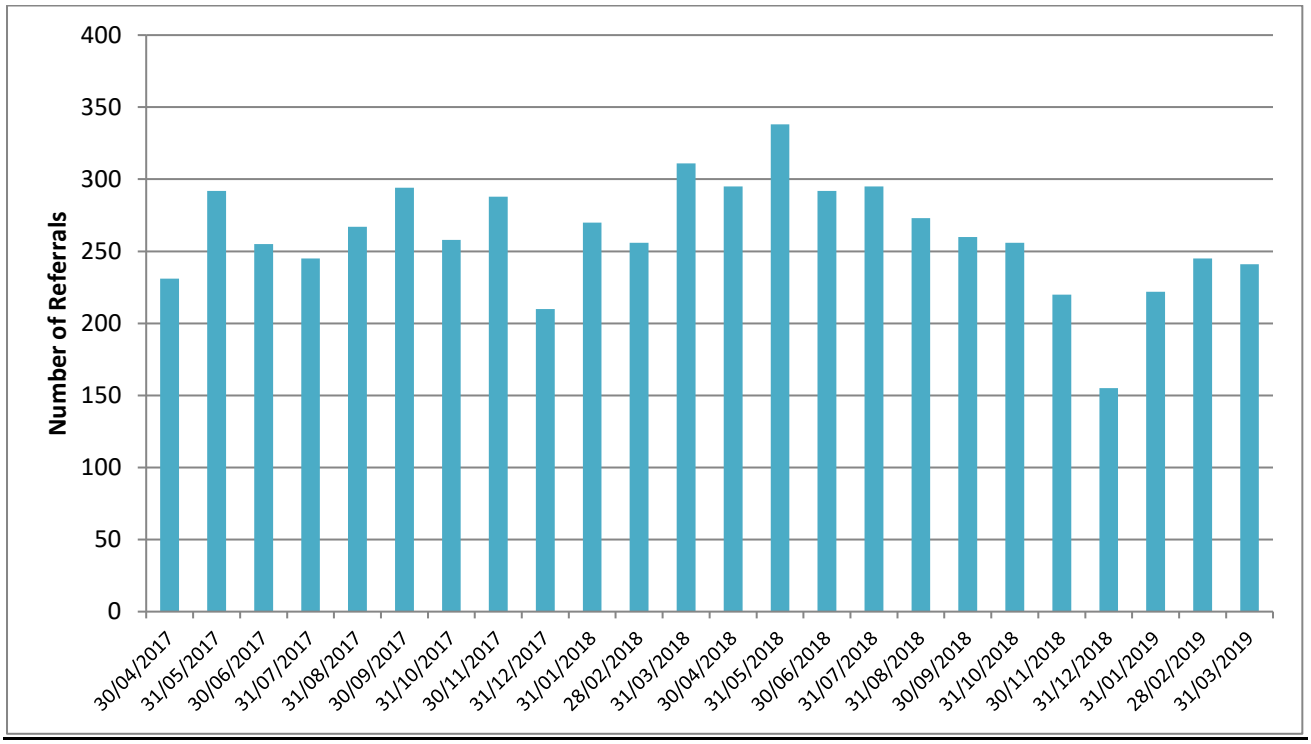
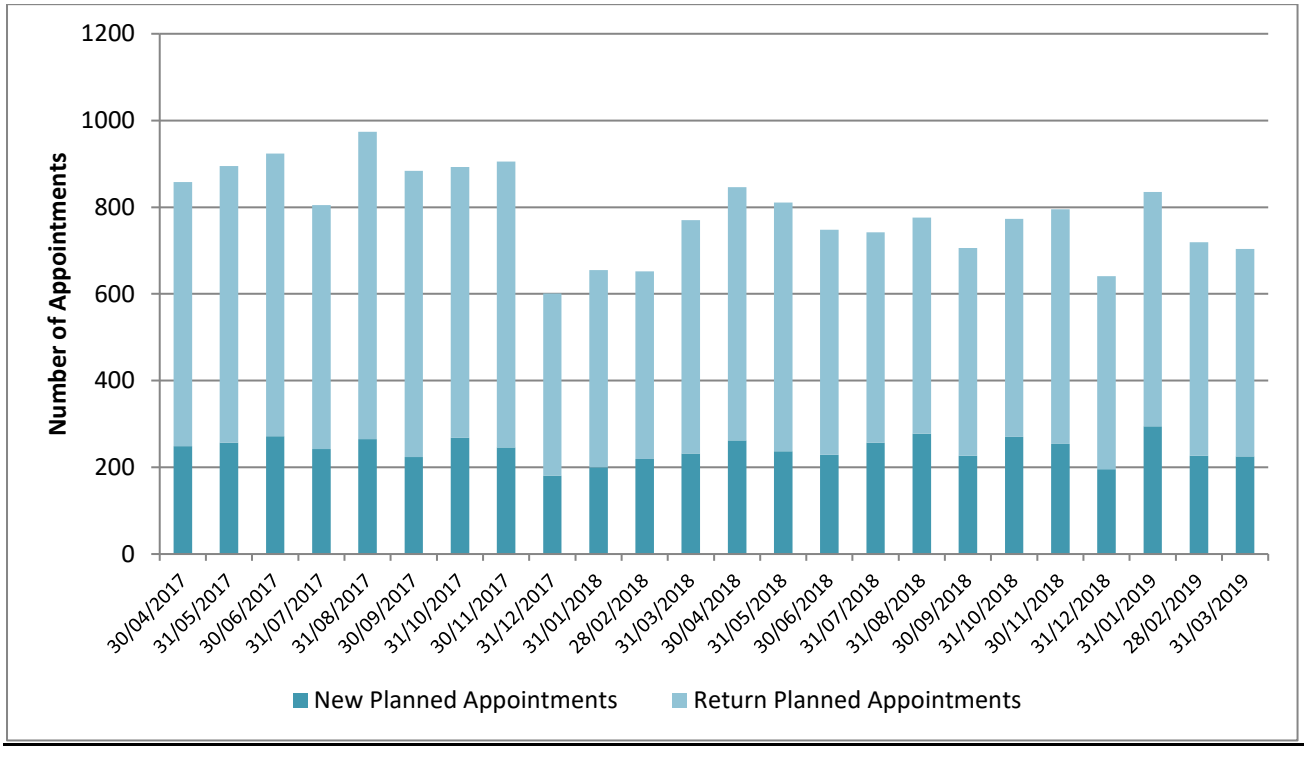


Figure 42: North Physiotherapy Planned Appointments (Seen and Did Not Attend)



38. Podiatry Services

Podiatry services are provided to patients requiring assessment and treatment of conditions of the lower limb including nail surgery.

The service is looking to develop multi-disciplinary teams / foot protection teams, as per national strategy for high risk foot services, to optimise patient care and patient outcomes in primary care, thereby reducing pressures on secondary care. One example of this is a Band 7 Advanced Practitioner Podiatry (diabetes speciality) based at Martha Terrace, Wick. This post has direct links to the vascular surgeon and diabetes multi-disciplinary team (MDT) based at Raigmore Hospital in Inverness and, as a result, patients from Caithness are often fast tracked through to this team and previous excellent joint working has reduced treatment timeframes resulting in improved outcomes for patients. This invaluable MDT link has reduced the number of amputations within the Caithness area resulting in reduced hospital inpatient time and associated costs in relation to rehabilitation.

Challenges:

- The Podiatry service is facing a year-on-year increase in patient referrals. The complexity of cases is also increasing, with patients requiring a higher level of care and longer face-to-face contact with clinicians. It is anticipated that, with an aging population, complex referrals will further increase, creating additional pressure on staff and the service. However, the staffing level has not increased in line with greater demand; as such, the service requires greater capacity to manage in the long-term. A more sustainable model is required.
- There are ongoing staffing issues relating to long-term sickness (Band 7 Advanced Practitioner Podiatry post) and general recruitment. There are plans to recruit a locum to cover this post and to utilise bank staff to mitigate the clinical risks of longer waiting times on patients. However, there are threats to service sustainability as recruitment continues to be a challenge. This is becoming a significant concern and requires early planning to prevent future problems.
- Increasing demands from the Scottish Government can be difficult to meet, particularly in a remote and rural setting.

Figure 43: Net Referrals to North Podiatry Service

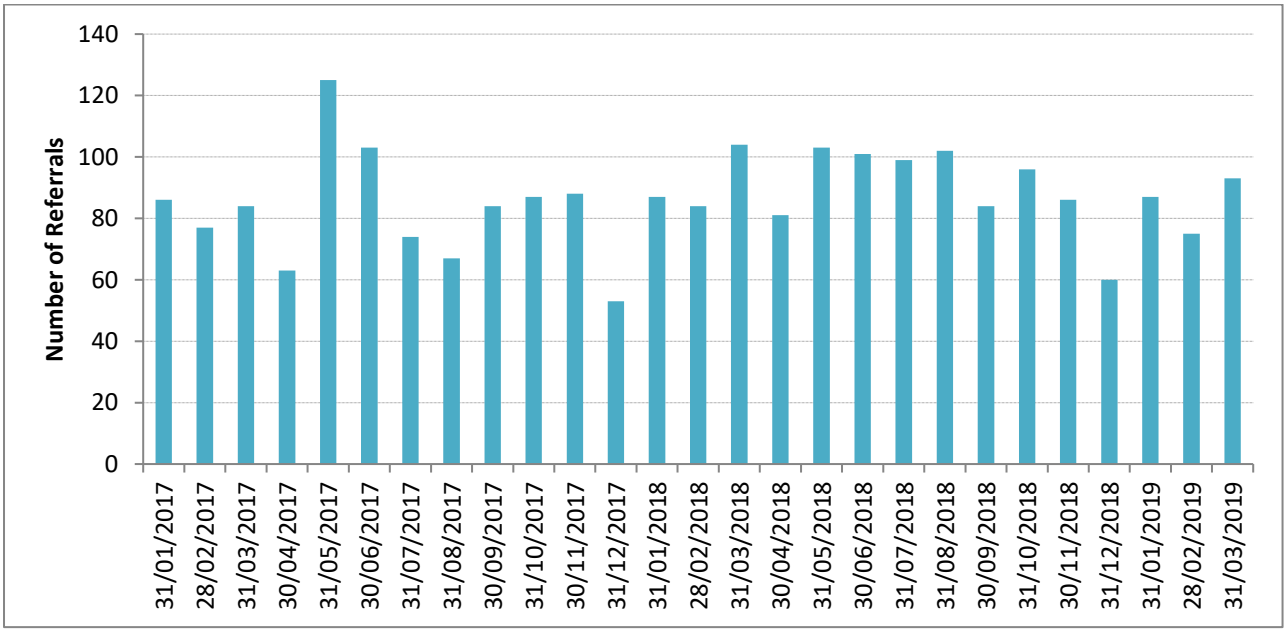
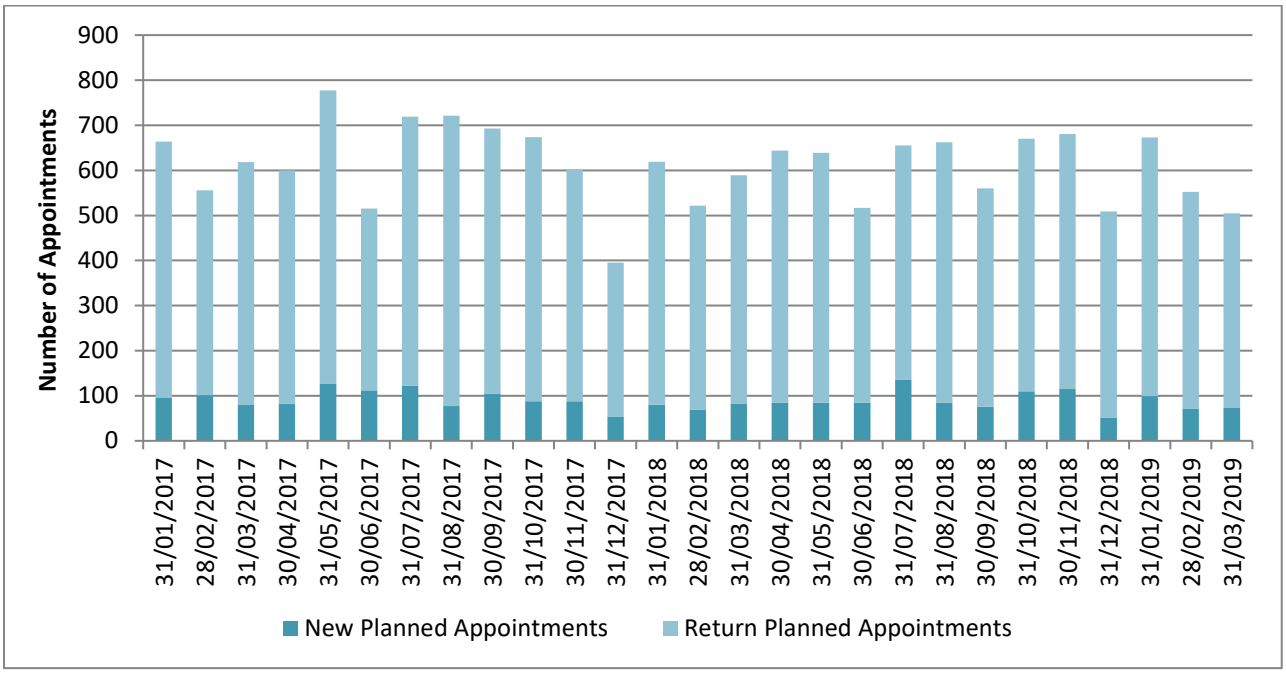


Figure 44:North Podiatry Planned Appointments (Seen and Did Not Attend)



39. Radiology Services

This is a Radiographer led service with support from Radiology Consultants based in Raigmore Hospital, Inverness, who provide a visiting service to Caithness General Hospital. Service is provided 365 days each year with emergency on-call provision 5.00 pm to 9.00 am on weekday evenings, Saturday, Sunday and Public holidays.

The Radiographers provide direct care and a comprehensive and co-ordinated Diagnostic Imaging service to a diverse range of patient types and clinical conditions in order to assist in the management of patients referred from clinicians located within and out with the hospital. They use diagnostic imaging equipment (X-ray, CT and Ultrasound) to carry out radiological examinations on patients and reports are provided to referring clinicians.

Challenges:

- Significant challenges exist around a lack of capacity due to a shortage of staff trained in ultrasound scanning. Recruitment issues are ongoing and vacancies often require multiple recruitment rounds before being filled. One current example is a dual trained (radiographer/ sonographer) post which has been advertised twice without success. This post is for retirement replacement and if it cannot be filled, waiting lists will increase and other staff will face a further workload increase.
- CT and X-ray waiting lists are currently manageable. However, trained, specialist staff have competing demands to remain on top of their competency in specialist areas.
- There are issues around access to training and CPD (Continuing Professional Development) opportunities. Budget pressures are significant; both in terms of funding training and also in providing back fill cover.
- As mentioned previously, staff are working at capacity. Greater demands on the service, providing cover for staff on training/ annual leave/ sick leave, as well as providing Out of Hours and weekend cover, is placing staff under significant pressure. Additional staffing is required to ensure the sustainability of the service long-term and to improve staff welfare and retention.
- There are pressures around managing patient expectations and also from senior management to reduce waiting times. This can be difficult when working to capacity.

Table 43: Radiography Appointments (Attendances) - Caithness (2018)

Attendances	Modality	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Grand Total
Caithness General	General	674	598	737	698	832	739	803	761	676	696	774	612	8600
	CT	206	169	189	246	245	226	202	173	235	270	193	220	2574
	OBUS	230	194	161	181	242	210	209	224	187	231	168	237	2474
	Ultrasound	217	167	161	166	240	271	169	242	150	149	240	211	2383
	Theatre	33	26	35	23	32	32	17	38	31	40	33	17	357
	Mobiles	13	14	23	9	7	2		18	12	12	16	20	146
	Dental	14	22	19	10	9	8	15	16	10	6	9	6	144
	Fluoro	1		11				11				7	1	31
Caithness General Total		**1388**	**1190**	**1336**	**1333**	**1607**	**1488**	**1426**	**1472**	**1301**	**1404**	**1440**	**1324**	**16709**
Dunbar Hospital Total	General	**38**	**19**	**27**	**17**	**49**	**28**	**22**	**4**				**1**	**205**
Grand Total		**1426**	**1209**	**1363**	**1350**	**1656**	**1516**	**1448**	**1476**	**1301**	**1404**	**1440**	**1325**	**16914**

Table 44: Radiography Appointments (Did Not Attend) – Caithness (2018)

Did Not Attend	Modality	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Grand Total
Caithness General	CT	20	10	11	6	15	13	11	14	17	18	17	12	164
	DENTAL	16	1	5	7	9	14	15	14	12	9	20	12	134
	General	2		4	3	4	3	7	5	1	6	1	11	47
	OBUS	4	1	5	1	2	1			2	8	1	1	26
	Theatre	3	5	2		1	4		1	1	4			21
	US			1		1				3	1			6
Caithness General Total		45	17	28	17	32	35	33	34	36	46	39	36	398
Dunbar Hospital	General	1			1	5								7
Grand Total		**46**	**17**	**28**	**18**	**37**	**35**	**33**	**34**	**36**	**46**	**39**	**36**	**405**

Table 45: Radiography Appointments (Cancellations) - Caithness (2018)

Cancellations	Cancellation Type	Modality	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Grand Total
Caithness General	Hospital Cancellation	OBUS	17	3	7	14	16	15	16	18	9	13	9	9	146
		General	11	5	8	10	7	14	10	16	12	9	11	13	126
		US	4	8	8	3	6	10	2	27		4	1	4	77
		CT	3	2	4	4	10	2	2	3	8	7	2	15	62
		Theatre	14	1	6	3	2	2	3	1	4	6	3	3	48
		Mobiles						1		5			4		10
		DENTAL			2		1		1	2	1		1		8
		Fluoro			1				1						2
	Hospital Total		49	19	36	34	42	44	35	72	34	39	31	44	479
	Patient Cancellations	US	19	14	8	6	19	23	15	17	12	10	21	20	184
		General	8	6	14	9	15	5	9	16	7	13	15	11	128
		CT	10	6	8	8	8	5	2	6	6	13	3	10	85
		OBUS	3	1	1	4	2	3	5	6	3	3	1	6	38
		DENTAL		1							1		1		3
		Theatre		1								1			2
	Patient Total		40	29	31	27	44	36	31	45	29	40	41	47	440
Caithness General Total			**89**	**48**	**67**	**61**	**86**	**80**	**66**	**117**	**63**	**79**	**72**	**91**	**919**
Dunbar Hospital	Hospital Cancellation	General		1										1	2
	Patient Cancellation	General	1				1								2
Dunbar Hospital Total			**1**	**1**			**1**							**1**	**4**
Grand Total			**90**	**49**	**67**	**61**	**87**	**80**	**66**	**117**	**63**	**79**	**72**	**92**	**923**

Table 46: Radiology Service (Rural General Hospitals) - Expenditure (2017 - 2018)

Hospital	CT Scanner			Ultrasonics			Other Radiology			Total Expenditure	
	Examinations	Net Cost per Examination		Examinations	Net Cost per Examination		Examinations	Net Cost per Examination		Net Cost per Examination	
		£	Group Index		£	Group Index		£	Group Index	£	Group Index
RGH Average:	**1,817**	**121.77**	**210**	**2,692**	**96.69**	**175**	**8,695**	**90.74**	**148**	**105.68**	**142**
Balfour Hospital, NHS Orkney	1,558	219.36	263	2,250	78.9	143	7,260	70.35	115	93.06	125
Belford Hospital, NHS Highland	1,956	122.72	147	2,058	105.99	192	7,134	77.34	126	90.59	122
Caithness General Hospital, NHS Highland	2,280	145.02	174	2,837	119.4	216	8,138	92.57	151	107.33	144
Gilbert Bain Hospital, NHS Shetland	1,475	213.8	256	2,878	58.74	106	7,976	94.95	155	100.71	135
Lorn and Islands, NHS Highland	-	-	-	3,437	120.4	218	8,866	89.9	146	123.06	165
Western Isles Hospital, NHS Western Isles	-	-	-	-	-	-	12,796	119.31	194	119.31	160

Data Source: ISD Cost Book – Radiology Services 2017-18 (R120)

40. Scottish Ambulance Service

The Scottish Ambulance Service (SAS) will be co-located in the refurbished Caithness General Hospital and also within the new facility in Dunbar Hospital. This will further support a more integrated approach to healthcare provision, with many positives including:

- SAS staff can often be isolated working from remote ambulance stations. Co-location, on the aforementioned sites, will help to deliver closer working relations with NHS Highland colleagues to deliver a more seamless transition of care.
- SAS staff will be able to assist during downtimes, particularly at the Minor Injuries Unit at the Dunbar Hospital. This will enable a mutual sharing and development of skills. There may also be opportunities for SAS and NHS Highland staff to undertake Training and Development opportunities together, further developing professional relationships.
- Being based at each hospital/ hub site will allow SAS staff the opportunity to become more familiar with individual patients and involved in patient care, particularly those with complex needs. This multi-disciplinary approach will help to facilitate appropriate discharge planning, particularly as staff become more integrated within the Multi-disciplinary Team.

Challenges:

- The existing Ambulance Stations are no longer suitable for the level of service that is being provided in Caithness. Staffing levels have increased at both sites:
  - Thurso – 18 staff (16 A&E, plus 2 Patient Transport Staff)
  - Wick – 20 staff (16 A&E, plus 4 Patient Transport Staff)

  There is insufficient locker space, as well as no training facilities. There is a requirement to move to larger premises that are fit for purpose and co-located with NHS Highland at the Caithness General and Dunbar Hospital sites.

Table 47: Scottish Ambulance Service Responses (2017)

999 Emergency Calls	2,075
Urgent Requests	1,004
Routine Requests	124
Patient Transport Requests*	2,000
TOTAL:	5,203

*Patient Transport Requests relate to patients whose journey begins in Caithness. Each patient usually generated two journeys (inward and outward).

Of the above total number of journeys, 706 were for Inter-Hospital Requests. These are defined as any transfer between hospitals, where the journey starts in Caithness. These include transfers between Caithness hospitals, transfers to Inverness (Raigmore or New Craigs) or to hospitals elsewhere. It has not been possible to break this data down further.

41. Social Work Services

The role of the social work team is to support individuals and their families through difficult times, assessing those who may require a service. They also provide a statutory service and protect vulnerable adults in the community to safeguard them from harm.

The Social Work team is comprised of registered social workers and forms part of the integrated team, attending multi disciplinary meetings with ward staff at Caithness General Hospital to ensure safe and appropriate discharges for their clients. The social workers also: provide information relating to Self Directed Support (SDS); organise Adults with Incapacity meetings when appropriate; act as Welfare Guardian on behalf of the Chief Social Work Officer (CSWO); liaise with other

agencies to protect adults under Adult Support and Protection legislation; and present applications for Long Term Care, Respite and SDS.

The social work team is available Monday to Friday from 9:00am to 5:00pm. However, there is an out of hours service that provides weekend cover and 5:00pm to 9:00am from Monday to Friday.

Challenges:

- There are significant challenges around people who do not have a Power of Attorney or Guardianship in place. This often results in long delays in discharging someone from hospital and transitioning them to a more appropriate care setting.
- Social Work is able to make emergency payments to vulnerable people experiencing financial hardship under Section 12 of the Social Work (Scotland) Act 1968. This budget is coming under increased pressure due to the number of people presenting in crisis.

Figure 45: Telecare Clients (Caithness East) By Type of Service (April 2018 to March 2019)

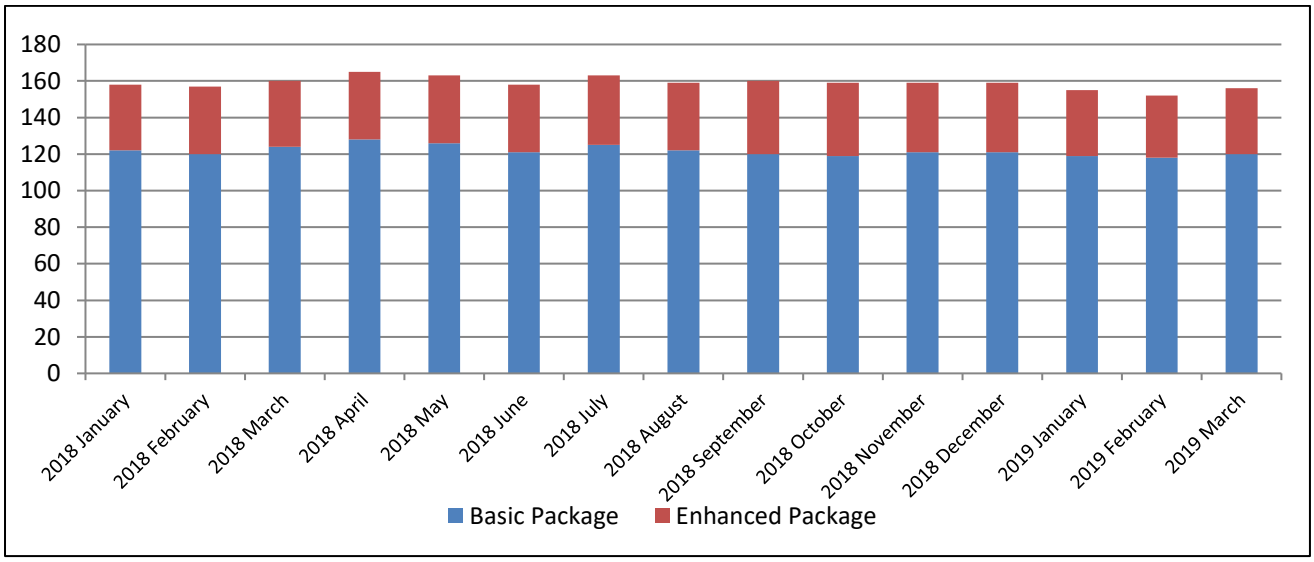


Figure 46: Telecare Clients (Caithness West) By Type of Service (April 2018 to March 2019)

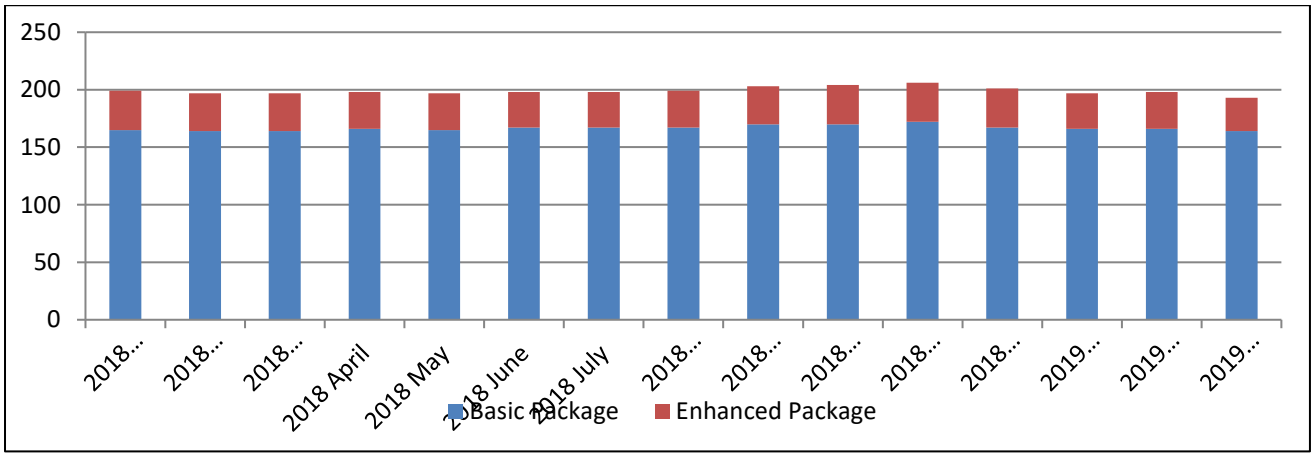


Table 48: Telecare Clients (East Caithness) – January 2018 to March 2019

Month	Basic Package	Enhanced Package	Total
2018 Jan	122	36	158
2018 Feb	120	37	157
2018 Mar	124	36	160
2018 Apr	128	37	165
2018 May	126	37	163
2018 Jun	121	37	158
2018 Jul	125	38	163
2018 Aug	122	37	159
2018 Sep	120	40	160
2018 Oct	119	40	159
2018 Nov	121	38	159
2018 Dec	121	38	159
2019 Jan	119	36	155
2019 Feb	118	34	152
2019 Mar	120	36	156

Table 49: Telecare Clients (West Caithness) – January 2018 to March 2019

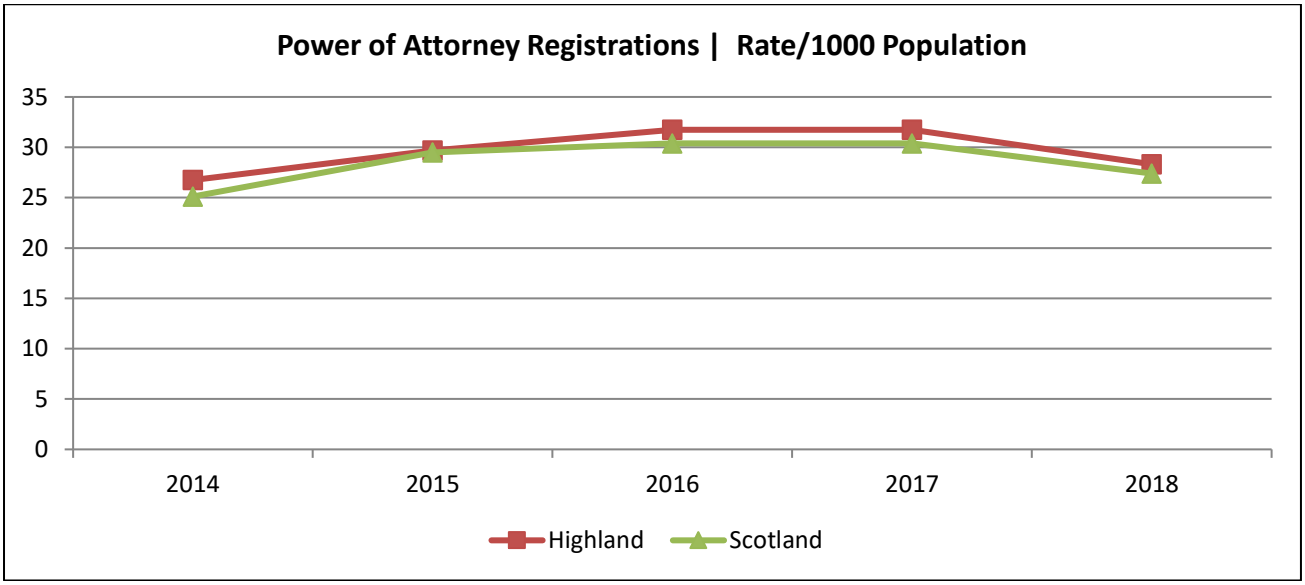
Month	Basic Package	Enhanced Package	Total
2018 Jan	165	34	199
2018 Feb	164	33	197
2018 Mar	164	33	197
2018 Apr	166	32	198
2018 May	165	32	197
2018 Jun	167	31	198
2018 Jul	167	31	198
2018 Aug	167	32	199
2018 Sep	170	33	203
2018 Oct	170	34	204
2018 Nov	172	34	206
2018 Dec	167	34	201
2019 Jan	166	31	197
2019 Feb	166	32	198
2019 Mar	164	29	193

Table 50: Power of Attorney Registrations

these years averaged due to backlog in 2016

	2014	2015	2016	2017	2018
Highland	26.74674	29.69444	31.73945	31.73945	28.32752
Scotland	25.11303	29.48829	30.39017	30.39017	27.40759

Figure 47: Power of Attorney Registrations - Rate per 1000 Population



42. Speech and Language Services

The local element of this service transferred to Care and Learning within Highland Council and any requirements for inpatients within Caithness General Hospital are provided by a visiting service from the Raigmore team. The focus of the service locally is on prevention, as well as improving health and wellbeing. There is currently one Adult Speech and Language Therapist covering all of Caithness and North West Sutherland.

Challenges exist around securing appropriate clinic space in Caithness. A lack of availability often results in the Speech and Language Therapist having to make home visits, which is not a good use of time. There are also issues around accessing electronic patient information. Moving forward, this is something that will need to be addressed to enable efficient Multi-Disciplinary Team working.

Adult Caseload:

Figure 48: Referral and Discharge Overview - May 2018 to end April 2019*

*The current caseload is twenty.

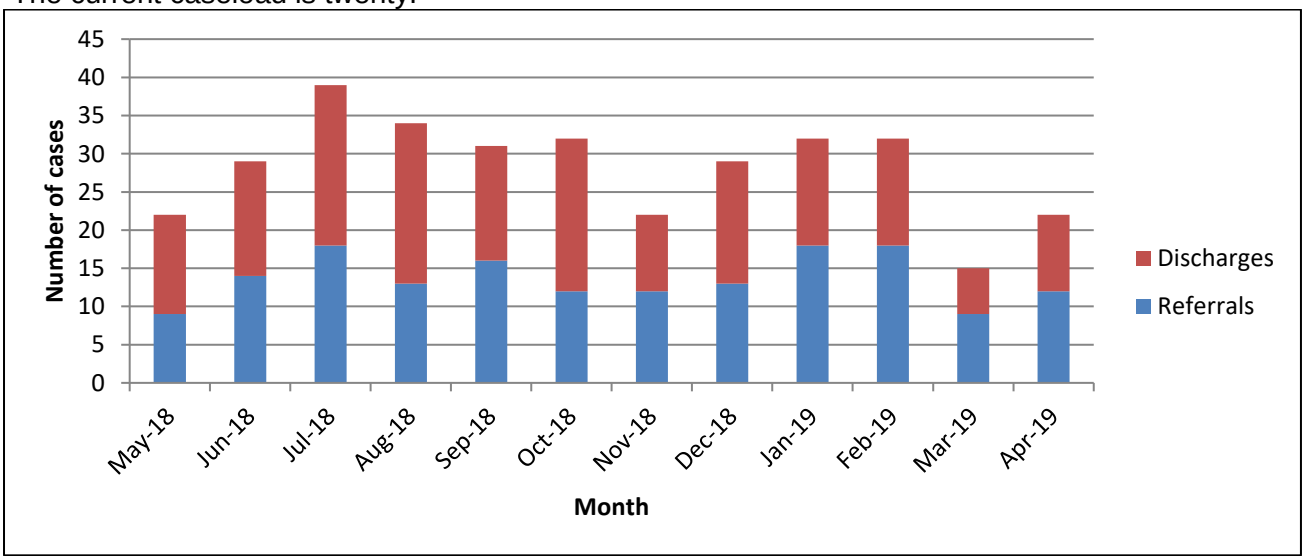


Figure 49: Age Range of Referrals

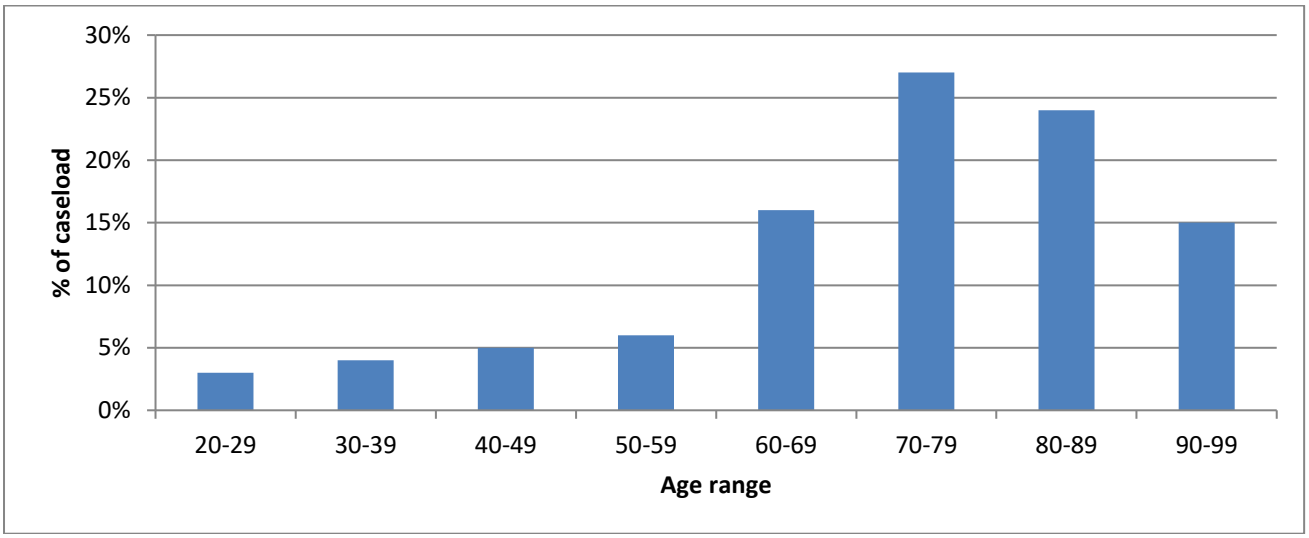
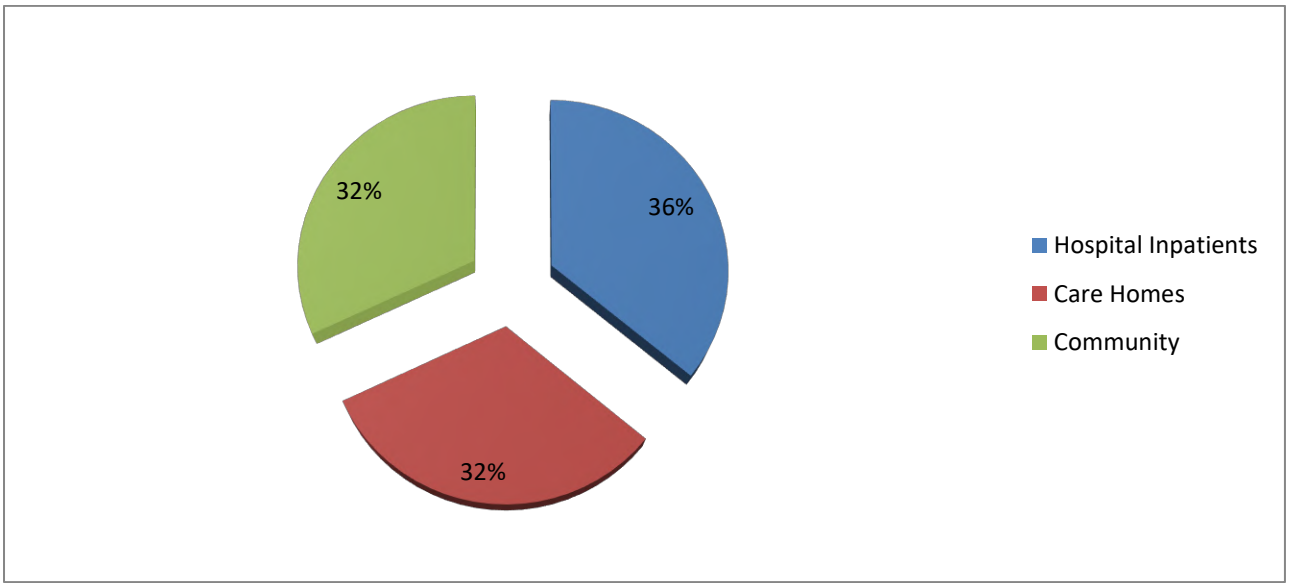


Figure 50: Referral Source



Data Source: Speech and Language Therapy Services

Paediatric Caseload:

Figure 51: Referral and Discharge Overview - May 2018 to end April 2019.*
*The current caseload is 241.

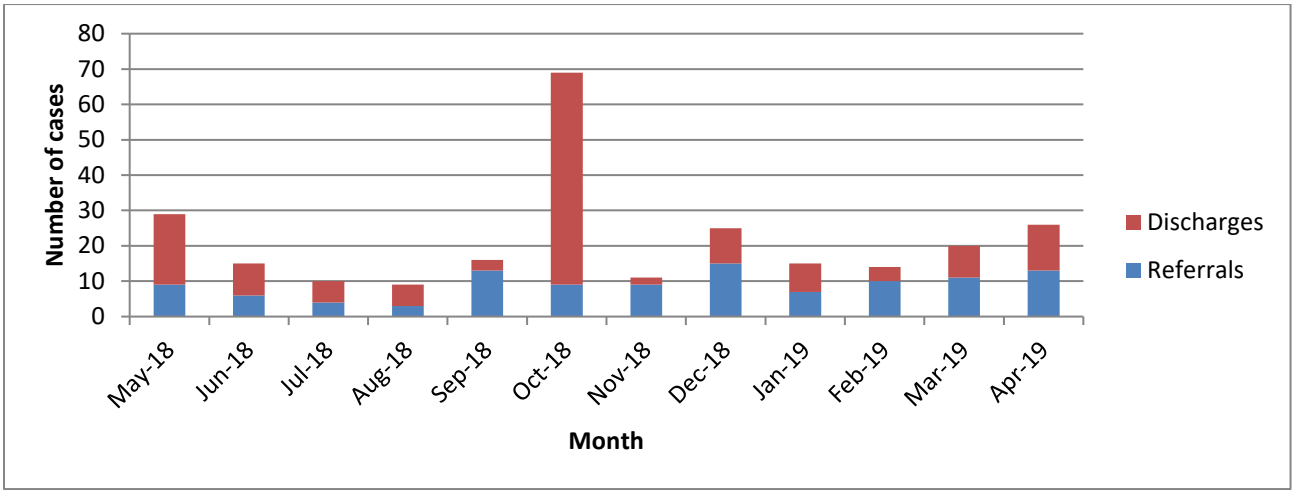


Figure 52: Age Range of Referrals

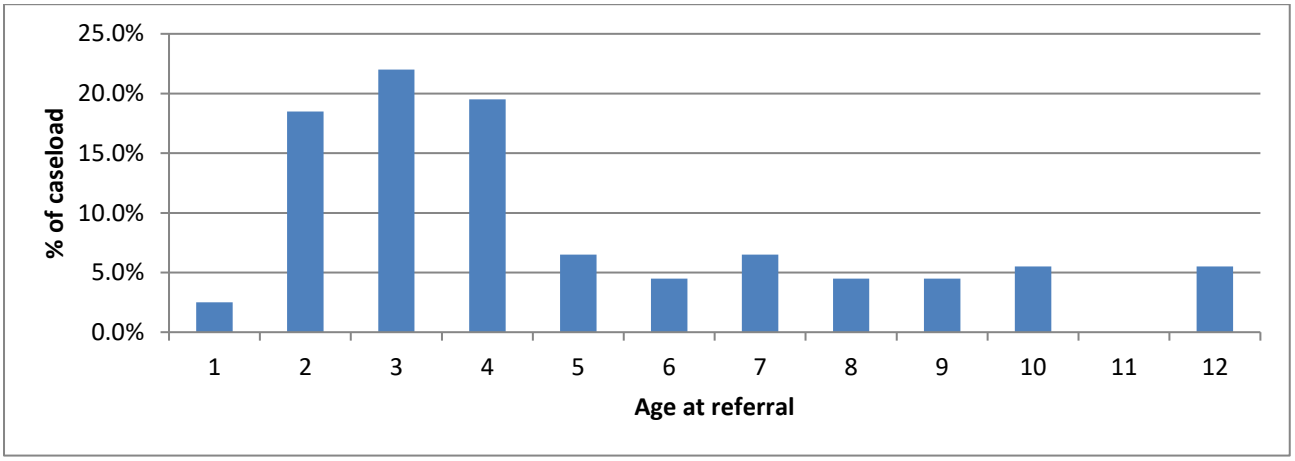
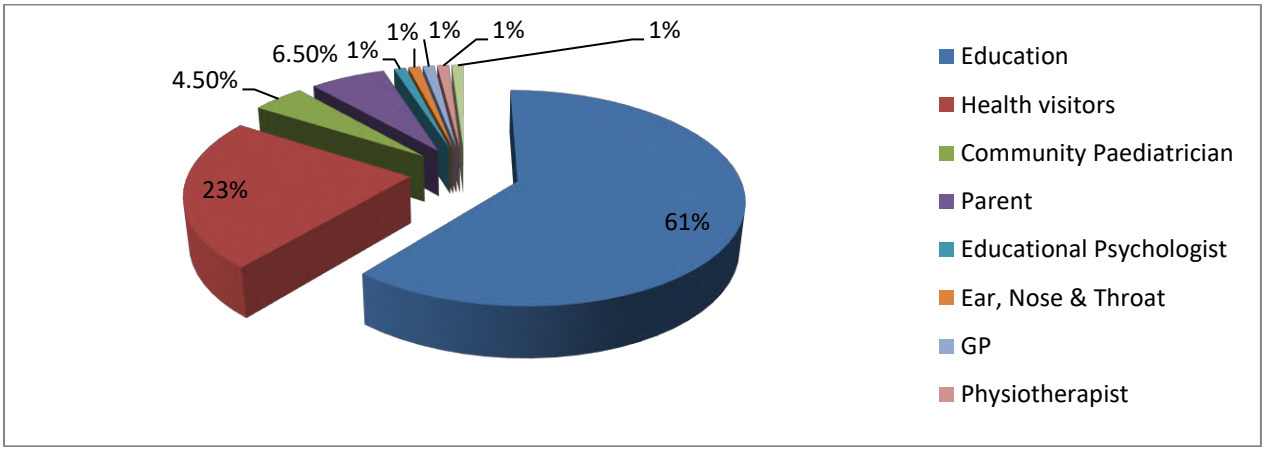


Figure 53: Referral Source



Data Source: Speech and Language Therapy Services

43. Stroke Services

This service is jointly funded by Chest, Heart and Stroke Scotland (CHSS) and NHS Highland and the role of the posts is reviewed on an annual basis as part of the Service Level Agreement. CHSS also provide quarterly feedback at the Stroke Clinical Network meetings which meets quarterly. The CHSS stroke nurse follows up all patients referred to the service with a new stroke or Transient Ischemic Attack (TIA) diagnosis. Referral sources are from both inpatient and outpatient services, primary care and self referrals are also acceptable.

The role of the nurse is to support and advice the patient and their carers /families, sign-posting them to other services, for example: Citizens Advice Bureau for a benefits check; liaising with other health professionals; and helping the patients to self manage their stroke condition and make lifestyle changes. The support is tailored to each patient for up to one year post discharge/ post stroke and this will normally be a mix of home visits and telephone / on line support.

The CHSS stroke nurse is also responsible for the collection of data for the Scottish Stroke Care Audit which collates the information on stroke treatment for Caithness General Hospital and feeds into the national database. They also have a teaching role within their remit and help to support and deliver training with the Stroke Coordinator to health professional and other local groups (e.g. schools, first aiders).

Challenges:

- This service is provided by a 20-hour post, so the post holder has limited capacity, particularly during periods with greater numbers of referrals. The post holder is currently on maternity leave and due to recruitment issues, the post is being covered from Inverness by the Stroke Coordinator for the Highlands.

Table 51: Stroke Cases dealt with at Caithness General Hospital

Time Period	Stroke Diagnosis		No. of initial stroke patients receiving appropriate bundle of care	% of initial stroke patients receiving appropriate bundle of care (Stroke Standard is 80%)
	Initial	Final		
2017	68	56	52	76.5
2018	58	47	35	60.3
Latest 12 months	46	44	27	58.7
June 2018	7	4	5	71.4
July 2018	5	4	5	100.0
August 2018	2	2	1	50.0
September 2018	5	3	2	40.0
October 2018	4	4	3	75.0
November 2018	2	2	1	50.0
December 2018	3	5	2	66.7
January 2018	7	9	6	85.7
February 2018	5	4	2	40.0
March 2018	2	2	0	N/A
April 2018	0	1	0	N/A
May 2018	4	4	0	N/A

Data source: SSCA Monthly Report, 112, Highland (June 2019)

44. Surgical Suite (Theatre, Endoscopy and Day Case)

The Surgical Suite provides nursing care for all patients undergoing elective or emergency procedures within the Theatre environment, Endoscopy Unit, Day Case area and Pre Operative Assessment clinics.

Theatre is staffed Monday to Friday 8.00 am to 4.30 pm and an On-Call team is available for 24 hour cover. Sessions are utilised by General Surgeons, Obstetrician/Gynaecologists, Physicians, Oral Surgeons, Ophthalmologists and Anaesthetists. Recent refurbishment has brought the theatre suite compliant with Infection Control standards and recommendations.

Challenges:

- Recruitment to vacant posts continues to be challenging, with no or few suitable applicants for advertised posts. Should posts remain unfilled, continuation of existing services will be unsustainable.
- Day Case has limited capacity and restricts theatre and day case activity. The Day Case area requires relocation to meet the current and projected service needs.
- The Endoscopy Suite is situated on the first floor and is covered by the surgical team based on the second floor. The current space is restricted and is not compliant with recommended standards. Relocation to the surgical suite on the second floor would enhance service provision and improve efficiency.
- Gynaecological services are currently reduced due to the number of available consultants.

Figure 54: Caithness General Hospital Theatre Activity: Number of Procedures by Day of Week | Days with Operating (2018)

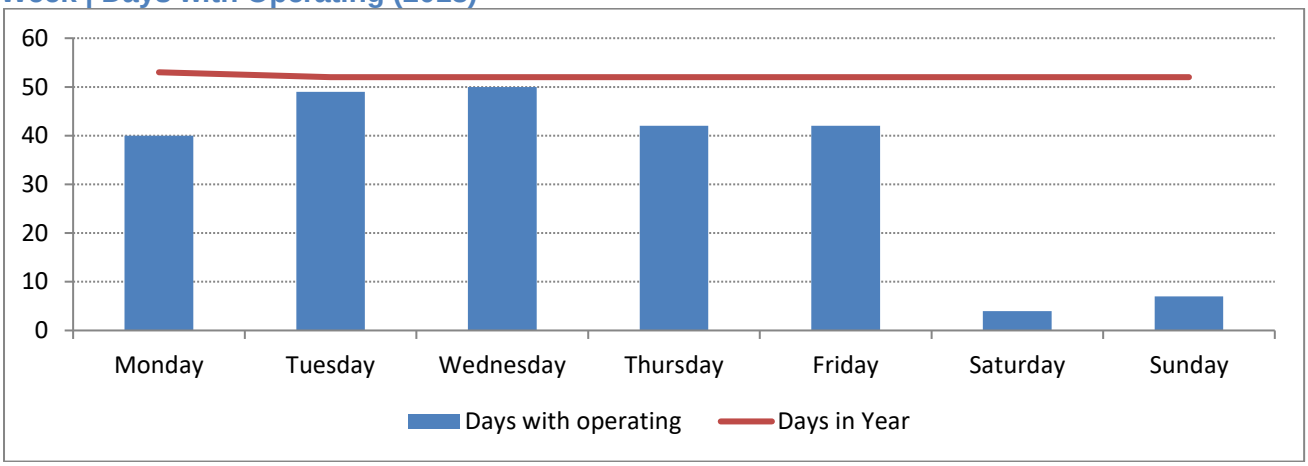


Figure 55: Caithness General Hospital Theatre Activity: Number of Procedures by Day of Week | Days with No Operating (2018)

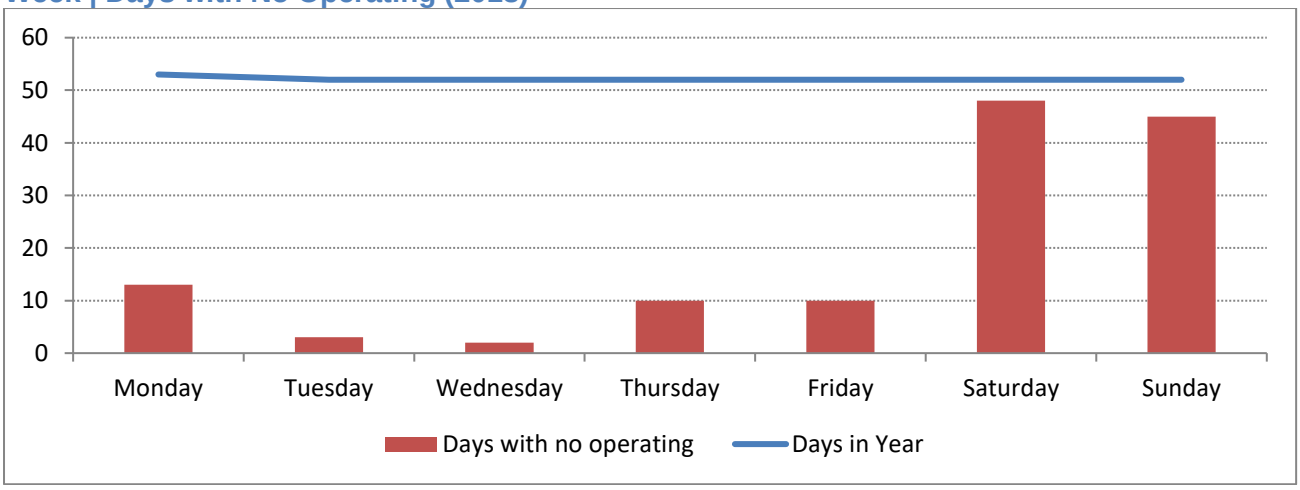


Table 52: Caithness General Hospital Theatre Activity - Urgency of Procedure (2018)

Operation Type	NCEPOD Classification	Total
CPD1	Life, Limb, organ-saving	3
CPD2A	Acute onset or deterioration of conditions that threaten life, limb or organ (6 hr wait max)	21
CPD2B	Acute onset or deterioration of conditions that threaten life, limb or organ (24 hr wait max)	30
CPD3	Stable, requires early intervention (days wait max)	18
CPD4	Planned in advance of routine admission	1234
Grand Total		**1306**

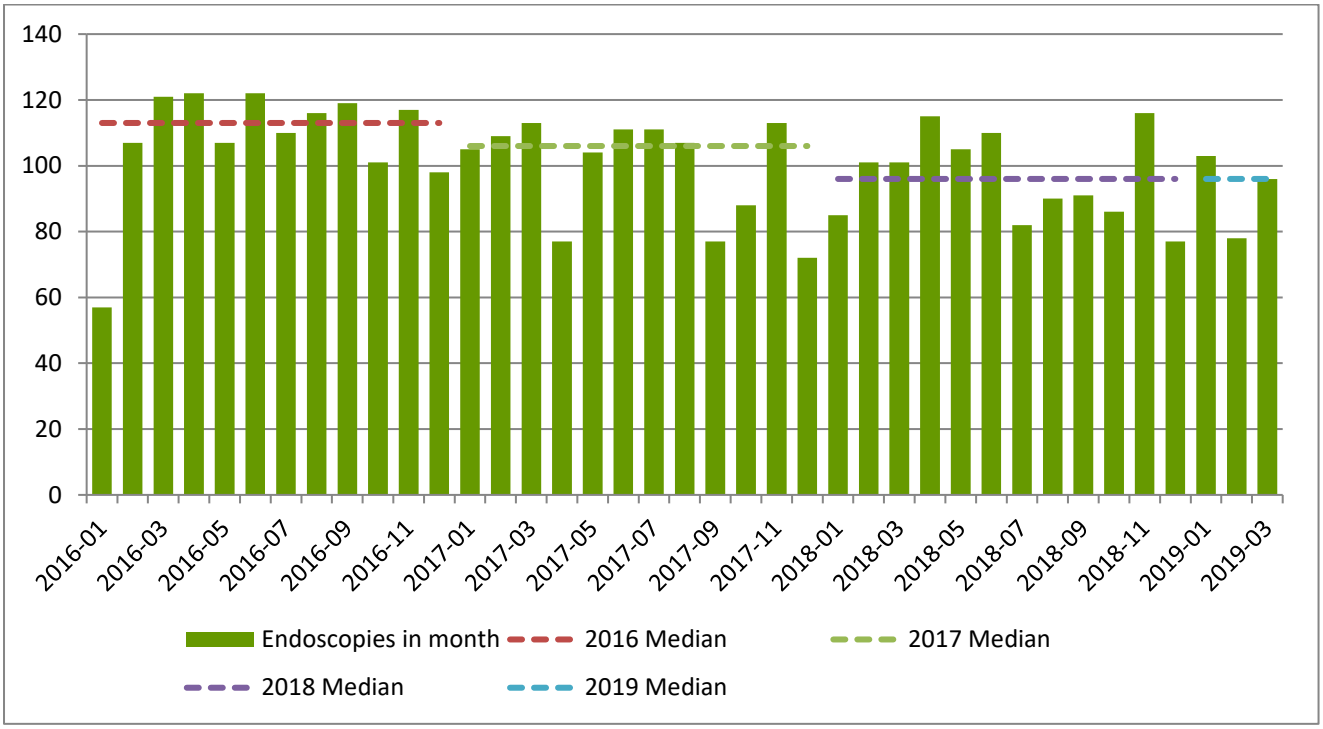
Table 53: Most Common Procedures (Primary Procedure) – Caithness General Hospital (2018)

Day Case	Total Procedures 2018
Skin	350
Eye	200
Bones and Joints of Skull and Spine	154
Nervous System	98
Soft Tissue	95
Upper Female Genital Tract	54
Other Bones and Joints	46
Lower Digestive System	44
Male Genital Organs	43
Other Abdominal Organs, Principally Digestive	36
Mouth	29
Miscellaneous Operations	12
Total Other Day Case Procedures	**30**

Inpatient	Total Procedures 2018
Lower Digestive System	26
Upper Female Genital Tract	17
Lower Female Genital Tract	14
Upper Digestive System	12
Total Other Inpatient Procedures	**35**

A&E	Total Procedures 2018
A&E	11

Figure 56: Caithness General Hospital - Endoscopies (January 2016 to March 2019)



45. Vocational Support Service

Vocational Support is an NHS service that works with adults with mental ill-health (mild, moderate or severe). The ethos of the project is to offer one-to-one support to help people identify and achieve their goals. We support people to create a personal development plan that identifies their goals and any barriers in place to achieving them. The service is provided Monday to Thursday, between 09:00 and 17:00 and is delivered from our office in the grounds of the Dunbar Hospital, Community Mental Health Team (Bankhead) Wick, Caithness General Hospital and in the local community

Challenges:

- There are significant challenges around limited local support for people experiencing mental health issues. This includes statutory based support (Community Mental Health Team) as well as community based services. All services are under increased pressure and demand and many people we support are vulnerable and can 'fall through the cracks'; this in turn increases demand on our service.
- A lack of local community groups, as well as training and job opportunities (paid and voluntary) for clients, can lead to them becoming isolated and de-motivated. There are also significant issues around local public transport, with many people struggling to access services, particularly in rural areas.

Table 54: Vocational Support Caseload - 1st April 2018 to 31st March 2019

Carried forward from 2017/18:	**57**
New Referrals:	**77**
TOTAL:	**134**
Breakdown of Referral Source:	
Community Mental Health Team	73
Department for Work and Pensions	16
Criminal Justice	6
GP	9

Cognitive Behavioural Therapist	7
Self	8
Psychiatry	12
Community Occupational Therapist	2
New Craigs	1
TOTAL:	**134**

Table 55: Outcome for Clients who engaged with the service - 1st April 2018 to 31st March 2019

Community Engagement	17%
Employment	9%
Learning	14%
Ongoing support	28%
Voluntary work	4%
Awaiting admission to caseload	28%
TOTAL:	100%

Data Source: Vocational Support Team

46. Other Supporting Services

Caithness benefits from a well established network of Third sector organisations, both locally based and those providing outreach services from bases out with the area. NHS Highland has long recognised the value of the Third Sector and their ability to work in a flexible, creative and proactive way to meet the needs of the local community. Their work enables individuals, who may struggle to engage with statutory organisations, to access the help and support they need. This innate understanding of the local community enables organisations to work in innovative ways to prevent issues from escalating or arising in the first place. The Third Sector also provides many employment and voluntary opportunities, adding value to the local economy, improving individual's wellbeing and working to create a more cohesive, supportive community.

NHS Highland currently (October 2019) contracts Community based services from the following Third Sector organisations in Caithness:

Table 56: Third Sector Contracted Organisations (Caithness)

Organisation:	Purpose:	Delivery:
Advocacy Highland	The provision of an independent citizen's/ individual's advocacy service.	Outreach
Befrienders Highland	The delivery of a befriending service to people with a mental illness.	Locally based
Caithness Mental Health Support Group (The Haven, Wick and Stepping Stones, Thurso).	The delivery of drop-in facilities for individuals with mental health issues.	Locally based
Chest, Heart and Stroke Scotland	The delivery of communication support services and stroke specialist support services.	Locally based
Dunbeath Health & Wellbeing Hub	The delivery of a community health and wellbeing hub from	Locally based

Organisation:	Purpose:	Delivery:
	the Dunbeath and District Centre.	
Hearing and Sight Care	The provision of sensory services.	Locally based
Highland Senior Citizen's Network	Provision of consultation/ engagement of older people.	Outreach
Let's Get on With It Together (LGOWIT)	Lay led self management classes and peer support groups.	Locally based
Partnerships for Wellbeing (Step-it up Highland)	Provision of health walks	Health walks delivered locally. Step-it up Highland based in Inverness.
Rape and Sexual Abuse Service Highland (RASASH)	Support service to people aged over 13 living in Highland affected by rape and/ or sexual abuse.	Outreach
Samaritans of Caithness	Provision of confidential support to people living in Caithness and surrounding area who are experiencing feelings of distress or despair.	Locally based
Scottish Huntington's Association	The delivery of a support and advice service to people living with Huntington's Disease.	Outreach
Sight Action	The delivery of sensory services in Highland.	Locally based (Hearing and Sight Care)

NHS Highland currently contracts commissioned services from the following Third Sector organisations:

Table 57: NHS Highland Third Sector Commissioned Organisations (Caithness)

Organisation:	Purpose:	Delivery:
Laurandy Day Centre	Day care – older adults	Locally based

NHS Highland is currently undertaking a strategic review of current contracted/ commissioned services with the Third Sector. It is anticipated that this will be completed by end 2019 and is to ensure alignment with NHS Highland's strategic objectives.

47. List of Tables

48. List of Figures

Benchmark **Caithness General Hospital**

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	1	YES
A.02	The design facilitates the care model	1	1	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	2	YES
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2	1	YES
A.06	Where possible spaces are standardised and flexible in use patterns	1	3	YES
A.07	The design facilitates both security and supervision	1	3	YES
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	1	YES
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	3	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	1	6	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	2	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	3	YES
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	1	YES
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	1	YES
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	4	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	1	2	YES
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	2	YES
C.06	There is adequate storage space	1	2	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	NO
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	4	YES	G.01
D.02	The building and grounds are easy to clean and maintain	1	4	YES	G.02
D.03	The building and grounds have appropriately durable finishes and components	2	3	YES	G.03
D.04	The building and grounds will weather and age well	1	2	YES	G.04
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	2	YES	G.05
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	2	YES	G.06
D.07	The design minimises maintenance and simplifies this where it will be required	1	4	YES	G.07
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0			G.08

Engineering

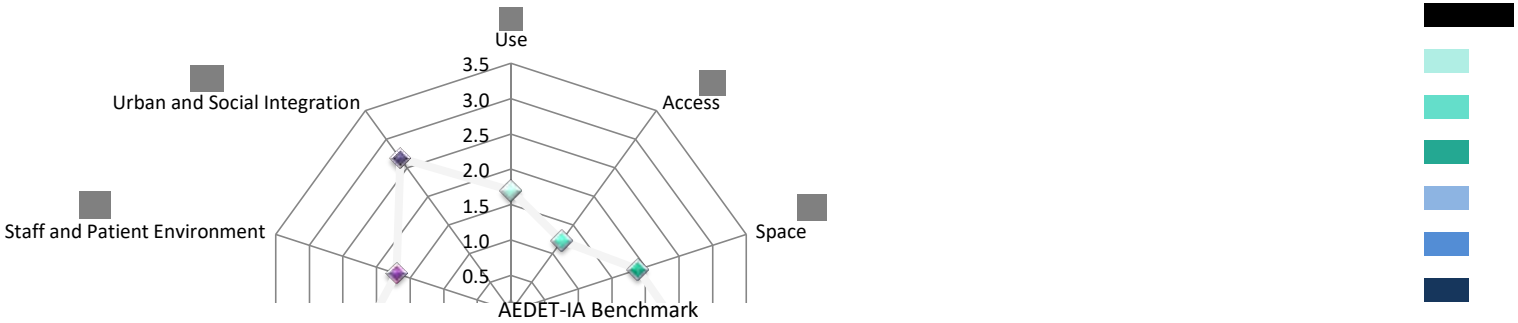
		Weight	Score	Notes	
E.01	The engineering systems are well designed, flexible and efficient in use	1	2	YES	H.01
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	2	NO	H.02
E.03	The engineering systems are energy efficient	1	3	YES	H.03
E.04	There are emergency backup systems that are designed to minimise disruption	1	5	YES	H.04
E.05	During construction disruption to essential services is minimised	1	4	YES	H.05
E.06	During maintenance disruption to essential healthcare services is minimised	2	4	YES	H.06
E.07	The design layout contributes to efficient zoning and energy use reduction	1	2	YES	H.07

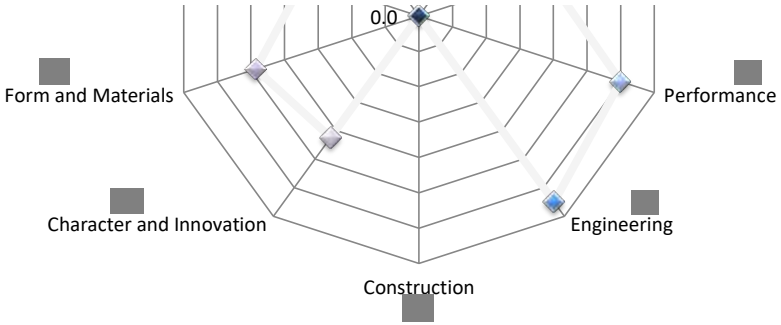
Construction

		Weight	Score	Notes	
F.01	If phased planning and construction are necessary the various stages are well organised	0			I.01
F.02	Temporary construction work is minimised	0			I.02
F.03	The impact of the building process on continuing healthcare provision is minimised	2			I.03
F.04	The building and grounds can be readily maintained	0			I.04
F.05	The construction is robust	0			I.05
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0			I.06
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0			I.07
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0			I.08
F.09	The construction contributes to being a good neighbour	0			I.09
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0			I.10

J.01
J.02
J.03
J.04
J.05
J.06

AEDET Refresh Benchmark Summary




0.0
Form and Materials
Performance
Character and Innovation
Engineering
Construction

AEDET Refresh v1.2 Mar 2016

Impact

Character and Innovation	Weight	Score	Notes
There are clear ideas behind the design of the building and grounds	1	1	YES
The building and grounds are interesting to look at and move around in	1	3	YES
The building, grounds and arts design contribute to the local setting	2	3	YES
The design appropriately expresses the values of the NHS	1	3	YES
The project is likely to influence future designs	1	1	YES
The design provides a clear strategy for future adaptation and expansion	1	1	NO
The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	2	NO
The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

Form and Materials	Weight	Score	Notes
The design has a human scale and feels welcoming	1	3	YES
The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	2	1	YES
Entrances are obvious and logical in relation to likely points of arrival on site	1	4	YES
The external materials and detailing appear to be of high quality and are maintainable	1	2	YES
The external colours and textures seem appropriate and attractive for the local setting	1	3	YES
The design maximises the site opportunities and enhances a sense of place	1	3	YES
The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

Staff and Patient Environment	Weight	Score	Notes
The design reflects the dignity of patients and allows for appropriate levels of privacy	1	1	YES
The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	2	YES
The design maximises the opportunities for access to usable outdoor space	1	1	YES
There are high levels of both comfort and control of comfort	1	1	YES
The design is clearly understandable and wayfinding is intuitive	2	2	YES
The interior of the building is attractive in appearance	1	4	YES
There are good bath/ toilet and other facilities for patients	1	2	YES
There are good facilities for staff with convenient places to work and relax without being on demand	1	1	YES
There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	1	NO
The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0		

Urban and Social Integration	Weight	Score	Notes
The height, volume and skyline of the building relate well to the surrounding environment	1	4	NO
The facility contributes positively to its locality	2	2	YES
The hard and soft landscape contribute positively to the locality	1	3	YES
The overall design contributes positively to neighbourhood and is sensitive to passers-by	1	3	YES
There is a clear vision behind the design, its setting and outdoor spaces	1	2	YES
The benchmarks in the Design Statement in relation to INTEGRATION are met	0		

	Benchmark
Use	1.7
Access	1.2
Space	1.9
Performance	3.0
Engineering	3.3
Construction	0.0

Character and Innovation	2.1
Form and Materials	2.4
Staff and Patient Environment	1.7
Urban and Social Integration	2.7

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

Health Facilities Scotland

AEDET Refresh v1.2 Mar 2016

	Ref	Note	
	A.01	1 - Poor flow, adjacencies betw depts not right. ED / imaging adjacency is fine & 2 wards fine, others not. E.g. pharmacy & laboratories at rear, theatres on 1st floor. ED - not	
	A.02	1 - as above	
	A.03	1 - privacy, toilets on ward not suitable for disabled, no private room for confidential conversations with relatives, no designated place of safety. Hospital chapel serves a	
	A.04	2 - Physio gym and Occupational Therapy department too far from rehab ward, pharmacy at rear of hospital, privacy & dignity compromised due to poor flow & patients	
	A.05	1 - landlocked, no space for expansion of depts that need more space	
	A.06	3 - spaces are designed to be used flexibly where possible, e.g. ACU	
	A.07	3 - Security of building reasonable at night (front door locked), lifts not secure which compromises ED security - can enter ED directly via lift. Imaging secure at night, but	
	A.08	1 - confined site, very little access to suitable outdoor space	
	A.09	3 - can change large bits of kit relatively easily (e.g. CT scanner replacement was straightforward), VC & NHS Near Me provision good, looking to increase resilience of IT	
	A.10		
	B.01	6 - Train station at rear & bus stop at front. Noted frequency of transport provision could be improved on	
	B.02	1 - location of parking for those with poor mobility or are ill - a long walk round to front of building & patients struggle.	
	B.03	1 - Ambulance access under canopy at an angle, hit wing mirrors on approach. Parking provision limited. No automatic door on entry to building. Lifts & routes shared with	
	B.04	2 - Limited space at back for deliveries / estates vehicles, sometimes impacts on staff / visitor / patient / ambulance vehicle movement. One way system does help to	
	B.05	1 - Outside ED path is very narrow (especially where Audiology unit sits) - not suitable for wheelchairs. Long route from parking to front door.	
	B.06	3 - Recently upgraded, new emergency lighting system installed & lighting levels surveyed, up to standard. Lack of outdoor space.	
	B.07	1 - Long route from car park "encourages" active travel! No designated cycle routes / limited active travel routes locally. There are cycle shelters but go via dirt to get in.	
	B.08	1 - cars dominate access to building, have to cross main access road to get to building from main pedestrian route from town.	
	B.09		
	C.01	1 - Definitely not, except for pharmacy which is reasonably good. Size of waiting areas, Tx rooms etc insufficient	
	C.02	4 - Ratio is good & space not wasted, albeit space not always used appropriately.	1
	C.03	2 - ED / outpatients / imaging quite efficient, but pharmacy, labs, wards, OT / physio etc involves a long route. Relatively small facility so routes are not excessive overall.	2
	C.04	2 - no. Can be isolated in ED but room not suitable (too small & remote from staff space). Poor segration on ward - patients trying to sleep & overnight visitors. No	
	C.05	2 - Dining room is a nice area, well used, but no separate staff dining area - shared with patients. Day rooms are not central; located at end of corridor. Used more often by	3
	C.06	2 - Pharmacy & admin storage is adequate. Other areas not (wards, x-ray, ED). ED storage combined with kitchen, no equipment store. Lots of small stores dotted	4
	C.07	1 - very limited green space on site	5
	C.08		6
	C.09		
	D.01	4 - windows require replacement, infrastructure / utilities easy to replace & upgrade	
	D.02	4 - overall fairly easy to clean, lots of work done to theatres etc to improve this. Carpet in office areas proves not easy to clean.	
	D.03	3 - wooden bump rails & plasterboard finish so not as good as it could be. External stonework - porous, moss under windows. A good portion of walls along corridors are	
	D.04	2 - Re-roofed main part of building recently, service block still to be done. Porous stonework - requires treatment to prolong life	**Ref**
	D.05	2 - Windows & doors leak, let in draughts. Windows need replaced. Entrance foyer and back door service yard is very cold due to draughts. Wind direction at ambulance	
	D.06	2 - No plants, little wildlife. Waste reduction systems in place, water alliance. CGH is connected to district heating scheme.	
	D.07	4 - Easy to maintain, e.g. ceiling heights, good access to replace lighting etc.	
	D.08		
	E.01	2 - Not to modern standards; late 1970s technology.	
	E.02		
	E.03	3 - On Biomass district heating scheme, LED lighting	
	E.04	5 - 100% generator coverage (2 years old), contingency plans in place	
	E.05	4 - Can isolate areas to allow work on system without impacting on service operations (electrical, heating etc)	
	E.06	4 - could be improved on but recent maintenance carried out without significant adverse impact	
	E.07		
	F.01		
	F.02		
	F.03		
	F.04		
	F.05		
	F.06		
	F.07		
	F.08		
	F.09		
	F.10		
	G.01	1 - There were when first constructed, but not now	
	G.02	3 - Prominent position in town, focal point. Local staff & patients have a lot of affection for the building. Utilitarian, dated, not pretty externally, more interesting internally.	
	G.03	3 - Not much by way of arts design; some local artwork, poetry & photos on display, not integrated to the design.	
	G.04	3 - Inaccessible toilets. From patient perspective the staff lift the spirits, building less so. Patients would prefer to use this building than Raigmore Hospital. Building is a bit	
	G.05	1 - other clinicians come to see processes & systems but not building	
	G.06		

	G.07	
	G.08	
	H.01	3 - Exterior not particularly welcoming, a bit drab except for the small outdoor space in front of the hospital with some greens and benches where the statue sits. Small &
	H.02	1 - Laughter(!),design doesn't help to provide shelter against local weather. Bedrooms not optimally located to take advantage of sunlight. Pedestrian route from car park
	H.03	4 - Entrance visible on arrival, pass it on way to car park at rear
	H.04	2 - box profile sheeting, utilitarian
	H.05	3 - Reassuring presence, natural stone in keeping with characteristics of Wick
	H.06	3 - Sea views from some areas of wards, visual connection to town, services at back
	H.07	
	I.01	1 - Privacy poor, no private room for conversation with relatives, no designated place of safety, multi-bedded rooms (4 beds). Route for ambulance transfers shared with
	I.02	2 - town centre location, majority of waiting areas internal with limited views out, daylight & views not maximised.
	I.03	1 - no usable outdoor space
	I.04	1 - Not a good Building Management System, lots of complaints - either too hot or too cold
	I.05	2 - Staff get stopped for directions quite often. Wayfinding within the hospital is not great to manouver around.
	I.06	4 - Room for improvement but is clean, bright, welcoming & functional
	I.07	2 - ED specimen toilet opens out on to waiting area. Ward - not space to turn in shower, toilets don't have sufficient space for moving & handling, inaccessible toilets (for
	I.08	1 - Staff dining shared with visitors / patients, very few depts have suitable space
	I.09	
	I.10	
	J.01	
	J.02	2 - arrival route from train station has view of plant / FM area, this side of hospital does not contribute positively to local area
	J.03	3 - View from town / bridge is of green space & trees. Limited if approach by road
	J.04	3 - View from playing fields back to hospital not great
	J.05	2 - although 1/3 thought 3 - Mostly agreed that the designer(s) had clear vision when it was built.
	J.06	

Caithness General Hospital Benchmark

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

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

Actions	by date	Owner	Completed

Benchmark

Caithness Community Hubs - Thurso & Wick

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	1	YES
A.02	The design facilitates the care model	1	1	NO
A.03	Overall the design is capable of handling the projected throughput	1	1	NO
A.04	Work flows and logistics are arranged optimally	1	1	YES
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2	1	NO
A.06	Where possible spaces are standardised and flexible in use patterns	1	2	YES
A.07	The design facilitates both security and supervision	1	3	YES
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	3	YES
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	1	NO
A.10	The benchmarks in the Design Statement in relation to building USE are met	0		NO

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	5	YES
B.02	There is adequate parking for visitors/ staff cars/ disabled people	2	3	YES
B.03	The approach and access for ambulances is appropriately provided	1	2	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	2	YES
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	1	YES
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	2	YES
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	2	YES
C.02	The ratio of usable space to total area is good	2	3	YES
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	1	YES
C.04	Any necessary isolation and segregation of spaces is achieved	1	3	YES
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	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	2	YES
C.08	The relationships between internal spaces and the outdoor environment work well	1	4	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	2	YES	G.01
D.02	The building and grounds are easy to clean and maintain	1	2	YES	G.02
D.03	The building and grounds have appropriately durable finishes and components	1	2	YES	G.03
D.04	The building and grounds will weather and age well	1	2	YES	G.04
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	2	2	YES	G.05
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	1	YES	G.06
D.07	The design minimises maintenance and simplifies this where it will be required	1	1	YES	G.07
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0	0		G.08

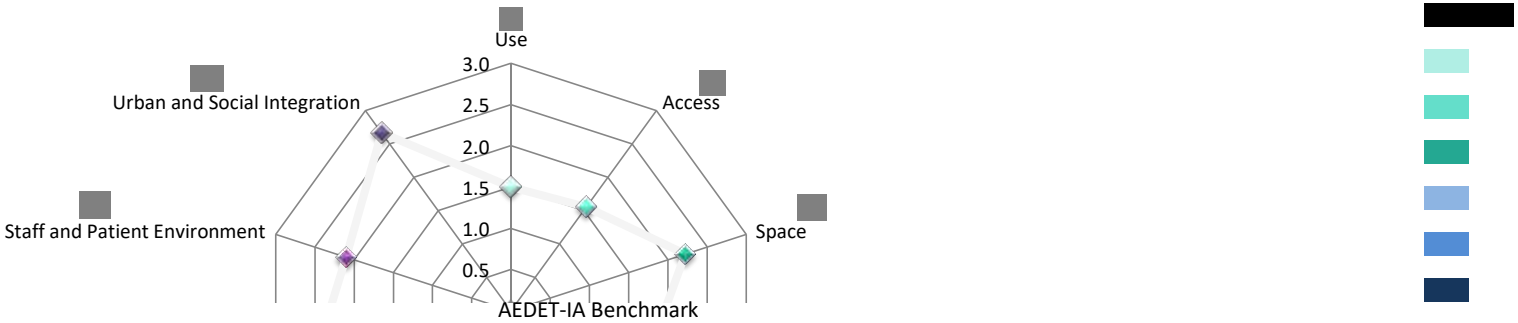
Engineering

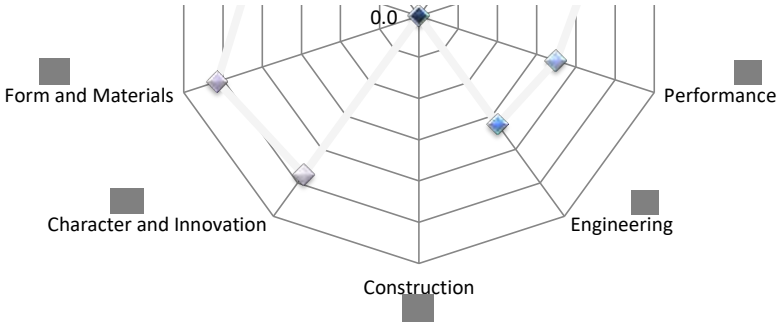
		Weight	Score	Notes	
E.01	The engineering systems are well designed, flexible and efficient in use	1	1	YES	H.01
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	1	YES	H.02
E.03	The engineering systems are energy efficient	1	2	YES	H.03
E.04	There are emergency backup systems that are designed to minimise disruption	1	3	YES	H.04
E.05	During construction disruption to essential services is minimised	1	2	YES	H.05
E.06	During maintenance disruption to essential healthcare services is minimised	1	2	YES	H.06
E.07	The design layout contributes to efficient zoning and energy use reduction	2	1	YES	H.07

Construction

		Weight	Score	Notes	
F.01	If phased planning and construction are necessary the various stages are well organised	0			I.01
F.02	Temporary construction work is minimised	0			I.02
F.03	The impact of the building process on continuing healthcare provision is minimised	2			I.03
F.04	The building and grounds can be readily maintained	0			I.04
F.05	The construction is robust	0			I.05
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0			I.06
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0			I.07
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0			I.08
F.09	The construction contributes to being a good neighbour	0			I.09
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0			I.10

AEDET Refresh Benchmark Summary




0.0
Form and Materials
Performance
Character and Innovation
Engineering
Construction

Impact

Character and Innovation	Weight	Score	Notes
There are clear ideas behind the design of the building and grounds	1	3	YES
The building and grounds are interesting to look at and move around in	1	3	YES
The building, grounds and arts design contribute to the local setting	1	4	YES
The design appropriately expresses the values of the NHS	1	2	YES
The project is likely to influence future designs	1	2	YES
The design provides a clear strategy for future adaptation and expansion	1	1	NO
The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	2	2	YES
The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

Form and Materials	Weight	Score	Notes
The design has a human scale and feels welcoming	1	4	YES
The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	2	2	NO
Entrances are obvious and logical in relation to likely points of arrival on site	1	3	YES
The external materials and detailing appear to be of high quality and are maintainable	1	2	YES
The external colours and textures seem appropriate and attractive for the local setting	1	3	YES
The design maximises the site opportunities and enhances a sense of place	1	2	YES
The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

Staff and Patient Environment	Weight	Score	Notes
The design reflects the dignity of patients and allows for appropriate levels of privacy	1	2	YES
The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	2	YES
The design maximises the opportunities for access to usable outdoor space	1	3	YES
There are high levels of both comfort and control of comfort	1	2	YES
The design is clearly understandable and wayfinding is intuitive	1	3	YES
The interior of the building is attractive in appearance	1	2	YES
There are good bath/ toilet and other facilities for patients	1	2	YES
There are good facilities for staff with convenient places to work and relax without being on demand	2	2	YES
There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	1	YES
The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0		

Urban and Social Integration	Weight	Score	Notes
The height, volume and skyline of the building relate well to the surrounding environment	1	4	YES
The facility contributes positively to its locality	1	3	YES
The hard and soft landscape contribute positively to the locality	1	3	YES
The overall design contributes positively to neighbourhood and is sensitive to passers-by	1	4	YES
There is a clear vision behind the design, its setting and outdoor spaces	2	1	NO
The benchmarks in the Design Statement in relation to INTEGRATION are met	0		

	Benchmark
Use	1.5
Access	1.6
Space	2.2
Performance	1.8
Engineering	1.6
Construction	0.0

Character and Innovation	2.4
Form and Materials	2.6
Staff and Patient Environment	2.1
Urban and Social Integration	2.7

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

AEDET Refresh v1.2 Mar 2016

Ref	Note
A.01	1 overall. Services operating from multiple different bases which makes joint working very difficult. Community services - 1. Davidsons Lane 1 - poor fabric, heating doesn't
A.02	**Key - DL = Davidson's Lane, OMC = Old Wick Medical Centre, T&C = Wick Town & County Hospital, Bayv = Bayview Care Home, Thor = Thor House, Pult / PH = Pulteney**
A.03	
A.04	1, except Pearson practice (2)
A.05	
A.06	Overall 2 e.g. Riverbank - can make reasonable flexible use. Some are 1 e.g. Davidson's Lane
A.07	Overall 3. Davidson's Lane 1 - security very poor. Dunbar Hosp 3 - lots of entrances, CCTV. T&C 1 - no receptionist, anyone can walk in & access patients. Thor - 5. Pulteney -
A.08	Overall 3. T&C 4 - gardens very good with staff access, patients don't tend to use them. Bayview 2 - poor, on main road, lots of ground but not utilised & not greenspace.
A.09	
A.10	
B.01	Overall 5. DL & Riverbank 5 - handy for access to public transport. Dunbar H 5 - bus stop outside on main road.Bayview 5. Thor - 5. Old Wick - 5. Pulteney - 5. T&C - 4. Martha
B.02	Overall 3. Dunbar H - 5. T&C 3- reasonable but not enough spaces. Old MC - 2 or 3. Others quite poor.
B.03	Overall 2. Pulteney, Thor & Dunbar - 5
B.04	Overall 1. Dunbar 3.
B.05	Overall 1. Riverbank - 2, DL - 1, Pult -1 , Bayv - 1, T&C - 1, Martha Terrace - 2.
B.06	Overall 2. Pult 4, Thor 3, DL 1, T&C 2, Riverbank - 3, OMC - 1, Bayview 2
B.07	1 - most buildings have no green routes, designed around cars
B.08	Overall 2 execept DL - 1
B.09	
C.01	Overall 2. OMC - 1, Riverbank 3 - size of rooms not too bad, lots of wasted space, waiting area too big. PH - 3. T&C - 2 inpatients have small side rooms. Dunbar - 2. DL - 1.
C.02	Overall 3. DL 3 - not wasted space. T&C 4. OMC - massive corridor but being used for storage etc.
C.03	Overall 1 as circulation between lots of different buildings. Within the buildings; Bayview - 1. T&C and OMC - 4. Pulteney - 4. Martha Terrace - 4. Riverbank - 4.
C.04	Overall 3. Thor and DL - 1, OMC - 2. Pulteney, Bayview 2. T&C, Dunbar & Riverbank 4.
C.05	Overall 1 - Staff based in lots of different buildings so overall interaction poor. Pulteney - 3, T&C 1.
C.06	1. Riverbank - storage space sufficient but in wrong place (upstairs)
C.07	Overall 2. T&C 5 - nice space there but not used to full potential, Thor - 3. Bayview - 2 there is space but not used to full potential. DL - 1 no outdoor space
C.08	Overall 4. T&C 5 - has good connection. Pulteney 4 - views & nice space with access door, surfaces uneven. Thor 4. Overall Dunbar 4 - nice views & access to small area
C.09	
D.01	Overall 2. DL & Riverbank = 1, Bayview, Dunbar, Pult, Riverview & OMC = 2, T&C - 3.
D.02	Overall 2 - domestic services comments in D03. Estates scores; Bayview, DL, Riverbank, Riverview & OMC = 1, Dunbar, PH & T&C = 2
D.03	Overall 2. Domestic services; DL - 1 old type carpets difficult to clean. T&C - 4. Bayview 2 - original carpets, difficult to access windows for cleaning. Riverview - carpet.
D.04	Overall 2, except; DL, Riverbank & OMC = 1
D.05	Overall 2. Bayview, DL, PH, Riverbank, Riverview & OMC = 1, T&C = 5.
D.06	Overall 1, except T&C = 3
D.07	Overall 1, except T&C and Bayview = 2
D.08	
E.01	Overall 1, except T&C and OMC = 2
E.02	Overall 1, except T&C = 2
E.03	Overall 2. DL, PH & Riverbank = 1, Dunbar, Riverview & OMC = 2, Bayview & T&C = 3
E.04	Overall 3. DL, Riverbank, Riverview & OMC = 1; Bayview & PH = 3, Dunbar and T&C = 5
E.05	Overall 2. Except DL, OMC & Riverbank = 1; T&C = 3
E.06	Overall 2. Except DL, PH & Riverview = 1, T&C = 3
E.07	Overall 1, except T&C = 2
F.01	
F.02	
F.03	
F.04	
F.05	
F.06	
F.07	
F.08	
F.09	
F.10	
G.01	Overall 3. Dunbar - outpatient entrance at rear, not clear / well signposted. T&C 4 - visitors standing about waiting, unclear where to go.
G.02	Overall 3. DL - 1, OMC - 1, Bayview 4 - initial impression is lovely. Dunbar 4 - front of building nice but not other approaches, nice grounds & setting. T&C 3 - initial approach
G.03	Overall 4 except DL & OMC. Bayview, Dunbar & Medical Centres are good. Arts on display inside buildings, old Caithness photos etc. DL & OMC - 1. T&C - 4.
G.04	Overall 2. Dunbar 2 internally no - not modern. Martha Terrace Medical Centre 3 or 4 - reasonable, medical practices 4. OMC & DL - 1.
G.05	Overall 2. Most are 1 except Pulteney House fire evacuation is good. T&C outside area is exceptional but some concern re: suitability for cognitive impairment
G.06	

Ref
1
2
3
4
5
6

	G.07	Overall 2. T&C - grounds are lovely. Generally grounds are quite exposed & little shelter (or don't have suitable space) so very limited opportunity to use them
	G.08	
	H.01	Overall 4. T&C -2 part of entrance quite dark, not particularly inviting. Dunbar - physio dept not welcoming at all. Riverbank 5 - very welcoming, big open space, bright, high
	H.02	
	H.03	Overall 3. Riverbank - 5 or 6. Dunbar - confusion with different areas, outpatients round back. OMC - confusion as to where to go. T&C - 1. DL - confusing, proximity to
	H.04	Overall 2. DL - 1. T&C, Pulteney, Bayview & Thor - 2. Medical Centres - 4.
	H.05	Overall 3. Medical Centres - good. Bayview OK. Front of Dunbar very appropriate for setting. T&C - fairly standard design, inoffensive. DL and OMC - 1.
	H.06	Overall 2. Bayview - lovely view but not maximised.
	H.07	
	I.01	Overall 2. OMC - 1, T&C - yes, DL - 1. Martha Terrace - not great, conversations overheard at reception. Bayview privacy on 2 floors good, 1 floor no. Dunbar MIU waiting
	I.02	Overall 2 Not maximised. T&C - most single rooms look on to cars.
	I.03	Overall 3. T&C - 4 or 5, Pulteney & Bayview - 3. DL and OMC - 1
	I.04	Overall 2. DL - 1. T&C - 2 no heating in entrance-way. Medical centre variable depending on what room. Riverview - fairly poor. Bayview - depending on wind either really
	I.05	Overall 3. Services based across multiple sites. Bayview 3 - could be better. Riverbank - 4. Dunbar - multiple entrances, confusing. T&C - 2. Martha Terrace - 2. Pulteney - 5.
	I.06	Overall 3. T&C - 3, Practices - 4, Bayview - 2 (day care poorer), Pulteney - 2. DL & OMC - 1. Dunbar - 2. Thor House - 4.
	I.07	Overall 2. T&C - palliative 2, rest no. Martha Terrace 4 - disabled access not good. Riverbank - 4. Bayview 2 - difficult to accommodate M&H equipment etc. DL & OMC - 1.
	I.08	Overall 2. T&C - have staff facilities, others not good, many are not accessible to those with disabilities. Pulteney - 3.
	I.09	Overall 1 except for T&C - 4. Bayview - nice area at back but no view and can only be used weekends & evenings.
	I.10	
	J.01	Overall 4. Generally yes (Dunbar, Bayview, T&C etc), but some no (DL, OMC).
	J.02	Overall 3. Bayview & Dunbar yes. Others fairly non-descript, some not great.
	J.03	Overall 3. T&C - 4
	J.04	Overall 4 except for DL & OMC which are 1.
	J.05	
	J.06	

Health Facilities Scotland

Caithness Community Hubs - Thurso & Wick Benchmark

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

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

Actions	by date	Owner	Completed

Caithness Initial Agreement – Appendix SC06

Economy and Demographics

Economy

The Caithness landscape and economy has been dominated by Dounreay Nuclear Power Station since 1955. Dounreay has provided significant economic value to Caithness and North Sutherland for sixty years. However, the site is undergoing decommissioning and the eventual closure is forecast to be around 2033. There are currently up to 2,000 people, including contractors, working on the site, with an expected gradual decrease over the next fifteen years, with around 200 staff and contractors forecast to leave within the next twelve months. The Caithness and North Sutherland Regeneration Partnership (CNSRP) is actively working to encourage new employment and promote the area as an attractive location to live and work. They estimated that the area economy was 12% dependent on Dounreay work in 2016. The Nuclear Decommissioning Authority (NDA) has invested more than £10M in economic development projects identified as a priority by CNSRP. The total investment from CNSRP partner organisations exceeds £30M.

In addition to the large number of jobs sustained by Dounreay, the largest sources of employment in the Caithness, Sutherland and Easter Ross Parliamentary Constituency falls within: Human Health & Social Work activities (13%); Wholesale & Retail Trade (including sale and repair of motor vehicles) (13%); Accommodation & Food Service activities (9.8%; Manufacturing (8.7%; and Education (7.6%) [1].

A report published by Fair Start Scotland (Scottish Government , November 2019) stated that the areas expected to grow in the Highlands and Islands were in construction, administrative and support services, and professional, scientific and technical jobs. However, early indications into the impact of the COVID-19 pandemic and Brexit on the local economy show that these areas have been severely impacted, with many staff furloughed, facing redundancy and uncertainty.

A recent report prepared by Highlands and Islands Enterprise (HIE), predicts the COVID-19 pandemic to have significant, long-term effects in the Highlands and Islands, further compounding existing pressures such as youth employment opportunities and the de-population of the area due to people having to move elsewhere for work. These impacts are expected to be more severe in the Highlands and Islands due to reliance on industries most impacted by the lockdown and associated restrictions (e.g. tourism & hospitality; retail and construction), as well as a higher number of self-employed individuals and people employed by micro-businesses.

Key headlines include:

- Between March and June 2020, Highland had the highest number of eligible employments furloughed – 35% - than any other part of Scotland (Scottish average, 32%);
- Analysis has shown that 29% of furloughed employment in Highland is at risk, ranking third in Scotland;

[1] Source: Nomis 'Labour Market Profile – Caithness, Sutherland and Easter Ross Parliamentary Constituency

- The dominance of small and micro-business in Highland indicates a more severe impact than anywhere else in Scotland;
- With rising unemployment, young people will be at most disadvantage as they will be competing against experienced workers for jobs, resulting in many having to leave the Highlands and Islands region to seek employment in urban areas;
- Predicted decrease in 2020 GDP in the Highlands and Islands between £1.5bn and £2.6bn;
- Recovery highly likely to lag Scotland in the short-term (2020 & 2021) with full recovery not likely until 2023;
- Economic scarring and loss of productive capacity may be evident for years to come.

Source: (Highlands and Islands Enterprise (HIE), 2020)

Caithness demography

Summary

The population of Caithness in 2018 was 25,413. The area currently has a slightly higher proportion of people aged over 65 years than the Highland Council area (figure 1).

Assuming that recent fertility, mortality and migration trends continue, the total population of the area is projected to decrease by 21 percent by 2041 (figure 3). Over the period, large reductions are projected in the number of children and adults of working age. Older people will increasingly make up greater proportions of the population (figures 2, 3, 7 and 8). The number of people aged over 85 years of age living in the area is projected to more than double by 2041 (figure 3).

In the most recent Highland Council population projections, sustained net out migration from Caithness adds to the loss of population from negative natural change with the number of deaths exceeding births (figures 5 and 6). The Scottish Index of Multiple Deprivation 2020 (version 2) identifies four small areas that have deprivation outcomes similar to areas in the most deprived 20 percent nationally (figures 12 and 13). All four of these areas are in Wick (figure 14).

Current population

Figure 1: Population of Caithness, Highland and Scotland, 2018

	Caithness				% of population	
	Male	Female	Total	% of population	Highland	Scotland
00-14	2,027	1,922	3,949	15.5	15.6	15.9
15-34	2,705	2,560	5,265	20.7	21.2	25.4
35-64	5,100	5,224	10,324	40.6	41.1	39.9
65-74	1,597	1,624	3,221	12.7	12.5	10.5
75-84	873	1,116	1,989	7.8	7.0	6.1
85+	258	407	665	2.6	2.6	2.3
Total	12,560	12,853	25,413	100	100	100.0

Data source: National Records of Scotland mid-2018 Small Area Population Estimates (SAPE)1 ;based on best fit of 2011 data zones to Caithness Community Partnership

Projected population

Population projections are an essential starting point for considering future demands on health and social care services. However, they merely provide evidence of the population levels and age structures that would result if past trends continued into the future. Projections are robust for the population as a whole and over short periods, but their reliability reduces with time and for subgroups because small changes in assumptions are compounded and can have substantial impacts by the end of a projection course.

The population projection information in this report is derived from projections produced by the Highland Council in 2018 that inform the Highland Council Corporate Plan 2019-2022.2 The projections use the same population cohort component method as National Record of Scotland employ in their projections for Scottish Administrative Areas3.

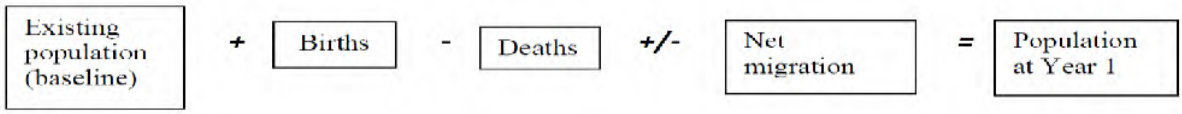
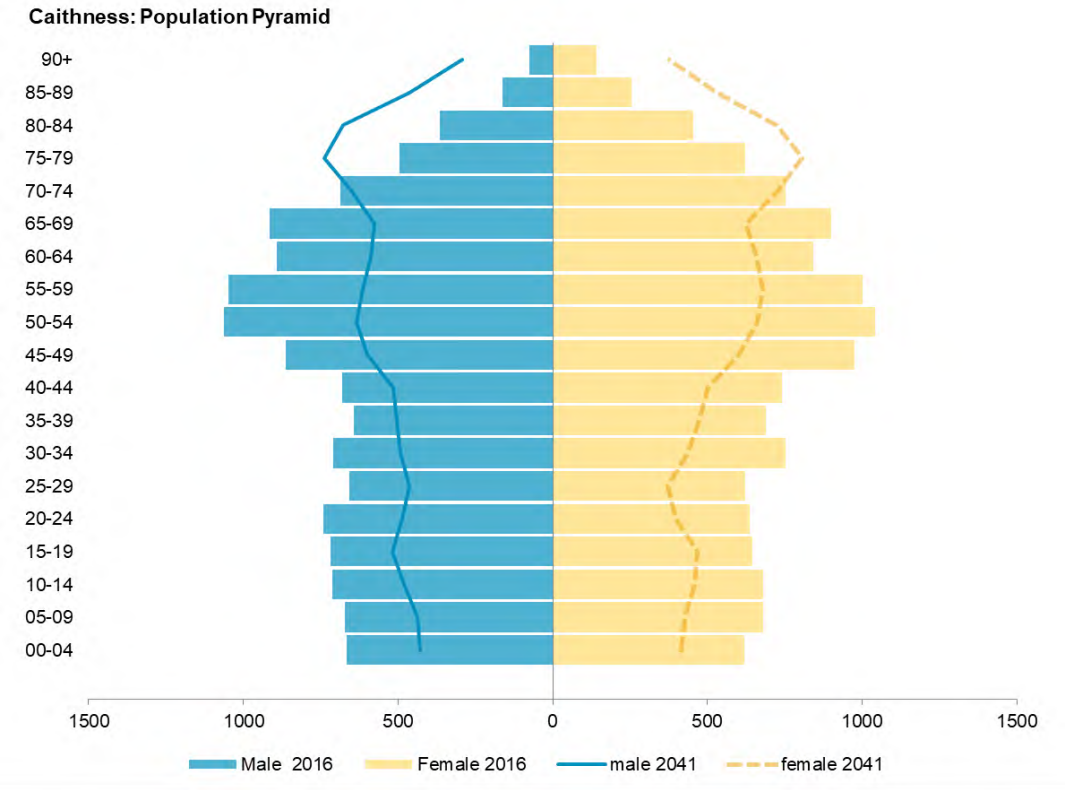


Figure 2: Caithness projected population profile 2016 and 2041



Data source: Highland Council Area Population Projections

Figure 3: Projected change in the population of Caithness and Highland, 2016-2041

	Caithness			Highland
	2016	2041	% change 2016-2041	% change 2016-2041
00-14	4,028	2,719	-32.5	-9.8
15-34	5,481	3,621	-33.9	-9.9

35-64	10,475	7,123	-32.0	-10.7
65-74	3,253	2,759	-15.2	8.0
75-84	1,937	2,807	44.9	74.8
85+	633	1,340	111.7	140.6
total	25,807	20,367	-21.1	1.4

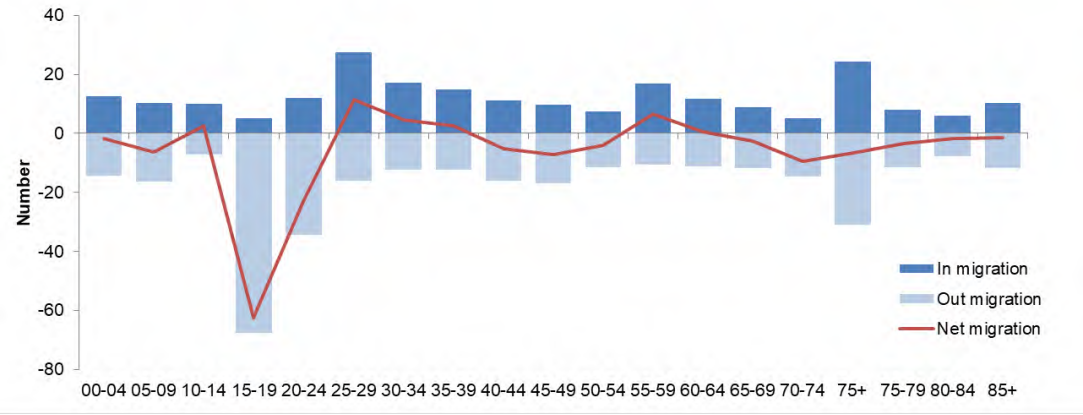
Data source: Highland Council Area Population Projections

Components of population change

Migration

Migration is particularly difficult to predict because it is sensitive to economic, political and social changes and therefore a major uncertainty in the longer-term projections for Caithness. On average the projections for Caithness assume an annual net loss of 105 people from out migration. Particularly large losses are projected in younger age ranges at the point that young people are taking up educational opportunities or employment after leaving school (figure 4).

Figure 4: Annual projected in and out migration in Caithness by age band, 2020-21

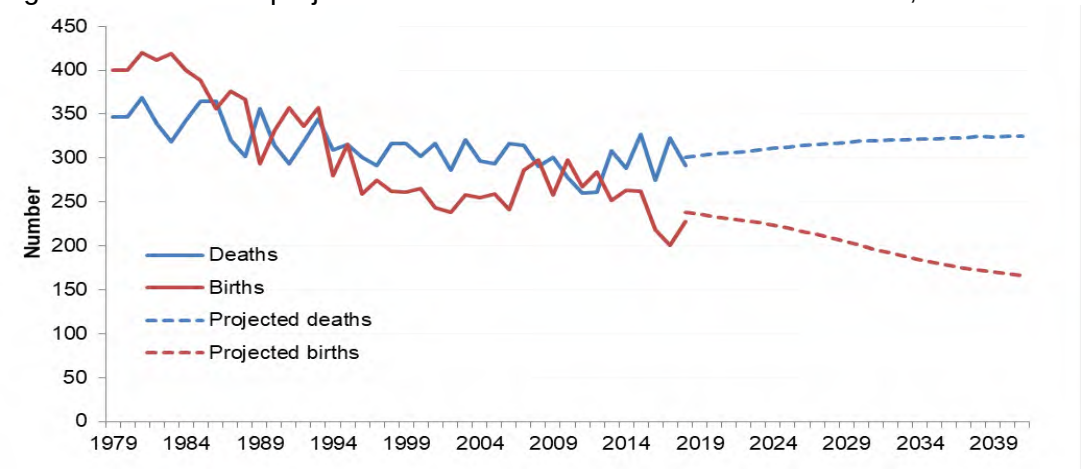


Data source: Highland Council Area Population Projections

Births and deaths

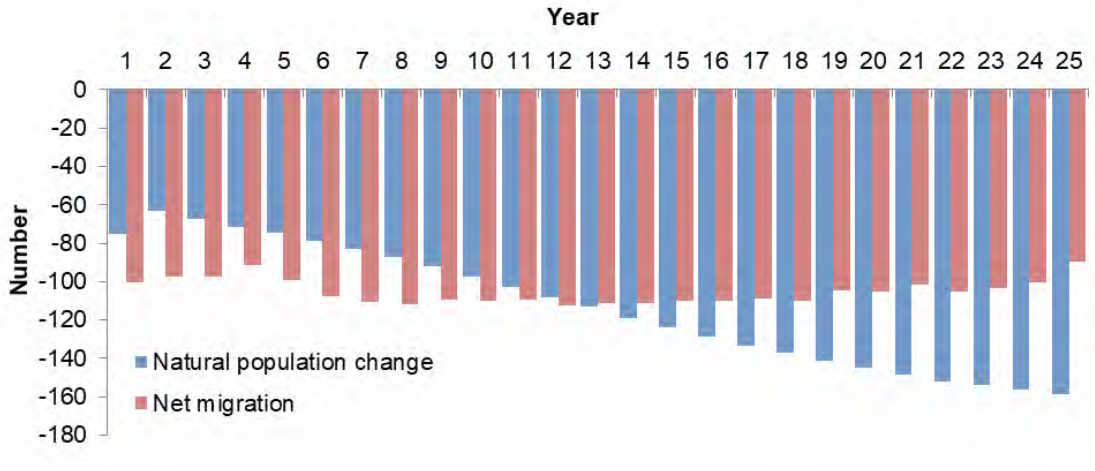
The impact of population loss from migration is compounded by the numbers of deaths increasing as the numbers of births decline, resulting in negative natural population change over the projection course (figure 5). If current trends continue, negative natural population change contributes a larger share of the population loss from the area in the later years of the projection (figure 6).

Figure 5: Actual and projected births and deaths in the Caithness area, 1979-2041



Data source: National Records of Scotland Vital Events Recording and Highland Council Area Population Projections

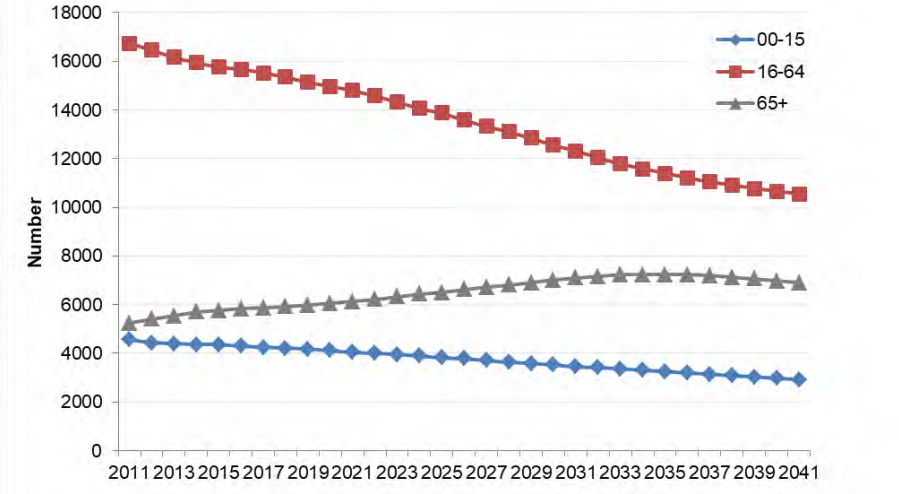
Figure 6: Net migration and natural population change in Caithness over the 25 years of the projection period



Data source: Highland Council Area Population Projections

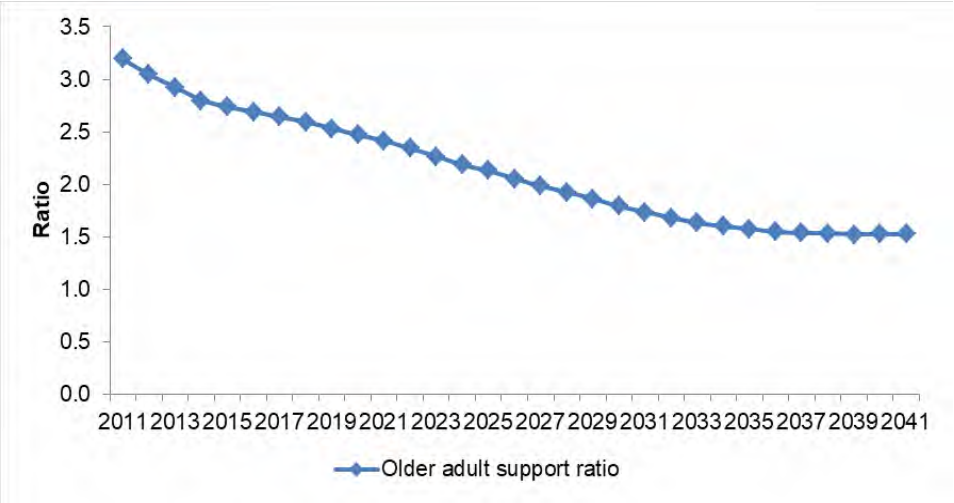
By the end of the projection course the ratio of people of working age to those aged over 65 years will have significantly reduced. In 2018 there were 26 people of working age for every 10 people aged 65 years or older living in the area. By the end of the period this figure will have reached to a low of 15 people of working age for every 10 people aged 65 years and older. Relating changes in the population structure directly to changes in demand and capacity is not straightforward, but the demand for services in the area will need to be met by a declining and ageing working population in the future.

Figure 7: Actual and projected population change in Caithness by broad age group



Data source: Highland Council Area Population Projections

Figure 8: Projected change in the older adult support ration in Caithness (population of working aged/population aged over 65 years old)



Data source: Highland Council Area Population Projections

Deprivation in Caithness

Where people live affects their health and life chances. The links between socio-economic deprivation and people's health and well-being outcomes are well evidenced and deprivation impacts on child development, people's lifestyle choices, healthy life expectancy, including living with an illness or chronic condition, and life expectancy. A consequence of deprivation and poverty is generally an increased demand for health and social care services.

The Scottish Index of Multiple Deprivation (SIMD) is the official and widely used composite measure of deprivation for data zones (small areas with a median population of about 760 people) in Scotland. The most recent version of the SIMD was published in 2020 and is based upon 2011 Census geography5.

A revised version of SIMD 2020 was released in April 2020 and is used in this report. Multiple deprivation does not just identify areas with 'poor' or 'low income'; it can also mean people live in areas that have relatively fewer resources and opportunities within the seven domains of the index: Income, Employment, Education, Health, Access to Services, Crime and Housing.

The SIMD is put together by combining indicator scores from these 7 domains for every small area and ranking these areas from the most to the least deprived, where 1 is the most deprived and 6,976 the least deprived in Scotland. These ranks are commonly grouped into quintiles (20% bands) and deciles (10% bands) of deprivation by data zone either within Scotland, Health Board or Council Area2.

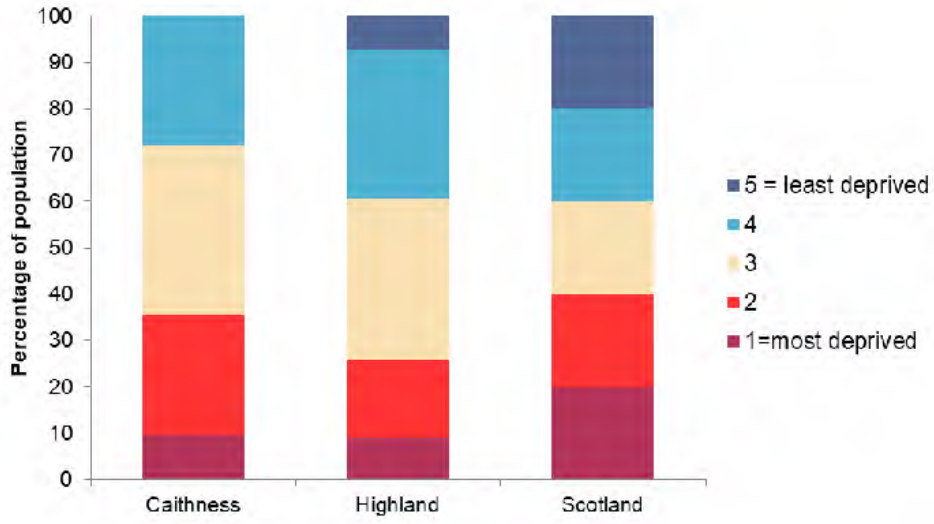
There are thirty eight data zones in the Caithness area. Two small areas in Wick are identified as being in the 10 percent most deprived areas in Scotland (figure 11). A further two data zones are in the most deprived twenty percent of areas nationally. The domain scores of these areas highlight that a significant proportion of their populations experience socio-economic challenges and poorer health and educational outcomes. Over 2,400 people live in these four areas – 10 percent of the population of Caithness (figures 9 10 and 14).

Figure 9: Percentage of people living in small areas which are in the most to least deprived quintiles of national deprivation measured by SIMD 2020v2

	National quintile of deprivation (SIMD 2020)				
	1=most deprived	2	3	4	5 = least deprived
Caithness	9.6	26.0	36.5	27.9	0.0
Highland	9.2	16.6	34.9	32.1	7.2
Scotland	20	20	20	20	20

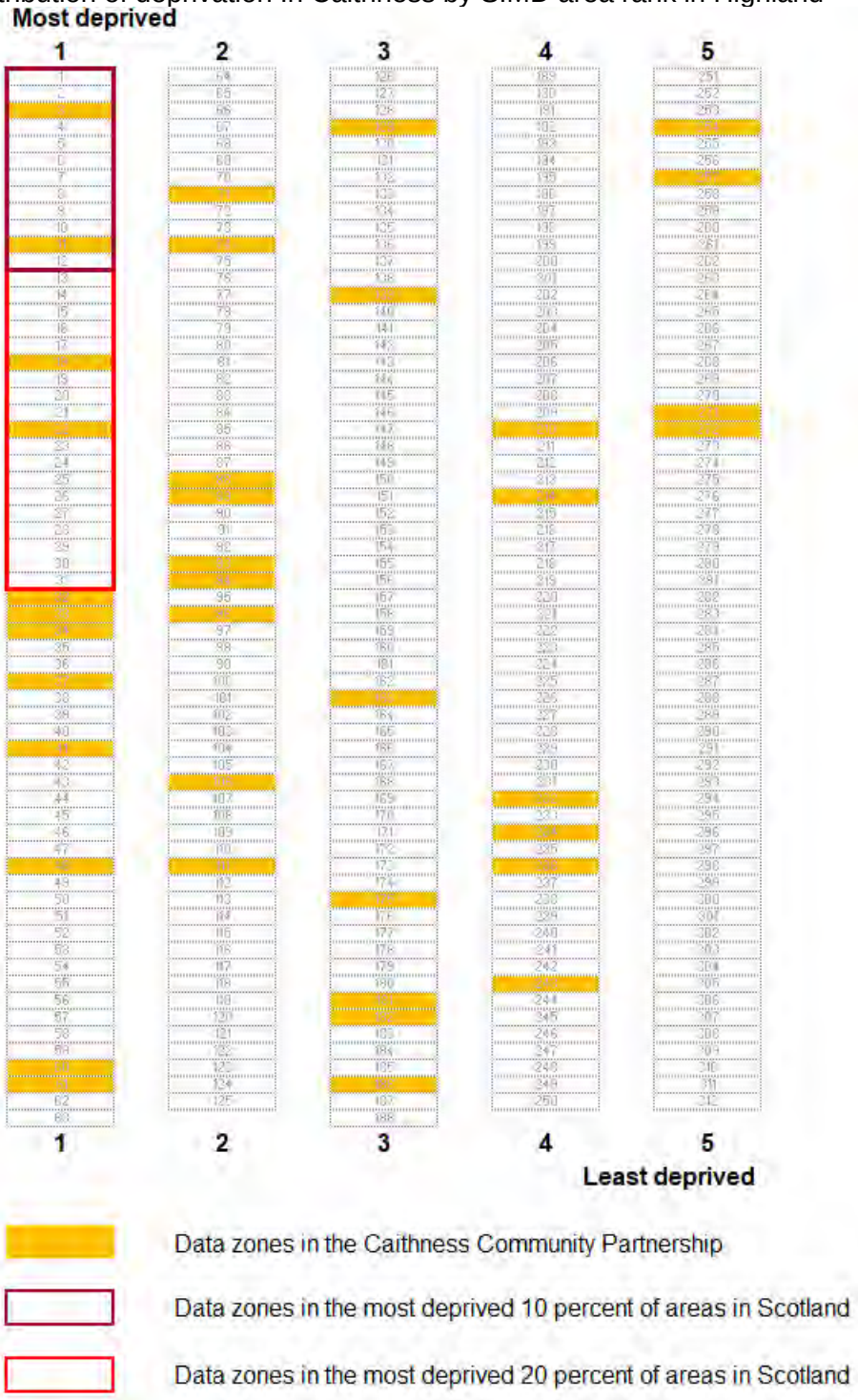
Data source: SIMD 2020v2

Figure 10: Percentage of people living in small areas which are in the most to least deprived quintiles of national deprivation measured by SIMD 2020v2



SIMD 2020v2

Figure 11: Distribution of deprivation In Caithness by SIMD area rank in Highland



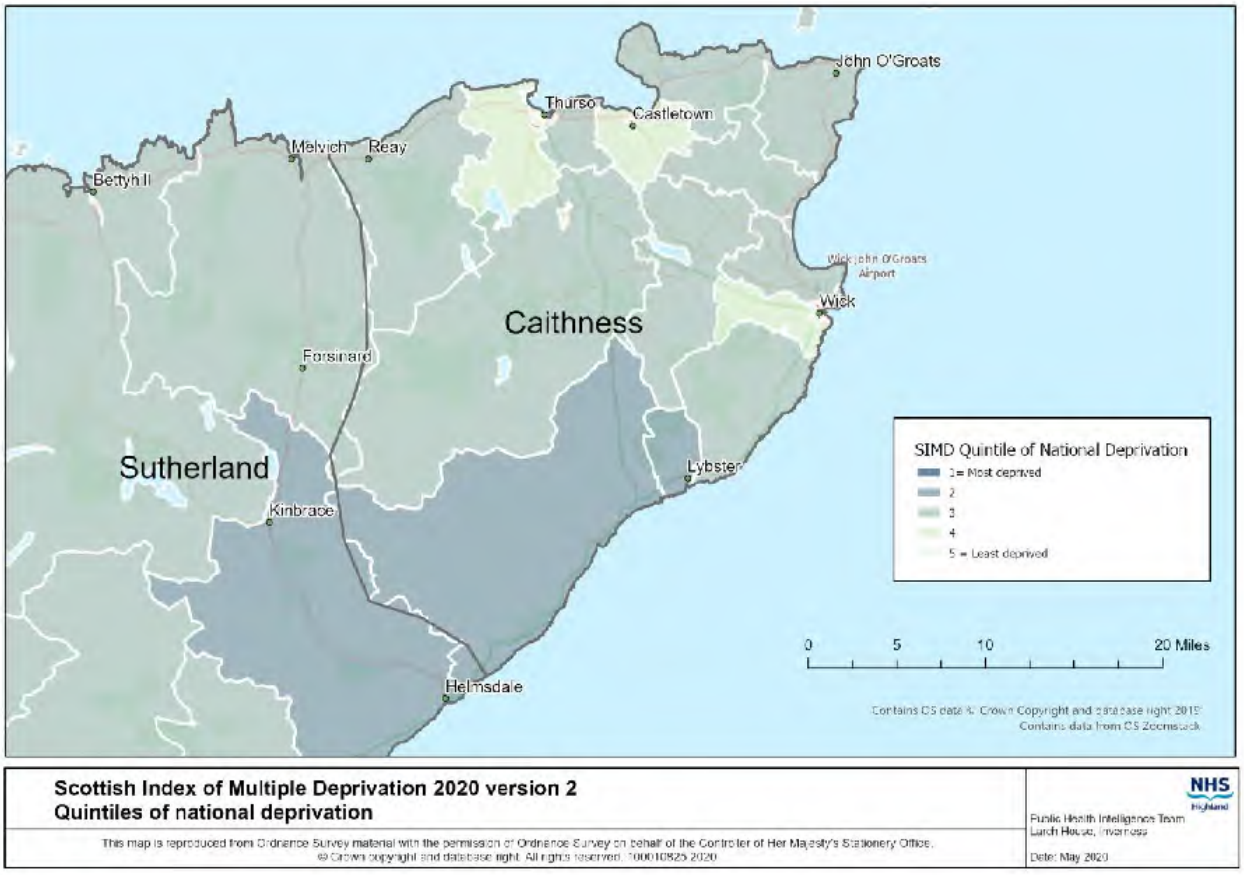
There are 312 small areas (data zones) in the Highland Local Authority area and these are ranked in the chart by deprivation from the top left (most deprived) to bottom right (least deprived). The first column contains the most deprived 20 percent of areas (63 in total). The second one has the next 20 percent of areas and so on. The coloured shading represents the deprivation profile of the small areas in the Caithness Community Partnership
Data source: SIMD 2020v2

Figure 12: Data zone areas in Caithness in the most 20 perecent of deprived areas nationally

Data zone	Name	Rank in Scotland (1 = most deprived area and 6976 = least deprived)	National quintile of deprivation
S01010778	Wick Pultneytown South	215	1
S01010784	Wick Hillhead North	659	1
S01010777	Wick South Head	912	2
S01010779	Wick South	1004	2

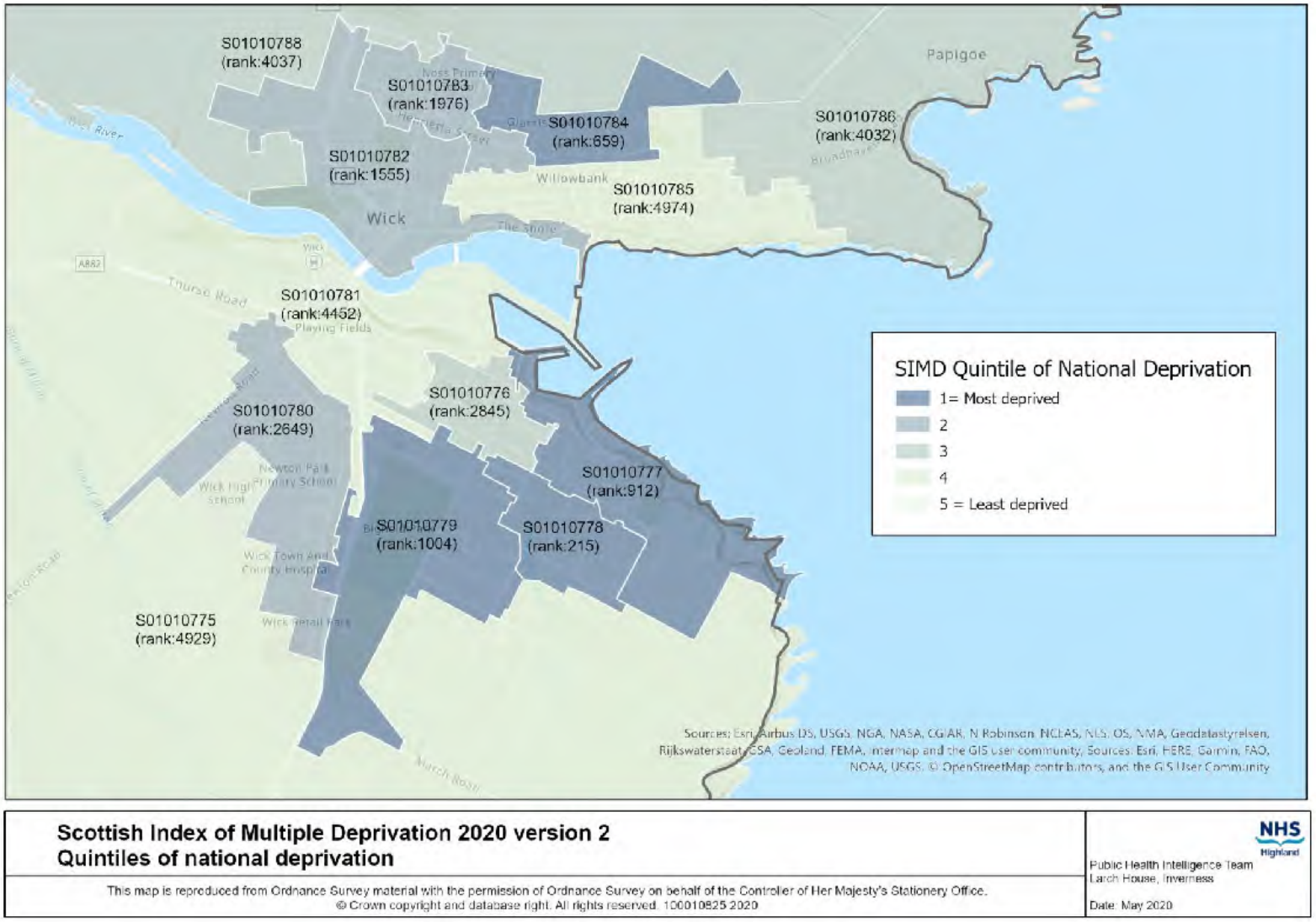
Data source: SIMD 2020v2

Figure 13: Scottish Index of Multiple Deprivation 2020v2, national quintiles of deprivation



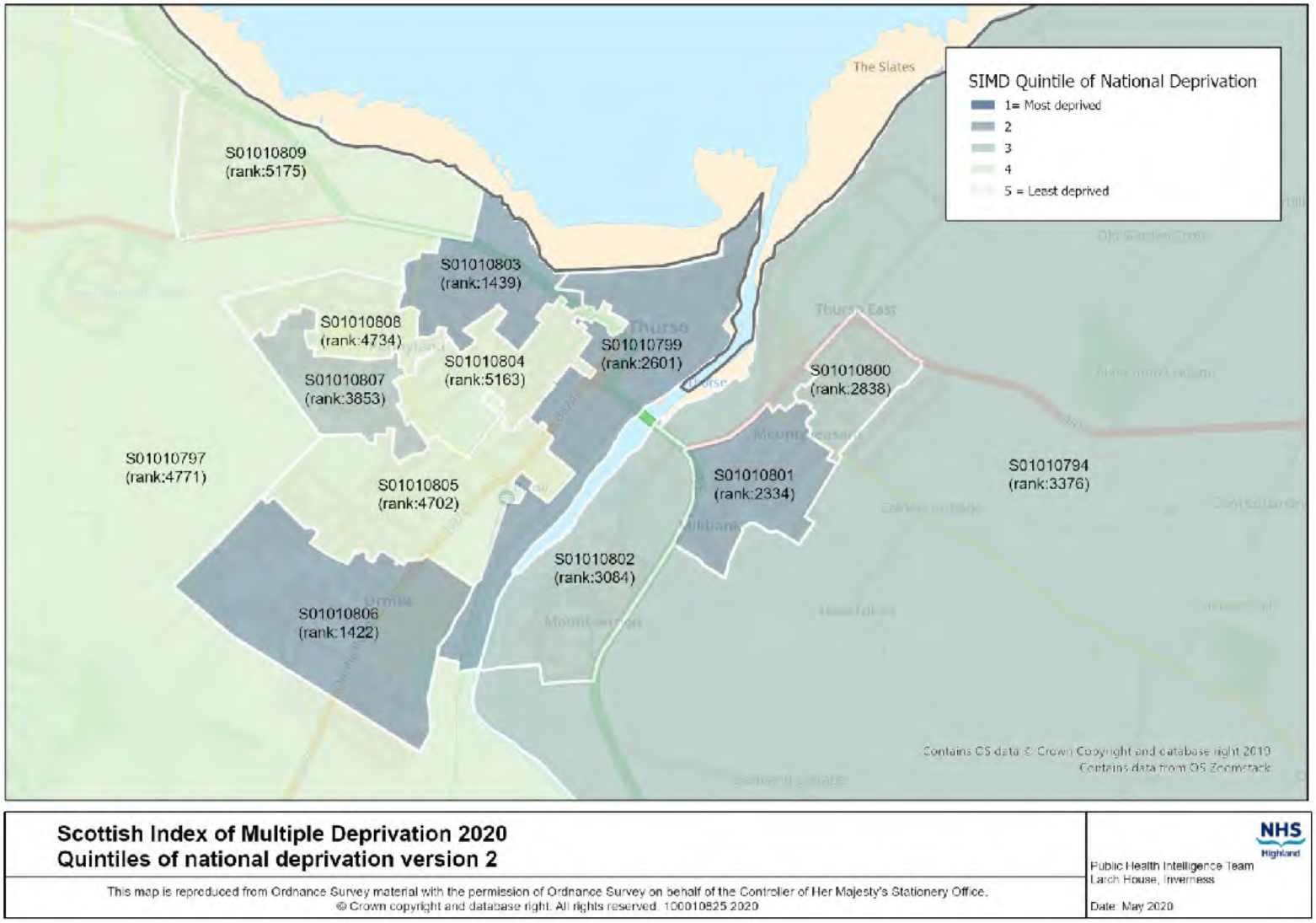
Data source: SIMD 2020v2

Figure 14: Scottish Index of Multiple Deprivation 2020, national quintiles of deprivation, Wick



Data source: SIMD 2020v2

Figure 15: Scottish Index of Multiple Deprivation 2020, national quintiles of deprivation, Thurso

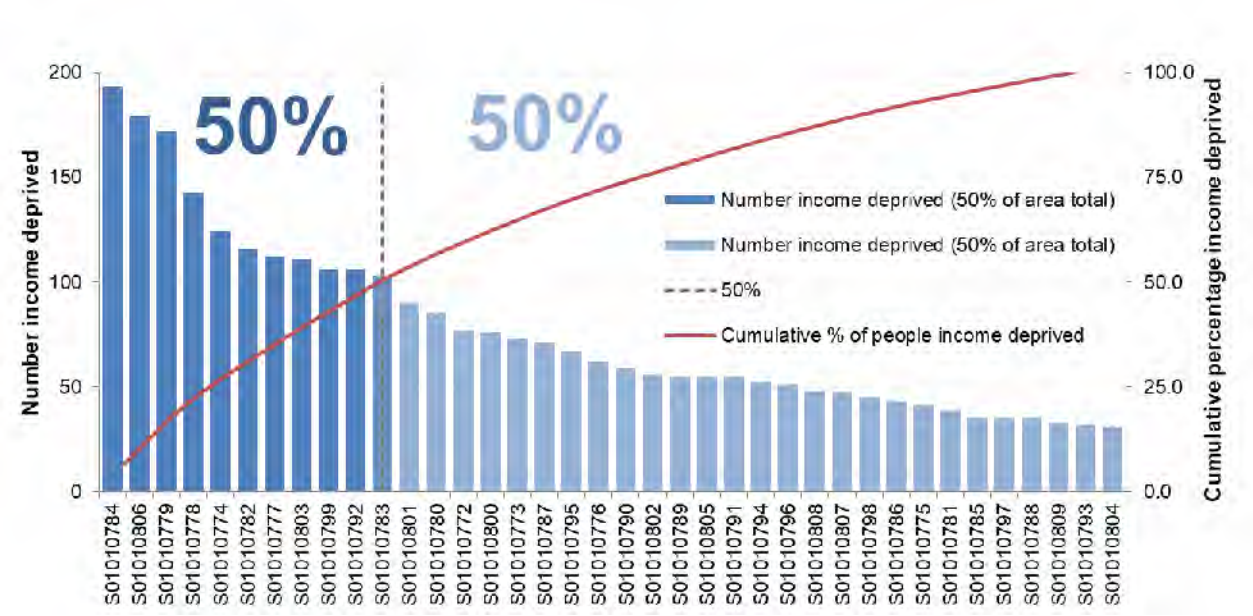


Data source: SIMD 2020v2

The SIMD is recognised as being less sensitive to deprivation in a rural context where populations are more spatially dispersed and socially heterogeneous. Not all deprived people live in deprived areas and using the income domain of SIMD it is possible to show that many income deprived people do not live in the most multiply deprived areas in Caithness.

Equally, while income deprivation is more concentrated in deprived areas not everyone living there is deprived

Figure 16: Number and cumulative percentage of income derprived people in the 38 data zones in the Caithness Community Partnership



Data source: SIMD 2020v2

In remote rural Caithness many disadvantaged individuals and households will live in areas not identified as being particularly deprived by SIMD. These people live at distance from service access points and therefore present a particular challenge to those providing health and social care.

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1. National Records of Scotland. *Mid-2018 Small Area Population Estimates for 2011 Data Zones.* 2020. Available from: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/2011-based-special-area-population-estimates/small-area-population-estimates/mid-2018 [Accessed May 2020].

2. Highland Council. *Population Projections for Eight Areas (2016-based).* Provided on request by the Highland Council.

3. National Records of Scotland. *Population projections for Scottish areas (2018-based) - detailed tables.* 2020. Available from: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/sub-national-population-projections/2018-based [Accessed May 2020].

4. Skerratt, S., Atterton, J., Brodie, E., Carson, D., Heggie, R., McCracken, D., Thomson, S. and Woolvin, M. 2014. Rural Scotland in Focus 2014, Edinburgh: Rural Policy Centre, SRUC, Scotland's Rural College. [Online]. Available. https://www.sruc.ac.uk/info/120485/thriving_communities_archive/1265/2014_rural_scotland_in_focus_report. [Accessed 20 May 2020]

5. Scottish Government. The Scottish Index of Multiple Deprivation. 2020. Edinburgh. [Online]. Available: https://www.gov.scot/publications/scottish-index-of-multiple-deprivation-2020v2-indicator-data/. [Accessed 16 May 2020].

Summary Health Inequalities Impact Assessment for Caithness Redesign Process

"Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups.
Health inequalities go against the principles of social justice because they are avoidable. They do not occur randomly or by chance. They are socially determined by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live longer, healthier lives.
The existence of health inequalities in Scotland means that the right of everyone to the highest attainable standard of physical and mental health is not being enjoyed equally across the population." (What are health inequalities? - Health inequalities - Public Health Scotland)

Purpose:

To review the Redesign of Health and Social Care Services in Caithness Process and the range of activities undertaken to date to establish what are considered to be the key Health Inequalities, and to identify the contribution of the Caithness Redesign Process to addressing these. The scope of the Caithness Redesign process is for all adult services for those aged 18 and over. However, it is essential that emerging services are steeped in consideration of cradle to grave health outcomes, and of known, specific and prevalent challenges around mental wellbeing, mental distress and alcohol and drug use.

Additional considerations:

Increased inequalities due to the COVID-19 pandemic have been felt across communities, and particularly by those already experiencing inequalities. Employment, social pressures, isolation, mental health, stress and anxiety are all major issues at this time. The compounding impact of services not being accessible in person, reduced capacity and variable imposed restrictions on movement and social contact has exaggerated existing disadvantage.

Limitations:

It is not presumed or expected that the Caithness Redesign Process can solve these wider societal health inequalities, however being aware of them and continuing to develop mitigating and preventative actions through the Redesign Process and beyond is necessary to realise the contribution to minimising their impact on the health and wellbeing of the Caithness Population

Process:

An Equalities Impact Assessment for the project as a whole produced in June 2018, identifying the scope of the work and how people might be affected by it. This has been reviewed and updated in February 2021 utilising renewed format of NHS Highland EQIA documentation.

The original EQIA preceded an extensive period of public consultation from August through November 2018. This wide-ranging consultation was described in a paper to Highland Health and Social Care Committee (January 2019) as "one of the most extensive and comprehensive ever carried out by NHS Highland, and arguably by any NHS or public sector organisation in Scotland". During the consultation, the Redesign Project Team sought to remove as many barriers as possible to enable people to engage with and contribute to the consultation process.

A report by the Scottish Health Council into the consultation process found that "The engagement process and the range of consultation activities undertaken by NHS Highland enabled local people to be informed about and give their views on the proposals. NHS Highland demonstrated that it was listening and responding to views and suggestions expressed during the process and adapted its communication and engagement plans in response".

The breadth of this consultation is important to reflect when considering inequalities. A key issue for tackling inequalities is to promote inclusion in the making of decisions that affect people's lives. Strong efforts were made by NHS Highland to achieve this. It is also acknowledged that there is still more to do in order to access and include the most vulnerable and isolated within the community.

Ongoing project development meetings and events have continued to include a wide range of stakeholders.

In October 2020 a working group undertook a further review of processes and progress, and carried out a further Health Inequalities Impact Assessment through the use of a Health Inequalities Checklist – appended for information.

Key issues that have been highlighted and who is affected most:

The consultation process further informed key equalities questions such as how people might be affected by this work, and who might be disproportionally affected or disadvantaged: i.e. who may be more at risk of inequalities caused by the Redesign process:

Considerations of age and an aging population, along with the associated increases in healthcare needs, have been the major driver for the Redesign Process. Age remains an important factor in how inequalities affect different sections of the community.

Mental Health, and concerns over both the level of need in Caithness and accessibility of the right services was another well documented topic during the consultations. Whilst wider mental health services per se are not a specific focus of this Redesign Process, this is clearly a matter of concern to the community and to service providers. Strong anecdotal evidence continues to raise concerns over the numbers of individuals experiencing mental distress, and of higher incidents of suicidal behaviours. Associated consultation undertaken through Aspiring Communities project reinforces these concerns and highlights the picture of mental health need across Caithness. Ongoing work with the Social Isolation and Mental Wellbeing Action Group (a subgroup of the Caithness Resilience Group) is assisting the collection of service user experiences to inform ongoing service improvement. The contribution of this Redesign Process to improve accessibility of mental health support services should be considered and maximised.

Transport across the region, and further afield for necessary specialist services, was highlighted throughout the consultation events. Public transport options are limited, and fuel poverty is a significant issue in rural Highland. Transport links to local services were raised frequently. Any relocation of services will change existing issues of proximity. This may result in more convenience and easier access for some, but will inevitably cause more inconvenience, time pressures and cost for others. Transport to access services can be particularly challenging for certain groups, e.g. people living with disabilities and long term conditions, carers, single parent families, etc. Solutions to regional and local transport issues are challenging, and not directly within the gift of NHS Highland; however any relocation of services must be considerate of transport infrastructure, and active lobbying and partnership working to influence transport services should be planned for and committed to.

The range and access to appointments, especially more specialist consultations, was another frequently raised issue throughout the consultation events. Many discussions also incorporated the roll out and use of NHS Near Me. Equality of digital connectivity, whether related to technical signal availability or levels of confidence continue to present challenges. Whilst digital options work well for some people, further support is required for others, especially older people.

The Health Inequalities Impact Assessment workshops (October 2020) discussed that significant numbers of Caithness residents are not registered with a GP, raising questions of what complex issues might they be facing and how do we reach them. Communication and information needs were highlighted to ensure that vulnerable and isolated people are aware and informed of services and how to access them. COVID-19 has highlighted this and has caused some people in particular need to be identified and engaged; but we must consider how we maintain this contact and facilitate access to appropriate services and community support.

This HIIA process has also highlighted economic, employment, education and attainment issues. These have a significant and wide ranging impact on communities and their health and wellbeing. Whilst these issues are not directly within the scope of this Redesign Process it is crucial that services are developed and delivered with an awareness of these circumstances and their impact on health and wellbeing.

There is a need for ongoing and further investigation to specific impacts/barriers for some protected characteristics, e.g. minority ethnic, LGBTI. The HIIA workshop identified the benefits of further engaging individuals and groups within the community to ensure inclusion of voices of people who may not usually be involved.

The HIIA workshop discussions also highlighted the importance of person-centred language, anti-discriminatory practice and trauma-informed care as foundations to the effective tailoring of care and support.

How does the redesign process contribute to reducing Health Inequalities?

Viewing health as a complex picture of wider determinants means that holistic solutions for health and wellbeing are required where inequalities are caused or amplified by these wider life circumstances. The model of integrated Care Hubs /Care Villages, including a range of health related services along with input from, and presence of, third sector community support allows these holistic solutions to be developed and applied more effectively. The HIIA workshop highlighted the positive impact of wrap-around multi-disciplinary teams (MDTs) within the model of care: emphasising that the more truly multi-disciplinary they are the more effective the outcomes. Issues around income maximisation, housing support, mental health, alcohol or drug use, carer consideration, and many more may require to be addressed in order for any medically-related care package to be achieved. The central principle is that people get right level support from right person at right time. Combining elements of MDTs, anticipatory planning, Single Point Of Access (SPOA), etc. is key to ensuring ease of access to individualised, holistic and timely care.

This combination of services and support provides synergistic opportunities to address key Health Inequalities identified through this process. Whilst for some individuals transport maybe increased, the existence of multiple services in one hub can reduce the number of occasions that travel is necessary. Having dedicated space, technology and support for people to attend Near Me appointments maximises digital connectivity and confidence. SPOA streamlines individuals' route to and through the services that are right for their

situation at that time. Knowledge experience and referral opportunities are shared more easily across collocated services

The relationship between and across services located within Care Hub, Caithness General Hospital (CGH) and the wider community is very important. The application of Place Based Care nurtures greater opportunities for building connections and supportive networks that can be better integrated into people's real life circumstances.

Building and environment design play a central role in holistic care. Aesthetic and ergonomic factors impact on our sense of value, our mood, our stress and anxiety and ultimately our overall mind-set to receiving treatment, support and referral. Creating and enhancing the natural environment surrounding health care facilities is a key element of this and should be considered as an integral aspect of holistic care.

Reducing inequalities also involves embedding prevention as well as treatment into our services. We need to actively promote things that keep people well in addition to addressing specific causes if illness. Effective person-centred care and multi-agency cross-referral opportunities are central to this. The development of Community Link Worker posts embedded in Primary Care will assist in the addressing wider life circumstances that may be preventing someone from being as well as they can or managing to adhere to treatment and support plans. This role (one of the key strands of the Modernisation of Primary Care) greatly enhances the personalisation of care, supports ongoing service improvement and is a vital signposting service.

Ensure people at most risk have access to preventative health interventions and other appropriate support. Considering the focus of the Redesign Process around older adults, it is suggested that greater use of tools which help to segment the population (for example, the e-Frailty Index, SPARRA – Scottish Patients at Risk of Readmission and Admission - and pHHG – High Health Gain Potential), can support a process of identifying people most in need, and increase the use of early intervention.

The Redesign Process and associated consultations have highlighted examples of extremely good practice. High quality, positive experiences of health and care are recorded and acknowledged. An opportunity exists within the Redesign Process to analyse and understand what features of those care experiences made it so positive and 'successful'; and the formal sharing of good practice, with purposeful inclusion of these elements into the design and approach of integrated Care Hubs, provides an opportunity for perceptions of care and accessibility to be improved. It also reduces barriers of previous negative experiences.

Is there a risk that this Redesign Process might widen Health Inequalities?

Any change to the design and delivery of services carries a risk that Health Inequalities may be widened as a result of the changes. Ongoing positive action is required to mitigate and prevent the issues identified. Regular service review and continued involvement and consultation with key groups and individuals is necessary to avoid unintentional widening of health inequalities through the completion of the Redesign Process and beyond.

The HIIA workshop (and review of the consultation and stakeholder involvement processes) has identified that there is a wide range of support options available across the community, but it was felt that these often do not join together as effectively as they need to. Attention is required to ensure structured, appropriate, clear and full communication between services; and also with patients and communities.

It will be important to avoid ongoing unintentional exclusion of 'hidden' populations. Those individuals that have been revealed through the COVID pandemic are at risk of fading away again, and more individuals have become increasingly isolated and detached during the pandemic.

Potential actions / next steps to consider:

Locally, public resources need to be allocated according to need so that they do not make inequalities worse, and may make a contribution towards their reduction. Providing universal services with added intensive support for vulnerable groups (known as proportionate universalism) is effective at reaching all of those that need them by ensuring that there are fewer or no barriers in terms of price, stigma, accessibility and discrimination.

(What are health inequalities? - Health inequalities - Public Health Scotland)

The HIIA workshops identified the need to ensure that the breadth of representation and the connections established through the consultation process are maintained and nurtured. Sharing skills, knowledge, resources and connections within and across communities is vital. Attention is required to enhancing close working relationships with Caithness Community Partnership, Caithness Resilience Group (including Social Isolation and Mental Wellbeing Action Group, community development initiatives (including recent Aspiring Communities work), Caithness Voluntary Group, Caithness Health Action Team and other local interest groups.

Understanding of Health Inequalities - including root causes, self-awareness, approaches to mitigate and reduce inequalities, and effective person-centred care related to wider determinants of health – is not universally high. Training in this area was identified as a key offering to roll out across NHS staff and community organisations.

Attention must be paid to realising the health improving potential of new and refurbished buildings. Use of space, light, natural features, clear signage and direction are key to this. Providing spaces that are calming, safe and accessible (both within the building and the immediate outdoor environment) brings significant contribution to supporting people to attend services and maximises positive outcomes.

Summary of key recommendations to develop into specific actions:

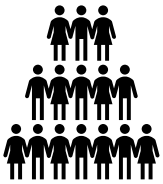
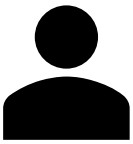
- Develop a programme of Health Inequalities training that can be rolled out across NHS and community staff
- Nurture and maintain close links between Redesign Project Team and Community Partnership, Caithness Resilience Group and relevant community, including representatives of identified protected characteristics.
- Work closely with Social Isolation and Mental Wellbeing Group to develop and improve responsive and supportive services for people experiencing mental distress.
- Using patient experiences to facilitate sharing of good practice across elements of the Redesign.
- Improve identification of current 'hidden' individuals and populations, reaching those at most risk in order to achieve links to treatment and health improvement services.
- Enhance the information flow and communication to wider public as well as stakeholders, about the Redesign Process and then awareness of services and how to access them, requires continued attention and resource. This includes a range of channels and accessible formats.
- Pursue negotiations and actively participate in development of local and regional transport solutions and sustainable / active travel infrastructure.

Caithness Initial Agreement – Appendix SC10

Proposed Future Local Model of Care

Place Based Care	"Local care is place based, focuses on population cohorts with high needs and is centred on addressing the priorities of the individual patient." (Carnall Farrar, 2019)

The Caithness Local Model of Care uses the Place Based Approach. For population health approaches to work effectively, they must consider local contexts and have a clear understanding of what the local assets, pressures, needs are. It requires active involvement and local authorities to tailor initiatives according to local strengths and goals. In this business case the area we are looking at is the county of Caithness. Such a place-based approach facilitates a focus on the social determinants such as housing, education, employment, wider planning partners, social connectedness and community assets. Taken together, these they will have a greater impact on wellbeing and health compared to care and health service on their own. It also promotes a more proactive approach to care, focussing on strengthened primary and community services designed to enable people to self-manage and seek appropriately support, avoiding a reactive response and hospitalisation or longer-term social care wherever possible.

	**Place** • Local care recognises the role of place in supporting the health and care needs of vulnerable members of society • It builds the capacity of local communities to collectively take support the needs of more vulnerable individuals in a co-ordinated fashion •
	**Population** • Segmentation allows us to understand: - What are the main population groups, sizes and consumption of resources? - What are their needs - What are the biggest opportunities? -
	**Person centred** • Once segmented we can understand for each population how we can best organize health and care around the person, focusing on: - Improved health and wellbeing through use of community assets - Coordinated care around the individual through new processes - Minimising the use of institutional care including discharge planning, reablement packages, access to specialist opinion and diagnostics -

Remote Consulting and Monitoring	"The need for change should be balanced against the opportunities that are available to respond to the challenges through the application of innovation, best practice and the use of technology at scale. Emerging solutions can help to deliver more care at home, support people to improve their health and manage their own conditions, remove unnecessary steps in patient pathways, improve service efficiency and enhance the experience of people who need health and social care services." Delivering Health & Social Care to the North of Scotland 2018-2021, pp. 7.

Caithness has been a key area leading the roll-out of remote consulting technology and acted as the pathfinder for NHS Near Me in the Highlands. The COVID-19 pandemic has accelerated the roll-out of digital solutions to remote consulting and monitoring and we will continue to work with NHS Highland to find ways to enable patients and their families to access specialist services without the need to travel long distances when this could have been avoided. Detailed below are two solutions as to how we will achieve this.

NHS Near Me

"NHS Near Me enables us to provide appointments where patients want them, rather than expecting patients to fit their lives around the NHS. It reduces health inequalities related to access and limits the detrimental effects of having to travel for appointments - for frail patients and relatives, it is less exhausting; for others, less time needs to be taken off work or school." (Chief Medical Officer, 2019)

- NHS Near Me Service was co-designed by NHS Highland in Caithness with patients, members of the public, clinicians and other staff over a seven-month period.
- Evaluation was supported by Health Foundation and University of Highlands and Islands.

Near Me can be used in any care setting. This may include GP appointments, outpatients, translation services, delivery of acute care, ward rounds and for home 'visits. It also enables professionals to work remotely from their base. Due to the remote and rural location of Caithness, NHS Near me was already being utilised to increase patient access to specialities, as well as reducing the need to travel to Inverness and beyond for health appointments. Usage has increased dramatically accelerated during the COVID-19 pandemic and it is even more crucial in enabling the re-start of many services.

Technology Enabled Care
The role of the Technology Enabled Care (TEC) team is to promote technology that helps people self-manage their own health and wellbeing, and enable them stay happy, safe and independent in their own homes, complementing the ethos of the Local Care Model.

TEC Services have the potential to:

- Promote a safer, quicker discharge from hospital
- Reduce patient and clinician travel time
- Reduce repeated hospital admissions
- Promote safety and independence
- Improve patient experience

We are aiming to expand TEC services in Caithness to in both Telehealth and Telecare.

Telehealth - the provision of health care at a distance, using technology to provide options for remote monitoring. We are supporting people with a wide range of conditions and challenges to comply with medical advice, modify their behaviour or lifestyle, and self-manage their condition.

Telecare - the use of technology to help anyone to live independently and safely in their own home with confidence, whatever their situation.

Community Led Support

Prevention	*"We will improve everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management"* (Health & Social Care Delivery Plan, Scottish Government, December 2016).

NHS Highland recognises and values preventative work and early intervention to tackle inequality, promote good health and wellbeing and help people maintain good health for longer. We are seeking to continue and improve existing ways of working, as well as collaborate to develop innovative ways to prioritise 'upstream' interventions and build local capacity and resilience.

Working as a partner in the Caithness Community Planning Partnership, NHS Highland is working collaboratively to develop community-led solutions to inequality. Below are some examples of collaborative work that is helping to keep people healthy and well for longer.

Case Study – Self Care

Let's Get On With It Together (LGOWIT), hosted by the Highland Third Sector Interface, is active in Caithness and works collaboratively with NHS Highland to support and encourage individuals with long-term conditions to live independently. The partnership of public, private and Third sector (voluntary) organisations provides people with self-help resources including:

- Self-Management Toolkit - a dedicated website with a range of resources and a self-management guide co-written by local people living with long-term conditions, carers and professionals.
- Living Better Groups – peer support groups open to all ages and conditions for people to come together to socialise and support one another. There are monthly groups in both Thurso & Wick.

Highland Boccia Tournament – Seated bowls that can be played by anyone. There is currently a monthly meet up in Wick, with an annual tournament for all LGOWIT groups.

Decider Skills – Winning Strategies for Mental Health

NHS Highland has been delivering Decider Skills training to local organisations and adults since 2017 and this approach is now embedded within Community Mental Health as the default for addressing emotional regulation and self-management. This successful skills-based method has been developed on the theoretical base of Cognitive Behavioural Therapy and Dialectical Behavioural Therapy and teaches individuals to recognise their own thoughts, feelings and behaviours. Often the teaching of and the further practise of these skills is all that someone might need to stabilise and prevent further deterioration (Emotional Dysregulation) in their Mental Health. The teaching of Life skills is often interwoven with other psychological therapies delivered in NHS Highland and these can include Supporting Self-Management and Dialectical Behavioural Therapy (all for adults).

The Decider skills are:

- Developed with service users, teachers & students
- Evidence-based (CBT & DBT) and effective
- Memorable and easy to use
- Creative, fun and interactive
- Adaptable to suit the learning needs of all ages & abilities

Whilst the Adult Community Mental Health Team are unable to work directly with children and young people, they have delivered training to teachers and lecturers to enable them to teach the skills to pupils and students: In addition to this, Dr Tim Agnew, Consultant Psychiatrist in Psychological Therapies, has been instrumental in the push out of the skills training, and is in discussion with the children's services about rolling out training to

children. There is a wide evidence base that shows that intervening early and teaching children and young people to effectively manage their emotions, reduces the number of people who present to Mental Health Services in a deregulated emotional state (Acute crisis). “It is easier to build strong children than it is to fix broken men” Frederick Douglass.

Delivery of the training is flexible and can be delivered through online resources, training videos, apps, as well as traditional, face-to-face training.

Wick Walking Group (Paths for All, Health Walks)

The Caithness Health Improvement Coordinator runs a weekly walking group in Wick, supported by Paths for All, Walking for Health. This successful group started in 2016 with 10 members and several volunteer walk leaders. Membership has now increased to around 60, the majority of whom walk regularly, and seven trained walk leaders.

The aim of the group is to help people become more active in a way that is as accessible to as many people as possible. It is open to all ages and abilities and a variety of walks are available each week to take account of different needs. Benefits of this gentle exercise lead to improved health and wellbeing, both physical and mental plus reduced social isolation and loneliness.

Social Prescribing and Community Links Workers

Research proves that “sufficient, consistent and high-quality primary care is the bedrock of a high performing health system.”[1] “Shifting resources from dealing with the consequences of health inequalities to effective early intervention and access to preventative services is essential to tackling health inequalities."[2] The 2018 General Medical Council contract seeks to expand and enhance multi-disciplinary working to ensure that patients are seen by the right person at the right time, with one of the key priorities being the introduction of embedded Community Links Workers in all GP practices. Work is already well advanced in Caithness and will see two WTE posts covering five GP practices across the county. Measures are being taken to explore involving additional Community Links Worker posts within the Multi-Disciplinary Team. It is anticipated that these posts will be delivered in partnership with Third Sector partners to harness their local, expert knowledge of community-based interventions.

Community Links Workers are non-clinical practitioners (often with the Third Sector/ Community background) who work in situ within GP Practices. They have established links with a significant range of local community-based services and contexts and using a social prescribing model, work alongside patients who often have complex circumstances. “They support people to identify goals and enable them to achieve those goals through identifying and enabling access to local community assets. Community Links Practitioners will work with people in the practice, the person’s home, and in the community. They will share the person’s journey for as long as it takes to enable them access to more specific or longer-term support. “[3]

[1] BMJ2013; 347:f4627 “Remember Barbara Starfield: primary care is the health system’s bedrock.” Michael Caley, Specialist Registrar in Public Health.
[2] Health Inequalities in Scotland – Audit Scotland, December 2012 pp. 5
[3] http://links.alliance-scotland.org.uk/about/

Community Self Care	Build resilience in local communities to enable individuals and carers to manage their conditions themselves with appropriate support.

NHS Highland Cardiac Rehabilitation Service

Research shows that people who have experienced a cardiac event and have attended cardiac rehabilitation classes and increased their physical activity levels have improved health outcomes, including fewer future heart attacks and hospital attendances.

The Cardiac Rehabilitation Service in Caithness works in partnership with Highlife Highland and suitable participants are invited to attended exercise classes delivered by an NHS Physiotherapist at local leisure centres alongside Physiotherapy Support Workers and Highlife Highland staff. The service aims to provide the patient and their family with the knowledge and skills to self-manage, by facilitating psychological and physical recovery and educating them on ways to reduce risk and further events.

The service has been impacted by COVID-19 with face-to-face contact being stopped. All consultations and support have been offered via telephone, with patients assessed as being low risk able to access virtual exercise classes delivered by Highlife Highland instructors. Work is underway through the Remobilisation Programme to resume face-to-face contact.

Partnership working with the Third Sector

There is a strong, well developed Third Sector network in Caithness. This has been further strengthened throughout the COVID-19 pandemic, with many community organisations working innovatively to proactively reach out to those who have been affected. NHS Highland currently funds several Third Sector organisations to work within their communities to help build local resilience and help people to remain connected, manage their conditions and stay at home for longer.

Dunbeath Health & Wellbeing Hub – NHS Highland funds an intergenerational Health & Wellbeing Hub in the Dunbeath and District area in East Caithness. The aim of the Centre is to deliver flexible services to help people live healthier lives for longer. A small staff team and numerous volunteers run regular activities that appeal to a wide range of ages with the aim of creating a caring, cohesive local community, reducing isolation, and promoting healthy living and lifelong learning. They provide nutritious cooked meals on weekdays, deliver services that form part of Care Packages to help local people return home from hospital and live at home for longer and deliver a volunteer led Good Neighbour Scheme to provide reassurance and early intervention for elderly and vulnerable living locally. The approach has been successful in helping people to remain within the community and has helped to reduce dependency on statutory services.

Caithness Mental Health Support Group (CMHSG)

NHS Highland funds a Mental Health charity to provide a drop-in service in Thurso (Stepping Stones) and Wick (The Haven) for people living with mental health conditions. CMHSG works proactively with individuals to promote positive mental health and to prevent deterioration of conditions. Each centre is open 365 days a year, including Christmas and New Year and provides services users with nutritious meals, social activities, a listening ear, as well as helping people to access other services.

Throughout the COVID-19 pandemic, the organisation has had to quickly change how it interacts with service users. Supported by the local Clinical Lead, staff have been able to

deliver food to service users who were struggling, as well as provide support via telephone and video conferencing. Referrals were also received from the Distress Brief Intervention Helpline for Caithness based callers who would benefit from the non-clinical chat. Work is ongoing to safely re-open centres and additional funding is being sought to enable to the organisation to support more people because of increased pressure on mental health services because of the pandemic.

Planned Care

Anticipatory Care Planning	"Anticipatory and advance care planning is about 'thinking ahead'. It encourages practitioners to work with patients, carers and relatives to plan for the right person to do the right thing, at the right time, to achieve patient goals, facilitating shared decision-making and person-centred care in the appropriate setting." (Tasfield, Hall, & Lunan, 2016)

Research has shown that good community care, effective Anticipatory Care Planning (ACP), alongside a well written Key Information Summary (KIS), can reduce the risk of hospital admissions by between 30% and 50%. (Baker, Leak, Ritchie, Lee, & Fielding, 2011) There is also a proven increase in the number of patients dying in the place where they would like to, more than often at home. ACP is a person centred, proactive approach to 'thinking ahead' and planning for any future care needs. It works best when completed in partnership with someone familiar with the patient, alongside their family and carer (if appropriate). They work together to "have the right conversations and set personal goals to ensure that the right thing is done at the right time, by the right person with the right outcome." (Reference – iHub – ACP for Professionals) They can also a valuable tool to recognise inequalities and help to remove barriers that so many face. All are given information and support to improve health literacy, understand their condition/s and take control over decisions about future treatment and care should the need arise.

Our vision is that Anticipatory Care Planning will become a normal part of routine care, with every individual having the opportunity to have meaningful, open dialogue about their wishes for any future care. Our aim is that all patients enrolled in the MDT will have completed an Anticipatory Care Plan, and that this will be a living document – regularly reviewed in line with their care and any changing needs. We recognise that one element of this will be to encourage patients and their families to set up a Power of Attorney to ensure that should the patient lack capacity, their family/ carers or guardian will be able to act on their behalf, ensuring their care is in line with their wishes and reducing unnecessary delays.

Enrolment onto MDT/ SPOA caseload	Put in place interventions to anticipate and prevent exacerbations of patient's chronic illnesses.

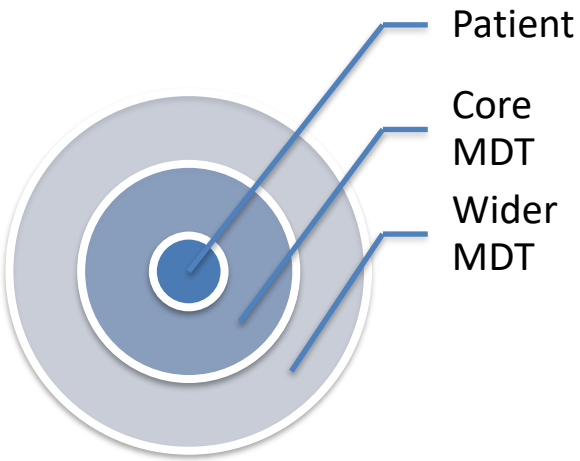
Nationally, 11% of the population (those with the most complex needs) consume 56% of spend and 81% of bed days[4]. Local care relies on identifying those most at risk, and through careful case management, planning their care with them.

[4] Source? ISD? See CF paper

By creating one multi-skilled Multi-Disciplinary Team for all at risk/ complex patients in Caithness, we will:

- Deliver person-centred, coordinated, seamless care;
- Work in partnership with patients and their families to maintain independence and optimum health for as long as possible;
- Help patients access support and resources;
- Anticipate and plan for patients' needs;
- Have all health & social care skills in one Multi-Disciplinary Team;
- Develop an Electronic Patient Record to enable appropriate sharing of information;
- Deliver a streamlined process with a fast response time and quick decision making.

What is the Multi-Disciplinary Team?



Core Team (daily involvement)

- Allied Health Professional
- Care at Home
- Community Link Worker
- Coordinator
- District/ Community Nurse
- GP
- Consultant Geriatrician
- Pharmacist
- Social Work

Wider Team (involved when necessary)

- Acute specialists
- Care Home
- Charge Nurse/ key Ward Staff
- Day Care
- Dietetics
- Highland Council (Housing etc.)
- Mental Health
- Palliative Care Specialist
- Police
- Scottish Ambulance Service
- Scottish Fire & Rescue Service
- Speech and Language Service
- Technology Enabled Care (TEC)
- Third Sector

Core Team members will:

- Be involved with most patients.
- Take responsibility for individual patients (e.g., Lead Professional/ Named Person)

Wider MDT members will:

- Be involved with the patients relevant to them.
- Take part in daily discussions, only if necessary.

• Take part in daily discussions, plus in-depth, regular MDT meetings.	• Attend in-depth MDT meetings when required.

- **Identify** – Identify people to enrol into the MDT by combining professional opinion and a data driven approach. Having researched various methods of identifying patients at risk, we will be using a variety of electronic tools to identify patients (both initially and on an ongoing basis). We will primarily use the E-Frailty Index, alongside data from SPARRA (Scottish Patients at Risk of Readmission and Admission) and pHHG (High Health Gain Potential). Professional opinion from the MDT will be used alongside the data to determine who would benefit most from MDT support.

- **Enrol** – The patient will be offered the chance to receive MDT care, explaining what it entails and enrolled if they wish to take it up.

- **Assess** – Complete one patient assessment in partnership with the patient and their family. The aim is that this assessment will eradicate multiple patient assessments and will be transferrable between community and acute settings. We will use a complete Electronic Patient Record to facilitate easier joined up working, better communication and to ensure that all involved can access relevant patient information to enable them to carry out their role and meet the needs of the patient.

- **Plan** – Where it has not already been done so, an Anticipatory Care Plan will be developed alongside patients (and their families and carers when appropriate), ensuring their wishes for their care and faithfully captured.

- **Intervene** – Put in place support to help the individual (and their carer) manage their condition. Should the individual's condition exacerbate, enact previously agreed response to manage the exacerbation as close to home as possible.

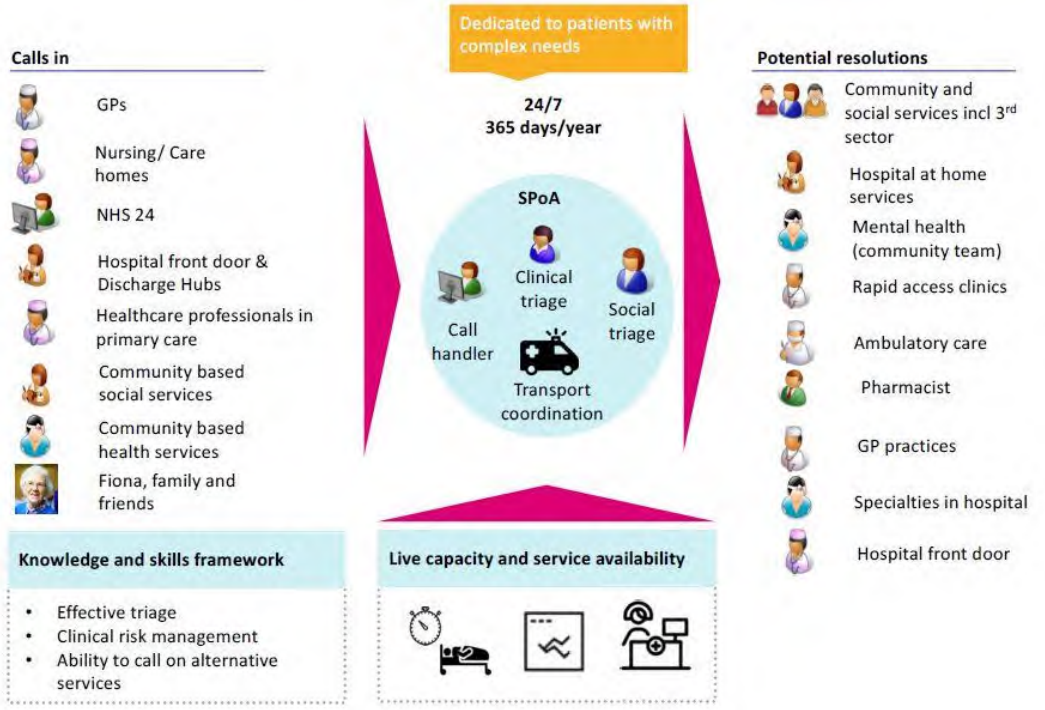
- **Review** – Review the person's Care Plan at regular intervals, particularly following a change in frailty score or any unplanned admission. Patients will be discussed by the whole team, ensuring that all voices are heard and that the patients' whole circumstances are considered, and all needs are met.

What is a Single Point of Access (SPOA)?

Our ambition for a SPOA in Caithness is:

- A single, 24/7 SPOA for patients with complex needs, which includes the Scottish Ambulance service, transport partners and the Third Sector in the list of SPOA services;
- SPOA will help to facilitate the right care, by the right person, at the right time;
- SPOA has access to a single electronic patient record to facilitate appropriate triage of callers;
- SPOA has access to a live feed of resource availability which enables them to signpost to available resources;
- SPOA is resourced to enable all the whole patient population in Caithness to access certain services through one point of contact.

What could the SPOA look like?



Source: Carnall Farrar, Pathfinder Deliverable (Caithness)

Rapid Response and Step-Up	Put in place a rapid response to manage exacerbations as close to home and in the community as possible, rather than in hospital.

Rapid Response Team

This service aims to:

- To act as an on call rapid response service to support patients with chronic illness exacerbations and non-medical crisis either within the step-up facility, or in their own home, rather than in hospital;
- To provide a 24/7 outreach and assessment service to support people in the community who have gone into crisis and to work alongside and support the Scottish Ambulance Service, Third Sector, Emergency Department, Fire & Rescue Service, on call GP's and Social Work out of hours service;
- To assist vulnerable people in the community who have an urgent, temporary service need which, when met, will enable them to stay in their own homes;
- To help prevent hospital admissions and facilitate early discharges;
- To link in to SPOA and MDT for appropriate professional referral/intervention where required; and
- To support use of technology enabled care and to offer a responder service.

Test of Change:

A trial rapid response function will be introduced in the area. This will involve two Senior Health & Social Care Support Workers providing support between 10pm and 7am, 7 days a week.

Step-Up Beds

This service aims to:

- Provide the option for short-term enhanced support for patients who are at risk of hospital admission. This will be provided through temporary admission to a 'Step-up Bed' located in the Care Hub and will enable assessment, treatment and additional care plan measures to enable the patient to return to their own home. We envisage that this will reduce the number of unscheduled care admissions.

Test of Change:

It is proposed to put in place two Step-up Beds as a PDSA test of change in advance of the Community Hubs being built. This will allow the new model of care to be tested, reviewed and refined to inform the requirements for the permanent workforce and building solutions.

The beds would be short-term and would be used for admission from community back to community, not for step-down from hospital. The existing community nursing and AHP teams will support the person in the Step-up Bed, linking with the Care at Home service. Advice and support would be provided from acute services as required, without the need to admit the patient via the acute Emergency Department.

Timely access to expert opinion and diagnostics	"Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting…. 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." (NHS Scotland)

Our vision is that patients (initially those enrolled in the MDT) will be easily referred (via SPOA) to access expert opinion, advice and diagnostics without the need to be admitted to hospital.

- The ongoing 'Hub and Spoke' model of rotational Consultants from Raigmore Hospital provides a level of continuity and timely access to experts elsewhere.
- Rural Practitioners (RPs) are an innovative team of senior generalists who provide a focal point for acute medical services in Caithness General Hospital (CGH). Providing intermediate care to all admissions and an accident and emergency role. RPs are an important aspect of the clinical model for a CGH.
- VC Telelink within ED enables timely access to senior clinicians in Raigmore and experts in other areas across Scotland e.g., Aberdeen, Edinburgh, Glasgow.
- Uploading of test results to SCI Store enables access by all clinical staff/GPs, facilitating diagnosis and plan of care.

- Clinical Decision-Making Unit (CDU) will be introduced within the footprint of ED to accommodate GP referrals and return patients for senior review and diagnostic tests. An uplift request for staffing has been approved to support this.
- Investigation and Treatment Review (ITR) clinics have been increased within the Outpatients Department to provide timely review and treatment of patients.
- Transient Ischaemic Attack (TIA) clinics reintroduced to CGH – assessed appropriately and weekly clinics held with Consultant Geriatrician (virtual clinics and face to face appointments).
- Appointment of Emergency and Urgent Care Practitioner who is based at CGH enables timely access to CMHT and facilitates assessment by Consultant Psychiatrist, preventing delays and inappropriate transfers to Inverness.

The model of care and treatment being as close to home as possible, improves access for Caithness patients and reduces travel.

Enhanced Support

End of Life Care	Palliative care uses a team approach to support patients and their caregivers…. It offers a support system to help patients live as actively as possible until death. Palliative care is explicitly recognised under the human right to health. It should be provided through person-centred and integrated health services that pay special attention to the specific needs and preferences of individuals. (WHO (World Health Organisation), 2018)

Up to 50% of health and social care delivery takes place in the last year of life. Spending typically increases as death approaches and in the 'last days of life' care at home or in-patient bed usage is at its greatest, especially in the community hospital setting. Caithness provides palliative care across all health and social care settings.

Through better identification, care planning, availability of 24/7 responsive care and responsive monitoring and evaluation, a proactive end of life care system can be built based on access to sound knowledge of the system and objective outcomes. Currently, the reactive nature of much of our end-of-life care is what can lead to poor care experience and emergency admission to hospital.

Working within the End-of-Life Care Together partnership (Highland Hospice, Macmillan Cancer Support, Marie Curie and NHS Highland), the aim is to optimise existing resources and through appropriate Anticipatory Care planning and MDT support, to enable End of Life Care to be delivered in accordance with the wishes of the patient and their family.

Developments will include:

- Improved identification and care planning;
- Enhanced Community Services delivered alongside the MDT to enable patients to remain at home (with support) if they wish;
- 24/7 care available at the Thurso and Wick Health and Wellbeing Hubs, with each having flexible beds to meet the demand and;
- A clear framework for measuring success.

Palliative and End of Life Care will continue to be delivered locally, 24/7, in Independent Residential and Nursing Homes and Caithness General Hospital.

Hospital Care as Close to Home as Possible	'Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting…. 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 re-admission.' (NHS Scotland)

- Patient care will be managed within the community, in a planned way, for as long as possible;
- Hospital at Home (integral to the MDT) would be provided as a short-term intervention, providing acute level care within a patient's home;
- Scheduled hospital admission, as close to home as possible, will be used when it is the best option for the patients;
- Remote consultation and technology will be deployed and used to enable the patient to be treated locally when appropriate;
- Hospital care out-with Caithness will be used when it is in the best interest of the patient;
- Discharge planning will begin, fully involving the MDT or Community Teams (when the patient is suitable for the MDT caseload), on the day of admission with an Estimated Date of Discharge agreed by the Team;
- The Reablement Team will be involved from an early stage to facilitate discharge and to manage the recovery from hospital admission and the regaining of independence.

Caithness Initial Agreement – Appendix SC11

Caithness Redesign – Local Care Model Multi-Disciplinary Team (LCM MDT)

Our vision for a Local Care Model in Caithness:

- Person-centred, coordinated, seamless care;
- Working in partnership with patients and their families to maintain independence & optimum health for as long as possible;
- Anticipating and planning for patients' needs;
- All skills in one Multi-Disciplinary Team (MDT);
- Streamlined process – fast response time – quick decision making.

Fiona's Story - Today

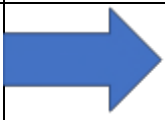
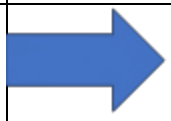
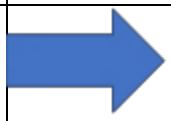
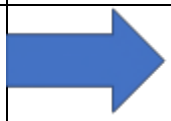
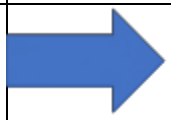
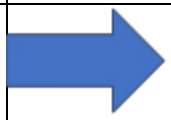
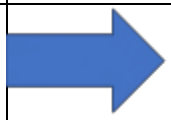
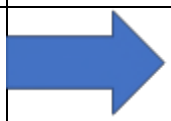
Fiona is an 83-year-old lady living at home alone, having been widowed suddenly two years ago. She lives in Rural Caithness and her only family support, her daughter, lives and works in Edinburgh. Her daughter tries to visit as often as possible, but it is difficult to visit more than once a month due to the distance and existing family and work commitments. Up until her husband died, Fiona had been managing well and she and her husband enjoyed an active and busy social life together. They were very independent, doing all their shopping, cooking and cleaning, with her husband still able to drive.

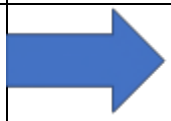
Since her husband's sudden death from a heart attack, Fiona has struggled with depression and loneliness. She was diagnosed with osteoarthritis around ten years ago, which has been controlled with medication. Five years ago, she was diagnosed with COPD, but again, this has been managed well through medication and regular appointments with the Specialist Respiratory Nurse.

Fiona keeps well for about six months but begins to have regular exacerbations of COPD and UTIs. Initially, she is treated by the Primary Care team, with a referral to the District Nursing Team for follow up support and monitoring. Her GP recently retired, and the practice has been managing with several locum GPs, who rotate frequently. The District Nursing team relies on a paper-based record system and do try to feed back to the GP as often as possible, although staffing pressures in both District Nursing and Primary Care, make clear communication difficult. The District Nurse has become increasingly concerned about Fiona, as she seems to have lost weight and her mood is low. She has left a message with the GP practice, but hasn't heard back from them.

Fiona has had a bad fall overnight and has been discovered lying on the floor in her hallway by the Postman, who 'phoned for an ambulance. She was admitted to hospital where she was treated for a UTI and dehydration. Following a seven day stay on a rehabilitation ward, she is transferred to the local community hospital as her lack of nearby family support and rurality was making it difficult to set up a Care at Home package.

When she is discharged home, she often becomes confused with the number of people visiting her at home and her daughter has no one to contact to find out what is going on with her mother.

Currently, Fiona's care can be…..		Fiona's care will be……
Inconsistent and overlapped: Unfamiliar staff provide similar services, and no one fully understands her health and care needs.		**Consistent and well organised**: She is visited by friendly faces who are familiar with her needs. All staff are part of a dedicated LCM MDT and their work will be focused on supporting these patients.
Uncoordinated: There is no clear professional responsibility and support is not coordinated.		She has a **Named Person (Named Professional)** who knows her, as well as her family/ carers and who is responsible for all aspects of her care There is a **Team Coordinator** who oversees the whole caseload, with joint decision making shared by the whole team alongside Fiona and her family
There is often **poor communication** and no overall picture of Fiona's health and social circumstances		**Communication** regarding any decisions is clear (both between the LCM MDT and the patient and between professionals) and documented. **An Electronic Patient Record** provides up-to-date relevant information on the patient's circumstances related to health and social care. Future capabilities will enable the patient to access their own records.
Decided without her involvement: She feels excluded from all major care decisions and doesn't get to say what she would like.		**Decided with her:** She is involved with all decisions made regarding her care. An Anticipatory Care Plan is written as soon as possible and is regularly updated to reflect Fiona's current circumstances and wishes.
Difficult to access: There are multiple, confusing points of contact for different services when she has a health or care issue.		**Simple to access:** She has one phone number – the Caithness Single Point of Access - that she is confident can help her in any way required.
Focused only on her health needs: She does not understand the wider community support available to her.		**Focused on her:** Her wider health and social needs are understood, and it is easy for her access any community support she needs.
Only assessed by a specialist when she visits the hospital: When she quickly needs diagnostic tests or an expert opinion, she must travel to multiple outpatient appointments, often out with Caithness.		**Assessed by an expert without her having to go to the hospital:** She is quickly provided with the specialist opinion or diagnostic results needed without requiring hospital admission.
Requires Inpatient Hospital admission: Should Fiona's condition deteriorate, she is admitted to hospital, often requiring a long stay.		Fiona's MDT team will be responsive to any changes in her condition and hospital admission will only be when is medically necessary.

Currently, Fiona's care can be…..		Fiona's care will be……
		A pro-active, anticipatory approach to discharge will begin on admission in liaison with the LCM MDT. Hospital at Home admission will be used as an alternative when appropriate.
Little choice over place of death: Fiona has little choice and control over where she would like to die. There is no up-to-date record of her wishes.		**Choice:** When approaching the end of her life, Fiona will have choice and control over where she would like to die. Her wishes, as recorded in her up-to-date Anticipatory Care Plan, will be enacted. 24/7 appropriate support from familiar faces will be available.

Fiona's Story – Future

Since her husband's sudden death from a heart attack, Fiona has struggled with depression and loneliness. She was diagnosed with osteoarthritis around ten years ago, which has been controlled with medication. Five years ago, she was diagnosed with COPD, but again, this has been managed well through medication and regular appointments with the Specialist Respiratory Nurse

Recently, Fiona attended her GP Practice for her Flu vaccination; the Practice Nurse noticed that Fiona seemed a bit more unsteady on her feet. Her GP recently retired, but the practice has a stable staff team following a successful recruitment drive, and had allocated Fiona a new, named GP. The Practice Nurse spoke with Fiona's new GP, who checked her records and as the Practice codes all adult patients for frailty, noticed that Fiona's frailty score had increased, with her now classed as moderately frail. The GP visits Fiona at home and as the Practice is part of the Local Care Model in Caithness, explains what it could do for her, asking if it would be okay if he made a referral? Fiona's daughter is visiting, and they agree that Fiona be enrolled.

The District Nurse (her Named Person) who visits from the team, completes a single (holistic) assessment for Fiona and they agree and put in place a Care Plan to help keep her well. They also agree actions should she become ill, as well as an Anticipatory Care Plan, so that Fiona's wishes for any future interventions are recorded. Discussion takes place around Power of Attorney and it is confirmed that this was already in place. They are given contact details for the Caithness Single Point of Access this will give access to all the health and social care services that they may need.

Everything is recorded in the Care Portal and Fiona's case is discussed at the daily MDT meeting, with her GP in attendance. Fiona has a Care at Home worker who visits her daily, she is referred to the Technology Enabled Care Team, as well as Befriending Caithness for both one-to-one and Group Befriending. Fiona is matched with a Volunteer Befriender and together, they attend the regular Group sessions held in the Mey Hall, which Fiona really enjoys. She also receives support from one of the young befrienders, who shows her how to use the Tablet that her daughter bought her for Christmas. Before long, Fiona can use it to make video calls, helping her to keep in touch with friends and family, and she even tries out online shopping. Her daughter is able to relax, knowing that Fiona is being well looked after; she is delighted by the positive change in her Mum.

Fiona keeps well for around six months but begins to have regular exacerbations of COPD and UTIs. Rather than admitting her to hospital, Fiona accesses one of the 'step-up' beds in the new Health and Wellbeing Hub, which her Named Person refers her to. This means that Fiona can be assessed, get some extra care before she has stabilised enough to go home, with some additional Care at Home support for a few days until she is well again. She was due to have a visit with the Befriender on the day she was admitted, but due to the Information Governance arrangements in place, Befriending Caithness were notified of this through the Care Portal system, as well as when Fiona was discharged home again.

As time progresses, Fiona and her family decide in conjunction with the LCM MDT that it would be good for her to take up an offer of one of the Care Home beds at the Health & Wellbeing Hub. She is finding that living at home is becoming increasingly difficult, even with the Care at Home support, plus she is still a bit isolated. She and her family are delighted with the move – she can retain some independence and is able to join in with the activities at the Hub, access her GP, Dentist, Befriending Group, Day Care – it really gives her another lease of life.

She is still cared for as part of the LCM MDT, but as her COPD has now progressed, palliative care begins, as part of the wrap-around care available to her. Her Anticipatory Care Plan is checked and updated in accordance with her wishes. She continues to take part in activities at the Hub but is becoming increasingly frail. She is eventually moved to one of the Palliative Care suites, where her daughter can come and stay with her, 24/7. She dies at the age of 86, with her daughter and surrounded by people who have known her and cared for her over the years.

Caithness Initial Agreement – Appendix SC13

Summary of Relevant National and Local Strategies (in order of publication)

Document	Summary
2020 Vision for Health and Social Care (Scottish Government)	"*Safe, effective and person-centered care which supports people to live as long as possible at home or in a homely setting*."
Commission on the Future Delivery of Public Services (Christie Report) (Scottish Government, 2011)	Highlighted the need for reform across the public sector; service integration at a local level, a greater shift towards prevention, addressing health inequalities and improving outcomes for people.
Public Bodies (Joint Working) Scotland Act, 2014	The Public Bodies (Joint working) Scotland Act 20146 identified four key objectives: • Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members. • Health and social care services should be characterised by strong and consistent clinical care and professional leadership. • The providers of services should be held to account jointly and effectively for improved delivery. • Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.
Health and Social Care Delivery Plan (Scottish Government, December 2016)	Sets out key actions to deliver a health and social care system that: • is integrated; • focuses on prevention, anticipation and supported self-management; • will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting; • focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and • ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.
NHS Highland Quality and Sustainability Plan published in May 2017	Sets out the plan to deliver NHS Highland's vision to create better health, better care, better value. This outlines that; • the current model of health and social care delivery is not sustainable; • there is an overreliance on costly hospital and institutional care; • new models of care will involve more people being cared for at home, delivered through a combination of prevention and anticipatory care, better use of technology and developing and embedding more community capacity; and • a collaborative approach is required, working with our statutory partners, voluntary and third sectors

Document	Summary
Public Health Priorities for Scotland (Scottish Government, June 2018)	• Sets out the plan to improve the health and healthy life expectancy across Scotland through identification and tackling of inequalities where they exist; early intervention and prevention; and co-production with local communities.
Place Principle (Scottish Government, April 2019)	• Help overcome organisational and sectoral boundaries, to encourage better collaboration and community involvement, and improve the impact of combined energy, resources and investment. Place-based approaches are emerging as a way of encouraging a clearer focus on prevention and early intervention to improve population health (Naylor & Wellings, 2019). It supports inclusiveness and sustainable outcomes. Planning and working together with the community are vital to ensure a positive, shared understanding and agreement on future community developments.
Protecting Scotland's Future: The Government's Programme for Scotland 2019-2020	• Focus on the delivery of better patient care, better health and better value for the people of Scotland, so that we live longer, healthier lives at home or in a homely setting.
Remobilise, Recover, Re-design: the Framework for NHS Scotland (Scottish Government, May 2020)	Outlines how NHS Scotland will restart as many NHS services as possible following the Covid-19 pandemic. Based on the principles of: • greater integration; • realistic medicine; • delivering services close to patients' homes, minimising travel and developing virtual consultations; • sustainable communities, reducing inequality and improving health and wellbeing outcomes.
Independent Review of Adult Social Care (The Feeley Report) (Scottish Government, February 2021)	An independent review of Adult Social Care services in Scotland, commissioned by the Scottish Government. The report sets out how improvements can be made to social care to improve outcomes and experiences of people who use the services. • Shift the paradigm – "We need to shift the paradigm of social care support to one underpinned by a human rights-based approach" • Strengthen the foundations – build on existing good practice; nurture and strengthen the workforce; value and support cares; and • Redesign the system – Create a new delivery system – the National Care Service.
A Changing Nation: how Scotland will thrive in a digital world (Scottish Government, March 2021)	Addresses digital inequalities and the ambition to support a 'Green Recovery'. Also sets out how Public Services can utilise digital technology to reimagine how services are delivered.
Remobilise, Recover, Redesign: NHS Highland Strategic Direction 2021-2022	Sets out the key areas and focus of NHS Highland's Remobilisation Plan for the coming year and sets out the organisation's vision, values and board level objectives.

Benefits Register						
	NHS Highland: Caithness Redesign	Appendix SC15				
1. Identification						2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
	Person-centred					
P1	Ensure that people who use health and social care services in Caithness have positive experiences and their dignity respected.	Qualitative and Quantitative	Percentage of adults supported at home who agree that their health & care services seemed to be well co-ordinated	2017/18 "*I am informed if my regular care worker is on holiday*" 92% positive.	Increase	4
		Quantitative	Percentage of adults supported at home who rate it as excellent or good (positive)	2019 **Caithness** C@H questionairre Positive **95.2%** Neutral **2.9 %** Negative **1.9%**	Increase	4
		Quantitative	Proportion of Care Home & Day Centre Services graded 'good' (4) or better in Care Inspectorate inspections.	**2017 - 2019** 87.5% of NHS, Council and Privately run services score 4 or above in all aspects	Increase	4
		Quantitative	Percentage of patients (where death is expected) have a power of attorney completed	1/10/2016 - 31/3/2017 **26%**	Increase	5
		Quantitative	Percentage of people (where death is expected) in Caithness have an anticipatory care plan completed	1/10/2016 - 31/3/2017 **60%**	Increase	5
		Quantitative	Number of care at home reviews/assessments carried out per annum	1/1/2019 - 31/12/2019 East Caithness **157** West Caithness **123** **Total 280 home assessments undertaken**	Increase	4
		Quantitative	Number of patients per annum from Caithness area who have their discharges delayed	**2019** Awaiting community care (care home) - 113 Awaiting community care (home) - 83 Complex delay codes - 74	Decrease	4
		Quantitative	% of people aged 65 or over with long term care needs receiving personal care at home	April 2019 **67%**	Increase	4

	NHS Highland: Caithness Redesign	Appendix SC15				
	1. Identification					2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
P2	Improves support to allow people in Caithness to live independently in the community	Quantitative	Total number of clients supported by telecare	Feb 2020 Total number of clients 400 Basic equipment 344 Enhanced equipment 56	Increase	4
		Quantitative	Total number of adult carers per annum who have support plans completed	2018/19 **58** carers plans	Increase	5
		Quantitative	Average age admitted to care home	**Pulteney House,** Wick 2019-2020 Male age **83**, Ladies age **94** **Bayview**, Thurso 2019-2020 Male age **83,** Ladies age **91**	Increase	4
		Quantitative	Number of clients receiving support •Opt 1 Analysis – SDS Option 1 direct payments which are active for Caithness at M11 2019/20. This is the number per client category and the projected cost for the year • Caith Opt 2 Analysis – SDS option 2 Individual Service Funds (ISF) packages active for Caithness at M11 2019/20. This is number of folk per client category with full year costs. • Opt 3 Analysis – SDS Option 3 (Traditional Service) packages active at M11 2019/20 for Caithness. These are the service delivered by providers such as support work and Care at Home. Number of folk and full year costs. • LTHS Analysis – The Long Term Housing Support services delivered for Caithness clients at M11 2019/20. These are really Option 3 services but are separately accounted for • LTC Analysis – The long term care packages open for Caithness clients at M11 2019/20.These are people who are are out of the North Highland area.	Option 1 (**25** clients) Option 2 (**13** clients) Option 3 (**240** clients) LTHS (**25** clients) LTC (**132**)	Increase	3
P3	Increase the number of patient episodes delivered in Caithness	Quantitative	% of total OPD appts delivered in Caithness (face to face and remote)	October 2019 **61.3%**	Increase	4
		Quantitative	% of total OPD appts delivered remotely (NM, phone, video)	October 2019 **7.8%**	Increase	4
		Quantitative	% of total OPD appts where patient has to travel outside area	October 2019 **38.7%**	Decrease	4
		Quantitative	% of total delivered by NHS Near Me	October 2019 **2.7%**	Increase	4

	NHS Highland: Caithness Redesign	Appendix SC15				
	1. Identification					2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
		Quantitative	Travel miles saved by Near Me	October 2019 **16,686**	Increase	4
P4	Help people in Caithness take active steps to connect to community groups and activities based on individaul needs	Quantitative	Number of "social prescribing" opportunities afforded through access to 3rd sector organisations	2019 Unable to collect this information at present. The commencement of the Communuty Link Worker posts will allow us to gather this.	Link workers in post	5
P5	Reduce duplication of assessments for Caithness people through better care co-ordination	Qualitative	Presence of Single Point of Access	2019 Nil	SPOA in place	5
P6	Reduce the number of times Caithness people will need to repeat their medical history to professionals and improve care co-ordination	Qualitative	Number of services with electronic patient records/ using care portal	2019 Nil	Everyone using patient electronic patient records	5
	Safe					
S1	Decrease staff abscence in Caithness to reduce pressure on those remaining at work and ensure patients receive high quality care	Quantitative	Number of recorded DATIX incidents, staff availability and business continuity	2016 - 2017 **73** datix reports	Decrease	4
S2	Reduce the reliance on single member of staff which could disrupt service provision for Caithness people	Quantitative	Number of points in the health and care system where a single critical member of the staff team being unable to attend could cause disruption including increase in patient waiting times	2019 Dietetics Specialist Nurses - Diabetic, COPD, Tissue Viability. Consultants , Anaesthetists, Radiographers	Decrease	5
			% of Caithness staff who are up to date on information governance training	Feb 2021 CGH - 76% Caithness District - 78.5% C@H East - 69% C@H West - 76.3%	Increase	
			% of Caithness staff who are up to date on fire safety training	Feb 2021 CGH - 67.9% Caithness District - 65.8% C@H East - 75.9% C@H West - 73.7%	Increase	

	NHS Highland: Caithness Redesign	Appendix SC15				
	1. Identification					2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
S3	Appropriately trained staff who are up to date on statutory and mandatory training	Quantitative	% of Caithness staff who are up to date on equality & diversity training	Feb 2021 CGH - 77.2% Caithness District - 80.7% C@H East - 82.8% C@H West - 81.6%	Increase	4
			% of Caithness staff who are up to date on moving & handling training	Feb 2021 CGH - 76.3% Caithness District - 74.4% C@H East - 72.4% C@H West - 78.9%	Increase	
			% of Caithness staff who are up to date on hand hygiene training	Feb 2021 CGH - 76.6% Caithness District - 77.1% C@H East - 79.3% C@H West - 78.9%	Increase	
			% of Caithness staff who are up to date on infection prevention and control training	Feb 2021 CGH - 79.2% Caithness District - 76.6% C@H East - 72.4% C@H West - 81.6%	Increase	
	Effective Quality of Care					
E1	Reduce emergency admissions for Caithness people by improved anticipatory care	Quantitative	Rate of emergency admissions per 1000 population	2019 **86**	Decrease	4
E2	Reduce occupied bed days for Caithness people as clinically appropriate	Quantitative	Patients aged 75+ per 1,000 population –as a proportion of acute occupied bed days	2019 **CGH 63.73%** **T & County 70.78%** **Dunbar 93.34%**	Decrease	4
E3	Reduce readmission rate for	Quantitative	Ratio of emergency readmissions within **7 days** of discharge following an admission to **medical** specialty	April 2019 to June 2019 No. of emergency readmissions: **27** No. of predicted readmissions: **35** Standardised ratio: **76.6**	Decrease	4
		Quantitative	Ratio of emergency readmissions within **28 days** of discharge following an admission to **medical** specialty	April 2019 to June 2019 No. of emergency readmissions: 73 No. of predicted readmissions: 80 Standardised ratio: **91.2**	Decrease	4

	NHS Highland: Caithness Redesign	Appendix SC15				
	1. Identification					2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
E3	Caithness people	Quantitative	Ratio of emergency readmissions within **7 days** of discharge following an admission to **surgical** specialty	April 2019 to June 2019 No. of emergency readmissions: **13** No. of predicted readmissions: **15** Standardised ratio: **89**	Decrease	4
		Quantitative	Ratio of emergency readmissions within **28 days** of discharge following an admission to **surgical** specialty	April 2019 to June 2019 No. of emergency readmissions: **32** No. of predicted readmissions: **30** Standardised ratio: **105.4**	Decrease	4
E4	Reduce length of stay for Caithness people as clinically appropriate	Quantitative	Ratio of adjusted average length of stay following admission to a **medical** specialty	April 2019 to June 2019 Observed bed days **2** Expected bed days **2** Standardised ratio: **100.0**	Decrease	4
		Quantitative	Ratio of adjusted average length of stay following admission to a **surgical** specialty	April 2019 to June 2019 Observed bed days **6** Expected bed days **11** Standardised ratio: **53.3**	Decrease	4
E5	Decreases the rate of avoidable attendance at A/E	Quantitative	A/E attendances for Caithness GP practices, rate per 1,000 population.	1st Jan 2017 - 31 Dec 2019 897 per 1,000	Decrease	4
E5	Patients have a reduced wait from arrival to admission, discharge or transfer from accident and emergency treatment	Quantitative	Percentage of patients who were four hours or less in the emergency department at Caithness General	April - June 2019 **96.1%**	**98%**	4
E6	Decrease theatre cancellations in Caithness	Quantitative	Reduction in cancellations of planned operations	Sept 2018 - Sept 2019 **14.4%** of planned operations were cancelled	Decrease	4
E7	Increase (or as a minimum no reduction in) the number of new procedures being carried out in Caithness	Qualitative	Elective admissions - number of different procedure types carried out in Caithness General Hospital	2018 - 58 different procedures 2019 - 67 different procedures	Increase	4

	NHS Highland: Caithness Redesign	Appendix SC15				
	1. Identification					2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
	Health of the Population					
H1	Delivers services and facilities able to deal with the demographic challenges facing services over the next 20-30 years	Qualitative	Number of hospital beds in Caithness General Hospital compared to bed capacity modelling predictions based on 83% occupancy 2019/20 - do nothing = 46, redesigned service = 37 2030 - do nothing = 54, redesigned service = 43 2040 - do nothing = 60, redesigned service = 47	2019 - 45 beds in CGH	Projected bed numbers for redesigned service	4
		Qualitative	New facility compliant with agreed ACRs	n/a	Facilities compliant with ACRs	4
		Qualitative	Repeatable room design in new facilities	n/a	Presence of repeatable rooms	4
		Qualitative	Facilities allow for expansion or change of use in future	Current Facilities not designed to support modern healthcare, little expansion room PAMs data?	Min 20% expansion	4
	Value & Sustainability Benefits					
V1	Improves statutory compliance (of premises)		Overall percentage compliance score for Caithness health and care premises using Statutory Compliance and Audit Reporting Tool (SCART)	**SCART - 24/04/2020** CGH - **45.3%** Thurso community (Bayview, Dunbar, Riverbank, Davidson's Lane) - **44.51%** Wick community (Old WMS, Pulteney H, Wick T&C) - **43.86%**	Increase	
V2	Improves the quality, physical condition and functional suitability of the health and social care estate		Proportion of estate categorised as either A or B for the Physical Condition appraisal facet		All cat A or B	
			AEDET access score; Caithness General Hospital and Community Hub buildings (baseline = Wick T&C Hospital, Dunbar Hospital, Old Wick Medical Centre, Martha Terrace, Riverbank, Pulteney House, Bayview, Davidson's Lane (baseline), William Smith House (interim), Thor House)	Caithness General Hospital - 2 Community Hubs - 2.1	4.4 4.4	
V3	Improves design quality in support of increased quality of		AEDET overall average score of all categories; Caithness General Hospital and Community Hub buildings (baseline = Wick T&C Hospital, Dunbar Hospital, Old Wick Medical	Caithness General Hospital - 2.2		

	NHS Highland: Caithness Redesign	Appendix SC15				
	1. Identification					2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
V3	support of increased quality of care and value for money		Centre, Martha Terrace, Riverbank, Pulteney House, Bayview, Davidson's Lane (baseline), William Smith House (interim), Thor House)	Community Hubs - 2.1	Average AEDET score of 4.4	
V4	Optimises overall running cost of buildings		Property maintenance cost of Caithness buildings	£61,767	Decrease	
			Annual NHSH utilities costs for Caithness buildings	£885,794	Decrease	
			Rent or rates £ per sq.m.		Decrease	
V5	Decreases backlog maintenance and/or future lifecycle replacement expenditure		Reduction in backlog maintenance costs	£5.1million	No backlog maintenance	
			Significant & high risk backlog as percentage of total backlog	NHSH (2021) - 9%	0%	
V6	Decreases energy consumption		Percentage reduction in energy consumption, total heat, light & power KWH, for Caithness General Hospital, Wick community (hub) and Thurso community (hub)	2018/19 financial year CGH - 3,966,486 KWH Wick Community - 1,920,964 KWH Thurso Community - 2,070,966 KWH	Decrease	
V7	Improves the attraction and retention of an appropriately skilled workforce	Quantitative	Staff sickness levels	**May-19** Caithness acute - **6.85%** Caithness district - **6.49%**	4%	4
		Quantitative	Staff turnover (annual)	**May-19** Caithness acute - **13.96%** Caithness district - **25.40%**	TBC	4
		Quantitative	Age profile of staff in Caithness (District and Acute)	**Mar-20**		
				<20 0.4%, 20-24 3.8%, 25-29 7.5%, 30-34 7.2%, 35-39 8.6%, 40-44 9.2%, 45-49 12.7%, 50-54 14.5%, 55-59 20.3%, 60-64 11.8%, 65+ 3.9%	More younger, less older	4
		Quantitative	Vacancy info - posts filled first time in Caithness (District, Acute health care and Adult Social Care, excluding medical)	**1st April 2019 - 31st March 2020** 79% health care 57.5% adult social care	Increase	4
				1st April 2019 - 31st March 2020 68% posts filled first time		
		Quantitative	% of staff in Caithness who have a complete or partially complete Turas appraisal	01/04/2019-31/03/2020 **8.1%** complete		4

	NHS Highland: Caithness Redesign	Appendix SC15				
	1. Identification					2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
V8	Increases opportunities for staff and student training and advancement		complete Yuras appraisal	**3.9%** partially complete	Increase	
		Quantitative	% of Caithness staff who are up to date on statutory training			4
		Qualitative	Waiting list for training of social care & healthcare support workers?			
		Qualitative	Number of student placements offered in Caithness by profession	Social work - no placements in 2019	Increase	3
V9	Decreases/removes the need for locums/other temporary staff		Locum staff expenditure per annum		Decrease	
			Number of supplemantary staffing hours required by nursing staff	Week ending 23rd Feb 2020	Decrease	
				Registered Nurse - **124** hours		
				Health Care Support Workers - 289.75 (infomation obtained from S. Sears, Lead Nurse)		
			Bank staff use	**May-19**	Decrease	
				Caithness acute - 1**2.82**WTE		
				Caithness district - **4.57**WTE		
	Wider/Social					
W1	Make Caithness attractive to people as a place to come and live	Quantitative	National Population Statistics Place Standard Tool (jointly developed by NHS Health Scotland, ADS and Scot Gov) to enable physical, social and environmental quality of a place to be evaluated.	Utilise data gathered in 2018 14 place standard parameters as measured by survey in Wick, Thurso, and Rural Caithness		
W2	Keep Caithness money local - make Caithness attractive to people as a place to invest	Mix of Quantitative and Qualitative	Place Standard Tool (jointly developed by NHS Health Scotland, ADS and Scot Gov) to enable physical, social and environmental quality of a place to be evaluated.	Utilise data gathered in 2018 14 place standard parameters as measured by survey in Wick, Thurso, and Rural Caithness - impact of improved health care services can be described anecdotally (what good looks like "without numbers")		
W3	Attract specific partner/stakeholder interest and investment	Quantitative	Information on employment and training opportunities	Skills Development Scotland will hold this information for Caithness		
W4	Bring jobs and investment through the construction process	Quantitative	Number of jobs created locally and nationally by the selected provider as a result of the investment	N/A	TBC	

	NHS Highland: Caithness Redesign	Appendix SC15				
1. Identification						2. Prioritisation (RAG)
Ref No.	**Investment Objective/Benefit What are we seeking to achieve?**	**Assessment**	**As measured by:**	**Baseline Value (status quo)**	**Target Value**	**Relative Importance**
W5	Creates apprenticeships and training opportunities for the local workforce and school leavers	Quantitative	Number of training places / apprenticeships offered by the selected provider	N/A	TBC	

Appendix SC16 - Caithness Redesign Risk Register 20 Oct 2021

Risk ID	Identification		Assessment			Control		Monitoring		
	Risk Description	Risk Category	Consequence	Likelihood	Risk	Proposed Treatment/Mitigation	Action Taken	Risk Type	Risk Owner	Status
2	Demand for services currently unknown.	Demand Risk	Major (4)	Unlikely (2)	8	Clear process in place to arrive at projected levels, including planned assumptions.	Services mapped, data gathered, issues identified	Threat	Project Team	Open
3	Workforce projections might not be service-model focused	Business Risk	Major (4)	Unlikely (2)	8	Gather sufficient data to inform strategic case and service model. Ensure service model informs workforce plan	Information gathered on staff currently in post, service model being finalised. Programme in place, workforce plan to follow service model	Threat	Project Team	Open
4	Project milestones are unrealistic	Construction Risk	Major (4)	Possible (3)	12	Review and update project programme, seek ratification at Programme Board, regularly monitor and report at Project Team & Programme Board	Programme v0.9 agreed by Project Board in June 2021	Threat	Project Team	Open
5	Scope of project not clearly defined.	Business Risk	Major (4)	Unlikely (2)	8	Clearly define scope, ensure roles & responsibilities are well understood between Project Team members. Communicate scope of project to all stakeholders	3P events held, workstream structure in place, action plans in place	Threat	Project Team	Open
6	Pathfinder project (SFT), implementing untested model; project team may be unclear on requirements to deliver	Business Risk	Major (4)	Possible (3)	12	Early understanding of unique/untested elements and explore potential legislative/statutory implications. Implement tests of change. Work with other pathfinder sites to share learning	Tests of change being implemented. Workshop held with pathfinder sites	Opportunity	Project Team	Open
7	Potential loss of key project staff disrupts project.	Business Risk	Moderate (3)	Possible (3)	9	Ensure frequent updates take place between key project staff and accurate record keeping and documentation maintained.	Key project team members meet weekly, monthly formal project teams, written action plans in place & updated monthly	Threat	Project Team	Open
8	Staff morale impacted by poor communications.	Reputational Risk	Moderate (3)	Possible (3)	9	Agree and implement comms & engagement strategy and action plan, review regularly.	Strategy & action plan in place	Threat	Project Team	Open
9	Services collapse during transition period which would undermine public confidence throughout the redesign process.	Reputational Risk	Moderate (3)	Unlikely (2)	6	Co-produce contingency plan with Redesign Consultation group. Robust business continuity plans in place. Deliver project on programme. Keep public informed on status of services. Regularly review at Project Team		Threat	Project Team	Open
10	National / NHSH strategy may change, impacting on agreed clinical model	Business Risk	Major (4)	Unlikely (2)	8	Keep abreast of national / NHSH strategy development, monitor ongoing developments nationally.	Project in line with national & NHSH direction of travel	Threat	Project Board	Open
11	Scottish Government do not support selected option therefore finance unavailable.	Funding Risk	Extreme (5)	Unlikely (2)	10	Early and ongoing engagement with Scottish Government, follow SCIM process. Regular engagement with Scottish Futures Trust and Scottish Health Council	Full formal consultation undertaken and major service change approved by Cabinet Secretary. Clear support from SG - funding provided for CGH phase 1	Threat	Project Team	Open
12	Lack of clear communications and engagement strategy impacts on public confidence	Reputational Risk	Major (4)	Possible (3)	12	Agree and implement comms & engagement strategy and action plan, review regularly. Regular engagement with Head of Communications & Engagement	Strategy & action plan in place	Threat	Project Team	Open
13	Crosscutting theme projects associated with the Programme Management Office (PMO) could impact on other pieces of work and put Caithness Redesign Project at risk.	Business Risk	Major (4)	Possible (3)	12	Regular engagement with PMO, request regular updates from PMO linking all workstreams, identify impact on redesign, review at Project Team Escalate to Project Board	Met with PMO lead to raise awareness, PMO workstreams & contact details shared with project team leads. Clinical advisor linking with PM workstreams	Threat	Project Team	Open

Risk ID	Identification		Assessment			Control		Monitoring		
	Risk Description	Risk Category	Consequence	Likelihood	Risk	Proposed Treatment/Mitigation	Action Taken	Risk Type	Risk Owner	Status
14	Unable to implement service model due to failure to provide hubs and upgrade CGH	Operational Risk	Extreme (5)	Unlikely (2)	10	Ensure clear accommodation brief for building elements, aligned to provision of service model. Clear programming	Accommodation schedule in place for CGH	Threat	Project Team	Open
15	Staff morale impacted by lack of progress	Reputational Risk	Moderate (3)	Possible (3)	9	Deliver project on programme, clear comms & engagement in place, early investment in changes (WSH, CGH phase 1)	WSH lease in place, work starting at CGH	Threat	Project Team	Open
16	Staff resistant to adopt new ways of working, leading to failure to implement new service model	Operational Risk	Moderate (3)	Possible (3)	9	Identify root cause, identify key stakeholders / change leaders, set achievable responsibilities, clear comms plan.	Staff demonstrated ability to change in response to Covid-19	Threat	Project Team	Open
17	eHealth solutions are not fully in place to support new service model	Technology Risk	Major (4)	Likely (4)	16	Set up eHealth workstream with appropriate Project Manager resource to deliver, clear communication by eHealth re: Highland-wide strategy and timescales. Seek funding and support from SFT / NHSH	eHealth session held Dec 2020, Head of eH sits on PT. External consultant appointed to support the team to define the deliverables	Threat	Project Team	Open
20	Lack of robust activity and planning data results in service model that does not meet demand	Project Information Risk	Major (4)	Possible (3)	12	Work with eHealth and planning & performance to ensure suitable systems and processes are in place, and robust data analysis. Appoint external support for service modelling	eHealth and P&P sit on PT Outcome of bed modelling presented to PT Jan 2021.	Threat	Project Team	Open
21	New service model costs exceed current budget and is unaffordable	Funding Risk	Extreme (5)	Likely (4)	20	Clear costing of current and proposed service model at OBC stage to identify affordability once service model detail further advanced and workforce & accommodation requirements better known	Bed modelling exercise to identify the impact on inpatient services if no investment in community services is made.	Threat	Project Team	Open
22	Capacity required to deliver project disrupts day to day operations	Operational Risk	Moderate (3)	Possible (3)	9	Ensure sufficient resource in place to deliver project, efficient working	Dedicated project resource in place embedded in operational unit	Threat	Project Team	Open
23	Project Team does not have the capacity or capability to deliver the project	Business Risk	Major (4)	Unlikely (2)	8	Use of SCIM / SFT guidance to identify skill-sets required, ensure adequate resourcing of project. Put clear governance structure in place. Provide projects training		Threat	Senior Responsible Officer	Open
25	Project budget estimates may be inaccurate	Funding Risk	Extreme (5)	Unlikely (2)	10	Follow SCIM guidance, robust service model & workforce plan & cost, robust cost estimates for build options	Indicative cost being developed for CGH & Hubs for IA	Threat	Project Team	Open
26	Inflation rises above projected levels	Economic risk	Major (4)	Possible (3)	12	Follow SCIM guidance on optimism bias. Robust indicative costing at IA stage		Threat	Project Team	Open
28	Dependencies between workstreams may lead to differing priorities and expectations	Business Risk	Moderate (3)	Unlikely (2)	6	Set clear goals for each workstream, good communication between workstream PMs / leads and project team / SPM / PD. Detailed programme to identify all dependencies	Weekly core PT meetings, sharing action plans, programme in place & being further developed	Threat	Project Team	Open
29	Project programme may not be understood, leading to missed deadlines and project delay	Construction Risk	Major (4)	Unlikely (2)	8	Clear programme in place, communicate to project team, regularly review at project team. Put dedicated planner resource in place. Further develop programme detail so that all interdependencies are captured and fully understood	Programme v0.7 presented to Project Team May 2020. All team members understand programme and interdependencies	Threat	Project Team	Open
30	Poor stakeholder involvement in workstreams results in lack of progress	Business Risk	Moderate (3)	Possible (3)	9	Clear comms plan, action orientated meetings, visible responsibility. Message to stakeholders to highlight importance & opportunity to influence. Escalate to Project Director	SS meetings focus on specific areas. PD raised awareness, engagement has improved. Risk reduced 9/3/20	Threat	Project Director	Open
31	Unable to recruit suitable staff for new posts	Operational Risk	Major (4)	Likely (4)	16	Involve staff, early identification of training requirements, succession planning. Seek to support overseas workers to relocate.		Threat	Project Team	Open
32	Planning & performance may not prioritise project work, leading to lack of data to enable project team to make informed decisions	Project Information Risk	Major (4)	Unlikely (2)	8	Regular engagement with planning & performance. Escalate to head of service planning / PD. Liaise with Planning & Performance and Research & Development about submitting a funding application to the Health Foundation to employ a dedicated Data Analyst.		Threat	Project Team	Open
33	Other cross-cutting projects (e.g. covid-19 response) potentially impacting on redesign workstreams	Business Risk	Moderate (3)	Likely (4)	12	Regular engagement with other project leads, request regular updates, identify impact on redesign, review at Project Team. Escalate to Project Board. Raise awareness at NHSH exec level		Threat	Project Team	Open

Risk ID	Identification		Assessment			Control		Monitoring		
	Risk Description	Risk Category	Consequence	Likelihood	Risk	Proposed Treatment/Mitigation	Action Taken	Risk Type	Risk Owner	Status
34	Concern over existing service provision impacts on public support / buy in to redesign	Reputational Risk	Moderate (3)	Possible (3)	9	Clear comms & engagement so public understand what services are being provided	General support for project	Threat	Project Team	Open
35	Current funding levels may reduce due to organisational demands i.e. recurring savings that need to be achieved	Funding Risk	Extreme (5)	Possible (3)	15	Regular engagement with PMO and Senior Management in NHSH. Escalate to Project Board / SRO. Raise awareness with NHSH Execs	Project Board in place with membership from senior level of organisation	Threat	Project Board	Open
36	Inadequate governance structure in place to deliver project	Business Risk	Major (4)	Unlikely (2)	8	Escalate to Chief Officer and NHS Board to ensure that Programme Board and SRO put in place, agree Terms of Reference, set up Project Board meetings	SRO confirmed, Project Board established June 2020	Threat	Senior Responsible Officer	Open
37	Primary care / community care / secondary care systems incompatible, unable to share patient information	Business Risk	Major (4)	Likely (4)	16	eHealth workstream in place, adequate resourcing of eHealth workstream, continue to escalate with eHealth	Head of eHealth on PT	Threat	Project Team	Open
38	Services collapse before new service model fully in place	Operational Risk	Major (4)	Unlikely (2)	8	Business continuity plans in place. Deliver project on programme		Threat	Project Team	Open
40	Covid-19 pandemic impacts on capacity to progress project work (availability of key project leads, social distancing impact on clinical stakeholder workshops) resulting in project delay	Construction Risk	Major (4)	Likely (4)	16	Progress slowed as many NHSH staff prioritising response to Covid-19. Some pieces of work require input from clinical staff, planning & performance etc. Dedicated project staff to progress IA, data analysis and service model work as far as possible. Technology options to be explored for virtual meetings / workshops	5 members of project team are dedicated to the project. Programme v0.7 updated to reflect expected impact Raised at NHSH EDG - commitment given to project & ensuring resources are available to deliver	Threat	Project Director	Open
41	New NHSH operational structure (Caithness General now part of Acute Services) may result in conflict between redesign priorities and acute service priorities, resulting in failure to fully implement new service model	Business Risk	Major (4)	Possible (3)	12	Regular engagement with head of acute services to confirm support and agree joint approach. Escalate to SRO to ensure joint strategic approach and to raise profile of project with NHSH Executive Directors	Discussion taken place with Head of Acute Service. Highlighted at Capital Programme Board	Threat	Senior Responsible Officer	Open
42	Covid-19 pandemic impacts on construction working practices, resulting in increased programme and increased delivery cost	Construction Risk	Major (4)	Likely (4)	16	NHSH Quantity Surveyor to seek external guidance on likely impact and incorporate this in cost planning		Threat	Project Team	Open
43	Covid-19 pandemic and need for social distancing results in increased space requirements, with increased cost	Demand Risk	Major (4)	Possible (3)	12	Robust service model, increased use of Near Me technology, more efficient patient flow. Follow national guidance		Opportunity	Project Team	Open
45	Lack of data sharing agreement with GPs and other providers impacts on ability to deliver planned service model	Business Risk	Extreme (5)	Likely (4)	20	Escalate to SRO / Project Board members to influence GP-sub data sharing agreement. Complete data protection impact assessment. Expore potential for local data sharing agreements with individual GP practices	Escalated to SRO and Primary Care reps on Project Board. Data sharing agreement completed Dec 2020	Threat	Project Board	ISSUE
46	Unable to progress option appraisal for interim accommodation solution for East Community Teams due to lack of resource, impacting on ability to deliver services & implement service model	Business Risk	Major (4)	Likely (4)	16	Escalate resourcing issue to Estates Project Leads Group to identify suitable resource	Highlighted to Head of Estates / Head of Projects	Threat	Project Board	Open
47	Potential for duplication of work and lack of co-ordination between MDT, SPOA and North & West Enhancing Community Care workstreams, dependencies not fully understood	Business Risk	Moderate (3)	Possible (3)	9	Review action plans of the various workstreams to identify overlap Clear leadership and direction of various elements to ensure common vision and aims, clear task allocation to team members	Action plans reviewed 8/12/20, discussions taken place between SPOA & MDT PMs and project leads for N&W ECC work	Threat	Project Director	Open
50	Operational managers / project leads have insufficient time to carry out project work, resulting in project delay	Business Risk	Major (4)	Possible (3)	12	Escalate to SRO / Head of Community Services. Ensure individuals have protected time for project duties	Escalated to EDG - assurances received that resource will be freed up. Risk reduced	Threat	Project Director	Open

Risk ID	Identification		Assessment			Control		Monitoring		
	Risk Description	Risk Category	Consequence	Likelihood	Risk	Proposed Treatment/Mitigation	Action Taken	Risk Type	Risk Owner	Status
51	Insufficient workforce resource to deliver 2 new Hubs and refurb of Caithness General within timescales agreed by Programme Board, project delay	Construction Risk	Major (4)	Likely (4)	16	Prepare resourced programme to identify gaps. Consider re-scheduling of design and procurement phases to match available resource or re-organise structure to ensure resourced delivery of all building elements, in line with proposed procurement routes. Seek external resource to support delivery of agreed programme.		Threat	Senior Project Manager	Open

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Professor Boyd Robertson
Interim Chair
NHS Highland

By Email.

2 May 2019

MAJOR SERVICE CHANGE PROPOSALS: HEALTH AND SOCIAL CARE SERVICES IN CAITHNESS

I acknowledge receipt of the letter from David Alston, dated 31 January 2019 along with accompanying papers seeking my approval for NHS Highland's proposals for the redesign of health and social care services in Caithness. These proposals were endorsed by the Board of NHS Highland at its meeting on 29 January.

First of all, I would like to put on the record that I am aware that the engagement and consultation process on the proposals for the Caithness area has been carried out by the Board in a positive and constructive manner which has been acknowledged and welcomed by local people, other stakeholders and elected representatives. I note the positive support for the Care Hub model for the delivery of health and social care services in Caithness and that the proposed Care Hub model for Thurso and Wick has the support of 70% of the people who participated in the formal consultation process.

I have now carefully considered the proposals. In doing so, I had to be convinced that the plans are in the best interests of patients; that key local services would be safeguarded and improved; and that the Board had credible and viable plans for the provision of the Care Hubs in Thurso and Wick. In addition to the proposal to develop Care Hubs, I note that the proposals include plans to redevelop Caithness General Hospital, which I know will be welcomed by the local community.

Having considered all the available information, I am content to approve the Board's proposed model of care and direction of travel which is to develop two Care Hubs; one in Wick and one in Thurso alongside the redevelopment of Caithness General Hospital. I note that the model of care is supported by the majority of local stakeholders including clinical staff, planning partners, local people and their representatives. The broad vision set out should provide modern, fit-for-purpose services for the benefit of local people in Caithness. I am also pleased to note that the view of the Scottish Health Council (SHC), as the independent arbiters of how consistent Health Boards' activity is with national guidance on effective engagement and consultation, that NHS Highland enabled local people to be informed about and give their views on the proposals. The SHC consider that NHS Highland demonstrated that it is listening and responding to the views and suggestions expressed by stakeholders during the process and adapted its communication and engagement plans in response.

That said, while I am content to approve the model of care being proposed, I consider that the Board must set in a train a further programme of engagement and consultation with all local stakeholders to develop the detailed proposals, including reaching a consensus on the location for the Care Hub in Wick, the location of the GP Practices, and evidenced modelling of proposed bed numbers and staffing requirements across all of the affected services and sites – Caithness General Hospital and the facilities at Wick and Thurso. I expect this work to be taken forward in dialogue with the SHC, including seeking their view on whether any proposals constitute major service change and a final decision by Scottish Ministers.

It is also key that the Board's re-design programme for Caithness should include the on-going roll out of *NHS Near Me* to enable as many Caithness patients as possible to have appointments locally, therefore reducing any unnecessary travel to Inverness for routine appointments.

I have noted the concerns raised during consultation about the location of the Hub in Wick and the location of GP Practices, including access, parking and transport links to these services. I note the Board will continue to work with local people and all other stakeholders to consider viable solutions and ensure no local community will be disadvantaged by any proposed changes.

In conclusion, I am grateful to NHS Highland for the considerable efforts that have been made to date in bringing these proposals forward. As already noted, there is more work needed to agree and shape local services, and I expect the changes to bring considerable improvements to the provision of healthcare services for the benefit of local people. I know the Board will appreciate the need to ensure that all local stakeholders continue to be kept fully informed and involved in the on-going development and delivery of these services.

I look forward to seeing this work progress.

Kind regards

JEANE FREEMAN

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Caithness Initial Agreement – Appendix EC05

Timeline of Option Appraisals, Public Consultation and Stakeholder Engagement

Date	Event Title	Participants	Outcomes
23/05/2017	Reference Group	Public & Patient reps, staff & service reps, Community councils, Councillors, Partner orgs, CHAT	Update on workstreams, feedback, discuss options
04/08/2017	Summit Meeting	Local councillors, MSP, MP, NHSH CEO & NHSH Chair	Agreement on way forward
28/08/2017	Reference Group Stakeholder Workshop	Public & Patient reps, staff & service reps, Community councils, Councillors, Partner orgs, CHAT	Bed Strategy option development
02/11/2017	Reference Group Stakeholder Workshop	Public reps, Staff and Service reps, Third sector, NHSH Chair and Non-execs, Councillors, Community Councils, CHAT, Scottish Health Council	Inform principles and next steps, agree principles and ground rules for charter
28/11/2017	NHSH Board Meeting	NHSH Board members, Project leads, CHAT	Approval of Project Initiation Document, agreed to restart process of engagement
19/03/2018	Stakeholder event: Case for Change	Staff & Service reps, Voluntary groups, Third sector, CHAT, Community Councils, Councillors, NHSH Board reps, MSPs, Patient Council & patient reps, Scottish Health Council	Gain shared understanding of the problem and confirm need for change
18/05/2018	Option Appraisal: Workshop 1	Staff & Service reps, NHSH Board reps, Partner Organisations, Councillors, Community Orgs, Public & Patient reps, CHAT, Community Councils	Develop and appraise possible future options
22/05/2018	Option Appraisal: Workshop 2	As previous	Develop and appraise possible future options
31/05/2018	Option Appraisal: Workshop 3	As previous	Develop and appraise possible future options
12/06/2018	Option Appraisal: Workshop 4	As previous	Options scored & preferred option identified
24/07/2018	NHSH Board Meeting	NHSH Board members, Project leads	Endorsed recommendation for major service change, agreed to formal public consultation

Date	Event Title	Participants	Outcomes
20/08 – 23/11/2018	Public Consultation • 2,017 responses • 105 public meetings 28 staff meetings	Caithness public	70% of respondents supported proposals for change
Jan 2019	Consultation Report	Scottish Health Council	Assessment of NHSH's engagement and consultation process - concluded NHSH has met SG national guidance
15/01/2019	Highland Health & Social Care Committee	HHSC Committee members, Project Leads	Endorsed the consultation process, the preferred way forward and next steps
29/01/2019	NHSH Board Meeting	NHSH Board members, Project leads	Endorsed the consultation process, the preferred way forward and next steps
02/05/2019	Letter	Cabinet Secretary for Health & Sport	Approved the major service change process and proposed model of care
07 – 09/05/ 2019	3P Process Design Event	Staff & Service reps, Voluntary & Third Sector Orgs, Scottish Futures Trust	Development of service redesign workstreams and action plans
28/05/2019	NHSH Board Meeting	NHSH Board members, Project leads	Update provided on process & next steps
05-07/06/ 2019	3P Process Design Event	Staff & Service reps, Partner Voluntary & Third Sector Orgs, Patient & Public reps, CHAT, Councillors, SG	Developed service redesign workstreams and action plans. Identified tests of change
30/09 – 12/10/2019 (6 dates)	Pop Up Shop – Wick Hub site options	Project reps, General Public	Public feedback on third site option put forward for Wick Hub
11/11/2019	Benefits Workshop	Staff & Service reps, Partner Voluntary & Third Sector Orgs, Patient & Public reps, CHAT, Councillors	Draft benefits register for project
09/01/2020	AEDET & Design Statement workshop for Caithness General	Staff & Service reps, Partner Orgs, Patient reps, CHAT	AEDET assessment of current facility Development of Design Statement
10/01/2020	AEDET & Design Statement workshop for Wick and Thurso Hubs	Staff & Service reps incl GP, Partner Voluntary & Third Sector Orgs, Patient reps, CHAT, Access Panel	AEDET assessment of current facilities Development of Design Statement
28/01/2020	Design Statement workshops for - Hubs - CGH	Staff & Service reps incl GP, Partner Voluntary & Third Sector Orgs, Patient reps, CHAT, Access Panel	Draft design statements for Wick & Thurso Hubs and Caithness General

Appendix EC08 - SWOT Analysis of Care Hub Site Options

Thurso Hub - Dunbar Hospital Site

Strengths	• Existing healthcare site • Existing Infrastructure (e.g., utilities) and transport links
Weaknesses	• Site on edge of town
Opportunities	• Opportunities for local businesses during construction phase • Availability of land on site for new build aspects • Green Space
Threats	• Ageing building; may require significant upgrade • Failure to achieve planning permission

Wick Hub – Pulteney House Site

Strengths	• Care home (Pulteney House) already on site • Assisted living (Caberfeidh Court) adjacent to site • Existing infrastructure (e.g., utilities) and transport links • Opportunities for local businesses during construction phase • Close to town centre • Open outlook over sea and playground
Weaknesses	• Care Home requires significant upgrade & extension • Impact of (temporary) move for residents during construction phase • Assisted living (Caberfeidh Court) unlikely to meet current building standards • Existing infrastructure may not have sufficient capacity (e.g., utilities) • “Hub” would be split across three buildings on one site which would need to be joined up • Site to be accessed three different locations
Opportunities	• Opportunities to invest in area which requires development • Increased access to health care services in area recognised as disadvantaged • Increased opportunity to expand links with local community and community organisation (e.g., Pulteneytown People’s Project, PPP) • Opportunities for local businesses during construction phase • Green space • [If not used] potential for alternatives use of site
Threats	• Ageing building (30+ years); may require significant upgrade • Concern of increased traffic in the area • Failure to achieve planning permission • Emotional attachment to other buildings and resistance to change • [If not used] large building left un-occupied

Wick Hub - Town & County Site

Strengths	• Existing healthcare site • Existing infrastructure (eg. utilities) • Open outlook • Relatively level site
Weaknesses	• Full demolition of building required • Impact of (temporary) move for residents during construction phase • Site on edge of town (transport links)
Opportunities	• Intergenerational working (Newton Park Nursery & Primary School located nearby) • Opportunities for local businesses during construction phase • [If not used] potential for alternatives use of site
Threats	• Full rebuild • Possible need to buy additional land • [If not used] large building left un-occupied • Failure to achieve planning permission • Emotional attachment to other buildings and a resistance to change • Acceptability of location • Lack of public transport

Wick Hub - Noss Site

Strengths	• Large area available • Highland Council's "Local Plan" identified land as available for mixed use purpose • Open outlook and south facing
Weaknesses	• Investigation needed re infrastructure (e.g., utilities) • Possible flood risk from surface water on site
Opportunities	• Intergenerational working (Noss Primary School located nearby) • Potential to share services (e.g., utilities) with adjacent buildings / organisations • Opportunities for local businesses during construction phase • No emotional attachment to existing building (on site) • Opportunity to provide satellite service across town (e.g., GP access) • Greenfield site: No requirement to adapt/demolish existing buildings; Design efficiencies, optimum space use; No need to move residents during construction stage
Threats	• Full build; no opportunity to re-use existing buildings • Failure to achieve planning permission • Acceptability of location • Emotional attachment to other buildings and a resistance to change

Equality Impact Assessment Template: Please complete alongside the guidance document

Title of work: **Redesign of Health and Social Care Services in Caithness**	**Date of completion: 18.03.21**	**Completed by: Dan Jenkins (with collaboration)**

Description of work:

The combined impacts of our ageing population, demographic changes and clear implications for the workforce with increasing costs and demands, mean that the current model of health and social care delivery is not sustainable.
A review and redesign of existing health and social care services, primarily for adults, across Caithness to ensure that services are safe and sustainable, as well as effective and efficient for the future. This will result in:

- investment in community services; and
- a re-furbished Caithness General Hospital (improved Emergency Department, out-patients and day case, as well as purpose-built community maternity and ambulatory care units).

This is a new review of services which involved significant pre-engagement activity in 2017. It was launched in spring 2018 with an event at which the case for change was agreed. This was followed by a series of option development and appraisal workshops.

NHS Highland is proposing to develop two Care Hubs: one in Thurso (located on the Dunbar Hospital site) and one in Wick (located on a new site adjacent to Noss Primary School). Developing the Care Hubs will allow more services to be co-located across fewer sites and in improved facilities. This includes community beds, residential and palliative care, out-patients, day care, community teams, dental and GP services, third sector and community support, alcohol and drug services, mental health support
The options have been subject to a period of public consultation, looking for feedback on all the options, as well suggestions for alternative options or component part of the options.

Whilst the scope of this redesign is centred around adult care services, with an emphasis on older adults, there are clear considerations around further development of associated services to support mental health, drug and alcohol use, community health improvement, workplace health, etc.

It is also inescapable to consider the cross over to services for children and young people. This redesign process involves planning for the long-term future and creating seamless service transition across the life course. How can we use this work to break the cycle of ill health and inequality?

Outcome of work:

This redesign will move more towards a place-based care model (aligning with the 'Place Principle' as published by the Scottish Government in April 2019) ensuring care is 'person-centred, flexible and adaptable, effective and efficient'. Such a place-based approach facilitates a focus on the social determinants such as housing, education, employment, wider planning partners, social connectedness and community assets. Taken together, these they will have a greater impact on wellbeing and health compared to care and health service on their own. It also promotes a more proactive approach to care, focussing on strengthened primary and community services designed to enable people to self-manage and seek appropriately support, avoiding a reactive response and hospitalisation or longer-term social care wherever possible.

The intent is to develop a local care model with enhanced approaches to prevention and self-care, primary care, and community services with less reliance on acute and institutional care. This will be supported through the development of two Care Hub / Care Villages – one in Thurso and one in Wick. These will be delivered in collaboration with key public-sector partners, independent and voluntary sector and empowering and enabling individuals and communities

The development of 'NHS Near Me' and technology enabled care services offers benefits for all the population.

Who:
Stakeholders: (who will this work affect?)

The proposed changes could impact on people with protected characteristics. It may also impact on carers and people living in rural and remote communities and those living in areas recognised to be disadvantaged (SMID). Specific impacts on protected characteristics are described below

Staff may also be affected by changes e.g., change of base, therefore consideration of the impact of any change on ability to travel to and from work should be included. Sustainability of services has been an issue and by changing/redesigning, there are opportunities to improve staff experience as well as creating a more sustainable model.

Other key stakeholders include:
Adults in the community (and by association children and young people)
Care home residents and day care users
Carers

Wider NHS service providers Caithness Community Partnership, Covid Resilience Group and sub-groups Community organisations / third sector services / private care providers Isolated rural communities and individuals People living with mental health challenges and people who experience periodic or new episodes of mental distress – strong anecdotal evidence, and community observation since the outbreak of Covid-19 and associated lockdown measures, have revealed a rise in mental distress and suicidal behaviours
How do you know: Stakeholder engagement: How will you know what impact this will have - please detail what work you have done to find this out? The co-production of options and public consultation carried out in 2018 was one of the most extensive and comprehensive ever carried out by NHS Highland, and arguably by any public-sector organisation in Scotland. Through that process, there was support for better collaboration with partners and ongoing community involvement, to improve the impact of combined resources and investment. Some significant changes to service location and composition have been made as a result of feedback from the consultation process. Further public information sessions were held in the former Graham Beggs building Wick Town Centre during September and October 2019 to provide more detailed information and a chance to comment on the change to the proposed Wick site. Continued stakeholder engagement events around key design elements of hub have been coordinated. Ongoing liaison with stakeholders representing a range of community interests, including: Monthly Caithness Redesign Consultation Group meetings, with representatives from the community, local authority and patient groups. They provide scrutiny and comment around the ongoing redesign process. A series of workshops to undertake a specific Health Inequalities Impact Assessment – also revealing that certain specific population groups require further engagement and representation to ensure no unseen disadvantages occur. Caithness Covid Resilience Group (coordinated through Caithness Voluntary Group and with representation from local communities throughout Caithness) has maintained close, direct contact with those communities, and vulnerable people within

them. This (along with previous community consultation work) has led to the creation of the Action Group for Social Isolation and Mental Wellbeing.

What will the impact of this work be? (see appendix 1 for list of protected characteristics and other groups that you may wish to identify)

Transport and access – relocation of services will mean they are more convenient and easier to access for some people, and less convenient and potentially more difficult to access for others

Age - older adults are clearly affected by this redesign process. Care needs of the aging population underpin this work. Also, it is necessary to include young people if we want to improve services for the future.

Disability - access restrictions have been identified, including in current care home establishments, and are highlighted as priority issues in service and building design – e.g., single floor access, quiet areas available, etc. In addition to legislative guidance, close consultation with local access panel and community representatives is required.

Gender reassignment – remote and rural provision of specialist services and support is known to be challenging. No additional, new impacts or barriers are identified for this population group.

Marriage and civil partnership - no additional, new impacts or barriers are identified for this population group.

Pregnancy and maternity – maternity services in Caithness have face significant challenges over recent years and whilst maternity services are not an element of the redesign, the widely discussed need for safety and quality of these services is acknowledged.

Race – whilst general research and experience highlights that additional race and cultural sensitivity and awareness is required to ensure services are accessible, no additional, new impacts or barriers are identified for this population group.

Religion or belief - whilst general research and experience highlights that additional religious and cultural sensitivity and awareness is required to ensure services are accessible, no additional, new impacts or barriers are identified for this population group.

Gender – whilst general research and experience highlights that additional gender awareness is required to ensure services are accessible, no additional, new impacts or barriers are identified as a result of service redesign. The exception to this consideration

is around caring responsibilities, which fall disproportionately to women. Due to this fact, the improvements in care services should benefit women overall across Caithness.

Sexual orientation - no additional, new impacts or barriers are identified for this population group

It has also been highlighted that wider issues within Caithness communities require to be considered. Whilst the solutions to these challenges are not directly within the gift of this service redesign process, the impact of these issues has significant effects on the health of the current and future populations. These include general employment/unemployment, academic achievement/aspiration, youth employment/unemployment, sense of place and belonging, retention of younger population through perceived opportunities in the area, attraction and retention of new populations through perceived opportunities in the area. Successful economic and social generation and regeneration can only be achieved through a whole system approach, of which NHS is a key player.

Given all of the above what actions, if any, do you plan to take?

Transport and travel planning, including active travel opportunities. Close liaison with transport providers and travel initiatives. Caithness Rural Transport is available and may be used to mitigate any changes in locations.

Health Inequalities training across partnerships and staff teams has been identified as a priority action through the Health Inequalities Impact Assessment working group.

Mental health services, and alcohol and drug services, developed in closer alignment with ongoing community conversations. This includes young people's services and the emerging initiatives through the Caithness Cares workstream.

Collaborative working through the Caithness Community Partnership will need to ensure that life circumstances are addressed, as well as lifestyle. This would include: equality of access for everyone, including those with multiple and complex needs; providing universal services that are responsive to and meet the needs of the community; investing in communities and groups who experience inequality, and identifying and building on local strengths within communities. Developing interventions that are inequalities sensitive and measuring the impact of these is a fundamental aspect of developing fairer communities and improving health outcomes. Therefore, maintaining close relationships across sectors and services. For Care Hubs to achieve their goals, a broad range of services and stakeholders require to be involved and many to be co-located for holistic community-based care to be successful. Continued networking and collaboration are essential.

Several protected characteristics identified above are currently perceived to have no additional, new impacts or barriers brought about through this redesign process. However, it is recognised that small population numbers and lower visibility (BAME, LGB, Trans) risk assumptions that no barriers exist. It has been identified through the Health Inequalities Impact Assessment working group that specific additional effort is required to ensure greater visible representation of small minority population groups.

Technology Enabled Care (TEC) team is to promote technology that helps people self-manage their own health and wellbeing, and enable them stay happy, safe and independent in their own homes, complementing the ethos of the Local Care Model. We are aiming to expand TEC services in Caithness to in both Telehealth and Telecare. The ongoing development of 'NHS Near Me' offers benefits for all of the population. This also brings considerations around digital access, requiring continuation of support for digital inclusion initiatives, with particular attention to additional support required by those who may be less confident using technology

A section dedicated to the redesign in Caithness has been added to the NHS Highland Website and can be found at http://www.nhshighland.scot.nhs.uk/News/PublicConsultation/CaithnessRedesign/Pages/Welcome.aspx

Approved by:
Caithness Redesign Project Team – 29th March 2021

Our Caithness, Our Health

Delivering Healthcare and Health Improvement in Caithness

Version Control

Version	Date	Update	Author(s)	Status
V1 – 6	Oct 2020 – Jun 2021	Drafts developed with local service leads, District Manager & Rural General Hospital Manager	Josie Thomson Naomi Watson	Working Drafts
V7	23rd July 2021	Final draft developed by Area Manager, District Manager and Rural General Hospital Manager	Diane Forsyth	Final draft - to share with NHSH Strategic Leads
V8	30th July 2021	Incorporate feedback from NHSH Strategic Leads (Maternity) Version control added	Diane Forsyth	Final draft – for ratification by Project Team and Programme Board
V9	8th Oct 2021	Updated to incorporate feedback from Caithness Redesign Programme Board (29 Sep 2021)	Diane Forsyth	Final version – for inclusion in Initial Agreement

Introduction

This document sets out the high-level clinical and care specification to underpin the future model for health and social care services in Caithness. Securing these changes will require significant changes to the way people work. This is a dynamic process and over the coming months we will be developing the model further. The high-level strategic model of services was agreed as part of the major service change process including a three-month public consultation and various events with staff and partner agencies. Some of the detail reflects feedback received during the Options Appraisal process, the public consultation and ongoing dialogue with staff.

The specification is broken down into several sections with management and professional leads identified. Within each section there is a brief description of what will be provided, and any further work still required prior to submission of Outline Business Case.

National Context

There is currently significant economic uncertainty for Caithness along with the rest of the UK and the world. It is anticipated that this will continue to put pressure on all parts of the public sector over the next few years.

Local Context

NHS Highland, like all other Scottish Health Boards, is facing a challenging future. In Caithness in particular we are dealing with significant increases in demands for healthcare services as the number of older people in the population and the level of chronic ill health increases. Patients and service users are now better informed and rightly expect faster, more personalised care which is delivered closer to home. Not only are the demands on services increasing, but we are trying to deal with these demands at a time when the working age population is shrinking, and healthcare funding is reducing. Half of the Caithness workforce is aged 55 and over with no clear succession planning. Furthermore, there are significant concerns about the availability of key clinical staff to meet predicted future clinical demands.

Local Care Model

Individuals will be provided with the opportunity to be supported in their own homes where this is possible and practical thereby preventing unnecessary admissions to hospital. The ability to do this will be enhanced by two Community Hubs, one in Wick and one in Thurso, which will allow patients who do not require medical intervention within an acute hospital setting to be cared for appropriately and greater embedding of realistic medicine principles.

Figure 1: Caithness Local Care Model

KEY THEMES OF CLINICAL MODEL

1. Building local services which respond to the needs of our communities.
2. The right care in the right setting at the right time by the right person.
3. Governance structures and procedures will underpin our ability to provide safe care and inform continuous improvement.
4. Involving service users, their families and carers in the development and design of our services.
5. Standards of care will be based on best practice guidelines.
6. Partnerships will be developed which enable us to deliver the best possible care and improve health.
7. Clinical Services will be supported by a responsive technological infrastructure.
8. Service plan will be based on robust health and epidemiological data.
9. Services will be easy to access.
10. Service user and carer feedback will be central to service development and improvement.
11. Service users, carers and staff will be involved in decisions affecting services we are unable to provide locally.

Outline of services

Community Led / Community Based Support:

1. Adult Social Care / Social Work

Management Lead: Christian Nicolson, District Manager (Caithness)
Clinical / Professional Lead: Ruth MacDonald, Head of Service - Social Work Services

Following a process of integration of Health and Social Care Services in 2012, NHS Highland now delivers a range of Adult Social Work and Social Care Services on behalf of the Highland Council, across the whole of the Council area. Health and Social Care professionals work together effectively to assess for, plan and provide care and support to individuals and their carers. Registered Social Workers have within their remit to protect vulnerable adults in the community to safeguard them from harm and statutory responsibilities e.g. organising Adults with Incapacity (AWI) meetings when appropriate; act as Welfare Guardian on behalf of the Chief Social Worker Officer (CSWO), liaise with other agencies to protect adults under Adult Support and Protection legislation. Care and support can be provided for people aged 16 or over who are assessed as having a care or support need and who require assistance. NHS Highland works closely in partnership with its Third and Independent sector colleagues to help people achieve the outcomes they seek.

The adult social care team in Caithness will continue to fulfil its statutory duties and will be co-located in the new Community Hubs as part of the integrated community team. As part of the development of the team and with the local care model in mind a review of the skill mix within the team has taken place. The result of this review has been the recruitment of Referral & Assessment Officers (ROA) to compliment and support the registered Social Worker and the development of a specialist social worker in housing issues. This post is jointly funded by the Highland Council's Housing Department.

2. Care at Home

Management Lead: Lesley Martin, Care at Home Manager (North)
Clinical/ Professional Lead: Jackie Hodges, Head of Registered Services

The Care at Home service is provided by in-house NHS staff, in conjunction with four independent sector providers. The service is provided according to the assessed need of the individual service user and reviewed regularly to detect any changes in need promptly and to ensure that the right support is being provided. The Care at Home team delivers a range of services to help the service users retain their

independence at home for as long as possible and prevent hospital admissions. These services are delivered to a wide range of service users, from those who require very little assistance, to those with complex care needs.

The Enablement Service facilitates an early discharge from hospital for those who are medically fit but require some additional assistance at home to regain independence. It also offers an intervention service to prevent hospital admission. An assessment is carried out by an Allied Health Professional and a programme of outcome focused activities, usually delivered over six weeks. The service is reviewed on a weekly basis and adjusted if necessary. If anyone has been unable to return to being independent and ongoing support is required, then appropriate Care at Home (mainstream) services would take over.

These services will continue, co-located with the wider team in the new Care Hub.

3. Care Hubs

Management Lead: Christian Nicolson, District Manager

NHS Highland is proposing to develop two Care Hubs: one in Thurso (located on the Dunbar Hospital site) and one in Wick (site to be determined). Developing the Care Hubs will allow more services to be co-located across fewer sites and in improved facilities.


Care Village
Community Pharmacy
Assisted Housing
Care Hub
GP/Primary Care Services
Community Beds
Transport Services
Health & Wellbeing Hubs
NHS Highland
24/7
Adult Day Care
Palliative Care
Outpatients
Mobile Library
Community Garden
Co-locate Ambulance + Fire
Rapid Response
Modern Apprenticeship
Befrienders
Hairdresser/ Beautician
Training & Development
Inreach - Outreach
University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean
Caithness General Hospital

Table 1: Services provided at each of the Care Hubs in Caithness

Thurso Hub:	**Wick Hub:**
Complex Patients Multi-Disciplinary Team*	
Out of Hours*	
Single Point of Access*	
Assisted Living Accommodation	Assisted Living Accommodation
Community Beds	Community Beds
Community Mental Health Team	Community Mental Health Team
Community Space	Community Space
Day Services (Older adults & adults with learning disabilities)	Day Services (Older adults)
Dunbar Dental Service (already on site)	- ^
Health Centre facilities	Health Centre facilities
Minor Injuries Unit (already on site)	- ^
Palliative & End of Life Care	Palliative & End of Life Care
Respite Care	Respite Care
West Caithness Integrated Team	East Caithness Integrated Team

*Base to be confirmed, but this service will cover all of Caithness from one of the Care Hubs.

^ In Wick the Minor Injuries Unit and Public Dental Service are based at Caithness General Hospital, and dental services at Lochshell Dental Clinic

Community Adult Health services are delivered by Integrated Teams, encompassing all community-based health and social care services (District Nursing, Social Workers, Care at Home, Community Mental Health and Community Learning Disabilities Nurses). These are arranged along geographical lines with the East Caithness Integrated Team based in Wick, and the West Caithness Integrated Team in Thurso. The changes to staff bases will support better team working and enable more 'joined up' care.

By Outline Business Case (OBC) we will have:

- Carried out a full technical and financial appraisal of the three Wick sites (Noss, Pulteney House and Town & County) to determine the final site for development of the Wick Care Hub; and

- Confirmed the accommodation brief for the Care Villages in Wick and Thurso.

4. Community Beds

Management Lead: Christian Nicolson, District Manager (Caithness)
Clinical/ Professional Lead: Sara Sears, Associate Nurse Director, HHSCP and Margaret Moss, Associate Director, AHPs (North Highland)

Each Hub will contain 40 Community Beds: these will be a combination of the beds currently in the two Community Hospitals (Dunbar, Thurso and Town & County, Wick), as well as the two NHS Highland run residential Care Homes, Bayview House, Thurso and Pulteney House, Wick, along with the re-provision of residential beds lost to the county when Achvarasdal House closed. These would provide people with care when they need extra support, but do not require hospital admission. The beds will be flexible in nature and would provide end of life/ palliative care, residential care, respite, and step-up beds dependent on the need within Caithness at the time. The flexible nature of these NHS beds will support those patients with incapacity waiting for Guardianship as the legal process is completed.

5. Community Mental Health Team

Management Lead: Nikki Mackenzie, Integrated Team Manager Caithness East / Community Mental Health Team Manager
Clinical/Professional Lead: Jonathan Davies, Associate Lead Nurse, Mental Health

The Community Mental Health Team (CMHT) is a multi-disciplinary team providing community-based support for adults of all ages experiencing moderate to severe mental health concerns or for any adult concerned about their use of substances. The four distinct service areas are general adult; older adult; alcohol and drug recovery services; and psychological services; which includes cognitive behavioural therapy and guided self-help.

The future service provision will include preventative work focusing on mental health improvement, health inequalities and problem drug and alcohol use. The CMHT are well placed to deliver this. We have already commenced work to look at our skill mix to meet the increased demand, including the introduction of a Band 7 Emergency Care Practitioner, a community role, but based in the Emergency Department of Caithness General Hospital. Through the new GP contract, there are now practice based First Contact Community Psychiatric Nurses.

NHS Highland will continue to work in partnership with Third Sector organisations to provide additional local support for people with mental health concerns.

6. Community Nursing

Management Lead: Christian Nicolson, District Manager (Caithness)
Clinical/ Professional Lead: Sara Sears, Associate Nurse Director, HHSCP

The Community Nursing Team provides a community nursing service for patients requiring a clinical intervention who are unable to leave their home. The service is currently provided from 09:00hrs to 17:00hrs seven days a week with an on call out of hours provision for end of life care which is on an informal basis. The service is seeing a gradual increase in the complexity of patient needs on their caseloads. Patients often require more frequent, intensive interventions such as IV antibiotics at home, taking up more staff resources.

We will review the operating hours in line with other services to ensure that we have responsive provision 24/7. We will review and increase the staffing required to allow this to happen. In line with the increasing acuity within the community we will look to develop a hospital at home service. Our community nursing teams, whilst playing a key role in the function of the multidisciplinary team, will be at the core of the hospital at home service development.

7. Day Care Services

Management Lead: Christian Nicolson, District Manager, Caithness
Clinical/Professional Lead: Jackie Hodges, Head of Registered Services

Day Care facilities for older adults are provided at Bayview, Thurso and the Laurandy Centre, Wick (third sector provider). Day Care facilities for adults with learning difficulties (aged 18 to 65) are provided at Thor House, Thurso.

We will continue to provide day services to those who need it and their carers, to continue to allow people to live at home. These services will be provided within the Care Hubs.

By OBC we will have finalised arrangements with the Laurandy Centre in Wick regarding their potential co-location at the Wick Care Hub.

8. Dental and Oral Health Improvement Services

Management Lead: Alex Fraser, Dental Services Development Manager
Clinical/Professional Lead: Tom McWilliam, Assistant Clinical Dental Director

Independent contractor and public dental services will continue to be provided in their current locations. Provision will be made in the new Care Hubs to allow the Oral Health Improvement team to be co-located with the wider health and care team.

By OBC details of increased public dental service provision in Caithness General Hospital will be finalised.

9. Dietetics

Management Lead: Nikki Mackenzie, Integrated Team Manager, East Caithness
Clinical/Professional Lead: Margaret Moss, Associate Director AHPs (North Highland)

The Dietetics Service is a community service that also covers hospital inpatients and paediatrics.

The Dietitians based in Caithness provide a cradle to grave service, covering Caithness and the North Coast area. This service will continue to be provided, based at the Care Hubs.

10. Drug & Alcohol Services

Management Lead: Nikki Mackenzie, Integrated Team Manager, East Caithness
Clinical/Professional Lead: Bev Horton, Head of Service; Drug & Alcohol Services

We are a specialist service for anyone aged 16 and above who have left school and would like advice/treatment for drug and/or alcohol use. We support long-term recovery from alcohol and/or drug dependence by increasing opportunity and choice and will continue to do so as part of the local care model.

11. Equipment, Aids and Adaptations

Management Lead:

There will be provision of a local aids and adaptations service that can provide responsive adaptations to homes (rails, ramps, stair lifts etc) to keep people out of hospital and/or reduce delayed discharges. This service may be 'in house' or private/voluntary sector provision and will be delivered in conjunction with Highland Council Housing Service. We will continue to review the provision of equipment to ensure that it meets the needs of the local population.

12. General Ophthalmic Service

Management Lead: Fiona Mackenzie, Primary Care Manager, West
Clinical/ Professional Lead: Cora MacLeod, Head of Optometry

General Ophthalmic Services (GOS) across NHS Highland are provided by Community Optometrists who are independent contractors of the NHS. GOS makes provision for eye examinations that establish the need for refractive correction and assess the eye and visual system for signs of abnormality. If an abnormality is detected (or suspected), the optometrist decides whether further investigation is warranted or whether referral to the Hospital Eye Service (HES) for confirmation/establishment of diagnosis and/or commencement of treatment is required. This will not change.

13. Health Centres

Management Lead: Evan Beswick, Primary Care Manager, North
Clinical/ Professional Lead: Alison Brooks, District Medical Lead, Caithness / Sadat Muzammil, Clinical Director, North

There are seven GP Practices in Caithness. Their current and proposed future locations are provided in the table below:

GP Practice:	Practice Type:	Current Location:	Dispensing Practice?	Proposed change?	List size (as of 01/01/2020)
	East Caithness:				
Dunbeath Health Centre	17J	Dunbeath Health Centre	Yes	No change	631
Lybster Medical Practice	2C (since 2004)	Lybster Health Centre	Yes	No change	1,127
The Pearson Practice	17J	Wick Health Centre, Martha Terrace	No	Final location to be agreed by Practice.	2,221
Riverview Medical Practice	2C (since 2014)	Wick Health Centre, Martha Terrace	No	Wick Care Hub.	7,446
	West Caithness:				
Riverbank Medical Practice	2C (since 2012)	Riverbank Medical Practice	No	Thurso Care Hub.	5,480
Thurso & Halkirk Medical Practice	17J	2 x sites: Princes Street, Thurso & Halkirk Health Centre	Yes (Halkirk Surgery part-dispensing)	Thurso Care Hub.	6,059
	East & West Caithness:				
Canisbay & Castletown Group Practice	17J	2 x sites: Canisbay & Castletown	Yes	Improvements to be made to both practices to facilitate additional requirements under new GMS contract.	2,877

Most GPs work as independent businesses with a standard, nationally negotiated contract with the Scottish Government (a 17J Practice). However, NHS boards have taken on the responsibility for some GP practices and these are termed as "salaried practices" (2C Practice).

Feedback received during the public consultation indicated that the community would like to see a continued GP presence close to the town centres.

Future planned developments include:

- Practices will have seen further enhancements through the Primary Care Modernisation programme (i.e. the new GP contract).
- Recruitment to a full complement of pharmacists will see greater pharmacotherapy support and the progression of the mental health workstream will see input of primary care dedicated mental health workers.
- Community Link Workers have been allocated to all Caithness GP Practices and will be established working preventatively to reduce the pressure on GP services; ensure that patients receive the right support at the right time; and help people to live well within their community.
- In addition, as part of the GP contract, community, treatment and care funding will be used to enable a range of multi-disciplinary staff to work in practice to reduce GP workload, with the makeup of this team to be decided

By OBC we will:

- Confirm and formalise arrangements for co-location of the Wick and Thurso practices in the new Care Hubs.
- Finalise arrangements for potential satellite GP surgeries in the town centres of Wick and Thurso.

13.1 First Contact Physiotherapists

Management Lead: Judith Arnaud, Clinical Lead MSK Primary Care Physiotherapist
Clinical/Professional Lead: Margaret Moss, Associate Director AHPs (North Highland)

First Contact Physiotherapists (FCPs) assess, diagnose and guide the management of patients with Musculoskeletal conditions in GP surgeries across Caithness. This reduces GPs workload and creates closer working relationships with the GPs and other practice staff including advanced nurse practitioners and Pharmacists. This enhances patient care by joining up the patient records and by providing more opportunities to discuss the overall management of the persons MSK condition. Patients are enjoying fast direct access by booking in through reception at their practices. This will continue in the proposed locations as indicated in the table above.

13.2 Primary Care Pharmacists

Management and Professional Lead: Thomas Ross, Associate Director of Pharmacy

The pharmacy team are aiming to ensure that the service is provided equitably across all GP Practices. Following some recent changes to the team, we are currently reviewing input to each practice to ensure equity.

Clinical pharmacy reviews are provided in both Dunbar and Wick Town and County hospitals, whilst Caithness General Hospital cover stock supply only.

Services provided to GP practices - medication reviews (complexity will depend on experience of pharmacy staff), medicines reconciliation on discharge from hospital, acute requests in some practices, medication queries and alternatives, liaison between primary care and community pharmacists, high risk medicines monitoring, serial prescribing, medicines safety, actioning medication changes on clinic letters. We will continue to look at the skill mix to improve access to the range of services that we offer, aiming for a staff ratio of 1WTE per 5000 weighted patients.

14. Health Improvement/ Smoking Cessation

Management Lead: Kate Kenmure, District Manager (Sutherland)
Professional Lead: Cathy Steer, Head of Health Improvement

Smoking cessation clinics are held in various locations in Caithness (by invitation). Referrals are received from GPs, ward staff, midwives and Consultants although people can also self-refer into the service.

Advice and support is available 09:00 to 17:00, weekdays. Out with these times, support is available nationally through 'Quit Your Way Scotland', run by NHS 24. There are occasional evening group sessions and health improvement activities, such as walking groups. Alcohol Brief Interventions are also undertaken within this service. This service will continue, with a clear focus on preventative work to improve health within Caithness.

15. Learning Disability Nurses

Management Lead: Nikki Mackenzie, Integrated Team Manager, East Caithness
Professional Lead: Arlene Johnstone, Interim Head of Mental Health, Learning Disabilities & Drug & Alcohol Recovery Services

Learning Disability Nurses work within a well-established value base: placing the individual at the centre, valuing choice, inclusion, citizenship, and social justice. They work with individuals to help them to maintain active and independent lifestyles. They support people to use and access services, maximise opportunities and entitlements, whilst supporting (and promoting) positive health and wellbeing outcomes. This service provision will continue.

16. Minor Injuries

Management Lead: Christian Nicolson, District Manager (Caithness)
Professional Lead: Sara Sears, Associate Nurse Director, HHSCP

The Minor Injuries Unit (MIU) is located within the Dunbar Hospital in Thurso. A nurse led service; the MIU is used to treat non-life threatening but painful injuries such as cuts, minor burns, sprains and strains. NHS24 may also refer patients with minor illness to the MIU where again they would be seen and treated by a nurse. The MIU service will continue and will be 24/7, operating from the Care Hub in Thurso.

17. Occupational Therapy

Management Lead: Penny Gardner, Integrated Team Manager, North & West Sutherland
Professional Lead: Margaret Moss, Associate Director AHPs (North Highland)

Occupational Therapy (OT) offers a wide range of services to in-patients, out-patients and those in the community. The remit of OT is to enable people to maintain their independence and/or reach their maximum level of potential in activities of daily living, through specialist assessment and treatment programmes. They work as part of the Integrated Team to prevent admissions to hospital and are integral in keeping people in the community, as well as managing safe discharge home following admission. This service provision will continue with an increased focus on reablement and rehabilitation. This will include a review of training and education and staff skill mix.

18. Physiotherapy

Management Lead: Penny Gardner, Integrated Team Manager, North & West Sutherland
Professional Lead: Margaret Moss, Associate Director AHPs (North Highland)

The Caithness Physiotherapy Service provides inpatient and outpatient support across a broad range of services: inpatient services (including complex neurological patients), community/ domiciliary physiotherapy, musculoskeletal outpatients, non-musculoskeletal outpatients (including First Contact Physiotherapists), vestibular, pelvic health, respiratory, cardiac and pulmonary rehabilitation.

This service provision will continue with an increased focus on reablement and rehabilitation. This will include a review of training and education and staff skill mix.

19. Podiatry

Management Lead: Christian Nicolson, District Manager, Caithness
Professional Lead: Margaret Moss, Associate Director AHPs (North Highland)

Podiatry services are provided to patients requiring assessment and treatment of conditions of the lower limb including nail surgery.
The service is developing multi-disciplinary teams / foot protection teams, as per national strategy for high risk foot services, to optimise patient care and patient outcomes in primary care, thereby reducing pressures on secondary care. One example of this is a Band 7 Advanced Practitioner Podiatry (diabetes speciality). This post has direct links to the vascular surgeon and diabetes multi-disciplinary team (MDT) based at Raigmore Hospital in Inverness and, as a result, patients from Caithness are often fast tracked through to this team and previous excellent joint working has reduced treatment timeframes resulting in improved outcomes for patients. This invaluable MDT link has reduced the number of amputations within the Caithness area resulting in reduced hospital inpatient time and associated costs in relation to rehabilitation. This service will continue, based in the Care Hubs.

20. Specialist Nursing

Management Lead: Christian Nicolson, District Manager, Caithness / Pam Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Sara Sears, Associate Nurse Director, HHSCP

A range of specialist nursing services are in existence currently across Caithness including Cardiac Rehab, Community Respiratory, Diabetes, Heart Failure, Macmillan and Stroke. These services will continue, and we will look to expand the provision of specialist nursing where we can, work to improve the links between specialist nurses, primary care and SAS to identify patients at high risk of admission to standardise care. Specialist nursing services will operate from the Care Hubs in Wick and Thurso and will be involved with the development of the hospital at home service.
In principle what each of these services offers now (and as noted will continue to do so) is as below:

- Cardiac Rehab: Delivered locally by the Cardiac Rehabilitation Nurse and Cardiac Physiotherapist the service aims to provide the patient and their family with the knowledge and skills to self-manage by facilitating psychological and physical recover and educating them one ways to reduce risk and further events.
- Community Respiratory: Is integral in keeping people with severe respiratory disease including COPD, Pulmonary Fibrosis, Bronchiectasis and Asthma in the community, preventing hospital admission and managing safe discharge home following admission. The service provides evidence based, quality and timely care, promoting self- management; working closely with the extended multidisciplinary team to facilitate palliative care; provide education to patients and staff, facilitate pulmonary rehabilitation.
- Diabetes: Delivered locally by a small team the Diabetes Nurses provide: immediate and/or urgent support to those newly diagnosed with type 1 diabetes; support to type 2 diabetics once a ceiling for oral therapy has been reached and where there is consideration of injectables; support to complex patients; support to carers and family. The service works very closely with the Dietetics service. This will continue under the new model.
- Heart Failure: Delivered locally and aims to support and educate patients and carers living with heart failure. The Heart Failure Nurse is a key role in delivering physical and psychological therapies and the relationship with the patient is often a long-term one as heart failure is a complex, long-term syndrome.
- Palliative / Macmillan: Palliative care for those living with a life limiting condition; and end of life care - care of those who are at risk of dying in the next year - is provided across all care settings in Caithness, from community to hospital. Professional clinical support is mainly by primary care teams with the patient's GP acting as the lead, with specialist nurses across disease areas and community nursing teams

play a large role in looking after people at the end of life. The local Macmillan team provide specialist nursing to patients undergoing cancer treatment.

- Stroke: the role of the stroke co-ordinator/stroke nurse is to support and advise the patient, their carer/family, sign-posting them to other services and helping them to self-manage their stroke condition and make lifestyle changes. The support is tailored to each patient discharge/post stroke. Normally it will involve a mix of home visits, telephone calls and online support. Referrals are via inpatient, outpatient and primary care services

21. Speech and Language Therapy

Management Lead: Ruth Deplacido, Speech Language Therapy Lead, The Highland Council
Clinical/ Professional Lead: Ruth Deplacido, SLT lead (Adult Services) and Evelyn Gault, SLT Lead (Children's Services, The Highland Council)

The local element of this service transferred to Care and Learning within Highland Council and any requirements for inpatients within Caithness General Hospital are provided by a visiting service from the Raigmore team. The focus of the service locally is on prevention, as well as improving health and wellbeing. There is currently one Adult Speech and Language Therapist covering all of Caithness and North West Sutherland. There will be no change to this service.

22. Telecare and Assisted Technologies

Management Lead: Mairi McIvor, TEC Service Manager

The role of the Technology Enabled Care (TEC) team is to promote technology that helps people self-manage their own health and wellbeing, and enable them stay happy, safe and independent in their own homes, complementing the ethos of the Local Care Model.

TEC Services can:

- Improve self-management and support disease management
- Prevent hospital and care home admissions
- Promote a safer, quicker discharge from hospital
- Reduce patient and clinician travel time
- Reduce repeated hospital admissions

- Reduce unscheduled care
- Promote safety and independence
- Improve patient experience

We will expand TEC services in Caithness to include both Telehealth and Telecare.

Planned Care

23. Ambulatory Care Unit

Management Lead: Pamela Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Evelyn Gray, Associate Nurse Director

The role of the Ambulatory Care Unit (ACU) is to provide person-centred, safe, effective, efficient, equitable and timely care for patients undergoing treatment within any of the three workstreams (Haemodialysis, Chemotherapy and Medical Infusions). This service will continue to be provided in Caithness General Hospital. There will be no change in the services that are provided, however we will seek to increase capacity to meet rising demand.

24. Chronic Pain Service

Management Lead: Michelle Johnstone, Area Manager, North
Clinical/Professional Lead: Dr John Macleod, Consultant in Chronic Pain Management

The Chronic Pain Service is hosted by North and West Operational Unit, providing a service to all North Highland. Currently there is provision of out-patient clinics and theatre procedures weekly in Caithness General Hospital. We will continue to provide chronic pain services within the area. The provision is currently under review with a hub and spoke model and the strategy is to enhance the local provision.

25. Community Midwifery Unit

Management Lead: Laura Menzies, Lead Midwife, Caithness
Clinical/ Professional Lead: Mary Burnside, Deputy Director of Midwifery

The role of the Community Midwifery Unit (CMU) is to provide person-centred, safe, effective, efficient, equitable and timely care to women and their babies throughout the antenatal, intrapartum and postnatal period.

The core service is provided by a team of midwives, maternity healthcare support workers and maternity care assistants. The on call obstetric consultants based at Raigmore provide 24/7 advice and support by telephone and VC. They also provide weekly on site or NHS Near Me antenatal clinics. The service runs 24/7 and manages planned workload as well as triage and assessment for all unscheduled maternity cases from within the Caithness and North Sutherland area.

Low risk births are delivered locally in the CMU. High risk births, including women booked for a planned caesarean section and emergency patients, are transferred to Raigmore Hospital in Inverness.

A new fit for purpose Community Midwifery Unit in Caithness General Hospital was completed in 2021, funded by the Scottish Government as part of the first phase of reconfiguration works on the site. This service will continue.

26. Multi-Disciplinary Team (Complex Patients)

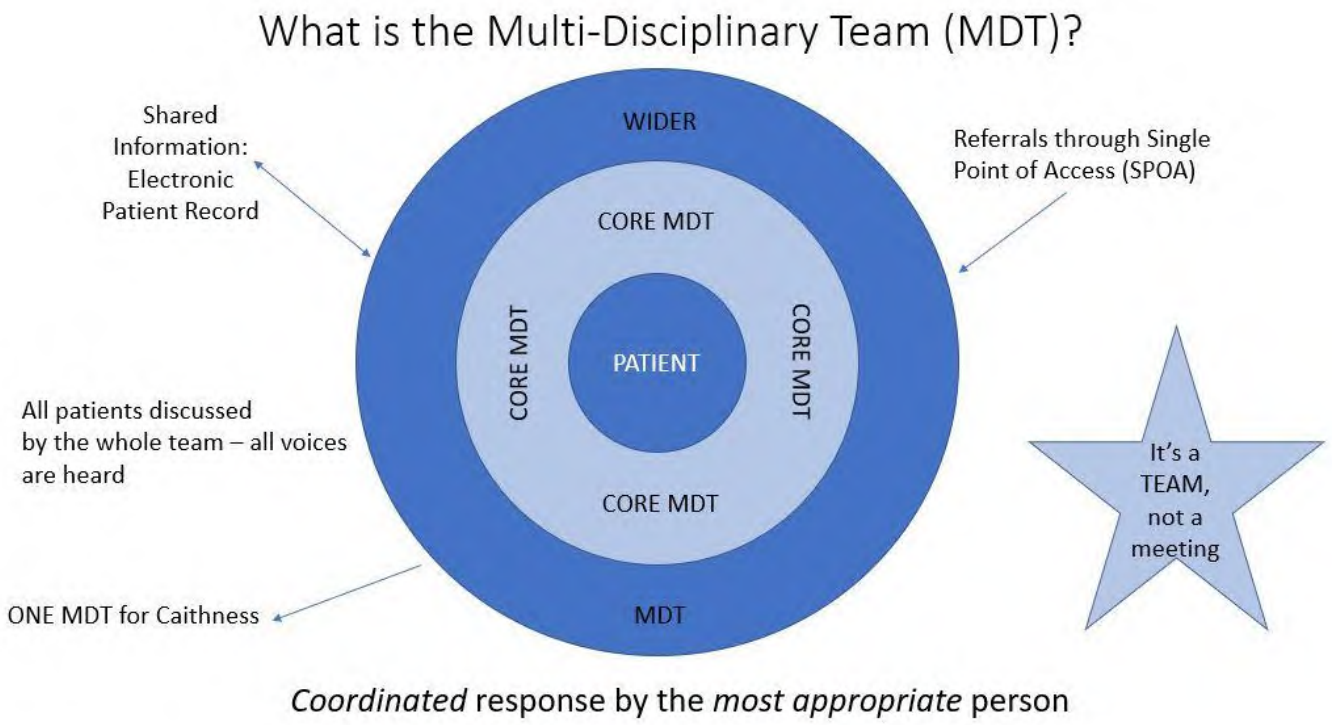
Management Lead: Michelle Johnstone, Area Manager
Clinical/ Professional Lead: Sadat Muzammil, Clinical Director, North

We are seeking to provide patients with complex needs and at high risk of hospital admission with dedicated care by a multi-agency, multi-disciplinary team. To do this, we need to be able to identify the most complex patients in Caithness (estimated to be around 11% of the population = c. 3,000 to 3,500 patients) to ensure that resources are targeted appropriately. We seek to do this initially and on an ongoing basis using a data driven approach (e-Frailty Index (eFI), Scottish Patients at Risk of Readmission and Admission (SPARRA) and High Health Gain (pHHG)), backed up by clinical judgement.

By grouping people with similar needs into cohorts, we can more fully understand the resource consumption. This will aid us to prioritise and plan where to target resources and realise the potential impact this could have on each cohort. We anticipate that by providing complex patients with more coordinated, anticipatory care, we can reduce the number of unnecessary hospital admissions and unscheduled care appointments, thus making best use of limited resources and providing patients with care close to home and in the most appropriate setting.

By creating one multi-skilled Multi-Disciplinary Team (MDT) for at risk patients in Caithness, we will:

- Deliver person-centred, coordinated, seamless care;
- Work in partnership with patients and their families to maintain independence and optimum health for as long as possible;
- Help patients access support and resources;
- Anticipate and plan for patients' needs;
- Have all health & social care skills in one Multi-Disciplinary Team;
- Develop an Electronic Patient Record to enable appropriate sharing of information;
- Deliver a streamlined process with a fast response time and quick decision making


What is the Multi-Disciplinary Team (MDT)?
Shared Information: Electronic Patient Record
WIDER
Referrals through Single Point of Access (SPOA)
CORE MDT
CORE MDT
PATIENT
CORE MDT
CORE MDT
All patients discussed by the whole team – all voices are heard
It's a TEAM, not a meeting
ONE MDT for Caithness
MDT
Coordinated response by the *most appropriate* person

Core MDT	Wider Team
• Allied Health Professional • Care at Home • Community Link Worker • Coordinator • District/ Community Nurse • GP • Consultant Geriatrician • Pharmacist • Social Work	• Acute specialists • Care Home • Charge Nurse/ key Ward Staff • Day Care • Dietetics • Highland Council (Housing etc.) • Mental Health • Palliative Care Specialist • Police • Scottish Ambulance Service • Scottish Fire & Rescue Service • Speech and Language Service • Technology Enabled Care (TEC) • Third Sector
Core Team members will:	**Wider MDT members will:**
• Be involved with most patients. • Take responsibility for individual patients (e.g. Lead Professional/ Named Person) • Take part in daily discussions, plus in-depth, regular MDT meetings.	• Be involved with the patients relevant to them. • Take part in daily discussions, only if necessary. • Attend in-depth MDT meetings when required.

By OBC we will confirm the resources required and set out the processes that need to be in place to deliver the MDT

27. Ophthalmology Service

Management Lead: Tina Monaghan, Service Manager
Clinical/ Professional Lead: Dr. Andrew Pyott, Ophthamology Head of Service

The Scottish Government National Ophthalmology Work stream report (2017) recognised "Ophthalmology is a high-volume specialty dealing with patients with acute and chronic eye diseases and systemic diseases that may be sight or life threatening. Ophthalmology is currently facing a series of challenges; not least high levels of demand for new and return appointments and pressures arising from the growth of the ageing population and the development of successful new treatments.

We will continue to develop and deliver the service with improved nurse-led clinics to meet rising demand. Cataract surgery at Caithness General Hospital will continue.

28. Outpatient Department

Management Lead: Pamela Garbe, Rural General Hospital Manager (CGH), Christian Nicolson, District Manager, Caithness (Dunbar Hospital)
Clinical/Professional Lead: Alison Geddes, Senior Charge Nurse, Outpatient Department (CGH)

The Outpatient Department located in Caithness General Hospital, is currently undergoing significant improvement work. The unit has expanded from five clinical rooms to nine, with three of these dedicated NHS Near Me rooms.

The Outpatient Department delivers clinics Monday to Friday. Specialties that are covered locally face to face are: Audiology; Colposcopies; Diabetics; Ear, Nose & Throat (ENT); Geriatric Medicine; Gynaecology; ITR; Medical; Ophthalmology; Orthopaedics; Paediatrics; Renal; Sexual health; Surgical; Urology; and Vascular. Evening sessions are also run for sexual and reproductive health.

There are a range of specialities that are delivered via NHS Near Me, this will continue to develop and expand to meet demand.

The Outpatients Department, Dunbar Hospital, Thurso provides a five day a week service, Monday to Friday providing a wide range of outpatient services. Services delivered currently at Dunbar Hospital will be provided in the new Thurso hub.

By OBC we will have reviewed all outpatient services and concluded the best location for delivery of these; acute (CGH) or community (Wick and Thurso hubs).

29. Radiology Service

Management Lead: Pamela Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Kirstin Mackay, Diagnostic Team Leader

The Radiology Service is Radiographer led, with support from Radiologist Consultants based in Raigmore Hospital, Inverness. Diagnostic Imaging services incorporate General, Dental, Theatre, Mobile Radiography, CT Scanning and Ultrasound (including Obstetrics, Abdominal Aortic Aneurysm Screening and Echoes). The North service is based at Caithness General Hospital Wick, with a satellite service also available at Lawson Memorial Hospital (LMH), Golspie providing General and Theatre X-ray and a visiting ultrasound service. Radiographers provide a comprehensive and coordinated Diagnostic Imaging service to a diverse range of patient type and clinical conditions.

Services are provided 365 days with emergency on-call cover 5pm – 9am weekday evenings, Saturday, Sunday and Public Holidays. The on-call service is single handed from home. There is no on-call service at LMH.

Over the past five years, staff development has taken place to respond to workforce challenges to develop a sustainable model. Currently operators at CGH are multi skilled which is not sustainable. Going forward, in line with other sites in NHS Highland, Sonographers will not undertake radiography duties / on-call rota.

30. Single Point of Access

Management Lead: Christian Nicolson, District Manager
Clinical/ Professional Lead: Lesley Martin, Care at Home Manager

As part of our vision for the Local Care Model in Caithness, we will enhance the existing Single Point of Contact (SPOC) and transition it to a Single Point Of Access (SPOA). Our vision for SPOA is:

- A single, 24/7 SPOA for patients with complex needs, which includes the Scottish Ambulance service, transport partners and the Third Sector in the list of SPOA services;
- SPOA will help to facilitate the right care, by the right person, at the right time;
- SPOA has access to a single electronic patient record to facilitate appropriate triage of callers;
- SPOA has access to a live feed of resource availability which enables them to signpost to available resources;
- SPOA is adequately resourced to enable all the whole patient population in Caithness to access certain services through one point of contact.

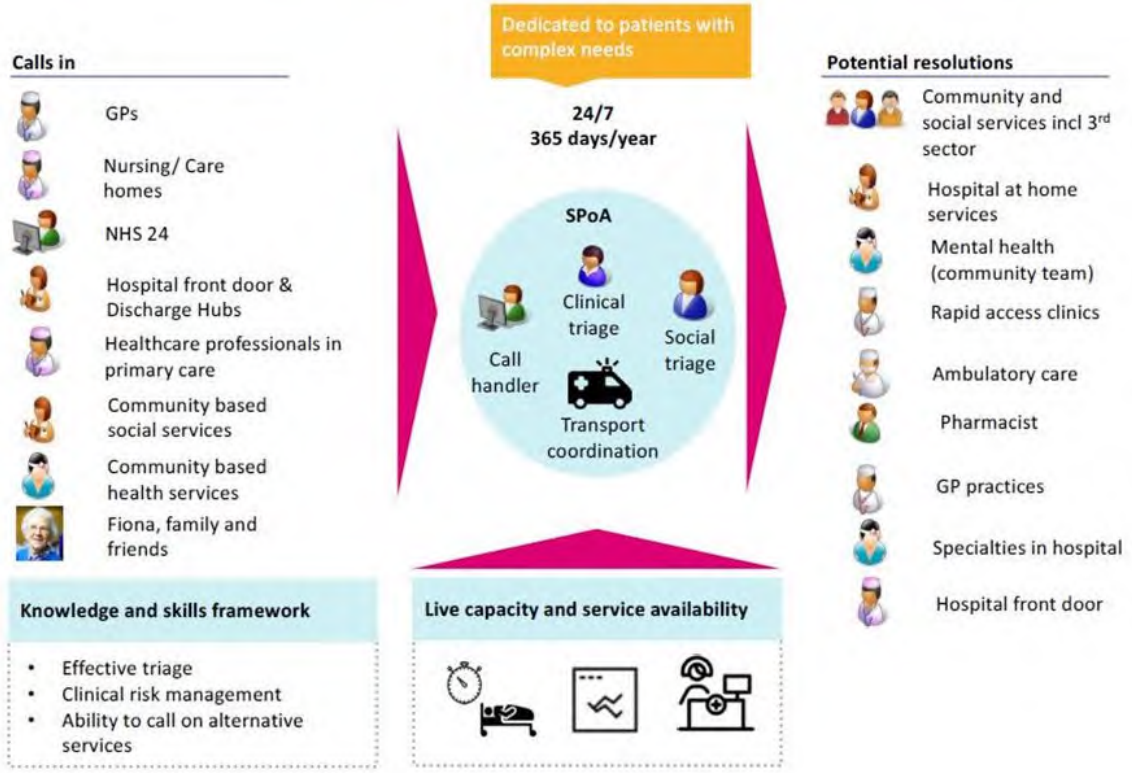


Figure 2: Single Point of Access

By OBC we will confirm the resources required and set out the processes that need to be in place to deliver the SPOA.

Acute Services / Bed Based Support

31. Emergency Department

Management Lead: Pamela Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Victoria Worrall, Senior Charge Nurse, ED

The Emergency Department, Caithness General Hospital provides a 24-hour service for the initial evaluation, diagnosis, and treatment of any patient requiring urgent medical, surgical, obstetric, gynaecological or psychiatric care. The ED team also supports the resuscitation team within Caithness General Hospital and their colleagues in other areas of the hospital.

The department recently expanded, and this space is being remodelled to meet the increasing demand and to accommodate the different referral pathways for unscheduled care.

In future the Scottish Ambulance Service (SAS) team will be co-located on site to further enhance the service provision within the area.

31.1 Clinical Decision-making Unit

The Clinical Decision-making Unit (CDU) is based within ED and is the pathway for GP referrals to provide timely access to assessment and diagnostics. The CDU operates Monday to Friday, between 09.00 and 17.00.

The service will improve the patient journey, ED performance, patient flow and reduce admissions to hospital. The remodelling of the ED will provide suitable accommodation to support service delivery. As this is a relatively new service, we will continue to monitor and develop it to meet local needs.

32. Hospital Inpatient Beds (Acute)

Management Lead: Pamela Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Evelyn Gray, Associate Nurse Director

Rosebank Ward:
Rosebank Ward is a 20-bed acute admissions unit, with 3 High Dependency Beds with the option to flex up 3 beds to respond to exceptional demand. The ward receives all medical and surgical acute admissions and there are several referral pathways (ED, other hospitals, GPs) in addition to providing post-operative care.

A rotating medical model from Raigmore provides physician cover Monday to Thursday, with locums providing weekend cover supported by Rural Emergency Consultants. Surgical consultant cover is provided 7 days a week by substantive and Raigmore rotational consultants. Additional support is provided from ward level Advanced Nurse Practitioners, in addition to FY2 Junior Doctors, and GPST trainees.

There will be no change to the current service provision.

Bignold Ward:
Bignold is a 21-bed inpatient rehabilitation and post-acute ward (step down care).

Medical cover is provided by a Consultant Geriatrician, a specialist doctor with geriatric medicine, FY2 and an Advanced Nurse Practitioner.

By OBC we will have confirmed our requirements for:

- Remodelling of both ward areas to increase the number of single rooms with en-suite facilities to a minimum of 50% and to provide a place of safety facility.
- A patients / discharge lounge.
- A multidisciplinary hub, shared by both wards, to improve facilities and communication and enhance quality and patient safety.

33. Hospital Pharmacy

Management Lead: Pamela Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Rhona Gunn, Associate Director of Pharmacy (Acute)

Currently, the Pharmacy Department at Caithness General Hospital provides pharmaceutical care across five sites in both Caithness and Sutherland. This includes, but is not limited to, a Clinical Pharmacy Service to inpatients, outpatients, and day cases (such as Renal & Medical infusions) as well as discharge planning, clinical advice and the education and training of other health professionals including GPs, Junior Doctors, and nursing staff. The department was reconfigured in 2020 to incorporate a Vaccine Holding Centre and provides a Primary Care supply service to GPs, podiatrists, physiotherapists, and community/school nursing staff.

The structure of the service is currently under review to establish the most appropriate skill mix and bring this in line with national delivery models.

34. Laboratory

Management Lead: Pamela Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Alex Javed, Laboratory Services Manager

Caithness General Hospital Laboratory is part for the wider NHS Highland Laboratory network. The laboratory operates between 09:00 and 17:30, Monday to Friday, 09:00 to 13:00 on Saturdays and 09:30 to 13:00 on Sundays. A non-residential Out-of-Hours service (24/7, 365 days a year) is available for urgent patient transfer or urgent patient diagnostics/management out with routine hours. The Laboratory also delivers a vital service to the North Highland GP's, outpatients and pre-op patients and processes daily bloods to ensure patient flow of these departments are maintained.

Staffing establishment is currently being reviewed to meet ever increasing demands on the service. Going forward we will introduce Point of Care Testing to provide bedside diagnostics to streamline the service and reduce the number of call outs.

To assist the local challenges with recruitment and retention, the Laboratory has been successful in achieving Training Status which is reviewed and awarded by the Institute of Biomedical Scientists. A training programme can now be delivered, ensuring a career path for Biomedical Scientists in Caithness that are available to work as HCPC registered BMS staff in rural sites with rural specific training and experience.

By OBC training status will be maintained, the Point of Care Testing will have been introduced and staffing will have been reviewed considering the changing demands on service.

35. Out of Hours Service

Management Lead: Christian Nicolson, District Manager, Caithness
Clinical/ Professional Lead: Lorien Cameron-Ross, Clinical Director, OOH

The Caithness Out of Hours (OOH) service is provided by Ash Locums 18:00 – 08:00, seven days a week. The weekend service is provided 08.00 – 18:00 by local GPs as sessional locums. The evening OOH GP is based in Wick and the Primary Care Emergency Centre (PCEC) is in Caithness General Hospital. The Dunbar Hospital has a PCEC which is nurse led and caters for the West Caithness population. We are gradually reintroducing this service as the staffing situation improves.

The existing OOH service will move to a multi-disciplinary model which, until the completion of the North (Sutherland) Coast Redesign, will cover the North Coast of Sutherland to include the GP catchment areas of Armadale and Tongue practices. This service will work out of the Dunbar Hub and will be staffed by Advanced Nurse Practitioners (ANPs) with clinical support from the OOH GP based in Wick. The Dunbar ANP service will be developed to support a 24/7 responder model and provide medical cover for the community and palliative care beds in the care hubs.

The new model of service will be fully integrated including input from GPs, Allied Health Professionals and nursing staff and will be supplemented by paramedics and unscheduled care nurses.

By OBC we will have agreed the OOH provision.

36. Scottish Ambulance Service

Management Lead: Graham Cormack, North Area Manager

The Scottish Ambulance Service has bases in Wick and Thurso where both the Accident and Emergency (A&E) and Patient Transport Service (PTS) vehicles are based. Vehicles are usually crewed by a Paramedic and a Technician.

The Ambulance Service is currently looking at its service model nationally and there are various projects currently being worked through.

SAS in conjunction with NHSH will develop the Advance Paramedic model in Caithness, with Advance Paramedics integrated with Health & Social Care Services and working in partnership to enable high level care to be delivered on location. This will benefit the local population by bringing a higher level of clinical care into the community and by preventing unnecessary admission to the Rural General Hospital. To achieve this the SAS will be co-located with NHSH teams on the Caithness General Hospital and Thurso Care Hub sites.

37. Theatre & Day Case Unit

Management Lead: Pamela Garbe, Rural General Hospital Manager
Clinical/ Professional Lead: Fiona Sinclair, Acting Senior Charge Nurse, Surgical Suite

The Surgical Suite provides nursing care for all patients undergoing elective or emergency procedures within the Theatre environment, Endoscopy Unit, Day Case area and Pre-Operative Assessment clinics. Current surgery undertaken includes: Gynaecology; General surgery; Chronic Pain; Special Needs Dental; and Cataract surgery. Several nurse-led clinics are also delivered such as Pre-Operative Assessment, Bowel Screening and Macular Degeneration Injections.

The Department has a two-theatre suite with reception and recovery area. Separate to this is a four-bed Day Case ward and Endoscopy Procedure Room with four trolley spaces. The Endoscopy Procedure Room and decontamination areas are on a different floor and staffed by the Theatre team.

The elective surgical and endoscopy services are provided Monday to Friday, with most patients admitted as day cases. Emergency admissions and those requiring an overnight stay are admitted to the Rosebank Ward.

The current medical staffing model allows for provision of an out-of-hours on call team when there is also a Consultant Surgeon on call. 24/7 anaesthetic support is provided to the anaesthetist for stabilisation and transfer of patients.

Moving forward, capacity within the day case unit will increase to provide eight beds and the endoscopy and decontamination unit will be co-located within the day case area.

By OBC we will have agreed the future model for provision of pre-operative assessment clinics.

Support Services

38. Access and Transport

The new facilities will support active travel links wherever possible, have clear connections to public transport, parking, cycle storage and drop off facilities sufficient to meet anticipated demand on the site and in accordance with planning requirements and accessibility guidance.

By OBC we will engage with transport providers to improve access and transport provision across Caithness and North Sutherland, and carry out a transport study in support of any associated planning applications.

39. Catering

Currently there is a production kitchen at Caithness General Hospital (CGH) and this will remain. The CGH kitchen also serves the two community hospitals. Pulteney House and Bayview care homes have on site production kitchens.

By OBC the catering model for the two new community hubs will be confirmed.

40. Dining Room/ Café (Public & Staff)

Caithness General Hospital has a shared dining room for staff and public. In the new model we will provide separate facilities to accommodate staff and public within Caithness General Hospital and the two hubs.

41. Laundry

The care homes currently have on site laundry facilities. There is a laundry at CGH which also supplies the community hospitals. This provides a selected range of services, with the remainder being laundered at Raigmore Hospital, Inverness.

Going forward, the two new community hubs and CGH will have on site laundry facilities.

By OBC we will explore whether an increased service can be provided locally and conclude the model of service provision.

42. Mortuary

There is a mortuary at CGH and a body storage (holding) facility at Dunbar Hospital. Post mortem facilities are located at Raigmore Hospital, Inverness.

To support the new clinical model, a mortuary is required at CGH and body storage (holding) facilities in the Wick and Thurso care hubs.

43. Social Enterprise

By OBC we will work with local communities to shape the care villages in Wick and Thurso.

44. Staff Training and Development

There is a post-graduate training facility in CGH for medical staff and a rolling training programme is in place for medical, nursing and AHP staff.

By OBC we will confirm our requirements for dedicated training facilities including a clinical skills lab. We will work in conjunction with UHI / North Highland College to develop a joint training campus.

Conclusion

The Caithness Redesign team is committed to developing this new model of care. We will continue to engage with our patients, staff, independent service providers and statutory partners to achieve this.

We will work with local communities to develop pilot projects where the concept of extended networks of health and social care staff working together flexibly can be evaluated. This will avoid changes being put in place which are reactive and unforeseen. We will ensure that local communities are kept fully informed of the proposed timelines for change.

Caithness General Hospital Redesign
SCIM - Initial Agreement
Main Summary

Phase 2

Retain QE building to house CMU (covered in Phase 1) , SAS, Renal, Chemo, IV (Ambulatory Care) and Clinical Skills. No further works to Emergency Department. Continued development from Phase 1 of Physiotherapy/OPD area. Retain existing Pharmacy and Lab areas but with reconfiguration to provide more space for Labs. Ward areas on Level 1 refurbished. Level 2 (excluding Theatres) refurbished to house Day Care/Endoscopy. Refurbish main waiting area including external canopy. Provision for Backlog Maintenance.

Assumptions:
Phase 1 works will include Staff Changing adjacent to Kitchen, 4 No treatment areas in new OPD and a new relocated Emergency Department. Construction costs do not include for the logistics of moving existing equipment, patients or staff or costs associated with the temporary rehousing of departments whilst refurbishment works are ongoing.

Date: 29-Jul-21 Rev 4

Total Project GIA (m²)	**5,209**	(excl GIA of Medical Centre demolition)	
Forecast Base Date	**2Q2025**		
Procurement	**Frameworks Scotland 2**		
Contract	**NEC3 Option A**		
Basis of Cost	**Estimate**		
		£	**£/m²**
Substructure		£0	£0
Superstructure		£3,569,071	£685
Internal Finishes		£0	£0
Fittings Furnishings and Equipment		£0	£0
Services		£4,461,346	£856
Building Sub Total		**£8,030,417**	**£1,542**
Facilitating Works		£87,009	£17
External Works		£229,658	£44
Prime Cost		**£8,347,083**	**£1,602**
Backlog Maintenance		£2,152,024	£215
Prime Cost including Backlog Maintenance		**£10,499,108**	**£1,818**
Main Contractor's Preliminaries @ 20%		£2,099,822	£403
Design Fee @ 10%		£1,049,911	£202
Framework PM/Supervisor @ 5%		£524,955	£101
Construction Cost Sub Total		**£14,173,795**	**£2,523**
PSCP Fee @ 7.77%		£1,101,304	**£211**
Total Construction Cost		**£15,275,099**	**£2,735**
Consultants	**£40,000**		
NHSH Equipment costs	**£0**		
Project Risk/Optimism Bias	**£0**		
Planning Approvals/Surveys	**£10,000**	**£50,000**	**£10**
Total Project Cost		**£15,325,099**	**£2,744**
VAT		**£3,065,019.82**	**£548.82**
Total Capital Cost		**£18,390,119**	**£3,293**

PHASE 2

Caithness General Hospital Redesign

SCIM - Initial Agreement

Summary Analysis

Hospital department	QE East Wing		Medical records		Main Waiting area		Physiotherapy/Outpatients		Medical/Surgical Wards		Day Case/Endoscopy		Pharmacy/Labpratories		Queen Elizabeth Core		Medical Centre		Total		Backlog Maintenance	
Total Project GIA (m²)	419		240		250		640		1,800		1,150		440		270		400		5,209		10,000	
Base Date	2Q2021		2Q2021		2Q2021		2Q2021		2Q2021		2Q2021		2Q2021		2Q2021		2Q2021		2Q2021		2Q2021	
Procurement	Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2		Frameworks Scotland 2	
Contract	NEC3 Option A		NEC3 Option C		NEC3 Option C		NEC3 Option C		NEC3 Option C		NEC3 Option C		NEC3 Option C		NEC3 Option C		NEC3 Option C		NEC3 Option C		NEC3 Option C	
Basis of Cost	Estimate		Estimate		Estimate		Estimate		Estimate		Estimate		Estimate		Estimate		Estimate		Estimate		Estimate	
Works	Refurbishment of QE East Wing. For use by SAS & Ambulatory Care. Includes new windows and roofing to wing area and both link corridors (Service at west end & consultant offices at east end). Allowance for sprinkler system.		Refurbishment of existing physiotherapy department. Does not include record storage system/specialist scanning facilities		Refurbishment of main hospital entrance and reconfiguration of external canopy area		Refurbishment to whole area excluding 4 No rooms previously converted under Phase 1. Sprinkler system included to whole area. Windows replaced.		Refurbishment of existing First Floor ward areas + core		Refurbishment of existing Second Floor maternity ward		Remain in same area but reconfiguration of work areas. Assumed no major reconfiguration of services.		Refurbish for use by Renal/IV/Chemo/Clinial skills		Demolition				Hospital-wide backlog maintenance	
	£	£/m²	£	£/m²	£	£/m²	£	£/m²	£	£/m²	£	£/m²	£	£/m²	£	£/m²	£	£/m²	£	£/m²	£	£/m²
Substructure	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Superstructure	£576,017	£1,375	£139,215	£580	£145,015	£580	£371,239	£580	£1,044,109	£580	£667,069	£580	£255,227	£580	£371,181	£1,375	£0	£0	£3,569,071	£685.17	£232,024	£23
Internal Finishes	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0.00	£0	£0
Fittings Furnishings and Equipment	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0.00	£0	£0
Services	£487,920	£1,164	£201,861	£841	£206,211	£825	£512,309	£800	£1,465,233	£814	£929,083	£808	£347,340	£789	£311,388	£1,153	£0	£0	£4,461,346	£856.47	£1,920,000	£192
Building Sub Total	**£1,063,938**	**£2,539**	**£341,076**	**£1,421**	**£351,227**	**£1,405**	**£883,548**	**£1,381**	**£2,509,341**	**£1,394**	**£1,596,152**	**£1,388**	**£602,567**	**£1,369**	**£682,569**	**£2,528**	**£0**	**£0**	**£8,030,417**	**£1,542**	**£2,152,024**	**£215**
Facilitating Works	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£87,009	£218	£87,009	£16.70	£0	£0
External Works	£19,444	£46	£0	£0	£116,012	£464	£464	£0	£0	£0	£0	£0	£0	£0	£12,529	£46	£81,208	£203	£229,658	£44.09	£0	£0
Prime Cost	**£1,083,381**	**£2,586**	**£341,076**	**£1,421**	**£467,239**	**£1,869**	**£884,012**	**£1,381**	**£2,509,341**	**£1,394**	**£1,596,152**	**£1,388**	**£602,567**	**£1,369**	**£695,098**	**£2,574**	**£168,218**	**£421**	**£8,347,083**	**£1,602**	**£2,152,024**	**£215**
Backlog Maintenance																			**£2,152,024**	**£215**		
																			£10,499,108	**£1,818**		
Main Contractor's Preliminaries @ 20%																			**£2,099,821.52**	**£403**		20%
Design Fee @ 10%																			**£1,049,910.76**	**£202**		10%
Framework PM/Supervisor @ 5%																			**£524,955.38**	**£101**		5%
Construction Cost Sub Total																			**£14,173,795**	**£2,523**		
PSCP Fee @ 7.77%																			**£1,101,304**	**£211.42**		8%
Total Construction Cost																			**£15,275,099**	**£2,735**		

	Project	Caithness General Hospital Redesign	Caithness General Hospital Redesign	Caithness General Hospital Redesign	Caithness General Hospital Redesign	Caithness General Hospital Redesign
	Health Board	QE East Wing	Medical records	Main Waiting area	Physiotherapy/Outpatients	Medical/Surgical Wards
	Cost status	SCIM - Initial Agreement	SCIM - Initial Agreement	SCIM - Initial Agreement	SCIM - Initial Agreement	SCIM - Initial Agreement
	KEY COST DRIVERS	BCIS All-In TPI	BCIS All-In TPI	BCIS All-In TPI	BCIS All-In TPI	BCIS All-In TPI
	BCIS All-In TPI as at Current Base Date	2Q2021 331	2Q2021 331	2Q2021 331	2Q2021 331	2Q2021 331
	BCIS All-In TPI as at Forecast Base Date	2Q2025 384	2Q2025 384	2Q2025 384	2Q2025 384	2Q2025 384
	Adjustment Factor	16.01% 1.160	16.01% 1.160	16.01% 1.160	16.01% 1.160	16.01% 1.160
	Location	Caithness	Caithness	Caithness	Caithness	Caithness
	Gross Internal Area (m²)	419 m² GIA excludes area of 2 No link corridors @ approx 200m² each	240 m²	250 m²	640 m² 730m² total GIF less 4 No Treatment rooms refurbished by Estates	1,800 m²
	Source					
	Total Costs	£ 933,852.00 £ 1,083,381.17	£ 294,000.00 £ 341,075.53	£ 402,750.00 £ 467,238.67	£ 761,600.00 £ 883,548.04	£ 2,163,000.00 £ 2,509,341.39
	Cost/m2	£ 2,228.76 £ 2,585.64	£ 1,225.00 £ 1,421.15	£ 1,611.00 £ 1,868.95	£ 1,190.00 £ 1,380.54	£ 1,201.67 £ 1,394.08
	Procurement route	Frameworks Scotland 2	Frameworks Scotland 2	Frameworks Scotland 2	Frameworks Scotland 2	Frameworks Scotland 2
	Contract	NEC3 Option A	NEC3 Option C	NEC3 Option C	NEC3 Option C	NEC3 Option C
	Basis of Cost	Estimate	Estimate	Estimate	Estimate	Estimate
	Option 1 Works	Refurbishment of QE East Wing. For use by SAS & Ambulatory Care. Includes new windows and roofing to wing area and both link corridors (Service at west end & consultant offices at east end). Allowance for sprinkler system.	Refurbishment of existing physiotherapy department. Does not include record storage system/specialist scanning facilities	Refurbishment of main hospital entrance and reconfiguration of external canopy area	Refurbishment to whole area excluding 4 No rooms previously converted under Phase 1. Sprinkler system included to whole area. Windows replaced.	Refurbishment of existing First Floor ward areas + core

	Benchmark analysis	SCIM - Initial Agreement				SCIM - Initial Agreement				SCIM - Initial Agreement				SCIM - Initial Agreement				SCIM - Initial Agreement			
	Elements	Cost	Adjusted Cost	Adjusted Cost per m2	Notes	Cost	Adjusted Cost	Adjusted Cost per m2	Notes	Cost	Adjusted Cost	Adjusted Cost per m2	Notes	Cost	Adjusted Cost	Adjusted Cost per m2	Notes	Cost	Adjusted Cost	Adjusted Cost per m2	Notes
0.0	**Facilitating Works**																				
0.1	Toxic / hazardous material removal	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
0.2	Major demolition works	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
0.3	Temporary support to adjacent structures	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
0.4	Specialist groundworks	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
0.5	Temporary diversion works	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
0.6	Extraordinary site investigation works	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
	Facilitating Works Total	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
1.0	**Substructure**																				
1.1	Substructure	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
	Substructure Total	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
2.0	**Superstructure**																				
2.1	Frame	£ 410,620.00	£ 476,368.82	£ 1,136.92	Assume £980/m² for general internal works based on CMU	£ 120,000.00	£ 139,214.50	£ 580.06	Assume £500/m² for general internal works. 50% of CMU	£ 125,000.00	£ 145,015.11	£ 580.06	Assume £500/m² for general internal works. 50% of CMU	£ 320,000.00	£ 371,238.67	£ 580.06	Assume £500/m² for general internal works. 50% of CMU	£ 900,000.00	£ 1,044,108.76	£ 580.06	Assume £500/m² for general internal works. 50% of CMU
2.2	Upper Floors	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
2.3	Roof	£ 85,895.00	£ 99,648.58	£ 237.82	Based on CMU costs @ £205/m2	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
2.4	Stairs	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
2.5	External Walls	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
2.6	Windows and External Doors	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -			£ -	£ -	
2.7	Internal Walls and Partitions	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -			£ -	£ -	
2.8	Internal Doors	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
	Superstructure Total	£ 496,515.00	£ 576,017.40	£ 1,374.74		£ 120,000.00	£ 139,214.50	£ 580.06		£ 125,000.00	£ 145,015.11	£ 580.06		£ 320,000.00	£ 371,238.67	£ 580.06		£ 900,000.00	£ 1,044,108.76	£ 580.06	
3.0	**Internal Finishes**																				
3.1	Wall Finishes	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
3.2	Floor Finishes	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
3.3	Ceiling Finishes	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	Internal Finishes Total	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
4.0	**Fittings Furnishings and Equipment**																				
4.1	Fittings Furnishings and Equipment		£ -	£ -			£ -	£ -			£ -	£ -			£ -	£ -			£ -	£ -	
	Fittings Furnishings and Equipment Total	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.0	**Services**																				
5.0	Mechanical, Plumbing & Electrical Installations		£ -	£ -			£ -	£ -			£ -	£ -			£ -	£ -			£ -	£ -	
5.0	Mechanical & Plumbing Installations	£ 286,177.00	£ 331,999.90	£ 792.36	Based on CMU costs at £683/m2	£ 90,000.00	£ 104,410.88	£ 435.05	AssumeE375/m2. Ventilation in Backlog maintenance	£ 93,750.00	£ 108,761.33	£ 435.05	AssumeE375/m2. Ventilation in Backlog maintenance	£ 240,000.00	£ 278,429.00	£ 435.05	AssumeE375/m2. Ventilation in Backlog maintenance	£ 675,000.00	£ 783,081.57	£ 435.05	AssumeE375/m2. Ventilation in Backlog maintenance
5.1	Sanitary appliances	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.2	Services equipment	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.3	Disposal installation	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.4	Water installations	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.5	Heat source	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.6	Space heating and air treatment	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.7	Ventilation installations		£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.8	Electrical Installation	£ -	£ -	£ -	Included in Backlog maintenance	£ -	£ -	£ -	Included in Backlog maintenance	£ -	£ -	£ -	Included in Backlog maintenance	£ -	£ -	£ -	Included in Backlog maintenance	£ -	£ -	£ -	Included in Backlog maintenance
5.9	Gas Installations	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.10	Lift Installation	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.11	Protective installations	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.12	Communications installations	£ -	£ -	£ -	Sprinkler system. 8% by area of total current estimated budget of £1,680,000	£ -	£ -	£ -	Sprinkler system. 5% by area of total current estimated budget of £1,680,000	£ -	£ -	£ -	Sprinkler system. 5% by area of total current estimated budget of £1,680,000	£ -	£ -	£ -	Sprinkler system. 12% by area of total current estimated budget of £1,680,000	£ -	£ -	£ -	Sprinkler system. 35% by area of total current estimated budget of £1,680,000
5.13	Specialist Installations	£ 134,400.00	£ 155,920.24	£ 372.12		£ 84,000.00	£ 97,450.15	£ 406.04		£ 84,000.00	£ 97,450.15	£ 389.80		£ 201,600.00	£ 233,880.36	£ 365.44		£ 588,000.00	£ 682,151.06	£ 378.97	
5.14	Builder's work in connection with services	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
	Services Total	£ 420,577.00	£ 487,920.15	£ 1,164.49		£ 174,000.00	£ 201,861.03	£ 841.09		£ 177,750.00	£ 206,211.48	£ 824.85		£ 441,600.00	£ 512,309.37	£ 800.48		£ 1,263,000.00	£ 1,465,232.63	£ 814.02	
	Building Sub Total	£ 917,092.00	£ 1,063,937.55	£ 2,539.23		£ 294,000.00	£ 341,075.53	£ 1,421.15		£ 302,750.00	£ 351,226.59	£ 1,404.91		£ 761,600.00	£ 883,548.04	£ 1,380.54		£ 2,163,000.00	£ 2,509,341.39	£ 1,394.08	
8.0	**External works**																				
8.0	External Works Generally	£ 16,760.00	£ 19,443.63	£ 46.40	Based on CMU costs at £40/m2	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
8.1	Site preparation works	£ -	£ -	£ -		£ -	£ -	£ -		£ 100,000.00	£ 116,012.08	£ 464.05	General allowance for replacing canopy & re-configuring drop off area	£ -	£ -	£ -		£ -	£ -	£ -	
8.2	Roads, paths & pavings		£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
8.3	Soft landscaping, planting & irrigation systems	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
8.4	Fencing, railings and walls	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
8.5	Site / street furniture and equipment	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
8.6	External drainage	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
8.7	External services	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
8.8	Minor buildings works and ancillary buildings	£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
	External Works Total	£ 16,760.00	£ 19,443.63	£ 46.40		£ -	£ -	£ -		£ 100,000.00	£ 116,012.08	£ 464.05		£ -	£ -	£ -		£ -	£ -	£ -	
	Building Sub Total (Excludes Facilitating & External Works)	***£ 917,092.00***	***£ 1,063,937.55***	***£ 2,539.23***		***£ 294,000.00***	***£ 341,075.53***	***£ 1,421.15***		***£ 302,750.00***	***£ 351,226.59***	***£ 1,404.91***		***£ 761,600.00***	***£ 883,548.04***	***£ 1,380.54***		***£ 2,163,000.00***	***£ 2,509,341.39***	***£ 1,394.08***	
	Prime Cost	£ 933,852.00	£ 1,083,381.17	£ 2,585.64		£ 294,000.00	£ 341,075.53	£ 1,421.15		£ 402,750.00	£ 467,238.67	£ 1,868.95		£ 761,600.00	£ 883,548.04	£ 1,380.54		£ 2,163,000.00	£ 2,509,341.39	£ 1,394.08	

	Project	Caithness General Hospital Redesign																							
	Health Board	Day Case/Endoscopy					Pharmacy/Labpratories				Queen Elizabeth Core				Medical Centre				Backlog Maintenance			
	Cost status	SCIM - Initial Agreement					SCIM - Initial Agreement				SCIM - Initial Agreement				SCIM - Initial Agreement				SCIM - Initial Agreement			
	KEY COST DRIVERS	BCIS All-In TPI					BCIS All-In TPI				BCIS All-In TPI				BCIS All-In TPI				BCIS All-In TPI			
	BCIS All-In TPI as at Current Base Date	2Q2021	331				2Q2021	331			2Q2021	331			2Q2021	331			2Q2021	331		
	BCIS All-In TPI as at Forecast Base Date	2Q2025	384				2Q2025	384			2Q2025	384			2Q2025	384			2Q2025	384		
	Adjustment Factor	16.01%	1.160				16.01%	1.160			16.01%	1.160			16.01%	1.160			16.01%	1.160		
	Location	Caithness					Caithness				Caithness				Caithness				Caithness			
	Gross Internal Area (m²)	1,150 m²					440 m²				270 m²				400 m²				10,000 m²			
	Source																					
	Total Costs	£ 1,375,850.00	£ 1,596,152.27				£ 519,400.00	£ 602,566.77			£ 599,160.00	£ 695,098.01			£ 145,000.00	£ 168,217.52			£ 1,855,000.00	£ 2,152,024.17		
	Cost/m2	£ 1,196.39	£ 1,387.96				£ 1,180.45	£ 1,369.47			£ 2,219.11	£ 2,574.44			£ 362.50	£ 420.54			£ 185.50	£ 215.20		
	Procurement route	Frameworks Scotland 2					Frameworks Scotland 2				Frameworks Scotland 2				Frameworks Scotland 2				Frameworks Scotland 2			
	Contract	NEC3 Option C					NEC3 Option C				NEC3 Option C				NEC3 Option C				NEC3 Option C			
	Basis of Cost	Estimate					Estimate				Estimate				Estimate				Estimate			
	Option 1 Works	Refurbishment of existing Second Floor maternity ward					Remain in same area but reconfiguration of work areas. Assumed no major reconfiguration of services.				Refurbish for use by Renal/IV/Chemo/Clinial skills				Demolition				Hospital-wide backlog maintenance			
	Benchmark analysis	SCIM - Initial Agreement					SCIM - Initial Agreement				SCIM - Initial Agreement				SCIM - Initial Agreement							
	Elements	Cost	Adjusted Cost	Adjusted Cost per m2	Notes		Cost	Adjusted Cost	Adjusted Cost per m2	Notes	Cost	Adjusted Cost	Adjusted Cost per m2	Notes	Cost	Adjusted Cost	Adjusted Cost per m2	Notes	Cost	Adjusted Cost	Adjusted Cost per m2	Notes
0.0	**Facilitating Works**																					
0.1	Toxic / hazardous material removal	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
0.2	Major demolition works	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ 75,000.00	£ 87,009.06	£ 217.52			£ -	£ -	
0.3	Temporary support to adjacent structures	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
0.4	Specialist groundworks	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
0.5	Temporary diversion works	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
0.6	Extraordinary site investigation works	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	Facilitating Works Total	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ 75,000.00	£ 87,009.06	£ 217.52		£ -	£ -	£ -	
1.0	**Substructure**																					
1.1	Substructure	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	Substructure Total	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
2.0	**Superstructure**																					
2.1	Frame	£ 575,000.00	£ 667,069.49	£ 580.06	Assume £500/m² for general internal works. 50% of CMU		£ 220,000.00	£ 255,226.59	£ 580.06	Assume £500/m² for general internal works. 50% of CMU	£ 264,600.00	£ 306,967.98	£ 1,136.92	Assume £980/m² for general internal works based on CMU	£ -	£ -	£ -			£ -	£ -	
2.2	Upper Floors	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
2.3	Roof	£ -	£ -	£ -			£ -	£ -	£ -		£ 55,350.00	£ 64,212.69	£ 237.82	Based on CMU costs @ £205/m2	£ -	£ -	£ -		£ 200,000.00	£ 232,024.17	£ 23.20	1,000m² @ £200
2.4	Stairs	£ -	£ -	£ -			£ -	£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
2.5	External Walls	£ -	£ -	£ -			£ -	£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
2.6	Windows and External Doors		£ -	£ -			£ -	£ -	£ -			£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
2.7	Internal Walls and Partitions		£ -	£ -				£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
2.8	Internal Doors	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	Superstructure Total	£ 575,000.00	£ 667,069.49	£ 580.06			£ 220,000.00	£ 255,226.59	£ 580.06		£ 319,950.00	£ 371,180.66	£ 1,374.74		£ -	£ -	£ -		£ 200,000.00	£ 232,024.17	£ 23.20	
3.0	**Internal Finishes**																					
3.1	Wall Finishes		£ -	£ -				£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
3.2	Floor Finishes		£ -	£ -				£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
3.3	Ceiling Finishes		£ -	£ -				£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	Internal Finishes Total	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
4.0	**Fittings Furnishings and Equipment**																					
4.1	Fittings Furnishings and Equipment		£ -	£ -				£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	Fittings Furnishings and Equipment Total	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -	
5.0	**Services**																					
5.0	Mechanical, Plumbing & Electrical Installations		£ -	£ -				£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.0	Mechanical & Plumbing Installations	£ 431,250.00	£ 500,302.11	£ 435.05	AssumeE375/m2. Ventilation in Backlog maintenance		£ 165,000.00	£ 191,419.94	£ 435.05	AssumeE375/m2. Ventilation in Backlog maintenance	£ 184,410.00	£ 213,937.89	£ 792.36	Based on CMU costs at £683/m2	£ -	£ -	£ -			£ -	£ -	
5.1	Sanitary appliances	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.2	Services equipment	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.3	Disposal installation	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.4	Water installations	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.5	Heat source	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	Replacement of 7 No AHU @ £25k + 2 No theatre AHU @ £50k + £50k for strip out and anciliary works
5.6	Space heating and air treatment	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.7	Ventilation installations	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ 325,000.00	£ 377,039.27	£ 37.70	
5.8	Electrical Installation	£ -	£ -	£ -	Included in Backlog maintenance		£ -	£ -	£ -	Included in Backlog maintenance	£ -	£ -	£ -	Included in Backlog maintenance	£ -	£ -	£ -		£ 1,080,000.00	£ 1,252,930.51	£ 125.29	9,000m² @ £120 for replacment of LV systems throughout hospital
5.9	Gas Installations	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.10	Lift Installation	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -		£ 250,000.00	£ 290,030.21	£ 29.00	2 Lift car replacements
5.11	Protective installations	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
5.12	Communications installations	£ -	£ -	£ -	Sprinkler system. 22% by area of total current estimated budget of £1,680,000		£ -	£ -	£ -	Sprinkler system. 8% by area of total current estimated budget of £1,680,000	£ -	£ -	£ -	Sprinkler system. 5% by area of total current estimated budget of £1,680,000	£ -	£ -	£ -			£ -	£ -	Total CGH floor area less unheated areas - 8,400m² . Sprinkler system @ £200
5.13	Specialist Installations	£ 369,600.00	£ 428,780.66	£ 372.85			£ 134,400.00	£ 155,920.24	£ 354.36		£ 84,000.00	£ 97,450.15	£ 360.93		£ -	£ -	£ -		£ -	£ -	£ -	
5.14	Builder's work in connection with services	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	Services Total	£ 800,850.00	£ 929,082.78	£ 807.90			£ 299,400.00	£ 347,340.18	£ 789.41		£ 268,410.00	£ 311,388.04	£ 1,153.29		£ -	£ -	£ -		£ 1,655,000.00	£ 1,920,000.00	£ 192.00	
	Building Sub Total	£ 1,375,850.00	£ 1,596,152.27	£ 1,387.96			£ 519,400.00	£ 602,566.77	£ 1,369.47		£ 588,360.00	£ 682,568.70	£ 2,528.03		£ 75,000.00	£ 87,009.06	£ 217.52		£ 1,855,000.00	£ 2,152,024.17	£ 215.20	
8.0	**External works**																					
8.0	External Works Generally	£ -	£ -	£ -			£ -	£ -	£ -		£ 10,800.00	£ 12,529.31	£ 46.40	Based on CMU costs at £40/m2	£ 20,000.00	£ 23,202.42	£ 58.01			£ -	£ -	
8.1	Site preparation works	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
8.2	Roads, paths & pavings	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ 50,000.00	£ 58,006.04	£ 145.02			£ -	£ -	
8.3	Soft landscaping, planting & irrigation systems	£ -	£ -	£ -			£ -	£ -	£ -			£ -	£ -		£ -	£ -	£ -			£ -	£ -	
8.4	Fencing, railings and walls	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
8.5	Site / street furniture and equipment	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
8.6	External drainage	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
8.7	External services	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
8.8	Minor buildings works and ancillary buildings	£ -	£ -	£ -			£ -	£ -	£ -		£ -	£ -	£ -		£ -	£ -	£ -			£ -	£ -	
	External Works Total	£ -	£ -	£ -			£ -	£ -	£ -		£ 10,800.00	£ 12,529.31	£ 46.40		£ 70,000.00	£ 81,208.46	£ 203.02		£ -	£ -	£ -	
	Building Sub Total (Excludes Facilitating & External Works)	£ 1,375,850.00	£ 1,596,152.27	£ 1,387.96			£ 519,400.00	£ 602,566.77	£ 1,369.47		£ 588,360.00	£ 682,568.70	£ 2,528.03		£ -	£ -	£ -		£ 1,855,000.00	£ 2,152,024.17	£ 215.20	
	Prime Cost	£ 1,375,850.00	£ 1,596,152.27	£ 1,387.96			£ 519,400.00	£ 602,566.77	£ 1,369.47		£ 599,160.00	£ 695,098.01	£ 2,574.44		£ 145,000.00	£ 168,217.52	£ 420.54		£ 1,855,000.00	£ 2,152,024.17	£ 215.20	

University of Glasgow
Gilmorehill Campus
1st Stage Works Pricing Document

Inflation on construction rates

Published October 2020

TPI All-In		
4Q 2008	240	
1Q 2009	223	
2Q 2009	216	
3Q 2009	216	
4Q 2009	212	
1Q 2010	209	
2Q 2010	218	
3Q 2010	219	
4Q 2010	220	
1Q 2011	219	
2Q 2011	223	
3Q 2011	220	
4Q 2011	223	
1Q 2012	215	
2Q 2012	230	
3Q 2012	223	
4Q 2012	224	
1Q 2013	234	
2Q 2013	236	
3Q 2013	232	
4Q 2013	239	
1Q 2014	247	
2Q 2014	259	
3Q 2014	257	
4Q 2014	259	
1Q 2015	270	
2Q 2015	283	
3Q 2015	271	
4Q 2015	270	
1Q 2016	275	
2Q 2016	282	
3Q 2016	281	
4Q 2016	291	
1Q 2017	301	
2Q 2017	307	
3Q 2017	307	
4Q 2017	317	
1Q 2018	326	
2Q 2018	327	
3Q 2018	328	
4Q 2018	331	
1Q 2019	331	
2Q 2019	335	
3Q 2019	335	
4Q 2019	333	
1Q 2020	335	Provisional
2Q 2020	335	Provisional
3Q 2020	330	Provisional
4Q 2020	328	Provisional
1Q 2021	328	Provisional
2Q 2021	331	Provisional
3Q 2021	334	Forecast
4Q 2021	338	Forecast
1Q 2022	340	Forecast
2Q 2022	341	Forecast
3Q 2022	344	Forecast
4Q 2022	349	Forecast
1Q 2023	353	Forecast
2Q 2023	355	Forecast
3Q 2023	358	Forecast
4Q 2023	363	Forecast
1Q 2024	367	Forecast
2Q 2024	370	Forecast
3Q 2024	372	Forecast
4Q 2024	377	Forecast
1Q 2025	382	Forecast
2Q 2025	384	Forecast
3Q 2025	387	Forecast
4Q 2025	392	Forecast
1Q 2026	397	Forecast

Tender Price Studies

Published 6 March 2020

Location		
Scotland		
East Central Scotland	88	0.88
Eastern Scotland	95	0.95
Highlands, Argyll & Bute	91	0.91
North Eastern Scotland	86	0.86
Southern Scotland	91	0.91
West Central Scotland	94	0.94
Western & Northern Islands	111	1.11

Building Design Adjustments

Building Regulations

Works commenced pre-	Percentage Addtition
2012	7.5%
2016	5.0%
2019	2.5%

Carbon reduction

Insert Carbon reduction price uplift from Base Date: 0%

CAITHNESS REDESIGN - BUILDING OPTIONS

SITE 3 - Dunbar Hospital, Thurso

Date: 29-Jul-21

Rev: 3

Works: Demolish Physciotherapy wing (porta-cabin), Generator and Garage outbuildings, clinic, store, accommodation bungalow and nurses house. Construct new healthcare facilities comprising assisted living, care beds, day care, GP surgery, physio and offices, access roads and car parking and general landscaping. Internal refurbishment of Inpatient and Palliative care building.

Drawings: Keppie 8520-0001 Rev 01 (Existing layout), NHS Existing Floor Plans dated 2.9.11, Keppie 8520-0006 Rev 01 (Proposed layout)

Execution: 1Qtr 2025

Exclusions: Any remedial works to retained Dental unit. Content removal of buildings to be demolished. FF&E fit out. Land owership issues. Any costs/income associated with T&C or Pulteney House. ICT provision. Net zero carbon technologies.

Option	Description		Area m²	BCIS £		S/Total £	Comments
	Demolition	Demolition of buildings	800	235	£	188,000.00	
		Service diversions			£	100,000.00	
	New Build	Two storey Assisted Living	3037	£1,524.00	£	4,628,388.00	Median of BCIS results for Supported Housing. Rate as of 1Q 2025
		Two storey care beds	1013	£3,718.00	£	3,766,334.00	Cost based on £3,261/m2 as per Tongue Care Home forecast + 14%
		Two storey and single storey office	992	£1,865.00	£	1,850,080.00	Median of BCIS results for non-air conditioned office. Rate as of 1Q 2025
		SFRS facility	210	£2,328.00	£	488,880.00	Lower Quartile of BCIS results for fire station. Rate as of 1Q 2025
		SAS facility	210	£1,767.00	£	371,070.00	Median of BCIS results for ambulance station. Rate as of 1Q 2025
	Refurb	Internal reconfiguration of existing	1572	£2,280.00	£	3,584,160.00	Based on CMU refurb @ £2,000/m2 + 14%
	External	Car Parking - 141 No spaces	141	£3,400.00	£	479,400.00	
		Landscaping			£	100,000.00	
		Build cost			**£**	**15,556,312.00**	
		10% for fees, site surveys and site investigation			£	1,555,631.20	
		Overall Build Cost			**£**	**17,111,943.20**	
		VAT @ 20%			£	3,422,388.64	
		TOTAL			**£**	**20,534,331.84**	

GIFA New Build (m²)	**4,449**
GIFA Refurb (m²)	**1,572**
Total (m²)	**6,021**
£/m² (incl VAT)	**£3,410.45**

CAITHNESS REDESIGN - BUILDING OPTIONS

SITE 4 - NOSS Primary School site, Wick

Date: 29-Jul-21

Rev: 3

Works: Greenfield site:
Ttwo storey 'Care Bed' and 'Assisted Living' units. New two storey office unit, single storey GP practice, single storey Physio Gym and Day Care plus car parking. New SFRS facility.

Drawings: Keppie 8520-0009 Rev 01 (Proposed layout)

Execution: 1Qtr 2025

Exclusions: FF&E fit out. Income Cost/income associated with disposl of Pultney House & T&C. ICT provision. Net zero carbon technologies.

Option	Description		Area m²	BCIS £	S/Total £	Comments
	New Build	Three storey Assisted Living	3037	£ 1,471.00	£ 4,467,427.00	Median of BCIS results for Supported Housing (over 2000m²). Rate as of 1Q 2025
		Two storey Care Beds	937	£ 3,718.00	£ 3,483,766.00	Cost based on £3,261/m2 as per Tongue care Home forecast + 14%
		Single storey Day Care centre	350	£ 2,223.00	£ 778,050.00	Median of BCIS results for Day Centre. Rate as of 1Q 2025
		Single storey GP surgery	382	£ 2,719.00	£ 1,038,658.00	Median of BCIS results for Public Group Practice Surgery. Rate as of 1Q 2025
		Two storey office	927	£ 1,865.00	£ 1,728,855.00	Median of BCIS results for non-air conditioned office. Rate as of 1Q 2025
		Single storey shared space	400	£ 1,865.00	£ 746,000.00	Median of BCIS results for non-air conditioned office. Rate as of 1Q 2025
		Physio Gym	214	£ 1,540.00	£ 329,560.00	Lower Quartile of BCIS results for Occupational Health & Physiotherapy. Excludes hydrotherapy. Rate as of 1Q 2025
		SFRS facility	210	£ 2,328.00	£ 488,880.00	Lower Quartile of BCIS results for Fire Station. Rate as of 1Q 2025
	External	Car Parking - 141 No spaces	141	£ 3,400.00	£ 479,400.00	
	Demolition	Site clearance			£ -	
		Construction Cost			**£ 13,540,596.00**	
		5% for fees, site surveys and site investigation			£ 677,029.80	
		Anticipated Build Cost			**£ 14,217,625.80**	
		VAT @ 20%			£ 2,843,525.16	
		Land purchase (5 acres)			£ 100,000.00	
		TOTAL			**£ 17,161,150.96**	

GIFA New Build (m²)	**6,457**
GIFA Refurb (m²)	**0**
Total (m²)	**6,457**
£/m² (incl VAT)	**£2,657.76**

CAITHNESS REDESIGN - BUILDING OPTIONS

SITE 2 - Pulteney House Care Home, Wick

Date: 29-Jul-21

Rev: 3

Works: Option B:
Two new extensions to Care Home comprising two storey 'Care Bed' and single storey 'Day Care' units. New two storey office unit in grounds of Caberfeidh Court plus car parking. New single storey units for office and for GP surgery/Physio Gym plus car parking on plot of existing playground. Internal refurbishment of Caberfeidh Court and Pulteney House. New SFRS facility.

Drawings: Keppie 8520-0002 Rev 01 (Existing layout), NHS Existing Floor Plans dated 2.9.11, Keppie 8520-0007 Rev 01 (Proposed layout)

Execution: 1Qtr 2025

Exclusions: FF&E fit out. Any costs/income associated with disposal of T&C.ICT provision. Net zero carbon technologies

Option	Description		Area m²	BCIS £	S/Total £	Comments
A	New Build	Single storey Day Care	350	£ 2,223.00	£ 778,050.00	Median of BCIS results for Care Centre. Rate as of 1Q 2025
		Single storey Care Beds	937	£ 3,718.00	£ 3,483,766.00	Cost based on £3,261/m2 as per Tongue Care Home forecast + 14%
		Two storey office	554	£ 1,865.00	£ 1,033,210.00	Median of BCIS results for non-air conditioned office. Rate as of 1Q 2025
		Single storey office	219	£ 1,865.00	£ 408,435.00	Median of BCIS results for non-air conditioned office. Rate as of 1Q 2025
		Single storey GP surgery	382	£ 2,719.00	£ 1,038,658.00	Median of BCIS results for Public Group Practice Surgery. Rate as of 1Q 2025
		Physio Gym	214	£ 1,540.00	£ 329,560.00	Lower Quartile of BCIS results for Occupational Health & Physiotherapy. Excludes hydrotherapy. Rate as of 1Q 2025
		SFRS facility	210	£ 2,328.00	£ 488,880.00	Lower Quartile of BCIS results for Fire Station. Rate as of 1Q 2025
	Refurb	Caberfeidh Court (Assisted Living)	2300	£ 2,280.00	£ 5,244,000.00	Based on CMU refurb @ £2,000/m2 + 14%
		Pulteney House (assumed GIFA)	1291	£ 2,280.00	£ 2,943,480.00	
	External	Car Parking - 141 No spaces	141	£ 3,400.00	£ 479,400.00	
		New playground facilities			£ 30,000.00	
	Demolition	Site clearance of playground (part)			£ 10,000.00	
		Construction Cost			**£ 16,267,439.00**	
		10% for fees, site surveys and site investigation			£ 1,626,743.90	
		Overall Build Cost			**£ 17,894,182.90**	
		VAT @ 20%			£ 3,578,836.58	
		Land purchase (4 acres)			£ 80,000.00	
		TOTAL			**£ 21,553,019.48**	

GIFA New Build (m²)	**2,866**
GIFA Refurb (m²)	**3,591**
Total (m²)	**6,457**
£/m² (incl VAT)	**£3,337.93**

CAITHNESS REDESIGN - BUILDING OPTIONS

SITE 1 - Town & County Hospital, Wick

Date: 29-Jul-21

Rev: 3

Works: Demolish existing In-patients & Palliative Care facilities, staff accommodation, miscellaneous out buildings, roads, paths and other hard landscaping. Construct new healthcare facilities comprising assisted living, care beds, day care, GP surgery, physio and offices, access roads and car parking and general landscaping. Construct new SFRS facilty.

Drawings: Keppie 8520-0001 Rev 01 (Existing layout), NHS Existing Floor Plans dated 2.9.11, Keppie 8520-0006 Rev 01 (Proposed layout)

Execution: 1Qtr 2025

Exclusions: FF&E fit out. Costs/income associated with disposal of Pulteney House site. ICT provision. NET zero carbon technologies

Option	Description		Area m²	BCIS £	S/Total £	Comments
	Demolition	Demolition of buildings	1600	235	£ 376,000.00	
		Removal of reduntant services			£ 100,000.00	
	New Build	Three storey Assisted Living	3037	£ 1,471.00	£ 4,467,427.00	Median of BCIS results for Supported Housing. Rate as of 1Q2025
		Two storey Care Beds	937	£ 3,718.00	£ 3,483,766.00	Cost based on £3,261/m2 as per Tongue Cre Home forecast + 14%
		Single storey Day Care centre	350	£ 2,223.00	£ 778,050.00	Median of BCIS results for Day Centre. Rate as of 1Q 2025
		Single storey GP surgery	382	£ 2,719.00	£ 1,038,658.00	Median of BCIS results for Public Group Practice Surgery. Rate as of 1Q 2025.
		Two storey office	927	£ 1,865.00	£ 1,728,855.00	Median of BCIS results for non-air conditioned office. Rate as of 1Q 2025
		Single storey shared space	400	£ 1,865.00	£ 746,000.00	Median of BCIS results for non-air conditioned office. Rate as of 1Q 2025
		Physio Gym	214	£ 1,540.00	£ 329,560.00	Lower Quartile of BCIS results for Occupational Health & Physiotherapy. Excludes hydrotherapy. Rate as of 1Q 2025
		SFRS facility	210	£ 2,328.00	£ 488,880.00	Lower Quartile of BCIS results for Fire Station. Rate as of 1Q 2025
	External	Car Parking - 141 No spaces	141	£ 3,400.00	£ 479,400.00	
		Construction Cost			**£ 13,540,596.00**	
		10% for fees, site surveys and site investigation			£ 1,354,059.60	
		Anticipated Build Cost			**£ 14,894,655.60**	
		VAT @ 20%			£ 2,978,931.12	
		Land purchase (2,000m²)			£ 20,000.00	
		Anticipated Project Total			**£ 17,893,586.72**	

GIFA New Build (m²)	**6,457**
GIFA Refurb (m²)	**0**
Total (m²)	**6,457**
£/m² (incl VAT)	**£2,771.19**

Target | **Caithness General Hospital** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	4	
A.02	The design facilitates the care model	1	4	
A.03	Overall the design is capable of handling the projected throughput	1	4	
A.04	Work flows and logistics are arranged optimally	1	4	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2	5	
A.06	Where possible spaces are standardised and flexible in use patterns	1	4	
A.07	The design facilitates both security and supervision	1	4	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	4	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	4	
A.10	The benchmarks in the Design Statement in relation to building USE are met	2	5	

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	4	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	2	5	
B.03	The approach and access for ambulances is appropriately provided	1	4	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	4	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	4	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	4	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	4	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	4	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2	5	

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	4	
C.02	The ratio of usable space to total area is good	1	4	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	2	5	
C.04	Any necessary isolation and segregation of spaces is achieved	1	4	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	4	
C.06	There is adequate storage space	1	4	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	4	
C.08	The relationships between internal spaces and the outdoor environment work well	1	4	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2	5	

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	4	
D.02	The building and grounds are easy to clean and maintain	1	4	
D.03	The building and grounds have appropriately durable finishes and components	2	5	
D.04	The building and grounds will weather and age well	1	4	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	4	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	4	
D.07	The design minimises maintenance and simplifies this where it will be required	1	4	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2	5	

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	4	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	4	
E.03	The engineering systems are energy efficient	1	4	
E.04	There are emergency backup systems that are designed to minimise disruption	1	4	
E.05	During construction disruption to essential services is minimised	1	4	
E.06	During maintenance disruption to essential healthcare services is minimised	2	5	
E.07	The design layout contributes to efficient zoning and energy use reduction	1	4	

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1	4	
F.02	Temporary construction work is minimised	1	4	
F.03	The impact of the building process on continuing healthcare provision is minimised	2	5	
F.04	The building and grounds can be readily maintained	1	4	
F.05	The construction is robust	1	4	
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1	4	
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1	4	
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1	4	
F.09	The construction contributes to being a good neighbour	1	4	
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1	4	

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	4	
G.02	The building and grounds are interesting to look at and move around in	1	4	
G.03	The building, grounds and arts design contribute to the local setting	2	5	
G.04	The design appropriately expresses the values of the NHS	1	4	
G.05	The project is likely to influence future designs	1	4	
G.06	The design provides a clear strategy for future adaptation and expansion	1	4	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	4	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2	5	

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	4	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	2	5	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	4	
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	4	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	4	
H.06	The design maximises the site opportunities and enhances a sense of place	1	4	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2	5	

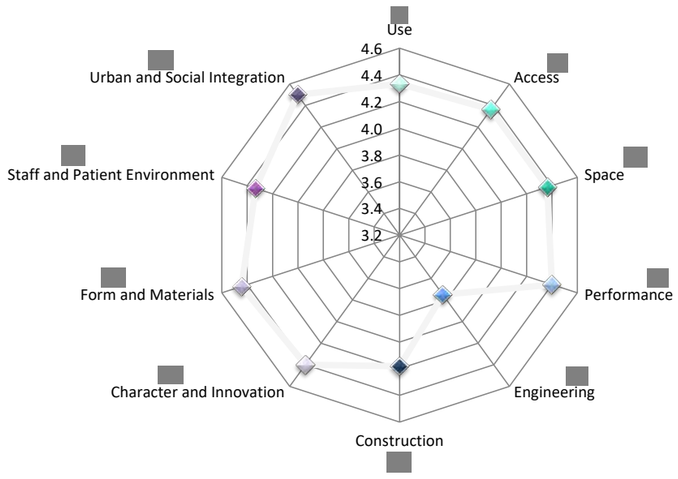
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1	4	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	4	
I.03	The design maximises the opportunities for access to usable outdoor space	1	4	
I.04	There are high levels of both comfort and control of comfort	1	4	
I.05	The design is clearly understandable and wayfinding is intuitive	2	5	
I.06	The interior of the building is attractive in appearance	1	4	
I.07	There are good bath/ toilet and other facilities for patients	1	4	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1	4	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	4	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2	5	

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	4	
J.02	The facility contributes positively to its locality	2	5	
J.03	The hard and soft landscape contribute positively to the locality	1	4	
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1	4	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	4	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2	5	

AEDET Refresh Target Summary



	Target
Use	4.3
Access	4.4
Space	4.4
Performance	4.4
Engineering	3.8
Construction	4.2
Character and Innovation	4.4
Form and Materials	4.4
Staff and Patient Environment	4.3
Urban and Social Integration	4.5

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

Caithness General Hospital

Target

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
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	B.02	
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	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

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

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Target | **Caithness Community Hubs - Thurso & Wick** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	4	
A.02	The design facilitates the care model	1	4	
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A.08	The design facilitates health promotion and equality for staff, patients and local community	1	4	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	4	
A.10	The benchmarks in the Design Statement in relation to building USE are met	2	5	

Access

		Weight	Score	Notes
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B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	4	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	4	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	4	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2	5	

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	4	
C.02	The ratio of usable space to total area is good	2	5	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	4	
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C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	4	
C.08	The relationships between internal spaces and the outdoor environment work well	1	4	
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Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	4	
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D.07	The design minimises maintenance and simplifies this where it will be required	1	4	
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Character and Innovation

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Urban and Social Integration

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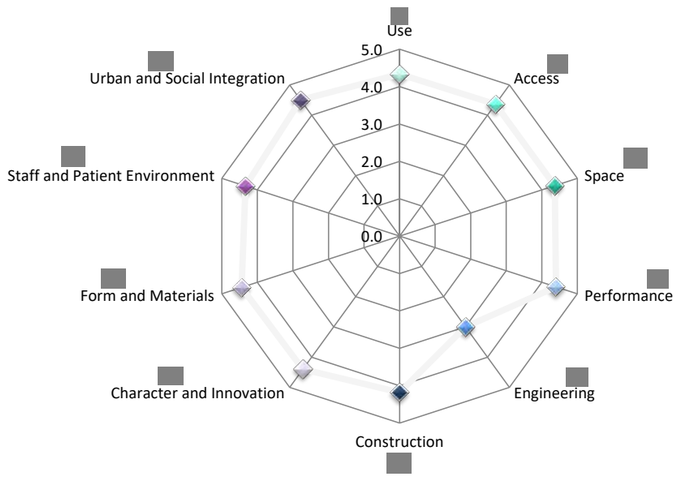
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2	5	

AEDET Refresh Target Summary



	Target
Use	4.3
Access	4.4
Space	4.4
Performance	4.4
Engineering	3.0
Construction	4.2
Character and Innovation	4.4
Form and Materials	4.4
Staff and Patient Environment	4.3
Urban and Social Integration	4.5

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

Caithness Community Hubs - Thurso & Wick

Target

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
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	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
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Scoring
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Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
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Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

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6. Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Caithness Service Redesign – Caithness General Hospital: SCIM DESIGN STATEMENT V5 FINAL 14 December 2021

NHS Highland is carrying out a redesign of health and social care services in Caithness. This major service change will include the reconfiguration and refurbishment of the local rural general hospital, Caithness General Hospital in Wick.

The Business Objectives for the wider redesign project are

- Delivering sustainable services
- Delivering services locally (in Caithness)
- Meeting the demographics challenge
- Addressing buildings issues
- Patient experience
- Staff experience
- Caithness as a proposition

To achieve these objectives the completed development must have the attributes described below. These experiences are expected for all people irrespective of physical, sensory or cognitive impairments.

1 AGREED NON-NEGOTIABLES FOR SERVICE USERS

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
1.1 The first impression of the facility must build confidence and reduce stress. It must convey all one service, be recognisable as a hospital, feel part of the community.	• It should appear be welcoming and professional, efficient and not too ostentatious - 'clearly of Caithness' • The facility should have a human scale, be light and green • Clear intuitive way finding from out with the site to indicate presence of facility and route to it (even during hours of darkness).  Green approach  Easily seen from main road, green landscape
1.2 Arriving must be easy and equitable and support self-reliance.	• Arrival routes and spaces, including parking areas, must be safe and pleasant for use in the day and also during darkness, e.g. through passive observation of walking routes, lighting, length of walking routes, quality of surface materials, integrating landscape etc. • The entrance must appear welcoming and be clearly visible from the route. • Patient arrival will be primarily by car therefore adequate and easy access must be provided from parking areas to the front door – this should be safe, easy and within 50 metres • Walking routes should be sheltered from the wind and all weathers by use of building or landscape/planting features

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	• Secure cycle storage and charging for bikes, e-bikes, e-scooters within 25 metres of entrance, attractively designed to encourage use • 10% of total parking provision to be electric vehicle charging points including infrastructure in place to provide more at a future date. Chargers must be placed at a height and location suitable for wheelchair users. Refer to SHTN 02-02 Sustainable EV charging Infrastructure.  Sheltered, clearly visible main entrance  Welcoming, obvious entrance

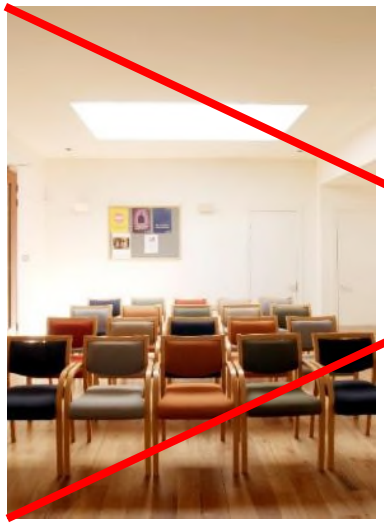
Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	 Building gives shelter, good mix of old and new  Pleasant route guides you to where you need to go  Local stone work, good mix of old and new, car parking and drop off close by

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	 Long route from main car park, little observation from building
1.3 Arrival experience to A&E must be discrete, maintain privacy and dignity of all.	• The route for emergency admission should be obvious and intuitive when approaching the site, not relying solely on signage to indicate where the entrance is and what that entrance is for • Adjacent to the entrance, within 20 metres there must be space to accommodate: Ambulances, Taxi or other drop-off • Limited emergency parking within 20 metres • The design of the routes and spaces must make it clear that these are not for general use and discourage general parking. • On entering the building, you must be able to find help immediately, visible from entrance and within 10 metres. • Patients arriving at A&E should be able to do so away from view from visitors to other services on the site

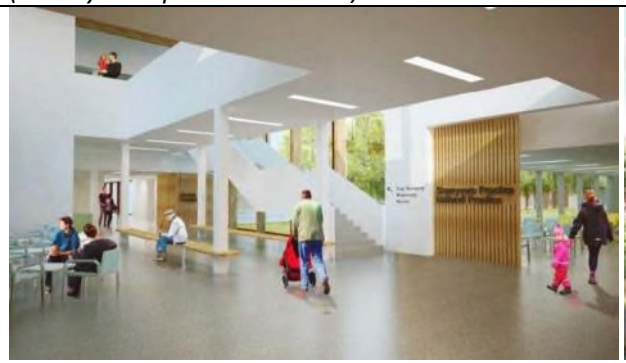
Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	  Discrete, sheltered access separate from main entrance  Reception is visible straight after entrance to department

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
1.4 Reception must set the tone for the onward patient journey, be accessible and welcoming, whilst maintaining the safety and security of staff.	• There should be access to help – in person and digitally – visible from entrance and within 10 metres from the front door • It should be light, comfortable, open and barrier-free • Reception desk(s) to have different heights to take account of all user needs • The design should ensure the safety and security of staff, particularly out of hours when lone working is more likely. This could be through unobtrusive measures such as a deep desk or proximity of reception to a secure area. The receptionist should be able to immediately summon help in the event of an incident. • Patients should only have to check in once, and be given options of where to go to wait for their appointments, with reliable information provided in real-time • There should be a place to go to manage private conversations within 15 metres  Obvious reception desk, clear wayfinding, cosy feel  Too clinical
1.5 Booking and patient planning systems should reduce waiting times, but where patients will wait (such as pre and post surgery or between tests and other appointments), waiting areas must be comfortable, pleasant	• Booking systems to enable appointments to align with patient's transport options, combined with clear information on transport options and accessibility of each • A variety of comfortable and accessible seating options to be provided. It should be arranged in groups to allow some personal choice and perception of privacy, and these groups should have space for wheelchair users and buggies as part of the group. • Good sound attenuation/acoustics to provide audio separation from private conversations

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
with positive distractions. Patients must feel not forgotten and be able to deal with their human needs (toilet, refreshments etc). Waiting while in a vulnerable condition (during and just post treatment, and on discharge) must be discretely located to maintain people's privacy and dignity.	• Good natural light, colour and views in all spaces where people may wait • Accessible toilets adjacent to and location visible from waiting areas • Access to food / refreshments for longer waits • Charging points and access to WiFi • Internal and external children's play area to be provided for supervised play • Space provided for visiting services, e.g. third sector charities and support organisations • You can see staff so you know there is help if you need it, maximum distance 10 metres from waiting areas  Personal choice and privacy, natural light and views  Range of seating options, natural light and views Design on glass good for dementia / accessibility

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	 Personal choice and privacy, staff visible  Discrete waiting during and post-treatment / discharge  No choice of seating  Rows of seats looking at blank walls (natural light is good though)

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
1.6 Routes throughout the building must create positive flow, provide dignity, privacy and not create stress unduly.	• Patient routes must minimise walking distance, by not requiring patients to double back through the sequence of progressing through the building • Maximum distance 20m between regular rest stops provided along the way • Waiting areas to be within 30m to enable clinicians to collect patients and build relationships • Easy access to pharmacy should be provided adjacent to normal patient routes in/out of the building • Circulation routes must make use of good daylight and intuitive wayfinding practices (routes having clear identity through use of views, art, colour etc.) • Space for quiet contemplation, or religious observance close to clinical areas • Circulation routes to allow for discrete transfer of patients in vulnerable condition (to/from theatre etc) away from public routes • Large materials/deliveries not to be through public routes  Rest stop on circulation route  Use of colour and natural light  Colour coding / shapes

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	  Good daylight, intuitive wayfinding  Private quiet space / religious observance  Informal space for quiet contemplation

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
1.7 Consulting and treatment spaces must promote open and trusting interactions, helping patients take in information and maintain dignity.	• Natural light and views to be provided without compromising privacy • Spaces that provide privacy and dignity to patients, not on view to visitors • Good sound attenuation to waiting and public areas • Options to view information provided by consultant (e.g. movable monitor/screen) • Equivalency between patient and practitioner achieved by having the same furniture and relationship to the table and screen so no hierarchy in the relationship is set up • There must be space to gather yourself again after the consultation before stepping out into 'public' • Adjacencies of clinical departments should be considerate of sensitivities, e.g. ultrasound, maternity, chemotherapy  Cluttered, cramped consulting space  Generic, bland (although no barrier between clinician and patient which is positive)

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	 Good: splashback behind sink / Bad: couch pushed up against wall     Bright and spacious clinical and treatment spaces with good use of natural light

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
1.8 Maternity rooms must feel safe, homely and build confidence in the service.	• Bedrooms to be adaptable for family use day and night • Rooms to have good daylight and views of nature, and to be within 20m of outdoor space to allow families a breath of fresh air. • Rooms should be designed to make it easy to control noise and lighting levels to allow rest/sleep when needed etc. • Maternity rooms not to feel too clinical or over medicalised  Homely, good daylight and views

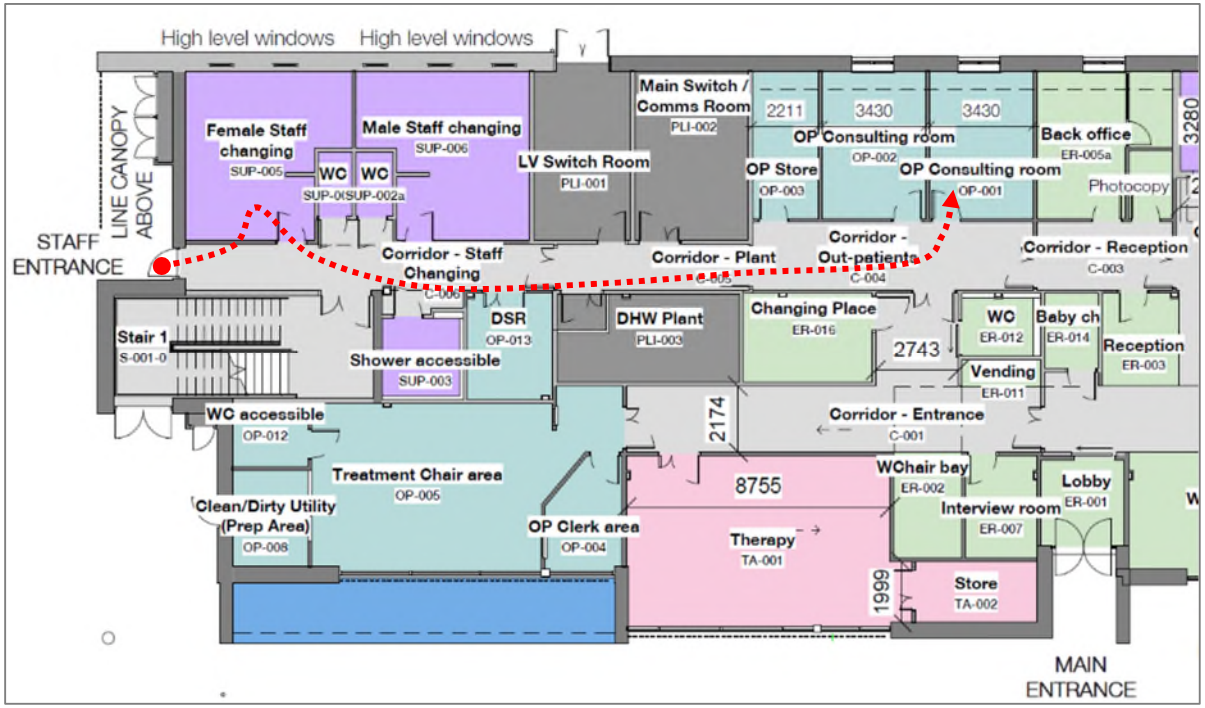
Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
1.9 Surgery spaces to provide positive distractions from the procedure and be comfortable for people in varying degrees of undress for different lengths of time.	• As 1.6 above (unless technically disallowed) • Visual distractions on ceilings where patients are prostrate • Secure areas for patient's belongings to be provided • Light and bright, with calming colours and lighting scheme that avoids glare  Light and bright  Visual distractions
1.10 Areas for extended periods of treatment (e.g. for chemotherapy) must support choice, comfort and the ability to personalise the space.	• As 1.6 and 1.8 above • It must be possible to control temperature of the rooms and play music etc. • Provide options for being sociable/mutual support or to be separate

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	   
1.11 Inpatient areas must help patients feel secure, connected and able to make choices for privacy, control of their social environment, and normalise the day as much as possible to aid recovery. Wards and bedrooms must enable rehabilitation.	• Space for private consultations prior to surgery • Easy access to social areas, to encourage patients to get up and about • Visual connections with staff and the life of the ward (to see others are progressing) from the bed, and outside to an interesting view while seated/lying • Spaces within the ward to come together with other patients for therapeutic work and social gatherings/eating • Ability to control privacy and level of social contact, e.g. allow family in / not be bothered by others

Non-Negotiable Performance objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each (what you expect there to be)*
	• Ward areas to have easy access to a breath of fresh air, without having to travel back through the building • Access to Wifi and TV • Ability to control environment in room/light levels, heating etc. and natural ventilation  View outside from bed  Sliding door to en-suite, discrete storage  Colour, connection with others, beds not facing each other  Informal social space, encourages mobilisation

2 AGREED NON-NEGOTIABLES FOR STAFF

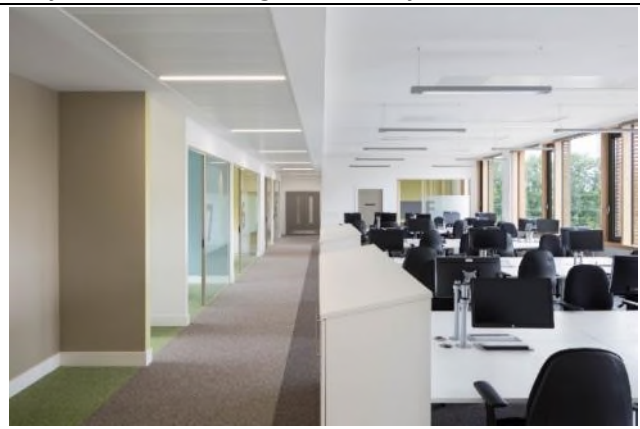
Non-Negotiable Performance objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each*
2.1 Getting to and from the facility must be easy and reliable considering different needs of shift and peripatetic workers.	• Reliable vehicular parking for staff, who may be working late at night / early morning to same standards as 1.1 above, though max walking distance from parking may be increased to 75m • Drop off facility within 15m of discrete entrance with equipment store max 15m from entrance to allow quick transfer of materials without going through public areas. • Changing facilities and safe storage of personal belongings close to route between arrival and working area. • There must be discrete and immediate access and egress for ambulances and clinicians on emergency calls, with sheltered parking for ambulances immediately adjacent to this entrance and dedicated on call staff parking max 20m from the same entrance. • Access to wider town amenities to enable exercise/shopping/banking etc as benchmark for 1.1 above • Vehicular parking should have direct access/short routes to facility and be well lit. • 10% of total parking provision to be electric vehicle charging points, with infrastructure in place to provide more at a future date. Chargers must be placed at a height and location suitable for wheelchair users.  Example of staff storage next to work area  Safe, well-lit access

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 for each*
	 Staff changing rooms next to staff entrance, on route to clinical work areas
2.2 The layout of the facility must enable staff to come together to share information and build working relationships and practice	• Services and departments connected by 'non-public' routes so that staff can seek/provide help to other areas without going through main entrance and have short impromptu sensitive conversations away from public. • Like activities (training, office-based working, rest) provided all together, not split by employer or area of working within the hospital. • Meeting areas immediately adjacent to clinical departments, and close to other services for regular staff meetings. These spaces should be away from public areas to enable confidential, uninterrupted meetings. • Spaces for 2-3 people to come together for impromptu chats (convey an issue or pastoral support) without leaving working environment.

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 for each*
	 Good meeting space  Poor confidentiality (sensitive info on monitors)
2.3 The layout of the facility, and specification of rooms, must allow flexibility of use.	• Circulation and consult/treatment rooms so that department/clinic sizes can flex and change without physical alteration • Standardised room layouts to enable multiple uses over time • Storage within 20m of rooms of equipment needed on daily basis
2.4 Working areas, away from public spaces, to convey welcoming, friendly, lively, modern and innovative culture.	• Mix of different types of spaces to enable agile and flexible working patterns • Access to daylight, external views and fresh air from office areas • Shape of space and choice of finishes/fittings to provide good acoustic environment • Wifi connectivity to allow flexible, agile working

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 for each*

Good mix of circulation, staff working and social



Agile working, good use of storage to separate areas, direct access to suitable meeting spaces

Mix of desk spaces to suit different ways of working

Quiet area for meetings / discussions

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 for each*
2.5 Staff must be able to have time off duty to relax away from patients, refresh, meet their own personal needs and build social connections with colleagues.	• Shared social space available 24/7, close to all working areas and not directly visible from public areas. Space must be in 'neutral' territory, not part of any one department or service so all feel they can use it. • Staff social area/s (with storage for packed lunches and area for self-prep food) within 3 minutes' walk of service areas and close to clinical areas to allow staff to have a quick turnaround when taking a meal break. • Seating organised to allow you to group with colleagues to be sociable or sit more quietly. This space must be attractive enough to encourage staff away from their immediate work environment to meet. • Direct access to external space for breath of fresh air.  Homely, separate spaces, natural materials  Different ceiling heights, break from clinical, café feel

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 for each*
	 Direct access to external balcony  External space (windbreak needed in Caithness)
2.6 The layout of the facility must enable phased shut down so that heating/fire/evacuation etc can be managed within the parts that are open at the time.	• Access to 24/7 areas not through internal routes to day services • Building to have distinct zones; 24/7 departments grouped together with access to staff facilities and "back of house" support areas without having to go through non-24/7 areas • Well-developed adjacency matrix at building briefing stage, with input and sign off from clinical stakeholders. • Clinical stakeholders involved throughout design development process so that design team have full understanding of how departments work together, and stakeholder sign off at key stages. • Well-designed building management system so building can be controlled and managed more efficiently
2.7 The facility must support further education and training of clinical staff and enable closer links to college and education facilities	• Dedicated clinical skills lab to allow education and training to be provided on site • IT technology and suitable learning space(s) to support closer links with University of Highlands and Islands and North Highland College

3 AGREED NON-NEGOTIABLES FOR VISITORS (FAMILY/FRIENDS/CARERS)

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 for each*
3.1 Family and friends must have access to a pleasant space to wait, with positive distractions, and feel supported in their own needs.	• Access to a café facility near the main entrance • Comforting, quiet space for family / friends / carers away from clinical areas (e.g. imaging and emergency departments) so that they can take time to themselves if needed • Choice of seating and spaces to suit different needs • Interesting things to look at; local art, views of nature and direct access outside to allow family and friends to get a breath of fresh air   Good natural light, mix of seating types, café feel, local art, views of nature and access to the outdoors 

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 for each*
3.2 External landscape must be therapeutic, accessible to all and promote interaction and relaxation	• Access to appropriate external spaces and accessible paths round the site to maximise therapeutic use • External areas should add interest, green spaces but be easy to maintain • Displays of local art and sculpture that enhance the “Caithness” connection  Easy to maintain, interesting features  Inviting, protected, appealing, visible when moving within building (needs a different surface, not gravel)    Caithness art

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 for each*
	 No green space, bland, uninteresting

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 for each*
4.1 The design of the facility must contribute to the wider regeneration in terms of townscape and contribution to the local economy.	• Joint planning with public sector agencies through NHS Highland participation in the Caithness Place-based Review process, working with public-sector agencies The Highland Council, Highlands & Islands Enterprise, Scottish Futures Trust, Scottish Fire & Rescue Service and Scottish Ambulance Service to look at Caithness as a place, and discuss and agree use of public assets jointly to benefit the community. Evidenced through notes of meetings and output documents. • Community stakeholder group set up to review proposals at key decision-making points. Outcome recorded illustrating how proposals will be adapted in line with feedback received. • Use of local sub-contractors in construction process, and generation of local training and employment through the new facility, e.g. number of apprenticeships created.
4.2 The improvements on the site must promote and improve active travel links around the town.	• Maintain awareness and links with Health Promotion and projects like the Wheelness Project (Cycling UK). NHSH health improvement team represented on Project Team and participates in development of service

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 for each*
	model, design brief, design development and AEDET and Design Statement reviews. Evidenced by meeting notes, attendee lists and outputs. • Co-production of whole neighbourhood active travel strategy with partner and third sector organisations such as Transport Scotland, Sustrans, HITRANS and Cycling UK. Alignment of the design with agreed strategy will be evidenced in our proposals, and partner views will be sought at each decision-making stage, with key recommendations for improvement incorporated into the site design. • Engagement with Caithness Community Transport, Highland Council and commercial transport providers to jointly agree the delivery of appropriate transport services to and from the facility and to influence improvements within the area more generally. To be evidenced through notes of meetings, email correspondence and joint travel plans. • Site travel surveys carried out pre and post development (with input from partner organisations as above) to evidence improvement. • Improved sheltered, safe pedestrian link from the adjacent railway station
4.3 The facility will be designed to support the NHS Scotland commitment to being a 'net-zero' greenhouse gas emissions organisation	• Appointment of project-specific Environment and Sustainability champion. • Value re-use of existing buildings as key criteria in site selection • Net Zero Carbon design brief informed by IES modelling and additional expertise brought in as required. • Application of and compliance with Sustainable Design and Construction (SDaC) Guide (SHTN 02-01). • Building design to achieve the aims set out in A Policy for NHS Scotland on the Climate Emergency and Sustainable Development – DL (2021) 38 and to support all focus areas of the NHS Climate Change and Sustainability Strategy 2020-2025. • Buildings designed to enable net zero greenhouse gas emissions by 2040 at the latest and heated from renewable sources by 2038 at the latest. • Building to achieve Net Zero Carbon objectives in operation through design of building fabric (airtightness), and renewable energy sources wherever possible. If renewable energy sources are not available now, the buildings will be designed with systems which can adapt to future sources e.g., district heating, hydrogen, heat pumps. • Buildings designed to optimise energy performance using climate projections to 2050. • Emissions minimised during construction, and construction site waste management plan in place. • Sustainability through linking into active travel networks, provision of bicycle storage and changing facility, and EV charging points.

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 for each*
	• Sustainability reviews carried out at key design stages and reviewed by the NHS Highland Sustainability Group. • Climate change risk assessment completed, and adaptation plan produced
4.4 Equality and diversity to be embedded into all functions and activities in line with the Equality Act 2010.	• Facility designed to comply with the Equality Act 2010, Equality Specific Duties (Scotland) Regulations 2012 and its amendments, and British Standards for accessible environments e.g. BS 8300:2018 parts 1&2. • Project EQIA in place, to be reviewed and developed at each stage with appropriate stakeholders and published on project website. • Stakeholder groups to include representatives of people who are disadvantaged or discriminated against because of who they are, their protected characteristic, for example: age, disability, race, gender or transgender, religion or belief and sexual orientation. • Local access panel input to the design brief and design development workshops, and involvement in the assessment of the design through participation in AEDET and Design Statement reviews at key decision-making points. • Access and equality specific group set up to review project-specific access and equality issues in detail, and input to key stages of briefing and design development. • External access and equality consultant engaged for specialist advice and asked for written advice at key decision-making points. • Project Team guided by NHS Highland Equality Outcomes and Mainstreaming Report 2021. • Equality reviewed through NHS Highland's Principal Officer Health Inequalities, Equality and Diversity being engaged with the Project Team. • Project Communications and Engagement Plan reflects these objectives.

5 SELF ASSESSMENT PROCESS

Decision Point	Authority	Additional Skills / Perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information required to allow evaluation
Site strategy	NHSH Board with advice from Programme Board	Caithness Place-based Review and agreed master strategy, Sustainable Design and Construction guide (SDaC), NHS Scotland Design Assessment Process (NDAP), external health care planner, external technical advisor.	Risk / benefit analysis of the capacity of the sites to deliver a development that meets the criteria identified above. Use of stakeholder workshops using the AEDET, SDaC, HAIscribe (stage 1), EQIA, KSAR and NDAP process to set criteria and review that these have been met	Site feasibility study based on best available information Completed HAIscribe, SDaC and NDAP reviews
Completion of brief	NHSH Programme Board with advice from Project Director and Senior Project Manager	Stakeholders, including service providers, internal technical advisors, public sector partners. Clinical modelling supported by Healthcare Planner.	This Design Statement should be integral to the design brief.	Early engagement with development partner (PSCP) to assess the affordability / deliverability of the project brief. Use of AEDET, SDaC, KSAR & NDAP Design Statement to check that the brief meets the agreed criteria.
Selection of Delivery / Design Team	Development Partner (PSCP) with input from NHSH Project Managers	HFS Capital Project Advisors, including internal / external technical advisors	Selection process as per HFS Framework Scotland 3, including cost and quality considerations, to ensure that the best design team is chosen from the Framework.	Previous experience / examples of work on developments of a similar nature and complexity. Interview process to include presentation and questions relating to

Decision Point	Authority	Additional Skills / Perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information required to allow evaluation
			NHSH will be involved in the selection process and can influence the outcome and, if necessary, nominate other designers for consideration	design approach and the potential to meet the criteria set. Consideration given to quality criteria set.
Early design concept selected from options developed	NHSH Programme Board with advice from Project Team	Internal / external technical advisors, HFS input through NDAP, planning authority	Use of AEDET, SDaC, KSAR & NDAP Design Statement to determine if the criteria are being met	Proposals developed to Stage 3 with enough detail to enable distinction between the main use types (including circulation and external space). Elevations/3D visuals
Approval of Design Proposals to be submitted to the Planning Authority	NHSH Programme Board with advice from Project Team	NDAP, The Highland Council Planning and Transport Departments	Use of AEDET, SDaC, KSAR & NDAP Design Statement to determine if the criteria are being met	Selected Design to Stage 4, with elevations
Approval of detailed Design to allow Construction	NHSH Programme Board with advice from Project Team	In-house architectural team and internal / external technical advisors	Use of AEDET, SDaC, KSAR & NDAP Design Statement to determine if the criteria are being met	Design developed to Stage 5 with agreed specification.
Post Occupancy Evaluation	Consideration by appropriate NHSH	Independent analysis by service providers / stakeholders. Potential Third Party evaluation	Assessment of completed development by representatives of the stakeholder groups involved in establishing the assessment criteria	Post Occupancy Evaluation

Decision Point	Authority	Additional Skills / Perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information required to allow evaluation
	governance and report sent to SGHD		(AEDET, Design Statement, KSAR, SDaC).	

This statement was developed through the engagement of the following stakeholders. A full list of attendees is provided in **Appendix A**:

- NHS Highland clinical staff including; Inpatient nursing, A&E, Community Midwifery, Physiotherapy, Palliative Care, Pharmacy, Dental Services
- NHS Highland support staff; admin, hotel services, estates
- NHS Highland local operational managers and project managers
- Partner agencies; Scottish Ambulance Service
- Caithness Disability Access Panel
- Public and patient representatives including; CHAT and Patient Council

The list of applicable guidance and standards to the project is provided in **Appendix B**.

Appendix A
List of Attendees for Design Statement / AEDET for Caithness General Hospital

Forename	Surname	Designation	Organisation	Role / Representing
Kay	Allan	Area Support Manager	NHS Highland	PM (Supporting Services)
Cara	Birnie	Midwifery Team Lead / Senior Charge Midwife	NHS Highland	Community Maternity Unit
Helen	Budge		Access Panel	Caithness Disability Access Panel
Sarah	Budge	Professional Lead	NHS Highland	Occupational Therapy
Ivor	Campbell	Estates Operations Manager	NHS Highland	Estates
Johan	Campbell	Laboratory Manager	NHS Highland	Laboratories
Heather	Chapple	Director of Design	Architecture & Design Scotland	Facilitator
Graham	Cormack	Acting Area Service Manager	SAS	Scottish Ambulance Service
Diane	Forsyth	Senior Project Manager	NHS Highland	Senior Project Manager
Grant	Franklin	Consultant Physician	NHS Highland	General Medicine
Pam	Garbe	Rural General Hospital Manager	NHS Highland	Project Lead (Supporting Services)
Paul	Gilligan	Architect	Oberlanders	Facilitator
Eric	Green	Head of Estates	NHS Highland	Project Technical Lead
Ron	Gunn	Patient rep	CHAT	Service users
Danny	Hunter		Architecture & Design Scotland	Facilitator
Nova	James	Lead ANP / Clinical Co-ordinator	NHS Highland	
Michelle	Johnstone	Area Manager	NHS Highland	Project Director
Michael	Loynd	Macmillan Advanced Nurse / Cancer Team Lead	NHS Highland	Palliative & End of Life Care
John	Lyon	Clinical Dental Director	NHS Highland	Public Dental Service
Marina	MacDonald	Patient rep	Patient Council	Service users
Russell	Mackay	Clinical Pharmacist	NHS Highland	Pharmacy
Steve	Malone		Architecture & Design Scotland	Facilitator
Julie	Marker	Member	Access Panel	Caithness Disability Access Panel

Forename	Surname	Designation	Organisation	Role / Representing
Pat	McGee	Senior Charge Nurse	NHS Highland	Acute Assessment, High Dependency & Inpatients
Laura	Menzies	Lead Midwife (North)	NHS Highland	Community Maternity Unit
Christian	Nicolson	District Manager	NHS Highland	Senior Manager / Project Team / Integrated Team
Shona	Paterson	Professional Lead	NHS Highland	Physiotherapy
Neil	Pellow	Senior Charge Nurse	NHS Highland	A&E and Outpatients
Duncan	Scott	Consultant Physician	NHS Highland	General Medicine
Francis	Sutherland	Assistant Support Manager	NHS Highland	Hotel Services
Zhen Ron	Tan	Project Manager	NHS Highland	PM (Estates)
Josie	Thomson	Clinical Advisor	NHS Highland	Project Clinical Advisor
Emma	Watson	Associate Medical Director	NHS Highland	Project Clinical Lead

Appendix B
Applicable Guidance - CGH Reconfiguration

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
3 - Highest	SHTN 02-01	Sustainability Design and Construction Guide	2021	
3 - Highest	BS8300-1:2018	Design of an accessible and inclusive built environment. Part 1: External environment - code of practice	2018	
3 - Highest	BS8300-2:2018	Design of an accessible and inclusive built environment. Part 2: Buildings - code of practice	2018	
3 - Highest	HBN 00-01	Core guidance - General design for healthcare buildings (HBN 00-01)	Oct-14	
2 - Normal	HBN 00-02	Core elements - Sanitary spaces (HBN 00-02)	Mar-17	
2 - Normal	HBN 00-03	Core guidance - Clinical and clinical support spaces (HBN 00-03)	Oct-14	
2 - Normal	HBN 00-04	Core Guidance - Circulation and communication spaces (HBN 00-04)	Oct-14	
3 - Highest	HBN 00-07	Core guidance - Planning for a resilient healthcare estate (HBN 00-07)	Oct-14	
2 - Normal	HBN 02-01	Cancer treatment facilities (HBN 02-01)	Oct-14	Ambulatory Care Unit
2 - Normal	HBN 06 vol 2	Diagnostic imaging: PACS and specialist imaging (HBN 06 vol 2)	Oct-14	
2 - Normal	HBN 07-01	Renal care - Satellite dialysis unit (HBN 07-01)	Oct-14	Ambulatory Care Unit
2 - Normal	HBN 08-02	Dementia-friendly Health and Social Care Environments (HBN 08-02)	Aug-16	
2 - Normal	HBN 12-01 sup A	Out-patient care: Sexual and reproductive health clinics (HBN 12-01 sup A)	Oct-14	
2 - Normal	HBN 14-01	Medicines management: Pharmacy and radiopharmacy facilities (HBN 14-01)	Oct-14	
2 - Normal	HBN 14-02	Medicines storage in clinical areas (HBN 14-02)	Sep-21	
2 - Normal	HBN 26 vol 1	Facilities for surgical procedures (HBN 26 vol 1)	Oct-14	
2 - Normal	HBN 37	In-patient facilities for older people (HBN 37)	Oct-14	
2 - Normal	HTM 65	Wayfinding -effective wayfinding and signing for healthcare facilities (HTM 65)	Aug-16	
2 - Normal	SFPN 00-01	Fire safety - A model management structure (SFPN 00-01)	Apr-04	
2 - Normal	SFPN 10	Fire Safety -Laboratories on hospital premises (SFPN 10)	Dec-99	
2 - Normal	SFPN 3	Fire safety - Escape bed lifts (SFPN 3)	Oct-10	
2 - Normal	SFPN 4	Fire Safety -Hospital main kitchens (SFPN 4)	Dec-99	
2 - Normal	SFPN 6	Fire safety - Prevention and control of deliberate fire-raising in healthcare premises (SFPN 6)	Dec-07	
2 - Normal	*SHFN 01-01*	*National Facilities Monitoring Framework Manual (SHFN 01-01)*	*Apr-21*	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
2 - Normal	*SHFN 01-02*	*NHSScotland National Cleaning Services Specification - NCSS (SHFN 01-02)*	*Jun-16*	
2 - Normal	*SHFN 01-03*	*Implementation and Communication Plan NCSS (SHFN 01-03)*	*Dec-16*	
2 - Normal	*SHFN 01-04*	*National average cleaning time (NACT) user guide (SHFN 01-04)*	*Apr-21*	
2 - Normal	*SHFN 01-05*	*Safe Management of the Care Environment (SHFN 01-05)*	*May-21*	
2 - Normal	SHFN 02	Access - Audit survey toolkit for disabled people in healthcare premises (SHFN 02)	Sep-07	
2 - Normal	*SHFN 02-01*	*Portering Services Standards for NHSScotland (SHFN 02-01)*	*Jun-21*	
2 - Normal	SHFN 03	Access - checklist for people with dementia in healthcare premises (SHFN 03)	Oct-07	
2 - Normal	SHFN 03-01	Security - Management Framework for NHS Boards in Scotland (SHFN 03-01)	Dec-08	
2 - Normal	SHFN 03-02	Security - Services Standards for NHSScotland (SHFN 03-02)	Jul-21	
2 - Normal	SHFN 03-04	Security Lockdown - Controlling movement and access in healthcare facilities (SHFN 03-04)	Mar-20	
2 - Normal	SHFN 04-01	Food in Hospitals (SHFN 04-01)	Mar-16	
2 - Normal	SHFN 04-03	Food Safety Assurance Manual (SHFN 04-03)	Mar-20	
2 - Normal	SHFN 04-04	Food Allergen Management (SHFN 04-04)	Mar-14	
2 - Normal	SHFN 14	Access - Disability (SHFN 14)	Sep-00	
3 - Highest	SHFN 30 Part A	HAI-SCRIBE Manual information for project teams (SHFN 30 Part A)	Oct-14	
3 - Highest	SHFN 30 Part B	HAI-SCRIBE Implementation strategy and assessment process (SHFN 30 Part B)	Oct-14	
3 - Highest	SHFN 30 Part C	HAI-SCRIBE questionsets and checklists (SHFN 30 Part C)	Jan-15	
2 - Normal	SHPN 04-01	Adult in-patient facilities (SHPN 04-01)	Oct-10	
2 - Normal	SHPN 06 Part 1	Facilities for diagnostic imaging and interventional radiology (SHPN 06 Part 1)	Mar-04	
2 - Normal	SHPN 08	Rehabilitation services facilities (SHPN 08)	Jan-02	
2 - Normal	SHPN 16-01	Mortuary and Post Mortem Facilities (SHPN 16-01)	Nov-17	Mortuary only, no post-mortem
2 - Normal	SHPN 22	Accident and emergency facilities for adults and children (SHPN 22)	Jan-07	
2 - Normal	SHPN 36 Part 2	NHS Dental Premises in Scotland (SHPN 36 Part 2)	Jul-06	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
2 - Normal	SHPN 4 sup 1	In-patient accommodation - supplement 1 - Isolation facilities in acute settings (SHPN 4 sup 1)	Sep-08	TBC
2 - Normal	SHPN 52 Part 1	Day care part 1 - Day surgery unit (SHPN 52 Part 1)	Jan-02	
2 - Normal	SHPN 52 Part 2	Day care part 2 - Endoscopy unit (SHPN 52 Part 2)	Jan-02	
2 - Normal	SHPN 52 Part 3	Day care part 3 - Medical investigation and treatment unit (SHPN 52 Part 3)	Jan-02	
3 - Highest	SHTM 00	Best practice guidance for healthcare engineering policies and principles (SHTM 00)	Feb-13	
2 - Normal	SHTM 02-01 Part A	Medical Gas Pipeline Systems: Design installation validation and verification (SHTM 02-01 Part A)	Jun-12	
2 - Normal	SHTM 02-01 Part B	Medical Gas Pipeline Systems: Operational management (SHTM 02-01 Part B)	Jul-15	
2 - Normal	SHTM 03-01 Part A	Ventilation for Healthcare - Design and validation (SHTM 03-01 Part A)	Feb-14	
2 - Normal	SHTM 03-01 Part B	Ventilation for Healthcare - Operational and verification (SHTM 03-01 Part B)	Oct-11	
2 - Normal	SHTM 04-01 Part A	Water safety for healthcare- Design installation and testing (SHTM 04-01 Part A)	Jul-14	
2 - Normal	SHTM 04-01 Part B	Water safety for healthcare- Operational management (SHTM 04-01 Part B)	Jul-14	
2 - Normal	SHTM 04-01 Part C	Water safety for healthcare- TVC Testing Protocol (SHTM 04-01 Part C)	Feb-14	
2 - Normal	SHTM 04-01 Part D	Water safety for healthcare- Disinfection of domestic water systems (SHTM 04-01 Part D)	Aug-11	
2 - Normal	SHTM 04-01 Part E	Water safety for healthcare- Alternative materials and filtration (SHTM 04-01 Part E)	Aug-15	
2 - Normal	SHTM 04-01 Part F	Water safety for healthcare- Chloramination of water supplies (SHTM 04-01 Part F)	Dec-11	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
2 - Normal	SHTM 04-01 Part G	Water safety for healthcare- Operational procedures and exemplar (SHTM 04-01 Part G)	Jul-15	
2 - Normal	SHTM 04-02 Part A	Water safety for emerging technologies - Solar domestic hot water heating (SHTM 04-02 Part A)	Jul-15	
2 - Normal	SHTM 04-02 Part B	Water safety for emerging technologies - Rainwater harvesting (SHTM 04-02 Part B)	Jul-15	
2 - Normal	SHTM 04-02 Part C	Water safety for emerging technologies - Grey water recovery (SHTM 04-02 Part C)	Jul-15	
2 - Normal	SHTM 06-01 Part A	Electrical services supply and distribution: Design considerations (SHTM 06-01 Part A)	Jul-15	
2 - Normal	SHTM 06-01 Part B	Electrical services supply and distribution: Operational management (SHTM 06-01 Part B)	Jul-15	
2 - Normal	SHTM 06-02	Electrical safety guidance for Low Voltage systems (SHTM 06-02)	Jul-15	
2 - Normal	SHTM 06-03	Electrical safety guidance for High Voltage systems (SHTM 06-03)	Jul-15	
2 - Normal	SHTM 07-03	Transport management and car parking (SHTM 07-03)	Jan-08	
2 - Normal	SHTM 07-04	Transport - NHSScotland Travel Plan Guidance (SHTM 07-04)	Sep-07	
2 - Normal	SHTM 08-01	Specialist Services: Acoustics (SHTM 08-01)	Jul-15	
2 - Normal	SHTM 08-02	Specialist Services - Lifts (SHTM 08-02)	Jul-15	
2 - Normal	SHTM 08-03	Specialist Services - Bedhead Services (SHTM 08-03)	Jul-11	
2 - Normal	SHTM 08-05 Part A	Building Management Systems: Overview and Management (SHTM 08-05 Part A)	Apr-12	
2 - Normal	SHTM 08-05 Part B	Building Management Systems: Design Considerations (SHTM 08-05 Part B)	Apr-12	
2 - Normal	SHTM 08-05 Part C	Building Management Systems: Validation and Verification (SHTM 08-05 Part C)	Apr-12	
2 - Normal	SHTM 08-05 Part D	Building Management Systems: Operational Management (SHTM 08-05 Part D)	Apr-12	
2 - Normal	SHTM 08-06	Specialist Services - Pathology Laboratory Gas Systems (SHTM 08-06)	Jul-11	TBC
2 - Normal	SHTM 08-07	Confined Spaces policies procedures and guidance (SHTM 08-07)	Feb-15	
2 - Normal	SHTM 08-08	Pressure Systems: Policies and Guidance (SHTM 08-08)	Jul-14	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
2 - Normal	SHTM 2035 Part 1	Mains signaling - Overview and management (SHTM 2035 Part 1)	Jun-01	
2 - Normal	SHTM 2035 Part 2	Mains signalling - Design considerations (SHTM 2035 Part 2)	Jun-01	
2 - Normal	SHTM 2035 Part 3	Mains signalling - Validation and verification / operation (SHTM 2035 Part 3)	Jun-01	
2 - Normal	SHTM 54	Building component series -User manual (SHTM 54)	Dec-06	
2 - Normal	SHTM 55	Building component series -Windows (SHTM 55)	Dec-06	
2 - Normal	SHTM 56	Building component series - Partitions (SHTM 56)	Dec-06	
2 - Normal	SHTM 57	Building component series - Internal glazing (SHTM 57)	Dec-06	
2 - Normal	SHTM 58	Building component series - Internal doorsets (SHTM 58)	Dec-06	
2 - Normal	SHTM 59	Building component series - Ironmongery (SHTM 59)	Dec-06	
2 - Normal	SHTM 60	Building Component Series - Ceilings (SHTM 60)	Oct-09	
2 - Normal	SHTM 61	Building component series - Flooring (SHTM 61)	Jul-09	
2 - Normal	SHTM 61 app 1a	Building component series - Flooring - matrix_example xls (SHTM 61 app 1a)	Jul-09	
2 - Normal	SHTM 62	Building component series - Demountable storage systems (SHTM 62)	Dec-06	
2 - Normal	SHTM 63	Building component series - Fitted storage systems (SHTM 63)	Dec-06	
2 - Normal	SHTM 64	Building Component Series – Sanitary assemblies (SHTM 64)	Dec-09	
2 - Normal	SHTM 66	Building component series - Cubicle curtain track (SHTM 66)	Dec-06	
2 - Normal	SHTM 67	Building component series - Laboratory storage systems (SHTM 67)	Dec-06	
2 - Normal	SHTM 69	Building component series - Protection (SHTM 69)	Dec-06	
2 - Normal	SHTM 81 part 1	Fire safety - Precautions in new healthcare premises (SHTM 81 part 1)	Jul-09	
2 - Normal	SHTM 81 part 2	Fire safety - Fire engineering of healthcare premises (SHTM 81 part 2)	Jul-09	
2 - Normal	SHTM 81 part 3	Fire safety - Atria in healthcare premises (SHTM 81 part 3)	Apr-13	
2 - Normal	SHTM 82	Fire safety - alarm and detection systems (SHTM 82)	Apr-13	
2 - Normal	SHTM 83	Fire safety - General fire precautions in healthcare premises (SHTM 83)	Apr-04	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
2 - Normal	SHTM 83 Part 2	Fire Safety - Fire safety training (SHTM 83 Part 2)	Jul-17	
2 - Normal	SHTM 85	Fire safety - Precautions in existing healthcare premises (SHTM 85)	Dec-07	
2 - Normal	SHTM 86	Fire safety - Risk assessment (SHTM 86)	Jun-13	
2 - Normal	SHTM 87	Fire safety - Textiles and furniture (SHTM 87)	Aug-09	
2 - Normal	SHTN 00-01	Property Appraisal Manual -PAMS (SHTN 00-01)	Mar-21	
2 - Normal	SHTN 00-02	Strategic property and asset management guidance for NHSScotland - PAMS (SHTN 00-02)	Nov-10	
2 - Normal	SHTN 00-03	Property appraisal guidance for NHSScotland - PAMS - Risk-based methodology (SHTN 00-03)	Nov-10	
2 - Normal	SHTN 00-04	Guidance on Management of Medical Devices and Equipment (SHTN 00-04)	Jun-21	
2 - Normal	SHTN 02-00	Sustainable Development Strategy (SHTN 02-00)	Feb-12	
2 - Normal	SHTN 02-01	Sustainable Design and Construction	Oct-21	
2 - Normal	SHTN 02-02	Sustainable - EV Charging Infrastructure (SHTN 02-02)	Dec-20	
2 - Normal	SHTN 3	Waste management - Segregation Chart (SHTN 3)	Nov-13	
2 - Normal	SHTN 3 Part A	Waste management - Summary of requirements - best practice overview (SHTN 3 Part A)	Feb-15	
2 - Normal	SHTN 3 Part B	Waste management - Policy template (SHTN 3 Part B)	Feb-15	
2 - Normal	SHTN 3 Part C	Waste management - Compendium of regulatory requirements (SHTN 3 Part C)	Feb-15	
2 - Normal	SHTN 3 Part D	Waste management - Guidance and example text for waste procedures (SHTN 3 Part D)	Feb-15	
2 - Normal	SHPN 13 Part 3	Decontamination - Endoscope Decontamination Units (SHPN 13 Part 3)	Sep-10	
2 - Normal	SHTM 2010 Part 1	Decontamination - Overview and management responsibilities Sterilization (SHTM 2010 Part 1) (PDF, 265KB)	Jun-01	
2 - Normal	SHTM 2010 Part 2	Decontamination - Design considerations Sterilization (SHTM 2010 Part 2) (PDF, 644KB)	Jun-01	
2 - Normal	SHTM 2010 Part 3	Decontamination - Validation and verification Sterilization (SHTM 2010 Part 3) (PDF, 1,34MB)	Jun-01	
2 - Normal	SHTM 2010 Part 4	Decontamination - Operational management Sterilization (SHTM 2010 Part 4) (PDF, 779KB)	Jun-01	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
2 - Normal	SHTM 2010 Part 5	Decontamination - Good practice guide Sterilization (SHTM 2010 Part 5) (PDF, 1MB)	Jun-01	
2 - Normal	SHTM 2010 Part 6	Decontamination - Testing and validation protocols Sterilization (SHTM 2010 Part 6)	Jun-01	
2 - Normal	SHTM 2022 Supp 1	Dental compressed air and vacuum systems (SHTM 2022 Supp 1)	Mar-04	
2 - Normal	SHTM 2030 Part 1	Decontamination - Design considerations Washer-disinfectors (SHTM 2030 Part 1)	Oct-01	TBC
2 - Normal	SHTM 2030 Part 2	Decontamination - Operational management Washer-disinfectors (SHTM 2030 Part 2)	Oct-01	TBC
2 - Normal	SHTM 2030 Part 3	Decontamination - Validation and verification Washer-disinfectors (SHTM 2030 Part 3)	Oct-01	TBC
2 - Normal	SHTM 2031 Part 1	Decontamination - Clean steam for sterilization (SHTM 2031 Part 1)	Jun-01	
2 - Normal	GUID 5006	Decontamination - Carriage of Dangerous Goods Regulations for Used Medical Devices (GUID 5006)	Dec-13	
2 - Normal	GUID 5007	Decontamination - Compliant Podiatry Instruments (GUID 5007)	Mar-20	
2 - Normal	GUID 5008	Decontamination - Disposal and Recycling of Medical Devices (GUID 5008)	Oct-14	
2 - Normal	GUID 5010 Part A	Decontamination - Reusable surgical instruments before and after clinical use - Design (GUID 5010 Part A)	Dec-14	
2 - Normal	GUID 5010 Part B	Decontamination - Reusable surgical instruments before and after clinical use - Operation (GUID 5010 Part B)	Dec-14	
2 - Normal	*GUID 5013*	*Decontamination - Compliant Endoscope Decontamination Units (GUID 5013)*	*Nov-14*	
2 - Normal	*GUID 5015*	*Decontamination - Engineering staff roles & responsibilities (GUID 5015)*	*Feb-17*	
2 - Normal	*SHTM 01-01 GUID 5017*	*Decontamination - of surgical instruments (SHTM 01-01 GUID 5017)*	*Sep-18*	
2 - Normal	*SHTM 01-01 Part A*	*Decontamination - Management (SHTM 01-01 Part A)*	*Sep-18*	
2 - Normal	*SHTM 01-01 Part B*	*Decontamination - Test equipment / methods (SHTM 01-01 Part B)*	*Sep-18*	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Comment
2 - Normal	*SHTM 01-01 Part C*	*Decontamination - Sterilization by steam (SHTM 01-01 Part C)*	*Sep-18*	
2 - Normal	*SHTM 01-01 Part D*	*Decontamination - Automated cleaning and disinfection equipment (SHTM 01-01 Part D)*	*Sep-18*	
2 - Normal	*SHTM 01-01 Part E*	*Decontamination - Sterilization by hydrogen peroxide or ethylene oxide (SHTM 01-01 Part E)*	*Sep-18*	
2 - Normal	*SHTM 01-01 Part F*	*Decontamination - Inspect, assemble and package (SHTM 01-01 Part F) (PDF, 882KB)*	*Sep-18*	
2 - Normal	*SHTM 01-02 Part A*	*Decontamination - Lab sterilizers and washer disinfectors - management and operation (SHTM 01-02 Part A)*	*Jun-20*	
2 - Normal	*SHTM 01-02 Part B*	*Decontamination - Lab sterilizers and washer disinfectors - test equipment / methods (SHTM 01-02 Part B)*	*Jun-20*	
2 - Normal	*SHTM 01-02 Part C*	*Decontamination - Lab sterilizers and washer disinfectors - sterilization by steam (SHTM 01-02 Part C)*	*Jun-20*	
2 - Normal	*SHTM 01-02 Part D*	*Decontamination - Lab sterilizers and washer disinfectors - cleaning and disinfection (SHTM 01-02 part D)*	*Jun-20*	

Caithness Redesign – COMMUNITY HUB AND CARE VILLAGES: SCIM Design Statement v4

NHS Highland is carrying out a redesign of health and social care services in Caithness. This major service change will include the creation of two new Community Hub and Care Villages, one in Wick and one in Thurso.

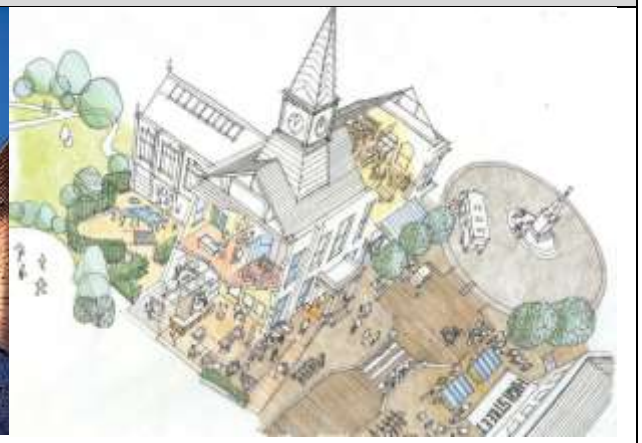
The Business Objectives for the wider redesign project are

- Delivering sustainable services
- Delivering services locally (in Caithness)
- Meeting the demographics challenge
- Addressing buildings issues
- Patient experience
- Staff experience
- Caithness as a proposition

To achieve these objectives the completed development must have the attributes described below. These experiences are expected for all people irrespective of physical, sensory or cognitive impairments. Although the experiences below are split by different user groups due to their different needs, this should not be read that each experience must be met through providing separate spaces. Where different groups' needs are compatible or can be accommodated in the same space at different times, the spaces for these experiences should be provided for together.

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*
Criteria common to all service users experience	
1.a Getting to and from the facility must be easy and reliable, safe and pleasant during daylight and darkness.	• Walking routes from street and public transport to be no longer than from general parking, and in no case more than 50m. • Pedestrian routes within the site to be prioritised over cars. • Drop-off within 25m of entrance, designed to discourage use for parking. • Pedestrian routes to have good lighting and visibility (no hidden corners) and passive observation from occupied areas of the facility/adjacent buildings. • Entrance(s) clearly visible from the arrival route and not obscured by parking • Walking routes, including those within parking, to be sheltered from the wind by use of building or landscape/planting features. • Storage and charging for bikes, e-bikes, e-scooters within 25m of entrance, attractively designed to encourage use • 10% of total parking provision to be electric vehicle charging points, with infrastructure in place to provide more at a future date. Chargers must be placed at a height and location suitable for wheelchair 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*
	  Well-designed drop off areas which discourage stopping for any length of time, pedestrian / cycle-friendly, community feel  

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.b The building(s) and landscape must provide a welcoming, homely, calm and safe impression so you feel reassured from first sight and invited to use as much of the place as possible (without compromising privacy requirements noted in sections below). It must not feel unnecessarily clinical or like a hospital.	• All external routes between amenities on the site to meet descriptions in 1a above • Route from 'day' facilities to hub, max 5 mins • Route from residential/bed areas to the day facilities and entrance area of hub max 5 mins. • Routes from all facilities to community growing area, with growing space visible during normal daily use of each (either from public areas or routes to/from the facility if used daily) to encourage use.  Welcoming, homely and non-clinical, merge of inside and outside space  Community spaces – inviting people in Dominated by tarmac
1.c Internal routes must be short, easy and direct so as not to create stress.	• Public routes must minimise walking distance by not requiring people to double back through the sequence of progressing through the building • Maximum distance 20m between regular rest opportunities provided along the way.

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*
	• Layout to support intuitive wayfinding – ideally the destination will be visible before setting off, but where this is not possible, routes must have features (views, art, colour etc.) at decision points to aid orientation. • Signage attractive supplement to wayfinding and interior design. • Waiting areas to be within 30m of consult/treatment spaces to enable staff to collect patients, assess their condition and build relationship as walking to the appointment.    Seating incorporated into corridor, natural light & views to garden space, clear links   Staircase too dominant Confusing corridor, no rest points

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*
Criteria specific to people going for an appointment, treatment, to take part in a group, or to access information.	
1.d The facility must draw people in gently and provide positive connections to other amenities (both within the care village and across the town) so that health and care are an integral part of the life of the town.	• Entrance within 10 mins (walk or public transport) of other amenities in the town to allow people to do more than one thing on their trip and to encourage unplanned use. • Space between the street and the entrance to have places to sit and get yourself together whilst sheltered from the wind. • Spaces for play and physical activity visible from arrival routes • Wide entrance with easy views into attractive internal space • Space to wait in comfort inside (within 15m of door) and outside (within 15m of pick-up & bus stops) where you can see transport/pick up location and reliable information on public transport.  
1.e The initial arrival space must accommodate individual needs and preferences and make clear the range of support/facilities available. It must be an attractor, a place to stay and feel comfortable.	• WCs and reception within 15m, and refreshments within 25m, of entrance; all visible from point of entry • Initial space to have a range of areas / heights / volumes to allow personal choice in environment, and enough space that you can stop without feeling hurried, or walk straight through without interrupting those stopped there • From this space you must be able to see and get direct access to external spaces used for rest, exercise and activity (1b & c above) to encourage people to engage in these.

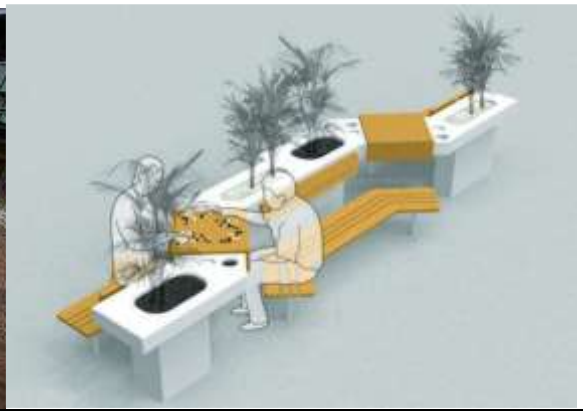
Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
	  • Bookable, meeting/activity rooms accessed directly off entrance area for training/in-reach/3rd sector/community use. Rooms to be designed to be used flexibly to allow safe space for sensitive discussions, or together and with entrance space for larger groups/events  

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.f Reception must set the tone for the onward patient journey, be accessible and welcoming.	• Patients should only have to check in once, and be given options of where to go to wait for their appointments, with reliable information provided in real-time • There should be a place to go to manage private conversations within 15m of the reception • Reception desks must not place obvious physical barriers to the conversation – staff security and comfort (heat and protection from draughts) to be provided through positioning and direct links to safe space.  
1.g Booking and patient planning systems should reduce waiting times, but where patients will wait waiting areas must be comfortable, pleasant with positive distractions. Patients must feel not forgotten and be able to deal with their human needs (toilet, refreshments etc).	• Booking systems to enable appointments to align with patient's transport options, combined with clear information on transport options and accessibility of each • A variety of comfortable and accessible seating options, arranged in groups to allow some personal choice and perception of privacy, and these groups should have space for wheelchair users and buggies as part of the group. • Good sound attenuation / acoustics to provide audio separation from private conversations • Good natural light, colour and views to interesting external spaces where people may wait for more extended periods of time • Toilets adjacent to (max 1 minutes' walk) and location visible from waiting areas

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*
	• Access to food / refreshments, and internal and external children's play area to be provided for supervised play within sight of spaces where people may wait for extended periods of time • Charging points and access to WiFi • Staff base visible and within 15m of waiting so you know there is help if you need it    

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.h Consulting and treatment spaces must promote open and trusting interactions, helping patients take in information and maintain dignity.	• Natural light and views to be provided without compromising privacy • Good sound attenuation to waiting and public areas • Options to view information provided by consultant (e.g. movable monitor/screen) • Equivalency between patient and practitioner achieved by having the same furniture and relationship to the table and screen so no hierarchy in the relationship is set up • There must be space to gather yourself again after the consultation before stepping out into 'public'  

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*
	 
Criteria specific to people using day care services	
1.i Arriving at the day care areas must support dignity and independence for service users who may be particularly vulnerable and/or need high levels of predictability in their experience.	• Walking routes and drop-off facilities to same standards as 1a above, within calm quiet space (not busy with lots of people/traffic). It must not be necessary for service users to navigate through general parking or other large/complex/busy spaces to reach the entrance. • Entrance obvious from public street/space, but with distinct domestic identity to reduce chance of general public seeking to access services through it.
1.j Internal spaces must offer flexibility and choice in activity and environment, and the ability to personalise your environment. The design of the space must not place boundaries on individuals choices.	• From arrival point can see the range of spaces/activities on offer and choose where to go. • Spaces of different size/nature to allow boisterous activity, or quiet controlled space. • No clinical features, but staff visible from all areas so help is always visible. • Acoustic control and adaptable lighting/heating in every room.

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.k The internal and external spaces must work together to extend options for quiet respite or activity with options being clear, easy and understandable.	• Direct access from 'boisterous' internal spaces to gardens for activities/eating (shared only with other users of facility), with onward connection to community garden. • Direct access from quiet area to private respite gardens, other people must not be able to look in or access this uninvited.  

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.l Mealtimes are a key experience in the day and the calendar. The environment must enable these to be meaningful and engaging without raising anxieties or conflicts.	• Spaces for people to sit together, or individually, depending on personal choice. • Options for external eating should the occasion permit  

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*
	
Criteria specific to people staying overnight, be that one night or in a place that's their home.	
1.m Arrival at the residential area must feel discrete and homely, with a warm welcome. It must feel distinctly different to the more public areas described above	• Benchmarks as 1k above • Immediately on entering there must a place to be greeted by 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*
1.n The layout of the area must be enabling, encouraging you to be up and about as much as possible under your own steam and carrying out realistic day to day activities staying in control of your options and activities.	• Spaces to sit/gather informally within 15m of each bedroom, and larger more social spaces within 30m of each bedroom. These spaces to have daylight and views to interesting distractions (nature/birds from more private areas, public spaces/gardens from more communal areas to watch the world go by) • Access to external spaces as benchmarks for 1m above. Spaces designed with steps and other features to help people practice managing common obstacles in local built environment and engage in green therapy exercises. • Tea prep/kitchen facilities within 30m of rooms to enable people to prepare own refreshments/food as they wish • Eating facilities as 1l above  

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.o The place must enable you to stay in touch with family and friends, maintaining your social routines and place in the community.	• Social spaces as 1n above • Garden areas, and access routes, designed to allow visiting family and pets access without disturbing other residents. • Routes to village gardens/café etc as above to enable family to take you out on a trip.   
1.p Residents must be able to maintain regular activities that are important	• Spaces both within the 'home' environment and wider village for religious observance and to hold special events of different scales like birthday/Christmas parties, cinema screenings.

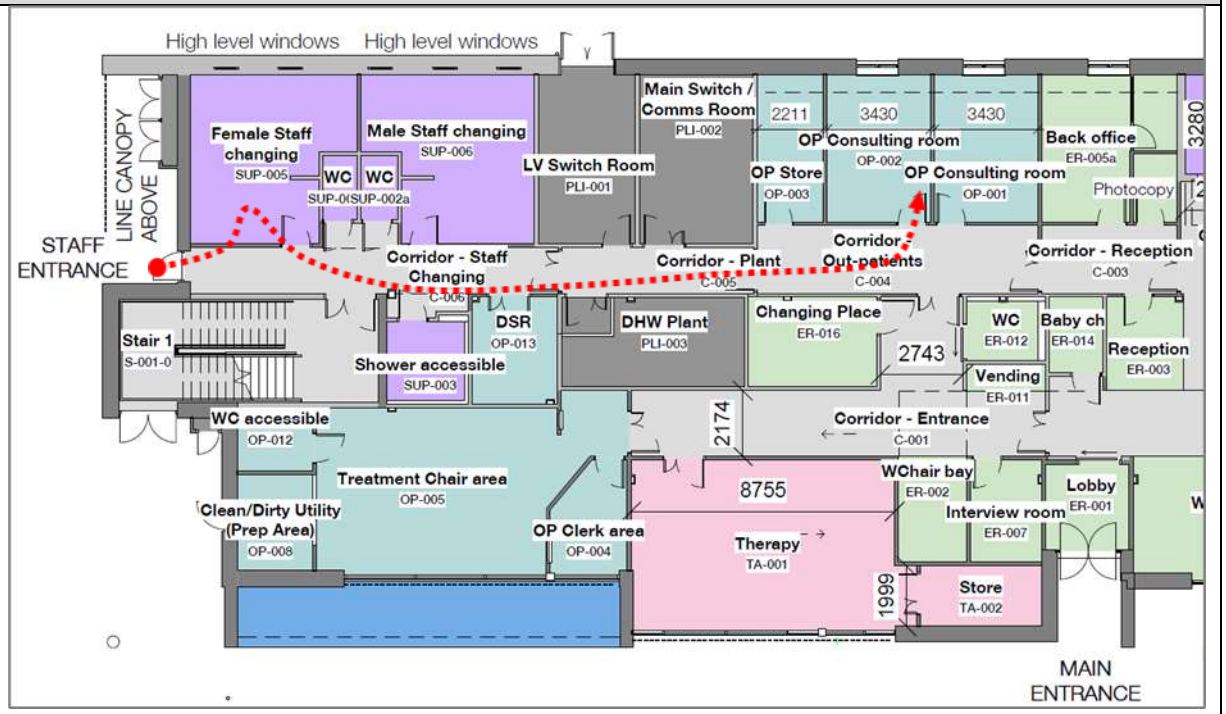
Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
to them or special ones which raise their spirits.	• Space for hairdressing and other personal care services to help maintain self esteem • Gardens and shared day spaces to have features/facilities that enable activities that are relevant for local population • Spaces out with the 'home' environment to be max 5 mins away and usable out of normal hours of other services.   
1.q The space(s) people live in daily must feel like their own space, where they're safe and not vulnerable to strangers.	• Layout should allow family/visitors/day service users to access communal areas without going past private bedrooms • Entrance to bedrooms designed with features to allow personalisation to aid recognition and comfort. • Building designed with option to join bedrooms to allow couples to live together on longer stays.

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.r Bedrooms must feel private, but not isolating, and provide personal control	• Windows with interesting, but not exposing, view from lying and seated position • Space to sit and carry out activities out of bed in comfy chair. Space for friends/family to sit in the room if visiting in social areas is not appropriate/wanted. • Homely interior design scheme considering wide age range of potential occupants • Ability to control light/temperature and views in from bed/seated. • Direct access to private external space from palliative care rooms and long-term residential rooms.

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) Non-Negotiables for Staff (all public and 3rd sector services, including those based on other sites)

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*
2a Getting to and from the facility must be easy and reliable considering different needs of shift and peripatetic workers.	• Reliable vehicular parking for staff, who may be working late at night / early morning, to same standards as 1a above, though max walking distance from parking may be increased to 75m. • Vehicular parking should have direct access/short routes to facility and be well lit. • 10% of total parking provision to be electric vehicle charging points, with infrastructure in place to provide more at a future date. Chargers must be placed at a height and location suitable for wheelchair users. • Drop off facility within 15m of discrete entrance with equipment store max 15m from entrance to allow quick transfer of materials without going through public areas. • There must be discrete and immediate egress for ambulances and clinicians on emergency calls, with sheltered parking for ambulances immediately adjacent to this entrance and on call staff parking max 20m from the same entrance (relevant to Thurso Hub only). • Changing facilities and safe storage of personal belongings close to route between arrival and working area. • Access to wider town amenities to enable exercise/shopping/banking etc as benchmark for 1c above  *Safe, well lit access*  *EV charging*  *Staff lockers on circulation route*

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*
	 *Staff changing facilities adjacent to staff entrance on route to work areas*
2b The layout of the hub must enable staff to come together to share information and build working relationships and practice	• Services and departments connected by 'non-public' routes so that staff can seek/provide help to other areas without going through main entrance and have short impromptu sensitive conversations away from public. • Like activities (training, office-based working, rest) provided all together, not split by employer or area of working within the hub. • Meeting areas immediately adjacent to residential service, and close to other services for regular staff meetings. These spaces to be away from public areas to enable confidential, uninterrupted meetings.

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*
	• Spaces for 2-3 people to come together for impromptu chats (convey and issue or pastoral support) without leaving working environment   
2c The layout of the hub, and specification of rooms, must allow flexibility of use.	• Circulation and consult/treatment rooms so that department/clinic sizes can flex and change without physical alteration • Standardised room layouts to enable multiple uses over time • Storage within 20m of rooms of equipment needed on daily basis
2d Working areas, away from public spaces, to convey welcoming, friendly, lively, modern and innovative culture.	• Mix of different types of spaces to enable agile and flexible working patterns • Access to daylight, external views and fresh air from office areas • Shape of space and choice of finishes/fittings to provide good acoustic environment • Wifi connectivity to allow flexible, agile working   

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*
2e Staff must be able to have time off duty to relax, refresh, meet their own personal needs and build social connections with colleagues.	• Shared social space available 24/7, within 5 mins walk of all working areas and not directly visible from public areas. Space must be in 'neutral' territory, not part of any one department or service so all feel they can use it. • Direct access to external space for breath of fresh air. • Space to store and prep food, with the capacity to deal with peak numbers at busy mealtimes. • Seating in a range of grouping and natures to allow people to choose a more social gathering or quieter corner.  

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*
	 
2f The layout of the hub must enable phased shut down so that heating/fire/evacuation etc can be managed within the parts that are open at the time.	• Access to 24/7 areas not through internal routes to day services. • Community/Meeting/group working/training areas to be able to operate without access through or to clinical areas, and without requiring these to be heated.

3) Non-Negotiables for Friends, Family and wider community

Most of the needs of these people will be met though the experiences for service users above, therefore only additional needs are listed below.

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*
3a Family and friends of residents must be enabled to take part in their care, and supported in their own needs	• Comforting, quiet space for confidential discussions with staff away from bedroom/social areas and to take time to themselves if needed  
3b Shared landscapes and amenities must encourage all members of the community in to use them	• Routes through the site and to amenities such as the growing space to be open and publicly accessible, with clear views to occupiable spaces on each part of the journey. • Spaces to be designed to encourage use for education and training at all ages

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) Alignment with Policy

The additional benefits to the community (not directly service related) sought from the investment and change.

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*
4a The location and design of the hub health and wellbeing village must support local business and public initiatives such as Wick townscape improvements.	• Joint planning with public sector agencies through NHS Highland participation in the Caithness Place-based Review process, working with public-sector agencies The Highland Council, Highlands & Islands Enterprise, Scottish Futures Trust, Scottish Fire & Rescue Service and Scottish Ambulance Service to look at Caithness as a place, and discuss and agree use of public assets jointly to benefit the community. Evidenced through notes of meetings and output documents. • Community stakeholder group set up to review proposals at key decision-making points (site selection, building design etc). Outcome recorded illustrating how design will be adapted in line with feedback received. • Proximity to existing business as 1d above • Entrance space and meeting room suite in 1d above designed to enable public and third sector use • Landscape design of hub, village and adjacent developments to be co-ordinated in terms of materials and uses so spaces between buildings read as one space, there's no physical barriers (other than for private gardens). Materials/services laid for one development must not need removing for another.
4b The released sites should be considered not only in their monetary value but in terms of how their redevelopment can be of benefit to the needs of the local community.	• Joint planning with local planning partners through NHS Highland participation in the Caithness Place-based Review process, as stated in 4a benchmarks above. • Maximise the potential for any sites to be released to ensure that their redevelopment will be of benefit to the local communities.
4c The facility will be designed to support the NHS Scotland commitment to being a 'net-zero'	• Appointment of project-specific Environment and Sustainability champion. • Value re-use of existing buildings as key criteria in site selection • Net Zero Carbon design brief informed by IES modelling and additional expertise brought in as required.

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*
greenhouse gas emissions organisation	• Application of and compliance with Sustainable Design and Construction (SDaC) Guide (SHTN 02-01). • Building design to achieve the aims set out in A Policy for NHS Scotland on the Climate Emergency and Sustainable Development – DL (2021) 38 and to support all focus areas of the NHS Climate Change and Sustainability Strategy 2020-2025. • Buildings designed to enable net zero greenhouse gas emissions by 2040 at the latest and heated from renewable sources by 2038 at the latest. • Building to achieve Net Zero Carbon objectives in operation through design of building fabric (airtightness), and renewable energy sources wherever possible. If renewable energy sources are not available now, the buildings will be designed with systems which can adapt to future sources e.g., district heating, hydrogen, heat pumps. • Buildings designed to optimise energy performance using climate projections to 2050. • Emissions minimised during construction, and construction site waste management plan in place. • Sustainability through linking into active travel networks, provision of bicycle storage and changing facility, and EV charging points. • Sustainability reviews carried out at key design stages and reviewed by the NHS Highland Sustainability Group. • Climate change risk assessment completed, and adaptation plan produced **Wellbeing** • Co-production of whole neighbourhood active travel strategy with partner and third sector organisations such as Transport Scotland, Sustrans, HITRANS and Cycling UK. Alignment of the design with agreed strategy will be evidenced in our proposals, and partner views will be sought at each decision-making stage, with key recommendations for improvement incorporated into the site design.

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*
	• NHSH health improvement team represented on Project Team and participates in development of service model, design brief, design development and AEDET and Design Statement reviews. Evidenced by meeting notes, attendee lists and outputs. • Site travel surveys carried out pre and post development (with input from partner organisations as above) to evidence improvement.
4d Equality and diversity to be embedded into all functions and activities in line with the Equality Act 2010.	• Facility designed to comply with the Equality Act 2010, Equality Specific Duties (Scotland) Regulations 2012 and its amendments, and British Standards for accessible environments e.g. BS 8300:2018 parts 1&2. • Project EQIA in place, to be reviewed and developed at each stage with appropriate stakeholders and published on project website. • Stakeholder groups to include representatives of people who are disadvantaged or discriminated against because of who they are, their protected characteristic, for example: age, disability, race, gender or transgender, religion or belief and sexual orientation. • Local access panel input to the design brief and design development workshops, and involvement in the assessment of the design through participation in AEDET and Design Statement reviews at key decision-making points. • Access and equality specific group set up to review project-specific access and equality issues in detail, and input to key stages of briefing and design development. • External access and equality consultant engaged for specialist advice and asked for written advice at key decision-making points. • Project Team guided by NHS Highland Equality Outcomes and Mainstreaming Report 2021. • Equality reviewed through NHS Highland's Principal Officer Health Inequalities, Equality and Diversity being engaged with the Project Team. • Project Communications and Engagement Plan reflects these objectives.

5) Self-Assessment Process

Decision Point	Authority	Additional Skills / Perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information required to allow evaluation
Site strategy	NHSH Board with advice from Programme Board	Caithness Place-based Review and agreed master strategy, Sustainable Design and Construction guide (SDaC), NHS Scotland Design Assessment Process (NDAP), external health care planner, external technical advisor. SDaC (SHTN 02-01) workshop(s) with sustainability consultants, Health Facilities Scotland and Design team prior to site selection.	Risk / benefit analysis of the capacity of the sites to deliver a development that meets the criteria identified above.	Site feasibility study based on best available information
Completion of brief	NHSH Programme Board with advice from Project Director and Senior Project Manager	Stakeholders, including health and care service providers and internal technical advisors, third sector and public sector partners. Clinical modelling supported by Healthcare Planner. Agreement on shared spaces with Independent GP practice, planning partners and third sector organisations.	This Design Statement should be integral to the design brief.	Early engagement with development partner (hub North Scotland Ltd) to assess the affordability / deliverability of the project brief. Use of AEDET, SDaC, KSAR & NDAP Design Statement to check that the brief meets the agreed criteria.

Decision Point	Authority	Additional Skills / Perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information required to allow evaluation
Selection of Delivery / Design Team	Development Partner (hNSL) with input from NHSH Project Managers	Development partner and stakeholders, including internal / external technical advisors	Selection process as per Development Partner Method Statements, including cost and quality considerations, to ensure that the best design team is chosen from the supply chain. NHSH will be involved in the selection process and can influence the outcome and, if necessary, nominate other designers for consideration	Previous experience / examples of work on developments of a similar nature and complexity. Interview process to include presentation and questions relating to design approach and the potential to meet the criteria set. Consideration given to quality criteria set.
Early design concept selected from options developed	NHSH Programme Board with advice from Project Team	Internal / external technical advisors, HFS input through NDAP, planning authority	Use of AEDET, SDaC, KSAR and NDAP to determine if the criteria are being met	Proposals developed to Stage 3 with enough detail to enable distinction between the main use types (including circulation and external space). Elevations/3D visuals
Approval of Design Proposals to be submitted to the Planning Authority	NHSH Programme Board with advice from Project Team	NDAP, The Highland Council Planning and Transport Departments	Use of AEDET, SDaC, KSAR and NDAP to determine if the criteria are being met	Selected Design to Stage 4, with elevations
Approval of detailed Design to allow Construction	NHSH Programme Board with advice from Project Team	In-house architectural team and internal / external technical advisors	Use of AEDET, SDaC, KSAR and NDAP to determine if the criteria are being met	Design developed to Stage 5 with agreed specification.

Decision Point	Authority	Additional Skills / Perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information required to allow evaluation
Post Occupancy Evaluation	Consideration by appropriate NHSH governance and report sent to SGHD	Independent analysis by service providers / stakeholders. Potential Third Party evaluation	Assessment of completed development by representatives of the stakeholder groups involved in establishing the assessment criteria (AEDET, Design Statement, KSAR, SDaC).	Post occupancy evaluation

This statement was developed through the engagement of the following stakeholders. A full list of attendees is provided in Appendix A:

- NHS Highland clinical and care staff including representatives from; Care Homes, Day Services, Community Mental Health, Learning Disabilities, Care at Home, Community Nursing, Occupational Therapy, Podiatry, Physiotherapy, Palliative and End of Life Care, Pharmacy, Dental Services, Health Improvement
- NHS Highland support staff; admin, hotel services, estates
- NHS Highland local operational managers and project managers
- Staff-side representative
- General Practices; Riverbank, Riverview and Pearson medical practice
- Partner agencies; Scottish Ambulance Service, Highlands and Islands Enterprise
- Third sector organisations; Laurandy Centre (older adult day services), Caithness Mental Health Group, Caithness Voluntary, Caithness Rural Transport
- Caithness Disability Access Panel
- Public and patient representatives, including CHAT

A list of applicable design guidance is provided is Appendix B.

Appendix A
List of Attendees for Design Statement / AEDET for Hub & Care Villages

Forename	Surname	Designation	Organisation	Role / Representing
Margaret	Allan	Manager	Laurandy Centre	Day Services - Older Adult
Sarah	Budge	Professional Lead	NHS Highland	Occupational Therapy
Ivor	Campbell	Estates Operations Manager	NHS Highland	Estates
Heather	Chapple	Director of Design	Architecture & Design Scotland	Facilitator
Gail	Clark	Manager	Thor House	Day Services - LD
Graham	Cormack	Acting Area Service Manager	SAS	Scottish Ambulance Service
Penny	Cormack	Care Home Manager	NHS Highland	Pulteney House Care Home
Angela	Edwards	Centres Manager	Caithness Mental Health Group	The Haven & Stepping Stones
Bill	Fernie	Public rep	CHAT	Service User
Diane	Forsyth	Senior Project Manager	NHS Highland	Senior Project Manager
Anne	Fraser	Mental Health Advanced Practitioner / Lead	NHS Highland	Community Mental Health
Pam	Garbe	Rural General Hospital Manager	NHS Highland	Project Lead (Supporting Services) / Wick T&C inpatients
Paul	Gilligan	Architect	Oberlanders	Facilitator
Eric	Green	Head of Estates	NHS Highland	Project Technical Lead
Joanna	Groves	Practice Manager	GP Practice	Riverview Medical Practice
Lynda	Gunn	Senior Charge Nurse	NHS Highland	Dunbar inpatients
Bev	Horton	Integrated Team Lead (East) / Mental Health Team Manager	NHS Highland	East Caithness Integrated Team / Mental Health
Danny	Hunter		Architecture & Design Scotland	Facilitator
Jane	Ingleby	Oral Health Improvement Co-ordinator	NHS Highland	Public Dental Service
Nova	James	Lead ANP / Clinical Co-ordinator	NHS Highland	

Forename	Surname	Designation	Organisation	Role / Representing
Dan	Jenkins	Health Promotion Officer	NHS Highland	Health Improvement / External Spaces
Michelle	Johnstone	Area Manager	NHS Highland	Project Director
Michael	Loynd	Macmillan Advanced Nurse / Cancer Team Lead	NHS Highland	Palliative & End of Life Care
Julie	Lewis	Deputy Manager	NHS Highland	Pulteney House Care Home
Cathy	MacKay	Day Care Manager, Bayview	NHS Highland	Couthie Corner Day Services
Tracy	MacKay	Assistant Manager	Laurandy Centre	Day Services - Older Adult
Chris	Mackenzie	Third sector	Caithness Mental Health Group	Third sector
Stephen	Makin	Consultant Geriatrician	NHS Highland	Medicine for the Elderly
Steve	Malone		Architecture & Design Scotland	Facilitator
Lesley	Martin	Care at Home Manager	NHS Highland	Project Lead (SPOA) / Care at Home
Julie	McGee	Senior Development Manager - Infrastructure	Highlands & Islands Enterprise	Community Planning Partner
Claire	McIntosh	Care Home Manager	NHS Highland	Bayview House Care Home
Heather	McLean	Public rep	Public	Service User - Thurso
Lindsay	Morrison	Integrated Team Lead (West)	NHS Highland	Caithness Integrated Teams
Catriona	Naughton	Practice Manager	GP Practice	Riverbank Medical Practice
Gordon	Nicoll	Team Leader	SAS	Scottish Ambulance Service
Christian	Nicolson	District Manager	NHS Highland	Senior Manager / Project Team / Integrated Team
Laura	O'Brien	Advanced Practitioner (West)	NHS Highland	Community Nursing
Shona	Paterson	Professional Lead	NHS Highland	Physiotherapy
Ewen	Pearson	General Practitioner	GP Practice	Pearson Practice
Eileen	Reed-Richardson	Associate Lead Nurse	NHS Highland	Project Lead (Education & Training) / Nurse Lead
Donna	Robertson	Hotel Services Manager	NHS Highland	Hotel Services
Morven	Shone	Project Manager	NHS Highland	PM (SPOA)
Hamish	Stewart	Professional Lead	NHS Highland	Podiatry

Forename	Surname	Designation	Organisation	Role / Representing
Allan	Tait	Third sector	Caithness Voluntary Groups	Caithness Voluntary Groups / Caithness Rural Transport / Caithness Access Panel
Zhen Ron	Tan	Project Manager	NHS Highland	PM (Estates)
Josie	Thomson	Clinical Advisor	NHS Highland	Project Clinical Advisor
Naomi	Watson	Project Manager	NHS Highland	PM (MDT)
Lyn	Wormald	Staff-side rep	NHS Highland	Staff side

Appendix B
Applicable Guidance - Community Hubs

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Links / Further info / Comments
3 - Highest		**Care Inspectorate** Building better care homes for adults - Design, planning and construction considerations for new or converted care homes for adults	2018	https://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf
3 - Highest	SHTN 02-01	Sustainability Design and Construction Guide	2021	
3 - Highest	BS8300-1:2018	Design of an accessible and inclusive built environment. Part 1: External environment - code of practice	2018	
3 - Highest	BS8300-2:2018	Design of an accessible and inclusive built environment. Part 2: Buildings - code of practice	2018	
3 - Highest	HBN 00-01	Core guidance - General design for healthcare buildings (HBN 00-01)	Oct-14	
2 - Normal	HBN 00-02	Core elements - Sanitary spaces (HBN 00-02)	Mar-17	
2 - Normal	HBN 00-03	Core guidance - Clinical and clinical support spaces (HBN 00-03)	Oct-14	
2 - Normal	HBN 00-04	Core Guidance - Circulation and communication spaces (HBN 00-04)	Oct-14	
3 - Highest	HBN 00-07	Core guidance - Planning for a resilient healthcare estate (HBN 00-07)	Oct-14	
2 - Normal	HBN 08-02	Dementia-friendly Health and Social Care Environments (HBN 08-02)	Aug-16	
2 - Normal	HBN 14-02	Medicines storage in clinical areas (HBN 14-02)	Sep-21	
2 - Normal	HBN 37	In-patient facilities for older people (HBN 37)	Oct-14	
2 - Normal	HTM 65	Wayfinding -effective wayfinding and signing for healthcare facilities (HTM 65)	Aug-16	
2 - Normal	SFPN 00-01	Fire safety - A model management structure (SFPN 00-01)	Apr-04	
2 - Normal	SFPN 3	Fire safety - Escape bed lifts (SFPN 3)	Oct-10	Depending on design
2 - Normal	SFPN 4	Fire Safety -Hospital main kitchens (SFPN 4)	Dec-99	Depending on outcome of catering model option appraisal
2 - Normal	SFPN 6	Fire safety - Prevention and control of deliberate fire-raising in healthcare premises (SFPN 6)	Dec-07	
2 - Normal	*SHFN 01-01*	*National Facilities Monitoring Framework Manual (SHFN 01-01)*	*Apr-21*	
2 - Normal	*SHFN 01-02*	*NHSScotland National Cleaning Services Specification - NCSS (SHFN 01-02)*	*Jun-16*	
2 - Normal	*SHFN 01-03*	*Implementation and Communication Plan NCSS (SHFN 01-03)*	*Dec-16*	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Links / Further info / Comments
2 - Normal	*SHFN 01-04*	*National average cleaning time (NACT) user guide (SHFN 01-04)*	*Apr-21*	
2 - Normal	*SHFN 01-05*	*Safe Management of the Care Environment (SHFN 01-05)*	*May-21*	
2 - Normal	SHFN 02	Access - Audit survey toolkit for disabled people in healthcare premises (SHFN 02)	Sep-07	
2 - Normal	*SHFN 02-01*	*Portering Services Standards for NHSScotland (SHFN 02-01)*	*Jun-21*	
2 - Normal	SHFN 03	Access - checklist for people with dementia in healthcare premises (SHFN 03)	Oct-07	
2 - Normal	*SHFN 03-01*	*Security - Management Framework for NHS Boards in Scotland (SHFN 03-01)*	*Dec-08*	
2 - Normal	*SHFN 03-02*	*Security - Services Standards for NHSScotland (SHFN 03-02)*	*Jul-21*	
2 - Normal	*SHFN 03-04*	*Security Lockdown - Controlling movement and access in healthcare facilities (SHFN 03-04)*	*Mar-20*	
2 - Normal	SHFN 04-01	Food in Hospitals (SHFN 04-01)	Mar-16	
2 - Normal	SHFN 04-03	Food Safety Assurance Manual (SHFN 04-03)	Mar-20	
2 - Normal	SHFN 04-04	Food Allergen Management (SHFN 04-04)	Mar-14	
2 - Normal	SHFN 14	Access - Disability (SHFN 14)	Sep-00	
2 - Normal	SHFN 20	Access - audits of primary healthcare facilities (SHFN 20)	Sep-00	
3 - Highest	SHFN 30 Part A	HAI-SCRIBE Manual information for project teams (SHFN 30 Part A)	Oct-14	
3 - Highest	SHFN 30 Part B	HAI-SCRIBE Implementation strategy and assessment process (SHFN 30 Part B)	Oct-14	
3 - Highest	SHFN 30 Part C	HAI-SCRIBE questionsets and checklists (SHFN 30 Part C)	Jan-15	
2 - Normal	SHPN 04-01	Adult in-patient facilities (SHPN 04-01)	Oct-10	
2 - Normal	SHPN 08	Rehabilitation services facilities (SHPN 08)	Jan-02	
2 - Normal	SHPN 16-01	Mortuary and Post Mortem Facilities (SHPN 16-01)	Nov-17	Storage facility only - no post-mortem
2 - Normal	SHPN 36 part 1	General Medical Practice Premises in Scotland (SHPN 36 part 1)	Jul-06	
2 - Normal	~~*SHPN 36 Part 2*~~	~~*NHS Dental Premises in Scotland (SHPN 36 Part 2)*~~	~~*Jul-06*~~	*Dental on site (Dunbar only) but no changes proposed to existing facility*

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Links / Further info / Comments
2 - Normal	SHPN 36 part 3	Community Pharmacy Premises in Scotland Providing NHS Pharmaceuticals (SHPN 36 part 3)	Aug-07	TBC
3 - Highest	SHTM 00	Best practice guidance for healthcare engineering policies and principles (SHTM 00)	Feb-13	
2 - Normal	SHTM 02-01 Part A	Medical Gas Pipeline Systems: Design installation validation and verification (SHTM 02-01 Part A)	Jun-12	
2 - Normal	SHTM 02-01 Part B	Medical Gas Pipeline Systems: Operational management (SHTM 02-01 Part B)	Jul-15	
2 - Normal	SHTM 03-01 Part A	Ventilation for Healthcare - Design and validation (SHTM 03-01 Part A)	Feb-14	
2 - Normal	SHTM 03-01 Part B	Ventilation for Healthcare - Operational and verification (SHTM 03-01 Part B)	Oct-11	
2 - Normal	SHTM 04-01 Part A	Water safety for healthcare- Design installation and testing (SHTM 04-01 Part A)	Jul-14	
2 - Normal	SHTM 04-01 Part B	Water safety for healthcare- Operational management (SHTM 04-01 Part B)	Jul-14	
2 - Normal	SHTM 04-01 Part C	Water safety for healthcare- TVC Testing Protocol (SHTM 04-01 Part C)	Feb-14	
2 - Normal	SHTM 04-01 Part D	Water safety for healthcare- Disinfection of domestic water systems (SHTM 04-01 Part D)	Aug-11	
2 - Normal	SHTM 04-01 Part E	Water safety for healthcare- Alternative materials and filtration (SHTM 04-01 Part E)	Aug-15	
2 - Normal	SHTM 04-01 Part F	Water safety for healthcare- Chloramination of water supplies (SHTM 04-01 Part F)	Dec-11	
2 - Normal	SHTM 04-01 Part G	Water safety for healthcare- Operational procedures and exemplar (SHTM 04-01 Part G)	Jul-15	
2 - Normal	SHTM 04-02 Part A	Water safety for emerging technologies - Solar domestic hot water heating (SHTM 04-02 Part A)	Jul-15	
2 - Normal	SHTM 04-02 Part B	Water safety for emerging technologies - Rainwater harvesting (SHTM 04-02 Part B)	Jul-15	

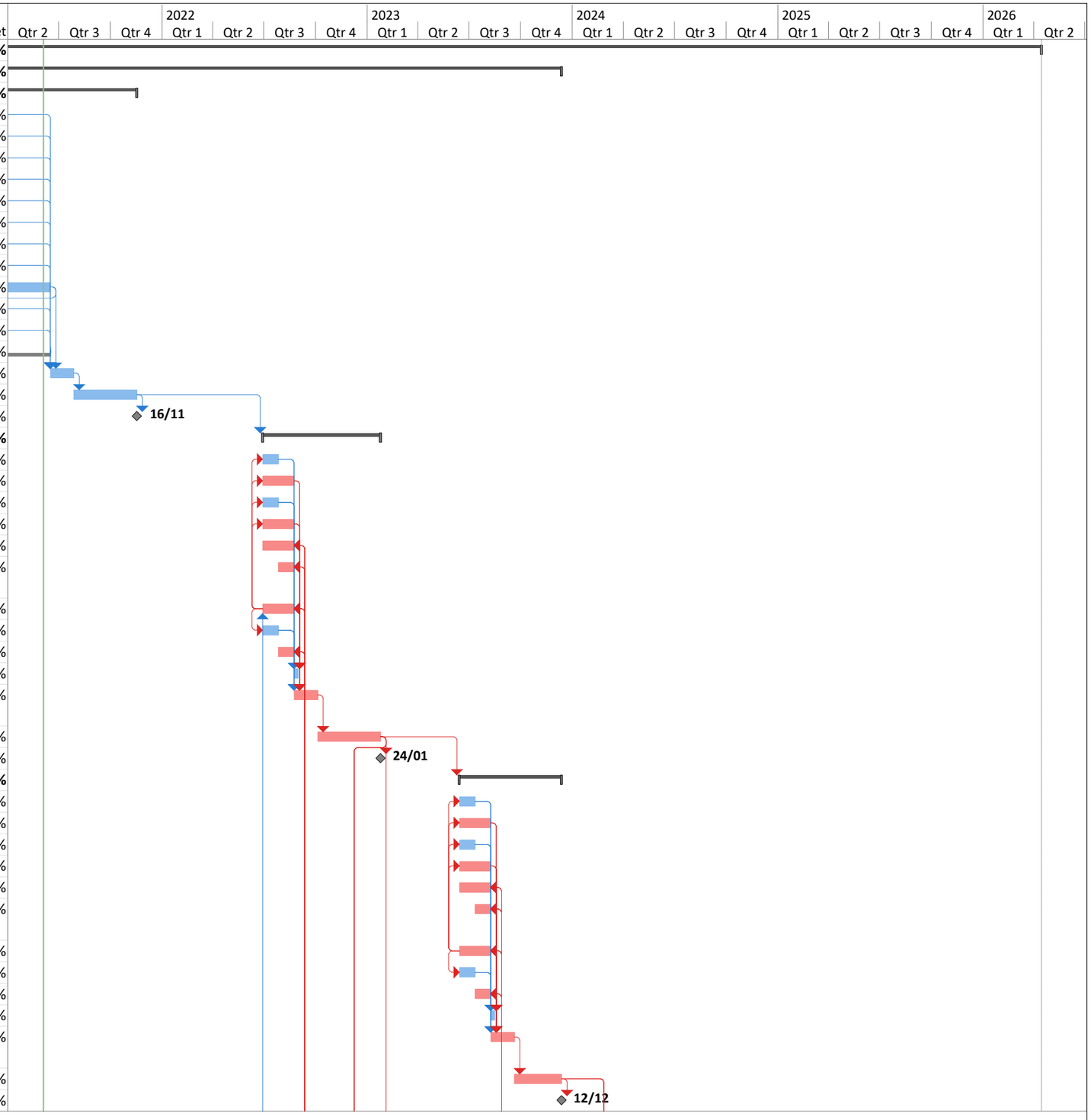
Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Links / Further info / Comments
2 - Normal	SHTM 04-02 Part C	Water safety for emerging technologies - Grey water recovery (SHTM 04-02 Part C)	Jul-15	
2 - Normal	SHTM 06-01 Part A	Electrical services supply and distribution: Design considerations (SHTM 06-01 Part A)	Jul-15	
2 - Normal	SHTM 06-01 Part B	Electrical services supply and distribution: Operational management (SHTM 06-01 Part B)	Jul-15	
2 - Normal	SHTM 06-02	Electrical safety guidance for Low Voltage systems (SHTM 06-02)	Jul-15	
2 - Normal	SHTM 06-03	Electrical safety guidance for High Voltage systems (SHTM 06-03)	Jul-15	
2 - Normal	SHTM 07-03	Transport management and car parking (SHTM 07-03)	Jan-08	
2 - Normal	SHTM 07-04	Transport - NHSScotland Travel Plan Guidance (SHTM 07-04)	Sep-07	
2 - Normal	SHTM 08-01	Specialist Services: Acoustics (SHTM 08-01)	Jul-15	TBC
2 - Normal	SHTM 08-02	Specialist Services - Lifts (SHTM 08-02)	Jul-15	
2 - Normal	SHTM 08-03	Specialist Services - Bedhead Services (SHTM 08-03)	Jul-11	
2 - Normal	SHTM 08-05 Part A	Building Management Systems: Overview and Management (SHTM 08-05 Part A)	Apr-12	
2 - Normal	SHTM 08-05 Part B	Building Management Systems: Design Considerations (SHTM 08-05 Part B)	Apr-12	
2 - Normal	SHTM 08-05 Part C	Building Management Systems: Validation and Verification (SHTM 08-05 Part C)	Apr-12	
2 - Normal	SHTM 08-05 Part D	Building Management Systems: Operational Management (SHTM 08-05 Part D)	Apr-12	
2 - Normal	SHTM 08-07	Confined Spaces policies procedures and guidance (SHTM 08-07)	Feb-15	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Links / Further info / Comments
2 - Normal	SHTM 08-08	Pressure Systems: Policies and Guidance (SHTM 08-08)	Jul-14	
2 - Normal	~~*SHTM 2022 Supp 1*~~	~~*Dental compressed air and vacuum systems (SHTM 2022 Supp 1)*~~	~~*Mar-04*~~	*Dental on site (Dunbar only) but no changes proposed to existing facility*
2 - Normal	SHTM 2035 Part 1	Mains signaling - Overview and management (SHTM 2035 Part 1)	Jun-01	
2 - Normal	SHTM 2035 Part 2	Mains signalling - Design considerations (SHTM 2035 Part 2)	Jun-01	
2 - Normal	SHTM 2035 Part 3	Mains signalling - Validation and verification / operation (SHTM 2035 Part 3)	Jun-01	
2 - Normal	SHTM 54	Building component series -User manual (SHTM 54)	Dec-06	
2 - Normal	SHTM 55	Building component series -Windows (SHTM 55)	Dec-06	
2 - Normal	SHTM 56	Building component series - Partitions (SHTM 56)	Dec-06	
2 - Normal	SHTM 57	Building component series - Internal glazing (SHTM 57)	Dec-06	
2 - Normal	SHTM 58	Building component series - Internal doorsets (SHTM 58)	Dec-06	
2 - Normal	SHTM 59	Building component series - Ironmongery (SHTM 59)	Dec-06	
2 - Normal	SHTM 60	Building Component Series - Ceilings (SHTM 60)	Oct-09	
2 - Normal	SHTM 61	Building component series - Flooring (SHTM 61)	Jul-09	
2 - Normal	SHTM 61 app 1a	Building component series - Flooring - matrix_example xls (SHTM 61 app 1a)	Jul-09	
2 - Normal	SHTM 62	Building component series - Demountable storage systems (SHTM 62)	Dec-06	
2 - Normal	SHTM 63	Building component series - Fitted storage systems (SHTM 63)	Dec-06	
2 - Normal	SHTM 64	Building Component Series – Sanitary assemblies (SHTM 64)	Dec-09	
2 - Normal	SHTM 66	Building component series - Cubicle curtain track (SHTM 66)	Dec-06	
2 - Normal	SHTM 69	Building component series - Protection (SHTM 69)	Dec-06	
2 - Normal	SHTM 81 part 1	Fire safety - Precautions in new healthcare premises (SHTM 81 part 1)	Jul-09	
2 - Normal	SHTM 81 part 2	Fire safety - Fire engineering of healthcare premises (SHTM 81 part 2)	Jul-09	
2 - Normal	SHTM 81 part 3	Fire safety - Atria in healthcare premises (SHTM 81 part 3)	Apr-13	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Links / Further info / Comments
2 - Normal	SHTM 82	Fire safety - alarm and detection systems (SHTM 82)	Apr-13	
2 - Normal	SHTM 83	Fire safety - General fire precautions in healthcare premises (SHTM 83)	Apr-04	
2 - Normal	SHTM 83 Part 2	Fire Safety - Fire safety training (SHTM 83 Part 2)	Jul-17	
2 - Normal	SHTM 84	Fire safety - Risk assessment in residential care premises (SHTM 84)	Apr-03	
2 - Normal	SHTM 85	Fire safety - Precautions in existing healthcare premises (SHTM 85)	Dec-07	
2 - Normal	SHTM 86	Fire safety - Risk assessment (SHTM 86)	Jun-13	
2 - Normal	SHTM 87	Fire safety - Textiles and furniture (SHTM 87)	Aug-09	
2 - Normal	SHTN 00-01	Property Appraisal Manual -PAMS (SHTN 00-01)	Mar-21	
2 - Normal	SHTN 00-02	Strategic property and asset management guidance for NHSScotland - PAMS (SHTN 00-02)	Nov-10	
2 - Normal	SHTN 00-03	Property appraisal guidance for NHSScotland - PAMS - Risk-based methodology (SHTN 00-03)	Nov-10	
2 - Normal	SHTN 00-04	Guidance on Management of Medical Devices and Equipment (SHTN 00-04)	Jun-21	
2 - Normal	SHTN 02-00	Sustainable Development Strategy (SHTN 02-00)	Feb-12	
2 - Normal	SHTN 02-01	Sustainable Design and Construction	Oct-21	
2 - Normal	SHTN 02-02	Sustainable - EV Charging Infrastructure (SHTN 02-02)	Dec-20	
2 - Normal	SHTN 3	Waste management - Segregation Chart (SHTN 3)	Nov-13	
2 - Normal	SHTN 3 Part A	Waste management - Summary of requirements - best practice overview (SHTN 3 Part A)	Feb-15	
2 - Normal	SHTN 3 Part B	Waste management - Policy template (SHTN 3 Part B)	Feb-15	
2 - Normal	SHTN 3 Part C	Waste management - Compendium of regulatory requirements (SHTN 3 Part C)	Feb-15	
2 - Normal	SHTN 3 Part D	Waste management - Guidance and example text for waste procedures (SHTN 3 Part D)	Feb-15	
2 - Normal	GUID 5006	Decontamination - Carriage of Dangerous Goods Regulations for Used Medical Devices (GUID 5006)	Dec-13	
2 - Normal	GUID 5007	Decontamination - Compliant Podiatry Instruments (GUID 5007)	Mar-20	

Project Applicability	Reference ID	Relevant NHS / Care Facility Guidance Document	Date Published	Links / Further info / Comments
2 - Normal	GUID 5008	Decontamination - Disposal and Recycling of Medical Devices (GUID 5008)	Oct-14	

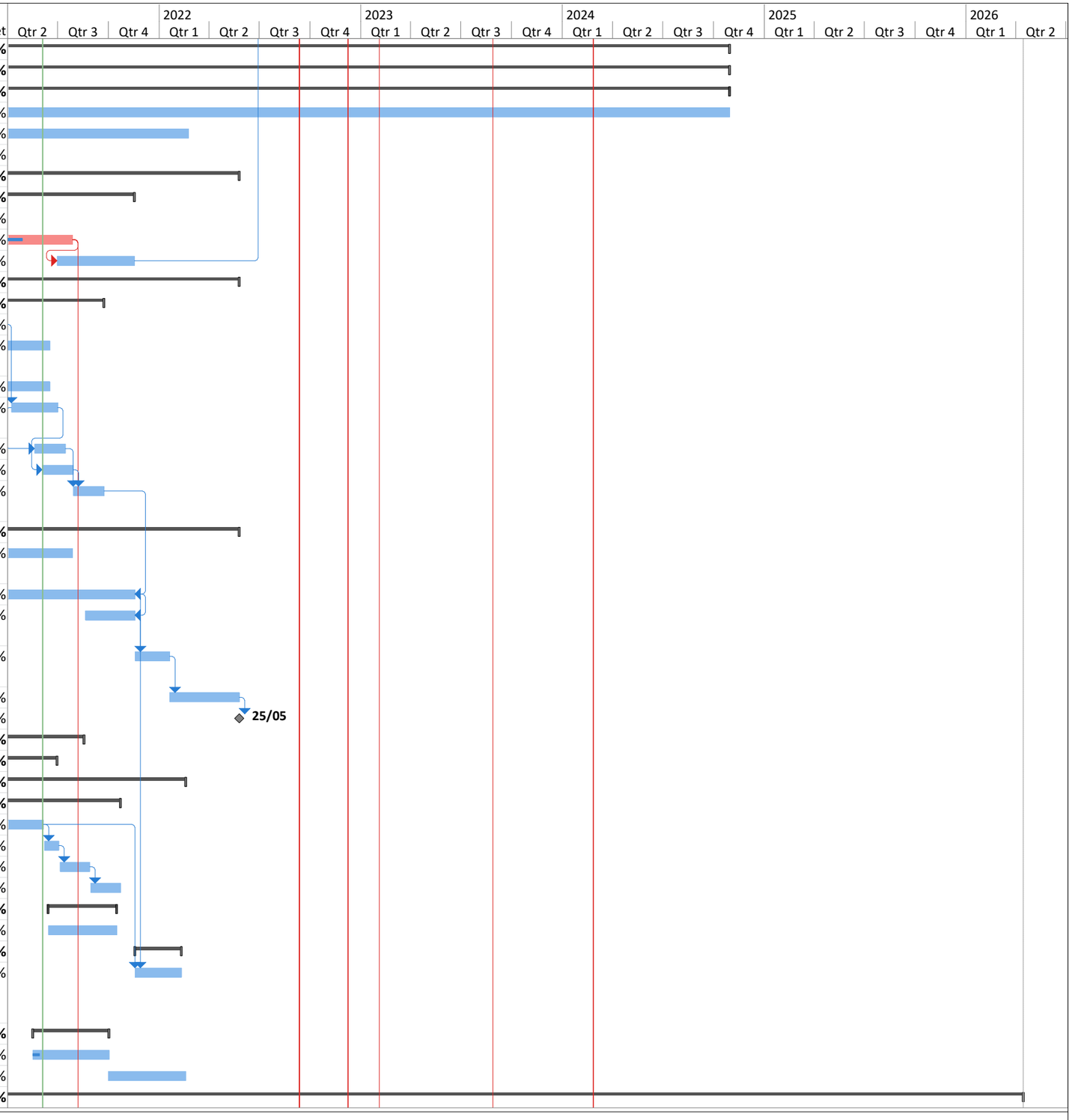
ID	Task Mod	Task Name	Duration	Start	Finish	% Complet
1		**Caithness Redesign**	**1592 days**	**Mon 09/03/20**	**Tue 14/04/26**	**15%**
2		**Business Case**	**970 days**	**Wed 25/03/20**	**Tue 12/12/23**	**32%**
3		**Initial Agreement**	**430 days**	**Wed 25/03/20**	**Tue 16/11/21**	**54%**
4		IA - describe current arrangements	40 days	Wed 25/03/20	Tue 19/05/20	100%
5		IA - case for change	60 days	Wed 25/03/20	Tue 16/06/20	90%
6		IA - investment objectives	40 days	Wed 25/03/20	Tue 19/05/20	100%
7		IA - benefits register; measures & targets	40 days	Wed 25/03/20	Tue 19/05/20	80%
8		IA - risk register	40 days	Wed 25/03/20	Tue 19/05/20	100%
9		IA - economic case / option appraisal / pref	240 days	Wed 25/03/20	Tue 23/02/21	80%
10		IA - AEDET & Design Statement	40 days	Wed 25/03/20	Tue 19/05/20	95%
11		IA - commercial case	20 days	Wed 25/03/20	Tue 21/04/20	95%
12		IA - financial case & external partners	320 days	Wed 25/03/20	Tue 15/06/21	10%
13		IA - management case	40 days	Wed 25/03/20	Tue 19/05/20	80%
14		IA - programme	40 days	Wed 25/03/20	Tue 19/05/20	90%
15		IA - exec summary	5 days	Wed 24/02/21	Wed 16/06/21	95%
16		IA - review, comment, collate & format	30 days	Wed 16/06/21	Tue 27/07/21	0%
17		IA - governance / NHSHB / CIG	80 days	Wed 28/07/21	Tue 16/11/21	0%
18		Initial Agreement Approved	0 days	Tue 16/11/21	Tue 16/11/21	0%
19		**Outline Business Case**	**150 days**	**Wed 29/06/22**	**Tue 24/01/23**	**0%**
20		OBC - strategic case	20 days	Wed 29/06/22	Tue 26/07/22	0%
21		OBC - benefits register & plan	40 days	Wed 29/06/22	Tue 23/08/22	0%
22		OBC - risk register	20 days	Wed 29/06/22	Tue 26/07/22	0%
23		OBC - economic case	40 days	Wed 29/06/22	Tue 23/08/22	0%
24		OBC - AEDET & Design Statement	40 days	Wed 29/06/22	Tue 23/08/22	0%
25		OBC - commercial case, procurement route	20 days	Wed 27/07/22	Tue 23/08/22	0%
26		OBC - financial case & external partners	40 days	Wed 29/06/22	Tue 23/08/22	0%
27		OBC - management case	20 days	Wed 29/06/22	Tue 26/07/22	0%
28		OBC - programme	20 days	Wed 27/07/22	Tue 23/08/22	0%
29		OBC - exec summary	5 days	Wed 24/08/22	Tue 30/08/22	0%
30		OBC - review, comment, collate & format	30 days	Wed 24/08/22	Tue 04/10/22	0%
31		OBC - governance / NHSHB / CIG	80 days	Wed 05/10/22	Tue 24/01/23	0%
32		Outline Business Case Approved	0 days	Tue 24/01/23	Tue 24/01/23	0%
33		**Full Business Case**	**130 days**	**Wed 14/06/23**	**Tue 12/12/23**	**0%**
34		FBC - strategic case	20 days	Wed 14/06/23	Tue 11/07/23	0%
35		FBC - benefits register & plan	40 days	Wed 14/06/23	Tue 08/08/23	0%
36		FBC - risk register	20 days	Wed 14/06/23	Tue 11/07/23	0%
37		FBC - economic case	40 days	Wed 14/06/23	Tue 08/08/23	0%
38		FBC - AEDET & Design Statement	40 days	Wed 14/06/23	Tue 08/08/23	0%
39		FBC - commercial case, procurement route	20 days	Wed 12/07/23	Tue 08/08/23	0%
40		FBC - financial case & external partners	40 days	Wed 14/06/23	Tue 08/08/23	0%
41		FBC - management case	20 days	Wed 14/06/23	Tue 11/07/23	0%
42		FBC - programme	20 days	Wed 12/07/23	Tue 08/08/23	0%
43		FBC - exec summary	5 days	Wed 09/08/23	Tue 15/08/23	0%
44		FBC - review, comment, collate & format	30 days	Wed 09/08/23	Tue 19/09/23	0%
45		FBC - governance / NHSHB / CIG	60 days	Wed 20/09/23	Tue 12/12/23	0%
46		Full Business Case Approved	0 days	Tue 12/12/23	Tue 12/12/23	0%



Project: Caithness Redesign IA Sta
Date: Fri 04/06/21

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline	Manual Progress
Split	External Tasks	Inactive Summary	Manual Summary	Critical	Slippage
Milestone	External Milestone	Manual Task	Start-only	Critical Split	
Summary	Inactive Task	Duration-only	Finish-only	Progress	

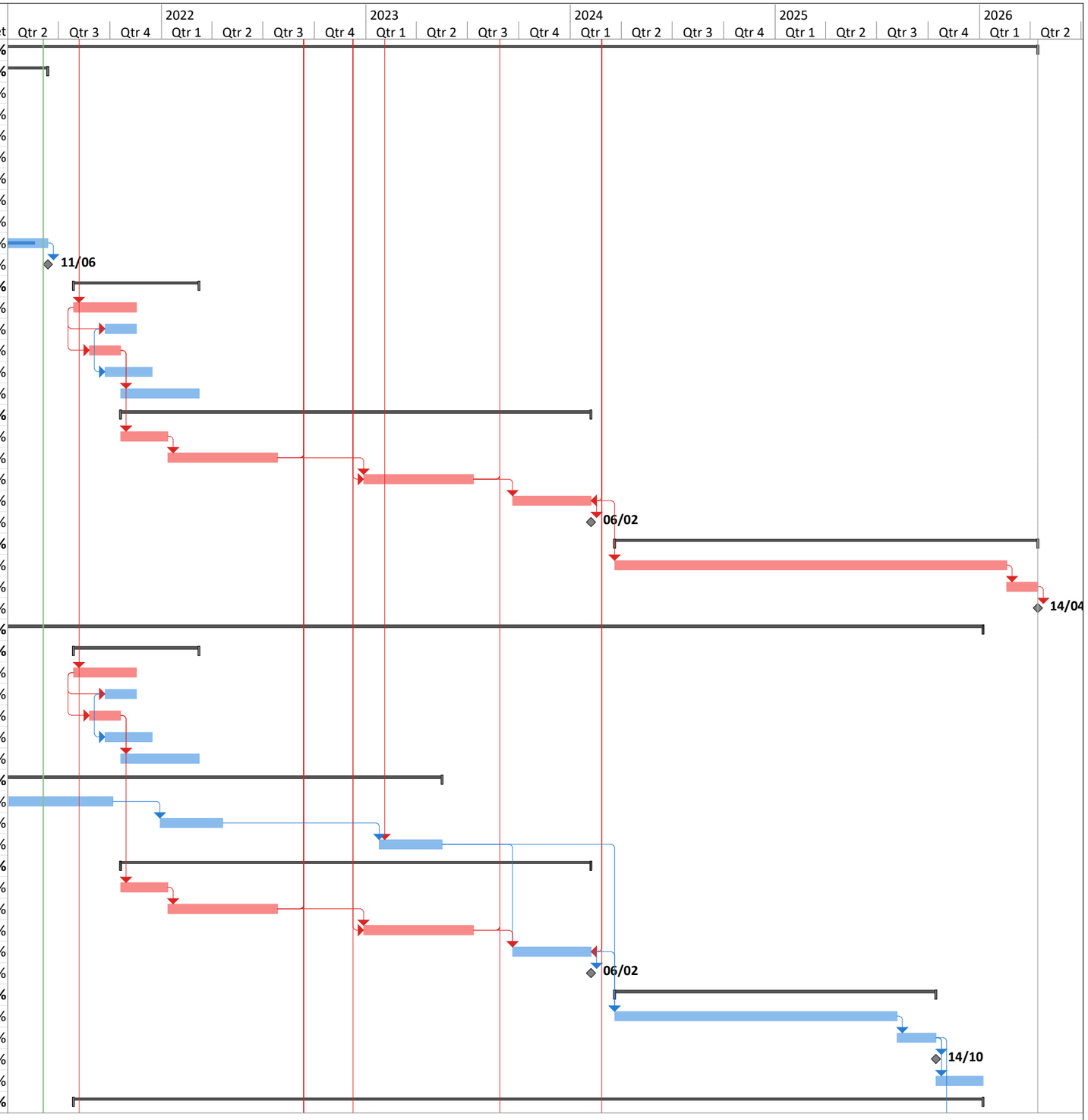
ID	Task Mod	Task Name	Duration	Start	Finish	% Complet
47		**Project Admin**	**1200 days**	**Wed 25/03/20**	**Tue 29/10/24**	**10%**
48		**Meetings**	**1200 days**	**Wed 25/03/20**	**Tue 29/10/24**	**0%**
52		**Comms & Engagement**	**1200 days**	**Wed 25/03/20**	**Tue 29/10/24**	**28%**
53		Comms & Engagement	1200 days	Wed 25/03/20	Tue 29/10/24	20%
54		Film production	500 days	Wed 25/03/20	Tue 22/02/22	15%
55		EQIA	215 days	Mon 01/06/20	Fri 26/03/21	100%
56		**Service Model**	**566 days**	**Wed 25/03/20**	**Wed 25/05/22**	**14%**
57		**Service Model**	**430 days**	**Wed 25/03/20**	**Tue 16/11/21**	**66%**
58		Data analysis / activity modelling	220 days	Wed 25/03/20	Tue 26/01/21	100%
59		Detailed service model	170 days	Wed 02/12/20	Tue 27/07/21	62%
60		Workforce plan	100 days	Wed 30/06/21	Tue 16/11/21	0%
61		**Multidisciplinary Team**	**566 days**	**Wed 25/03/20**	**Wed 25/05/22**	**0%**
62		**MDT - Patient identification**	**391 days**	**Wed 25/03/20**	**Wed 22/09/21**	**0%**
63		Obtain support from data protection offi	1 day	Wed 25/03/20	Wed 25/03/20	100%
64		Establish info sharing agreement with GP practices	240 days	Thu 16/07/20	Wed 16/06/21	0%
65		Establish info sharing agreement with LIS	240 days	Thu 16/07/20	Wed 16/06/21	0%
66		GP practices to begin coding patients for frailty	60 days	Thu 08/04/21	Wed 30/06/21	0%
67		GP practice training by LIST	40 days	Thu 20/05/21	Wed 14/07/21	0%
68		Data analysis by LIST	40 days	Thu 03/06/21	Wed 28/07/21	0%
69		eFrailty reports (using SPIRE) run routinely by GP practices	40 days	Thu 29/07/21	Wed 22/09/21	0%
70		**MDT Process**	**566 days**	**Wed 25/03/20**	**Wed 25/05/22**	**0%**
71		Develop function with SPOA & Supporting Services	350 days	Wed 25/03/20	Tue 27/07/21	0%
72		Develop service model & MDT processes	265 days	Thu 12/11/20	Wed 17/11/21	0%
73		Implement trial of MDT working in one GP practice	64 days	Fri 20/08/21	Wed 17/11/21	0%
74		Evaluate MDT working & make necessary changes	45 days	Thu 18/11/21	Wed 19/01/22	0%
75		Expand MDT working across Caithness	90 days	Thu 20/01/22	Wed 25/05/22	0%
76		MDT working in place	0 days	Wed 25/05/22	Wed 25/05/22	0%
77		**Single Point of Access**	**365 days**	**Wed 25/03/20**	**Tue 17/08/21**	**10%**
82		**Supporting Services**	**330 days**	**Wed 25/03/20**	**Tue 29/06/21**	**8%**
88		**eHealth**	**284 days**	**Mon 18/01/21**	**Thu 17/02/22**	**2%**
89		**Establish project resourcing**	**200 days**	**Mon 18/01/21**	**Fri 22/10/21**	**0%**
90		Map out digital requirements of project	100 days	Mon 18/01/21	Fri 04/06/21	0%
91		Confirm resource requirements	20 days	Mon 07/06/21	Fri 02/07/21	0%
92		Establish funding	40 days	Mon 05/07/21	Fri 27/08/21	0%
93		Recruitment	40 days	Mon 30/08/21	Fri 22/10/21	0%
94		**Electronic Patient Record**	**90 days**	**Mon 14/06/21**	**Fri 15/10/21**	**0%**
95		MORSE roll out	90 days	Mon 14/06/21	Fri 15/10/21	0%
96		**MDT systems**	**60 days**	**Thu 18/11/21**	**Wed 09/02/22**	**0%**
97		eHealth system to support patient identification & MDT working	60 days	Thu 18/11/21	Wed 09/02/22	0%
98		**Standardisation of documentation**	**100 days**	**Mon 17/05/21**	**Fri 01/10/21**	**10%**
99		Nursing & AHP	100 days	Mon 17/05/21	Fri 01/10/21	10%
100		Scanning of hospital records	100 days	Fri 01/10/21	Thu 17/02/22	0%
101		**Premises**	**1592 days**	**Mon 09/03/20**	**Tue 14/04/26**	**17%**



Project: Caithness Redesign IA Sta
Date: Fri 04/06/21

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline	Manual Progress
Split	External Tasks	Inactive Summary	Manual Summary	Critical	Slippage
Milestone	External Milestone	Manual Task	Start-only	Critical Split	
Summary	Inactive Task	Duration-only	Finish-only	Progress	

ID	Task Mod	Task Name	Duration	Start	Finish	% Complet
102		**Caithness General Hospital**	**1580 days**	**Wed 25/03/20**	**Tue 14/04/26**	**19%**
103		**CGH - Phase 1**	**318 days**	**Wed 25/03/20**	**Fri 11/06/21**	**94%**
104		Funding confirmed	33 days	Wed 25/03/20	Fri 08/05/20	100%
105		Develop & agree scope	20 days	Mon 11/05/20	Fri 05/06/20	100%
106		Concept design	20 days	Mon 08/06/20	Fri 03/07/20	100%
107		Design & scope approval	20 days	Mon 06/07/20	Fri 31/07/20	100%
108		Prepare tender packages	70 days	Mon 03/08/20	Fri 06/11/20	100%
109		Tenders & evaluation	50 days	Mon 09/11/20	Fri 15/01/21	100%
110		Appoint contractors	20 days	Mon 18/01/21	Fri 12/02/21	100%
111		Construction (phased)	85 days	Mon 15/02/21	Fri 11/06/21	79%
112		CGH phase 1 complete	0 days	Fri 11/06/21	Fri 11/06/21	0%
113		**CGH - Brief**	**160 days**	**Wed 28/07/21**	**Tue 08/03/22**	**0%**
114		CGH - clinical requirements	80 days	Wed 28/07/21	Tue 16/11/21	0%
115		CGH - non-clinical requirements	40 days	Wed 22/09/21	Tue 16/11/21	0%
116		CGH - SoA / Adjacencies	40 days	Wed 25/08/21	Tue 19/10/21	0%
117		CGH - ACRs (technical requirements)	60 days	Wed 22/09/21	Tue 14/12/21	0%
118		CGH - Room Data Sheets	100 days	Wed 20/10/21	Tue 08/03/22	0%
119		**CGH - Procurement / Design**	**600 days**	**Wed 20/10/21**	**Tue 06/02/24**	**0%**
120		CGH - engage development partner	60 days	Wed 20/10/21	Tue 11/01/22	0%
121		CGH - Concept design	140 days	Wed 12/01/22	Tue 26/07/22	0%
122		CGH - Detailed design	140 days	Wed 28/12/22	Tue 11/07/23	0%
123		CGH - Contract close	100 days	Wed 20/09/23	Tue 06/02/24	0%
124		CGH contract close complete	0 days	Tue 06/02/24	Tue 06/02/24	0%
125		**CGH Construction / Occupation**	**540 days**	**Wed 20/03/24**	**Tue 14/04/26**	**0%**
126		CGH - construction (refurb)	500 days	Wed 20/03/24	Tue 17/02/26	0%
127		CGH - Occupation	40 days	Wed 18/02/26	Tue 14/04/26	0%
128		CGH refurb fully operational	0 days	Tue 14/04/26	Tue 14/04/26	0%
129		**Wick Hub**	**1510 days**	**Wed 25/03/20**	**Tue 06/01/26**	**2%**
130		**Wick Hub Brief**	**160 days**	**Wed 28/07/21**	**Tue 08/03/22**	**0%**
131		Wick hub - clinical requirements	80 days	Wed 28/07/21	Tue 16/11/21	0%
132		Wick hub - non-clinical requirements	40 days	Wed 22/09/21	Tue 16/11/21	0%
133		Wick hub - SoA / Adjacencies	40 days	Wed 25/08/21	Tue 19/10/21	0%
134		Wick hub - ACRs (technical requirements	60 days	Wed 22/09/21	Tue 14/12/21	0%
135		Wick hub - Room Data Sheets	100 days	Wed 20/10/21	Tue 08/03/22	0%
136		**Wick Hub Site**	**820 days**	**Wed 25/03/20**	**Tue 16/05/23**	**7%**
137		Wick site - Options process	400 days	Wed 25/03/20	Tue 05/10/21	10%
138		Wick site - detailed technical appraisal /	80 days	Wed 29/12/21	Tue 19/04/22	0%
139		Wick site - legals / procurement	80 days	Wed 25/01/23	Tue 16/05/23	0%
140		**Wick Hub Procurement / Design**	**600 days**	**Wed 20/10/21**	**Tue 06/02/24**	**0%**
141		Wick hub - engage development partner	60 days	Wed 20/10/21	Tue 11/01/22	0%
142		Wick hub - Concept design	140 days	Wed 12/01/22	Tue 26/07/22	0%
143		Wick hub - Detailed design	140 days	Wed 28/12/22	Tue 11/07/23	0%
144		Wick hub - Contract close	100 days	Wed 20/09/23	Tue 06/02/24	0%
145		Wick Hub contract close complete	0 days	Tue 06/02/24	Tue 06/02/24	0%
146		**Wick Hub Construction / Occupation**	**410 days**	**Wed 20/03/24**	**Tue 14/10/25**	**0%**
147		Wick Hub Construction / Commissioning	360 days	Wed 20/03/24	Tue 05/08/25	0%
148		Wick Hub - Occupation	50 days	Wed 06/08/25	Tue 14/10/25	0%
149		Wick Hub Operational	0 days	Tue 14/10/25	Tue 14/10/25	0%
150		Disposal - Wick surplus buildings	60 days	Wed 15/10/25	Tue 06/01/26	0%
151		**Thurso Hub**	**1160 days**	**Wed 28/07/21**	**Tue 06/01/26**	**0%**



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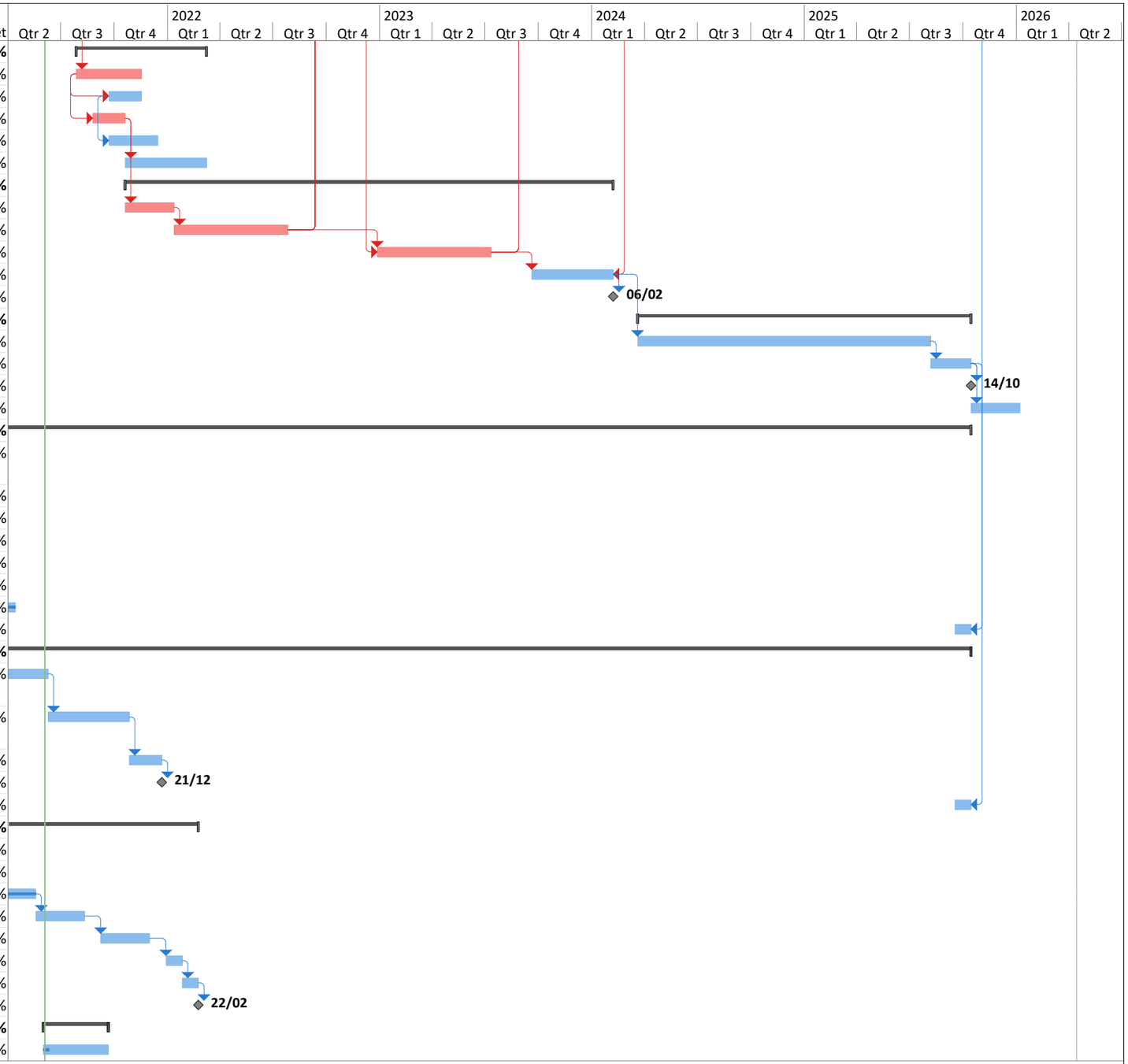
Date: Fri 04/06/21

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline	Manual Progress
Split	External Tasks	Inactive Summary	Manual Summary	Critical	Slippage
Milestone	External Milestone	Manual Task	Start-only	Critical Split	
Summary	Inactive Task	Duration-only	Finish-only	Progress	

ID	Task Mod	Task Name	Duration	Start	Finish	% Complet
152		**Thurso Hub brief**	**160 days**	**Wed 28/07/21**	**Tue 08/03/22**	**0%**
153		Thurso Hub - clinical requirements	80 days	Wed 28/07/21	Tue 16/11/21	0%
154		Thurso Hub - non-clinical requirements	40 days	Wed 22/09/21	Tue 16/11/21	0%
155		Thurso Hub - SoA / Adjacencies	40 days	Wed 25/08/21	Tue 19/10/21	0%
156		Thurso Hub - ACRs (technical requiremen	60 days	Wed 22/09/21	Tue 14/12/21	0%
157		Thurso Hub - Room Data Sheets	100 days	Wed 20/10/21	Tue 08/03/22	0%
158		**Thurso Hub Procurement / Design**	**600 days**	**Wed 20/10/21**	**Tue 06/02/24**	**0%**
159		Thurso Hub - engage development partn	60 days	Wed 20/10/21	Tue 11/01/22	0%
160		Thurso Hub - Concept Design	140 days	Wed 12/01/22	Tue 26/07/22	0%
161		Thurso Hub - Detailed design	140 days	Wed 28/12/22	Tue 11/07/23	0%
162		Thurso Hub - Contract close	100 days	Wed 20/09/23	Tue 06/02/24	0%
163		Thurso hub contract close complete	0 days	Tue 06/02/24	Tue 06/02/24	0%
164		**Thurso Hub Construction / Occupation**	**410 days**	**Wed 20/03/24**	**Tue 14/10/25**	**0%**
165		Construction - Thurso Hub	360 days	Wed 20/03/24	Tue 05/08/25	0%
166		Occupation - Thurso Hub	50 days	Wed 06/08/25	Tue 14/10/25	0%
167		Thurso Hub Operational	0 days	Tue 14/10/25	Tue 14/10/25	0%
168		Disposal - Thurso surplus buildings	60 days	Wed 15/10/25	Tue 06/01/26	0%
169		**West Community Team**	1462 days	Mon 09/03/20	Tue 14/10/25	**94%**
170		Teams vacate Davidson's Lane to temporary accommodation	0 days	Mon 09/03/20	Mon 09/03/20	100%
171		WSH Lease signed	0 days	Mon 20/04/20	Mon 20/04/20	100%
172		WSH - Community nurses interim move	20 days	Wed 25/03/20	Tue 21/04/20	100%
173		WSH - Permanent IT & phone connection	30 days	Wed 22/04/20	Tue 02/06/20	100%
174		WSH - remaining teams relocate	15 days	Wed 03/06/20	Tue 23/06/20	100%
175		William Smith House fully operational	0 days	Tue 23/06/20	Tue 23/06/20	100%
176		Davidson's Lane - disposal	255 days	Wed 22/04/20	Tue 13/04/21	100%
177		Move to Thurso Hub	20 days	Wed 17/09/25	Tue 14/10/25	0%
178		**East Community Integrated Team**	**1385 days**	**Wed 24/06/20**	**Tue 14/10/25**	**0%**
179		East Community Team - options for interim move	250 days	Wed 24/06/20	Tue 08/06/21	0%
180		East Community Team - progress preferred option	100 days	Wed 09/06/21	Tue 26/10/21	0%
181		East Community Team - interim move	40 days	Wed 27/10/21	Tue 21/12/21	0%
182		East CIT base operational	0 days	Tue 21/12/21	Tue 21/12/21	0%
183		Move to Wick Hub	20 days	Wed 17/09/25	Tue 14/10/25	0%
184		**Pulteney House Step up beds**	**500 days**	**Wed 25/03/20**	**Tue 22/02/22**	**67%**
185		PH - SBAR	75 days	Wed 25/03/20	Tue 07/07/20	100%
186		PH - governance / approvals	50 days	Wed 03/06/20	Tue 11/08/20	100%
187		PH - project set up (Highland Council)	200 days	Wed 12/08/20	Tue 18/05/21	100%
188		PH - Concept Design	60 days	Wed 19/05/21	Tue 10/08/21	0%
189		PH - Detailed Design	60 days	Wed 08/09/21	Tue 30/11/21	0%
190		PH - Construction	20 days	Wed 29/12/21	Tue 25/01/22	0%
191		PH - Occupation	20 days	Wed 26/01/22	Tue 22/02/22	0%
192		PH - step up beds operational	0 days	Tue 22/02/22	Tue 22/02/22	0%
193		**Canisbay Medical Practice**	**80 days**	**Tue 01/06/21**	**Mon 20/09/21**	**10%**
194		Premises - Canisbay feasibility	80 days	Tue 01/06/21	Mon 20/09/21	10%



Project: Caithness Redesign IA Sta
Date: Fri 04/06/21

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline	Manual Progress
Split	External Tasks	Inactive Summary	Manual Summary	Critical	Slippage
Milestone	External Milestone	Manual Task	Start-only	Critical Split	
Summary	Inactive Task	Duration-only	Finish-only	Progress	

NHS Highland

Appendix FC01

Caithness Redesign

Capital Affordability

Description	Caithness General Hospital	Town & County Hospital	Dunbar Hospital	Noss Site	Pulteney House	
	£'s	£'s	£'s	£'s	£'s	
Demolition		276,000	288,000			
Construct New Build		12,785,196	11,104,752	13,061,196	7,570,559	
Refurb	8,117,425	-	3,584,160	-	8,187,480	
External	229,658	479,400	579,400	479,400	509,400	
Fees, site surveys/investigation	2,161,215	1,354,060	1,555,631	677,030	1,626,744	
Land	-	20,000	-	100,000	80,000	
Backlog Maintenance	2,152,024	-	-			
Preliminaries	2,099,822	-	-			
Framework PM/Supervisor	524,955	-	-			
Consultants	40,000	-	-			
Total	15,325,099	14,914,656	17,111,943	14,317,626	17,974,183	
VAT	3,065,020	2,978,931	3,422,389	2,843,525	3,578,837	
Total Capital Costs	18,390,119	17,893,587	20,534,332	17,161,151	21,553,019	These figures match appendix EC12
Equipment	100,000	100,000	100,000	100,000	100,000	
VAT on Equipment	20,000	20,000	20,000	20,000	20,000	
Optimum Bias	4,851,992	4,035,939	4,853,411	3,875,458	4,858,340	
VAT on Optimum Bias	970,398	807,188	970,682	775,092	971,668	
NHSH related costs (estates team)	656,400	-	656,400	-	-	Project costs assigned against the 2 sites that we know are part of every option except the do nothing
VAT on NHS related costs	-	-	-	-	-	
Additional backlog Maintenance	1,781,566					Backlog maintenance still to be addressed (not included in EC12)
VAT on fees	356,313	-	-	-	-	
Technical fees that was in NR revenue	187,500	-	187,500	-	-	Assigned the fees against the 2 sites that we know are part of every option except the do nothing
VAT on fees	37,500	-	37,500	-	-	
Total Capital Costs	27,351,788	22,856,714	27,359,825	21,931,700	27,503,028	
Total Capital Costs excl VAT	22,902,557	19,050,595	22,909,254	18,293,084	22,932,523	

Description	Caithness General Hospital	Town & County Hospital	Dunbar Hospital	Noss Site	Pulteney House
	£000's	£000's	£000's	£000's	£000's
All construction/refurbishment works	8,347	13,265	15,268	13,541	16,267
Fees, site surveys/investigation, prelims, consultants	5,013	1,354	1,743	677	1,627
Land Purchase	-	20	-	100	80
Demolition costs	-	276	288	-	-
Backlog Maintenance	3,934	-	-	-	-
Equipment	100	100	100	100	100
NHSH related costs (estates/IT team)	656	-	656	-	-
Optimum Bias	4,852	4,036	4,853	3,875	4,858
Total	22,903	19,051	22,909	18,293	22,933
VAT	4,449	3,806	4,451	3,639	4,571
Total Capital Costs	27,352	22,857	27,360	21,932	27,503
	-	-	-	-	-

Description	Option 1 Do Nothing: As exsiting arrangements	Option 2 Care Hub/Village: Dunbar Hospital and Town & County Hospital	Option 3 Care Hub/Village: Dunbar Hospital and Pulteney House	Option 3a Care Hub/Village: Dunbar Hospital and NOSS
	£000's	£000's	£000's	£000's
All construction/refurbishment/backlog works	5,107	40,814	43,816	41,090
Fees, site surveys/investigation, prelims, consultants		8,111	8,383	7,434
Land Purchase		20	80	100
Demolition costs		564	288	288
Equipment		300	300	300
NHSH related costs (estates/IT team)		1,313	1,313	1,313
Optimum Bias		13,741	14,564	13,581
Total	5,107	64,862	68,744	64,105
VAT	1,021	12,706	13,470	12,538
Total Capital Costs	6,129	77,568	82,215	76,643

Caithness Redesign

Appendix FC02

Non-Recurring Revenue	Option 1 Do Nothing: As exsiting arrangements	Option 2 Care Hub/Village: Dunbar Hospital and Town & County Hospital	Option 3 Care Hub/Village: Dunbar Hospital and Pulteney House	Option 3a Care Hub/Village: Dunbar Hospital and NOSS
Description	**£ K**	**£ K**	**£ K**	**£ K**
Pay				
Decant costs	0	50	50	50
Staff costs - redeployment	0	150	150	150
Ehealth project resource	0	660	660	660
Non Pay				
Removal costs	0	30	30	30
Building double running cost until disposals	0	100	200	200
Temp accommodation costs ?	0	30	30	30
Demoilition costs	0	112	112	112
Insurance during construction	0	0	0	0
Equipment	0	1,553	1,553	1,553
Backlog maintenance	0	5	5	5
Total non-recurrent costs	**0**	**2,689**	**2,789**	**2,789**

Appendix FC03

Caithness Redesign

REVENUE COST ANALYSIS

Sq meters of new build	18113		17687		17687		17687	
Description	**Option 1**		**Option 2**		**Option 3**		**Option 3a**	
RECURRING COSTS	**Do Nothing: As exsiting arrangements**		**Care Hub/Village: Dunbar Hospital and Town & County Hospital**		**Care Hub/Village: Dunbar Hospital and Pulteney House**		**Care Hub/Village: Dunbar Hospital and NOSS**	
	Budget £'s	**wte**	**Budget £'s**	**wte**	**Budget £'s**	**wte**	**Budget £'s**	**wte**
Pay costs								
Secondary Staff costs	12,775,167		12,607,489		12,607,489		12,607,489	
Community Staff Costs	10,867,337		11,617,337		11,617,337		11,617,337	
Total - Pay costs	**23,642,504**	**0.00**	**24,224,826**	**0.00**	**24,224,826**	**0.00**	**24,224,826**	**0.00**
Non-Pay								
Direct Clinical/Care costs	11,967,120		11,967,120		11,967,120		11,967,120	
Non Direct Care Costs	1,026,681		1,026,681		1,026,681		1,026,681	
FHS	1,000		1,000		1,000		1,000	
0								
Total - Non-Pay Costs	**12,994,801**		**12,994,801**		**12,994,801**		**12,994,801**	
Asset Related Costs								
Property Maintenance	61,767		30,832		51,554		37,739	
Utilities	885,794		843,462		859,051		835,949	
Total - Asset Related Costs	**947,561**		**874,294**		**910,605**		**873,688**	
Capital Charges - depreciation	**583,985**		**2,219,001**		**2,295,243**		**2,168,150**	
Unitary Charge Costs								
Lifecycle costs	0		265,305		265,305		265,305	
Total - Unitary Charge Costs	**0**		**265,305**		**265,305**		**265,305**	
Income								
Other Operating Income	(417,391)		(417,391)		(417,391)		(417,391)	
SGHD UC - Lifecycle	0		(132,653)		(132,653)		(132,653)	
Income from Partner Organisations	0		(87,296)		(90,078)		(87,250)	
Total - Income	**(417,391)**		**(637,340)**		**(640,121)**		**(637,293)**	
Total - Recurring	**37,751,461**		**39,940,888**		**40,050,659**		**39,889,477**	
Total - Recurring (exclding depreciation)	**37,167,475**		**37,721,886**		**37,755,416**		**37,721,327**	

Appendix FC04 – Suitability and Capability of Project Leads

Senior Responsible Officer	Louise Bussell, Chief Officer, Community Services	Over thirty years' experience working for the NHS in various health and social care settings, with more than ten years in Senior Management positions. Registered mental health nurse and an experienced clinical and operational leader, working across in-patient and community settings, managing integrated teams and working in partnership with a broad range of partners including people who experience our services and the wider community. Experience of lead or oversight roles for various change management processes, projects and service redesigns, including several major capital projects. Interim Chief Officer for the North Highland Health and Social Care Partnership.
Caithness Redesign Project Director	Michelle Johnstone, North Area Manager	Over thirty years' experience working in healthcare – primarily within the NHS, with a brief period within the independent acute sector. Registered nurse, working across both community and secondary care. Over twelve years' experience within operational and strategic senior management roles, leading on change management processes across a large workforce to improve the patient and staff experience and outcomes. Previous role as Strategic Lead for Safeguarding - provided advice regionally across the East Midlands NHS Trusts in relation to safeguarding adults and adult protection working within clear governance frameworks. I was part of a working group supporting policy development for the implementation of safeguarding

		protocols for the Department of Health. Currently, Area Manager for Caithness and Sutherland - key to the role is the effective strategic development of the services utilising quality improvement methodology.
Capital Projects Lead	Eric Green, Head of Estates	Over twenty years construction project experience in nuclear and health care. • Operational responsibility for NHSH Estates service since 2009, including Acute and Primary Care project teams. • Technical Lead for Migdale and Nairn Hospitals, Tain Health Centre and Critical Care Upgrade at Raigmore Hospital.
Senior Project Manager	Diane Forsyth, Senior Project Manager, Estates	Over 20 years' experience in NHS Highland; 6 years in Operational Management, 13 years Project Management: • Delivered programme of new build and refurbished primary care dental premises across Highland 2008 - 2015. • Project Manager / Senior Project Manager on B&S and SLWR redesign bundle 2015 - 2019. • Experience includes Frameworks D&B, hub DBFM / DBDA, equipment procurement, stakeholder management, co-ordinating multiple projects. • Previously Operational Manager for NHSH Primary Care Dental Services and Assistant General Manager in acute setting supporting medical / surgical directorates. MA (Hons) Psychology, Diploma in Management, APM Project Manager

		Qualification, NEC3: ECC accredited Project Manager.
Communications & Engagement Lead	Christian Nicolson, District Manager (Caithness)	Over 20 years' experience quality improvement and operational management in both the third sector and NHS Scotland. • Quality improvement and communications/engagement support on previous service changes including Migdale Hospital (2011). • Managerial lead for the NHS Highland Stroke Managed Clinical Network from 2008 to 2019. • Senior Quality Improvement Lead for North & West Operational Unit 2018 to 2019. • District Manager for Caithness with operational role across the integrated team and adult social care since 2019.
Multi-Disciplinary Team Lead	Alison Brooks, GP, Thurso & Halkirk Medical Practice	Over thirty years' experience of working as a GP partner. Experience of a major redesign of healthcare delivery in General Practice to provide a sustainable model for the future. Additional responsibilities include: • District Medical Lead; • Cluster Quality Lead.
Single Point of Access Lead	Lesley Martin, Care at Home Manager	Thirty years' experience working in the Care at Home Service, with the last five years as Care at Home Manager for North Highland. Responsibility for 170 staff, approximately 600 service users across Caithness and Sutherland. Has led and overseen several major service restructures, taking the service from a Home Help service to one providing personal care, medication

		management, continence management and skin care. The recent focus has concentrated on service development and improvement, including: • managing the introduction and growth of six independent sector services to Caithness and Sutherland; • developing learning & development frameworks; introducing an enablement service in Caithness; • the development of improved documentation such as Personal Support Plans, service user reviews; and • staff practice observations and supervision. As a result of this work, the North Highland Care at Home Service has been rated as very good in the last two inspections by the Care Inspectorate.

Redesign of Adult Health & Social Care Services in Caithness
North Coast Health and Care Hub

Terms of Reference of Caithness and North Coast Programme Board (v9)

The terms of reference of the Caithness and North Coast Programme Board are set out below. These terms of reference are in relation to the Initial Agreement stage of the project through to project completion and post-project evaluation.

Role

The Programme Board provides governance to the Project Teams delivering the service redesign and estates infrastructure projects of the Caithness Redesign programme and North Coast Care Hub and reports on this to the NHS Highland Board and its committees. The Project Board will oversee the development of the business case from Initial Agreement to Full Business Case, infrastructure and commissioning elements of the bundled projects with the following remit:

Remit

The Programme Board will supervise the specification and delivery of the project, including:

- To ensure that the project is delivered consistent with the Scottish Capital Investment Manual (SCIM) and NHS Highland (NHSH) Board strategic objectives;
- To agree the **scope** of the project and ensure that the developed service model is consistent with the agreed scope, NHSH and national health and social care strategy;
- To agree the programme and budget for the project, for approval by NHSH Board and Scottish Government Capital Investment Group (CIG);
- To ensure that the Project Team delivers the project within the agreed **programme**;
- To ensure that the proposed service model is affordable to the NHSH Board and that the project is delivered within the **budget** identified in subsequent business cases approved by NHSH Board and CIG;
- To ensure the project is delivered to agreed **quality** standards as defined in the SCIM and that infrastructure elements obtain a supported status in the National Design Assessment Process;
- To ensure that a robust Initial Agreement, Outline Business Case (OBC) and Full Business Case (FBC) is developed in accordance with SCIM guidelines and to ratify this prior to submission to NHSH Board and CIG for approval;
- To ensure that appropriate governance processes are followed in line with SCIM guidance and NHSH Standing Financial Instructions;
- To ensure that an appropriate, adequately resourced project management structure is in place to deliver the project objectives;
- To ensure that the Project Team reports are clearly defined and clearly illustrate progress against planned activities;
- To review project **risks** on an ongoing basis, ensuring all risks are identified, appropriate mitigation strategies are actively applied and managed, and risks are escalated as necessary, providing assurance to the NHSH Board that all risks are being effectively managed. High level risks and changes will be reported at each Programme Board, with a full risk register review undertaken twice a year;
- To agree the Project Benefits Register and Realisation Plan, ensure that the Project Team is on track to deliver the agreed **benefits** and that progress is reported to the Project Board regularly;

- To ensure that the Caithness Redesign Project Team delivers as one of three national pathfinder sites for the development and delivery of the local care model, in conjunction with Scottish Futures Trust and the Scottish Government. The care model developed as part of the Caithness redesign will inform the development of care models to be replicated across NHS Scotland.
- To be assured of appropriate stakeholder engagement and public communications in respect of delivery of the project and major service change;
- To oversee post-project evaluation; and
- In respect of any infrastructure projects, ensure that the Project Team;
    - Follows the required procurement process to select an appropriate delivery partner;
    - Has a robust design brief in place that is aligned with project scope and enables delivery of the agreed service model;
    - Concludes Contract Close in partnership wth relevant stakeholders; and
    - Successfully plans and manages the functional commissioning and brings the facilities into operation in respect of the elements for which NHSH is responsible.

Reporting

The Project Teams are required to report to the Programme Board on the following;

- Status of project in respect of time, scope and cost. Should this be out with the agreed parameters, the Project Team should outline what steps are being taken to address this;
- Activities and milestones achieved during last reporting period, and planned activities and milestones for next period in relation to realising the agreed project objectives and benefits;
- Highest risks to project delivery and the actions taken to mitigate these. New risks or any changes to the rating of existing risks will be identified;
- Update on progress with service change elements – for information; and
- Update on stakeholder engagement and public communications – for information.

Administration

- Meetings will be held quarterly, or more frequently if required at key decision-making points.
- Papers will be circulated to members by email a minimum of 10 calendar days in advance of the meeting. These will clearly state if they are for information, advice or ratification. Late papers will be only issued with the permission of the Chair.
- A draft note of the meeting will be circulated to members by email within 2 weeks of the meeting date.
- Once ratified, meeting notes will be made available to the public on the NHS Highland website.
- Papers and notes of meetings can be provided to members in hard copy on request.
- Decisions will be made by consensus where possible and by majority vote in any other circumstance.

Membership

Chair

Name	Designation	Role [on Programme Board]
Louise Bussell	Chief Officer, Community Services	Senior Responsible Officer / Chair

Group (alphabetically by surname)

Name	Designation	Role [on Programme Board]
Governance role		
Tim Allison	Director of Public Health & Policy	Public Health Lead
Alexander Anderson	Non-Executive Director, NHS Highland Board	NHS Highland Board representative (Caithness)
Gaye Boyd	Deputy Director of Human Resources	Human Resources Lead
Rhiannon Boydell	Head of Community Services	Community Operations Lead
Elspeth Caithness	Staff-side representative	Staff Side representative
Paul Davidson	Deputy Medical Director (Community)	Primary Care Clinical Lead
Ruth Fry	Head of Communications & Engagement	Communications Lead
David Garden	Director of Finance	Finance Lead
Mike Hayward	Deputy Chief Officer (Acute)	Acute Operations Lead
Arlene Johnstone	Interim Head of Mental Health, Learning Disabilities and Drug & Alcohol Recovery	Mental Health & LD Lead
Deirdre MacKay	Non-Executive Director, NHS Highland Board	NHS Highland Board representative (North Coast)
Jill Mitchell	Head of Primary Care	Primary Care Lead
Kate Patience-Quate	Deputy Director of Nursing	Nursing and IPCT Lead
Simon Steer	Director of Social Care	Adult Social Care Lead
Alan Wilson	Director of Estates, Facilities & Capital Planning	Capital Planning Lead
Constantinos Yiangou	Deputy Medical Director (Acute)	Acute Clinical Lead
	Highland Council - TBC	
Reporting role		
Heather Cameron	Senior Project Manager	Senior Project Manager, North Coast Care Hub
Diane Forsyth	Senior Project Manager	Senior Project Manager, Caithness Redesign
Eric Green	Head of Estates	Capital Projects Lead
Michelle Johnstone	North Area Manager	Project Director, Caithness Redesign & North Coast

Role of Programme Board Members

- Members in a governance role will provide appropriate scrutiny to Project Teams in line with the remit of the Programme Board, as identified below.
- Members in a reporting role must provide relevant information to allow an assessment of progress against time, cost, quality and scope.

- Should Programme Board members be unable to attend they are required to provide a deputy to maintain continuity and to ensure that the meeting remains quorate.
- Quorate is defined as a minimum of 4 NHS Highland members in a governance role (2 management, 2 clinical / service) and 1 lay person representative.

Figure 1 – Formal Governance Arrangements and Reporting Structure

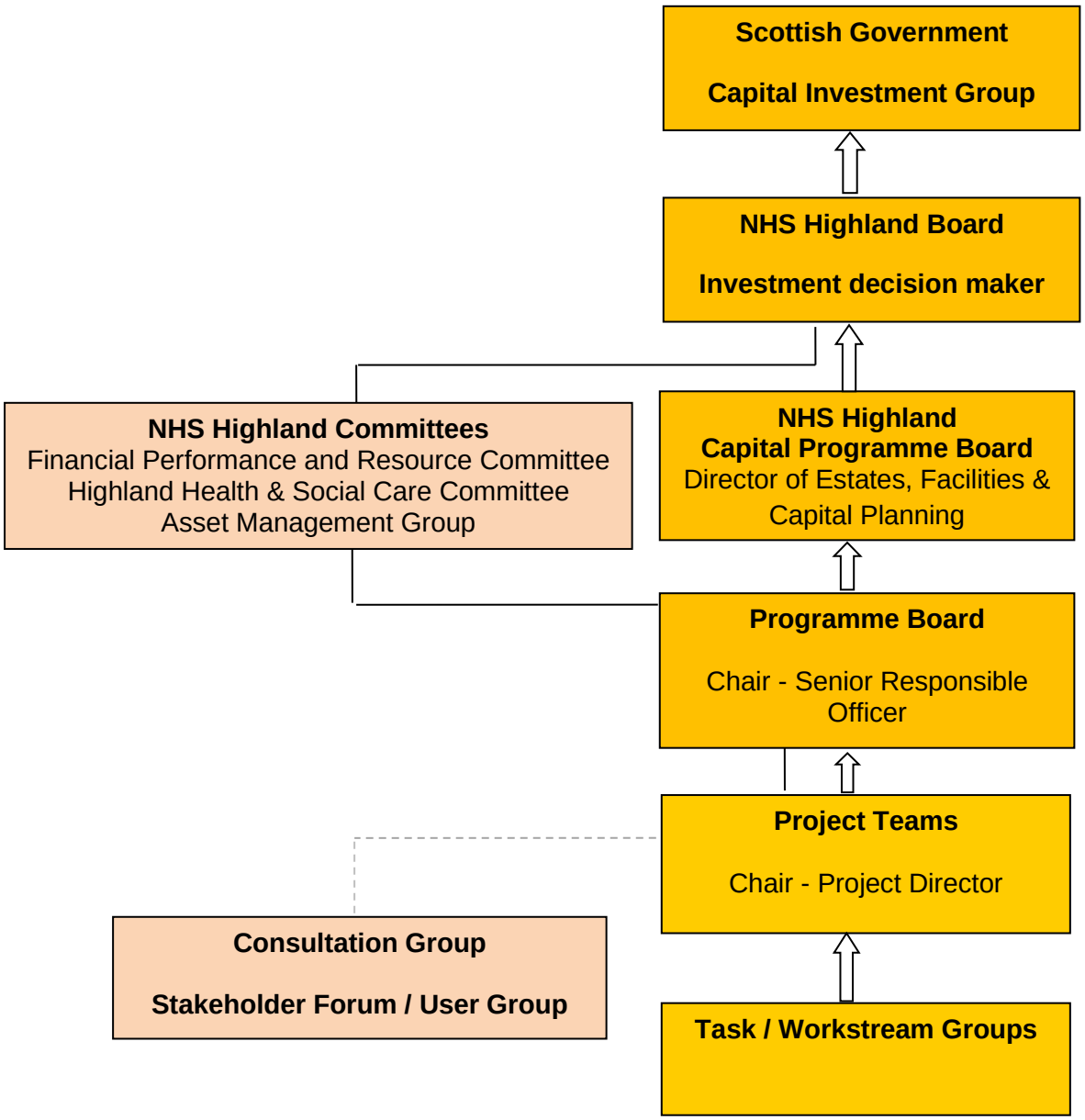


Table 1 Summary of remit for relevant groups

Groups	Remit
NHS Highland Board	▪ Ensure that a valid, viable and affordable business case exists for the project; ▪ Authorise allocation of funds to the project; ▪ Oversee programme board performance. ▪ *Meets bi-monthly*
Asset Management Group (AMG)	▪ Ensure board-wide co-ordination and decision making of proposed asset investment / disinvestment ensuring consistency with policy and the strategy; ▪ Agree allocation of funds within delegated limits. ▪ *Meets monthly*
Capital Programme Board (CPB)	▪ Supervise the strategic direction and delivery of the NHSH investment programme ▪ Agree and prioritise the projects on the programme and ensure that these are sufficiently resourced ▪ Ensure each project has an appropriate governance structure ▪ *Meets quarterly*
Highland Health and Social Care Committee	▪ Board wide co-ordination and implementation of the NHS Highland strategy and operational plan ▪ Internal assurance re: major service change process ▪ *Meets bi-monthly*
Senior Management Team	▪ To ensure board wide co-ordination of service redesign ▪ *Meets bi-monthly*
Programme Board	▪ To ensure that the project is delivered within the agreed scope and in line with SCIM guidance; ▪ To ensure the Project Team delivers the project to programme, within agreed budget and quality standards; ▪ To ensure a robust business case is developed and appropriate governance route is followed; ▪ To ensure that Project Team manages project risks effectively and delivers required project benefits. ▪ *Meets quarterly / more frequently as required*
Consultation Group	▪ To represent project stakeholders; ▪ To comment on and influence proposals; ▪ To comment on and advise on communications and engagement with stakeholders. ▪ *Meets quarterly*
Project Team	▪ To deliver the service change in line with SCIM guidance within the scope, programme, budget and quality standards agreed by the Project Board; ▪ To produce a robust business case for the project and present this through required governance route; ▪ To effectively manage project risks and maintain the project risk register; ▪ To ensure that the benefits of the project are realised; ▪ To direct the task groups to achieve project objectives. ▪ *Meets monthly*

Below the Project Team are a number of task or workstream groups. Each has an appointed lead from within the operational management team and has project support. The number, role and function of these groups will “flex” according to need as the projects progress.