Initial Agreement
Lochaber Redesign Programme

NHS Highland

08th April 2022

Version control:

Version	Owner	Comment
Draft v0.1	Gillian Bratt-McManus	Template created and sections 1-4 drafted
Draft v1	Gillian Bratt-McManus	Circulated to Laurence Casserly at Hub North
Draft v 1.1	Gillian Bratt-McManus	Included updates to workforce information in section 3.5. First draft of long list and shortlist in section 5.
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Draft v1.5	Iain Buchan	Track changes comments
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Draft v1.11	Gillian Bratt-McManus	Updating the strategic case, Revised investment objectives and format of risks. Additional content on RGH core clinical model and service options. Refreshed approach to option evaluation and preferred service option. Section restructure to aid document flow. Feedback comments incorporated throughout document. Appendices realigned to changes made. Conclusion and exec summary updated to reflect changes.
Draft v1.12	Iain Buchan	Final QA read through and minor amendments.
Draft v1.13	Ros Philip	Update finance sections/commentary
Draft v1.14	Heather Cameron	Updated in response to Project Team/Project Board/Stakeholder comments.
Draft v1.15	Laurence Casserly	Update Capital Costs/Appendices.

Contents

1 PURPOSE

The main purpose of this Initial Agreement (IA) is to affirm the need for investment in Health and Care services in Lochaber and to seek approval from the Scottish Government Capital Investment Group (CIG) to develop an Outline Business Case setting out the requirements for an investment in a Rural General Hospital (RGH) in Lochaber.

This follows the submission of the Strategic Assessment in 2018 from NHS Highland (see Appendix 1). Further work has now been undertaken in relation to the next stage of the capital investment lifecycle; the development of the Initial Agreement (IA) in line with the Scottish Capital Investment Manual (SCIM) process.

This paper explains the need for capital investment in healthcare premises within Lochaber and sets out the potential options for future healthcare provision. In line with the national policy direction, this proposal offers a significant opportunity for further integration of health and care in partnership with wider council and third sector services. A range of health and social care services will be provided in an environment that is more accessible than the current facilities; NHS Highland has responsibility for all adult health and social care services in the region.

The IA demonstrates the need for investment, aligned with a number of national strategic drivers for change, and will demonstrate that this is a good thing to do. It will do this by responding, as appropriate, to the following questions:

Initial Agreement (IA)		
	Questions	**Response**
Executive **Summary**	What is the proposal about?	An Executive Summary of responses to the following questions.
Strategic Case	What are the current arrangements?	Outline: □ Service details □ Service arrangements □ Service providers □ Associated buildings & assets
	Why is this proposal a good thing to do?	Outline: □ Need for change □ Investment objectives □ Benefits register □ Risk management strategy
Economic Case	What is the preferred strategic / service solution?	Confirm: □ Stakeholder involvement □ The Do Nothing / Minimum option □ Any major service change proposals □ Service change proposals □ Indicative costs □ Assessment of proposed solutions □ Preferred strategic / service solution □ Design Quality objectives
Commercial, Financial & Management Case	Is the organisation ready to proceed with the proposal?	Confirm: □ Procurement strategy & timetable □ Affordability & financial consequences □ Governance & project management arrangements
Conclusion	Is this proposal still important?	Confirm: □ Strategic Assessment template

Figure 1-1 Initial agreement content

2 WHAT IS THE PROPOSAL ABOUT?

	Questions	Response
Executive Summary	What is the proposal about?	An Executive Summary of responses to the questions: □ What are the current arrangements? □ Why is this proposal a good thing to do? □ What is the preferred strategic / service solution? □ Is the organisation ready to proceed with the proposal? □ Is the proposal still important?

Figure 2-1 Executive summary content from IA content summary

2.1 Introduction

2.1.1 This Initial Agreement describes the need for capital investment in healthcare premises within Lochaber and sets out the potential options for future healthcare provision.

2.1.2 The benefits to be achieved through these investments centre on meeting the objectives of NHS Highland. The key benefits include:

- supporting people to stay in their own home for as long as possible;
- increasing the choice and access to services in Lochaber;
- increasing flexibility and responsiveness of services;
- increased use of technology to support person-centred care;
- promoting self-management to allow people to stay healthy for longer;
- increasing early intervention and preventative work;
- addressing inequalities, taking cognisance of Fairer Scotland;
- increasing the opportunities to work jointly across health and social care, supporting increased co-location and integration of health and social care staff; and
- making optimum use of existing health and social care resources, staff facilities and accommodation.
- ensuring our services and proposals support and respond to the needs of the local economy, realising opportunities for joint working with partner agencies as appropriate.

2.2 Development of the Initial Agreement

2.2.1 A variety of stakeholders including service users, carers and staff have been involved in developing this proposal, which responds to, and supports, national and local healthcare strategy and meets the needs of the local people in Lochaber.

2.2.2 The IA covers the need to replace the Belford Hospital in Fort William as part of a wider redesign of local health and social care services in Lochaber. The redesign will look at the balance between services provided at home, in the community, in care homes as well as in the hospital.

2.3 The Strategic Case

The strategic case sets out an overview of the current services and facilities at the Belford Hospital in Fort William and some of the challenges associated with their delivery within the confines of the existing service model and infrastructure.

It explores the opportunities for improving the model of care and service afforded by investment in a new Rural General Hospital (RGH), explains why the proposal is a good thing to do and the likely impact, should the development be approved.

The service model will be part of the wider integrated healthcare system across NHS Highland. The proposed service solutions will be facilitated through the development of a new Rural General Hospital in Fort William which replaces the existing Belford Hospital.

The requirement for a new RGH in Fort William is clear in the context of the remote and rural characteristics of the Lochaber area. Rural patients' experience of care differs from that of urban patients in that they often have to travel greater distances to receive care, and although the pattern of disease is similar in urban and rural areas, differences which exist include:

- higher suicide rates;
- higher incidence of alcohol related disease;
- a higher number of accidents in rural areas: on roads, through climbing and other outdoor pursuits, farming, diving, and fishing;
- palliative care workload is proportionally higher than might be seen in urban areas as patients from remote areas often prefer to, or are enabled to, die at home rather than in a distant centre; and
- seasonal fluctuation in population.

The RGH undertakes management of acute medical and surgical emergencies and is the emergency centre for the community, including the place of safety for mental health emergencies. It is characterised by more advanced levels of diagnostic services than a Community Hospital and will provide a range of outpatient, day-case, inpatient and rehabilitation services.

An assessment of the benefits and risks which may arise through delivery of this investment were also considered as part of the Strategic Case. These registers are presented for reference in Appendices 4 and 5.

The Benefits Realisation Plan will be reviewed at each stage of development (OBC, FBC, Handover/Operation) to ensure the anticipated benefits are being assessed and the evaluation methods are being managed.

As the project develops, a structured approach to risk management will be implemented. This will enable all project stakeholders to identify, assess and control all the identified risks that may cause future delay or cost implications to the project. This proactive approach to risk management therefore allows the project team to track any risks that may emerge as the project progresses and support better decision making through improved understanding of

the risks inherent in the proposal, allowing the project board to take the appropriate mitigation actions.

2.4 The Economic Case

The Economic Case sets out the process which was undertaken to identify and assess the options which could deliver the preferred service solutions.

This process identified a long list of potential options, and assessed these against the agreed Investment Objectives, to approve which solutions should be taken forward for more detailed consideration at Outline Business Case Stage.

The Investment Objectives have been established from the work undertaken to complete the Strategic Assessment, and have been agreed by stakeholders as:

1. To deliver RGH services locally wherever possible and adapt to the unique and changing needs of the population in the remote and rural locality of Lochaber which is recognised as The Outdoor Capital of the UK.
2. Develop a sustainable RGH service which optimises the skills of the local workforce, improves recruitment and retention, and offers enhanced opportunities for training, including planned collaboration with other local agencies.
3. Deliver RGH services which maximise opportunities in current and future healthcare technology and innovation, making best use of this to benefit patients and staff.
4. Provide a modern flexible healthcare facility which supports the provision of a 21st century RGH model of care focused on patients and families.
5. Deliver services and infrastructure which will minimise environmental impact and deliver to Scottish Government's climate change targets, now and in the future.

To achieve these Investment Objectives, the project team will maintain a focus on the improved healthcare outcomes and the ambition to deliver improved models of care supported and enabled by appropriate facilities.

These Investment Objectives will be referred to at each stage of the project to measure progress and ensure that the objectives are kept in focus at each stage of the project lifecycle.

2.4.1 Service Options

The options were explored and the relative advantages and disadvantages of each discussed and noted. Each option was assessed for its ability to deliver against the investment objectives outlined above. A holistic assessment of each service option was then made to determine which option(s) were considered "preferred", "possible" or "rejected". The full detail of this process can be found in section 5.5.

The multi-disciplinary team who attended the service options assessment workshop were enthusiastic about pursuing an ambitious service model which seeks to enhance the local provision of care. At the same time, they were cognisant of the fact that there are limitations in the extent to which this is possible; this varies by specialty. There is recognition that more in-depth work is required to explore the "art of the possible" for practical and sustainable

implementation taking a specialty-by-specialty approach. Based on the evaluation of service solutions, two options have been selected for further work at OBC level:

- Proposed Option 3 – RGH core clinical model with Intensive rehab; and
- Proposed Option 4 – RGH core clinical model with Intensive rehab, and enhanced elective service provision over time.

Subject to the approval of this Initial Agreement, service solutions will be further reviewed and more detailed analysis around capacity requirements and workforce models will be identified to inform the optimal implementation solution for the service change proposal.

2.5 The Outline Commercial Case

The Commercial Case sets out the procurement and contractual arrangements which will be required to deliver the proposed service solution.

This includes arrangements for appointment of technical advisors, as well as a contractor and design team for design and construction of any future built assets.

NHS Highland will utilise the Health Facilities Scotland Frameworks 3 to select appropriately qualified and experienced consultants and a Principal Supply Chain Partner (PSCP).

Frameworks Scotland 3 embraces the principles of 'collaborative working' to ensure that teams within, and between, the public and private sectors work together effectively.

To achieve the objectives outlined above, the Framework adopts an NEC4 form of contract. The principal objective of an NEC4 contract is to engender a collaborative working approach by creating an open, cooperative, non-adversarial team approach to managing the contract.

The NEC contract will be used for the appointment of the PSCP and professional consultants.

2.6 The Outline Financial Case

The Financial Case sets out the financial requirements of this investment in terms of capital investment, and revenue costs relating to the staffing and ongoing operation of the facility. The affordability of this investment and the source of funding are detailed in the Financial Case section.

Capital costs have been estimated to be in a range between £89m and £144m although the mid-point has been used for each option. This cost includes construction costs, professional fees, optimism bias allowance, equipment, sustainability allowance and design risk.

Whilst the base costs remain the same, adjustments to risk allowances are included, and the cost estimate reflects the uncertainty in the construction market over the last 1 – 2 years, and the difficulty in applying accurate construction cost inflation allowances while material supply chain issues continue.

Costs also include allowances for designing a hospital which is 'Net Zero Carbon'. In the absence of guidance, this is applied as a 12% uplift which is based on Scottish Futures Trust (SFT) guidance in the education sector. Design work at OBC stage will allow a more accurate assessment of this.

For the purposes of the IA the capital costs have been calculated using a mid-point of construction date of Q2 2025.

These capital costs will be further developed at OBC stage as the preferred service solution is identified.

For this IA, revenue costs are based on the current revenue costs at Belford Hospital. The revenue consequence of the proposed service model and the changes this may entail is difficult to assess with accuracy at this stage. There are a number of options to be considered at the Outline Business Case stage, and as the service options become clearer and are differentiated, revenue costs can be applied to undertake the economic assessment.

The revenue costs of any changes to the model of care will be built into future budget setting, to ensure that the revenue consequences are known and are allowed for.

The future model of care is expected to benefit from digital innovations and use of existing technology such as 'Near Me' and this may provide revenue savings. The model of care will also be aligned with NHS Highland's Remobilisation plan and financial efficiencies will be identified. Transfer of budget will accompany any movement of services to or from Lochaber.

NHS Highland's Programme Management Office (PMO) is supporting the clinical and corporate functions in transforming their operations to deliver improvement opportunities. The service redesign will be supported by the PMO, and service improvement and revenue savings opportunities will be identified.

2.7 The Outline Management Case

The Management Case sets out the project management arrangements which NHS Highland will implement to ensure the organisation is ready to proceed with the proposed service change.

NHS Highland have an experienced project delivery team in place, with a track-record in delivering service change solutions and capital investments in community hospitals in Badenoch & Strathspey, Skye, and the National Treatment Centre in Inverness.

This internal team will be supplemented with appropriate expertise from external consultants where appropriate.

Through the development of this IA, the project team have worked collaboratively with NHS Assure to undertake the Key Stage Assurance Review process, with Health Facilities Scotland to undertake the AEDET process, and with Architecture & Design Scotland to prepare a Design Statement.

A clear governance structure is in place, with agreed Terms of Reference, and clear routes for escalation. A Project Board has been set up which is a key link in this governance framework which includes the NHS Highland Asset Management Group and the NHS Highland Board.

These boards provide direction and governance to the Project Team. Further details are provided in the Management Case.

2.8 Other relevant considerations

The Blàr Mòr site at Caol, Fort William has planning permission in principle for a mixed-use development (Highland Council planning reference 18/03647/PIP) including housing, community use and a serviced site allocated for:

- a new hospital for Lochaber and the wider West Highland area;
- a science, technical and construction training centre for further and higher education students by West Highland College, part of the University of the Highlands and Islands (UHI). This project is strongly supported by the UHI and by the Scottish Funding Council.

Following a major supermarket pulling out of a planned development at Blàr Mòr to the north of Fort William, the site, which had been cleared of peat and is part of a larger mixed-use masterplan, was purchased by the Highland Council in 2015 and 'land banked' for the development of a new hospital and adjacent STEM centre by West Highland College as part of the University of the Highlands and Islands (UHI), including medical training. The remainder of the site is allocated to housing.

The site is located close to Fort William Health Centre, the Scottish Ambulance Station and the police station with excellent links to the A82. Blàr Mòr is one of the only level areas for the expansion of Fort William. There are obvious advantages of co-location with - UHI on the same site which could be realised.

Whilst no final agreement has been reached, it is the Board's intention to consider this as part of the formal option appraisal process incorporated within the next stage of the business case process. Costs relating to the development of the Blàr Mòr site have been used as reference costs for the purposes of establishing indicative project costs as part of the Economic appraisal for the project within this IA.

2.9 Conclusion

This Initial Agreement builds on the position outlined at the Strategic Assessment and demonstrates the importance of this investment proposal in providing a sustainable healthcare service in Lochaber.

The development of this IA has wide stakeholder support, within the community, within NHS Highland, and with partner organisations including Highlands and Islands Enterprise, West Highland College UHI (University of the Highlands and Islands), and The Highland Council.

Through working with the project stakeholders, preferred service solutions have been identified which will deliver sustainable, modern, and appropriate services, forming a key

component of an integrated healthcare system across NHS Highland, and which help to address challenges around recruitment and retention of staff.

As noted in Section 2.7 above, NHS Highland are ready to proceed with this proposal to Outline Business Case stage, and governance arrangements and a project management team are in place to deliver this proposal.

The conclusion of this IA is that an investment in services in Lochaber is still important, and that NHS Highland recommend that this service change is further progressed through the development of an Outline Business Case.

STRATEGIC CASE

	Questions	Response
Strategic Case	What are the current arrangements?	Outline: • Service details • Service arrangements • Service providers • Associated buildings and assets
	Why is this proposal a good thing to do?	Outline: • Need for change • Investment objectives • Benefits register • Risk management strategy

Figure 2-2 Strategic Case content from IA content summary

3 WHAT IS THE STRATEGIC BACKGROUND TO THE PROPOSAL?

The following section will outline:

- Who is affected;
- Links to NHS Scotland's Strategic priorities;
- Links to other policies and strategies; and
- Influence of external factors.

3.1 Who will be affected by the proposal?

The table below outlines the stakeholder groups affected by this proposal and summarises the engagement and confirmed support:

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Patients/ service users	Patients and service users affected by this proposal include patients at Belford Hospital and patients receiving community-based care. Their involvement in its development includes responses to surveys, attendance at workshops including Case for Change, Risks and Benefits, Design Statement, and AEDET. The impact that this has had on the proposal's development includes the final Design Statement, the AEDET target scores, and input to the Strategic Case as presented in this IA.	Patient / service user groups were consulted on elements of this Initial Agreement including the Option Appraisal, risk workshop and NDAP process. The output from surveys of service users and a number of community groups were fed into development of the clinical model. The two public representatives who sit on the Project Team reviewed the final version of the IA. Their comments were addressed and their feedback was agreement that the document reflected the process undertaken to develop the IA, and the stakeholder input which has been incorporated into this proposal.
General public	The general public will be affected by this proposal by the redesign of clinical services in Lochaber. This is not considered to be 'major service change' and so this has not required a range of public consultation events. However, with reference to the communication and engagement plan, NHS Highland will continue to engage with the general public at each stage of the re-design process.	The level of support from the general public for this proposal is considered to be very strong. This is evidenced by active participation and input at Stakeholder Group Meetings, representation at Project Team Meetings and workshops to develop this IA.
Staff / Resources	Staff affected by this proposal include Lochaber Community Staff, staff at Belford Hospital, and NHS Highland colleagues providing support services from locations outside of Lochaber, notably	Staff representatives were consulted on this Initial Agreement by presentation of the IA at Project Board Meeting on 18/10/21 and circulation of this updated version for comment and feedback. Their

	Raigmore Hospital. Their involvement in its development includes representation on the Project Board and Project Team and attendance at workshops.	feedback was supportive of the case for change and proposed service solutions which has been incorporated into this proposal.
Other key stakeholders and partners	Other key stakeholders identified for this proposal includes West Highland College, The Highland Council, and Highlands and Islands Enterprise. Their involvement in the development of this proposal includes discussions on the optimum use of the Blàr Mòr site, and discussions on the opportunities for collaboration across all organisations in developing this proposal.	Confirmed support for this proposal has been gained through the agreement to develop a memorandum of understanding for the collaborative arrangements and opportunities which the parties will seek to develop.

Figure 3-1: Stakeholder engagement table

3.2 Engagement with Stakeholders

The project team includes a 'Community and Engagement Manager', and all engagement is being undertaken with reference to the Scottish Government's 'Planning with People the Community Engagement and Participation Guidance'.

A Community and Engagement Strategy has been drafted which sets out the approach for communication and engagement throughout the development of the IA.

NHS Highland have formed a Stakeholder Group for the Lochaber Health and Social Care Redesign, which is made up of representatives from community councils, local groups, elected members and health and social care staff.

This Stakeholder Group meet on a monthly basis to ensure local feedback and input is considered in the development of the proposed service change solution and investment.

In addition to the Stakeholder Group, NHS Highland are liaising with community stakeholder groups in the Lochaber region through:

- regular newsletters available by email and other formats;
- monthly short update videos, from the project team;
- documents and meeting notes are available on the NHS Highland website; and
- articles in the local newspaper at important stages in the design process.

During the development of the Initial Agreement, in June/July 2021 NHS Highland undertook surveys from patients and members of staff currently using services, to collate and consider their experiences of using services in Lochaber.

The output from these surveys has helped the project team to understand how services are working now, to better understand patient and staff views on which areas are working well and where things could be better.

The feedback has been used to develop plans and understand the challenges, as well as what will be needed for the new building, and will be used alongside other information collected to inform further plans for the new hospital.

This stakeholder engagement includes groups which include young people, people affected by mental health, disabled people and people who live in supported accommodation, people who have migrated here from another country and homeless people.

With increasing demands on services, resources and budgets comes the need to reshape the way we support people in our communities to allow them to look after themselves, in the knowledge that health and social care services are there when needed.

These services include hospitals, GPs, community nurses, occupational therapists, physiotherapists, podiatrists, speech therapists, social workers, housing officers, care homes, care providers, unpaid carers, voluntary and charitable organisations.

3.3 How does the proposal respond to NHS Scotland's strategic priorities?

NHS Scotland's strategic investment priorities are aligned to the Quality Strategy

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

To ensure that we are responding to the core strategic investment priorities, we will monitor the effectiveness of our new ways of working as outlined below.

NHS Scotland Strategic Investment Priority:	How the proposal responds to this priority	As measured by:
Person-Centred	• Improving access to health and care services locally, that are person centred, safe and clinically effective. • Facilitating improved co-ordination of integrated health and social care services. • Self-management of Long-term Conditions will increase the proportion of people with intensive needs being cared for at home.	• Reduced hospital bed days: key long-term conditions; lost to delayed discharges. • Reduced "Health-miles" – travel for services in Inverness.
Safe	• Work will support holistic care and anticipatory approaches. • Improved quality of the estate will be easier to clean and support the Patient Safety Programme.	• Reduced Healthcare Acquired Infections.

Effective Quality of Care	• Adoption of modern ambulatory care models in an appropriate environment will improve the ability to discharge patients home on the same day.	• Reduced proportion of admissions to hospital from unscheduled presentations.
Health of Population	• Service users will benefit from a wider range of services available and opportunities to increase the level of services locally; helping to support fewer unscheduled care admissions.	• Balance of care services delivered across community and hospital bases.
Value & Sustainability	• Operating out of modern fit for purpose buildings will be more energy efficient which will reduce the carbon footprint. • Delivering a safe, high-quality physical environment for service users and staff - visible investment in the health of Lochaber residents - sends a message that we value their health. • Staff working agilely will be equipped with the latest technology, allowing them access to the same information they would have in the office but now electronically from patient's home or wherever they are working.	• Reduced Carbon emissions. • Take up rates for health improvement services. • Positive staff survey results. • Proportion of staff working agilely. • Ratio of desk spaces to staff numbers.

Figure 3-2 Responding to NHS Scotland's Strategic Investment Priorities

3.4 What strategies does this proposal directly respond to, and how?

Policy	Key Themes	Impact
NHS Highland Remobilisation Plan 2021-22	NHS Highland's (NHSH) Remobilisation plan sets out the journey in its response to Covid19 and recovering performance in the context of the NHS Scotland Covid19 Framework for Decision Making of Re-mobilise, Recover and Re-design and the subsequent correspondence received from the Scottish Government regarding remobilisation. The plan can be referenced at Remobilisation June 2021.pdf (scot.nhs.uk).	This investment will learn lessons from management of the Covid 19 pandemic, ensuring that a future facility is better able to manage patients with infectious diseases in a safe and dignified manner, but also by examining how services can continue to be delivered flexibly.
NHS Recovery Plan, August 2021	£1 billion of targeted investment over the next 5 years to increase NHS capacity, deliver reforms in the delivery of care, and get everyone the treatment they need as quickly as possible. Focus on all parts of the pathway, including: • aiming to increase NHS capacity by at least 10%; • releasing capacity through redesign of care pathways; • Increasing diagnostic procedures; • Investing £11M in national and international recruitment campaigns; • Increasing medical undergraduate places; • Introducing a network of 10 national treatment centres; and • Redesigning urgent care.	The increase in requirements for outpatient and diagnostic capacity will have a direct bearing on the demand levels for services locally. The National treatment centre opening in Inverness in 2022 represents opportunities for improving waiting times for elective procedures for Lochaber residents in the specialties of Ophthalmology and Orthopaedics.

Digital Health and Care Strategy	The recently published strategy focuses on how digital can support this aim whereby, as a citizen of Scotland: '*I have access to the digital information, tools and services I need to help maintain and improve my health and wellbeing.* *I expect my health and social care information to be captured electronically, integrated, and shared securely to assist service staff and carers that need to see it……and that digital technology and data will be used appropriately and innovatively:* • *to help plan and improve health and care services* • *enable research and economic development* • *and ultimately improve outcomes for everyone*.'	This programme of investment includes adoption of the latest digital technologies to support person-centred care, improve the use of resources and offer increased co-production.
2020 Vision "Achieving sustainable quality in Scotland's healthcare"	The aim is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. This will be achieved through having a healthcare system where there is integrated health and social care, a focus on prevention, anticipation and supported self-management. 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. Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values, and which demonstrate compassion, continuity, clear communication, and shared decision-making.	This investment will support timely discharge and / or avoid unnecessary admission to hospital through the provision of increased access to a range of health and social care services, right sized in the right place within the health and care system.
Chief Medical Officer's Annual Report "Realistic Medicine"	The Chief Medical Officer's Annual Report for 2014-15 on Realistic Medicine gives food for thought and signals many areas for review. It challenges our thinking about how we share decision making with our patients and whether many of the treatments that we offer are not treatments that we would wish for ourselves and that we have become too focussed on delivering evidence-based medicine guidance that was developed to manage single system disease, while the patients that we treat often no longer fit into that category.	This investment will provide facilities which will enable the provision of services based on these principles, specifically through integrated team working across health and social care, efficient access to diagnostics and specialist advice, and clearer criteria for access to –and discharge from – acute services.
Reshaping Care for Older People: A Programme for Change	The Scottish Government vision that 'Older people are valued as an asset; their voices are heard, and they are supported to enjoy full and positive lives in their own home or in a homely setting' was a key driver of the re-shaping care agenda.	This programme will build on initiatives within the Change Fund enabling health and social care Partners to make better use of their combined resources for older people's services by shifting care towards anticipatory care and preventative spend.
Health and Social Care delivery plan for Scotland (2016)	This sets out a programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that: • is integrated; • focuses on prevention, anticipation and supported self-management;	This investment across health and social care seeks to maximise the opportunity created through integration from service delivery, staffing and infrastructure.

	• 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. The integration of health and social care is the biggest factor when considering the opportunities for improvement. Quite simply it allows services to holistically consider and address individual and community health and social care outcomes. How people currently experience health and social care services collectively has to improve. There is still significant duplication, for example, people having to give basic information to a number of different practitioners; delays in accessing services, frequently this is not to do with the capacity of a service, but the process associated with one practitioner having to 'make a referral' to another practitioner or multiple assessment processes, containing much of the same information.	

Figure 3-3 National, Regional and Local Strategies

The national policy context has a critical influence on the development of health and care services in Lochaber. While not intended to be exhaustive, the following list identifies some of the other key national policies that have influenced the current proposals:

- New GMS Contract;
- Self-Directed Support Act;
- Carers (Scotland) Act 2016;
- Renewing Scotland's Public Services;
- National Clinical Strategy;
- Getting it Right for Every Child;
- Hidden Harm;
- Changing Lives;
- Delivering for Health and associated guidance;
- Better Health, Better Care;
- Health and Homelessness Standards;
- Equality Legislation;
- Improving Health in Scotland: the Challenge;
- Respect and Responsibility – the national sexual health strategy;
- Equally Well – report of the ministerial task force on health inequalities; and
- Community planning and community justice agendas.

Each of these policies seeks to improve the health and social care service response to the people of Scotland. In summary, this policy context provides the following key drivers for the current project:

- Improving equitable access to services through the availability of a wide range of services in Lochaber. It will increasingly be possible to provide safe and effective services closer to people's homes and this will benefit people who use the services by improving access. The demand for locally-based services will grow and this will mean using facilities and staff in an imaginative way to expand capacity to meet this demand;
- People's expectations about the services they receive and where and when they receive them will continue to be demanding, and striving to meet these expectations will remain a policy priority;
- The creation of sustainable and flexible services and facilities that can absorb rising expectations and demand, especially to meet needs for increased programmed care for chronic disease;
- Breaking down barriers between primary and secondary care, and health and social care organisations and professions, through a whole-system approach to planning and delivering services. Nurses, allied health professionals and social care professionals, in particular, will continue to develop their roles in providing care in the context of extended primary care and community teams;
- Working more effectively and efficiently across the public and third sector to join up service provision to achieve better outcomes for the public;
- The high priority attached to the improvement of people's health and improvement of community services. Significant and sustained improvements in health and well-being are achieved through supported self-care and services and facilities are needed to motivate people to look after themselves and to help them to do this;
- Tackling health and social inequalities as a result of poverty and/ or discrimination because of people's ethnicity, disability, gender or sexual orientation;
- Good partnerships with staff, based on involvement and support to provide new, flexible and effective ways of working; and
- The use of advances in information and communications technology generally to benefit service users and reduce the professional isolation of its staff. Medical, information and communications technology will continue to improve and create opportunities for improving local access.

4 WHY IS THIS PROPOSAL A GOOD THING TO DO?

This section will set out the following:

- Current arrangements;
- Need for change;
- Investment objectives;
- Design quality objectives;
- Benefits realisation plan; and
- Risk management strategy.

4.1 What are the current arrangements related to this proposal?

4.1.1 NHS Highland

As one of 14 territorial Health Boards in Scotland, NHS Highland is responsible for the monitoring, protection and the improvement of the population's health and wellbeing and for the delivery of frontline healthcare services.

The Board serves a population of around 320,000 in a diverse geographical area which covers 12,500 square miles in the northwest of Scotland.

The Board employs over 10,500 staff, hosts one District General hospital (Raigmore Hospital in Inverness), 3 Rural General Hospitals in Wick, Fort William and Oban and is supported by a network of community hospitals and health centres, providing care and support for patients.

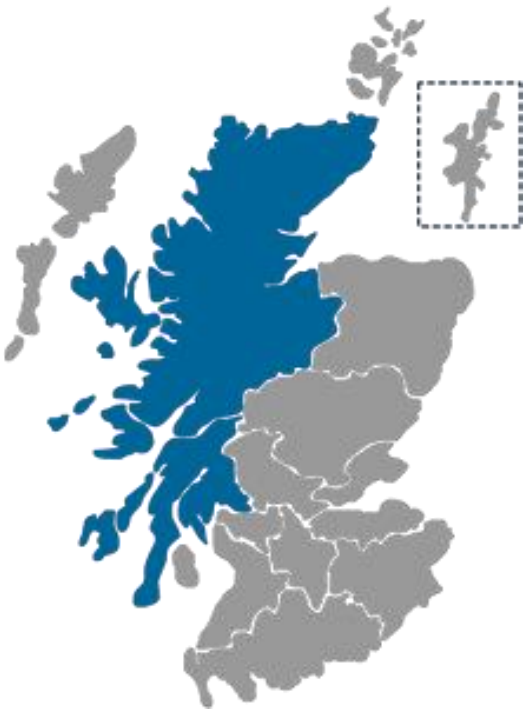


Figure 4-1 Map showing NHS Highland location in Scotland

4.1.2 Lochaber

As lead agency, NHS Highland has responsibility for all adult health and social care services in the region. There are significant features which distinguish Lochaber, and NHS Highland, from other Scottish Health Boards and many of these impact on health needs and in the way health services are delivered.

Figure 4-2 Lochaber region

Lochaber is a large area in the West Highlands, which is known for its scenery and is a major centre for tourism and outdoor activities. Fort William is the main urban centre and has a population of around 10,000. Outside of Fort William there are a number of rural, fragile areas that have more limited connectivity and access to infrastructure.

The population is ageing and has been declining.

Lochaber has also experienced particularly high rates of out migration of young people. Employment is particularly concentrated in the retail, accommodation, and food services sectors, reflecting the importance of tourism for the area.

The following areas have been summarised together to present a picture of the Scottish Index of Multiple Deprivation (SIMD) 2020 findings for Lochaber: Lochaber West, Lochaber East and South, Forth William North and Fort William South.

In 2020, Lochaber's population was estimated to be just over 19,800 representing a 1% decrease since 2011. Lochaber accounted for 8% of the total population of NHS Highland. Over the same period there was a 1% increase in the Highland population to 234,770, and a 2% increase nationally.

The SIMD 2020 database indicates the working age population of Lochaber to be just over 12,000, representing a 3% decline since 2011. Lochaber's working age population was 61% of the total population in 2020, slightly below the Scottish national average of 64%.

In the Fort William Travel to Work Area (TTWA) there was a total working age population of approximately 10,000 in 2016 and an employment rate of around 89%, higher than both the wider Highland Council area (78%) and national (73%) averages. Whilst this figure should be treated with some caution, as it is based on a small sample of the Annual Population Survey, data have consistently shown the Fort William TTWA to have an above average employment rate and anecdotal evidence supports these findings. There has been an upward trend in the employment rate in the area, with an eight-percentage point increase from 2012 to 2016.

Fragile Areas and deprivation

The map below shows areas defined as 'Fragile' in the Lochaber area. Fragile areas are a designation employed by Highlands and Islands Enterprise to identify places at risk of population decline, having fewer younger people, lacking economic and employment opportunities and with transport challenges.

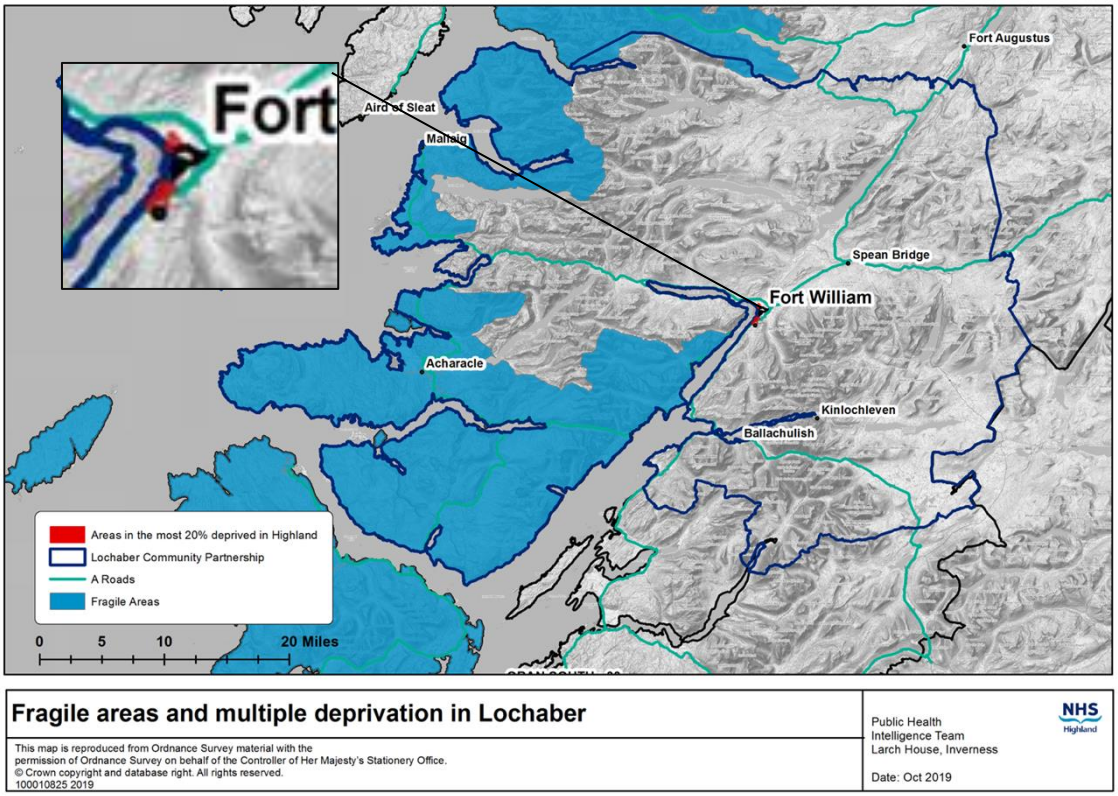


Figure 4-3 Map of fragile areas and 2016 top 20% most deprived areas

There are 3 small areas in Lochaber that were identified as among the 20 percent of areas classified as most deprived in Highland from the Scottish Index of Multiple Deprivation (SIMD 2016). The latest 2020 SIMD index shows that these areas have made progress and are no longer in the 20% of most deprived areas, though there are still local challenges with deprivation.

Further information sourced from the Scottish Index of Multiple Deprivation 2020 provides the following insights.

Where a standardised ratio is referenced, this should be considered in the context of the Scotland average value as **100** for a population with the same age and sex profile.

Key indicators from SIMD 2020	Lochaber	ALL Scotland
Total population (based on 2017 NRS small area population estimates)	19.8K	5.42m
% of Total Population of working age	61.4%	64.4%
Percentage of people who are employment deprived	6.2%	9.6%
Percentage of people who are income deprived	8.5%	12.3%
Average drive time to a GP surgery in minutes	12.4 minutes	3.6 minutes

Public transport travel time to a GP surgery in minutes	23.3 minutes	10.5 minutes

Health factor indicators from SIMD2020

Key indicators from SIMD 2020	Lochaber	ALL Scotland
Comparative Illness Factor: standardised ratio	80.9	100
Hospital stays related to alcohol misuse: standardised ratio	103	100
Hospital stays related to drug misuse: standardised ratio	42.2	100
Standardised mortality ratio	96.8	100
Proportion of population being prescribed drugs for anxiety, depression, or psychosis	16.4%	19.1%
Proportion of live singleton births of low birth weight	6.2%	5.2%
Emergency stays in hospital: standardised ratio	86.4	100

Figure 4-4 Summary of relevant Key indicators from SIMD 2020

4.1.3 Service Providers

The main providers of health and care services in Lochaber are centred in the Fort William area, which is where the current Belford Hospital is located. A number of NHS Highland services are delivered in the community by hospital-based teams; many other agencies contribute to the provision of services based in the community, in collaboration with NHS Highland, these include:

- NHS 24;
- Independent GPs;
- Third sector;
- Volunteers;
- Private Care Home providers;
- Dental clinics;
- Community Optometrists; and
- Complementary therapy providers.

Based on the April 2021 GP practice contact lists made available on ISD, 9 GP practices are located in Lochaber, with two of these operating as 2C practices in Argyll, one as a 17C practice in Kinlochleven and the remainder as 17J practices (see appendix 2 for details and definitions).

There are no Community hospitals in Lochaber. There is limited care home provision which is outlined in more detail at Section 4.1.9.

4.1.4 Belford as part of the Rural General Hospital (RGH) Network

Belford is one of six Rural General Hospitals in Scotland, with the most recent capital investment being The Balfour in Kirkwall. Rural General Hospitals have the following definition based on a report produced by the Rural Access action team as part of the National Framework for service Change in Scotland:

"A hospital sited in an area distant from urban conurbations which, because of compromised patient travel times, provides a locally based, consultant-led service to meet the healthcare needs of a population not large enough to require a district general hospital."

More recent work recognises that the consultants work as part of a wider multi-disciplinary service team, and while they play an essential role in aspects of service delivery, they work alongside a range of other healthcare professionals, including nursing staff and allied health professionals who often lead on core aspects of service provision.

Raison d'etre for Rural General Hospitals

- Emergency medical care: triage, diagnosis, resuscitation/stabilisation and treat where possible, transfer when necessary;
- Locally based elective care: diagnosis, treatment or transfer and follow up; and
- Care for chronic illness: care of the elderly, stroke, diabetic care and renal dialysis.

Siting
Within the areas of Scotland that have travel times greater than 2 hours from a population centre of more than 30,000 people there are eight towns which have populations of over 3,000. Six of them are served by Rural General Hospitals; the Balfour in Kirkwall, Orkney, the Gilbert Bain Hospital in Lerwick, Shetland, the Caithness General Hospital serving Wick and Thurso, the Belford Hospital in Fort William, the Lorne and Islands Hospital in Oban and the Western Isles Hospital in Stornoway, Western Isles.

4.1.5 Current services In Belford Hospital and Lochaber District

NHS Highland provides an extensive range of services to the community within Belford Hospital either directly by teams based in Lochaber or through visiting specialists from Raigmore hospital, Inverness. In addition, telemedicine links are frequently used to support the delivery of care using the "Near me" service.

A number of medical and surgical services are provided on an outpatient, day case and inpatient basis by the local team in Belford, while specialist outpatient clinics are provided by a team of consultants from Raigmore who visit at regular intervals.

Patients travel to Inverness for a range of specialist secondary care services, for example specialist surgery and specialist children's services.

There are approximately 10,000 attendances per annum to the Emergency Department (ED), the vast majority of which (~80%) are relatively minor and do not result in admission to hospital. The nature of many of these minor injuries relates to the variety of outdoor pursuits available locally in the recognised Outdoor Capital of the UK (OCUK); the number of attendances is up to 50% higher in summer months when tourist numbers swell the local population significantly, although it is worth noting that Lochaber is increasingly a year-round destination. Major trauma cases are typically flown directly to Glasgow once stabilised.

Please see appendix 3 for a full list of services currently provided in the hospital and community.

4.1.6 Current Workforce

NHS Highland employs around 8,150 WTE staff (10,170 posts) staff of which approximately 184 WTE (280 posts) are based at the Belford Hospital, Fort William. An additional 122 Bank Nursing posts are recorded at the Belford Hospital but not included here.

45% (126) of the 280 post holders are aged over 50 (75% Healthcare Sciences, 67% Support Services, 54% Medical & Dental).

The turnover rate for the period 01/07/2020 – 30/06/2021 is 7.58% (8.06% in Nursing & Midwifery, 16.13% in Medical & Dental).

The absence rate at the Belford Hospital is 4.97%, 0.97% above the national sickness absence target of 4%. The absence rates are higher across Clinical Support and Medical Services.

4.1.7 Current Premises and Assets

The Belford Hospital was built in 1965 with an expected lifespan of 60 years (2025). The clinical areas in Belford remain much as they were designed in the 1960s and the current building is functionally unsuitable and does not meet modern space standards or modern infection prevention and control standards.

There are significant issues with functional suitability in terms of infection control, patient dignity, flow within the building and accessibility, and the current facility limits the ability of the service to adapt to new ways of working and modern health care delivery.

Figure 4-5 Belford Hospital main entrance

The Belford Hospital needs significant modernisation; however, the method of construction (in-situ reinforced concrete) means that modification would be very disruptive, time-consuming, and expensive. These issues were identified during the AEDET review.

While investment has been made over recent years to maintain appropriate levels of safety and functionality, the facility remains cramped and dated, and the building does not provide flexibility to enable the delivery of new clinical models. Much of the ward accommodation is housed in multi-bedded bays with shared sanitary facilities on each ward corridor, and accessibility to the site is poor.

There is no room for expansion as the hospital site is constrained on all sides, in particular by the A82 to the North and by a cliff face to the south, with virtually no outside space, very limited parking and compromised delivery access.

Replacement is seen as the only viable option to addressing these issues. The hospital needs to be replaced by a facility that enables enhanced service provision as the current infrastructure cannot realistically be adapted to meet the requirements of new and emerging models of care.

Unit	Number of beds	Historic occupancy level	Records of delayed discharges
Combined Assessment Unit	15 inpatient beds (multi-bedded) 2 HDU beds	79.6%	Historically, 3-4 patients delayed each month (approx. 10% of bed capacity), rates in 2020/2021 exceeded this, 5-8 patients frequently waiting.
Ward 1	15 beds (mix of single and multi-bedded)		
Day Case Unit	9 bed spaces (multi-bedded)		

Figure 4-6 Table of beds by unit in Belford Hospital, Fort William

The current accommodation has high levels of unsatisfactory physical condition and often fails to meet DSDC Dementia Design Principles and modern accessibility standards such as BS8300; this makes compliance with the Equality Act 2010 particularly challenging.

4.1.8 Care at home usage

The Care at Home service is aimed at helping people to stay independent in their own home. The service at present lacks flexibility and at times capacity. Strengthened and responsive care at home is a key component of the new model and will contribute to less reliance on hospital beds. Care at Home is embedded within the Integrated Teams to provide greater support, responsiveness, and adaptability.

Area Client Category	<1 month	<3 month	<6 month	<1 year	>1 year	Total
Lochaber	8	13	24	26	180	**251**
Dementia	1	3	3	1	21	**29**
LD Mental Health Other	0	0	1	2	8	**11**
Physical disability	0	2	1	1	43	**47**
Problems arising from infirmity due to age	7	8	19	22	108	**164**

Figure 4-7 Number in Care at Home service by client category and length of time in service (Nov 2019)

The care at home service has been looking after approximately 75% of their clients for more than 1 year with few additions in categories other than old age. Over 75% of the current patients are more than 75 years old. Services are predominantly provided by in-house teams, with very little change in the proportion of care provided by in house or independent sector providers

4.1.9 Care Home Provision

In-House Care Homes

NHS Highland currently spends £13.6m per annum (gross) (£10.6m net) providing 205 registered care places. Unit costs range from £870 to £2,075 per person per week with a maximum gross charge of £1,100 applied by NHSH.

External Care Homes

NHS Highland currently spends £44.68m per annum (gross) purchasing 1,535 care home placements.

The complexity split in commissioned care home places is 50/50 within residential and nursing care. Up to 30% of current care placements are privately funded (Source: NHS Highland 2019-2020).

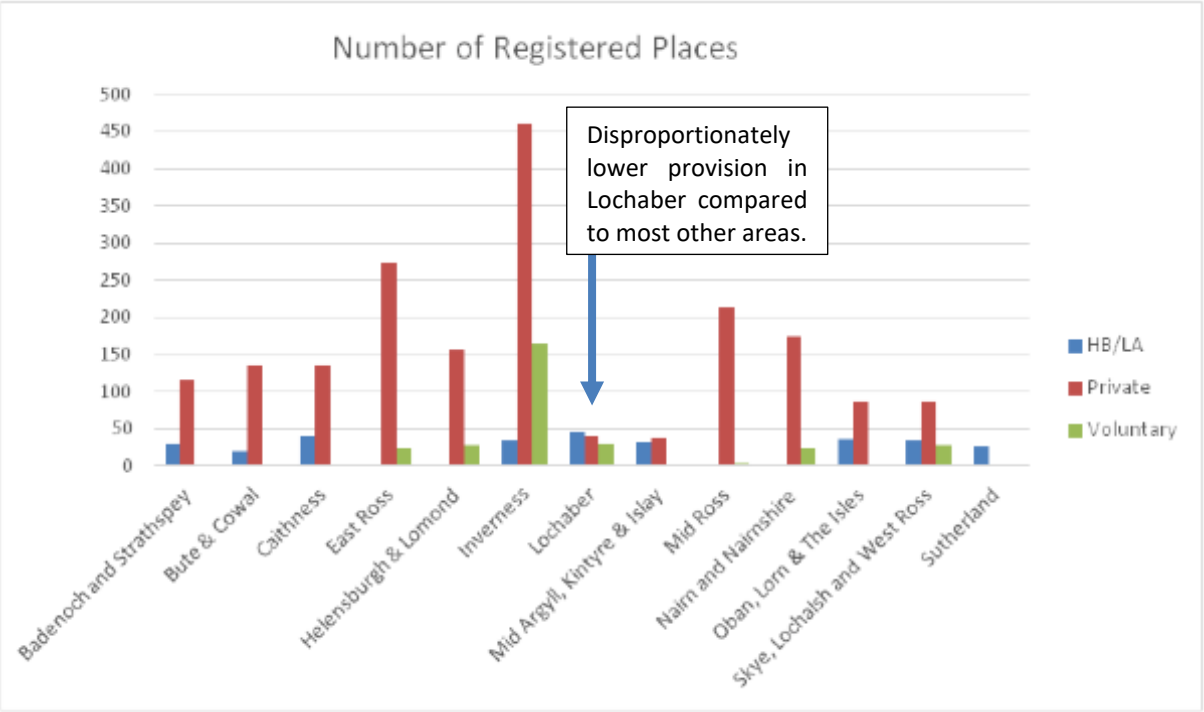


Figure 4-8 Number of registered Care Home places in NHS Highland, Lochaber highlighted

The population in care homes is changing. Residents are older, frailer and require more assistance than was the case in the past. “In Scotland the number of long stay care home residents aged 85 years and over has increased by 12%, the number of residents with dementia has increased by 30% and the average level of assistance required by those in such facilities to support activities of daily living (ADLs) has also increased” (Source: National Health Service Scotland. The changing functional needs and dependency of people living in care homes. Evidence from use of indicator of relative need in Scotland. 2016).

There is a need for closer working with primary care and care homes in relation to reducing the need for hospitalisation and reducing length of stay. This approach could be supported by exploring options to provide step-up and step-down beds either via a commissioning model, or as part of the new development within the service options.

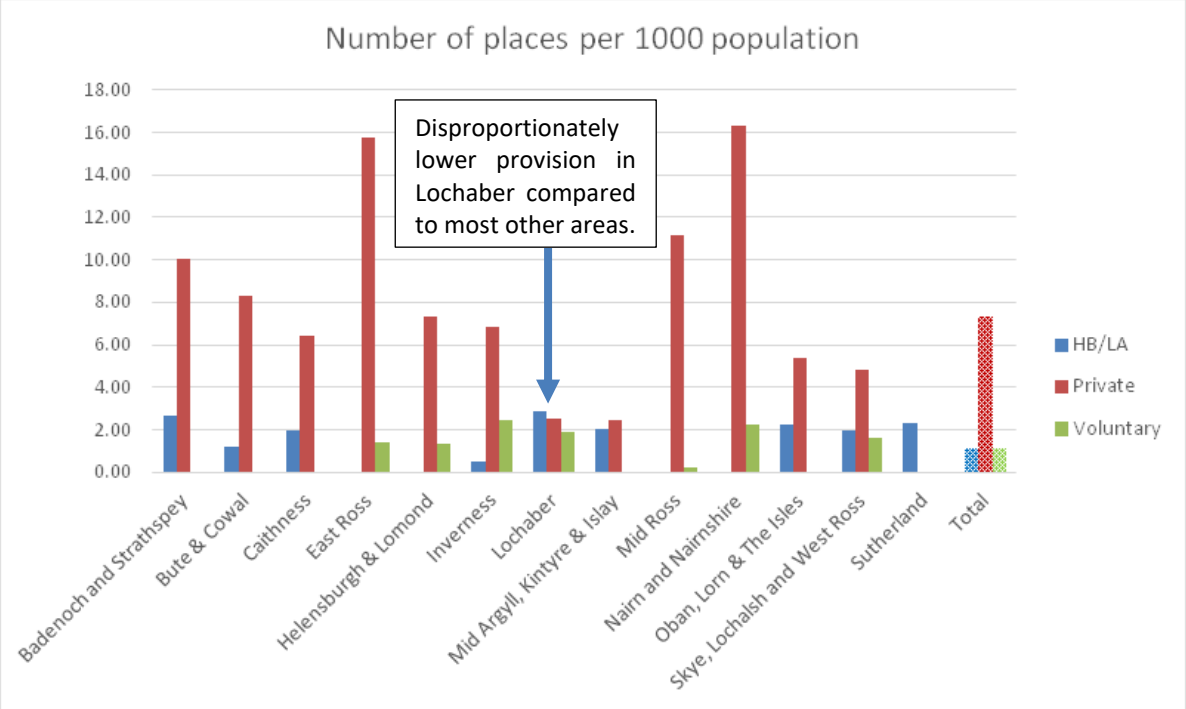


Figure 4-9 Number of registered Care Home places per 1K population in NHS Highland, Lochaber highlighted

There is considerable overlap in health status and need for care and support amongst residents in all care homes, and in particular a high prevalence of cognitive impairment, co-morbidity, and polypharmacy. Increasingly, care homes are becoming places where people with complex health care needs live. They are homes for people who are very frail or for people who are unable to care for themselves and who may present a risk to themselves or others.

4.1.10 Framework for delivering for Remote and Rural healthcare

This report presented to the Scottish Government the vision for the development of a sustainable health system for remote and rural Scotland. It provided a framework for rural health services to continue to develop and enhance their roles in the continuum of healthcare across Scotland. The framework was intended to help services orient themselves on the changing needs of communities and make best use of available resources to deliver further improvements in the health of people living in remote and rural areas.

The fundamental underlying principle of this work was that access to healthcare should be as local as possible, for the whole population of Scotland, no matter where they live. The remote and rural steering group were tasked to develop a policy for sustainable remote and rural healthcare services.

Figure 4-10 2007 report on Delivering for remote and rural healthcare

This report concluded that:

> "Within the remote and rural communities of Scotland, there are a limited number of health and social care professionals, whose **skills and expertise need to be shared** if communities are to have local access to the widest possible spectrum of care…. Services must be well-planned and co-ordinated with a greater focus on more collective and collaborative responses within and across communities. This will include the formalisation of networks to ensure that **larger centres are obligated to support and sustain healthcare services in remote and rural areas**."

Since the publication of this report, significant whole system redesign work has been undertaken across NHS Highland, and in Lochaber in particular, in order to reconfigure service delivery to optimise outcomes. The geography of the catchment area around Fort William, illustrated in the Transport Scotland network of key trunk roads map below, demonstrates the major access routes in Scotland.

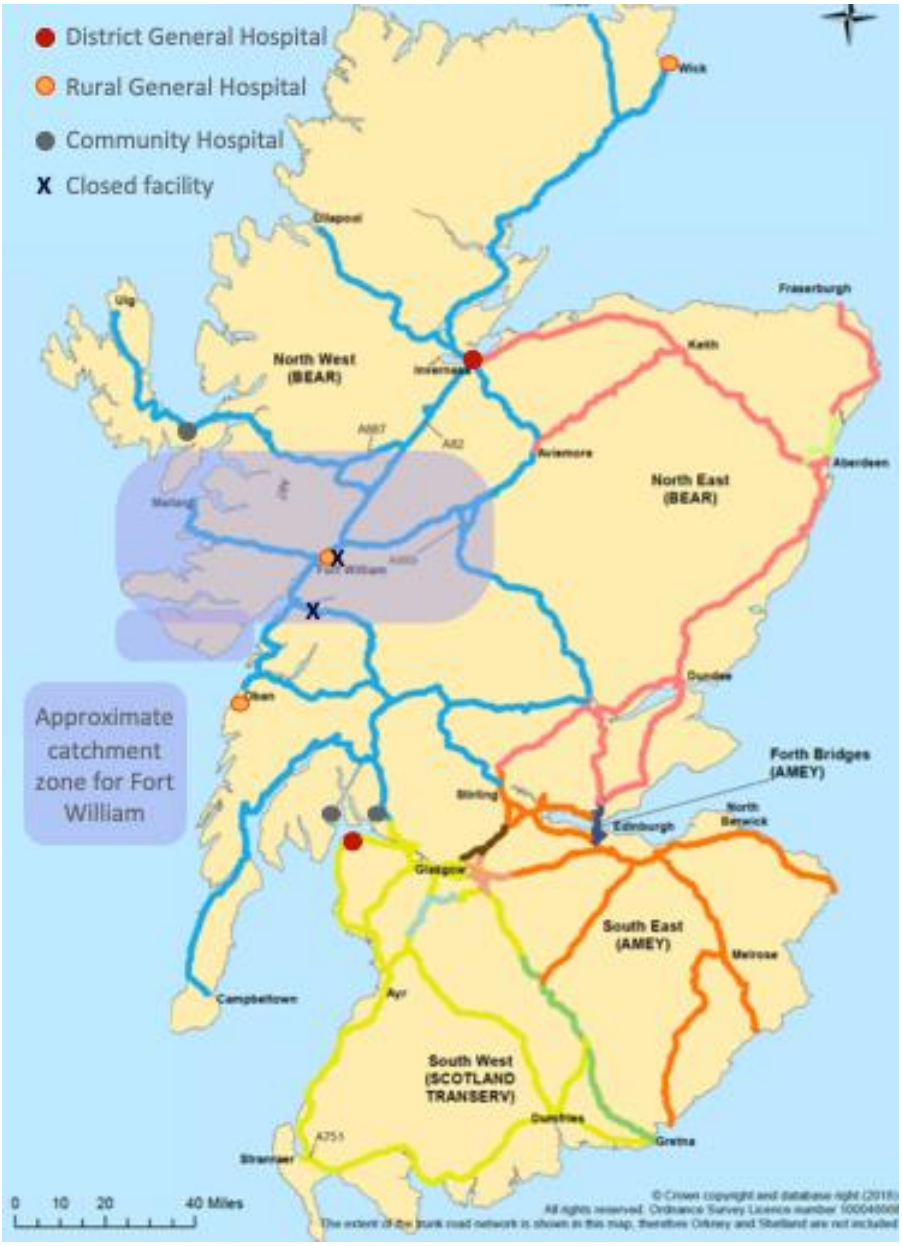


Figure 4-11 Transport Scotland trunk roadmap with NHS Highland annotations

The approximate population catchment area for Fort William is overlaid on the map above, alongside key nodes in the NHS Health and Care delivery network that services the North and West of Scotland. District general, Rural general and major Community hospitals are indicated, as are the sites of a number of key asset closures in the region.

It is clear from the geography, and the main access routes around the west and North of Scotland, that the Rural General hospital in Fort William is a key element of both the "formal network" and the "collective and collaborative response" to service provision in this region.

The Scottish Government Urban Rural classification report undertaken in 2016 contained this map, where colour codes are applied to areas based on rurality. Recent local discussion within NHS Highland indicates that it is likely that little has changed in this assessment in the last 5 years, with regard to the relative rurality of areas relevant to the scope of Lochaber redesign.

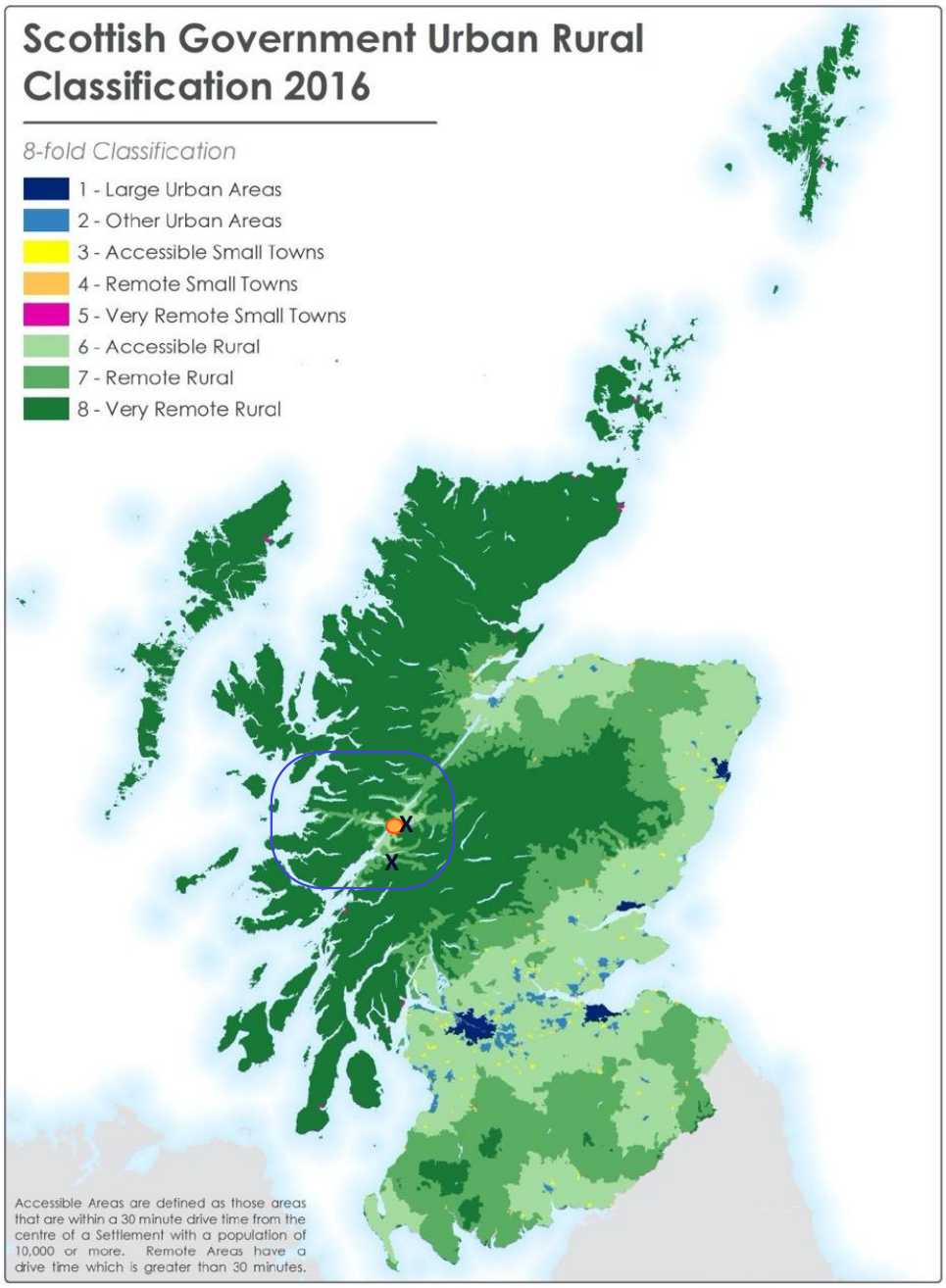


Figure 4-12 Scottish Government urban Rural classification, with Lochaber region highlighted

A Rural General hospital in the Lochaber region is considered a vital node in the Health and Care network to support local access to services and avoid otherwise potentially serious consequences for citizens who would have extremely long travel distances and journey times to District General hospitals. This view is even more relevant today, as NHS Highland seeks to optimise the use of all capacity for delivery of health and care services, relieving pressure on the acute site wherever possible, with a greater balance of care being delivered locally where safe to do so.

The key central location of the RGH at Fort William within NHS Highland is shown below map of hospital sites within the Board area, and both its position, and the suite of services it provides for the local population form an essential feature of the network of facilities and services across NHS Highland:

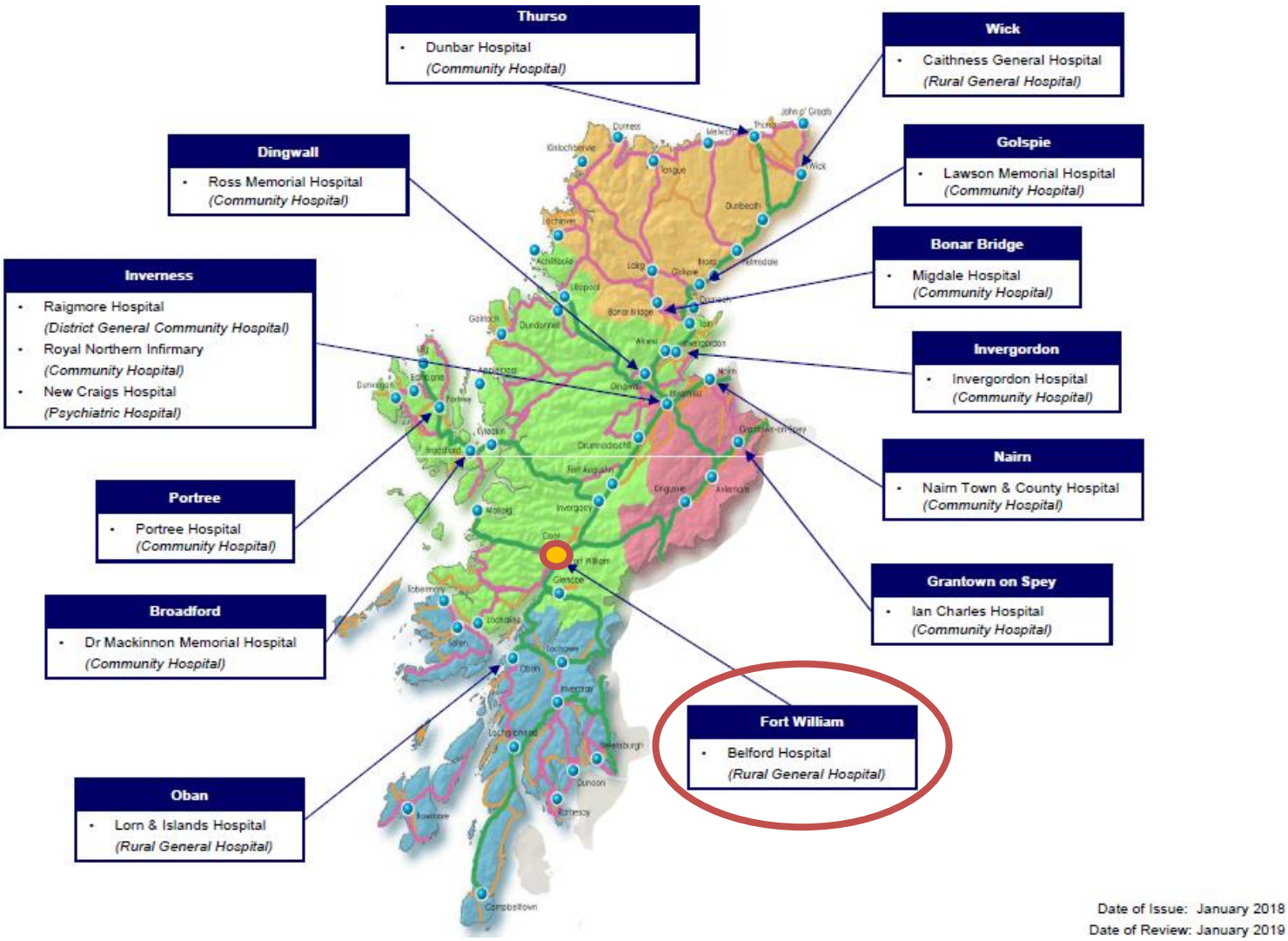


Figure 4-13 Network of facilities and services across NHS Highland

Travel is an important consideration in the context of health care provision in rural areas, as in many remote and rural areas, the travel times by public transport are significantly longer than by car and services, where they exist, are infrequent.

In a national context, the population of Lochaber lives at extreme distance and journey time from hospital services available at the nearest District General Hospital at Raigmore in Inverness. Approximately three-quarters of the population of Lochaber area would take between 90 and 120 minutes to reach Raigmore, taking the most direct route via the A82. The remaining 25 percent of the Lochaber population live beyond two hours' drive time of Inverness, and for those reliant on ferry services the journey time is considerably longer.

More than two-and-a-half hours driving time from Fort William is required to reach the nearest teaching hospital in Glasgow. In comparison, approximately three quarters of the population of Lochaber can access the Belford Hospital in 30 minutes by driving. When this travel time threshold is raised to 60 minutes, this proportion rises to 85% of the local population.

It is noted that local main routes, and the A82 and A828 in particular, have seen a significant number of road traffic accidents which can result in the road being closed for up to 8 hours, in addition to road closures and increased journey times due to weather conditions and landslides.

Lorne & Islands hospital in Oban is located 45miles away from Fort William, a drive of approximately 1h20m along a winding single carriageway. In the event the main route is closed the necessary detour increases that distance and travel time to over 80miles/ 2hours, with travel from more remote areas of Lochaber considerably longer.

The distance (and times) from Lochaber to the District General hospital in Raigmore or to Glasgow necessitates the provision of services locally to support an acute response as well as driving the need for access to Operating Theatres, the Emergency Department, Radiology and Lab services.

4.1.11 Whole System Service redesign

Lochaber service redesign work has continued to progress well and services endeavour to adapt as far as possible in relation to the changing needs and expectations of the local population, in response to developments in clinical care, as well as within health and care technology. A summary of many of the key changes which have been implemented as part of the long-term approach to service redesign in Lochaber are outlined below:

Year	Summary of key service development changes
2007	• Glencoe Hospital closed (12 beds) • Fort William Health Centre opened
2009	• Combined Assessment Unit (CAU), combined step-down ward (Ward 1) and a Day Case Unit implemented in Belford, requiring conversion of inpatient beds to day-case spaces
2010	• Virtual Ward implemented between Ballachulish GP Practice and Belford
2011	• Patients moved out of Belhaven. Used as a staff team base.

	• Upgrade of Belford Theatre and Endoscopy
2012	• Integration of health and social care including NHS Highland taking over management of care homes and care at home • GP bed introduced in Moss Park Care Home
2013	• Planned closure of Belhaven facility (30 beds) • Staff team base from Belhaven relocated to Fort William Health Centre
2014	• Integrated teams established
2015	• Flexible bed model implemented at MacIntosh Centre, Mallaig
2016	• Ambulatory care service introduced at Belford
2017	• Introduction of Mental Health Urgent Care Nurse
2018	• Strategic assessment for Development of Belford Hospital as part of Lochaber Redesign work
2019	• Introduction of Near Me to prevent unnecessary patient travel
2020-2022	• Increased used of virtual consultation to connect citizens to Raigmore based services, as well as GP and community-based services, in response to the COVID-19 pandemic

Figure 4-14 Summary of key events in supporting whole system redesign across Lochaber

The health and care teams in Lochaber have continuously looked at ways of improving quality of service delivery and patient outcomes. In 2009, the services within Belford were reconfigured to improve patient access, assessment, treatment/ stabilisation and transfer or discharge to the appropriate setting. Following an intensive change process, the Combined Assessment Unit was opened on the 30th November 2009. This unit was to designed place an emphasis on the management of acute medical and surgical needs, while Ward 1 concentrated on delivery of activities to support rehabilitation and intermediate care, similar to the function of a community hospital ward in other regions.

Potential for further change is constrained

NHS Highland and the population of Lochaber have been on a journey of service redesign, demonstrating impactful change over the last 15 years. The potential for continuing to deliver service change and service provision to meet the varying landscape of modern health and care delivery, in alignment with the shifting needs and expectations of the population is now rapidly diminishing, with the constraints of the existing Belford hospital beginning to limit the art of the possible.

Adapting the model of delivery to accommodate the size and shape of demand for modern health and care services, which is unrecognisable compared to many historic practices, is now at the limit of operational practice, constrained by the Belford facility.

Modern healthcare makes considerably more use of “joined up” care: optimising patient access to services by coordinating care, such as diagnostics, lab services, ambulatory and day case treatments and enhanced levels of outpatient-based care. The lack of continuing flexibility in layout and facilities at Belford make attempts to further “join up” elements of care considerably more complicated, with space, and key clinical adjacencies no longer appropriate to support efficient and effective patient flow and optimise treatment modalities.

Further service development is planned to improve and accelerate implementation of the following elements of care, which cannot fully be realised without an appropriate facility with sufficient flexibility, designed to support their delivery:

- Separation of flows for emergency and planned attendances;
- Optimisation of Emergency Department care with appropriate collaboration and management alongside minor injuries, GP out of hours and introduction of Same Day Emergency Care;
- Appropriate service model and facilities to support seasonal peaks of activity experienced as the official Outdoor Capital of the UK;
- Continued provision of emergency stabilisation and transfer of services for complex/ critical patients, including appropriate resuscitation facilities;
- Increased focus on managing frailty, from the front door, and supporting patients to lead active lives at home or in a homely setting for as long as possible;
- Appropriate focus and specialisation of community hospital level rehabilitation and intermediate care services from acute medical and surgical services;
- Ability to safely deliver a range of surgical interventions locally, where there is no need for critical care, ensuring appropriate capacity to support Elective Care Recovery and ongoing provision across NHS Highland;
- Enabling access to a local place of safety for citizens experiencing challenging Mental Health crises, before planned transfer to a more appropriate environment;
- Increased access to one-stop visits including diagnostics, clinic appointments and/or treatments;
- Improved collaboration and teamwork across acute, primary and community services, improving efficiency and effectiveness of staff with access to shared facilities; and
- Admission avoidance, and attendance avoidance through use of community-based teams and adoption of supporting technology for managing long-term conditions and managing treatments in a homely setting as part of a broader health and care network.

4.2 What is the need for change?

There are various reasons why a need for change can be driving forward an investment proposal; including overcoming a problem with the existing arrangements, responding to a driver for change, or presenting an opportunity to improve outcomes when compared to existing arrangements.

A full list of the main issues causing the need for change is provided below, much of which is a direct response to problems with the existing arrangements described earlier. The summary table at the end describes the effect it is having (or likely to have) if nothing is done about it, and an explanation of why action needs to be taken now and through this proposal.

4.2.1 Securing local access to services

Many services are available locally in Lochaber, from consultation through treatment and follow up regimes, while other specialist services make use of visiting consultants who travel from Raigmore Hospital to see patients locally and assess their ongoing needs for treatment.

Some treatments, e.g. specialist types of surgery, are only available at Raigmore Hospital, and there are often insufficient volumes of activity locally to provide a sustainable service in any other arrangement; there is no intention to alter the strategic planning assumptions for these services.

However, where services are available locally, there is evidence which suggests residents from Lochaber are being asked to travel to Raigmore Hospital for consultations and treatment, incurring time, cost and associated stress and disruption to their daily lives to access the advice and treatment they require. In optimising the service delivery model for the Belford Hospital, as part of the NHS Highland overall plan, we will ensure that both staff and patients have full transparency over which services can be accessed locally, and how and when this will be possible. In the spirit of co-design, the team will work with patients to decide together on the best course of action, based on the urgency of their condition, and the local capacity available.

The new Belford Hospital will be designed to support modern approaches to health and care delivery, in appropriately designed facilities, which optimise high quality patient outcomes and promotes local service delivery with an efficient and sustainable service model for staff and patients. Where local residents' needs, as agreed between patients, clinicians and carers can be met by local service provision, there should be a drive to ensure this is always met locally to reduce unnecessary travel for patients.

Travel is an important consideration in the context of health care provision in rural areas, as outlined earlier in 4.1.10.

The distances (and times) from Lochaber to the District General hospital in Raigmore or to Glasgow necessitates the provision of services locally to support an acute response as well as driving the need for access to Operating Theatres, the Emergency Department, Radiology and Lab services.

Reducing unnecessary travel can contribute to reducing the carbon footprint of the local Health and Care economy, which aligns with the national drive for a Net-Zero Carbon society.

4.2.2 Relieving pressure on the acute site in Raigmore

System-wide, the capacity in the NHS in Scotland is under considerable pressure, both in terms of managing unscheduled care demand and in responding to the rapidly-growing crisis of backlogs/ waiting lists of elective procedures.

Effective use of NHS flow hubs can ensure that all cases where the most appropriate setting for the catchment population relating to Fort William are directed as appropriate to attend Belford hospital Emergency Department (ED) and/or a minor injuries area within it. In order for this to function well, managing the demand and providing the right service at the right time safely for patients, the size and configuration of the ED in Fort William will need to be appropriate for the task. It is currently constrained in terms of space, and limited in capacity, which can be particularly challenging when seasonal peaks of activity are experienced.

From a planned care perspective, ensuring the adequate service provision in day treatments such as Renal Dialysis, Infusion therapies and Chemotherapy will enable the maximum number of patients who can safely be managed in the RGH site to be accommodated, lessening the demand for the same services in Raigmore. With increasing number of biologics and infusions being used and developed, and rising numbers of cancer cases likely accelerating demand for these services, optimising local provision will help protect the acute capacity at Raigmore for the most complex cases requiring specialist input.

Similarly, ensuring adequate provision of elective theatre capacity, with supporting day-case facilities, delivered by a combination of resident and visiting specialty workforce, will enable waiting lists to be more effectively managed, for less complex patients and where intensive care support is not required. NHS Highland is seeking to make optimal use of all available theatre capacity, with flexible deployment of workforce in an effort to boost elective care recovery. Having a suitably supported service and environment in Fort William will enable this recovery to happen more quickly as well as provide an optimal service locally for eligible patients, avoiding the need for unnecessary travel.

4.2.3 Avoiding admissions and overnight stays where clinically appropriate

Advancements in models of care such as treating more patients on a day-case and ambulatory basis and avoiding bed-based admissions unless essential for patient care require appropriate environments to support the model. Patient flow, types of accommodation, adjacencies and equipment are all essential in providing care in this manner; the current facilities do not support this.

To support unscheduled care, a Same Day Emergency Care model would be beneficial to introduce, treating patients in an ambulatory setting and ensuring they are discharged home or to a homely setting rather than admitted to hospital. This ensures that inpatient beds are used by only the most complex and/or acutely unwell patients, protecting the capacity for the most vulnerable. At the same time, this approach ensures many more patients can return to their own place of residence following a same day treatment in hospital, which improves patient experience and avoids the sometimes-inevitable deterioration that comes with an unexpected admission to an inpatient hospital bed. There is currently no physical available area to facilitate this approach, and an appropriate supporting multi-disciplinary workforce model will need to be developed to support its function.

An Ambulatory care service was introduced in 2016, primarily treating individuals referred by GPs (or occasionally presenting through ED) on an ambulatory basis. The only means of delivering this service currently is from the space within the Combined Assessment Unit, effectively utilising what would otherwise be an inpatient space to deliver treatments on a day-case basis. This necessitates staff mixing patients in the ward environment including use of shared sanitary facilities, juggling available bed capacity, while trying to maintain gender segregation and having patients waiting in the ward environment until they can access the space for receiving treatment. While the introduction of the service has improved care for patients in the sense that overnight admissions are avoided, the means of delivery due to capacity and space constraints limits the services on offer considerably. A more appropriate ambulatory environment is required to deliver such services efficiently and optimally for both patient experience and outcomes.

Many more surgical procedures can now be safely carried out on a day-case basis, and most endoscopy activities are similarly delivered on a day-case basis. The current layout, capacity, and flow to support these planned, day-case activities is mixed among the scheduled and unscheduled inpatient care area, with little opportunity to change this. As far as possible spaces have been cohorted together in one area to support management of day-case activities, and simplify care from a workforce perspective, but the key adjacencies to theatre and endoscopy suites cannot be optimally configured in the current setting. Access to the day-case environment is embedded within inpatient facilities, with no clear separation and specialisation of patient and visitor flow for these services.

The current Belford Hospital building does not offer any flexibility to respond to advances in clinical practice and there are no expansion zones on the current site, which is bounded by a steep slope to the south and the A82 to the North. It needs to be replaced to enhance current service provision and support the future development of models of care and patient treatment pathways.

4.2.4 Separating elective and emergency care flows

There has long been recognition of the fact that separating unscheduled and planned care flows from one another allows both service elements to be provided more optimally, ensuring patients only access the services they require. This learning has been reinforced significantly through the covid-19 pandemic, where health and care teams sought to further separate flows to manage risk and protect patients attending the hospital environment.

With a constrained footprint and services built up piece by piece over time, Belford currently operates in a situation where returning (planned) fracture clinic patients (Orthopaedic trauma) attend through the Emergency Department, and related treatment activities (including access to the plaster room) operate in tandem with, and around the day-to-day emergency department activities in the same space.

This is suboptimal for both groups of patients, and can be a source of great frustration for staff, as well as compounding the issues of constrained capacity and space available for peaks of activity in the ED. Best practice would highlight the need to separate and appropriately support planned activity in a quieter and less pressurised area than the ED. Neither the adjacencies, equipment nor capacity are available in the current outpatient department to facilitate this at present.

Section 4.1.3 above highlights a similar mixing of elective and unscheduled care in relation to surgical activity, which would be better served by a specific managed flow for elective services, improving both patient and visitor experiences, and reducing unnecessary footfall through inpatient and emergency environments.

4.2.5 Inefficient current service models

How and where people are treated locally offers another area for improvement. Current models continue to bring people to the acute setting for out-patient appointments and to GP practice appointments that could have been delivered remotely in the community or in

people's homes utilising technology; people are rarely given a choice of where and how they access services.

The current service model also lacks suitable alternatives to remaining in hospital following an episode of acute care, usually Care at Home provision or a Care Home placement. There is inconsistency of services needed to enable people to stay safely at home or in a homely setting available quickly enough, and a lack of community hospital beds in Lochaber meaning that acute inpatient beds are often the default place of care for people waiting to access these services. This is sub-optimal from a patient perspective, constrains an already pressured acute hospital facility and is a poor use of resource. People are too often unnecessarily delayed in hospital when they are clinically ready to be discharged.

As Lochaber does not have any community hospital beds, the establishment of flexible use beds is an important part of the clinical model to support keeping people at home. Any reduction in acute beds within the redesigned hospital will impact on this. This development has already been piloted at the Macintosh Care home in Mallaig with significant success.

While rehabilitation activities are delivered within the hospital environment, it should be noted that the constraints of the current infrastructure and configuration (which was not specifically designed for this function), limit the efficiency of rehabilitation services which can be delivered and does not promote independence or support reablement.

Up to 10% of beds at any one time are occupied by patients who are medically fit for discharge but awaiting other aspects of support to be in place before they can safely leave the hospital environment. Records indicate that the most common reasons for delayed discharge in the hospital relate to delays incurred while the patient is awaiting either assessment of care needs, or the required care package/ care home place being made available. These are the top reasons relating both to the number of patients delayed, as well as the total days spent in hospital during the delay.

Almost 60 percent of current care home residents are considered to have some form of dementia, an increase of almost 20 percent since 2006. Analysis of care home placements and discharges (primarily deaths) shows that a '1 in and 1 out' pattern operates in Highland. The high occupancy rate of care homes inevitably means that it can be very difficult to match the supply of places to the individual needs of those requiring the service. Source: Assessing the needs of individuals with high levels of dependency in NHS Highland, Public Health Department, 2018).

Across Scotland, 38% of the spend on adult social care was on care homes and 25% on home care (2013/14 figures). There is a case for spending a greater proportion on home care. (Source: Information Services Division (ISD). Scottish Health Service Costs. 2016).

4.2.6 Inability to meet future service demand

The population served by NHS Highland, and within Lochaber in particular may be relatively static, but the proportion of older people in the community is projected to grow considerably over the next 20 years. It is estimated that there will be decreases in all age groups up to 65, whilst there will be a 37% increase in 65–84-year-olds and the number of people aged 85+ will nearly triple. People aged 65+ will account for almost one third of the Lochaber population

by 2041. The working age population in Lochaber is projected to decline by 19%, compared with 12% across Highland Council area.

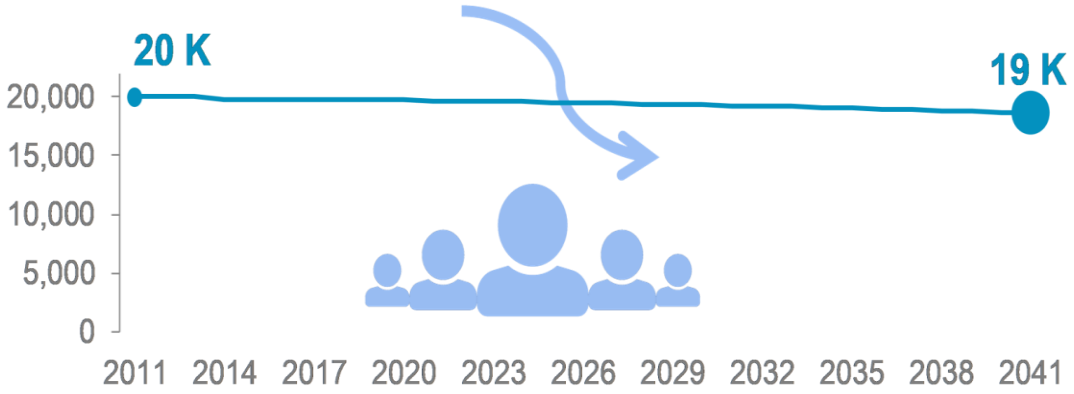


Figure 4-15 – Population projections for Lochaber region

As a result, demand for certain types of health and care services associated with older adults is increasing year-on-year.

Despite many improvements, there are still major health inequalities across our local communities which need to be addressed. Growing numbers of people are also developing preventable health conditions linked to alcohol, smoking and being overweight. All of this presents a huge challenge to the NHS and our healthcare services need to adapt to meet these challenges.

The NHS needs to work with partners, community organisations and the voluntary sector to deliver more care and support in people's homes, GP practices and health centres to help reduce emergency hospital admissions.

Rising demand for long-term care

Whilst the population is increasingly healthy and more people are living to an older age, the number of people living with one or more long term condition is also increasing rapidly. Future models should help people focus on positive well-being, preventing disease and complications, anticipating care needs and self-management tailored to their needs.

The human costs and the economic burden of managing long-term conditions for health and social care are profound, as 60% of all deaths are attributable to long-term conditions.

Advancement of Frailty as a specialism

It is recognised locally, as well as across the UK, that increasing numbers of people are at risk of developing frailty. People living with frailty are experiencing unwarranted variation in their care. In an effort to better respond to the needs of these patients, Frailty as a specialty is receiving additional focus, pathways are being developed and teams are being co-ordinated to work together on the specific challenges presented by this patient group. Guidance is provided by NICE and other bodies in informing the design for the needs of an increasing number of frail and elderly people.

Building on this to enable early identification, prevention of admission, hospital flow and safe timely discharges would be highly beneficial for patients, the hospital, and the wider

community. Ensuring that the hospital is designed with the intention of being "Frailty Friendly" with attention given to patient orientation, flooring and wayfinding would benefit everyone. The future service will have the capability and flexibility to adapt to increasing volumes of patients, including those with frailty and multi-morbidity and to other changes in demand over time. Knowing an individual is living with frailty, knowing individual choices, knowing what health and care input individuals with frailty are receiving is important for the whole system.

Additional Housing

The Housing Land Audit 2020 is an assessment of the housing land supply available in the Highland Council area as of 1st June 2020. With regard to specific plans for Lochaber, the audit identifies and provides a programme of expected housing delivery over the initial and two following 5-year periods and includes expectations for the delivery of new homes up to and including the year from June 2035. Based on this audit an additional 411 homes are planned for delivery in Lochaber between 2020 and 2025, with a further 219 to be completed June 2025-May 2030.

While additional housing is planned, it should be noted that the demographics for the region indicate a likely static/ decreasing total population for the area, even if the number of households is anticipated to increase.

The map below indicates the areas identified for housing development in Lochaber during this period, highlighted in pink:

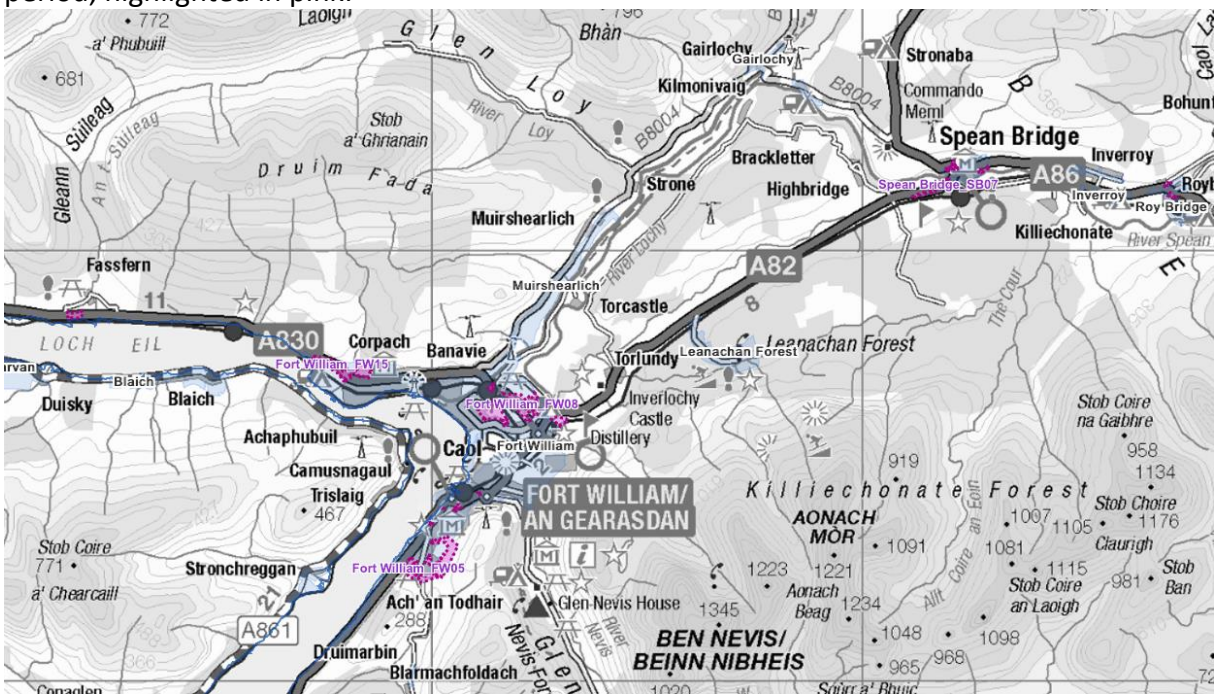


Figure 4-16 – map of planned housing developments within short travelling distance of Fort William

Sites included in the Audit are housing sites under construction, sites with planning consent, sites in the relevant adopted or finalised Local Plans/Development Plans and, as appropriate, other buildings and land with agreed potential for housing development. All new housing development, redevelopment, conversions, and subdivisions are included. In addition to sites allocated in the relevant Local Development Plans (LDPs), there are a number of other sources of development that provide additional supply through windfall (WF) sites. Where such a site

has planning permission on 1st June 2020 and will provide 4 or more housing units it has been included in the audit.

No one size housing model appears to fulfil all requirements for older people living independently in the community. Irrespective of the housing developed it should meet a range of needs within the local area. Accessibility, adaptability, and flexibility are key elements to providing housing for people as they become older.

4.2.7 Inadequate facilities, unable to support modern models of care

The most recent Property and Asset Management Strategy (PAMS) identified approximately £1.5m of backlog maintenance associated with the Belford hospital in Fort William.

Almost all aspects of the facilities fail to meet modern building guidelines on minimum size, and staff feedback indicates that activities are restricted in certain spaces due to inadequate space to accommodate appropriate equipment and furnishings. Many services have identified single spaces as being expected to cover multiple functions, without the appropriate flexibility in configuration or capacity in the time schedule to adequately accommodate all of these at an optimal and sustainable level.

The accommodation has high levels of unsatisfactory physical condition and often fails to meet DSDC Dementia Design Principles and modern accessibility standards such as BS8300 which makes compliance with the Equality Act 2010 particularly challenging.

There is a lack of single room provision which leads to operational challenges, including reduction in hospital capacity as a result of bed closures due to Flu and Norovirus etc. as well as making placement of patients on a gender segregated basis extremely difficult. Services are poorly co-located which leads to reduced service delivery efficiency. In addition, a number of facilities and a lack of technology do not support the NHS Boards vision for agile and flexible working to support an improved work-life balance.

In addition to the inability to effectively separate elective and emergency patient flows within the hospital (which compromises the effective streamlining of clinical pathways and management of patient cohorts), the current building layout, adjacencies, and access routes in the hospital do not facilitate separation of patient, visitor and flows associated with cleaning, maintenance, transport etc.

Learning from the COVID-19 pandemic

The Covid – 19 pandemic has required significant changes to how staff work, and in the ways that clinical services are delivered in and across NHS Highland. The need for facility reconfiguration to create a safer working environment has underlined the importance of ensuring that staff in Lochaber and across NHS Highland have a clear understanding of the lessons learned from working during a pandemic situation, to ensure that the final design of services and the supporting infrastructure has the resilience to manage similar situations in future and respond to ongoing changes in service delivery models.

4.2.8 Improve patient privacy and dignity

The challenges of the aging infrastructure mean that patients access accommodation which is predominantly shared with other patients that does not comply with modern space standards. Poor layouts and patient flow compound this issue resulting in the dignity of patients being compromised during their experience in hospital.

Providing future facilities which respect modern design standards and are designed in line with modern pathways of care, with patient safety, privacy, and dignity as core requirements of the design will improve this substantially for patients, compared to the current arrangements.

4.2.9 Current service models do not always offer person-centred care

How we engage with those that use our services is changing. Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to the person so that the care of their condition fits their needs and situation. This is supported the "*What matters to you*?" initiative (http://www.whatmatterstoyou.scot/) and other approaches used within the Person-Centred Health and Care Programme.

Realistic medicine recognises that a one-size-fits-all approach to health and social care is not the most effective path for the person receiving services. Realistic medicine is not just about doctors. 'Medicine' includes all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness. This includes, for example, nursing, pharmacy, occupational therapy, physiotherapy, and social work.

Current health and social care service models do not always support person-centred care, for example, there is a lack of co-produced service models and lack of choice of service options available.

Communication, both amongst services and with the people who use them, also presents opportunities for improvement; services not knowing what other services are involved with the person and/or failing to communicate effectively or co-ordinate with the person are still commonplace.

Focus on citizen wellness rather than patient illness

Supported self-management can delay the progression or exacerbation of illness and aims to maintain people in a state of optimum health and independence for as long as possible

From a Social Care perspective, Self-Directed Support has a very similar approach to Realistic medicine. The Social Care (Self-directed Support) (Scotland) Act 2013 places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their social care and support. Self-directed Support allows people, their carers, and their families to make informed choices about what their support looks like and how it is delivered, making it possible to meet agreed personal outcomes.

Increased mobility of services, and a greater shift in treatment and care to a home situation has been proven to improve patient health outcomes. This will enable NHS Highland to shift its focus from illness to wellness.

4.2.10 Advancements in Digital Health capabilities

'Digital technology is key to transforming health and social care services so that care can become more person centred'. Scottish Government, Health and Social Care Delivery Plan

Digital technology plays an ever-increasing role in all of our lives, whether or not we want it to and no matter how much, or little we engage with it. There are opportunities to use technology to make our services more effective and efficient, whilst that journey has been ongoing for some, for others it has barely started. For people who use our services, many expect to be able to use technology to access services, monitor their own health or self-manage their long-term condition. Others find readily accessible information about available services online or to help them maintain their independence, yet we continue to be reluctant to genuinely embrace technology due to what, on many occasions, stems from personal professional preferences or making assumptions about the views of those who use our services without asking.

"Near Me" services were introduced to improve local patient access to specialist services provided at Raigmore, accessed in suitable spaces in Belford hospital; this has been hugely beneficial in avoiding travel. Patients have valued the increasing availability of remote consultations accessible from home, though as part of a mixed model of care rather than a replacement for face-to-face contact.

The technology landscape supporting health and care in Lochaber today remains embedded inside individual organisational domains. Whilst good work exists inside the partner organisations there are no joined up services stretching across organisational boundaries or allowing citizens to interact digitally in ways they have come to expect in other areas of their life.

There is an opportunity to leverage the emerging technologies in digital health and system integration to empower citizens to better manage their health and wellbeing, to create a virtual by default approach, and to empower and develop our staff. This is a paradigm shift. The technology in use across Highland meets the needs of the organisations in the way in which the services are configured today, it does not deliver against our national strategies or vision.

Some services have more recently been able to access support for staff and patients, and have specialist input, through digital apps which has been positive. This facilitates adoption of new approaches in self-management, rehabilitation, and other areas.

4.2.11 Improved collaboration and co-ordination with primary care and Scottish ambulance services

There is an opportunity to improve collaboration and coordination of services with GPs and community teams operating in Fort William Health Centre, as well as with the Scottish Ambulance Service, both of whom are located adjacent to the Blàr Mòr site, which is the likely

location of the proposed hospital development. This close proximity lends itself to improved teamwork and communication, and greater opportunities for cross learning between services.

4.2.12 What other drivers for change are there?

With the increasing demand on services, resources and budgets comes the need to reshape the way we support people in our communities to allow them to look after themselves and have the knowledge that health and social care services are there when needed. These services include hospitals, GPs, community nurses, occupational therapists, physiotherapists, podiatrists, speech therapists, social workers, housing officers, care homes, care providers and unpaid Carers, voluntary and charitable organisations.

4.2.13 Summary of the Need for Change

The table below summarises the need for change:

	What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
1	Inefficient current service models	There are unnecessary admissions to hospital. Whilst there is some improved use of technology there is considerable room for improvement. Delayed discharges indicate a consistent use of beds for patients who are clinically able to be discharged, but area awaiting a form of care package or care home place. Capacity is being consumed.	Continuation of the existing service performance is unsustainable. Maximise the use of all available resources. Need to improve the support for people to live safely and independently in their communities by improving access to services and enabling the use of modern technologies and communications systems.
2	Unable to meet future service demand	Existing capacity is unable to cope with future projections of demand. A reducing working age population results in fewer people available to care for an increasing number of older people.	Requirement to maximise the capacity available from existing resources. Need to develop new staffing models to ensure a sustainable future workforce through organisational staffing resource deployed across health and social care settings.
3	Current service models do not always offer person centred care	Inability to separate scheduled and unscheduled pathways. Limited choice of service model available. Insufficient access to digital technologies. Poor communication between services resulting in duplication and inefficiencies. Inability to fully implement realistic medicine.	A service that does not meet user requirements is unsustainable, even in the short term. Services need to be more person-centred, delivered safely, effectively, efficiently, and sustainably. To provide a choice of service options that have been co-produced to better support people to meet their outcomes.

4	Poor facilities and physical infrastructure	Increased safety risk from outstanding maintenance and inefficient service performance. Significant recent and ongoing investment required simply to maintain service access and improve patient and family experience. A number of privacy and dignity issues associated with the inadequacy of the physical environment. Unable to implement new models of care.	Building condition, performance and associated risks will continue to deteriorate if no action is taken, with maintenance at considerable cost. Improves the functional suitability of the healthcare estate providing facilities to deliver high quality care which has greater privacy and is more user friendly for patients, carers, and visitors. Promotes recruitment and retention of staff, which is an ongoing challenge for the region. New models of care will provide better outcomes for patients and more efficient and effective use of resources.

Figure 4-17 Summary of the need for change

4.3 What is the organisation seeking to achieve?

This section of the IA identifies the investment objectives of the proposal by considering what the organisation is seeking to achieve. It is not, at this stage, aimed at identifying the potential solution.

The table below provides a response to the effects of the cause on the organisation, as highlighted in the Strategic Assessment and in doing so defines the investment objectives for the project:

	Effect of the need for change on the organisation:	**What has to be achieved to deliver the necessary change? (Investment Objectives)**
1	There are unnecessary admissions to hospital. Whilst there is some improved use of technology there is still some considerable room for improvement. Delayed discharges indicate a consistent use of beds for patients who are clinically able to be discharged but are waiting for a care package or care home place. Capacity is being consumed.	To deliver RGH services locally wherever possible and adapt to the unique and changing needs of the population in the remote and rural locality of Lochaber which is recognised as The Outdoor Capital of the UK **– Investment Objective 1.**
2	Existing capacity is unable to cope with future projections of demand. A reducing working age population resulting in fewer people to care for an increasing number of older people.	Develop a sustainable RGH service which optimises the skills of the local workforce, improves recruitment and retention and offers enhanced opportunities for training, including planned collaboration with other local agencies– **Investment Objective 2.**

3	Unable to fully implement realistic medicine. Inability to separate scheduled and unscheduled pathways. Limited choice of service model available. Insufficient access to digital technologies Poor communication between services resulting in duplication, inefficiencies	Deliver RGH services which maximise opportunities in current and future healthcare technology and innovation and make best use of this to benefit patients and staff – **Investment Objective 3.**
4	A number of privacy and dignity issues associated with inadequate physical environment. Inability to implement new models of care. Increased safety and environmental risk from outstanding maintenance and inefficient service performance. Significant recent and ongoing investment required simply to maintain service access and improve patient and family experience.	Provide a modern flexible healthcare facility which supports the provision of a 21st century RGH model of care focused on patients and families - **Investment Objective 4.** Deliver services and infrastructure which will minimise environmental impact and deliver to Scottish Government's climate change targets, now and in the future - **Investment Objective 5.**

Figure 4-18 Investment Objectives

4.4 What benefits will be gained from this proposal?

Benefits were identified in a series of focussed workshops with a cross-functional group of stakeholders, involving clinical and operational management staff located within the Belford, in community-based services in Lochaber and involving public representatives. A full list of benefits identified, ordered by rating levels can be found in Appendix 4.

Key themes of the benefits were identified as follows, and a structured discussion based around these:

- Patient experience;
- Improved performance;
- Positive outcomes;
- Impact on assets; and
- Wider, system-wide impacts.

Benefits proposed by the cross-functional team were also sense-checked against NHS Scotland's strategic investment priorities – person centeredness, safety, effective quality of care, improved health of the population, value, and sustainability.

The team were asked to assess the importance of the benefits on a 1-5 scale. The following benefits were identified, with priority ratings ranging from 3-5.

Rating	Relative priority
1	Fairly insignificant
2	Somewhat important
3	Moderately important
4	Very important
5	Vital

Figure 4-19 Benefits priority rating scale

Theme	Benefit	Rating
Patient Experience	Timely care with a reduction in delays	5
	Improved access and egress from hospital site in Lochaber - making it easier to get into and out of the hospital site	4
	Creation of a healing and caring environment, reducing recovery times	4
	Improved extent to which the patients are appropriately informed and appropriately involved in their care, and treated with dignity and respect.	5
	Patients receive integrated care, both within the hospital and the wider health and care system	4
	Reduction in patient travel for healthcare, reducing time out of day for pts and reducing carbon emissions	4
Improved performance	Improved A&E waiting time performance and access to ambulatory/ same day emergency care.	4
	Improve timeliness of receiving treatment on the day and decrease likelihood of admission for overnight stays.	5
	Reduced average length of stay, timelier discharge home/homely setting with higher functional capability (after receiving rehab input during acute stay).	5
	Reduction in incidence of HA infections, improved score against monitored aspects of infection control. Impact on loss of capacity as a consequence.	5
Positive outcomes	Improved recruitment and retention of staff	5
	Training, development and upskilling of workforce means everyone can work at their topmost skill level	4
	Improved staff morale and sickness/ absence rate	4
	Improved community confidence and morale	3
	Improving health and wellbeing of local population	5

Theme	Benefit	Rating
Assets	Reduced/eliminated backlog maintenance and associated risks/costs, improved financial position	4
	Reduced carbon footprint and ongoing energy requirements/ costs	5
	Improved flexibility of configuration and ability to separate different types of flow within hospital easily and at pace in response to changing situations.	4
System -wide	Increased confidence in portfolio of local health and care services, supporting OCUK status	3
	Partnership with West Highland College offering synergies on site and opportunities for education	4
	Supporting implementation of system-wide Lochaber health and care redesign strategy	5

4.5 What risks could undermine these benefits?

A similar, workshop-based approach with a cross-functional team was used to explore the risks associated with the project at this stage of its development. Risks were assessed both in terms of impact/ consequence and for likelihood of occurrence on the project. A full list of the risks identified can be found in appendix 5.

Likely risks were identified across the following categories:

- Client/ business risks.
- Planning and design risks.
- Construction and property risks.
- Finance risks; and
- External risks.

Risk rating scales:

Rating	Impact / consequence
1	Negligible
2	Minor
3	Moderate
4	Major
5	Extreme

Rating	Likelihood
1	Rare
2	Unlikely
3	Possible
4	Likely
5	Almost Certain

Figure 4-20 Risk rating scales

These two factors were multiplied together to produce a risk rating, which has been attributed a red, amber, or green status based on the value of this rating, to facilitate prioritisation of effort as we move forward in the project and identify means of mitigating and monitoring the risks as part of ongoing project management activities.

		Initial Risk Consequence				
		Low	Moderate	High	Very High	Extreme
Initial Risk Likelihood	Certain	Medium	Medium	Medium	High	Extremely High
	Almost Certain	Medium	Medium	High	Extremely High	Extremely High
	Likely	Low	Medium	Medium	Medium	High
	Unlikely	Low	Low	Medium	Medium	Medium
	Highly Unlikely	Low	Low	Low	Medium	Medium

Figure 4-21 Red, amber, green status based on overall risk rating

No red or green status risks were identified at this stage of the project. A full list of the risks identified, and their associated ratings can be found in Appendix 5.

4.6 Are there any constraints or dependencies?

A project of this nature is intrinsically linked to activities across the wider health and care sector in the region, as well as directly related to the wider strategy and intent of NHS Highland. Some of the key constraints and dependencies are outlined below.

Constraints include:

- Workforce available to deliver future service model, both within the hospital setting and in community settings;
- Locally availability of accommodation to facilitate staff relocating to the area;
- Compliance with all current health guidance;
- Business case process including build and commission; and
- Financial resource available to deliver the future service model.

Dependencies include:

- There is a dependency on adopting new working models;
- Investment in out of hospital care services;
- Capital investment in premises;
- Investment in recruiting and training appropriate workforce to support the new model of care;
- Investment in technology; and
- Changes in primary care as a consequence of the changes in the GMS contract and the implementation of the Primary Care Improvement plan.

ECONOMIC CASE

	Questions	Response
Economic Case	What is the preferred strategic / service solution?	Confirm: • The Do Nothing / Minimum option • Any major service change proposals • Stakeholder involvement • Service change proposals • Indicative costs • Assessment of proposed solutions • Preferred strategic / service solution • Design Quality objectives

5 WHAT IS THE PREFERRED STRATEGIC / SERVICE SOLUTION?

This section includes the following:

- Do Nothing Option;
- Service Change Proposals;
- Developing and assessing the long list of proposed solutions;
- Impact of Proposed Service Option;
- Indicative Costs; and
- Design Quality Objectives.

5.1 Option 1: Do Nothing /Minimum Option

The table below sets out the do-nothing option; how services in Lochaber are currently delivered. As a future service option, the assumption would be that demographic changes would drive demand growth (particularly in older age groups), but that the model of care would remain the same as presently delivered.

Strategic Scope of Option:	**Do Nothing**
Service provision:	**Hospital based care:** - Emergency Department - Acute assessment - Inpatient care - Inpatient rehab - Continuing Care - Outpatient care - Ambulatory care (dialysis, SACT, infusions) - Surgical services - Diagnostic services **Out of hospital:** - Primary care - Care at home - Care homes - End of Life care
Service arrangements:	**Hospital service arrangements:** - Inpatient care (1 day to >6months) - Continuing Care (>6 months) - End of Life care (no designated hospital capacity) - Outpatients (20% virtual/phone)
Service provider and workforce arrangements:	NHS Highland (lead agency). Workforce teams spread across hospital and community. Community teams include: - Community nursing services, West, East and South Lochaber - AHP services, Physio, OT, Dietetics, SLT - Learning Disability nursing and transition planning teams - Integrated Social Work team - Community Mental Health Team, Older adult CPNs, Adult CPNs, CBT therapy, Urgent Care Nurse, Drug and Alcohol Recovery Services, Specialist MH Occupational Therapy - Community Midwifery services

Supporting assets:	▪ Belford Hospital - 15 Combined assessment beds - 2 HDU beds - 15 Ward 1 rehab beds - 9-day case recovery spaces - 1 theatre - 1 endoscopy room ▪ Fort William Health Centre ▪ Care homes: - 6 nursing beds, 2 intermediate care beds and 1 respite bed, Abbeyfield Nursing Home, Ballachulish - 1 GP bed, Moss Park nursing home, Fort William ▪ Care at home: ~ 250 clients ▪ Telecare: ~ 245 telecare patients on average
Public and service user expectations:	Maintaining and improving local access to services

Figure 5-1: Do Nothing Option summary table

5.2 Service change proposals

The development of service change proposals is driven by the identified drivers for change and requirement to deliver a wider range of services, equitable and accessible to Lochaber residents.

The board have sought to explore a range of service delivery models to inform the option development process from traditional to radical. These focus on the level of service which could be delivered locally in Lochaber, and the relationships to key services which residents require to access located elsewhere in the country.

NHS Highland have engaged with Healthcare Improvement Scotland and in considering the proposed investment presented in this Initial Agreement, it is expected that this proposal will not be considered to be 'major service change'.

5.3 Core clinical model for Rural General Hospitals in NHS Highland

Workshops held over 2 days in February and March 2022 brought together a range of stakeholders in a variety of clinical and operational roles across NHS Highland, to discuss and define the clinical model for a Rural General Hospital (RGH) within NHS Highland. Many of the team were from Lochaber, involved in the Lochaber redesign project and they were joined by colleagues from Caithness General and Lorne and Isles hospitals in an effort to ensure a common approach across the region. Please see appendix 6 for a full list of those involved in the discussions.

The team were facilitated to explore inpatient and ambulatory care settings, hospital-based and community-based care, and define the thresholds of safety and sustainability in delivery of services locally, compared to those requiring acute, centralised and specialist services accessible in Raigmore or in Tertiary centres elsewhere.

5.3.1 The core RGH model

Services in the RGH will manage both unscheduled care and planned care demands, while explicitly describing and communicating the limitations of the safe local delivery model to local residents and GPs, to ensure a common understanding of the extent of local service provision.

The schematic below represents the essence of the core clinical model arrived at through these facilitated sessions. More detail behind the different aspects of services, and what is considered appropriate within the RGH setting can be found in Appendix 7.

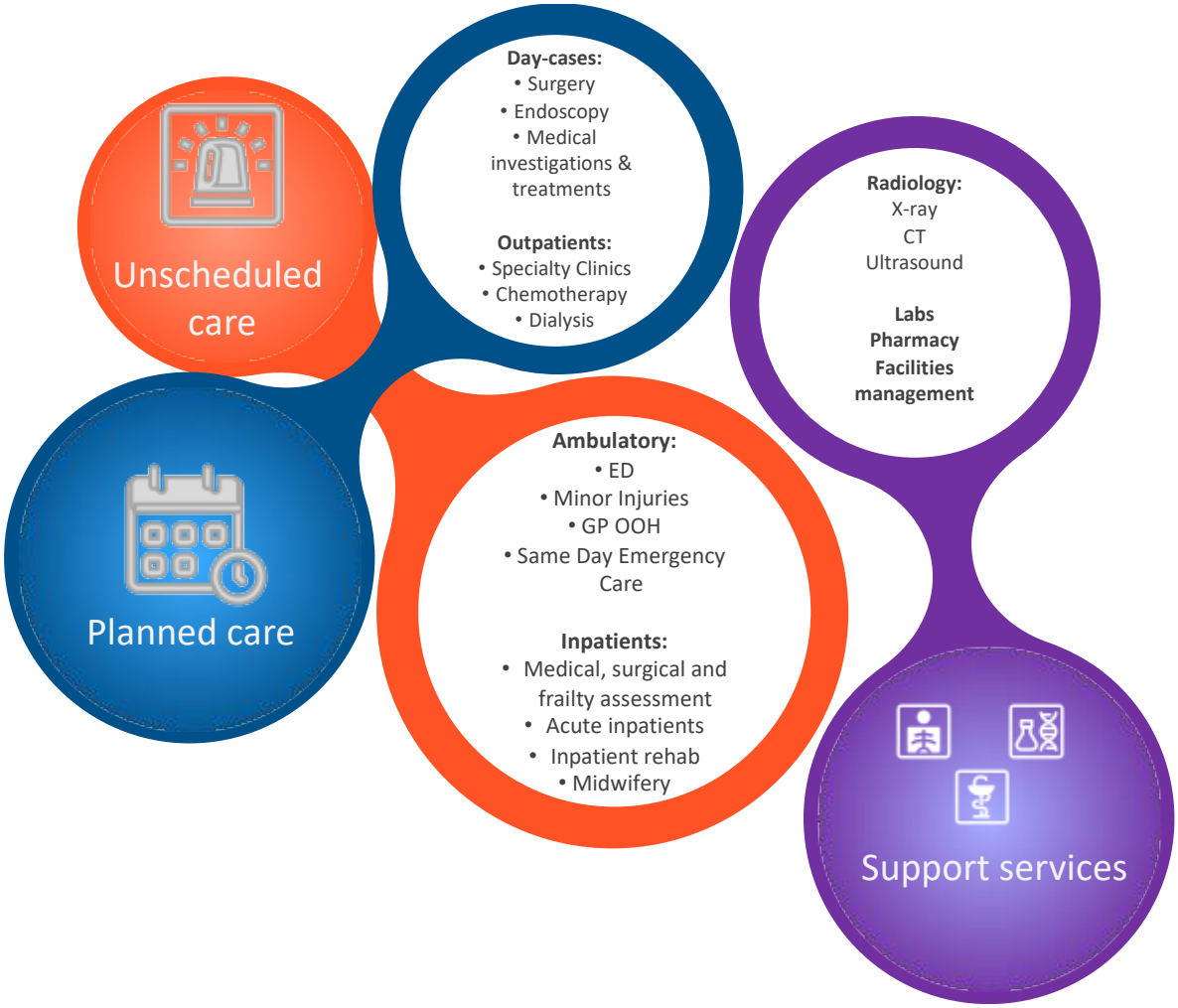


Figure 5-2: RGH clinical model summary

This newly defined core clinical model forms the basis of a number of service options within this initial agreement, which will be assessed for their advantages and disadvantages, and tested against the investment objectives to determine their ability to fulfil these.

Where the preferred service option relates to this model of service provision, further work will be undertaken at OBC stage to fully develop the supporting workforce models to deliver these services, create plans to address any gaps to enable the provision of appropriate training and equipment where necessary to ensure the safe and sustainable delivery of the core model in RGHs in future.

5.4 Developing a long list of proposed service solutions

A range of solutions has been considered and captured in the form of 5 potential service options, alongside the "Do Nothing" Option, in alignment with SCIM guidance on the development of strategic service solutions.

The options are described here in detail then summarised in tabular form at the end of this section.

5.4.1 Option 2 – Delivery of the core RGH clinical model

This model focusses service provision within the proposed new development on the scope and range of service defined by clinical and operational colleagues in February 2022, agreed across multiple RGHs within NHS Highland. This model sees delivery of a range of ambulatory and inpatient services delivered in an RGH environment (termed category A activities), complemented by delivery of a range of community -based services locally (termed category B services), with access to specialist acute services for local residents hosted by Raigmore, or by a tertiary centre in the central belt where appropriate.

Access to specialist services will be managed using a blended approach of virtual and face to face interactions, limiting travel for patients to attend Raigmore or tertiary hospitals only where strictly necessary.

Community-based services include those offered on an outpatient basis from the local health centre, as well as interventions in patients' own homes by community-based teams and provision of nursing or residential care beds in care home environments out with the hospital campus.

The virtual ward concept will be thoroughly explored and new opportunities sought to enhance this service. Further development of GPs with specialist interest as part of a multi-agency network of support across particularly remote and rural areas, including all first responders, will be prioritised.

RGH based services will cover planned and unscheduled care activities as follows:

Unscheduled care will be managed in the most appropriate setting, making use of a minor injuries area to minimise Emergency Department (ED) footfall, co-located with an Out of Hours (OOH) GP service area to optimise patient flow and improve communication and collaboration across primary and secondary care.

Patients will continue to be treated in and discharged from the ED where appropriate, or stabilised for transfer to a Major Trauma Centre based on the severity of their condition. Where pathways indicate the necessity for an RGH inpatient stay e.g. stroke, patients will flow directly to the inpatient environment to commence treatment and recovery. Where treatment of longer duration or intensity than manageable in ED is required, patients will initially flow to a Same Day Emergency Care (SDEC) area, where based on predefined pathways

and protocols, as many patients as possible will be treated and discharged home on the same day, avoiding an inpatient admission.

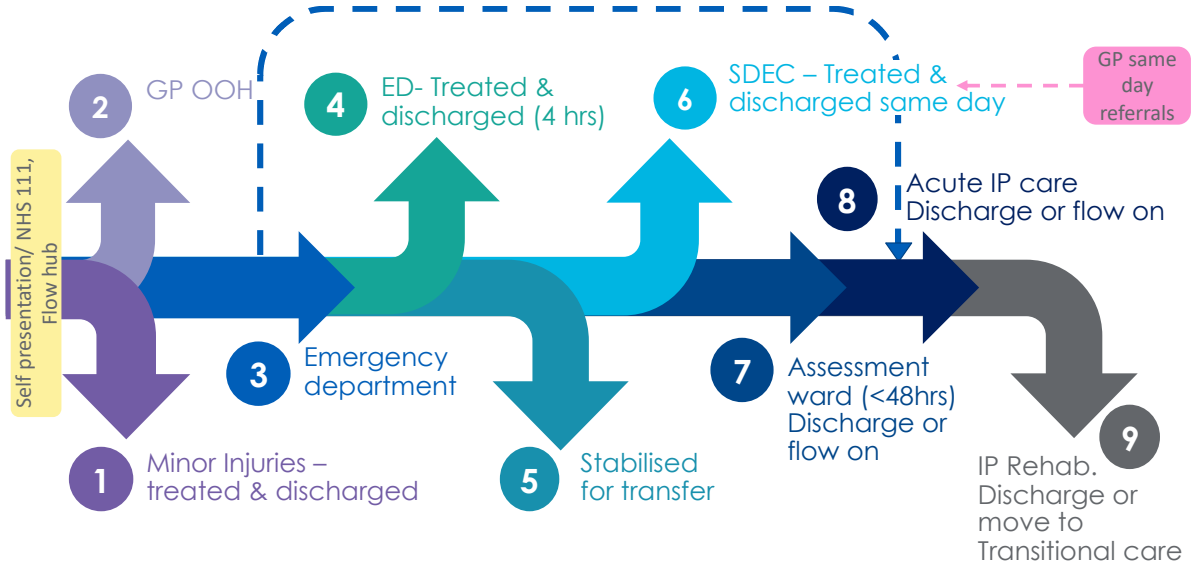


Figure 5-3: Unscheduled care flow in the RGH

Where an admission is the most appropriate course for the management of the patient, the patient will undergo an initial period of assessment and treatment, where a plan for discharge or further inpatient treatment will be created and implemented.

Services will cater for planned care pathways predominantly on an outpatient and day-case basis. They will increasingly make use of a co-ordinated approach to providing multi-disciplinary one-stop clinics, reducing the need for multiple attendances by patients.

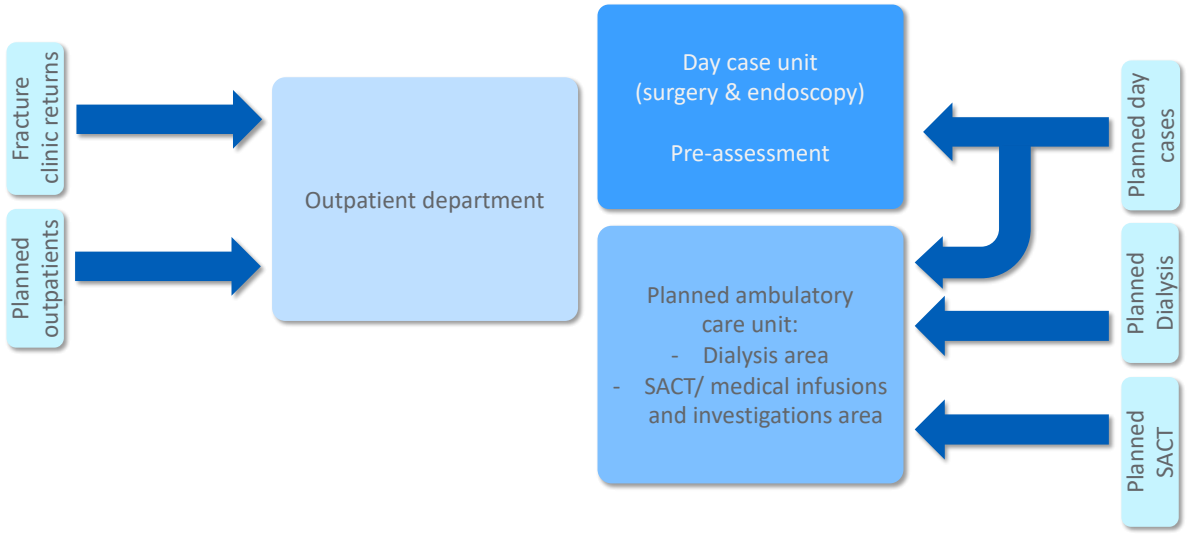


Figure 5-4: Planned care flow in the RGH

Outpatient and diagnostic services will continue to bring patients to the acute site for key investigations, consultation, and treatment where necessary. The use of Near me or telephone appointments will be utilised as part of a blended delivery model, optimising access to specialist input, while minimising travel wherever possible.

Planned ambulatory care will bring together services including outpatient dialysis, Systemic Anti-Cancer Therapy (SACT – Chemotherapy), as well as a range of medical investigations, treatments and infusions which can be delivered on an ambulatory basis. This will negate the need for patients to attend the ward environment, reducing foot traffic and allowing inpatient areas to remain calmer and uninterrupted. Many of the patients undergoing procedures highlighted as suitable for this ambulatory treatment model are managed in an inpatient environment in the current and Do-Nothing scenarios, signifying an opportunity to reduce the inpatient bed-base as a consequence of this shift in the model of care.

Inpatient services will be reshaped to cover a variety of distinctive functions. Acute inpatient treatment focussing on rapid intervention over a short admission will be an improved area of focus, as well as facilitating rehabilitation and reablement activities for patients experiencing both short- and longer-term stays.

More work will be required at OBC stage to fully explore this model, appropriately size the areas and different physical capacity required as well as define the workforce model to enable the effective clinical delivery of services and improve patient outcomes.

Surgical services provided on the site will remain largely unchanged in scope, but will seek to ensure that where procedures can be undertaken locally, this is the default location of provision for such services, avoiding historic incidences of unnecessary travel for patients to Raigmore hospital for activities which could have been delivered closer to home.

Accessibility of diagnostic services will be enhanced through the reintroduction of open access clinics for plain film x-rays based on primary care referrals.

5.4.2 Option 3 – Building on Option 2 with intensive multidisciplinary rehab service

This option recognises local challenges in supporting the Health and Care system and builds on Option 2 above to include provision of some category B services on the same hospital campus. Services will be designed to improve and support system wide flow and, in particular, recognise the challenges in relation to the lack of a local community hospital and minimal care home provision regionally, compared to other areas of Scotland.

The focus will be on supporting the transition of patients' from hospital to home or homely setting, with intensive rehabilitation input. A combination of bed-based and ambulatory services would be offered, supporting patients who live locally to return home more quickly, with a planned programme of ambulatory rehabilitation attendances to support their continued improvement and reablement until their goals are achieved. Input would be multi-disciplinary and multi-agency, ensuring appropriate access to support and advice from partner agencies to facilitate the patient's progress and eventual discharge home.

Rehabilitation is a critical element of patient care which is currently delivered on an inpatient basis, on an outpatient basis or in the patient's home. Extended inpatient hospital stays to facilitate rehabilitation when there is no longer a requirement for acute medical or nursing care is often not desirable from either a patient or service perspective however, the gap between the intensity of multi-disciplinary rehabilitation possible in hospital and the

outpatient or domiciliary provision available in the more remote areas of Lochaber means that inpatient stays are currently necessary to allow patients to meet their functional potential.

In service option 3, the intention would be to transform the service to deliver intensive multi-disciplinary rehabilitation on a day case basis, which would allow patients to receive a high standard of rehabilitation while maintaining links to home and family life and would reduce the number of extended admissions to the RGH.

While day case is the preferred model, there will be instances where due to distance or by virtue of care needs, individuals would continue to require an inpatient stay. This would be facilitated within the rehabilitation unit and delivered in a reablement paradigm, encouraging independence in all activities to support a 24hour rehabilitation approach. This could be in a nurse or AHP led unit, potentially with primary care medical input.

5.4.3 Option 4 – Increase local volumes of elective activity in a range of specialties

This option builds on the scope of services outlined above in option 3 but seeks firstly to further broaden the surgical and outpatient services offered in Lochaber, reducing the need for acute specialist input to be provided from Raigmore. Building on the specialist services who already have a presence in the current hospital, this option would seek to optimise the numbers of patients able to access treatment locally.

The proportion of cases treated locally may be improved upon through better communication with GPs and members of the public, clearer articulation of local service provision (based on the new definitions of RGH core clinical services), and optimisation of the operational processes around scheduling of planned treatments to ensure where local delivery is an option, patients are made aware of this choice at all times.

Expanding the breadth of services locally involves engaging the clinical delivery teams around the new defined core services model and ensuring that adequate training and equipment are provided to enable a local delivery model for additional services, treatments or procedures. This will be led by the resident clinical teams and visiting teams with an established presence in RGHs. This must be supported by clear communication of the factors involved in recommending local delivery of the service, including explaining to patients and GPs the rationale where in individual cases this may not be appropriate or safe for delivery in an RGH.

Over time, the option seeks to further extend the scope of services offered locally by introducing an additional number of visiting specialties to Lochaber, which are currently concentrated in Raigmore. Visiting specialist consultants would provide regular face-to-face appointment sessions in outpatients within the Belford Hospital and undertake surgical procedures locally, to reduce the need for patients to travel to Raigmore for elective procedures. This would be complemented by virtual outpatient consultations and reviews to optimise the delivery model and provide holistic support potentially between scheduled visiting sessions.

It is recognised that the ability of NHS Highland to introduce sustainable consistent services on a planned sessional basis may have to be approached in a phased manner. This option

would recognise the ambition to provide these additional services and ensure that flexibility and capacity are adequate to support this delivery in future, though services may not be available immediately upon the opening of a new development.

This approach would offer an opportunity to provide access to capacity in support of the elective care recovery programme, enabling waiting times to be addressed and backlog to be reduced, while simultaneously offering improved local access to services.

The nature of the procedures which would be undertaken in Lochaber as part of the enhanced set of services would remain primarily day case activity and continue to align with the safety parameters established in the core RGH clinical model. This would also differentiate them from the activity planned for delivery in the NHS Highland National Treatment Centre, with has a focus on Orthopaedic Arthroplasty and a range of Ophthalmology services.

5.4.4 Option 5 – Ambulatory Care centre

This option envisages a radical redesign of services locally, and a shift away from the RGH core services described in option 2. It would do this by developing an ambulatory care centre in Lochaber, maximising those services which can be delivered locally in a community and ambulatory care setting.

This option seeks to provide outpatient, minor injuries, and ambulatory care facilities such as renal dialysis, chemotherapy and medical investigations locally in a new development, supported by an optimised set of community and primary care-based services locally, in alignment with only the ambulatory aspects of the RGH core clinical model in option 2. This model would shift any acute-based inpatient services from Lochaber to Raigmore hospital campus in Inverness.

Community-based services include those offered on an outpatient basis from the local health centre, as well as interventions in patients' own homes by community-based teams and provision of nursing or residential care beds in care home environments out with the hospital campus.

The virtual ward concept will be thoroughly explored and new opportunities sought to enhance this service. Further development of GPs with specialist interest as part of a multi-agency network of support across particularly remote and rural areas, including all first responders, will be prioritised.

5.5 Short list of proposed solutions

Option name	Description
Option 1 – Do Nothing	Do Nothing service option: continue to provide the same level of surgical and medical services in the current delivery service configurations of ambulatory/outpatient care and inpatient care, in an improved environment. **This option is capacity constrained and unable to facilitate the delivery of the new model of care.**
Option 2 – RGH Core	Deliver the optimum service model of Core RGH functions only, as defined in workshop 1, ensuring the model of care is updated to reflect modern best practice and optimal delivery on ambulatory and day case basis. Community-based services are aligned to the new model, facilitating improved patient access. **This option would facilitate the delivery of the new models of care reflecting current best practice and avoid unnecessary inpatient admissions, but omits transforming services to improve system-wide flow in Lochaber.**
Option 3 – RGH Core + intensive rehab	Recognise local challenges in the supporting Health and Care system, and build upon Option 2 above to include a transformation in the Rehabilitation service. This would provide intensive multi-disciplinary rehab on a day case basis where possible, and nurse/AHP led inpatient service where required on the same hospital campus. Services will be designed to improve and support system wide flow and in particular recognise the challenges in the lack of a local community hospital, and minimal care home provision regionally, compared to other areas of Scotland. **This option would facilitate the delivery of the new models of care reflecting current best practice, and address many of the challenges specific to Lochaber in system-wide flow and care.**
Option 4 – RGH Core, intensive rehab and enhanced elective care	Building on option 3 above, in alignment with the defined core RGH model, broaden the scope of elective outpatient and day case procedures offered in Lochaber, reducing the need for acute specialist input to be provided from Raigmore. Optimising the specialist services who already have a presence in the current hospital, this option would firstly seek to increase the numbers of patients able to access treatment locally. Over time we would seek to provide access to a wider range of visiting medical and surgical services locally, where safe to do so. We would recognise the ambition to do more locally and widen access to support delivery of elective care for other NHS Highland to allow further future expansion of services in a sustainable operating model. **This option would facilitate the delivery of the new models of care reflecting current best practice, and address many of the challenges specific to Lochaber in system-wide flow and care. It would also enable increased access to elective care locally and offer additional capacity to support the wider demands of elective care across NHS Highland.**
Option 5 – ambulatory care centre	Concentrate local provision on community based and integrated district services, ambulatory care, outpatients and MIU services. Relocate inpatient based services to Raigmore. **This option would drastically reduce local access to a range of services, and place considerable pressure on Raigmore, with increased travel for patients, and potentially higher levels of risk for the population of Lochaber. Ambulatory care services would be optimised.**

The summary table below outlines these potential options.

Strategic Scope of Option:	Option 2 - RGH core	Option 3 – RGH Core + Intensive Rehab (IR)	Option 4 – RGH core, IR, enhanced elective activity over time	Option 5 – ambulatory care centre
Service provision:	H&SC for Lochaber focussing on the following: - Core RGH clinical model including separation of planned and unscheduled care, enhanced ambulatory services and inpatient care. - Acute specialist inpatient and ambulatory care provided in Raigmore - Community-based services in health centre, own home or care home environments	H&SC for Lochaber focussing on the following: - Option 2 plus additional hospital-based intensive multidisciplinary rehabilitation service on day-case and inpatient basis to support reablement and return to home or homely environment	H&SC for Lochaber focussing on the following: - Option 3 plus broader range of services from resident specialties, reduced Raigmore acute specialist input for resident specialties - recognising the ambition and potential to introduce additional visiting specialties to Lochaber on a regular basis	H&SC for Lochaber focussing on the following: - Minor injuries, Outpatient, and ambulatory care services locally - Primary care and community-based care services - All acute, specialist and inpatient services delivered from Raigmore
Service arrangements:	- Lochaber core RGH model with medical, nursing and AHP input.	- Lochaber core RGH model with medical, nursing and AHP input. - Enhanced intensive rehab and transitional care using a nurse/ AHP led model.	- Lochaber core RGH model with medical, nursing and AHP input. - Enhanced intensive rehab and transitional care using a nurse/ AHP led model. - Increased local access to elective care from resident specialties and introduction of new visiting specialties over time. - Access to elective surgical services extended to include patients from outwith Lochaber in wider NHS Highland catchment area.	- De-centralisation from Lochaber - Multi-disciplinary input to ambulatory care services - Extensive service provision in Raigmore
Service demand	Service demand: - ED attendances ~10K per annum, with seasonal peak in summer - Increasing proportion of care delivered on day-case basis. <2400 IP admissions - Increase in elective surgical	Service demand: - ED attendances ~10K per annum, with seasonal peak in summer - Increasing proportion of care delivered on day-case basis - Increase in elective surgical activity locally	Service demand: - As per option 3 - With further increase in elective surgical demand, potentially > 1000 cases per annum - With improved utilisation of theatre, day case suite and outpatient capacity as more	Service demand: - MIU attendances ~5K per annum, with seasonal peak in summer - ~900 endoscopies per annum, outpatient only

	activity locally >800 procedures - 900-1000 endoscopies per annum	- Improved throughput and discharge rate in inpatient beds	services are introduced in line with ambition	
Service provider and workforce arrangements:	No change to NHS Highland as service provider with core team at Belford hospital. Continued challenges in recruitment and retention of skilled staff.	Modernised approach to care model provides NHS Highland staff with new development opportunities. Enhanced facilities would support recruitment and retention activities.	Modernised approach to care model provides NHS Highland staff with new development opportunities. Enhanced facilities would support recruitment and retention activities.	NHS Highland remain service provider, but significant workload shift from Belford hospital to Raigmore hospital required.
Supporting assets (hospital):	ED cubicles & resuscitation MH place of safety SDEC area Beds: Assessment, Inpatient including HDU and Rehab beds Theatres suite encompassing Endoscopy with supporting day unit Outpatient suite Dialysis, SACT & medical day treatment suite	As for Option 2 Rehab beds configured in therapy suite with multi-disciplinary and multi-agency input on day and inpatient basis.	As for Option 3 Independent Endoscopy room integrated as part of day-case suite, with additional supporting clinical spaces.	Local ambulatory care development. Required assets: MIU Endoscopy suite Outpatients' suite Dialysis, SACT & medical day treatment suite No inpatient provision required in Lochaber development. Supporting assets for inpatient care on Raigmore Hospital campus.
Supporting assets (non-hospital):	Improved access to community resource providing services in patients homes, on an outpatient basis from health centre, and with commissioning of care home and nursing home beds to provide longer term out of hospital care, including End Of Life care.	Improved links with community teams, more joined up approach across community and hospital delivered care settings. Potential reduction in need for care at home, care home and/ or intermediate care beds in future.	As for option 3	Significant access to community resource, increased access to services based in Raigmore.
Public and service user expectations:	Clarity of local service provision, and clear communication around expectations. Represents enhancement compared to current provision.	Improved position locally with regard to support for transitional care and reablement. Represents enhancement compared to current provision.	Reduced patient travel (care closer to home). Has potential to offer greater enhancement in elective care than other options, and more than current provision.	Significantly Increased patient travel, loss of local access to a broad range of services.

Figure 5-5 Summary table of options

5.6 Indicative Costs

5.6.1 Capital Costs

Table 5.6 below provides high-level indicative cost range for a new build hospital which would accommodate each of the Proposed Solutions.

Costs in £millions	Option 1 – Do Nothing	Option 2 – RGH core	Option 3 – RGH Core Intensive Rehab (IR)	Option 4 – RGH core, Intensive rehab, enhanced elective activity over time	Option 5 – ambulatory care centre
Capital cost (or equivalent value)	1.5	113.2	113.2	115.0	78.7
Whole of life capital costs	1.3	105.1	105.1	106.7	73.2
Whole of life operating costs	339.8	371.2	369.2	389.5	382.6
Estimated Net Present Value of Costs	341.1	476.2	474.3	496.2	455.9

Figure 5-6: Indicative costs table

For the purposes of Economic Appraisal, all costs exclude VAT and inflation with a lifetime of 60 years. Costs relate to the provision of a new build hospital on the Blàr Mòr site in Fort William, as this is the most likely built solution to facilitate the preferred service change solution.

The Blàr Mòr is considered to be the optimal location for a new hospital in Fort William as it is the only development site which can accommodate a development of this scale, and the site is adjacent to the health centre, the ambulance base, the police station, and new housing developments. The site is already part of public transport and green travel routes and is also the proposed location for development of a STEM Centre by West Highland College/UHI which will provide opportunities for collaborative working with NHS Highland, and the development of shared accommodation.

Capital Costs include construction costs, professional fees, other construction related costs, optimism bias, sustainability allowance, design risk and equipment, as detailed in Appendix 8. Construction costs are based on estimated prices as at 1ST Quarter 2022 (the base date). Capital costs in the table above exclude VAT and inflation beyond the base date, for the purposes of economic appraisal. In addition to this, there will be a requirement to purchase land for options 2 to 5 at an estimated value of £1.0m to £1.5m.

Construction costs for the proposed solutions have been developed on behalf of NHS Highland by Thomson Gray, Construction Consultants, based on their experience of similar projects. Thomson Gray provided a lower, mid, and high range of costs depending on the treatment of risks. For the purposes of the Economic Appraisal calculation, the mid-range has been used. Construction costs have been based on an exemplar Schedule of Accommodation for a Rural General Hospital. Thompson Gray have also provided initial lifecycle costs based on rates per

m2 from a report commissioned for the National Treatment Centre. Costs for equipment have been based on an allowance of 15%. All other costs were developed by NHS Highland finance department.

As the project progresses and a service solution is identified, and detailed designs are developed, both the capital and revenue costs will be reviewed and refined.

5.6.2 Optimism Bias

The Project Team followed HM Treasury Green Book guidance and the Risk Management Guide in the Scottish Capital Investment Manual to determine the level of Optimism Bias that should be applied to the Proposed Solution, based on each of the proposed solutions requiring a new build hospital.

The upper bound percentage was calculated be determining the build complexity, location, scope of the scheme and changes to service delivery. The team then worked through an assessment of the mitigation already carried out based on experience of previous projects to determine the mitigation factor to be applied to the upper bound percentage. The resulting Optimism Bias rate is summarised in the table below.

Description	Proposed Solution
Upper Bound %	39.5%
Mitigation Factor	90.4%
Optimism Bias	**35.7%**

As the project progresses and detailed designs are developed, the level of optimism bias applied to the preferred solution will be reviewed and considered against the level of quantified risk that can be established. The expectation is that the more risks that can be quantified, the level of optimism bias will reduce. Future reviews of optimism bias will also take account of any inflationary increases beyond those already included.

5.7 Initial assessment of proposed solutions

A workshop was held with a broad cross-functional team of clinical and operational staff, with involvement from representatives of the public including community councils and representatives from groups with protected characteristics on 22nd March 2022, to assess the relative advantages and disadvantages of the options with a view to identifying (a) preferred strategic service solution(s).

A SWOT analysis was undertaken for each of the options as part of the workshop. A high-level assessment of the relative match between the proposed service options and the investment

objectives was carried out, with some options appearing to more fully meeting the objectives than others. The output of this session is outlined below:

	Do nothing option	Option 2 - RGH core	Option 3 – RGH Core + Intensive Rehab (IR)	Option 4 – RGH core, IR, enhanced elective activity over time	Option 5 – ambulatory care centre
Advantages (Strengths & Opportunities)	▪ Familiarity for staff and patients ▪ Limited requirement to alter workforce model	▪ Improved patient experience and outcomes ▪ Core services agreed by broad consensus across hospital and community staff ▪ Services described enhance and maintain existing services compared to "Do Nothing" ▪ Model of care is modernised, focussed on safety, patient experience and outcomes ▪ Optimises use of ambulatory care environments for planned and unscheduled pathways ▪ Enables admission avoidance	Advantages apply as per option2. In addition: ▪ Targets some of the challenges around sub-optimal use of inpatient beds ▪ Provides an alternative to IP bed or care services only ▪ Supports independent living philosophy, focusses on reablement ▪ Research suggests this will improve outcomes for patients ▪ Reduced economic impact of high levels of disability and impairment in community ▪ Potential reduction in need for care ▪ Improved whole system flow ▪ Reduced requirement for care home visits ▪ Further increases potential for admission avoidance ▪ Improves communication across primary and secondary care	Advantages apply as per option 3. In addition: ▪ Reduces instances of patient travel for certain procedures ▪ Improves access locally for patients ▪ Potentially provides capacity to support elective recovery and waiting list management across NHSH ▪ Improves utilisation of theatre and day unit capacity in Lochaber ▪ Frees up capacity in Raigmore (theatres and beds) ▪ Enables mentoring of consultants, upskills local workforce both for surgical and medical teams ▪ Enables future-proofing of services ▪ Supports OCUK brand by enhancing confidence in range of local services	▪ Simple care model – easy for patients to understand, no confusion over local service availability ▪ Consistency of provision across specialist services ▪ Focuses clinical teams on ambulatory delivery

	Do nothing option	Option 2 - RGH core	Option 3 – RGH Core + Intensive rehab (IR)	Option 4 – RGH core, IR, enhanced elective activity over time	Option 5 – ambulatory Care centre
Disadvantages (Weaknesses & Threats)	▪ Poor mental health place of safety provision ▪ Poor ability to recruit ▪ Lacks flexibility ▪ Poor system flow ▪ Mixed model of elective and emergency patient flow ▪ Significant proportion of care is inpatient based ▪ Poor ability to adapt to changes in demand ▪ Doesn't meet the "unmet need" and system-wide flow challenges	▪ Fails to address local system challenges and specifics of Lochaber area ▪ Hospital-focussed, stops short of community-based service redesign ▪ Still requires considerable patient travel for some services ▪ May not support training and career development opportunities ▪ Does not optimise inpatient bed usage	▪ Requires further work on clinical and care model ▪ Workforce model implications in terms of nursing, AHP input, CSWs and care staff ▪ May need to be part of a bigger development to enable affordable and safe staffing models ▪ Still requires patient travel for a broad range of elective services ▪ Requirement to establish a new model for the locality ▪ Risk of bed blocking du e to lack of local care home places	▪ Requires consistent levels of training and skills in surgical workforce ▪ May require investment in surgical kit ▪ Increases transport and logistics for increased surgical instrument usage ▪ Low demand levels may mean infrequent service provision ▪ Waiting time for local access may rise (patient choice?) ▪ Challenging to consistently support and run in the face of workforce challenges ▪ Increases workforce travel requirements ▪ May increase demand on radiology and lab services, with workforce implications	▪ Drastically reduces local access to services ▪ Increased patient travel ▪ Increases demand on Raigmore service provision ▪ Increases demand on patient transport and ambulance services ▪ Doesn't align with Scottish Government policy or NHS Highland strategy ▪ Disadvantages to the local economy (time out of work for patients and relatives) ▪ Staff retention at risk – insufficient challenge and career development opportunities ▪ Lack of emergency department may increase risk for residents and visitors (does not support OCUK) ▪ Location already remote for some patients, further travel exacerbates this ▪ Increased travel costs

How well do the options meet the investment objectives?

Investment objectives	Option 1 – Do Nothing	Option 2 – RGH core	Option 3 – RGH Core + Intensive Rehab (IR)	Option 4 – RGH core, IR, enhanced elective activity over time	Option 5 – ambulatory care centre
To deliver RGH services locally wherever possible and adapt to the unique and changing needs of the population in the remote and rural locality of Lochaber which is recognised as The Outdoor Capital of the UK	Partially	Partially	Yes	Yes	No
Develop a sustainable RGH service which optimises the skills of the local workforce, improves recruitment and retention and offers enhanced opportunities for training, including planned collaboration with other local agencies.	No	Partially	Partially	Partially	No
Deliver RGH services which maximise opportunities in current and future healthcare technology and innovation and make best use of this to benefit patients and staff.	No	Yes	Yes	Yes	Partially
Provide a modern flexible healthcare facility which supports the provision of a 21st century RGH model of care focused on patients and families.	No	Yes	Yes	Yes	Yes
Deliver services and infrastructure which will minimise environmental impact and deliver to Scottish Government's climate change targets, now and in the future	No	Yes	Yes	Yes	Yes

	Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)				
Affordability	Yes	Yes	Yes	Yes	Yes
Possible/ Preferred/ Rejected	Rejected	Possible	Preferred	Preferred	Rejected

Figure 5-7: Service options to develop more fully at OBC stage

The "preferred" service options are solutions 3 and 4 in the table above. The focus at OBC stage will be to develop these service solutions more fully and investigate the relative merits of aspects of service provision with a view to developing the optimal model at OBC stage; it will seek to maximise advantages, minimise disadvantages and most closely match with the investment objectives.

5.8 Design Quality Objectives

5.8.1 AEDET

An Achieving Excellence Design Evaluation Tool (AEDET) workshop was facilitated by Health Facilities Scotland (HFS) using Microsoft Teams on 4th August 2021.

The purpose of this workshop was to engage with project stakeholders to consider the AEDET statements and facilitate a discussion to reach a consensus on scoring these.

The workshop was attended by a broad stakeholder group and assessed the current facilities to determine a benchmark score and set a target score against which the future hospital design will be measured against at future business case stages.

The comments, notes and actions were recorded and distributed to all attendees who had a further opportunity to contribute to the final AEDET version.

The AEDET output can be provided on request.

5.8.2 NHS Scotland Design Assessment Process

The NHS Scotland Design Assessment Process (NDAP) was introduced in 2010 as a means of helping Boards describe a clear path between the business objectives for a project and the necessary qualities of the building development.

The process provides assistance in checking the project is on target to meet these objectives and national standards for healthcare design and sustainability, providing comfort to decision-makers at key points.

The process requires that a Design Statement is developed which sets out project specific design standards which are incorporated into the project's governance.

A Design Statement workshop was facilitated by Architecture & Design Scotland (A&DS) on 1st September 2021 and was attended by the Stakeholder Group, and clinical representatives from NHS Highland.

'Supported verified' status was confirmed on 31st January 2022.

5.8.3 NHS Scotland Assure

NHS Scotland Assure was established in June 2021 and seeks to move the culture around projects to one of more rigorous control of compliance, and adherence to technical guidance and standards.

NHS Scotland Assure will provide reassurance to NHS Highland that the project has been developed with due consideration to the Health Associated Infection System for Controlling

Risk in the Built Environment (HAI-SCRIBE) and infection control, and compliance on the main building services e.g., ventilation, drainage, electrical, and that sufficient briefing and governance arrangements are in place.

The Key Stage Assurance Review (KSAR) guidance and checklist for IA stage was published in June 2021, and the project team have worked collaboratively with NHS Assure to address the requirements at this stage of the process. The review concluded in December 2021 and the final report was issued on 18th of January 2022. The report, which was accepted in full by NHSH, highlighted 27 issues. Of the issues raised, the majority (20) where classed as Minor, with one issued classed as Moderate and a further 6 classed as an Observation and Improvement Activity.

It should be noted that the project will be designed in accordance with all published guidance and technical standards, with a minimum of derogations.

5.8.4 Net Zero Carbon

The project team are cognisant of the requirement for NHS Scotland to be a 'net-zero' Greenhouse Gas (GHG) organisation by 2045 at the latest, and for all NHS Scotland new buildings and major refurbishments to be designed to have net-zero GHG emissions from April 2020.

The Net Zero Carbon requirements have been considered by NHS Highland through the development of this IA.

NHS Highland have engaged with IES Consulting to undertake energy modelling work which will set performance targets which the building will need to achieve through design and construction.

Low carbon systems which will be considered for any future development will include:

- Shared Energy Centre (with West Highland College);
- Solar Thermal Hot Water;
- Solar Photovoltaics (PV);
- Heat Pumps (Ground Source or Air Source);
- Rainwater Harvesting; and
- Wind Turbines.

NHS Highland are in the process of establishing a Climate Change/ Sustainability Governance Group to oversee their transition to a net-zero emissions service, and the project team will work collaboratively with this group to ensure the investment in Lochaber aligns with their work across the board.

NHS Highland will also adopt the new Sustainable Design and Construction (SDaC) Guide (SHTN 02-01).

5.8.5 Equality Impact Assessment

An Equality Impact Assessment (EQIA) has been drafted and workshops with appropriate stakeholders were held during October and November 2021. The EQIA will be reviewed at regular intervals as the project develops and service models are further defined.

The design of the facility will be fully compliant with statutory guidance in relation to access, and with input from appropriate stakeholder groups, including the Lochaber Disability Access Panel in addition to independent access consultants, access to the hospital will be significantly improved from the current arrangements.

This investment will address health inequalities through improving access to the hospital and ensuring appropriate accommodation and facilities are provided for all patient groups, providing enhanced patient experience and quality of care for Lochaber patients.

5.8.6 HAISCRIBE

The project team carried out the Stage 1 HAISCRIBE assessment on 1st October 2021, facilitated by Infection Prevention and Control (IPC) and attended by appropriate members of the project team.

An IPC resource has been identified to support the project as it progresses through the future stages, and HAISCRIBE assessments will be undertaken at each stage of the project.

COMMERCIAL, FINANCIAL AND MANAGEMENT CASES

	Questions	Response
Commercial, Financial and Management Case	Is the organisation ready to proceed with the proposal?	Confirm: • Procurement strategy and timetable • Affordability and financial consequences • Governance and project management arrangements

6 IS THE ORGANISATION READY TO PROCEED WITH THE PROPOSAL?

6.1 Commercial Case

6.1.1 Procurement Strategy

Frameworks Scotland 3

To deliver the project in accordance with current NHS Scotland construction procurement policy, it is anticipated that Frameworks Scotland 3 will be the preferred option via traditional Capital Funding. This process ensures a strategic and flexible partnering approach to the Procurement of publicly funded construction work projects, for the delivery of health facilities in Scotland.

The Framework provides NHS Scotland Boards with the ability to readily appoint pre-qualified contractors, alongside pre-agreed commercial arrangements, to act as sole point of responsibility for the management and delivery of an integrated design and construction project on time, within budget and fit for purpose. This enables NHS Highland to immediately focus on the needs of the project rather than be involved in a protracted advertisement, selection, and appointment process.

This Framework has been established to achieve the following key benefits:

- Earlier and faster delivery of projects;
- Certainty of time, cost, and quality;
- Value for money; and
- Well-designed buildings procured within a positive collaborative working environment.

The Framework is procured and managed by Health Facilities Scotland (HFS) on behalf of NHS Scotland Health Boards.

Frameworks Scotland has been used successfully by NHS Highland for several years and there is a clear organisational understanding of the process for appointment of the Principal Supply Chain Partner (PSCP).

Principal Supply Chain Partner (PSCP)

In Frameworks Scotland 3 terminology, the single contractor is referred to as the 'Principal Supply Chain Partner' (PSCP). The PSCP's on Frameworks Scotland 3 are as follows:

- Balfour Beatty;
- Graham Construction;
- Kier Construction;
- McLaughlin and Harvey;
- RMF Health; and
- BAM.

To undertake the process of appointing a PSCP, a High-Level Information Pack (HLIP) will be issued by NHS Highland to the PSCP's on the Framework inviting expressions of interest. There will then be an evaluation and shortlisting process after which a short list of PSCP's with the

relevant experience and supply chain will be invited to make a second stage submission. This will be followed by presentations by the shortlisted PSCP's, followed by interviews. Appointment will be made based on the highest scoring PSCP on a Quality / Cost evaluation.

This process will commence on approval of this Initial Agreement, with the appointed PSCP providing pre-construction and supply chain expertise through the Outline and Full Business Case Stages to optimise programming and achieve best value from the process.

Lead Advisor

NHS Highland is in the process of appointing a Lead Advisor from the HFS Lead Advisor Framework to assist on this and a number of other projects. This appointment will provide access to technical consultancy services including NEC Project Manager, Cost Advisor, NEC Supervisor.

The call off process, via an HLIP, is being carried out in accordance with the HFS Framework Scotland process and will conclude in April 2022. NHS Highland will continue to seek guidance and support as required from the HFS Capital Advisers.

Collaboration

Frameworks Scotland 3 embraces the principles of 'collaborative working' to ensure that teams within and between the public and private sectors work together effectively. Collaborative working is defined as a relationship between purchasers and providers of goods and services throughout the supply chain, based on mutual objectives, maximising the effectiveness of each participant resource while continually seeking continuous improvement. This approach is designed to deliver ongoing tangible performance improvements due to repeat work being undertaken by the supply chains.

NEC Contract

To achieve the objectives outlined above, the Framework adopts an NEC4 form of contract. The principal objective of an NEC4 contract is to engender a collaborative working approach by creating an open, cooperative, non-adversarial team approach to managing the contract.

NEC4 encourages the use of the contract as a management tool, and this is facilitated using the Health Facilities Scotland Contract Administration Toolkit (CAT), which is a series of pro-forma which if used effectively enable contract parties to comply with contract clauses, or a project collaboration software tool such as CEMAR.

Key features of the NEC contract include:

- The contracting parties are encouraged to work together 'work together in a 'spirt of mutual trust and cooperation, as partners in an open and transparent approach, and to ensure this partnering approach is maintained;
- Under Option C, there is a 'Gain/Pain share' mechanism to incentivise the delivery team, by rewarding good performance and penalising poor performance;
- A clear and transparent process is in place to enable negotiation and agreement of cost;
- A level of 'price certainty' is determined;
- All price thresholds are set using quantitative risk analysis; and

- A key principle of the NEC4 Option C contract is the payment of 'Defined Cost' and an open book accounting philosophy. These require a robust, reliable, and transparent system to record staff time and manage the invoicing process.

6.1.2 Implementation Timetable

An outline programme has been developed. This will be subject to more detailed development following approval of the IA and appointment of a PSCP allows consideration of design and construction methodology for the preferred service solution.

Milestone	Key Date
Re-submit Initial Agreement to Capital Investment Group (CIG)	April 2022
Approval of Initial Agreement	May 2022
Appointment of Lead Advisor	April 2022
Appointment of PSCP	August 2022
Commence Outline Business Case	April 2022
Approval of Outline Business Case	April 2023
Commence Full Business Case	May 2023
Approval of Full Business Case	May 2024
Construction Commencement	June 2024
Construction Handover	June 2026

Figure 6-1: Implementation Timetable

6.2 Financial Case

The Initial Agreement is an early stage in the overall development of a business case for the project therefore, in accordance with SCIM guidance, these costs are indicative at this stage.

6.2.1 Affordability

NHS Highland have considered the affordability of this proposal by undertaking a review of the financial implications of investment, both capital and revenue.

A Financial and Economic Appraisal is included in Appendix 9 which presents the financial implications of investment and provides the economic appraisal of the short-listed options. The methodology and assumptions applied to derive the comparative cost implications of the options are outlined in the report.

On a purely financial basis, the 'Do Nothing' option does give the lowest recurrent revenue impact and also the lowest lifetime costs. This does not provide any service model improvements or meet any of the investment objectives so is only used as a baseline for measuring the other options.

All of the change Options have significant recurrent revenue consequences, and all have similar non-recurrent costs at this stage.

The Capital Cost per Option is detailed in Figure 6.2 reflecting the figures provided by Thomson Gray.

Costs in £millions	Option 1 – Do Nothing	Option 2 – RGH core	Option 3 – RGH Core Intensive Rehab (IR)	Option 4 – RGH core, Intensive rehab, enhanced elective activity over time	Option 5 – ambulatory care centre
Construction / Refurbishment	1.5	49.6	49.6	50.4	34.5
Sustainability	-	6.0	6.0	6.0	4.2
Fees, surveys, project team costs	-	8.6	8.6	8.7	6.0
Land Purchase	-	1.5	1.5	1.5	1.0
Inflation	-	10.7	10.7	10.9	7.4
Equipment	-	7.4	7.4	7.6	5.2
Optimum Bias	-	29.4	29.4	29.9	20.5
Total (excluding VAT)	1.5	113.2	113.2	115.0	78.8
VAT	0.3	22.3	22.3	22.7	15.5
Total Capital Costs	1.8	135.5	135.5	137.7	94.3

Figure 6-2: Indicative Capital costs

Indicative Non-Recurring Revenue Costs are shown in Figure 6.3 with further detail including assumptions is described in Appendix 9.

Costs in £millions	Option 1 – Do Nothing	Option 2 – RGH core	Option 3 – RGH Core Intensive Rehab (IR)	Option 4 – RGH core, Intensive rehab, enhanced elective activity over time	Option 5 – ambulatory care centre
Pay Costs	-	0.3	0.3	0.3	0.3
Non Pay Costs	-	0.9	0.9	0.9	0.8
Total Non-Recurring Costs	-	1.2	1.2	1.2	1.1

Figure 6-3: Indicative Non-Recurring revenue costs

Indicative Recurring revenue costs are summarised in Figure 6.4 with more detail provided in in Appendix 9. All of the change options include an assumed significant investment ranging between £3.3m-£4.4m, the majority of which is due to the additional depreciation derived from the significant capital investment required.

Costs in £millions	Option 1 – Do Nothing	Option 2 – RGH core	Option 3 – RGH Core Intensive Rehab (IR)	Option 4 – RGH core, Intensive rehab, enhanced elective activity over time	Option 5 – ambulatory care centre
Pay Costs	11.5	12.6	12.5	13.3	11.8
Non Pay Costs	1.4	1.6	1.6	1.7	3.1
Building Costs	0.3	0.6	0.6	0.6	0.4
Income	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)
Total Recurring Costs excluding Depreciation	12.9	14.5	14.4	15.3	15.0
Depreciation	0.3	2.2	2.2	2.3	1.5
Total Recurring Costs	13.2	16.7	16.6	17.6	16.5

Figure 6-4: Indicative Recurring revenue costs

To provide the indicative costs at this Initial Agreement stage, the following assumptions have been made:

- An optimism bias of 35.7% has been applied to the capital cost of each option. This has been calculated in accordance with Scottish Capital Investment Manual guidance;
- Land purchases are included where relevant but any proceeds from disposals are assumed to be returned to Scottish Government in line with guidance, rather than being offset against capital requirements;
- External advisors' costs (included within capital cost figures) are based on estimates from similar recent projects undertaken in NHS Highland;
- Discounted cash flow (used to calculate NPV figures) use a discount rate of 3.5% to 30 years adjusting to 3% thereafter in line with Scottish Capital Investment Manual guidance;
- Assumes a useful asset life of 60 years;
- Capital cost options are as detailed in Appendix 8; and
- Revenue and capital costs for Option 1 are in line with current activity and bed numbers.
- Revenue cost option assumptions are as detailed in Appendix 9.

6.2.2 Resources

For this Initial Agreement, staff costs have been calculated as based on 2021/22 pay scales including all employers costs. Staff costs will be reviewed in more detail at OBC stage to align with the preferred service solution.

Non-pay, and consumables, have been included in the financial modelling, using the costs of the current services as a guide on the potential service changes at this stage.

The resources required to deliver the proposed estimate are included within the capital cost estimates.

6.2.3 Capital and revenue constraints

The revenue costs have been considered and prepared for each option and are noted in the Financial and Economic Appraisal.

The capital costs have been considered and prepared for each option and these are noted in Section 5.6.1, and a detailed breakdown of these costs are included in Appendix 8. These capital costs have been calculated using the assumed schedule of accommodation for each of the proposed options based on an exemplar Rural General Hospital.

6.2.4 Financial contributions

The capital costs of the investment will be through a capital contribution from the Scottish Government. No additional contributions are identified at this point. Any revenue consequences will require to be included as part of the budget setting process within NHS Highland.

6.3 Management Case

6.3.1 Organisation Chart

To deliver the project successfully, good governance is required to monitor and direct it. The governance structure presented below has been set up and will be followed to ensure the project is delivered on time, on budget and to the required quality standard.

This provides the structure for approval of project matters, and a route to escalate decision making.

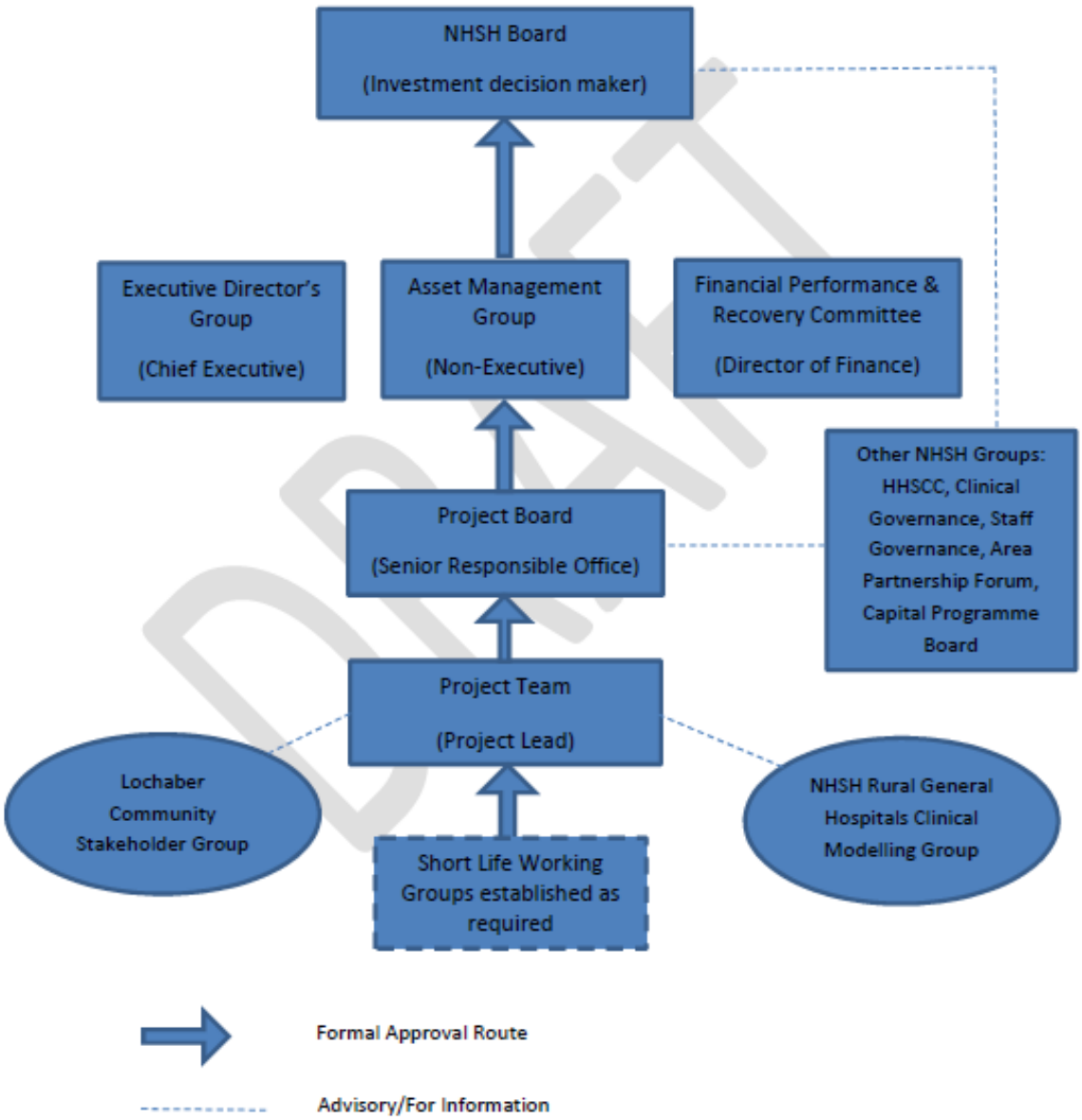


Figure 6-5: Governance Structure

6.3.2 Governance

The governance support for this proposal is set out in the table below:

Governance Group	Engagement that has taken place	Confirmed support for the proposal
Organisation	NHS Highland are fully supportive of this proposal.	This Initial Agreement was approved by the NHS Highland on 30/11/21.
Service or Department	The Director involved in this project is Katherine Sutton, Director of Acute Services, NHS Highland.	This Initial Agreement was approved by the Asset Management Group on 22/10/21.
Healthcare Improvement Scotland	Healthcare Improvement Scotland have been informed of the impact of any proposed service change on patient care through representation at the workshops.	Healthcare Improvement Scotland that they are content with the kind and level of engagement carried out to date, and that it is in line with guidance.

Figure 6-6: Governance Support

6.3.3 Project Structure

Project Board

NHS Highland Project Board monitors progress providing the necessary steer to resolve issues which cannot be resolved at Project Team level, as well as approving key project documents such as Business Cases.

The Board will also be responsible for approving key project documents such as Business Cases, Compensation Events (variations) and key stage reviews.

Membership of the Project Board is shown in Table 6.7 as follows:

Name	Role	Organisation / Group
Louise Bussell	Senior Responsible Officer/ Chief Officer for Community Services (Chair/Sponsor)	NHS Highland
Alan Wilson	Director of Estates (Deputy Chair)	NHS Highland
Mike Hayward	Deputy Chief Officer, Acute Services	NHS Highland
Boyd Peters	Medical Director	NHS Highland
Heidi May	Board Nurse Director	NHS Highland
David Garden	Director of Finance	NHS Highland
Fiona Hogg	Director of Human Resources and Organisational Development	NHS Highland
Arlene Johnstone	Head of Mental Health	NHS Highland
Rhiannon Boydell	Head of Community Services	NHS Highland
Elspeth Caithness	Staff Representative	NHS Highland
Gerard O'Brien	Non-Executive Board Member	NHS Highland
Graham Bell	Non-Executive Board Member	NHS Highland

Figure 6-7: Project Board

The Project Board will be accountable for the delivery of the project through:

- Ensuring the project direction meets with the overall strategic direction of NHS Highland;
- Agreeing the scope and supervising development and delivery of the project;
- Approval of key project documents, in particular the business case and briefing documentation;
- Assuring the project remains within the framework of the overall strategy, scope, timescale, and budget;
- Assuring business continuity during project implementation;
- Assuring appropriate communication and engagement with stakeholders;
- Resolve issues escalated by the Project Team; and
- Advising Project Team of any developments external to the project which need to be considered.

Project Team

The project team sits below the Project Board and is responsible for delivering the project on a day-to-day basis. This includes, developing the business case in accordance with the Scottish Capital Investment Group (SCIM) Guidance, developing the design, managing risks, developing the costs, constructing the facility, commissioning the facility, and successfully handing the facility over to NHS Highland at completion.

Involvement and participation will continue throughout the planning phases and project leads will attend the various subgroup meetings as appropriate.

Membership of the Project Team is shown in Table 6.8 as follows:

Name	Role	Organisation / Group
Alex Kelso	Belford Hospital Manager (acting)	NHS Highland
Chris Stirrup	Senior Charge Nurse & Emergency Nurse Practitioner, ED	NHS Highland
Heather Cameron	Senior Project Manager	NHS Highland
John Hutchison	Community Representative	Kilmallie Community Council
Josie Thomson	Clinical Advisor	NHS Highland
Catherine Lee	Infection Control Nurse	NHS Highland
Fiona Gordon	Health & Safety	NHS Highland
Stephen Gilbert	Clinical Lead, Belford Hospital	NHS Highland
Karen Anne Wilson	District Manager, Lochaber	NHS Highland
Marie McIlwraith	Community and Engagement Officer	NHS Highland
Alan Paton	Service Planning Analyst	NHS Highland
Ross MacKenzie	Area Manager	NHS Highland
Evelyn Gray	Associate Nurse Director	NHS Highland
Patricia Jordan	Community Representative	Fort William Inverlochy & Torlundy Community Council
Allan Ross	Estates Officer	NHS Highland
Tony Clapham	Staffside Representative	NHS Highland
Ros Philip	Head of Finance	NHS Highland
Laura Menzies	Midwifery Team Leader	NHS Highland
Iain Ross	Head of Ehealth	NHS Highland
Mike Hayward	Chief Officer, Acute Services	NHS Highland
Rob Cargill	Deputy Medical Director, Management	NHS Highland
Jo McBain	Deputy Director for Allied Health Professionals	NHS Highland
David Main	Project Manager	NHS Highland
Aileen MacLean	Clinical Nurse Manager, Belford	NHS Highland

Figure 6-8: Project Team

The Project Team will be accountable for the delivery of the project through:

- Managing the successful delivery of the project within the framework of the overall strategy, scope, and budget, reporting regularly on progress;
- Identify and coordinate activities required to deliver the project and monitor delivery against programme;
- Develop a robust business case for approval by relevant parties;
- Implement the cultural and workforce changes required to support the project;
- Ensure effective ongoing engagement and communication with stakeholders;
- Quantify and measure benefits;
- Identify and manage risks and escalate to Project Board as required;
- Develop a clear and appropriate brief for the project which meets the needs of the service, and once approved, monitor and control changes; and
- Set up and supervise sub-groups as required, ensuring deliverables are completed on time and to the required standard.

External Advisors

NHS Highland have appointed an experienced team of advisors through Hub North Scotland Limited to develop this Initial Agreement.

These advisors are noted in Table 6.9 as follows:

Name	Role	Organisation / Group
Graham McCorkindale	Project Director	Hub North Scotland Ltd
Gillian Bratt McManus	Healthcare Planner	Buchan + Associates
Iain Buchan	Healthcare Planner	Buchan + Associates
Laurence Casserly	Project Manager	Thomson Gray
Ross Lovatt	Cost Advisor	Thomson Gray
Samuel Hey	Architect	Keppie Design

Figure 6-9: External Advisors

NHS Highland are also engaged through HiTrans with Derek Halden Consultancy Ltd to provide transport consultancy services and ensure that the transport impact of any changes to service provision are clearly understood against the baseline, both to assure local communities that any impact is fully considered in decisions and to enable assessment of reduced 'health miles'.

6.3.4 Project Plan

The key project milestones are set out in Table 6.10 below:

Milestone	Key Date
Re-submit Initial Agreement to Capital Investment Group (CIG)	April 2022
Approval of Initial Agreement	May 2022
Appointment of Lead Advisor	April 2022
Appointment of PSCP	August 2022
Commence Outline Business Case	April 2022
Approval of Outline Business Case	April 2023
Commence Full Business Case	May 2023
Approval of Full Business Case	May 2024
Construction Commencement	June 2024
Construction Handover	June 2026

Figure 6-10: Project Milestones

6.3.1 Readiness to Proceed

No	Checklist	Yes/No	Proposal
1	Is the reason made clear why this proposal needs to be done now?	Yes	The Strategic Case sets out the imperatives for this proposal on a national, regional, and local level.
2	Is there a good strategic fit between this proposal, NHS Scotland's Strategic Priorities, national policies, and the organisation's own strategies?	Yes	There is a compelling case for this proposal, when referenced against the strategic priorities. Refer to Table 7.1
3	Have the main stakeholders been identified and are they supportive of the proposal?	Yes	The main stakeholders have actively engaged in the development of this proposal and are supportive of the service change proposal.
4	Is it made clear what constitutes a successful outcome?	Yes	The investment objectives are identified. These will be a reference measure for success as the project outputs are developed.
5	Are realistic plans available for achieving and evaluating the desired outcomes and expected benefits to be gained, including how they are to be monitored?	Yes	A Benefits Realisation Plan has been drafted and will be further developed through the OBC stage with input and ownership from key stakeholders
6	Have the main project risks been identified, including appropriate actions taken for mitigating against them?	Yes	A Risk Register has been developed to identify and manage project risks.
7	Does the project delivery team have the right skills, leadership, and capability to achieve success?	Yes	The project delivery team are experienced in the delivery of business cases and construction projects in an acute healthcare environment.
8	Are appropriate management controls explained?	Yes	A robust project governance structure is in place. This is explained in Section 6.
9	Has provision for the financial and other resources required been explained?	Yes	Financial implications of this proposal (both capital and revenue) are detailed in Section 5.5.

Figure 6-11: Readiness to proceed checklist

7 CONCLUSION

	Questions	Response
Conclusion	Is this proposal still important?	Confirm: • Strategic Assessment template

7.1 Is this proposal still important?

On conclusion of this Initial Agreement, this proposal remains important for NHS Highland.

The proposal will address issues with the provision of services in the Lochaber area and will meet the stated investment objectives agreed by the stakeholders, allowing a detailed assessment of the preferred service solutions at the next stage.

Two options have been selected for further work at OBC level:

- Proposed Option 3 – RGH clinical model with Intensive rehab; and
- Proposed Option 4 – RGH clinical model with Intensive rehab, and enhanced elective services provision over time.

Further development of the proposed service solutions will provide a basis for a modern, sustainable model of care which improves healthcare services for the population of Lochaber.

This service redesign will support the delivery of NHS Highland's policies and strategies which include the:

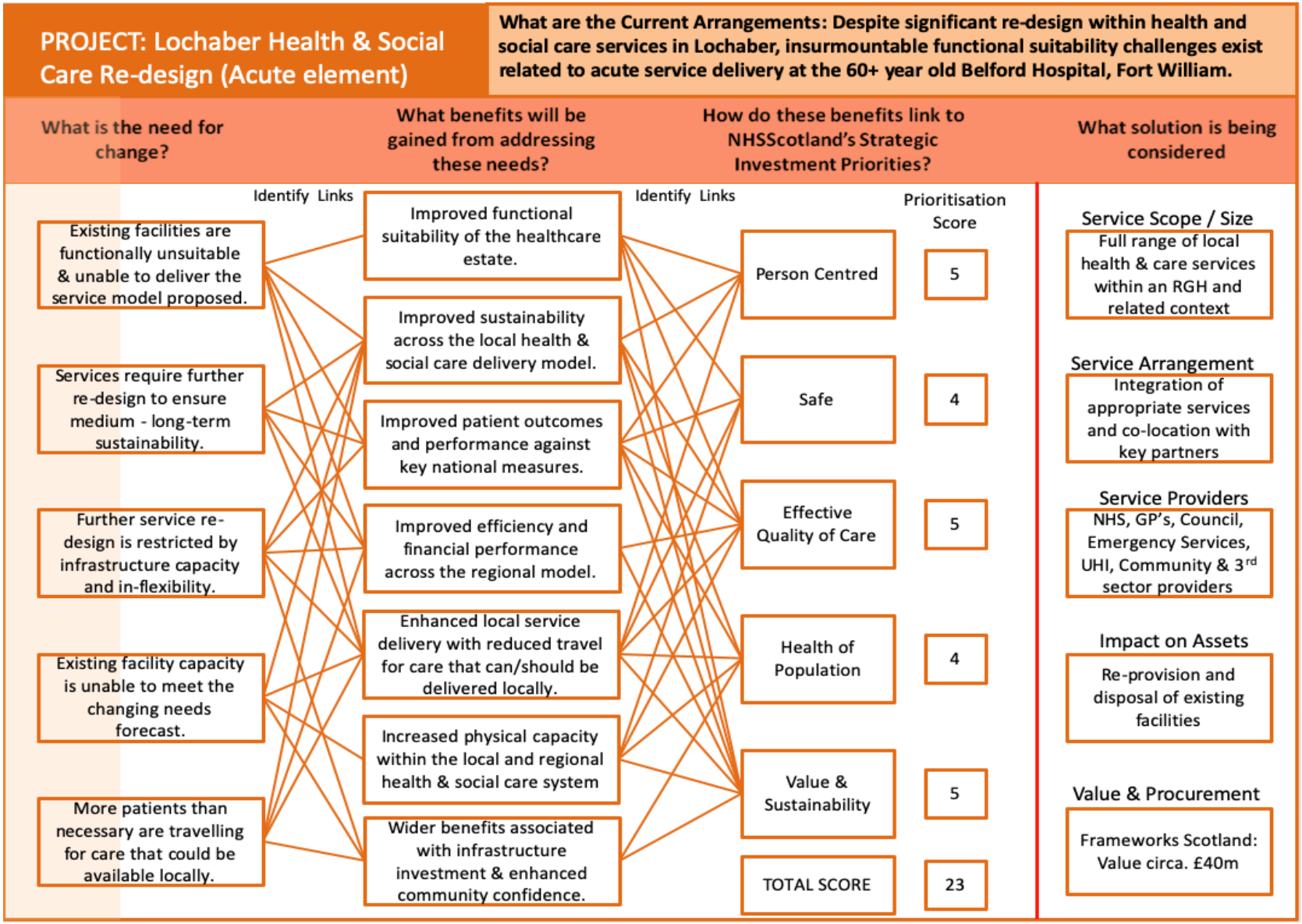
- Operational Plan;
- Primary Care Improvement Plan; and
- Remobilisation Plan 2021 – 2022.

The proposal will achieve NHS Scotland's Strategic Priorities (refer to table below) and will also deliver service change which responds to the vision set out in the National Strategy for Scotland as detailed throughout this proposal.

NHS Scotland's Strategic Priorities:	Lochaber redesign
Person Centred	Equity of access to services.
Safe	Modern compliant facilities ensuring a safe environment.
Effective quality of care	Redesigned model of care will enable effective quality of care.
Health of population	Access to a redesigned model of care for population of Lochaber.
Value & sustainability	This proposal will enable a sustainable, efficient, patient-focused service.

Figure 7-1 – Alignment to NHS Scotland Strategic Priorities

8 APPENDIX 1: STRATEGIC ASSESSMENT (COMPLETED 2018)



9 APPENDIX 2: GP PRACTICES IN LOCHABER, INC. POPULATIONS SERVED

Practice Name	Code	Address Line 1	Address Line 2	Practice type	Population served
Craig Nevis Surgery	55605	Fort William Health Centre	Camaghael	17J	3717
Glen Mor Medical Practice	55610	Fort William Health Centre	Camaghael	17J	5475
Tweeddale Medical Practice	55624	Fort William Health Centre	Camaghael	17J	5148
Kinlochleven Medical Practice	55639	Kearan Road	Kinlochleven	17C	897
Lochaline Medical Practice	55643	Morvern Medical Centre	Rowanbank	17J	331
Acharacle Medical Practice	55662	The Pines Medical Centre	Acharacle	2C	1373
Cill Chuimein Medical Centre	55732	Fort William Road	Fort Augustus	17J	1490
Ballachulish Medical Practice	56025	East Laroch	Ballachulish	2C	1590
Mallaig And Arisaig Medical Practice	56030	Mallaig Health Centre	Victoria Road	17J	1796
					21817

Map of GP practice locations and Belford hospital located in Fort William

GP practice types – descriptions (from PHS Data and Intelligence)

2C practice: In general terms, this is most likely to mean that the practice is run by the NHS Board (as opposed to being run by GPs and/or other partners, as is the case for practices with 17C or 17J contract types). With effect from 1st April 2004, The Primary Medical Services (Scotland) Act 2004 amended The National Health Service (Scotland) Act 1978 by placing a duty on NHS Boards to provide or secure 'primary medical services' for their populations. NHS Boards can do so by making arrangements with 17C and/or 17J practices (see below). Additionally, they can arrange for services to be provided directly (this is known as 'direct provision') or via another organisation (this is known as a 'Health Board Primary Medical Services' contract). These additional options are included under Section 2C of the 1978 Act.

17C practice: A 'Section 17C' practice (formerly known as 'Personal Medical Services' or 'PMS' practice) is one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances. Section 17C is in respect of The National Health Service (Scotland) Act 1978, as amended under The Primary Medical Services (Scotland) Act 2004.

17J practice: A 'Section 17J' or 'GMS' (General Medical Services) practice is one that has a standard, nationally negotiated contract. Within this, there is some local flexibility for GPs to opt out of certain services (such as additional services) or opt into the provision of other services (such as enhanced services). Section 17J is in respect of The National Health Service (Scotland) Act 1978, as amended under The Primary Medical Services (Scotland) Act 2004.

10 APPENDIX 3: LIST OF SERVICES CURRENTLY PROVIDED IN LOCHABER

Belford Hospital, Fort William

- 24-hour Nursing cover
- 24-hour A&E service
- 24-Hour Laboratory Service
- 24-hour on site medical cover
- 24-hour on site Surgical cover
- 24-hour Radiography cover
- 24-Hour Theatre cover
- Cardiac Rehabilitation Service
- Cardiology Service
- Chemotherapy service
- Community Dental Service
- Day Case Unit (Surgery and Endoscopy)
- Diagnostic Ultrasound service
- Dietetics Service
- Integrated Midwifery service
- Virtual Fracture Clinic
- Macmillan Nursing Service
- Occupational Therapy
- Out of Hours Service
- Palliative Care
- Pharmacy Service
- Physiotherapy
- Podiatry
- Rehabilitation Ward
- Renal Dialysis
- Speech & Language Therapy
- Injection Clinic
- Pain Clinic

Services provided by specialists from Raigmore on a visiting basis:

- Audiology Clinics
- Chest Clinic
- Colorectal Clinic
- Colorectal Nurse Specialist
- Dermatology Clinics
- Diabetic Nurse Clinics
- ENT Clinics
- Eye Clinics
- General Medical Clinics
- Gynaecology Clinics
- Haematology Clinic
- Highland Sexual Health Clinic
- Injection Clinic
- Obstetric Clinics
- Oncology Clinics
- Orthopaedic Clinics
- Orthoptic Clinics
- Orthotics Clinics
- Pacemaker Clinic
- Paediatric Clinics
- Rehabilitation Medicine Clinics
- Renal Clinic
- Rheumatology Clinic
- Sleep Apnoea Clinic
- Vascular Clinic

Services provided in Lochaber District:

- Community nursing services, West, East and South Lochaber
- AHP services, Physio, OT, Dietetics, SLT
- Learning disability, transitions teams
- Integrated Social Work team
- Community Mental Health Team, Older adult CPNs, Adult CPNs, CBT therapy, Urgent Care Nurse, Drug and Alcohol Recovery Services, Specialist MH Occupational Therapy
- Community Midwifery service
- Macintosh Centre, Mallaig (registered place 8) Telford Centre, (registered places 10) Invernevis House, Care Home (registered places 30), Moss Park Nursing Home (40 places). Abbeyfield, Ballachulish (30 places), Dail Mhòr, Strontian (Planned respite). Montrose Centre, day care venue for adults with learning or physical disability
- GP bed, Moss Park nursing home, Fort William
- Fund 6 nursing beds, 2 intermediate care beds and 1 respite bed, Abbeyfield Nursing Home, Ballachulish
- NHS facilitates and currently chairs the Lochaber Community Partnership

11 APPENDIX 4: LIST OF PROJECT BENEFITS IDENTIFIED

No benefits were identified with a priority rating of less than 3.

Benefit Rating 3	Benefit Rating 4	Benefit Rating 5
Increased confidence in portfolio of local health and care services, supporting OCUK status	Improved access and egress from hospital site in Lochaber - making it easier to get into and out of the hospital site	Timely care with a reduction in delays
Improved community confidence and morale	Creation of a healing and caring environment, reducing recovery times	Improved extent to which the patients are appropriately informed and appropriately involved in their care and treated with dignity and respect.
	Patients receive integrated care, both within the hospital and the wider health and care system	Improved A&E waiting time performance and access to ambulatory/ same day emergency care. Improve timeliness of receiving treatment on the day and decrease likelihood of admission for overnight stays.
	Training, development and upskilling of workforce means everyone can work at their topmost skill level	Reduced average length of stay, timelier discharge home/homely setting with higher functional capability (after receiving rehab input)
	Reduction in patient travel for healthcare, reducing time out of day for pts and reducing carbon emissions	Reduction in incidence of HA infections, improved score against monitored aspects of infection control. Impact on loss of capacity as a consequence.
	Reduced/eliminated backlog maintenance and associated risks/costs, improved financial position	Improved recruitment and retention of staff
	Improved staff morale and sickness/ absence rate	Improving health and wellbeing of local population
	Improved flexibility of configuration and ability to separate different types of flow within hospital easily and at pace in response to changing situations.	Reduced carbon footprint
	Partnership with West Highland College offering synergies on site and opportunities for education	

12 APPENDIX 5: LIST OF RISKS IDENTIFIED, INCLUDING RATINGS

Risk ID	Identification		Assessment		
	Risk Description	Risk Category	Consequence	Likelihood	Risk
1	The project disrupts day to day business operations	Business Risk	Minor (2)	Possible (3)	6
2	The Board doesn't have the capacity or capability to deliver the project	Business Risk	Major (4)	Possible (3)	12
3	The proposed clinical model not clear and complete and therefore not accepted by internal and external stakeholders	Business Risk	Major (4)	Possible (3)	12
4	The clinical need for change and expected outcomes are not clearly defined	Business Risk	Moderate (3)	Unlikely (2)	6
5	If assessed as major service change requirements could result in project delay	Business Risk	Moderate (3)	Unlikely (2)	6
6	Poor stakeholder involvement results in a lack of support for the project	Business Risk	Major (4)	Unlikely (2)	8
7	Scottish Government do not support the business case resulting in unavailability of capital	Business Risk	Extreme (5)	Possible (3)	15
8	Adverse publicity occurs due to an issue with the project	Reputational Risk	Major (4)	Unlikely (2)	8
9	Poor communication results in stakeholder interests being ignored	Reputational Risk	Moderate (3)	Unlikely (2)	6
10	Demand for the service does not match the levels planned, projected, or presumed	Demand Risk	Major (4)	Possible (3)	12
11	The available / proposed accommodation is unable to support the proposed service model	Operational Risk	Major (4)	Rare (1)	4
12	Unable to decant services from one site to another in a timely manner	Decant Risk	Minor (2)	Unlikely (2)	4
13	Assumptions regarding use of technology to support service model are not met	Technology Risk	Major (4)	Possible (3)	12
14	Local community objects to the project	Planning Risk	Major (4)	Rare (1)	4

15	Uncertainty about the development of community-based services to support the hospital redesign impacts on the scope of the project	Planning Risk	Major (4)	Possible (3)	12
16	External factors impact on service requirements at new hospital	Planning Risk	Moderate (3)	Possible (3)	9
17	Information used as part of the strategic & project brief is unreliable	Project Information Risk	Major (4)	Unlikely (2)	8
18	The design does not meet the Design Assessment expectations / requirements	Design Risk	Major (4)	Rare (1)	4
19	Critical programme dates are unrealistic	Construction Risk	Moderate (3)	Unlikely (2)	6
20	The project cost estimate is poorly prepared and inaccurate	Funding Risk	Major (4)	Possible (3)	12
21	The project becomes unaffordable as a result of scope creep and / or service developments	Funding Risk	Moderate (3)	Unlikely (2)	6
22	Changes in legislation or tax rules increase project costs	External Risk	Moderate (3)	Possible (3)	9
23	Changes to non-legislation policy affects project cost or progress	Policy Risk	Moderate (3)	Possible (3)	9
24	Availability of staff to attend and contribute to key programme sessions in light of operational pressures and covid-19 pandemic. Organisational change and realignment of roles and responsibilities may be contributing.	Planning Risk	Moderate (3)	Likely (4)	12

13 APPENDIX 6: STAKEHOLDERS INVOLVED IN CLINICAL MODEL DEVELOPMENT

Workshop 1 participants 25/2/2022

Name	Designation
Aiden Ness	Student
Aileen MacLean	Clinical Nurse Manager • Emergency Department
Alan George Knox	SAS
Alex Kelso	Pharmacy Manager, Pharmacy Services
Beth Hadden	Rural Emergency Practitioner
Caroline Henderson	Manager, locality Service
Catherine MacDonald	Team Leader, Maternity Unit
Chris Stirrup	Senior Charge Nurse & Emergency
David Main	Project Manager
Denise Macfarlane	DMD Community
Diane Forsyth	Project Manager (Caithness)
Dr Rebecca Weir	GP Cluster Lead
Dr Sam Spinney	Consultant Anaesthetist
Elizabeth Knox	Staff Nurse
Eric Green	Head of Projects
Evelyn Gray	Associate Nurse Director - Acute
Heather Andrews	Charge Nurse
Heather Cameron	Senior Project Manager
Helen Cree	Senior Staff Nurse
Jo McBain	Deputy Director AHPs
Jodie Sandilands	Senior Pharmacy Technician, Pharmacy Services
Johnathan Davies	Clinical lead Belford Hospital
Josie Thomson	Clinical Advisor
Karen King	Associate Director Midwifery
Katrina Gannon	Consultant Anaesthetist
Lanah Dunsmuir	Community Psychiatric Nurse
Lesley Pow	Staff Nurse
Mandy Sillars	Charge Nurse, Outpatients
Mariasoosai Pathmarajah	Locum Consultant Surgeon, General Surgery
Mhairi Mackinnon	Associate Lead Nurse
Mike Hayward	Deputy Chief Officer, Acute Services
Nicola Turner	Team Leader, Community Nursing
Pauline Yeung	Senior Charge Nurse
Peter MacNamara	Senior Physiotherapist • Physiotherapy
Rob Cargill	Deputy Medical Director, Management
Sheelagh Purdie	Macmillan Advanced Nurse
Sheila Morris	Occupational Therapist
Stephen Gilbert	Clinical lead Belford Hospital

Workshop 2 participants 11/3/2022:

Name	Designation
Aileen MacLean	Clinical Nurse Manager
Beth Hadden	Rural Emergency Practitioner
Catherine MacDonald	Maternity Unit, Team Leader
Christian Nicolson	District Manager North and West Operational Unit
David McArthur	Senior Nurse Service Redesign and Policy
David Main	Project Manager
Diane Forsyth	Project Manager
Donald Paterson	Staff Nurse, Accident and Emergency
Eric Green	Head of Estates
Evelyn Gray	Divisional Nurse Manager, Medical and Diagnostics
Heather Cameron	Senior Project Manager
Heather Andrews	Charge Nurse
Helen Cree	Senior Staff Nurse
Jo McBain	Deputy Director AHPs
Jonathan Davies	Mental Health Liaison Nurse
Josie Thomson	Clinical Advisor
Karen King	Associate Director Midwifery
Karen-Anne Wilson	District Manager, Community
Klara Campbell	Administration Manager, Belford
Lanah Dunsmuir	Community Psychiatric Nurse
Lesley Pow	Staff Nurse
Michelle Johnstone	Area Manager
Pamela Garbe	Manager CGH
Rebecca Weir	GP Partner
Ros Philip	Head of Finance
Sam Spinney	Consultant Anaesthetist
Sheelagh Purdie	MacMillan Advanced Nurse
Sheila Morris	OT Professional Lead West Operational Unit
Stephen Gilbert	Clinical lead Belford Hospital

14 APPENDIX 7: DETAILS OF RGH CLINICAL MODEL

Core RGH services – Category A - Inpatient services

Service/ specialty name	Example high end complexity supported	Examples of where treatment is appropriate in non-RGH setting
Medical assessment	All conditions assessed	
Surgical assessment	All conditions assessed	
Frailty assessment	Within the: Emergency Department Assessment Unit Ambulatory Emergency Care/SDEC	Within Out-of-Hospital services
Paediatric assessment	Further discussion with paediatric team required to clarify scope of service	
Inpatient medical	All General Medicine admissions where 'on-site' medical expertise is available e.g. a patient presenting with a non-renal condition who requires dialysis.	Management of patients who have a need for specialty input that is not available within the RGH. These patients would be transferred to Raigmore or Glasgow.
Inpatient surgical	• High volume, low risk elective procedures e.g. hernia repair, cholecystectomy and gynae procedures which would not require more than level 2 care post-operatively. This would include bowel resections in future. • Low risk 'semi-elective' procedures that have presented as an emergency but can be scheduled as an urgent case.	Low volume, medium/ high risk procedures. All procedures that may require Level 3 care post-operatively.
Enhanced and Level 2 Care	The ability to manage: arterial lines, central lines, inotropes and non-invasive ventilation.	
Orthopaedic Surgery	Reduction of fractures	No procedures that involve the use of internal fixation e.g. hip fractures.
Inpatient rehabilitation	Physiotherapy and Occupational Therapist rehabilitation where acuity, complexity and intensity dictate that inpatient environment is the appropriate one.	Rehabilitation which doesn't require the inpatient environment based on acuity, complexity and intensity of patient need.
Mental Health place of safety	Short-term (up to 24hrs) only for adults and young people (if appropriate), with support from Community Mental Health Nurses/ CAMHS – requires training, appropriate facilities and standard operating procedures.	
Inpatient Palliative and end of life care (P&EOLC)	Need the ability to accommodate P&EOLC within an RGH. May have one single room that is configured differently for this purpose as well as a general inpatient room.	The majority of palliative care is, and should be, delivered at home. Palliative care Children – not in RGH

Continuing care	HBCCC. Not an RGH function but in the meantime the ability to deliver this service should be on site (Lochaber) - approximately 1-2 patients per year are admitted due to complexity (long length of stay).	Further discussion required. Need for creation of an NHSH model. To be reviewed.

Midwifery services	Community Midwifery Unit services including:
	• Midwifery lead intra-partum care
	• Emergency treatment of:
	  ○ neonatal jaundice
	  ○ post-natal bleeding
	• Transitional care
		Emergency Caesarean Section should be undertaken at Raigmore Hospital unless in exceptional circumstances and life-threatening conditions (surgeons and anesthetists need to be upskilled and skills maintained). Obstetric opinion required.

Paediatric Services	Low risk, day case surgery	No surgery requiring an inpatient stay

Core RGH services – Category A - Ambulatory services

Service/ specialty name	Example high end complexity supported	Examples of where treatment is appropriate in non-RGH setting
Emergency Department	All presentations	-
Minor injuries	All presentations	More activity seen at Community Pharmacies and Optometrists (signposting!)
GP OOH	All presentations	Benefits of co-location, forms part of future model but not essential to co-locate currently disparate services
Same Day Emergency Care/ Ambulatory Emergency care (SDEC/AEC)	SDEC registry and AEC directory conditions are appropriate. First line management through minor injuries, SDEC for patients who would otherwise historically have been admitted to a bed.	-
Outpatient dialysis	All new and established dialysis patients.	-
Outpatient SACT	All SACT administration with a treatment time of less than 8 hours.	-
Outpatient biologics/infusions	All biologics/infusions with a treatment time of less than 8 hours.	-
Planned medical day case treatment	OPAT SST + Bloods Blood Transfusions Pre-Op Rehydration Humira Injections DC cardioversion PICC Line Cath Insertion Hydrocortisone Info & Teaching Fistuloplasty CT Guided Pre-Op AB	-

	Venesection Methotrexate Injections Lumbar puncture Pre & Post CT Fluids	
Endoscopy	Planned day case Some emergency (inpatient) Paediatric emergency (specific cases – e.g. suspected battery ingestion) Variceal banding	-
Outpatients	Diabetes (adult) 100% virtual or Near Me during pandemic; mixture of virtual and face-to-face for Paediatrics. General Medicine, General Surgery and Chronic Pain clinics currently delivered as routine f2f – pre-covid. One-stop MDT clinics Pre-operative Assessment Medical Paediatrics Virtual fracture clinic – physio led	-
Midwifery services	Note the importance of maintaining an integrated and holistic maternity service and pathways. Cardiotocography (CTG) Retention of activities within RGHs that involve the use of heavy and bulky equipment.	Phlebotomy Glucose tolerance testing Neonatal hearing
Physiotherapy	Inpatient rehab only	All other physiotherapy is delivered at the Health Centre
Occupational therapy	Inpatient OT only	All other Occupational Therapy is delivered at the Health Centre. Focus on a re-ablement model.
Podiatry	In-reach to inpatients where required	Community based with 'in reach' to the RGH
S&LT	In-reach to inpatients where required	Community based with 'in reach' to the RGH
Dietetics	In-reach to inpatients where required	Community based with 'in reach' to the RGH

Core RGH Support services

Service/ specialty name	Example high end complexity supported	Examples of where treatment is appropriate in non-RGH setting
Radiology	X-ray, Ultrasound, CT. Provision of infrastructure to support mobile MRI & CT units to come on campus	Interventional radiology, Fluoroscopy, Nuclear medicine, MRI, PET CT, Dental X-rays.
Pharmacy	Clinical Pharmacy Dispensing Additional space to store high volumes of vaccines (covid-19)	Aseptic Pharmacy, Oral SACT.
Labs	Microbiology Biochemistry Haematology Blood bank POC testing	More work required on this to provide further clarity on scope.

Community-based services – Category B

Service/ specialty name	Delivery model
Palliative and End-of-Life Care	Mosspark – 1 bed commissioned (Independent Care Home)
Long term nursing care	6 nursing beds in Abbeyfield Nursing Home, Ballachulish
Care homes	Macintosh Centre, Mallaig (registered place 8) Telford Centre, (registered places 10) Invernevis House, Care Home (registered places 30) Moss Park Nursing Home (40 places) Abbeyfield, Ballachulish (30 places)
Intermediate care	2 intermediate care beds in Abbeyfield Nursing Home, Ballachulish (max 2 weeks LoS, step up/ step-down from/to home/ homely setting)
Step up/step down Respite	Dail Mhòr, Strontian (Residential care/ assisted living, 6 places) Emergency step up and step down. Focussed on preventing hospital admission (respite care potentially returning post-covid)
Sexual Health	GPs Generic clinic setup – hospital or high street?
Minor Surgery 'Lumps & Bumps'	GPs/ Health centre treatment room Limited by GP interest and cautery. No benign minor surgery in hospital.
OPAT (non-intravenous)	Community nursing
SACT/ Chemotherapy	Review with cancer services team, Community nursing could support home delivery and self-administration

Intermediate Treatment Room/CTAC	Benefits of co-location (funding streams need to be validated) Primary care practices
Enhanced Recovery After Surgery (ERAS), including pre-habilitation	Community physio and dietician links
Integrated MDT Out-of-Hospital service	Ambulatory AHP MDTs, medical input where required, work alongside local leisure facilities, etc.

15 APPENDIX 8: CAPITAL COST APPRAISAL

See attachment provided by Thomson Gray.

Lochaber Rural District Hospital

for

NHS Highland

Cost Estimate - Rev 2
14 October 2021

THOMSONGRAY
CONSTRUCTION CONSULTANTS

Contents

Prepared by: AD / RL

Checked by: JSG

Date: 14/10/2021

1.0 Introduction

1.1 This estimate has been prepared to assess the likely construction cost of re-providing the clinical services of Belford Hospital within Fort William in a new purpose build rural general hopsital serving the community of Lochaber. The works will include 30 to 35 in-patient single bedrooms along with 2 theatres, renal, ED / OOH, radiology, maternity and outpatient services

1.2 The estimate is based on the schedule of accommodation baseline example dated 13 10

1.3 A list of assumptions and exclusions are contained within Section 4

1.4 Due to the fluidity of the construction market, unknown design risk and construction risk, a range of costs have been provided. We have categorised this as low, medium and high. Whilst the base costs remain the same, adjustments to risk allowances are included.

2.0 Key Facts

Client	NHS Highland Assynt House Beachwood Park Invenress IV2 3BW	**Status of Estimate**	Feasibility Option Appraisal
		Base Date	4th Quarter 2021
Lead Advisor	Thomson Gray Prospect House 5 Thistle Street Edinburgh EH2 1DF		
Basis of Estimate	Rural General hopsital SOA Version 0.6 dated 13.10.21		
Optimism bias	OB calculation from workshop 01.10.2021 - 35.70%		
Programme	OBC Q3 2022 FBC Q1 2024 Construction 30 months - completion Q3 2026		
Inflation	BCIS TPI - Calculated to the mid-point of construction Q2 2024 (forecast index of 345)		
Procurement	Two stage procurement route - capital funded		
Preliminaries	Refer to benchmarks (pro-rata)		
Design risk	Allowance of 5% of construction costs		
OH&P	Allowance of 7.5% of construction costs		
Cost range	+/- 5% of to provide a possible low and high risk cost range		
Sustainability	Sustainability Uplift - Net Zero Carbon - details not available therefore cost uplift percentage included at 12% which is in line with SFT funding for schools programme		

Cashflow FY	
2021/2022	£0.3m
2022/2023	£5.2m
2023/2024	£7.3m
2024/2025	£35m
2025/2026	£52m
2026/2027	£30m

4.0 COST ESTIMATE

Element	Quntity	Unit	Rate	Total (£)
New build general hospital	9,115	m2	4,425.00	40,333,875
Design Risk	5%	item		2,016,694
Design fees including pre construction	11%	item		4,658,563
OH&P	7.5%	item		3,525,685
Sub-Total				**50,534,816**
Add On Costs				
Professional and NHS Project Team Fees	15%	item		7,580,222
Other costs - surveys / IT / domestics / estates	2%	item		1,162,301
Equipment - Group 2+3 client direct	15%	item		7,580,222
Inflation [4Q21 base date (345) to 2Q2025 (386)]	11.88%	item		7,945,391
Sustainability Uplift - Zero Carbon	12.00%	item		6,064,178
Optimism Bias	35.70%	item		28,869,566
SUB TOTAL				**109,736,697**
VAT	20.00%	item		21,947,339
CAPEX				**131,684,036**
SAY				**132,000,000**
LOW RANGE			£	**126,000,000**
HIGH RANGE			£	**139,000,000**
GIFA	9,115	m^2		
Construction Rate /m2			£	5,544 /m^2
Development Rate /m2			£	14,482 /m^2

7.0 Assumptions and Exclusions

Description

Assumptions

The SOA assumes a gross total of 8,868 which includes 15% communication and 20% plant; planning, circulaiton and engineering allowances are as per the SOA and are indicative. Central Decontamination is excluded.

Design fees calculated at 11% (this includes pre construction contractor involvement)

Professional and project team fees calculated at 15% (7% NHS direct; 6% PM, CA, Supervior, CoW; 2% Technical)

Other costs - surveys / IT etc 2% allowance included

Equipment - 15% allowance

SOA to be referred to for % allowances included for plant, engineering and circulation

SOA scheduling risks were discussed and included within the Optimism Bias calculations / workshop

VAT included at 20%

Exclusions

Land purchase costs

Decant costs

Life cycle / FM costs

Finance charges

Legal fees

Car parking and road infrastructure upgrades beyond notes below

De-commissioning existing facility

VAT recovery

Charitable works / donations and contributions

Notes

External works and road realignment included for the site area only; this equates to a net construction prime cost of approx. £3m

Risk contingencies included as follows:

Inflation based on programme dates

Uplift for zero carbon included at 12% - criteria / guidelines to be confirmed

Optimism Bias workshop carried out 01.10.21 - 35.7%

contractor / design risk contingency included at 5%

8.0 Benchmarking

PROJECT DESCRIPTIONS							
BENCHMARK PROJECTS - Adjusted for Inflation to 4Q2021	Skye & Lochalsh	Bedenoch & Strathspey	National Treatment Centre - Fife	National Treatment Centre - Highland	Heatherwood Hospital	Private Hospital - Nottingham	AVERAGE
	2Q2019	2Q2019	4Q2020	4Q2019	4Q2021	4Q2021	
	New Build health facility will have 24-beds, a midwife-led community maternity unit, a minor injuries unit, a dental surgery, x-ray and ultrasound facilities.	New build 24 bed community hopspital with 24-beds, 12 consulting/treatment rooms, an Accident & Emergency department and x-ray facilities.	New build facility including 3 operating theatres, a supporting inpatient ward and associated outpatient facilities. Connected to existing acute site	New build acute hopistal comprising 24-bed inpatient rooms, five operating theatres, clinics and outpatient departments offering healthcare for bone, muscle and eye conditions	4 storey elective care hospital 48Nr inpatient beds (24Nr ensuite), 22Nr day case spaces, 6Nr operating theatres, imaging and endoscopy units, treatment rooms, GP Practice offices and cafe	New build hospital comprising 62 beds including 6Nr bed critical care unit, 20Nr consulting rooms, 6nr cubicle oncology suite, 4Nr theatres, endoscopy suite, MRI and central tomography.	
Contract	Hub DBDA	Hub DBDA	NEC 3 Option A	NEC 3 Option A	NEC option C	Traditional	
Area (m2)	3,290	4,320	6,310	7,906	9,109	7,687	
Excavation and Earthworks	£0	£0	£271	£0	£0	£0	£270.92
Piling	£0	£0	£59	£32	£0	£0	£45.61
Concrete Work	£0	£0	£0	£59	£0	£0	£58.83
Brickwork & Blockwork	£0	£0	£44	£32	£0	£0	£37.81
Substructure	**£391**	**£219**	**£374**	**£530**	**£462**	**£158**	**£355.69**
Frame	£445	£273	£263	£154	£208	£196	£256.50
Upper Floors	£37	£30	£95	£22	£176	£101	£76.93
Roof	£538	£153	£172	£93	£92	£186	£205.55
Stairs & Balustrades	£35	£14	£11	£18	£37	£15	£21.68
External Walls	£313	£317	£178	£139	£369	£354	£278.45
Windows & External Doors	£128	£126	£73	£54	£68	£150	£99.85
Internal Walls & Partitions	£184	£227	£153	£215	£210	£160	£191.34
Internal Doors	£111	£172	£145	£168	£119	£136	£142.06
Superstructure	**£1,790**	**£1,312**	**£1,091**	**£864**	**£1,278**	**£1,299**	**£1,272.35**
Wall Finishes	£27	£94	£35	£16	£40	£50	£43.59
Floor Finishes	£95	£83	£85	£45	£65	£95	£77.87
Ceiling Finishes	£90	£72	£112	£55	£66	£75	£78.08
Painting and Decorating	£101	£0	£53	£63	£0	£0	£72.10
Finishes	**£312**	**£248**	**£285**	**£178**	**£171**	**£220**	**£235.60**
FF&E	**£115**	**£131**	**£78**	**£65**	**£94**	**£69**	**£91.91**
Sanitary Appliances	£72	£57	£0	£0	£92	£79	£75.03
M&E installations	£1,612	£1,194	£19	£1,142	£1,975	£1,379	£1,220.30
M&E	**£1,684**	**£1,251**	**£1,351**	**£1,142**	**£2,068**	**£1,458**	**£1,492.32**
External Works	**£931**	**£560**	**£100**	**£77**	**£760**	**£394**	**£470.24**
External Services	**£48**	**£67**	**£0**	**£0**	**£0**	**£103**	**£72.89**
Prime Cost	**£5,271**	**£3,789**	**£3,279**	**£2,855**	**£4,833**	**£3,701**	**£3,954.55**
Preliminaries	£527	£379	£286	£442	£671	£511	£469.19
Prime Cost & Preliminaries	**£5,799**	**£4,168**	**£3,564**	**£3,297**	**£5,503**	**£4,212**	**£4,423.74**
Pricing adjustments							
	£0	£0	£0	£0	£0	£0	£0.00
REVISED TOTAL	**£5,799**	**£4,168**	**£3,564**	**£3,297**	**£5,503**	**£4,212**	**£4,423.74**
Intelligent benchmark (mean of above)			**£4,424**				

Notes Costs exlcude inflation beyond 4Q 2021, VAT etc

Excludes design fees / contingency / OH&P - costs rebased to Q4 2021

16 APPENDIX 9: FINANCIAL AND ECONOMIC APPRAISAL

The recurring revenue cost analysis is show in the table below:

REVENUE COST ANALYSIS

Sq meters of new build	6089		8900		8900		9049		6193	
Description	**Option 1**		**Option 2**		**Option 3**		**Option 4**		**Option 5**	
RECURRING COSTS	**Do Nothing: As exsiting arrangements**		**RGH Core Model**		**RGH Core Model + IR**		**RGH model, IR, enhanced elective activity**		**Ambulatory Care Centre**	
	Budget	**wte**	**Budget**	**wte**	**Budget**	**wte**	**Budget**	**wte**	**Budget**	**wte**
Pay costs	**£'s**		**£'s**		**£'s**		**£'s**		**£'s**	
Direct Clinical Staff Costs	10,662,386	194.10	11,549,794	217.00	11,467,801	214.92	12,264,841	230.71	10,426,828	199.18
Non Direct Clinical Staff Costs (Soft FM, Staff accom, Mgt	859,270	25.94	1,019,762	31.11	1,019,762	31.11	1,028,269	31.38	1,346,237	39.80
Total - Pay costs	**11,521,656**	**220.04**	**12,569,556**	**248.11**	**12,487,563**	**246.03**	**13,293,110**	**262.09**	**11,773,065**	**238.98**
Non-Pay										
Direct Clinical/Care costs	1,252,610		1,434,036		1,427,968		1,602,928		2,598,727	
Non Direct Care Costs (Soft FM, Staff accom, Mgt)	122,093		128,326		122,121		113,242		498,771	
Total - Non-Pay Costs	**1,374,703**		**1,562,362**		**1,550,089**		**1,716,170**		**3,097,497**	
Asset Related Costs										
Property Maintenance/FM Services	60,000		303,134		303,134		308,209		210,934	
Utilities	292,891		277,490		277,490		282,135		193,089	
Total - Asset Related Costs	**352,891**		**580,624**		**580,624**		**590,344**		**404,023**	
Capital Charges - depreciation	**80,216**		**2,230,971**		**2,230,971**		**2,268,009**		**1,553,689**	
Income										
Other Operating Income	(293,338)		(293,338)		(293,338)		(293,338)		(293,338)	
Total - Income	**(293,338)**		**(293,338)**		**(293,338)**		**(293,338)**		**(293,338)**	
Total - Recurring	**13,036,128**	**220.04**	**16,650,175**	**248.11**	**16,555,908**	**246.03**	**17,574,295**	**262.09**	**16,534,936**	**238.98**
Total - Recurring (excluding depreciation)	**12,955,912**		**14,419,204**		**14,324,937**		**15,306,286**		**14,981,247**	

The methodology and assumptions applied to derive the comparative cost implications of the options are:

	Option 1 – Do Nothing	Option 2 – RGH core	Option 3 – RGH Core Intensive Rehab (IR)	Option 4 – RGH core, Intensive rehab, enhanced elective activity over time	Option 5 – ambulatory care centre
Inpatient Beds	Current - 34	34	28 + 6 IR – reduction of 10% for weekly cost per bed for OPD beds	28 + 6 IR – reduction of 10% for weekly cost per bed for OPD beds	0 inpatient – provided offsite using relevant Medical and Surgical cost per bed per week
Layout of Beds (single rooms)	Current - 11	34 – 13.44wte increase HCSW	28 - 13.44wte increase HCSW	28 - 13.44wte increase HCSW	0

Day Case Beds	Current - 9	14 – 55% increase in HCSW nurses	14 – 55% increase in HCSW nurses	14 + 2 recovery – 55% increase in HCSW nurses	14 – 55% increase in HCSW nurses
Theatre Activity	Current - 4 weekly sessions	5 weekly sessions (25% cost increase)	5 weekly sessions (25% cost increase)	8 weekly sessions (100% cost increase)	4 weekly sessions offsite using theatre cost per hour
Patient Travel	Current	25% reduction	25% reduction	100% reduction	325% increase to offsite location
Hotel Services - Cleaning Costs	Current	46% increase based on floor area	46% increase based on floor area	49% increase based on floor area	2% increase based on floor area
Hotel Services – Catering Costs	Current	Current	12% reduction	12% reduction	Current but provided off site
Utility Costs – Rates and Council Tax	Current	46% increase based on floor area	46% increase based on floor area	49% increase based on floor area	2% increase based on floor area
Utility Costs – Oil, Gas, Electric	Current	46% increase based on floor area and 50% efficiency reduction	46% increase based on floor area and 50% efficiency reduction	49% increase based on floor area and 50% efficiency reduction	2% increase based on floor area and 50% efficiency reduction
Maintenance Costs	Current	£34.06 per m2	£34.06 per m2	£34.06 per m2	£34.06 per m2
Depreciation	Current + backlog spend over 60 years	Capex over 60 years	Capex over 60 years	Capex over 60 years	Capex over 60 years

Further detail on the assumed non-recurring revenue cost is provided in the table below. These are based on costs and assumptions from previous projects carried out by NHS Highland. These costs are broadly similar for each of the change options.

Lochaber Redesign
Non Recurring Revenue Costs

Non-Recurring ONLY	Option 1 Do Nothing: As exsiting arrangements	Option 2 RGH Core Model	Option 3 RGH Core Model + Transitional Care	Option 4 RGH model, intensive rehab transitional care and enhanced elective activity	Option 5 Ambulatory Care Centre
Description	**£ K**	**£ K**	**£ K**	**£ K**	**£ K**
Pay					
Decant costs	0	50	50	50	50
Staff costs - redeployment	0	0	0	0	0
Ehealth project resource	0	220	220	220	220
Non Pay					
Removal costs	0	30	30	30	30
Building double running cost until disposals	0	270	270	270	270
Temp accommodation costs ?	0	30	30	30	30
Fees not in capex	0	100	100	100	100
Insurance during construction	0	5	5	5	5
Equipment	0	518	518	518	345
Backlog maintenance	0	0	0	0	0
Total non-recurrent costs	**0**	**1,223**	**1,223**	**1,223**	**1,050**

The capital cost appraisal in Appendix 8 highlights the assumptions made for the capital spend. The full investment costs including the land purchase is shown below:

Description	Option 1 £000's	Option 2 £000's	Option 3 £000's	Option 4 £000's	Option 5 £000's
All construction/refurbishment works	-	49,622	49,622	50,447	34,540
Sustainability uplift (net zero carbon)	-	5,955	5,955	6,054	4,145
Fees, site surveys/investigation, project team	-	8,585	8,585	8,727	5,975
Land Purchase	-	1,500	1,500	1,500	1,000
Backlog Maintenance	1,500	-	-	-	-
Equipment	-	7,443	7,443	7,567	5,181
Inflation	-	10,687	10,687	10,865	7,439
Optimum Bias	-	29,378	29,378	29,866	20,449
Total	1,500	113,169	113,169	115,026	78,729
VAT	300	22,334	22,334	22,705	15,546
Total Capital Costs	1,800	135,503	135,503	137,731	94,275

The economic appraisal as shown in section 5.6 is based on the guidelines set out in the Scottish Capital Investment Manual and is shown below including the equivalent annual cost of capital and revenue.

INDICATIVE COSTS PER SCIM TABLE - ECONOMIC APPRAISAL

	Option 1 Do Nothing: As exsiting arrangements £000's	Option 2 RGH Core Model £000's	Option 3 RGH Core Model + IR £000's	Option 4 RGH model, IR, enhanced elective activity £000's	Option 5 Ambulatory Care Centre £000's
Capital cost (or equivalent value)	1,500	113,169	113,169	115,026	78,729
Whole of life capital costs	1,263	105,065	105,065	106,723	73,206
Whole of life operating costs	339,814	371,152	369,200	389,527	382,649
Estimated Net Present Value of All Costs	341,077	476,217	474,264	496,249	455,854
Equivalent Annual Cost Capex	45	3,713	3,713	3,772	2,587
Equivalent Annual Cost Revenue	12,010	13,118	13,049	13,767	13,524

17 APPENDIX 10: NDAP SUPPORTED (VERIFIED) STATUS

Architecture & Design Scotland
Ailtearachd is Dealbhadh na h-Alba

The Scottish Government
Riaghaltas na h-Alba

NHSScotland Design Assessment Process

Project No/Name:	Lochaber: Health & Social Care Service Redesign
Business Case Stage:	IA
Assessment Type:	Desktop
Assessment Date:	November 2021
Response Issued:	16 November 2021 (31 Jan 22 'verified' v1-1)

The below response is based on the NDAP Design Statement received 19 Oct21, and subsequent update to its Section 4 - 7 received 12 Nov21, along with IA stage AEDET.

Joint Statement of Support

Having considered the information provided, Health Facilities Scotland and Architecture & Design Scotland have assessed the project and consider that it is of a suitable standard to be

SUPPORTED (verified)

With the following recommendations:

Essential Recommendations

1. That the following benchmarks be improved in order to set an appropriate standard for the facility (numbers as items in 19 Oct21 Design Statement):
   - 1.1: With reference to EV charging points 'incl. infrastructure in place to provide more at a future date' to be added (as per DS 2.1) to accommodate future demand.
   - 1.5: Further information (and/or image) to be provided to clarify what is required for children's waiting area. Further information (and/or image) should be provided to clarify expectations on 'café facility'.
   - 1.6 Images to support benchmarks should be improved – e.g. benchmark notes "distinct spaces and not just chairs in corridors", images show chairs in corridors
   - 1.7: Additional benchmarks to be provided for Outpatient Services in addition to images of suitable spaces.
   - 1.8: Additional images to be provided, particularly showing socialisation and activity spaces described in the benchmarks.
   - 1.9: Images to support benchmarks to be improved.
   - 1.10: Image(s) to be provided showing suitable internal as well as external spaces to support this objective and benchmark.
   - 2.2 Although daylight for staff is mentioned for some spaces, it is key that staff have access to daylight through their working day; benchmarks to make ambition clearer.
   - 2.3: Additional images to be provided which support benchmark of suitable education and training spaces. Consider adding benchmark for any critical travel time times / distance if remote.

- 2.4: Additional benchmarks should be provided to clarify requirements of staff working environments.
- 3.2: Additional images should be provided showing suitable Relatives Rooms and Visitors Rooms as stated in the benchmark.

2. Objective 2.6 is incorrectly labelled and should be 2.5 (as there is currently no 2.5).

3. Where Section 4 numbering for the objectives in are incorrect and repeat Section 3 numbering. This should be amended/ corrected.

4. Section 4 (update:4) welcome updates to Net Zero, Sustainability & Equality benchmarks, incl ref to requirement for added resource. This section requires some further improvement, pre first Decision Point, to better reflect aims in: www.sehd.scot.nhs.uk/dl/DL(2021)38.pdf - NHSS Climate Emergency Policy Letter www.gov.scot/publications/nhs-scotland-draft-climate-emergency-sustainability-strategy/ Both published last week by Scottish Government; e.g. Building to be heated from renewable sources by 2038, at the latest; confirm validity of BREEAM 'excellent'

5. List of applicable Guidance & Standards (update:Section 5) relocate Technical list from NDAP Design Statement. Update default applicability/ priority, to reflect project specific function requirements pre first Decision Point e.g. if no CAMHS state 0- no applicability for HBN 03-02, before agreeing a site strategy / selection.

6. Section 5 (update:6) Self Assessment to be improved in order to define co-production/ collaboration, project key Decision Points and Skills/Perspective details. To include ref. to "Use of AEDET, SDaC, KSAR and NDAP, incl. stakeholder workshops, to set/ review criteria are met, plus evidence partnership, collaboration, mitigation etc" For example, SDaC (SHTN 02-01) requires workshop(s) at early key decision points, e.g. site selection, option selection, completion of brief.

7. Where Section 5 (update:6) states: : 'HFS input' or 'Use of AEDET to determine if the criteria are being met' this should be corrected to include SDaC, KSAR & NDAP Design Statement, e.g. states: 'Use of AEDET, SDaC, KSAR & NDAP Design Statement to determine if the criteria are being met…'.

8. Section 6 (update:7) lists attendees, welcome good community group representation generally, but per your updated Section 4 Equality Statement, this requires expansion to include potentially disadvantaged or discriminated groups. This recommendation also applies to AEDET attendees, and future SDaC attendees.

Advisory Recommendations

A. That the following benchmark images are added/improved (numbers as items in 19 Oct21 Design Statement:

- 1.1: Additional images could be added which show more 'protected pedestrian routes' as cited in the benchmark.
- 1.3 Benchmarks could be enhanced to ensure they capture the essence of arrival 'reflecting the area we live in'
- 1.4: Image showing 'GP Reception' could be improved to align more with the benchmarks listed.
- 1.4 Reference is made her to accessible and dementia friendly signage however it should be noted that all aspects of design should try and ensure they are fully accessible and dementia friendly
- 2.1: Additional images could be added which help illustrates benchmarks, particularly for Staff Entrances.

- 3.1: Image provided for this benchmark is the same as that provided for 2.1 so it would be good to provide alternative image(s) here.

B. AEDET Welcome good range of stakeholder engagement reflected in notes. These should be included in Design Team brief and monitored at key Decision Points. Also confirm actions dated Oct21 completed; i.e. two actions to arrange early stakeholder site 'visits' to better support them in briefing & decision making.

Notes of Potential to Deliver Good Practice

- The Design Statement is comprehensive and describes clear objectives and benchmarks which, if delivered upon, could lead to examples of good practice in terms of patient, staff and visitor environments.
- Welcome pilot of Sustainability Design and Construction (SDaC) Guide: SHTN 02-01

Next Stage Processes

Next Actions at Current Business Case Stage

The Board is encouraged to provide amended information, as described below, to address the Essential Recommendations and allow the status of the report to be verified as **SUPPORTED** to CIG. Please indicate your intent by **13 Dec 2021** to *nss.hfsdesignassessment@nhs.scot* cc: *health@ads.org.uk ;* and the anticipated timescale for submitting amended information. If we do not receive a notification of your intention by the above date the above report may be automatically reverted to an **UNSUPPORTED** status and this update forwarded to CIG.

Evidence required pre Design Statement's first key Decision Point:

- Updated Design Statement
- Updated List of applicable Guidance & Standards

VERIFICATION CIG (to be completed once above has been received and considered):

The above evidence was received and conditions discharged on ...14 Jan 22....

A Copy of NHS Highland letter/evidence in this regard is attached. The above **SUPPORTED** status is therefore **VERIFIED**.

Signed .....*Susan Grant*..... Dated .....31 Jan 22.....

Process at Next Business Case Stage

- Desktop Assessment

Notes on Use And Limitations To Above Assessment

Any Design Assessment carried out by Health Facilities Scotland and/or Architecture & Design Scotland shall not in any way diminish the responsibility of the designer to comply with all relevant Statutory Regulations or guidance that has been made mandatory by the Scottish Government.

NHS Highland

Chair's Office
Assynt House
Beechwood Park
Inverness, IV2 3BW
Telephone: 01463 717123
Fax: 01463 235189
www. nhshighland.scot.nhs.uk

Alan Morrison,
Interim Deputy Director of Health
Infrastructure, Investment and PP
Scottish Government
Floor BR, St Andrew's House
Regent Road
EDINBURGH EH1 3DG
nhscig@gov.scot

Date: 3 December 2021
Your Ref:
Our Ref: BR/SH

Dear Alan,

NHS Highland Board approval of Initial Agreements for Lochaber and Caithness

We are delighted to confirm that at our meeting on 30 November 2021 the NHS Highland Board formally ratified the Initial Agreement business cases for the Lochaber Redesign and the Redesign of Health and Care Services in Caithness, which were submitted to the Capital Investment Group for consideration on 20 October 2021. The Board noted the considerable work and community engagement that has taken place to develop the projects to this stage and affirmed their absolute commitment and support to deliver the transformational change outlined in the two documents.

Furthermore, on behalf of the Board we acknowledge receipt of the NHSScotland Design Assessment Process reports for Lochaber and Caithness on 16th and 24th November 2021 respectively, and the supported (unverified) status provided therein. We confirm our intention to implement the essential and advisory recommendations set out in the reports and will take account of the potential to deliver good practice as these projects develop. We welcome the opportunity to pilot the new Sustainability Design and Construction (SDaC) Guide: SHTN 02-01.

We commend these service change proposals to the Capital Investment Group and look forward to the opportunity to continue to work with the communities of Lochaber and Caithness to develop our proposals to Outline Business Case.

Kind regards,

Pamela Dudek
Chief Executive

Professor Boyd Robertson
Chair

Cc: Susan Grant, Principal Architect, Health Facilities Scotland
nss.hfsdesignassessment@nhs.scot
Louise Bussell, Chief Officer – Community, NHS Highland
Alan Wilson, Director of Estates, Facilities & Capital Planning, NHS Highland

18 APPENDIX 11: NHS ASSURE – KSAR CONFIRMATION

NHS Highland

NHS Highland Estates Department
Assynt House
Beechwood Business Park
Inverness
IV2 3BW

www.nhshighland.scot.nhs.uk

Date:	8th April 2022
Our Ref:	H17_011_L20220408_KSAR
Your Ref:	
Enquiries to:	Heather Cameron
Extension:	
Direct Line:	07833 058815
Email:	heather.cameron2@nhs.scot

LOCHABER HEALTH & SOCIAL CARE REDESIGN: INITIAL AGREEMENT KEY STAGE ASSURANCE REVIEW

Dear Thomas,

We formally acknowledge receipt of your report following the Key Stage Assurance Review of the Lochaber project and confirm that NHS Highland accept the findings in full.

An action plan is currently in draft format and is expected to be finally approved by the Project Board in June and will be issued to yourselves following this. The Action Plan will also form part of the Information Pack for appointment of a PSCP.

Should you have any concerns please do not hesitate to get in touch, and we look forward to working with you again at OBC stage.

Yours Sincerely,

Heather Cameron
Senior Project Manager

19 APPENDIX 12: BLÀR MÒR - MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding
between
Highlands and Islands Enterprise (HIE)
and
NHS Highland (NHSH)
and
West Highland College UHI (WHC UHI)
and
The Highland Council (THC)

21st January 2022 (Draft Version 5)

Background

a. The four parties wish to collaborate on the development of a new rural healthcare development co-located with academic, research and commercial and residential and community facilities.
b. The development area is known as Blar Mor, located to the north of Fort William – as shown edged red on the attached plan.
c. The working title for the project is Blar Mor Collaboration.
d. NHSH wish to deliver a new, rural general hospital to replace the existing Belford Hospital. A design brief for the new facility is still to be produced but will include the following key facilities: inpatient beds including a community maternity unit, emergency department, operating theatres and outpatient department. No formal engagement with planning authorities has yet been under taken.
e. WHC UHI has advanced plans to build a new Centre for Science, Technology, Health and Engineering (STEM Centre) adjacent to the hospital. Planning permission for a scheme has been obtained and is available to view online – reference 18/05654/FUL.
f. Funding for both projects is being sought from the Scottish Government, who are aware of both proposals. The NHSH has completed an Initial Agreement for the hospital proposal and this was submitted in October 2021 to the Scottish Government for approval. The Outline Business Case stage will commence from January 2022, with final funding approval dependent on a Full Business Case, currently expected to be submitted in late 2023.
g. Discussions on a funding package for the STEMH Centre are in process between WHC UHI, the Scottish Funding Council and Scottish Government
h. Both NHSH and WHC UHI will be expected to meet the Scottish Government's Carbon Net Zero target.
i. THC's development plans are set out in the Blar Mor Mixed Use Masterplan which received Planning permission in Principle in 2018. Details of the scheme are available to be view online – ref 18/03647/PIP. The Masterplan includes housing in addition to the hospital and STEM centre sites. The initial phase of housing construction to the east of the NHSH/WHC UHI site is now complete, and THC wish to proceed imminently with the second phase of housing to the west.
j. While it is understood that there is some scope for provision of accommodation within areas zoned for housing, or for minor amendments to the NHSH/UHI site boundaries, the focus of this collaboration is primarily to make most effective use of the NHSH/WHC UHI Sites as allocated in the Blar Mor Mixed Use Masterplan and identified as such on the Approved Site Layout Plan (attached).

The parties agree to work in partnership on the following basis in seeking to confirm or otherwise the terms on comprehensive development of the site can take place:

1. **Responsible Officers** – These will be as follows from each party:

   - **HIE** - Alastair Nicolson/Stuart Macpherson
   - **NHSH** - Alan Wilson/Heather Cameron
   - **WHC UHI** - Jackie Wright/David Campbell
   - **THC** - Allan Maguire

   Responsible Officers will be required to authorise any joint decisions and ensure these are recorded clearly in writing. Each party will be responsible for ensuring their own organisation's governance processes are satisfied. Meetings will be arranged as required.

2. **Project Working Group** – a Project Working Group of representatives from each of the four parties will be set up and will meet on a 6-weekly basis or otherwise as necessary to coordinate progress with the project. Meetings will be minuted and any agreements recorded in writing.

3. **Common Objectives** – the parties have agreed that there is shared benefit in collaborating on the development of the building project and other joint opportunities, as the realisable benefits from a collective approach will be more significant that what could be achieved by each party acting in isolation. This collaboration falls into three main categories:

   a) Joint opportunities for training and development: Future joint opportunities will need to be considered and agreed through existing or new collaborations on a regional level, and may have an impact on physical works due to space requirements for any facilities required. Examples might include shared training space, collaborative learning spaces, break out spaces, clinical simulation suites, library, IT learning space and meeting spaces.

   b) Coordinated/shared construction across the Site as a whole: examples might include transport infrastructure such as bus stops or access roads, energy centre including district heating potential, SUDS, greenspace.

   c) Use of each other's or third party facilities, such as creche, café, meeting or conference spaces. As per 3.a) above, this may have an impact on space required where capacity is increased.

   For each area of collaboration, a formal agreement will be agreed between the parties and clearly recorded.

   The project is till at an early stage, and so a number of key elements need to be defined, including:

   - Layout of the proposed site and buildings
   - Specification and capital cost of the projects
   - Procurement route for detailed design and delivery
   - Long-term land and building ownership
   - Site and building(s) operation and management to the extent a joint approach could be beneficial.

   The intention of this MoU is to put in place a basis of agreement between the parties to allow the group to work collectively in seeking to address the points set out above.

4. **Basis of Agreement between Parties** – The basis of agreement between the parties is as follows:

a) To collaborate on the development of an agreed layout for the NHSH/WHC UHI site which maximises opportunities for joint working and minimises environmental impact and risk. It is noted here that the WHC UHI design already has planning approval and while WHC UHI is happy to participate in these discussions, this agreement does not commit WHC UHI to revising the approved plans.
b) To support each parties' business case for delivery of the project by emphasising potential benefits in a joint approach. Each party will remain responsible for their own governance and approval processes.
c) To agree a procurement plan and programme for delivery of any shared infrastructure. It is expected that each party will procure their own project independently with the exception of shared infrastructure.
d) To agree a land purchase and a land/building ownership plan for the project.
e) To agree what the work plan for the project is to be following production of the joint site plan referred to in a) above, and extend the duration, or clarify the terms, of this agreement as necessary for the next phase.

5. **Town Planning –** All parties agree to collaborate on the best approach to securing any further planning permissions required to allow the project to proceed.

6. **Due Diligence** – Each party will be responsible for its own due diligence in entering into this MoU and thereafter in providing any funding required to advance feasibility work identified and agreed under this agreement.

7. **Programme** – The parties have agreed to work together and to use all reasonable endeavours to deliver the project. The MoU is expected to be in place for an initial period of 18 months or until such time as the parties reach a formal agreement on the delivery of the project, or else where one or more of the parties provides clear notification to the other parties that they no longer wish to participate in the collaboration. The MoU may be extended by agreement.

8. **Funding** – Each party will be responsible for their own consultant and other third party costs unless otherwise agreed. Where a shared appointment is made or shared facilities are to be delivered, a lead organisation and appropriate share of costs will be agreed beforehand.

9. **Other Stakeholder Briefings and Public Relations/Communications** – All parties will agree a joint approach and strategy for external public relations and communication in respect of the project, and will agree a list of key external stakeholders where a joint approach to briefing is to be taken at all times.

10. **Legal Status – it is accepted that this is not a legally binding agreement between the parties, and is not intended to create any form of legally binding contract.**

Signed on behalf of Highlands and Islands Enterprise

……..

NAME:

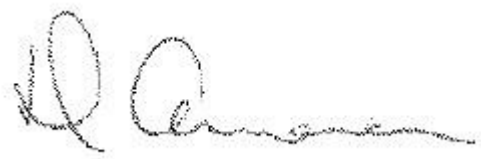
POSITION:
DATE:

Signed on behalf of West Highland College UHI

……

NAME:
POSITION:
DATE:

Signed on behalf of NHS Highlands



NAME: Heather Cameron
POSITION: Senior Project Manager
DATE: 2/3/22

Signed on behalf of The Highland Council

……..

NAME:
POSITION:
DATE: