NHS Highland
Initial Agreement

Redesign of Health and Social Care Services in Caithness

Final v15 – 28 March 2022

Version Control

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Due to the comprehensive nature of the proposals and the long list of associated documents, a core list of appendices will be provided, as indicated on page 5. The remaining reference documents are available via a hyperlink to the published document online and/ or on request from the Project Team.

Contents

APPENDICES AND REFERENCE DOCUMENTS

Reference	Description	Available
Strategic Case		
SC01	Place Based Investment Strategy	On request
SC02	Current Service Model	**Included**
SC03	Description of Services and Activity Data	**Included**
SC04	AEDET assessment - Caithness General Hospital	**Included**
SC05	AEDET assessment - Community and Primary Care premises	**Included**
SC06	Workshop Briefing Notes – March 2018	HERE
SC07	Workshop Output Notes – March 2018	HERE
SC08	Economy and Demographics Data	**Included**
SC09	Health Inequalities Impact Assessment	**Included**
SC10	Proposed Model of Care	**Included**
SC11	Case Study	**Included**
SC12	Bed Modelling	On request
SC13	National and Local Strategies	**Included**
SC14	COVID-19 Remobilise, Recover, Redesign	HERE
SC15	Benefits Register	**Included**
SC16	Risk Register	**Included**
Economic Case		
EC01	Cabinet Secretary Approval of Major Service Change	**Included**
EC02	NHS Highland Board Cover Paper – January 2019	HERE
EC03	Public Consultation Summary Document	HERE
EC04	Scottish Health Council Report	HERE
EC05	Timeline of Consultation Events	**Included**
EC06	Option Appraisal Workshop Report	HERE
EC07	Option Appraisal SWOT Analysis and Supporting Information	HERE
EC08	SWOT analysis – Care Hub / Village Sites	**Included**
EC09	Equality Impact Assessment	**Included**
EC10	High-level Health and Care Specification	**Included**
EC11	Early Accommodation Schedules	On request
EC12	Capital Cost Estimates for individual sites	**Included**
EC13	AEDET Target Scores – Caithness General Hospital	**Included**
EC14	AEDET Target Scores – Care Hub / Villages	**Included**
EC15	Design Statement – Caithness General Hospital	**Included**
EC16	Design Statement – Care Hub / Villages	**Included**
Commercial Case		
CC01	Project Programme	**Included**
Financial Case		
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FC02	Non-recuring revenue costs	**Included**
FC03	Revenue costs	**Included**
FC04	Capability and Experience of Key Project Leads	**Included**
Management Case		
MC01	Programme Board Terms of Reference	**Included**

1 EXECUTIVE SUMMARY

NHS Highland are pleased to present this Initial Agreement (IA) co-produced with the people of Caithness and its extensive range of planning partners. The approval of this IA would permit us to progress to an Outline Business Case (OBC) detailing significant improvements to services currently offered that would, in turn, realise huge benefits for the people of Caithness.

1.1 Introduction and Scope

The purpose of this IA is to clearly demonstrate the need for change in the provision of all health and social care services and support for those who live in Caithness.

Caithness is a remote and rural District in the far North of Scotland, over 2 hours' drive north of Inverness. It has around 25,000 residents with a relatively low population density. The towns of Thurso and Wick host the largest populations, however roughly one third of the population live in rural areas.

These ambitious service change proposals seek to modernise all adult health and social care services in the district - social care, community health services, primary care and acute. The focus is on prevention, working with our partners to build resilient communities and thus moving away from hospital-based care as the default, enabling those who live in Caithness to stay at home, healthier, for longer.

1.2 Current Situation

The extensive range of Health and Social Care services across Caithness are described in detail in section 2.1. NHS Highland is the lead agency for delivery of adult social care services, a unique arrangement in Scotland. We directly manage care at home, social work, and care home services and our adult social care teams are integrated with our community health care teams. These comprise of Community Nursing, Community Mental Health, and Allied Health Professionals. Day Services are provided by NHS Highland and third sector partners.

Primary care is provided by independent and salaried practitioners across eight different sites, and dental care by independent general dental practitioners and the public dental service.

There is community hospital and acute hospital provision locally, with a wider range of specialist services available at the nearest District General Hospital in Inverness, over 100 miles away.

There are five locations in Caithness which provide 24/7 services:

- two NHS Highland run care homes (41 beds in total), Pulteney House in Wick and Bayview in Thurso;
- two Community Hospitals (15 beds in total); Town and County in Wick and Dunbar Hospital in Thurso; and
- one Rural General Hospital (43 beds); Caithness General Hospital in Wick.

1.3 Drivers for Change

The Caithness economy is fragile, with 12% dependent on the former Nuclear Power Station, Dounreay, which is now undergoing decommissioning with a loss of up to 2,000 jobs over the next 15 years.

There are pockets of high deprivation, and 10% of the population lives in the most deprived 20% of areas in Scotland. In remote and rural Caithness there are pockets of disadvantaged individuals and households who live at some distance from service access points and struggle to access health and social care. A consequence of deprivation and poverty is generally poorer health and an increased demand for health and social care services.

The population is ageing, and younger people of working age are migrating to urban areas, adding to our workforce pressures. In 2018 there were 26 people of working age for every 10 people over 65 years. By 2041 this is projected to reduce markedly to 15 people of working age for every 10 people over 65 years.

Recruitment of nursing and social care staff in Caithness is challenging, with only two-thirds of posts filled on first advert. Locum and agency use is high, accounting for a significant overspend, and in Highland overall nearly 10% of consultant posts were vacant (March 2020). Half of the 600 staff employed in the Caithness area are over the age of 50.

1.4 Opportunities for improvement

The Caithness Redesign is one of three **national pathfinder schemes** to test how to implement local care and then roll it out, supported by the Scottish Futures Trust and Carnell Farrar (Specialist Health Care Planners). A key aspect of the new approach is the **Local Care Model**. This is place based, focusing on population cohorts with high needs, and centred on addressing the priorities of the individual.

A Multi-Disciplinary Team, supported by a Single Point of Access, will provide targeted community-based support to individuals with complex needs, and there is compelling evidence that this reduces hospital admissions and length of stay as well as other acute interventions such as Outpatient appointments and emergency attendances. This is a more sustainable and flexible model of health and social care achieved through true integration of services, making greater use of technology, and embracing the Place Principle.

Advancements in technology are a key enabler to the delivery of the Local Care Model with improvements in eHealth systems, remote working, and an increase in virtual consultations through digital solutions. The COVID-19 pandemic has necessitated the need for more appointments and care reviews to take place remotely. Caithness was at the forefront of **NHS Near Me** technology well before this, reducing the need for patients to travel (often long distances) to attend appointments which can now take place in their own home.

A **Place Based Investment Strategy** is underway in Caithness with hub North, NHS Highland, the University of the Highlands and Islands, Scottish Futures Trust, and other partners. This involves collaboration sitting at the heart of a better future, to improve services, create opportunities, and enhance quality of life for communities in a changing Caithness. This will take a whole systems view enabling more efficient public services through better use of resources, a faster pace of service transformation with more opportunities for community empowerment and leveraging investment opportunities to improve jobs in the area. In a post-COVID-19 world, collaboration ensures a more effective approach to economic recovery, more resilience to shocks, and more effective transition to a low carbon future.

1.5 Why change now?

The current service model is too focussed on hospital-based care rather than care delivered at or as close as possible, to the individual's home. Health and social care services are integrated but based across multiple sites, which can be a barrier to effective multi-disciplinary working.

There are gaps in some community service provision, particularly out of hours, which results in inappropriate hospital attendances and admissions. Mental Health and Social Work services are particularly stretched. With the added challenges resulting from COVID-19, hospital services are under increasing pressure.

Patients are taking longer than they should to be discharged and this is compounded at times by a lack of power of attorney or anticipatory care plan. While in hospital patients become more dependent, making a successful return home less likely. This in turn increases pressure on community hospital and care home beds, which was intensified further in 2018 with the closure of Achvarasdal residential care home and a loss of 28 registered places.

With significant workforce challenges, delivering 24/7 care across five different sites is making it increasingly difficult to sustain services. The Primary Care Emergency Service at Dunbar Hospital is experiencing significant disruption because of this, with frequent closures and patients in the West of the area having to travel to Wick.

Caithness patients are travelling unnecessarily to access some services that could be provided locally or digitally. The use of NHS Near Me needs to be maximised in all settings to fully realise the benefits.

We have too many buildings, they are ageing and are in relatively poor condition, consuming resources that could otherwise be invested in our workforce. Our buildings are also not functionally suited to support how we deliver services now and into the future.

If we continue with the current model of care, services will become increasingly unsustainable. This was highlighted sharply by external data analyst models of the potential impact on inpatient activity due to the projected future demographics for Caithness. This demonstrated that by continuing to provide services in the same way, by 2040 we would need to increase the number of beds at Caithness General Hospital by 17, with an estimated recurring revenue cost of £1.2million, assuming we can recruit to substantive posts. Implementing the Local Care Model, however, would allow current bed numbers to be sufficient to meet demand.

There has never been a greater need to shift the focus to preventative care. Unless fundamental whole-system change is undertaken, there will be significantly increased pressure on already limited services. This is fully aligned with national and local strategy that places emphasis on supporting people to stay at home for longer, and working collaboratively with people, communities, and partner organisations to enable them to become more independent and resilient.

1.6 What is trying to be achieved?

These ambitious proposals aim to shift the balance of care from hospital-based to community, with a focus on prevention. This will be achieved through investment in our community health and care workforce and implementation of the Local Care Model, targeting the cohort of patients with complex needs to keep them well and independent, and out of institutional care wherever possible.

The solution is wider than health, and true partnership working is needed to address health inequalities, deprivation, economic and workforce challenges and really make Caithness an attractive place to live and work. It is only by working in partnership that we can address these significant challenges and make our services more sustainable and better able to meet the needs of the local population.

1.7 What are the benefits?

A comprehensive benefits register has been developed (section 2.3.2) to allow us to track and monitor the positive outcomes of the change. The key benefits that will be delivered as a result of the proposed changes are:

- enabling people in Caithness to live independently with improved community resilience;
- making Caithness an attractive place for people to live and work;
- more sustainable services that can respond to the demographic challenges;
- improved recruitment and retention, and a valued and supported workforce;
- an increase in the number of episodes of care delivered locally in Caithness;
- a reduction in emergency attendances / admissions, waiting times and length of stay;
- better co-ordination, communication, and reduced duplication; and
- improved quality, condition, and functional suitability of our estate.

1.8 Stakeholder Engagement

Our redesign journey so far has not been without its challenges. It has taken us from widespread public protests to the service changes proposed by NHS Highland in 2017, to the development of a preferred service solution supported by 70% of respondents to our public consultation. The key to this turn-around was working with our communities and partner organisations to help them to understand the challenges faced, and co-production of the solution.

This is major service change, and the formal public consultation was the most extensive and comprehensive ever carried out by NHS Highland. It had one of the highest response rates with strong local consensus, culminating in approval by the Cabinet Secretary for Health and Sport in May 2019.

Our Community Planning Partners have been involved from the outset and are in full support, with the proposals which received formal backing from The Highland Council, Highlands and Islands Enterprise, Caithness Chamber of Commerce; Caithness Rural Transport; Caithness and North Sutherland Regeneration Group, Caithness Volunteer Group, The Highland Hospice, Police Scotland, The Scottish Ambulance Service, the Scottish, Fire and Rescue Service, and the University of the Highlands and Islands (North Highland College).

1.9 Option Appraisal

An independently facilitated Options Appraisal process was conducted with representation from the public, local community, staff, and Community Planning Partners and resulted in a clear consensus on a future model of care for Caithness. The group agreed the following seven non-financial benefits criteria and weightings to score each option:

- Delivering sustainable services (22 points);
- Meeting the demographic challenge (20 points);
- Patient experience (15 points);
- Staff experience (12 points);
- Delivering services locally (14 points);
- Addressing buildings issues (10 points); and
- Caithness as a proposition (7 points).

A long list of 40 possible options was developed, and following extensive discussion and debate, a short-list of four was agreed by all participants. This was largely shaped by; a

formal need to score the "do nothing" option, a desire to develop combined "care hubs" within existing population centres as an alternative to the traditional disparate models of health and social care delivery, and a need to formally address historically challenging questions over hospital sites, particularly in Wick.

The four shortlisted options were scored by the group with the outcome provided below.

Table ES01 – Scoring of shortlisted outcomes

Option	Description:	Score (out of 1,000)
1	No change – current arrangements continue	277 (benchmark)
2	Care Hub / Care Village at Dunbar Hospital site (Thurso) and Town & County Hospital site (Wick), plus refurbished Caithness General Hospital	683 (alternative)
3	Care Hub / Care Village at Dunbar Hospital site (Thurso) and Pulteney House site (Wick), plus refurbished Caithness General Hospital	783 (preferred)
4	Care Hub / Care Village at Dunbar Hospital site (Thurso) and Caithness General Hospital site (Wick)	510 (rejected)

Following scoring, Options 1, 2 and 3 were taken forward to public consultation. Option 4 was rejected as it had the lowest score of the three change options, and it was felt that an acute hospital site was not an appropriate fit for a community care hub and care village.

The consultation indicated strong public support for two 24-hour Care Hub / Care Villages, one in Wick and one in Thurso, and a reconfiguration of Caithness General Hospital. On the question of the Wick site, Pulteney House was preferred (38.5% of respondents), with Town and County Hospital a close second (31.5%). There was general support for co-location of GP services, although a desire to maintain a presence in the town centres.

1.10 Site Selection

Through the public consultation exercise a third potentially suitable site in Wick was identified, the "Noss" site. In line with Scottish Health Council advice, it was agreed to seek further views from the public on this alternative (Option 3a), and pop-up shop events were held to inform the public and gain feedback. Of those who attended, 60% preferred the Noss site, 20% Town and County, and 5% Pulteney House. In February 2020, the Noss site was confirmed by the Project Team as the preferred option in principle for the Wick Care Hub / Care Village, subject to further detailed technical and cost appraisal of the options during Outline Business Case.

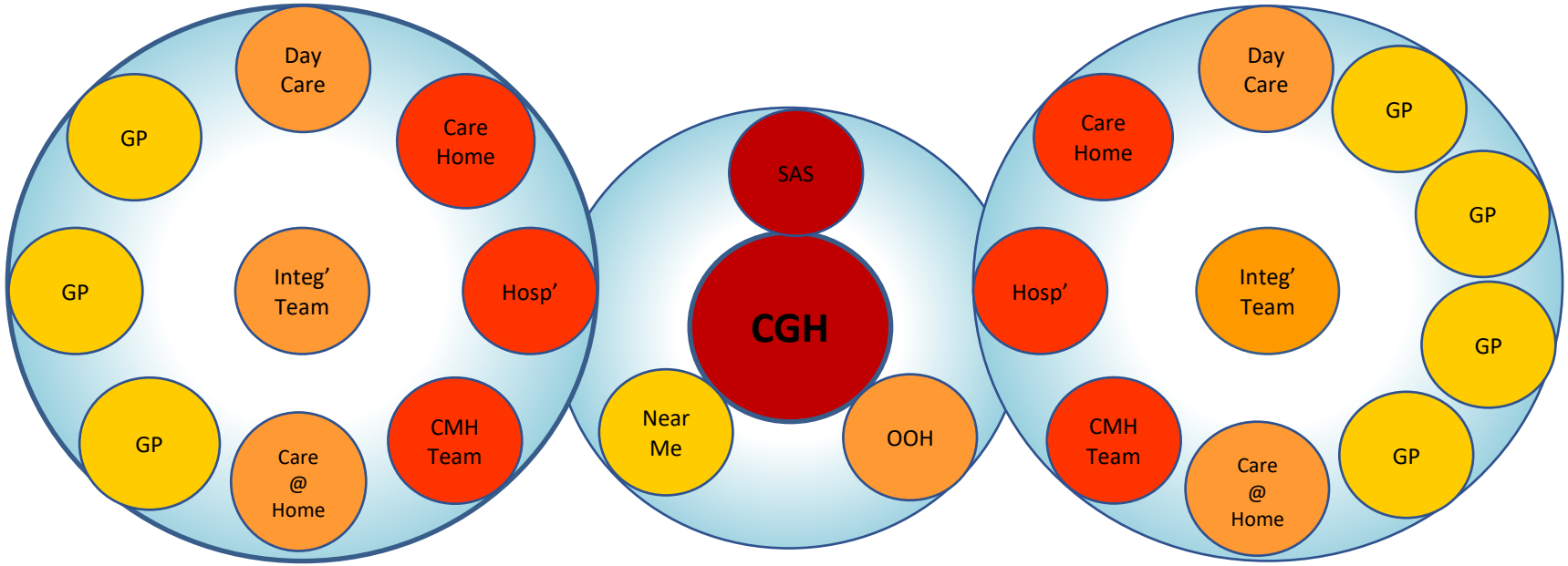
1.11 Proposed Solution

Diagram 1 illustrates the proposed future delivery of services compared to current provision. At its heart is investment in community services and delivery of the Local Care Model, targeting individuals with complex care needs to support them to be independent, preventing admission and shifting the balance of care from hospital-based to community.

Services will be easily accessible through a Single Point of Access, with a multidisciplinary team approach and delivered in the person's own home or a homely setting wherever possible. Anticipatory Care Planning will become the norm, enabling people to set out their wishes for future care. Service provision will be further embedded in realistic medicine principles and supported by Technology Enabled Care and NHS Near Me, reducing the need for travel. Two new Community Health and Wellbeing Hubs will replace and consolidate our existing (community and primary care) healthcare estate.

Diagram 1 – Summary of Service Model Change

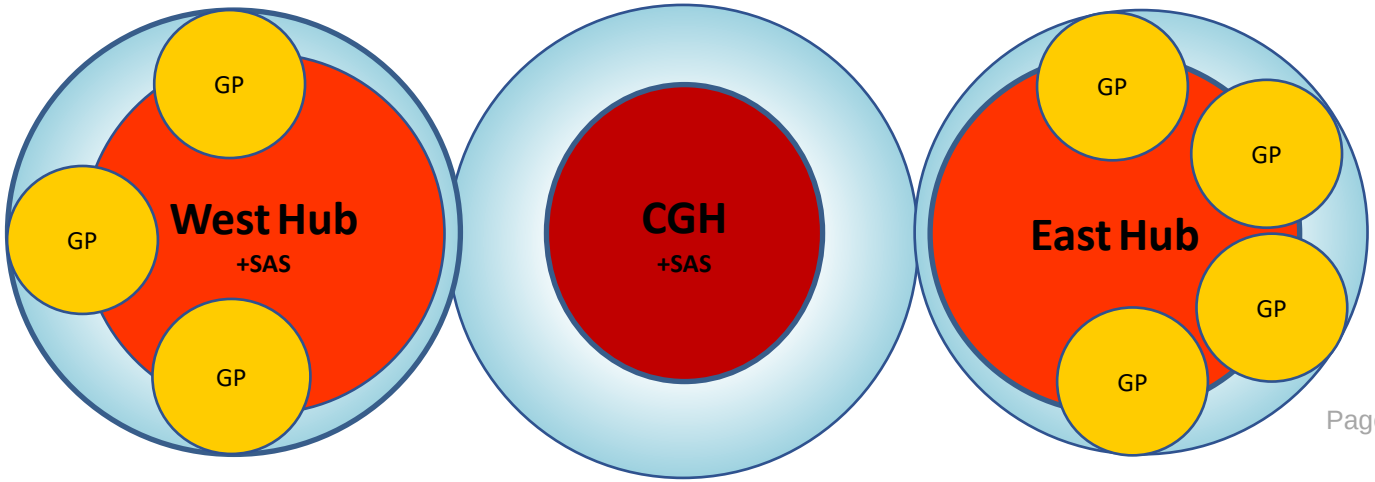
Current Local Provision (in Caithness)



Future Local Provision (in Caithness)

Hubs to include:

- Day care
- Care home
- Community Hospital
- CMHT
- Integrated team
- Care @ Home
- GPs



The Hubs will bring together community integrated adult health and social care teams with GP practices, registered care homes, community beds, palliative and end of life care, step-up beds, day services, supported living accommodation, community and third sector support and potentially a Scottish Fire & Rescue Service base. The Hub in Thurso will also include a Primary Care Emergency Centre and Scottish Ambulance Service base (in Wick these will be located at Caithness General Hospital), and dental services which are already on site.

Caithness General Hospital will be reconfigured to allow the building to support the delivery of modern healthcare now and into the future. This will include an improved Emergency Department and Clinical Decision Unit, outpatient, and day case services, and will address the need for increased provision of single-room accommodation with en-suite facilities.

The proposals will address service sustainability challenges, reducing the number of 24/7 sites from five to three.

- A Care Hub / Care Village in Thurso on the existing Dunbar Hospital site (40 beds);
- A Care Hub / Care Village in Wick at a site to be determined (40 beds); and
- Caithness General Hospital in Wick (43 beds).

The proposals would deem the following buildings surplus to requirements, dependent on the outcome of the Wick site option appraisal:

- In Thurso; Bayview House, William Smith House, and Riverbank Medical Practice; and
- In Wick; the Old Medical Centre on the Caithness General Hospital site, Town and County Hospital and Pulteney House.

The potential future use of Martha Terrace in Wick, purchased from the independent GP practice in March 2021, will be determined at Outline Business Case.

1.12 Indicative costs and affordability

NHS Highland would require a capital allocation from the Scottish Government to fund the infrastructure changes. This is estimated to be £76 – 82 million, however we will work with our Community Planning Partners to explore other funding sources to help reduce this.

The proposed service change will require additional recurring revenue in the region of £0.5-0.6 million, plus depreciation costs for the capital (£2.2 – 2.3 million), which is currently not affordable within the Caithness £37.2 million budget. A non-recurring investment of £2.7-2.8 million would also be required from Scottish Government. There is likely to be double running of some services until the new local care model is fully bedded in. The detailed work to develop workforce and accommodation requirements (section 6.4) will inform more definitive costs and a clearer affordability position at Outline Business Case.

There is an increasing affordability risk to the organisation if we do nothing, with a historical overspend (£0.8 million) in Caithness General Hospital due to locum and agency use. This is being addressed by NHS Highland through another project, however the £1.2 million cost associated with an additional 17 beds (not currently included in the recurring revenue calculations of the “Do Nothing” option) assumes that all substantive posts can be filled. There is a significant risk that this would not be the case, incurring additional locum and agency spend and making the status quo increasingly unsustainable and unaffordable.

1.13 Commercial and Management Arrangements

Sections 4 and 0 set out the proposed commercial, management and governance

arrangements for the delivery of this substantial programme of work. We propose to deliver the Care Hubs using the hub procurement route, and the reconfiguration of Caithness General Hospital via Frameworks 3.

There is a well-established Project Team with workstreams reporting to it monthly, and this is overseen by a Programme Board. The required project resources are identified and incorporated in the capital costs presented, although additional non-recurring revenue support is requested from Scottish Government to help deliver the digital transformation that is so essential to the success of the Local Care Model.

The key milestones are provided in table ES02 below:

Table ES02 – Key Programme Milestones

Milestone	Date
Service model (high level health & care specification) - complete	Jul 2021
Caithness General Hospital phase 1 construction complete	Sep 2021
Initial Agreement approved by SGHD	Nov 2021
Workforce plan	Nov 2021
Pulteney House step up beds operational	Q4 2021/22
Local Care Model MDT working in place	Q1 2022/23
Outline Business Case approved by SGHD	Q4 2022/23
Full Business Case approved by SGHD	Q3 2023/24
Construction starts	Q4 2023/24
Construction complete (Wick and Thurso Hubs)	Q2 2025/26
Disposal of surplus buildings	Q4 2025/26
Construction complete (CGH)	Q4 2025/26

1.14 Readiness to Proceed

These major service change proposals and preferred solution are supported by the majority of the Caithness public, and are fully supported by our Community Planning Partners, the NHS Highland Board, and the Cabinet Secretary for Health and Sport. Our partners have provided a commitment in principle (section 5.5), and we will work with them throughout Outline Business Case to clarify their accommodation requirements and funding contributions.

Robust arrangements are in place to ensure the successful delivery of the service and infrastructure change elements, and the proposals are fully aligned with national and local strategy.

1.15 Conclusion

This Initial Agreement is the culmination of years of work taken forward in partnership with the Caithness Community. The change proposals will deliver significant benefits, and the cost of not delivering these, in terms of service sustainability and patient care, are huge. The additional pressures on the system caused by the COVID-19 pandemic make it imperative that we proceed with the proposed redesign of service in Caithness, and at pace.

2 STRATEGIC CASE

Across Scotland, the NHS is facing significant challenges that demand a reshaping of services to be more sustainable, make better use of technology and to tackle and reduce inequalities. The global COVID-19 pandemic has not only served to amplify these challenges but has also presented some important opportunities like increased utilisation of Near Me consulting, teams working remotely from home and significant moves forward in the use of digital technologies. It has accelerated our shared acceptance of new and different ways of doing some things that is also now supporting more sustainability. In NHS Highland, we face the dual pressures of the remoteness and rurality of some of our communities, such as Caithness, as well as a higher proportion of older people than other parts of Scotland.

The purpose of this Initial Agreement (IA) is to clearly demonstrate a strategic case for changes to the provision of adult health and social care services in Caithness. To support the preparation of the document, population and service projections were carried out including a capacity modelling exercise. The GP contract offers further opportunities to reshape some elements of service delivery, as does greater use of technology to deliver more care at home or in a homely setting.

The IA is the first of three documents which are required to be prepared as part of the Scottish Capital Investment Manual (SCIM) business case process. Once it has been approved by the Scottish Government Capital Investment Group (CIG) the project would progress to Outline Business Case (OBC) and Full Business Case (FBC).

This document details our thinking in terms of the most important issues that shape our strategic priorities and how these align nationally and across NHS Highland.

The co-production of options and public consultation carried out in 2018 was one of the most extensive and comprehensive ever carried out by NHS Highland, and arguably, by any public-sector organisation in Scotland. Through that process, there was support for better collaboration with partners and ongoing community involvement, to improve the impact of combined resources and investment.

The vision for the redesign of services and investment in Caithness fits with the 'Place Principle' as first published by the Scottish Government in April 2019. This proposal embraces the themes detailed in the principle around working collaboratively, in and from the two new hubs, and working with communities to make best use of resources.

The timing of the preparation of this document also means we have had an opportunity to ensure it is line with Scottish Government's Framework for Decision Making in COVID-19. This includes a commitment to build a fairer and more sustainable economy and society (Scottish Government, 2020a).

This IA is being developed in parallel with ongoing place-based strategy work being undertaken in Caithness with hub North, NHS Highland, the University of the Highlands and Islands, other partners and Scottish Futures Trust. The detail of this work is outlined in section 2.2.2.4 and **Appendix SC01**. NHS Highland believes that the proposed service model improvements will support the ethos and ambition of Place Based change.

The intent is to develop a local care model with enhanced approaches to prevention and self-care, primary care, long term condition management and community services with less reliance on acute and institutional care. This will be delivered in collaboration with the statutory, independent and third sectors to empower and enable individuals and communities to deliver locality based economic and health and social care benefits.

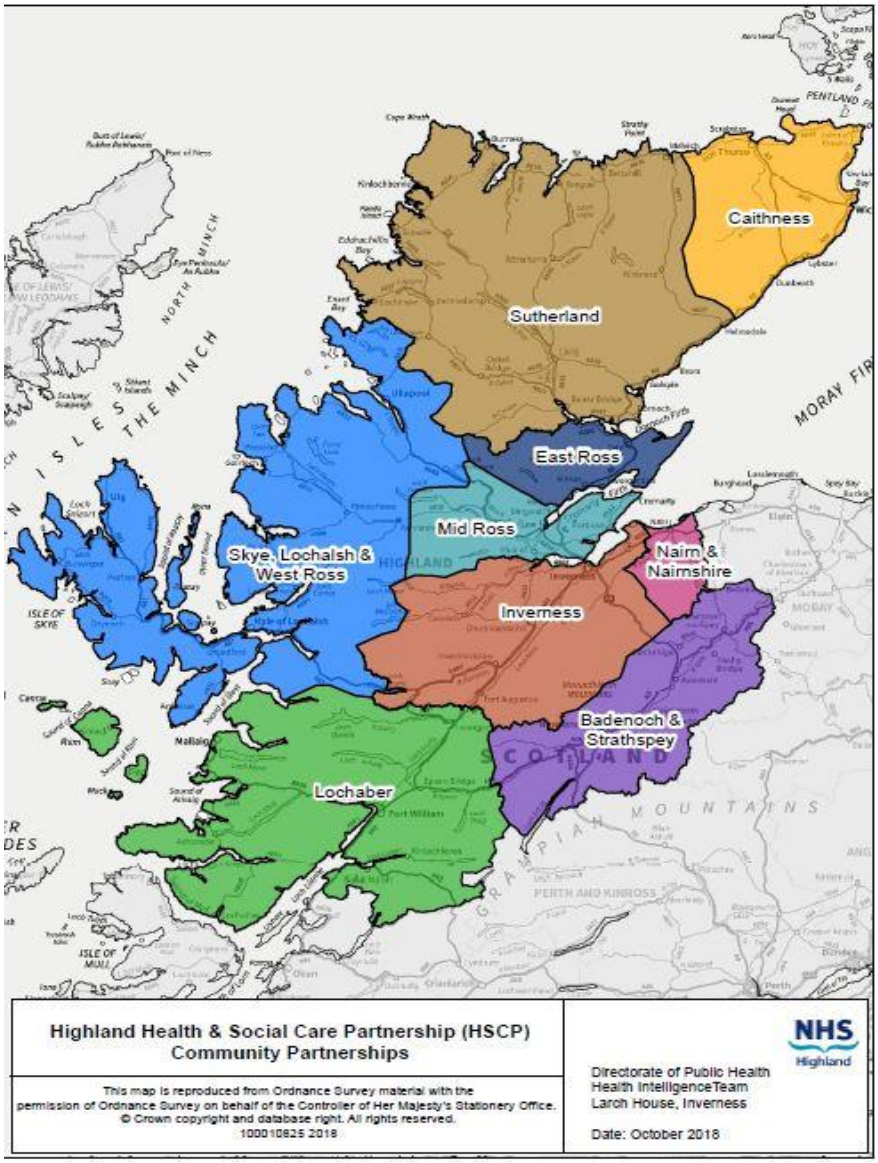
2.1 Current Arrangements

2.1.1 Service Details - Existing

2.1.1.1 Location of Service Users and Associated Catchment Areas

The proposal covers services delivered to the communities of Caithness in the far North of Scotland, as shown in diagram 2.

Diagram 2 – Community partnership areas, NHS Highland



Caithness is a large and predominately remote and rural part of the North Highlands. The resident population of over 25,000 people live in an area of 1,800 square kilometres with low population density of 14 people per square kilometre. Thurso and Wick are the major service centres for the area and the largest settlements accounting for roughly two-thirds of the population, with the remaining population rural.

Transport links are fragile, with no scheduled flights currently operating from Wick (Wick John O'Groats) Airport due to previous routes ceasing in March 2020 because of COVID-19 restrictions. However, under a public service obligation granted by Scottish Government in

February 2021, work is being undertaken to reintroduce flights as soon as possible. There are regular vehicle ferry services between Caithness and Orkney, with Northlink Ferries operating between Scrabster and Stromness and Pentland Ferries between Gills Bay and St. Margaret's Hope. Drive time from Thurso to Inverness (110 miles) is approximately 2 hours 30 minutes and from Wick to Inverness (105 miles) is 2 hours 20 minutes. The North Coast 500 route encompasses the Caithness coastline roads of A9, A99 and A836. The Far North Line links Thurso and Wick to Inverness by railway with a journey time of 4 hours 30 minutes from Wick and 4 hours from Thurso.

2.1.1.2 Services affected by the proposals

All adult health and care services in Caithness are affected by these proposals. A full description of the current arrangements can be found in **Appendix SC02** and they are summarised in **table SC01.**

Table SC01 – Full list of services affected by these proposals

Area of Service	Service	Status
Preventative/ early intervention	Health Improvement / Smoking Cessation Service	Green
	Third Sector	Green
Early Intervention	GP Services	Yellow
	Dental Services	Yellow
	Speech and Language Service	Yellow
	NHS Near Me	Yellow
Emerging Need	Adult Social Care	Light Orange
	Community Nursing	Light Orange
	Dietetic Service	Light Orange
	Occupational Therapy	Light Orange
	Physiotherapy Service	Light Orange
	Podiatry	Light Orange
	Social Work Services	Light Orange
	Care at Home	Light Orange
	Day Care Services	Light Orange
	Out of Hours/Urgent Care	Light Orange
	Specialist Nurses	Light Orange
Developing Need	Care Homes	Dark Orange
	Community Hospitals	Dark Orange
	Mental Health Services (Adult)	Dark Orange
	Scottish Fire & Rescue Service	Dark Orange
Increased Need	Acute Hospital (Rural General)	Red
	Scottish Ambulance Service	Red

The hospital and care home facilities affected are;

- Caithness General Hospital (CGH), a Rural General Hospital based in Wick;
- Two Community Hospitals; Town & County Hospital in Wick (TCH) and Dunbar Hospital in Thurso (DH)
- Residential care beds in Pulteney House (PH), Wick and Bayview House (BH) Thurso.

There are additional private nursing care home beds provided in Pentland View, Thurso, Riverside Wick and Seaview, Wick and as these are in the private sector, they are not in scope for this project. Achvarasdal, an independent care home, was deregistered as a care facility on 30th June 2018 with the loss of 28 registered places from the system.

Diagram 3 (overleaf) demonstrates the range of services provided, both within NHS Highland and with Community Planning Partners. Services are arranged from preventative work (green) to crisis and/ or acute services (red), in line with the categorisation in table 1.

2.1.1.3 Functional size of services affected

An indication of the size of the hospitals and care homes impacted is provided in **table SC02**.

Table SC02 – Bed numbers; acute, community hospital and care home (at June 2021)

Location	Acute Admission	Rehab	High Dependency	Community Maternity	Community Hospital	Care Home	Total
WICK							
Caithness General Hospital	17	21	3	2[1]			**43**
Town & County Hospital					9		**9**
Pulteney House						18	**18**
THURSO							
Dunbar Hospital					6		**6**
Bayview House						23	**23**
Total Beds	**17**	**21**	**3**	**2**	**15**	**41**	**99**

Additional services associated with these sites include;

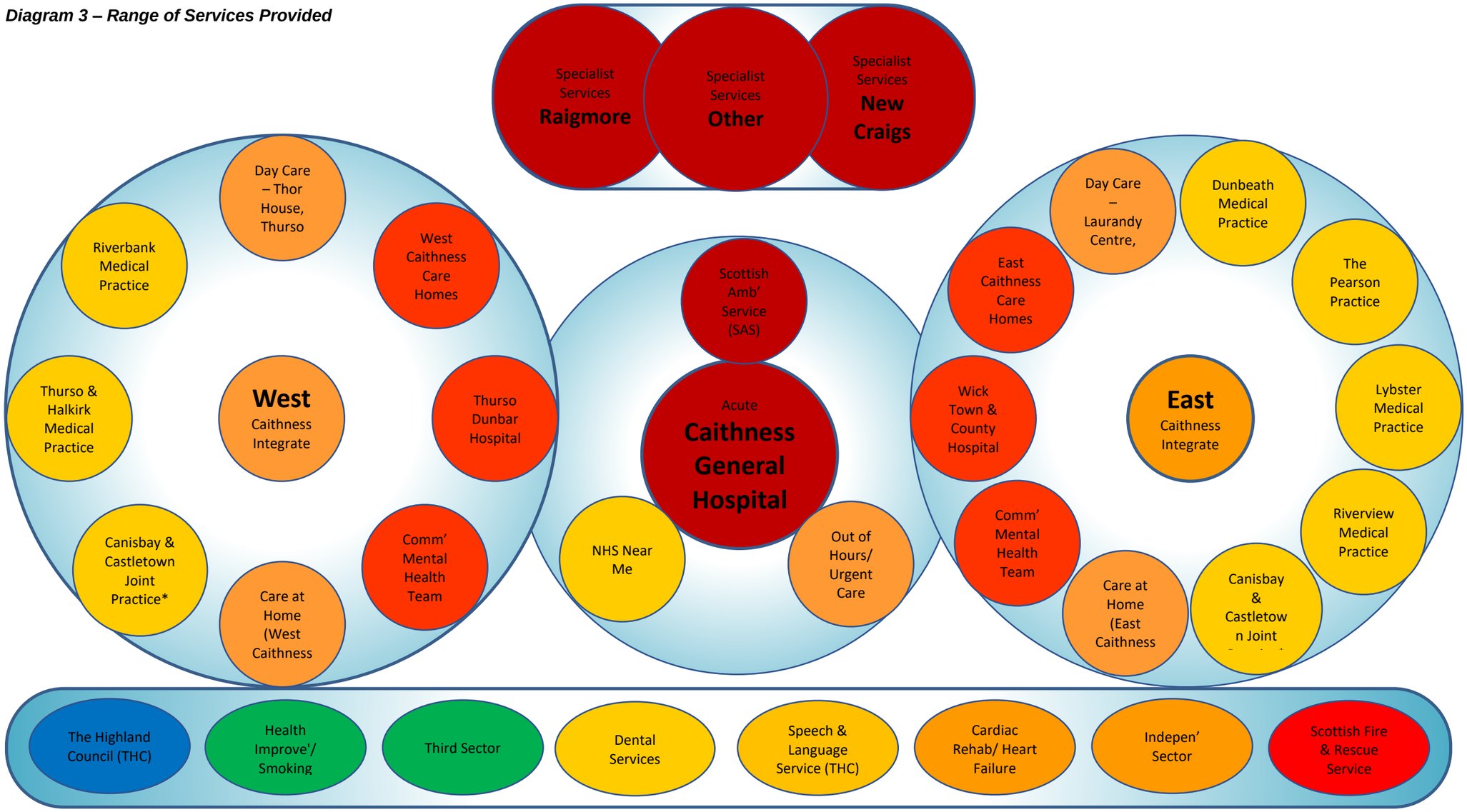
- Caithness General Hospital has a surgical suite with theatres (x2), day case and endoscopy, an emergency department (including primary care emergency centre), ambulatory care unit, outpatient and NHS Near Me services and a pharmacy. There are on site diagnostics with laboratory services and a radiology department with CT scanner, x-ray and ultrasound.
- Dunbar Hospital has outpatient services, a Primary Care Emergency Centre, occupational therapy and physiotherapy, and community mental health services.

There are 58 older adult day service places, 15 learning disability places plus third sector mental health provision.

Primary Care Services are delivered by seven GP practices from eight sites, covering 25,841 registered patients in total (as of 1st January 2020).

[1] Community Maternity Unit beds – not 24-hour inpatient stay

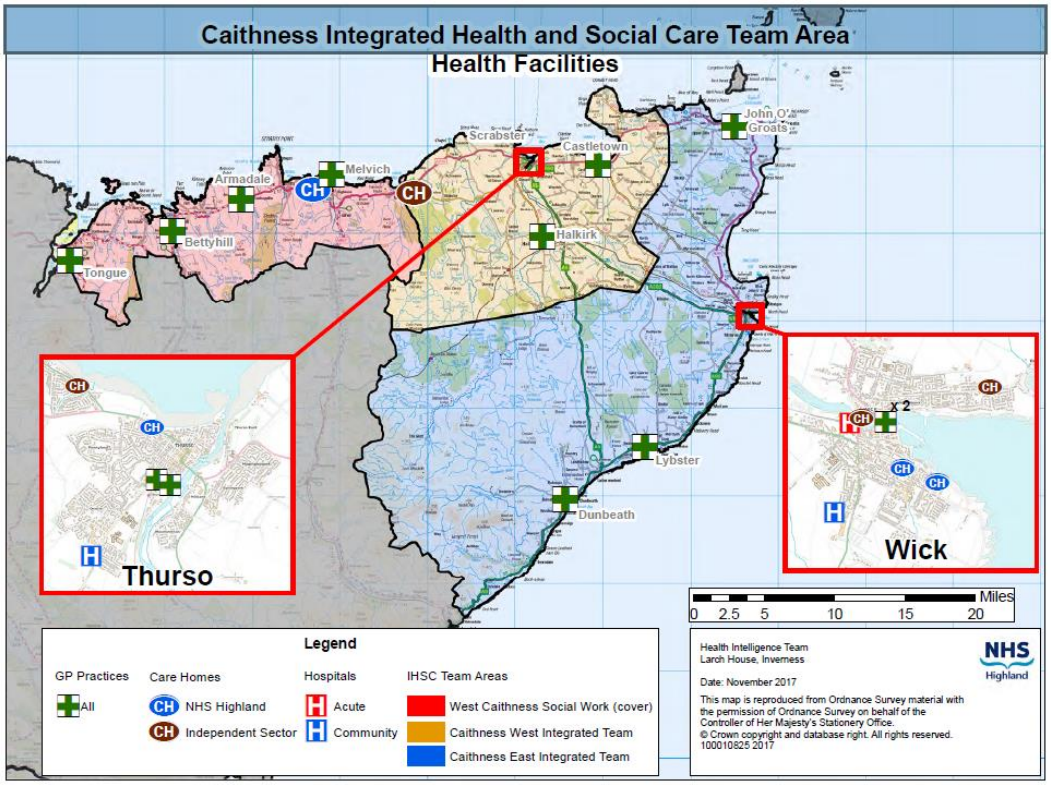
Diagram 3 – Range of Services Provided



2.1.1.4 Location of services

Health and Social Care Services across Caithness are provided from multiple facilities and sites across the region, as can be seen in diagram 4 below. Services are further supported by General Acute services at Raigmore Hospital in Inverness albeit with significant travel times for patients.

Diagram 4 – Location of health and care services in Caithness[2]



The affected services are based across a wide range of locations, as indicated in **table SC03**.

Table SC03 – Location of Affected Services

Service	Thurso (West) [3]				Wick (East)						
	DH	WSH	BH	TH	CGH	T&C	PH	WM	Lo	CH	La
Health Improvement											
GP Services (see diagram 4)											
Public Dental Service											
Speech & Language											
NHS Near Me											
Community Nursing											
Dietetic Service											
Occupational Therapy											
Physiotherapy											
Podiatry											
Social Work											

[2] North coast of Sutherland area covered by West Caithness Social Work team, services in Sutherland are not in scope

[3] DH = Dunbar Hospital, WSH = William Smith House, BH = Bayview House, TH = Thor House
CGH = Caithness General Hospital, T&C = Town & County Hospital, PH = Pulteney House, WM = Wick Medical Centre, Lo = Lochshell Dental Clinic, CH = Caithness House, La = Laurandy Centre

Service	Thurso (West) [3]				Wick (East)						
	DH	WSH	BH	TH	CGH	T&C	PH	WM	Lo	CH	La
Care at Home											
Specialist Nursing											
Day Care											
Out of Hours/Urgent Care											
Care Homes											
Community Hospitals											
Adult Mental Health											
Acute Hospital											

The Scottish Fire and Rescue Service has a base in Dunbeath, John O'Groats, Wick and Thurso. Scottish Ambulance Services bases are in Wick and Thurso, separate from the NHS sites.

2.1.2 Service Arrangements - Existing

2.1.2.1 Care pathways, patterns of working and service models

Unlike other boards in Scotland, NHS Highland (NHSH) directly manages all adult health and social care services via the Lead Agency model. That means that the NHSH Caithness District Manager is responsible for integrated community health and social care teams comprising of Community Nurses, Social Workers and Allied Health Professionals (Dietetics, Occupational Therapists, Physiotherapists and Podiatrists). These are arranged along geographical lines with the East Caithness Integrated Team based in Wick, and the West Caithness Integrated Team in Thurso. Neither team is fully co-located, with staff working from several bases as indicated in table 3. Measures have been put in place to help foster a greater sense of integrated working, including weekly Multi-Disciplinary Team meetings to discuss cases.

Service operating hours are provided in **table SC04** below, and descriptions of each service's working patterns is provided in **Appendices SC02 and SC03**.

Table SC04 – Service Operating Hours

Service	Operating Hours	Out of Hours cover
Health Improvement / Smoking Cessation	09:00 – 17:00 Tues. – Fri.	Nil
GP Services	08:00 – 18:00 Week days	Out of Hours (GP) from Wick PCEC at CGH (24/7) and Dunbar Hospital (reduced due to covid and staffing pressures)
Dental Services	08:30 – 17:00 Week days	Emergency appointments Sat / Sun
Speech and Language	Daytime, Week days	Nil
NHS Near Me	Available 24 hours a day, 365 days a year. Manned reception available 09:00 - 17:00, Week days.	Nil
Allied Health Professionals	08:00 - 18:00, Week days.	Nil
Community Nursing	East Caithness: 08:45 – 17:15 7 days a week	On-call service for End-of-Life patients on caseload.

Service	Operating Hours	Out of Hours cover
	West Caithness: 09:00 – 17:00 7 days a week	On-call service suspended and under review.
Social Work	09:00 – 17:00 Monday - Friday	Out of hours service weekdays 17:00 – 09:00 and weekends
Care at Home	07:00 - 14:00 & 17:00 - 22:00, 365 days a year	As per operating hours, 365 days a year
Day Care Services	Bayview: 09:30 – 15:30, Mon. – Fri.	Nil
	Laurandy: 09:00 – 16:00, Weekdays.	Nil
	Thor House: 09:00 – 15:30, Weekdays.	Nil
Out of Hours/Urgent Care	n/a	18:00 – 08:00, 7 days a week (locums) 08:00 – 18:00, weekends (local GPs or locums)
Specialist Nursing	09:00 – 17:00, Weekdays Individual services operate within these hours, daytime only.	Nil
Care Homes (in scope)	24/7, 365 days	n/a
Community Hospitals	24/7, 365 days	n/a
Adult Mental Health	09:00 – 17:00 Mon - Fri	On call cover by local team Wed & Thurs 17:00 – 09:00, and Inverness team for rest of week
Scottish Fire & Rescue Service	24/7, 365 days	n/a
Acute Hospital	24/7, 365 days	n/a
Scottish Ambulance Service	24/7, 365 days	n/a

2.1.2.2 Existing service capacity and current utilisation of this capacity

Community inpatient services are at capacity (82% bed occupancy) and in Caithness General Hospital they are stretched (80 – 99% occupancy), as demonstrated in **table SC05**.

During 2019, theatre utilisation in Caithness General Hospital was 70.4%, significantly lower than the Scottish Government target of 90%. Work is being led across NHS Highland to improve and maximise Theatre efficiency via the Theatre Cost Improvement Programme. The target that they have set for all theatres across Highland is 92% efficiency.

At Caithness General;

- The renal service can accommodate 12 places for weekly dialysis, and is currently using 11 of these, with demand growing.
- Outpatient services at Caithness General Hospital were at capacity in 2019, impacting on the ability to accommodate additional visiting consultant clinics.
- Waiting lists for CT and x-ray services are manageable, however demand exceeds current capacity for ultrasound scanning.

Many community and allied health professional services are operating at capacity with limitations on how they can meet demand. This includes Community Nursing, Dietetics, Physiotherapy and the Chronic Pain service.

Learning Disability day services are at capacity due to space constraints, and as most service users are long term there is limited turnover. Older adult day services are currently working at 80% capacity; however, the current accommodation limits the range of activities that can be provided.

2.1.2.3 Service performance data

The Caithness General Hospital Emergency Department was performing well on the 4-hour waiting time target in 2018, however this has worsened in recent years and we are starting to see a significant impact of COVID-19. The rolling annual figure showed 97.9% of patients were seen within 4 hours in April 2018. This dropped to 95.8% in April 2019 and 2020, 94.3% in April 2021 and the latest figures for June 2021 showed further deterioration to 93.7%. This is against a target of 95%, with Boards working towards 98%.

Inpatient length of stay and bed occupancy rates for Caithness General and the community hospitals are shown in **table SC05**. The occupancy figures for 2020/2021 do not include the occupied pressure beds.

Table SC05 – Average inpatient length of stay and bed occupancy in 2018, 2019, 2020 & 2021.

Hospital / ward	Length of Stay (days)				Bed Occupancy			
	2018	2019	2020	2021	2018	2019	2020	2021
Caithness General Hospital								
Bignold (post acute/rehab)	12.4	22.5	22.2	20.1	99.1%	99.9%	93.9%	95.7%
Rosebank (acute admission)	1.6	2.3	2.8	3.2	79.1%	89.9%	82.5%	85.8%
Community Hospitals								
Town & County Hospital	45.6	46.0	43.5	39.4	71.3%	82.4%	72.3%	75.7%
Dunbar Hospital	32.0	47.2	30.0	48.7	71.1%	82.2%	74.7%	87.6%

The performance in Caithness hospitals in relation to the treatment time guarantee for inpatient, day case and outpatient appointments demonstrates a clear impact from COVID-19, with a significant increase in patients waiting over 12 weeks in April 2020 and 2021 (**tables SC06, 07 and 08**).

Table SC06 – Caithness General Hospital Inpatient and Daycase Waiting List

	TTG (Inpatients/Daycase) Ongoing Waits Waiting List Snapshot as at			
	Apr-18	Apr-19	Apr-20	Apr-21
Total on Waiting List	205	196	211	167
% waiting >12 weeks	**31.7%**	**30.6%**	**53.1%**	**49.7%**

Table SC07 – Caithness General Outpatient Waiting List

	New Outpatient Ongoing Waits Waiting List Snapshot as at			
	Apr-18	**Apr-19**	**Apr-20**	**Apr-21**
Total on Waiting List	465	505	697	605
% waiting >12 weeks	**15.1%**	**11.5%**	**43.5%**	**47.3%**

Table SC08 – Dunbar Hospital Outpatient Waiting List

	New Outpatient Waiting List Ongoing Waits Snapshot as at			
	Apr-18	**Apr-19**	**Apr-20**	**Apr-21**
Total on Waiting List	162	131	58	34
% waiting >12 weeks	**28.4%**	**17.6%**	**50.0%**	**55.9%**

In 2018[4] there were 52 delayed discharges (1,430 days) in Caithness General, 10 (752 days) in Dunbar Hospital and less than 10 (1,387 days) in Town and County Hospital.

For Caithness residents in all Highland hospitals in 2019, there were 113 delayed due to patients awaiting a care home place, 83 delayed waiting for support to allow them to go back home, and 74 with complex delay codes[5].

2.1.2.4 Existing service demand and/or supply throughput

The current caseload, referrals and waiting lists (where applicable) for the Community Health and Care teams is provided in **table SC09**. There is currently no unmet need in the care at home service (September 2021) however there are waiting lists for Community Mental Health Services, Social Work and Care Home places.

TableSC09 – Community Services Caseload, Referrals and Waiting List Data (2020/21)

Service	**Caseload (Sep 2021)**	**Referrals (Sep 2020 – Aug 2021)[6]**	**Discharges (Sep 2020 – Aug 2021)**	**Waiting List (Sep 2021)**
Community Mental Health				
Older Adult	102	228	-	15
General Adult	121	57[7]	537	1
Alcohol & Drug Recovery	66	-	97	67
Emergency & Urgent Care Practitioner Service[8]	4	55	-	-
Community Nursing				
East Caithness	315	-	-	-
West Caithness	253	-	-	-

[4] Appendix SC03
[5] Benefits Register
[6] Full year referrals, unless otherwise stated
[7] New referrals, appointment offered awaiting assessment
[8] New service set up in response to Scottish Government Action Plan for Mental Health – currently Monday – Friday 9am-5pm so gap in service provision out of hours

Service	Caseload (Sep 2021)	Referrals (Sep 2020 – Aug 2021)[6]	Discharges (Sep 2020 – Aug 2021)	Waiting List (Sep 2021)
Care at Home				
In-house	159 users 761 hours	-	-	-
Independent sector	149 users 1,059 hours	-	-	-
Social Work	244	-	-	105
Care Home	-	-	-	26

In 2018 there were 17,571 outpatient appointments delivered in Caithness General Hospital, an increase of 50% in the past 10 years.

In 2019, Caithness residents attended 36,698 outpatient appointments, with 63.3% delivered locally, either face to face or remotely, and 36.7% requiring travel outside the area.

Waiting list numbers for outpatients, inpatients and day case in Caithness are provided in **tables SC06 to 8**.

In Highland there is a centralised waiting list to ensure longest waiters have access to next available appointment at any site across NHS Highland. Patients can choose to wait for an appointment in their local area. The demand for radiology services in Caithness General has risen in line with increased unscheduled attendances and admissions. There is an unmet demand for Ultrasound Scans due to high referral rates.

Repeat admissions have risen significantly. There is increased pressure to deliver medical infusions and chemotherapy services due to an increase in activity, complexity, capacity, and compliance with COVID-19 recommendations (Diagrams 5 and 6).

Diagram 5 – Medical infusion suite activity 2015 to 2021

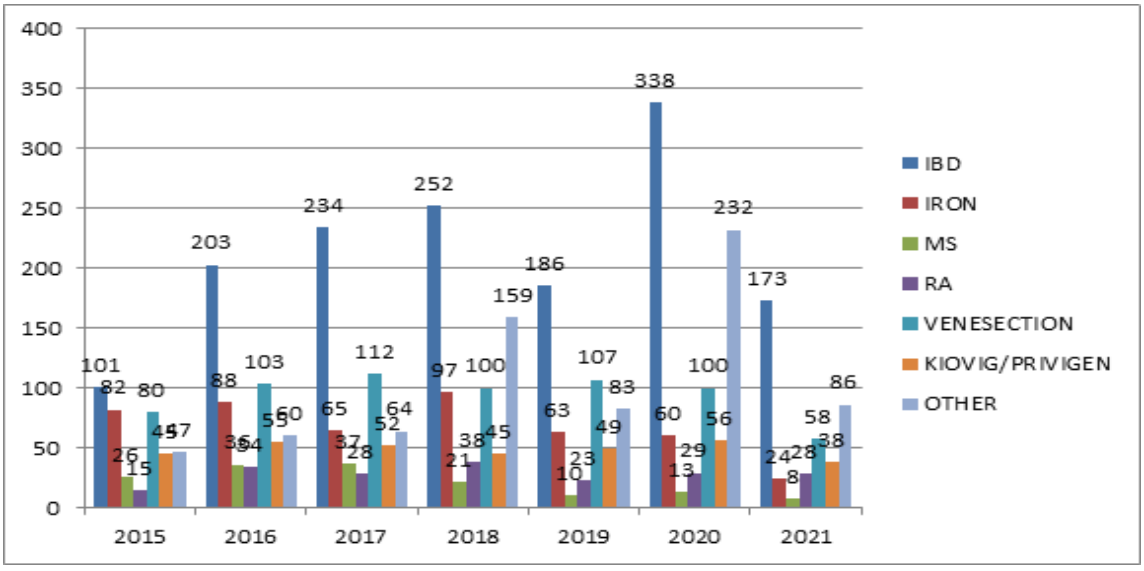
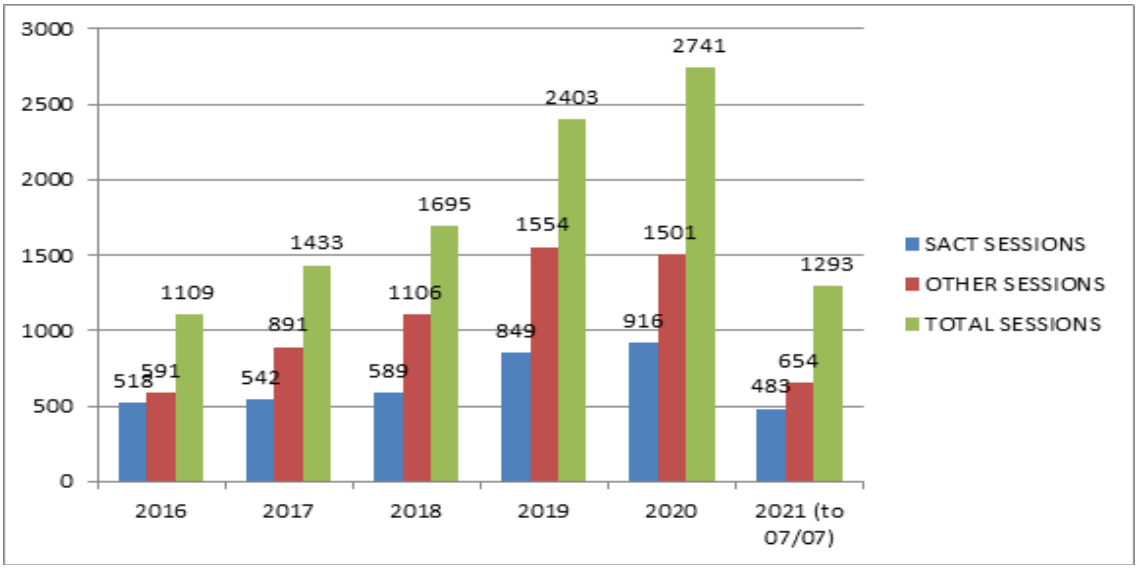


Diagram 6 – Chemotherapy activity 2016 to 2021[9]



2.1.3 Service Providers

Adult health and social care acute and community services are delivered by NHS Highland directly. This includes all acute, rehabilitation, community midwifery and community hospital inpatient services in Caithness and care homes in the scope of this project; Pulteney House and Bayview.

NHS Highland employs around 10,000 staff across the board area, and 600 in Caithness. Half of the workforce in Caithness are aged 50 and over.

Inpatient medical cover at Caithness General Hospital is provided by a combination of local consultants and rotational acute medicine consultants from Raigmore Hospital supporting the service 4 days per week. There are also four Rural Practitioners; GPs with enhanced emergency and resuscitation skills. These posts were developed in rural locations in Highland to meet the needs of local population. This innovative model has provided continuity of care reducing the reliance on locum cover.

Town & County Hospital is supported by Caithness General medics and the GP Out of Hours service. Medical cover at Dunbar Hospital is provided by local independent general medical practitioners and the GP Out of Hours Service.

Nurse Practitioners / Advanced Nurse Practitioner (ANP) roles have been developed across the hospital and in GP practice. These are nurses with advanced skills in clinical examination, assessment and prescribing.

Day care services are provided by NHS Highland and third sector organisations.

Primary care medical services in Caithness are delivered by general medical practices run by independent practitioners and NHS Highland salaried GPs. GP Out of Hours and Primary Care Emergency Centres (PCEC's) are covered by a combination of medical locums, GPs and NHS Highland nursing staff.

Primary care dental services are provided by NHS Highland and independent contractor General Dental Practitioners.

[9] SACT – Systemic Anti-Cancer Therapy

Highland Council are the lead agency for the delivery of children's services (out of scope for this project), and directly manage the local Speech and Language Therapy service.

There is an active Third Sector in Caithness and a proactive Health Improvement Forum organised by Caithness Voluntary Group and chaired by NHS Highland helps to build and maintain partnership working across the district. Contracts are in place with several organisations, funded by NHS Highland to support and deliver health and care services:

- Caithness Mental Health Support Group – drop-in service
- Laurandy Centre – registered day care service
- Hearing and Sight Care
- Samaritans
- Dunbeath and District Health and Wellbeing Hub
- Let's Get on With It Together (LGOWIT)
- Befrienders Highland

2.1.4 Associated Buildings and Assets

2.1.4.1 Condition and performance of key equipment

There are over 1,000 items of medical equipment in the three hospitals within the scope of this proposal, with a value of £3.6 million. Sixty-three percent (£2.285 million) are over 7 years old and reaching the end of their useful life (**table SC10**). The value of medical equipment within GP surgeries and care homes is relatively low, estimated at less than £10,000 per site.

Table SC10 – Summary of Medical Equipment within scope

Location	Number of items	Total Value	Age > 5 years	Age > 7 years
Caithness General Hospital	869	£3,450k	£2,500k	£2,200k
Town & County Hospital	73	£70k	£40k	£33k
Dunbar Hospital	85	£89k	£68k	£52k
TOTAL	**1,027**	**£3,609k**	**£2,608k**	**£2,285k**

The condition of the radiology equipment at Caithness General Hospital is good overall. The CT scanner was replaced in March 2021 and one x-ray was installed in March 2015. The second x-ray is much older (2003) and needs to be replaced. The Mobile Image Intensifier and Dental machine are seven years old and likely to need replaced within the next five years.

The Information Management & Technology equipment in the District is a combination of system servers, network hardware, PC devices and printers and telephony. The specific requirements for each location vary significantly; for acute and community hospital, general medical practices, and care homes.

For the locations within the scope of this proposal there are about 400 separate pieces of equipment totalling an estimated value of £500,000. The age of these varies from about one to eleven years of age.

Additional to this is a Wi-Fi network which is currently under replacement as part of a separate NHS Highland project.

2.1.4.2 Condition and performance of buildings

The buildings in the scope of this proposal are detailed in **table SC11**, which outlines ownership, condition, space utilisation, functional suitability and quality as defined in section

4.2 of the NHS Scotland Estates Asset Management Property Appraisal Manual, where A is considered excellent, and D is very poor and unacceptable.

Caithness General Hospital and the two Community Hospitals are in relatively good condition for their age with investment in recent years to bring them up to standard. However, the way health and care services are delivered has changed significantly over the years which means that in their current configuration they are no longer functionally suitable to support these services. This is reflected in the building performance scores.

NHS Highland leases the two care homes (Pulteney and Bayview) from the Highland Council, and NHS Highland are responsible for maintaining these. They require investment to bring them up to modern standards and to allow them to support changing models of care delivery.

The primary care facilities used by independent contractors and salaried services are a mix of NHS Highland owned, independent contractor owned and private lease. Overall, they are in good order and fit for purpose, however some have space pressures.

Table SC11 – Existing Buildings in Scope

BUILDING	OWNER	Condition	Space Utilisation	Functional Suitability	Quality
Wick					
Caithness General Hospital	NHS Highland	B	Fully	C	C
Town & County Hospital	NHS Highland	C	N[10] - Under H - Over	C	C
Pulteney House	Highland Council	C	Under	C	C
Old Medical Centre (CGH)	NHS Highland	C	Under	C	D
Dunbeath Health Centre	NHS Highland	B	-	-	-
Lybster Health Centre	NHS Highland	B	Fully	-	-
Wick Medical Centre, Martha Terrace	NHS Highland (since March 2021; was GP owned)	C	Over	C	D
Thurso					
Dunbar Hospital	NHS Highland	C	Under	C	D
Bayview House	Highland Council	C	Under	C	C
Davidson's Lane	Was owned by NHS Highland (sold April 2021)	D	Fully	D	D
William Smith House	Privately owned, leased by NHSH[11]	B	Fully	B	B

[10] N = Newton wing, H = Harmsworth wing
[11] Leased as an interim measure since 2020 to accommodate teams from Davidson's Lane

BUILDING	OWNER	Condition	Space Utilisation	Functional Suitability	Quality
Canisbay/Castletown	Privately owned, leased by practice	C	Over	-	-
Riverbank Medical Practice	Privately owned, leased by NHSH	B	Fully	C	B
Princes St, Thurso	Owned by GP Practice	B	Fully	C	C
Halkirk Surgery	NHS Highland	C	-	-	-

2.1.4.3 AEDET review of existing facilities

The multi-stakeholder Achieving Excellence in Design Evaluation Toolkit (AEDET) review held in January 2020 shows relatively low scores across the board for the existing buildings (**table SC12**), although build quality for Caithness General Hospital is fairly good. Two separate AEDET reviews were held, one for acute and one for community buildings, with aggregated scores detailed below. Full details including scores for individual buildings are provided in **Appendices SC04 and SC05**, and further information on the stakeholder groups and target scores is provided in section 3.8.1.

Table SC12 – Summary benchmark scores of existing facilities

Descriptor		Caithness General	Community (Various)
Functionality	Use	1.7	1.5
	Access	1.2	1.6
	Space	1.9	2.2
Build Quality	Performance	3.0	1.8
	Engineering	3.3	1.6
	Construction	0.0 (N/A)	0.0 (N/A)
Impact	Character and Innovation	2.1	2.4
	Form and Materials	2.4	2.6
	Staff and Patient Environment	1.7	2.1
	Urban and Social Integration	2.7	2.7

2.1.4.4 Confirmation that current services are still needed

Caithness is a remote and rural area in the far north of Scotland with a demographic of areas of high deprivation and older population (section 2.2.1.2). There are no alternative methods of delivering essential health and care services to its population of over 25,000 people and the nearest acute hospital is over 100 miles away. There is a need to continue delivering acute, community and primary care services locally.

In subsequent sections we will outline how we plan to deliver services differently to meet the challenges we are facing, and this will require necessary changes to the health and care estate to support this. The estate no longer supports the services we are trying to deliver, and we will not be able to fully realise the proposed new service model if nothing is done to address this.

2.2 Why is the Proposal a Good Thing to do?

2.2.1 Need for Change

The drivers for change were explored at a community workshop in March 2018, which focussed on making and explaining the case for change including an overview on demography, deprivation, workforce and finance. The briefing notes and output notes for that workshop are attached at **Appendix SC06** and **Appendix SC07** respectively.

A more recent refresh of some of the supporting data has been carried out for this Initial Agreement and the pressures and resultant challenges on health and deprivation across Caithness are set out in **Appendix SC08**.

2.2.1.1 Economy

Health and Social Work is one of the largest sources of employment (13%) in the Caithness, Sutherland and Easter Ross area.

The Caithness landscape and economy has been dominated by Dounreay Nuclear Power Station, which has provided significant economic value to the area since 1955. This site is now undergoing decommissioning with a resulting loss of up to 2,000 jobs over the next 15 years. It is estimated that the area economy was 12% dependent on Dounreay work in 2016.

Early indications into the impact of the COVID-19 pandemic and Brexit on the local economy show that this is predicted to be more severe in the Highlands and Islands due to its reliance on industries most impacted by the lockdown and associated restrictions, as well as a higher number of self-employed and micro-businesses. With rising unemployment, young people will be at most disadvantage as they will be competing against experienced workers for jobs, resulting in the risk that many will have to leave the Highlands and Islands region to seek employment in urban areas.

2.2.1.2 Demography

The population of Caithness in 2018 was 25,413, with a slightly higher proportion of over 65-year-olds compared to the Highland Council area. **Table SC13** demonstrates that if current trends continue, the total population is projected to decrease by 21% by 2041, with a much larger reduction seen in children and adults of working age. Older people will increasingly make up greater proportions of the population and the number of people aged over 85 years of age is projected to more than double by 2041.

Table SC13: Projected change in the population of Caithness, 2016 - 2041

	Caithness			**Highland**
	2016	**2041**	**% change 2016-2041**	**% change 2016-2041**
00-14	4,028	2,719	-32.5	-9.8
15-34	5,481	3,621	-33.9	-9.9
35-64	10,475	7,123	-32.0	-10.7
65-74	3,253	2,759	-15.2	8.0
75-84	1,937	2,807	44.9	74.8
85+	633	1,340	111.7	140.6
total	25,807	20,367	-21.1	1.4

In 30 years, it is projected that the ratio of people of working age to those aged over 65 years will have significantly reduced. In 2018 there were 26 people of working age for every 10 people

aged 65 years or older living in Caithness. By 2041 this figure will have reached a low of 15 people of working age for every 10 people aged 65 years and older. The demand for services in the area will need to be met by a declining and ageing workforce in the future.

2.2.1.3 Deprivation

Over 2,400 people, 10% of the population of Caithness, live in four small areas in Wick that are among the most multiply deprived 20% of areas in Scotland. A consequence of deprivation and poverty is generally poorer health and an increased demand for health and social care services.

In addition, in remote and rural Caithness many disadvantaged individuals and households live in pockets of areas not identified as being particularly deprived by SIMD. These people live at some distance from service access points and therefore may struggle to access health and social care services.

2.2.1.4 Health Inequalities

Developing interventions that are inequalities sensitive and measuring the impact of these is a fundamental aspect of developing fairer communities and improving health outcomes. A Health Inequalities Impact Assessment for this redesign proposal was carried out early in 2021 (**Appendix SC09**). The purpose of the assessment was to consider the key health inequalities and to identify how the proposed redesign could address these.

This underlined that the level of deprivation is consistently greater in Caithness than Highland, and the overall percentage of people in Caithness living in the lower three quintiles is greater than both Highland and Scotland.

People who live in deprived areas are more likely to die early from disease and have more years of ill-health. Those most socially deprived are at greater risk of living with multiple long-term conditions at earlier age[12]. Early death and illnesses associated with mental wellbeing, diet, drug use, tobacco and alcohol dependency are more common in poorer areas than in richer areas[13].

Some of the key points to emerge from the assessment are as follows:

- an increasing elderly population in Caithness;
- a slightly higher incidence of self-reported mental health issues compared to Highland overall;
- a slightly higher prevalence of people diagnosed with dementia compared to Highland and Scotland overall;
- long travel distances often required to access health care due to rurality; and
- a significant number of people not registered with a GP.

Key recommendations from the report are listed below:

- any new model of care should have a preventative aspect as well as a treatment aspect;

---

[12] *The Annual report of the Director of Public Health 2019: Past. Present and Future Trends in Health and Wellbeing, Supplementary Paper 6, Care dependency in the older population of NHS Highland*. DPH-Annual-Report-2019-and-appendices.pdf (scot.nhs.uk)

[13] *The Scottish Burden of Disease Study, 2016*. https://www.scotpho.org.uk/media/1733/sbod2016-overview-report-sept18.pdf

- develop a programme of health inequalities training that can be rolled out across NHS and community staff;
- nurture and maintain close links between the redesign project team, other partners and including representatives from identified protected characteristics; and
- work closely with social isolation and mental wellbeing group to develop and improve responsive and supportive services for people experiencing mental distress.

2.2.1.5 Workforce

There are around 600 staff employed by NHS Highland in the Caithness area. About half are aged fifty and over, and a third are within 10 years of retirement age (March 2020)[14].

Recruitment to some health and care posts is challenging and in April 2019 to March 2020 less than two-thirds of nursing and adult social care posts were filled on first advert[15]. This is slightly improved compared to March 2018, when for nursing and midwifery five in ten (Acute) and three in ten (Community) posts were filled on first advert. There has been a large increase recently in the use of agency staff in Nursing, Allied Health Professional, and other disciplines, which is impacting on spend.

For medical posts Highland-wide, the use of locums and vacancies remains high. In March 2020 the medical workforce had a median age of 55 years and 9.6% of consultant posts were vacant, 7.4% for 6 months or more[16]. Medical locum spend in North & West Highland (Caithness, Sutherland, Lochaber and Skye) exceeded £5million in 2019/20, accounting for one-third of the total NHS Highland spend. In Caithness, we have made some consultant appointments and improvements in recent years (section 2.2.2.2) which has positively impacted on locum use. However, it is still proving challenging to fill junior doctor posts and there remains a large requirement for agency medical staff.

2.2.1.6 Summary – need for change

Sections 2.2.1.1 to 2.2.1.5 set out a perfect storm of challenges for the Caithness area and sets the context for the proposed redesign of health and care services:

- potential substantial impact of the Dounreay closure and COVID-19 on the local economy;
- some significant areas of deprivation resulting in increased demand for health and care services;
- local communities disadvantaged due to long travel distances, a slightly higher incidence of mental health issues and prevalence of dementia;
- an ageing population with the number of people over 85 years old expected to more than double in 20 years;
- an ageing workforce with half of Caithness staff aged 50 years or more and a third within 10 years of retirement age;
- young people of working age leaving to find jobs in more urban areas; and
- difficulties in recruitment with a high use of locum and agency staff.

2.2.2 Opportunities for Improvement

2.2.2.1 Local Care Model

Opportunities to improve on the existing arrangements were clearly highlighted through the Option Appraisal process and public consultation (section 3). The Caithness Redesign project is one of three national pathfinder schemes to test how to implement local care and then roll it

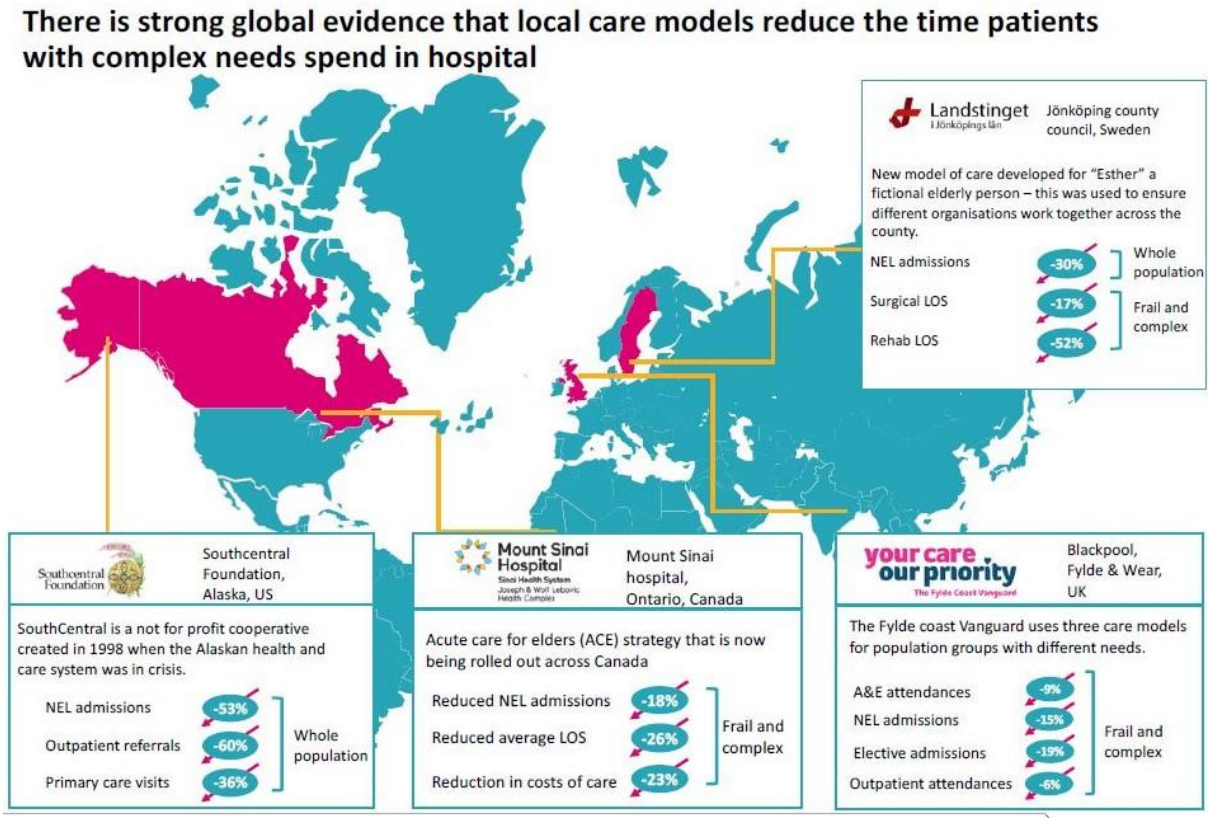
[14] Benefits register, Appendix SC14
[15] Benefits register, Appendix SC14
[16] Source – NES dashboard

out, supported by the Scottish Futures Trust and Carnell Farrar (Specialist Health Care Planners). A key aspect of the new approach is the Local Care Model. This is place based, focusing on population cohorts with high needs, and centred on addressing the priorities of the individual. The full details of the proposed new local care model are contained in **Appendix SC10**. It includes the key elements that underpin the model including:

- Place Based Care;
- Remote Consulting and Monitoring;
- Community Led Support;
- Planned Care; and
- Bed Based Support.

There is compelling evidence to suggest that local care models help to reduce hospital admissions, length of stay as well as other acute interventions such as Outpatient appointments and ED attendances for patients with complex needs, as evidenced in **diagram 7** below. This model will provide a more sustainable and flexible model of health and social care through true integration of services, making greater use of technology, embracing the Place Principle, combined with strategic co-location and rationalising of assets. The response needed to deal with the COVID-19 pandemic has highlighted the demand for further investment and reflects some of the emerging innovations and new approaches.

Diagram 7 – Supporting Evidence for Local Care Models



Carnall Farrar analysis of effectiveness of Local Care Models

As we continue through the planning process for the new model of care for Caithness, it is essential that creating health inequality sensitive services is embedded in everything we do. COVID-19 has brought local inequalities to the forefront. The community response has been outstanding, with a county-wide, multi-agency Resilience Group meeting weekly to coordinate

the local response. Measures have been put in place to continue this work, with issues-based Action Groups (as part of the Caithness Community Partnership) having been established to address inequalities as a community. The key to success for the community response has been collaboration, with statutory partners not dictating terms but working with the community to develop a flexible approach that is led by and works for the community. Community engagement and co-production need to be at the heart of COVID-19 recovery plans.

"Stop thinking of health as something we get at the doctor's office but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink…..It's time we expand the way we think about health to include how to keep it, not just how to get it back."
(Robert Wood Johnson Foundation , 2010)

An example Case Study has been prepared, attached at **Appendix SC11**, to evidence the improved and enhanced patient experience that the proposed local Care Model will deliver. Key elements of this include:

- the proposed redesign of health and social care services will realise the development of Local Care Model Multi-Disciplinary Team (LCM MDT);
- the team will provide proactive, rather than reactive, care through collaborative practice;
- the LCM MDT allows the whole person to be treated in a planned and efficient way using Anticipatory Care Plans (ACP) which are developed by the patient, their family and the team members; and
- the LCM MDT will be the mechanism for coordinating health and social care services to meet the needs of people with complex care needs. Care will be consistent and well organised, simple to access and communication with the patient, the family and within the team will be excellent.

Collaborative working through the Caithness Community Partnership will need to ensure that life circumstances are addressed, as well as lifestyle. This would include:

- providing equality of access for everyone, including those with multiple and complex needs;
- providing universal services that are responsive to and meet the needs of the community;
- investing in communities and groups who experience inequality; and
- identifying and building on local strengths within communities.

2.2.2.2 Improvements already made

In advance of the larger redesign of services, some progress has already been made by refocusing resources on areas where innovation can provide solutions including:

- Rural Practitioners - GPs with enhanced emergency and resuscitation skills, are new posts which have been developed to meet the needs of the local population. Six Rural Practitioners have been appointed to work in Caithness General Hospital, providing continuity or care and reducing the reliance on locum cover;
- Rotational Consultants – Acute Medicine Consultants based in Raigmore, work on a rotational basis, supporting Caithness General Hospital with four days per week of cover. This innovative model has moved towards addressing a sustainable staffing model of consultants across the Highlands; and

- Advanced Nurse Practitioners - nurses with advanced skills in clinical examination, assessment and prescribing have been appointed to work across hospital and GP services to help meet the needs of the population of Caithness.

The above improvements have developed a more sustainable workforce with consistency in delivery of care and has supported the development of nursing staff confidence and competencies, improving patient outcomes.

With investment from Scottish Government last year, we have refurbished an area in Caithness General Hospital to provide a modern Community Maternity Unit offering a one-stop shop with delivery suite, outpatient clinic and scanning facilities all in one place. This funding also allowed us to relocate and increase the capacity of our outpatient department, in turn releasing space to allow expansion of a cramped and landlocked Emergency Department (although further work is required to make this space functionally suitable to support patient flow).

2.2.2.3 Changing Technology

A key enabler to the delivery of the proposed local care model will be the implementation of a variety of key advancements in technology and these include:

- improvements in eHealth systems and their use;
- changing ways of working by provision of modern hardware and infrastructure systems to facilitate home and remote working and the “virtual office”; and
- increased utilisation of “virtual consultations” via digital solutions, for example, Near Me.

Table SC14: Percentage of appointments delivered in Caithness by Near Me technology

Month	Appointments delivered by Near Me %
Jan 19	1.8%
Jan 20	2.8%
Jan 21	10.8%

Caithness was at the forefront of the use of Near Me technology long before the COVID-19 pandemic and has been well received. The pandemic has necessitated the need for more appointments and care reviews to take place using this type of technology. It reduces the need for patients to travel (often long distances) to attend appointments which, with the use of technology, can now take place in their own home. The reduction in staff travel time also has great benefits in terms of the increased numbers of patients who can be “seen” and the decrease in travel costs and reduction in carbon emissions.

In addition, there have been significant travel miles saved by Near Me for patients. By the end of October 2019, the total miles saved for patients in Caithness exceeded 200,000, which more than doubled in 2020 to 463,000, delivering a noticeable reduction in carbon emissions.

2.2.2.4 Place based approach

An ongoing Place Based Investment Strategy is being undertaken in Caithness with Hub North, NHS Highland, University of the Highlands and Islands, other partners and Scottish Futures Trust (**Appendix SC01**).

The ambition of this review involves collaboration which will sit at the heart of a better future, which improves services, creates opportunities, and enhances quality of life for communities in a changing Caithness. Taking a whole systems view of Caithness as a place enables:

- A more efficient way of providing public services through better use of resources;

- A better way of providing public services with a faster pace of service transformation and more opportunities for community empowerment; and
- More and better jobs by leveraging investment opportunities.

In a post-COVID-19 world, collaboration ensures a more effective approach to economic recovery, more resilience to shocks, and more effective transition to a low carbon future.

By taking a joined-up approach, whole place opportunities are identified to create planned investments in health, energy, data, and public services. Regional economic transformation opportunities and community development would drive a step change in the way Caithness functions at national, regional, and local levels. This can accelerate activities already in motion and support new lead markets for new opportunities.

Initiatives such as the redesign of local care, the proposed Green Deal in the Programme for Government and planning for a post-Dounreay future, are most effectively working to a clear story of change for the future, with a shared set of objectives for Caithness and a clear approach to partnership working to maximise benefits.

The approach will look at the key elements of a whole place and the opportunities for Caithness are:

- Senior leadership agreement to pursue a place led approach across the key organisations in Caithness;
- A shared story for the future of Caithness, which sets out a service-led collaborative ambition and outcomes, and with community buy in;
- A place programme which sets out the plan for who does what and how;
- A formal change management process which puts the Place Brief and the Place Programme as essential steps on strategy, project and investment decision timelines, with collective leadership and anchor collaborations as necessary conditions for policy prioritisation and decision making; and
- A governance structure which ensures that stakeholder engagement and the assurance of funding or policy bodies are protected and reflected both at the programme or partnership board level and at key stages within the change process. This work should feed into the Community Planning Partnership.

2.2.3 Problems with the Current Arrangements

Section 2.1 illustrates that services are delivered from multiple sites across the Caithness district. Teams that work together to deliver health and care services are not strategically co-located and this can be a barrier to effective multi-disciplinary working.

There are currently five sites in Caithness (in Wick and Thurso) that provide 24/7 care: three hospitals and two care homes; and staffing pressures are making it increasingly difficult to sustain these separate rotas. Care at home, care home and hospital services are all competing for the same limited workforce resource. The Out of Hours service at Dunbar Hospital, Thurso has experienced significant disruption in recent years due to staff pressures and is currently operating daytime hours only, with patients having to travel to Wick to access out of hours emergency care out with these times.

There are gaps in some community service provision, particularly out of hours, which results in increased pressure on hospital services and inappropriate admissions as the community services are not available at the right time and in the right place. Mental Health and Social Work services are particularly stretched. The Emergency Department at Caithness General Hospital is under increasing pressure with a steep rise in attendances during 2021.Covid-19

has exacerbated this (section 2.1.2.3), putting teams under extreme pressure.

Once admitted, patients are taking longer than they should to be discharged due to limited resource in the integrated community teams, compounded by issues such as a lack of power of attorney or anticipatory care plan. While in hospital patients become more dependent and less able to look after themselves, increasing the level of support they require to facilitate a successful return home. This in turn increases pressure on community hospital and care home beds.

The closure of Achvarasdal residential care home in 2018 resulted in a loss of 28 registered places, and this has placed additional strain and demand for the remaining care homes places in the District, evidenced by the waiting list information

Caithness patients must sometimes travel significant distances to access services that could be provided locally. Changes in use of technology have led to improvements (section 2.1.2.3), and we need to build on this through a review of how we provide outpatient and GP services to fully realise the benefits.

Difficulties in recruitment of doctors and nurses has resulted in a heavy reliance on locum and agency staff, which is more costly and diverts scarce resource away from where it could be more effectively used, for example to enhance community services and prevent admissions.

The buildings within which we are delivering care are in relatively poor condition and are ageing. There has been some investment in recent years to address issues with building services and fabric, but the way health and care services are being delivered has changed over the years and our buildings are now functionally unsuitable to support the services we provide. This has resulted in under-utilisation of space in some buildings as they are not fit for purpose. Other buildings are over-crowded, and the lack of space is impacting on service delivery. Inpatient facilities do not meet current guidance for provision of single rooms and en-suite accommodation.

In continuing with the current model of care and dispersed facilities services will:

- Increasingly become less sustainable as recruitment and retention pressures grow in line with population statistics;
- Result in services and staff remaining dislocated from one another with patients experiencing multiple contacts;
- Lead to an increase in disruptions to service; and
- Result in persistence of and growth in person-dependent services with multiple single points of failure.

Unless fundamental whole-system change is undertaken and the proposed model of care is delivered, the outcome will result in significantly increased pressure on already limited services.

2.2.3.1 Activity modelling

NHS Highland commissioned an external data analyst to examine the projected future demographics for Caithness and model the impact on Caithness General Hospital inpatient activity if we do not change. They also modelled the potential impact of implementing specific elements of the proposed local care model as detailed below.

1. Identification and management of patients with complex care needs by the LCM MDT;
2. Enhanced out of hours care at home (5pm to midnight);
3. Step-up beds; and
4. Clinical Decision Unit (formerly known as Ambulatory Emergency Care Unit)

Full details are provided in **Appendix SC12** and summarised in **table SC15**. This illustrates very starkly that if we continue to provide services in the same way and the local demographic going forward is in line with projections, we will need to increase the number of beds at Caithness General Hospital from the current complement of 43, to 54 in 2030, and 60 beds by 2040. Caring for patients in an acute hospital is expensive and for some of these patients their needs could be better met in a community setting. A shift in focus to preventative care could avoid unnecessary admissions and reduce the number of hospital beds required in the area.

Table SC15: Summary of local care model impact scenarios (cumulative effect)

Scenario	2019-20			2030			2040		
	No. of admissions	No. of bed days	No. of beds	No. of admissions	No. of bed days	No. of beds	No. of admissions	No. of bed days	No. of beds
Scenario 0 (Do Nothing)	2,536	13,887	45.7	2,644	16,360	54.0	2,635	18,297	60.2
Scenario 1 (MDT Frailty)	2,391	12,725	41.9	2,470	14,911	49.2	2,448	16,626	54.7
Scenario 2 (OOH CaH)	2,239	11,493	37.8	2,288	13,373	44.1	2,247	14,823	48.8
Scenario 3 (Step-up Beds)	2,045	11,301	37.2	2,057	13,144	43.4	1,996	14,574	48.0
Scenario 4 (AEC)	1,851	11,109	36.6	1,826	12,915	42.6	1,745	14,325	47.2

Notes:
1. No. of beds - assumes **83%** bed occupancy
2. Total Population for 2019-20 = **25,144**
3. Total population for 2030 = **23,095**
4. Total population for 2040 = **20,616**

The cumulative effect of the four local care model interventions detailed above indicates that if we invest in our community services, in 2030 we could manage within the existing Caithness acute bed complement, with a potential modest increase (four beds) required by 2040. This data needs careful interpretation, as the impact of the four interventions may not necessarily be cumulative. However, we also need to consider that this is not an exhaustive list and there will be additional changes implemented as part of this wholescale redesign which we were unable to effectively model at this time. What is clear, is that if we do nothing this will have a significant impact on hospital-based services, and the status-quo is not sustainable or affordable.

2.2.4 Other Drivers for Change

The proposals set out in this Initial Agreement respond to several national and local strategies and a summary of these is attached at **Appendix SC13.** The Health and Social Care Delivery Plan published in December 2016 by the Cabinet Secretary for Health and Sport, brought into sharp focus the urgent need to address the rising demands and challenges facing the NHS in Scotland. Audit Scotland also prepared a Report "NHS in Scotland 2017" (October 2017) which further described how the NHS is under pressure with the need for change and longer-term planning, particularly regarding workforce. The Feeley report (February 2021) and recent announcement of the National Care Service will shape our proposals going forward.

NHS Highland's Quality and Sustainability Plan published in May 2017 reflected our local context around the challenges to sustain and transform services. This included reference to the need to redesign services in Caithness. It also set out several goals and principles that underpin the proposed redesign and transformation of services.

Sustainability goals include:

- Providing services and facilities which meet 21st Century health and social care needs;
- Providing high quality, integrated and cost-effective services;
- Reducing waste and inefficiency across services; and
- Ensuring that services are sustainable.

Principles include:

- Support for people to stay at home for longer;
- Supporting people and communities to be more independent and resilient;
- Increased choice for end-of-life care;
- Greater embedding of realistic medicine principles;
- Greater integration, co-location, and co-ordination of care;
- Greater Regional collaboration and solutions;
- Greater use of technology;
- Reduction in the length of time people spend in institutional care;
- Reduction in unnecessary attendances and appointments; and
- Reduction in waste, harm, and unwarranted variation.

The changes flowing from implementing our strategic vision and plan therefore require us to remodel our care pathways, workforce and our assets. It was highlighted that, over time, this would bring about a planned reduction in the number of staff working in traditional hospital settings. Services would instead be provided by co-located teams from fewer sites, in modern, strategically placed buildings. Such a transition would support more people to be looked after at home or in a homely setting. The new model will ensure service sustainability and will deliver services capable of meeting future demand.

Another key driver for change is the Climate Change (Emissions Reduction Targets) (Scotland) Act 2019. This landmark legislation commits Scotland to becoming net zero carbon by 2045 and requires us to think very differently about how we deliver services and utilise resources. As a public body NHS Highland need to lead by example in combating climate change and our future proposals will need to be sustainable and deliver a reduction in carbon emissions from current levels.

2.2.4.1 COVID 19: Remobilise, Recover, Redesign

The immediate impact of the COVID-19 outbreak was devastating internationally, nationally and across all regions. The Institute for Fiscal Studies (IFS) has warned that the long-term economic fallout could have "persistent negative health effects" and that unemployment and other financial concerns may cause enduring impacts such as mental health problems. Health inequalities have been exposed and amplified by the lockdown with those already experiencing the greatest deprivation impacted, more due to existing poor health, increased exposure to COVID-19, fragile employment, and insecure housing: “The virus will have taken an uneven toll on an already unequal society” (Ruth Thorlby, 2020). In addition to this, is the impact on both acute and community services of delays to treatment for long-term conditions, postponed surgery and cancer diagnoses.

A paper entitled Remobilise, Recover, Redesign was presented to NHS Highland on 30th March 2021. This details the road map out of the pandemic while presenting the Strategic direction for NHS Highland 2021-2022 (**Appendix SC14).**

Integral to this Caithness proposal is the Board’s aim to have a long term Clinical and Care Strategy in place by next year. The creation of the two Health and Wellbeing Hubs with a greater emphasis on multi-disciplinary working in and from them will help achieve the aims

set out in the Board's strategy.

As the workforce is our greatest asset, and this has been evidenced by their response to the pandemic, a key component of the new strategy is to develop a culture and practice of learning improvement; this is a key component of clinical and care excellence across the new model of care.

To support individuals with long-COVID, design and recruitment is underway to establish a Highland-wide multi-disciplinary diagnostic and rehabilitation service.

2.2.5 Summary of the Need for Change

In Caithness the combined impacts of an ageing population, demographic changes, and clear implications for the workforce with increasing costs and demands mean that the current model of health and social care delivery is not sustainable. The model of five sites providing 24/7 care is continually under pressure and leads to unplanned closure of services and disjointed multi-contact service delivery.

While such pressures are being experienced across the country and beyond, they are more severe for NHS Highland in general, particularly in the more remote and rural areas like Caithness. These pressures have been evident and growing for several years, yet the pace of change has been slow. This is in part due to resistance to change, including a belief by some that the solution is to have more money or to be more innovative around recruitment. Arguably while more money and innovation will certainly assist, it will not address the fundamental challenge of addressing issues of sustainability (workforce) and the associated need to transform some services and rationalise the current estate.

Health and social care needs to adapt and extend beyond the classical settings of hospitals, care homes, GP practices, and hospices. Improved multi-disciplinary and multi-agency working would help to reach more people, with communities becoming more resilient, gearing up for better use of technology. This has in part been facilitated through integration of health and social care which has been ongoing in Highland since 2012. The lead agency model has created several opportunities to develop more flexible care models that had previously not been thought of or implemented.

These challenges are not unique to Caithness, Highland, Scotland, or the United Kingdom. In fact, it is an international challenge and is faced across the public sector where many professions, such as education, are also facing significant recruitment and financial pressures. However, although not unique to Caithness, the challenges here are greater than in most other areas largely due to the rural and remote nature of the area. Rural depopulation plays a significant role in these challenges.

A summary of the need for change and the resulting impact on the organisation is provided in **table SC16**.

Table SC16 – Summary of 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:
More people living longer with complex needs, less people of working age to provide care	Existing capacity will be unable to cope with future projections of demand. Insufficient workforce to care for older population	Service sustainability will be at risk if this proposal isn't implemented now

What is the cause of the Need for Change	What effect is it having, or likely to have, on the organisation?	Why action now:
Half of the current NHS staff in Caithness are aged over fifty	Not enough staff to deliver care	Service sustainability at risk, high risk of service collapse
Only two-thirds of nursing and adult social care posts are filled on first advert	Unable to recruit suitably qualified staff	Service sustainability at risk, high risk of service collapse
Inpatient and 24/7 services are split across three hospital sites and two care homes	Unable to sustain 24/7 rotas, temporary closure of out of hours services	High risk of service collapse
Patients are not being cared for in the most appropriate place	Delayed discharges, increased cost, less efficient service, increasing demand for hospital beds	Growing ageing population, significant impact on demand for inpatient care expected by 2030, worsening financial situation
Too many people are having to travel long distances for outpatient appointments	Increased cost and inconvenience for patient, increased carbon footprint	Better patient experience, reduced carbon footprint
Services and teams based in multiple locations	Barrier to effective communication and multi-disciplinary team working	Need to work more efficiently and improve communications
Buildings no longer functionally suitable to deliver changing service need	Inefficient use of space, some areas too big, some too small, poor flow	Required changes to service model restricted by or not possible within current estate
Some buildings have a high level of unsatisfactory physical condition and backlog maintenance.	Increased safety risk from outstanding maintenance and inefficient service performance. Increased cost associated with addressing backlog and/or leasing alternative premises	Building condition, performance and associated risks will continue to deteriorate if action isn't taken now
Deteriorating economic climate in Caithness as result of the Dounreay closure and COVID-19	Increase in levels of deprivation, increased health inequalities and corresponding increase in demand for services	Service will be unable to meet future demand, sustainability at risk with potential loss of workforce to more urban areas

2.3 What is Trying to be Achieved?

These ambitious proposals involve a redesign of adult health and social care services in Caithness and aim to shift the balance of care from hospital-based to the community, with a focus on prevention. Two new Community Health and Wellbeing Hubs will be created in Wick and Thurso, bringing together community integrated teams with GP practices, registered care homes, community hospital beds, supported living accommodation and community and third sector support. Recognising that our workforce is our greatest asset, this will require investment in our community health and care teams to provide care closer to home in line with

national and local strategy, and to reduce pressure on already stretched hospital services.

The plans also include a reconfiguration of Caithness General Hospital, the rural general acute hospital in Wick, to allow the building to support the delivery of modern healthcare now and into the future. This will include addressing the need for increased provision of single-room accommodation with en-suite facilities.

Whilst this business case has a specific focus on investment in local health and care services, in line with the place-based approach, we recognise that the solution is wider than health, and true partnership working is needed to address health inequalities, deprivation, economic and workforce challenges and really make Caithness an attractive place to live and work. This will improve recruitment and retention and redress the balance of working age to older age population. Key to the success of this programme of improvement is building on the community resilience that came to the fore during the pandemic, and we will continue to work with our communities and the voluntary sector through the Community Planning Partnership to build health for all.

2.3.1 Investment Objectives

In seeking to address the issues outlined in this document, Investment Objectives (person centred, safe, effective, value and sustainability) were agreed to underpin the proposed new model of service provision (**table SC17**).

Table SC17 – Investment Objectives

Effect of the need for change on the organisation:	**What has to be achieved to deliver the necessary change? (Investment Objectives)**
Increase in levels of deprivation, increased health inequalities and corresponding increase in demand for services	Improve user experience **(Person centred)**
Existing capacity will be unable to cope with future projections of demand. Insufficient workforce to care for older population	Improve user experience **(Person centred)**
Barrier to effective communication and multi-disciplinary team working	Make best use of resources **(Value and sustainability)**
Unable to sustain 24/7 rotas, temporary closure of out of hours services	Improve safety of service delivery **(Safe)**
Not enough staff to deliver care	Make best use of resources **(Value and sustainability)**
Unable to recruit suitably qualified staff	Make best use of resources **(Value and sustainability)**
Delayed discharges, increased cost, less efficient service	Improve access to services and care **(Effective)**
Increased cost and inconvenience for patient, increased carbon footprint	Improve access to services and care **(Effective)**
Inefficient use of space, some areas too big, some too small, poor flow	Improve quality and effectiveness of accommodation **(Safe and effective)**
Increased safety risk from outstanding maintenance and inefficient service performance	Improve quality and effectiveness of accommodation **(Safe and effective)**

Table SC18 outlines how our proposals respond to our agreed investment objectives.

Table SC18 – How the Proposal Responds to our Investment Objectives

Investment objective	**Description**	**How proposal responds**
Improve user experience **(Person centred)**	Services which focus on the individual, their preferences, and choices. Respects peoples' dignity and privacy and provides services which demonstrate compassion, continuity, and shared decision-making.	Integrated and multidisciplinary approaches with greater co-location will support holistic and anticipatory care. Redesign will support clarity on clinical care pathways. Better team working and effective communication will reduce admissions and support timely discharges. Implementation of new GMS contract and integrated teams with Single Point of Access will support more people to be managed at home. Investment in community teams and working with our partners will ensure that we deliver the right care, in the right place, at the right time.
Improve access to services and care **(Effective)**	Provide easy and convenient access to the maximum range of services that can be safely provided locally.	Greater use of technology such as Near Me, to support outpatient consultations and reduce the need for travel. Creation of a Single Point of Access for patients in Caithness, with clinical and social triage for patients looked after by the Multi-Disciplinary Team. This will provide a single access point to Caithness-based NHS Highland services (excluding Primary Care).
Improve quality and effectiveness of accommodation **(Safe and effective)**	Provide modern, fit for purpose, well planned and designed accommodation which supports and facilitates effective and efficient service delivery and provides a pleasant and calming care environment for patients. An appropriate, clean, and safe environment will always be provided for the delivery of services.	New purpose-built facilities will be more functionally suitable to support new ways of working and the modern delivery of health and care services. Facilities will have single rooms and en-suite facilities and will be easier to clean. Immediate community will benefit from improved access to health.
Improve safety of service delivery **(Safe)**	There will be no avoidable injury or harm to people from health and social care services and this will consistently be provided across the full range of service provision, wherever it is delivered.	Reduction in 24/7 rotas from five to three will make services safer and more sustainable, with improvement in business continuity. Improvements in recruitment, retention and staff absence will reduce pressure on teams.
Make best use	Ensures that all available	Life-long learning and continuous

of resources **(Value and sustainability)**	resources (staff, finances, buildings, equipment etc.) are used effectively and efficiently to support services and provide good value for money i.e. maximises the benefits to patients from investment in staff time, buildings etc. Minimises waste, duplication and inefficient working practices	professional development will provide all health and social care staff with the opportunity to grow and develop and to experience different roles and opportunities. New roles, such as Advanced Nurse Practitioners and Rural Practitioners, have been developed to help meet the changing demands on services in a rural location. Staff working in the community will be equipped with latest technology allowing them to access information without having to be based in an office. The new facilities will be more efficient and will reduce running costs. Overall better use made of all facilities as they will be functionally suitable to support the services provided. Reduction in the number of leases and buildings will lead to improved efficiencies and reduced cost of our estate.

2.3.2 Benefits

The benefits of the proposed service change were developed by a multi-stakeholder group in November 2019 and subsequently refined by the Project Team. This provides a framework to assess how successful this programme of improvement will be at delivering our investment objectives and expected benefits and to demonstrate that the investment has delivered value for money once implemented.

The benefits register, attached at **Appendix SC15,** identifies the expected benefits arising from the service change and are aligned to NHS Scotland's strategic investment priorities. It includes a baseline and target measurement and gives a priority level to each benefit. Some of the key benefits include:

- Improved support to enable people in Caithness to live independently in the community, and improved community resilience;
- Increase in the number of episodes of care delivered locally in Caithness, and a reduction in unnecessary attendances;
- Better co-ordination, communication, and reduced duplication;
- Reduced staff absence, improved recruitment and retention and a workforce who are valued and supported, thus making services more sustainable;
- Reduction in emergency attendances / admissions, waiting times and length of stay;
- More sustainable services that can respond to the demographic challenges;
- Improved quality, condition and functional suitability of the health and social care estate; and
- Making Caithness an attractive place for people to live and work.

Detailed planning will be undertaken during Outline Business Case development to create a robust and realistic benefits realisation plan that will evidence the mechanisms required to ensure all benefits are ultimately achieved.

2.3.3 Risk Management

A project risk register, attached at **Appendix SC16,** was developed and agreed by the Project Team in October 2019 and is reviewed and updated regularly at Project Team meetings.

The most significant risks to delivering the project, and the mitigation strategy to manage these, is outlined in **Table SC19** below. Electronic systems, data sharing and robust service information are all key risks at this stage, which will require robust mitigation by the Project Team during Outline Business Case phase.

Table SC19 – Significant Project Risks

ID	DESCRIPTION	MITIGATING ACTIONS	RISK RATING
	Funding Risks		
21	New service model costs exceed current budget and is unaffordable	Bed modelling exercise to identify the impact on inpatient services if no investment in community services is made. Clear costing of current and proposed service model at OBC stage to identify affordability once service model detail further advanced and workforce & accommodation requirements better known	20
35	Current funding levels may reduce due to organisational demands i.e. recurring savings that need to be achieved	Regular engagement with NHSH Programme Management Office and Senior Management. Escalate to Project Board / SRO	15
	Operational and Business Risks		
31	Unable to recruit suitable staff for new posts	Involve staff, early identification of training requirements, succession planning. Seek to support overseas workers to relocate.	16
	Technology Risks		
17	eHealth solutions are not fully in place to support new service model	Set up eHealth workstream with appropriate resource to deliver, clear communication and co-ordination with eHealth re: Highland-wide strategy and timescales. Seek funding and support from SG / NHSH to ensure delivery of project digital requirements is adequately resourced	16
37	Primary care / community care / secondary care systems incompatible, unable to share patient information	eHealth is a dedicated workstream of the project. External consultant commissioned to define the eHealth deliverables. This will inform the work and resources required to deliver	16
45	Lack of data sharing agreement with GPs and other providers impacts on ability to deliver planned service model	Escalated to SRO / Project Board members to influence GP-sub-group data sharing agreement. Data protection impact assessment submitted Dec 2020. Local data sharing agreements being explored.	20 ISSUE

ID	DESCRIPTION	MITIGATING ACTIONS	RISK RATING
	Construction & Programme Risks		
40	Covid-19 pandemic impacts on capacity to progress project work, resulting in project delay	Dedicated project resource progressing the IA and service model. Programme updated to take account of ongoing pandemic impact	20 ISSUE
42	Covid-19 pandemic impacts on construction working practices, resulting in increased programme and increased delivery cost	External guidance sought on likely impact and this was incorporated in to cost planning	16
51	Insufficient internal resource to deliver 2 new Hubs and Caithness General reconfiguration within timescales agreed by Programme Board, project delay	Prepare resourced programme to identify gaps. Consider rescheduling of design and procurement phases to match available resource. Seek external resource to support delivery of agreed programme.	16

2.3.4 Constraints and Dependencies

2.3.4.1 Constraints

There are several significant constraints on the project finances and resources.

- The redesigned service needs to be achieved within NHS Highland's existing recurring revenue allocation, and within the current Caithness budget. Following the activity modelling exercise (section 2.2.3.1), this has been identified as a high risk for the project.
- The associated infrastructure improvements need to be delivered within the capital allocations available to NHS Scotland.
- The project must be delivered within existing NHS Highland staff resources: project management, operational and clinical, eHealth and finance. This has impacted on the programme, and the COVID-19 pandemic has slowed progress as teams have prioritised the response and associated remobilisation efforts. This issue has been escalated to the NHS Highland Capital Programme Board.

2.3.4.2 Dependencies

Delivery of the redesigned services and associated infrastructure requirements is dependent on several factors.

- The Wick Health and Wellbeing Hub will potentially be subject to the acquisition of additional land.
- The accommodation brief and workforce requirements are dependent on accurate modelling of the impact of the service change on activity levels and on finalising the service model detail. The modelling work is complete, and development of the detailed service model is underway. This will inform the workforce plan and accommodation briefing information at Outline Business Case stage.
- A key dependency to the success of the project is the roll out of digital improvement initiatives across NHS Highland. The introduction of patient record scanning, an electronic patient record across all service disciplines, data sharing and standardisation of documentation across NHS Highland are essential to allow NHS Highland, Primary Care, Public Sector partners and Third sector organisations to work together in a patient centred way. eHealth is a specific project workstream and we are working with eHealth to map out the inter-dependences between these initiatives to ensure that they are delivered in line with project timescales.

- Service redesign work overlaps with several other government-led and NHSH-led initiatives, all in keeping with the common strategic direction and vision. The Project Team is maintaining close links with these project groups to avoid duplication and to ensure we continue to operate within agreed national and NHSH strategy.

These complex inter-dependencies are identified in the programme and progress is monitored by the Project Team.

3 Economic Case

3.1 Do Nothing / Do Minimum Options

The current arrangements and their challenges were described in detail in section 2 and are summarised in **table EC01**.

Table EC01 – Summary Description of the "Do Nothing" Option

STRATEGIC SCOPE:	DO NOTHING

Service provision:	• 24/7 care across five sites; increasingly difficult to sustain due to staffing challenges:
	  ○ One Rural General Acute Hospital; Caithness General Hospital in Wick
	  ○ Two Community Hospitals; Dunbar Hospital, Thurso and Town & County Hospital, Wick
	  ○ Two NHS-run Care Homes; Pulteney House, Wick and Bayview, Thurso
	• Community integrated teams dispersed across multiple sites, not strategically located.
	• Primary care delivered from GP practices in multiple sites

Service arrangements:	• NHS Highland lead agency for health and social care services. • Gaps in community service provision out of hours, putting pressure on hospital services. • Inpatient, Emergency Department, and some community services are stretched, evidenced by waiting times, waiting lists, bed occupancy and length of stay data. This has been exacerbated by COVID-19. • Over a third of Caithness residents are travelling long distances to access outpatient services
Service provider and workforce arrangements:	• 600 NHS Highland staff, half are over 50 years old • Difficulties in recruiting nurses and social care staff • Medical cover provided by Consultants, Rural Practitioners and GPs • Heavy reliance on locum and agency staff • Day services by NHS Highland and third sector • Contracts with third sector to support and deliver health and care services
Supporting assets:	• Medical equipment £3.6 million, 63% over 7 years old • Some radiology equipment is ageing, one x-ray due replacement, and two other machines due within 5 years • eHealth equipment £500k ranging from 1 to 11 years old • Buildings dispersed, not strategically located, many in poor condition and quality and the majority are not functionally suited to the services that they support
Public and service user expectations:	• Continued local provision, better access, and reduced travel

STRATEGIC SCOPE:	DO NOTHING
	• Continuity of service provision and no service disruption – currently there are multiple single points of failure and service disruption (e.g. Dunbar out of hours)

Some upgrades and changes have already been implemented or are being explored as a 'Do Minimum' option as these were essential to ensure continuity of service delivery. This includes:

- a five-year lease has been entered into for William Smith House as a staff base until the new Thurso Health and Wellbeing Hub can be implemented. This was necessary due to a deterioration in the condition of Davidson's Lane making it unfit for purpose;
- options are being investigated for a similar interim solution for the East Community Teams in Wick due to the buildings they are based in being over capacity with insufficient space to deliver essential services. This has been exacerbated by the pandemic and the requirement to set up a COVID-19 assessment centre; and
- improvements to develop a more sustainable workforce (section 2.2.2.2) including Rotational Consultants, Rural Practitioners and Advanced Nurse Practitioners.

3.2 Stakeholder Engagement

In response to public protests, in November 2017 the NHS Highland Board agreed a fresh approach to the redesign of services in Caithness. A series of independently facilitated workshops were held involving 55 - 70 local representatives including elected members, partner agencies, patients, members of the public and staff. These explored the case for change, developed and appraised possible future options, and identified a preferred option to take forward. Details and briefing packs for all events are available on the NHS Highland website **here**.

Through consultation with the Scottish Health Council, the NHS Highland Board considered the proposed changes to be major. In accordance with Chief Executive Letter CEL (2010) 4, a full public consultation on the proposals was carried out between 20th August and 23rd November 2018. This was the most extensive and comprehensive ever carried out by NHS Highland, and arguably by any NHS Board in Scotland. It had one of the highest response rates with strong local consensus (Diagram 8), culminating in approval of the major service change and preferred option by the Cabinet Secretary for Health and Sport on 2nd May 2019 (**Appendix EC01**). Full details are provided in the papers approved by the board on 29th January 2019:

- Board Cover Paper – **Appendix EC02**
- Summary Consultation Document – **Appendix EC03**
- Scottish Health Council Assurance Report – **Appendix EC04**

A timeline and details of consultation and engagement events with detail on key stakeholders involved is attached at **Appendix EC05.**

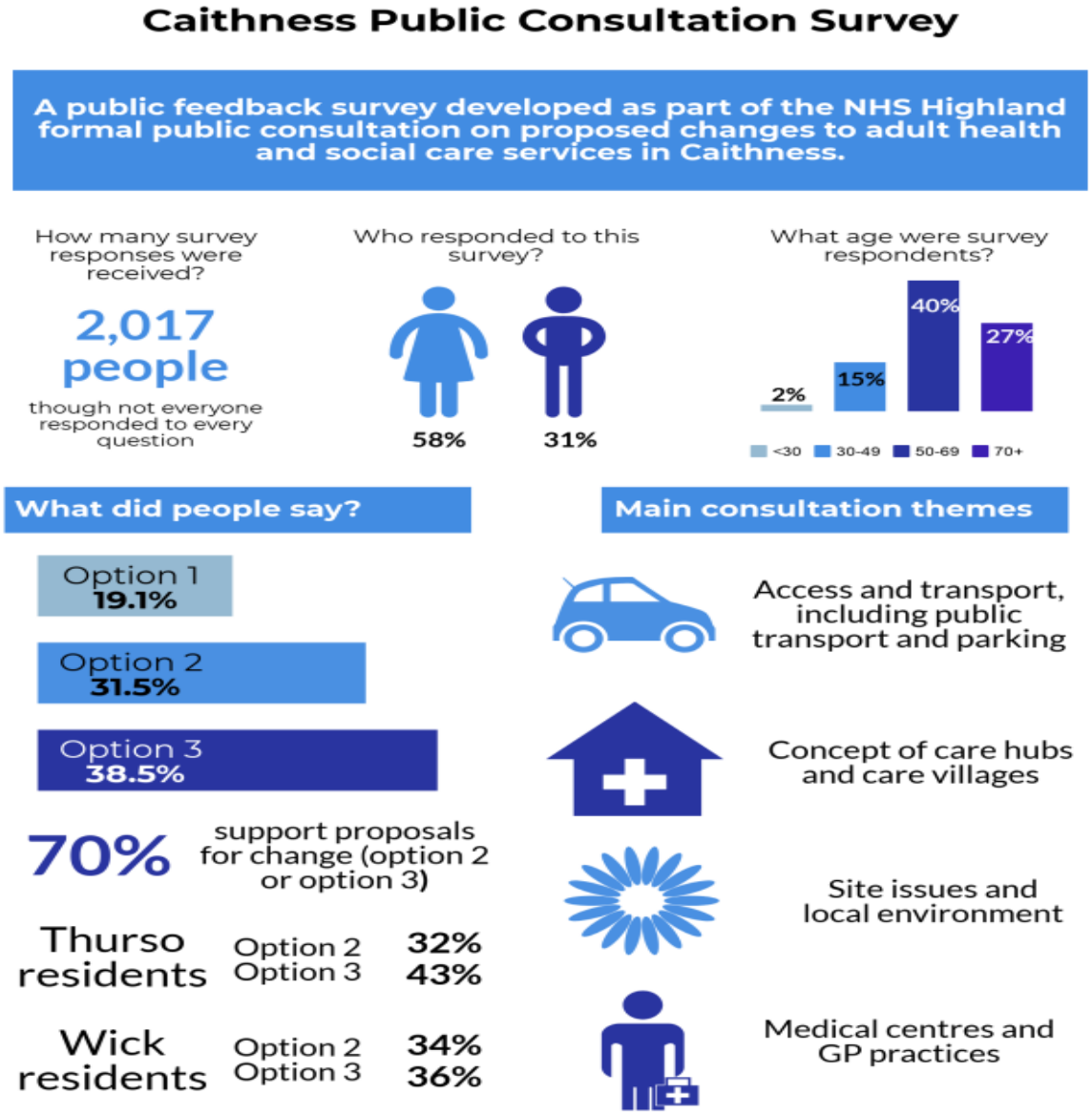
A summary of consultation activities and stakeholder support is highlighted in **table EC02**.

Table EC02 – Summary of Stakeholder Engagement and Support

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Patients / service users	Patients and service users were involved in the Options Appraisal,	• One in five households completed a survey with 2,017

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
	preparation of consultation materials and had the opportunity to take part in the public consultation. A survey form was sent all homes in the area. During the consultation there were over 100 events for patients and service users. Surveys specific to the possible re-location of NHS Highland managed practices in Thurso and Wick were also carried out. This included meetings with local Patient Participation Group.	responses received – a response rate of 14%. • Through this extensive process, seven out of ten people who responded to the consultation, supported the proposals (**Diagram 6**). • Specific feedback influenced the site for Care Hub in Wick (a new site was identified) and the decision to relocate GP Practices in Thurso and Wick.
General public	*As above*	As above. There were some concerns raised about maternity services which were out with the scope of the consultation. A specific piece of work through an independent facilitator was arranged as part of a separate process.
Staff / Resources	A comprehensive engagement programme with staff, including health, social care, and GP Practices, was also carried out. Staff also took part in public meetings to explain reasons why changes were necessary.	As above.
Other key stakeholders and partners	There was active engagement with community councils, local groups, local councillors, MSP/MP. There was also wider engagement with partner agencies - Scottish Ambulance Service, Scottish Fire and Rescue Service, Highland Council, Highlands and Islands Enterprise, and North Highland College.	• Letters of support for the proposals as documented in full consultation report. • The local councillors also proposed a motion of support at full Highland Council which was unanimously supported. Fully documented in consultation report.

Diagram 8 – Summary of Responses to Public Consultation Survey



3.3 Decision making process and non-financial benefits criteria

The decision-making process followed by the NHS Highland Board in partnership with stakeholders is outlined below:

1. Pre-engagement
2. Case for change
3. Agree benefits criteria to consider options against
4. Develop a long list of potential future options for change
5. Reduce this to a short list capable of delivering the agreed benefits criteria
6. Decision on preferred way forward as a basis for more widespread public consultation
7. Community engagement and public consultation
8. NHS Highland Board decision

Before participants sought to develop a long list of options, the group agreed seven non-financial benefits criteria to allow them to assess these. These criteria were prioritised by use

of a comparative matrix and scored collectively to identify relative priorities and weightings. There was overall broad agreement by the scoring groups and most groups rated the criteria in the same order. The agreed priorities and weightings are outlined below, noting that delivering sustainable services scored consistently highly:

1. Delivering sustainable services (22 points)
2. Meeting the demographic challenge (20 points)
3. Patient experience (15 points)
4. Staff experience (12 points)
5. Delivering services locally (14 points)
6. Addressing buildings issues (10 points)
7. Caithness as a proposition (7 points)

At the end of the prioritisation process the participants expressed the view that the issue of buildings and local service delivery scored considerably less than anticipated. It was felt that the process had helped to highlight that service delivery is more important than the buildings within which these services are delivered, and that the ability to deliver services in a sustainable way was more important than unsustainable local service delivery models.

Crucially, this process facilitated a dislocation between thinking about services and buildings that unlocked the decision-making process for many. This sense was summarised during the discussion process by the independent facilitator when, in reflection of the benefits criteria agreed by all stakeholders, he noted:

"*We have now agreed that our best measure of the successful delivery of health and social services in Caithness is not simply the number of hospitals we have – rather it is the services that we have now and, in the future, how effective they are and how easy it is for us all to access them".*

Full details of the benefits criteria and non-financial option appraisal process are available in the workshop report in **Appendix EC06**, and a summary is provided in the subsequent sections.

3.4 Long List of Proposed Solutions

It was noted, and agreed, by all participants that it would never be possible to include all theoretical options given the very high list of variables being considered, but that the long list should include all essential combinations. Key variations subsequently reflected within the long list of options generated therefore included:

- The number/range of services/sites/hubs involved;
- The location of facilities;
- Whether options included the refurbishment of Caithness General Hospital; and
- Whether options included the rebuild of Caithness General Hospital.

Overall, nine emerging themes or series of options were identified and agreed with participants, that represented around forty specific options. The nine themes are listed below, and full list of the forty options are provided in page 13 of the workshop report.

- Option 1 series: Do nothing (The status quo)
- Option 2 series: Three x 24-hour inpatient options
- Option 3 series: Two x 24-hour inpatient options
- Option 4 series: Two x "24-hour care hubs" plus Rural General Hospital (RGH) site

- Option 5 series: Two x “24-hour care hubs” including Caithness General Hospital (CGH)
- Option 6 series: New build RGH in Thurso +/- “care hubs” alternative
- Option 7 series: New build RGH in a new (central) location +/- “care hubs”
- Option 8 series: New build Caithness “combined hospital”
- Option 9 series: New build Caithness “acute health airport” +/- “care hubs”

These options were each developed to a stage where they included a descriptor, summary of change, impact, and a high-level SWOT analysis. A rational process was adopted in agreement with all participants to reduce this to a short list. This process removed options that:

- Failed to address “whole system issues”;
- Involved the rebuilding of any facility on a “like for like” basis on the same site;
- Clearly did not address any of the key challenges agreed;
- Were clearly not viable or counter intuitive; and that
- Failed to deliver previous commitments around local access to services.

The process also considered the estate implications and the physical environment.

This resulted in an initial shortlist of six, however further group discussion highlighted that there was no advantage in considering “24-hour inpatient options” further as they had effectively been replaced by “24-hour care hubs” in all instances. The group also agreed that the future of Town & County Hospital in Wick, a concept that has resulted in much public protest, should be considered within the formal option appraisal process. It was consequently agreed to sub-divide the “care hub” options to reflect the alternative locations of a Wick hub.

The amended shortlist taken forward for formal scoring was as follows:

- Option 1: Do nothing (the status quo)
- Option 4b (1): Two x “24-hour expanded care hubs” (Dunbar and Town & County) plus refurbished CGH
- Option 4b (2): Two x “24-hour expanded care hubs” (Dunbar and Pulteney House) plus refurbished CGH
- Option 5b: Two x “24-hour care hubs” (Dunbar and refurbished CGH)

3.5 Short List of Options

The shortlist was largely shaped by; a formal need to score the “do nothing” option, despite this being seen as unacceptable by all participants, a desire to develop combined “care hubs” within existing population centres as an alternative to the traditional disparate models of health and social care delivery, and a need to formally address historically challenging questions over hospital sites, particularly in Wick.

3.5.1 Description of shortlisted options

For ease of reading, from this point forward the shortlisted options have been re-numbered from the original nine themes and presented in line with the subsequent public consultation.

Option 1 as outlined in section 3.1 and summarised in the option appraisal as:

- Continue to deliver existing services from their present locations;
- Five 24/7 sites; three inpatient units at CGH, Town & County and Dunbar delivering the same services, plus two NHS care homes at Pulteney House (Wick) and Bayview (Thurso);
- No service improvements that require physical capacity change or building re-alignment;

- No investment in new buildings or facilities; and
- Accept all current risks associated with existing facilities and services.

Option 2 providing three x 24/7 sites including two care hubs located at the Dunbar and Town & County;

- A refurbished CGH, with improved Emergency Department, Outpatients and Day case;
- A care hub / care village in Thurso at the Dunbar site with a co-located range of services currently delivered from multiple sites in Thurso. This will include a Primary Care Emergency Centre (PCEC), NHS care home beds, community beds, palliative care, outpatients, day care, community teams, dental, and ideally GP services;
- A care hub / care village in Wick at the Town & County site with an expanded range of services currently delivered from multiple sites in Wick. This will include NHS care home beds, community beds, palliative care, outpatients, day care, community teams, and ideally GP services; and
- Bayview and Pulteney House would be surplus to requirements and available for redevelopment.

Option 3 providing three x 24/7 sites including two care hubs at Dunbar and Pulteney House;

- As per option 2 however Wick care hub / care village based at Pulteney House site; and
- Bayview and Town & County sites surplus to requirements and available for redevelopment.

Option 4 providing two x 24/7 sites including two care hubs at Dunbar and Caithness General Hospital;

- A refurbished CGH, with improved Emergency Department, Outpatients and Day case;
- A care hub / care village in Thurso at the Dunbar site as described in option 2 above;
- A care hub / care village at the CGH site with an expanded range of services as described in option 2; and
- Bayview, Pulteney House and Town & County would be surplus to requirements and available for redevelopment.

Options 2, 3 and 4 all include investment in community services.

3.5.2 Option scoring

The group then proceeded to formally score each of the four options against the agreed benefits criteria (section 3.3), applying a score ranging from 1 (could hardly be worse) to 10 (perfection). Participants were provided with detailed information as a basis for discussion and debate, which included;

- The above summary descriptions;
- An independent SWOT (strengths, opportunities, weaknesses, threats) analysis (**Appendix EC07**); and
- An appraisal of relevant service and estate / facility issues presented by the Area Manager and Head of Estates respectively.

3.5.3 Scoring Outcomes

The output from this scoring process is presented in **table EC03**.

Table EC03 – Output from scoring of shortlisted options

Option	Description:	Score (out of 1,000)
1	No change – current arrangements continue	277 (benchmark)
2	Care Hub / Village located at Dunbar Hospital site (Thurso) and Town & County Hospital site (Wick)	683 (alternative)
3	Care Hub / Village located at Dunbar Hospital site (Thurso) and Pulteney House (Wick)	783 (preferred)
4	Care Hub / Village located at Dunbar Hospital site (Thurso) and Caithness General Hospital site (Wick)	510 (rejected)

The status quo (Option 1) received a low score of 277 out of 1000, confirming that participants did not feel it was a good fit to address the challenges for the future.

Option 3 (Wick Hub in Pulteney House) scored as a clear preferred option with 783 out of 1000 and Option 2 (Wick Hub at Town and County) the next best, scoring 683.

Option 4, locating the Wick Care Hub at Caithness General Hospital, scored the poorest of the three change options, with 510 out of 1000. There was a general feeling from participants and senior managers that having the Care Hub / Care Village at Caithness General Hospital was not practical in terms of: 1) constraints relating to the site; and 2) being a busy acute site it did not fit with the Care Hub / Care Village concept. Therefore, this option was not taken forward to public consultation.

Sensitivity analysis was conducted to explore the potential impact of a range of variances on the numerical outputs from the option appraisal process. In all scenarios, Option 3 remained the preferred option and the overall ranking order did not change, indicating that this is a robust conclusion.

3.5.4 Preferred option and site selection

3.5.4.1 Public Consultation Outcome

The preferred option, Option 3 Care Hub / Villages at Dunbar Hospital and Pulteney House, was taken forward to public consultation. Public views were also sought on Option 2, Wick Care Hub / Village at Town and County. The status quo was included as the benchmark against which other options can be compared.

During the consultation, views were also sought on the opportunity to move NHS Highland salaried GP practices into the Care Hubs in Thurso and Wick.

As illustrated in diagram 6 (section 3.2), the outcome of the public consultation was as follows:

- Option 1, do nothing, was least preferred (19.1% of respondents);
- Option 2 was well supported at 31.5% of respondents; and
- Option 3 was preferred, supported by 38.5% of respondents.

The difference between Options 2 and 3 narrowed considerably when considering responses from Wick only, suggesting that either option would be publicly acceptable.

The consultation also indicated general support for co-location of Primary Care (GP) services on the Care Hub / Village sites, however there was a desire to maintain a presence in the town centres.

3.5.4.2 Site Option Appraisal

Although it is unusual to consider site-specific options at the Initial Agreement stage of a

business case process, it was agreed that this was essential in Caithness because of the backdrop to the redesign process and strong positions that stakeholder groups had taken in relation to “existing bricks and mortar”. It was consequently agreed by all stakeholders, as an early component of option appraisal work, that specific sites should be considered. A failure to be clear on the potential impact of all options, on all sites, would simply defer these concerns and frustrations to a later date and potentially harm the process.

In addition to the Wick sites of Pulteney House and Town & County Hospital, an additional site was proposed by a member of the public through the consultation process; the “Noss” site adjacent to Noss Primary School. This was investigated by the Project Team and agreed as a viable option, creating a third proposed solution:

- Option 3a; Care Hub / Villages at Dunbar Hospital, Thurso and Noss, Wick.

Pop-up Shop events were held in September and October 2019 to inform the public of the additional site option and allow people to feedback opinions on the three proposed sites. This included the presentation of a SWOT analysis of the potential Care Hub / Care Village sites (**Appendix EC08**).

Feedback from those who attended the pop-up shop events in September / October 2019 indicated that around 60% preferred the Noss site, 20% the Town and County site, and 5% Pulteney House. About 15% had no strong opinion or suggested alternative sites (which were deemed unsuitable).

The outcome from the events was considered by the Project Team in February 2020 and they confirmed the Noss site as their preferred option in principle for the Wick Care Hub / Care Village. This will be subject to further detailed technical and cost appraisal during Outline Business Case to allow a final recommendation to be made to the NHS Highland Board.

3.6 Proposed Solution

The proposed solution recommended to progress to Outline Business Case is the provision of two Care Hub / Care Villages located in Thurso and Wick, and a reconfiguration of Caithness General Hospital. This has clear support from service users, staff, the wider community, and our Community Planning Partners, and was approved by the Board and Cabinet Secretary for Health and Sport in 2019 as part of the major service change process.

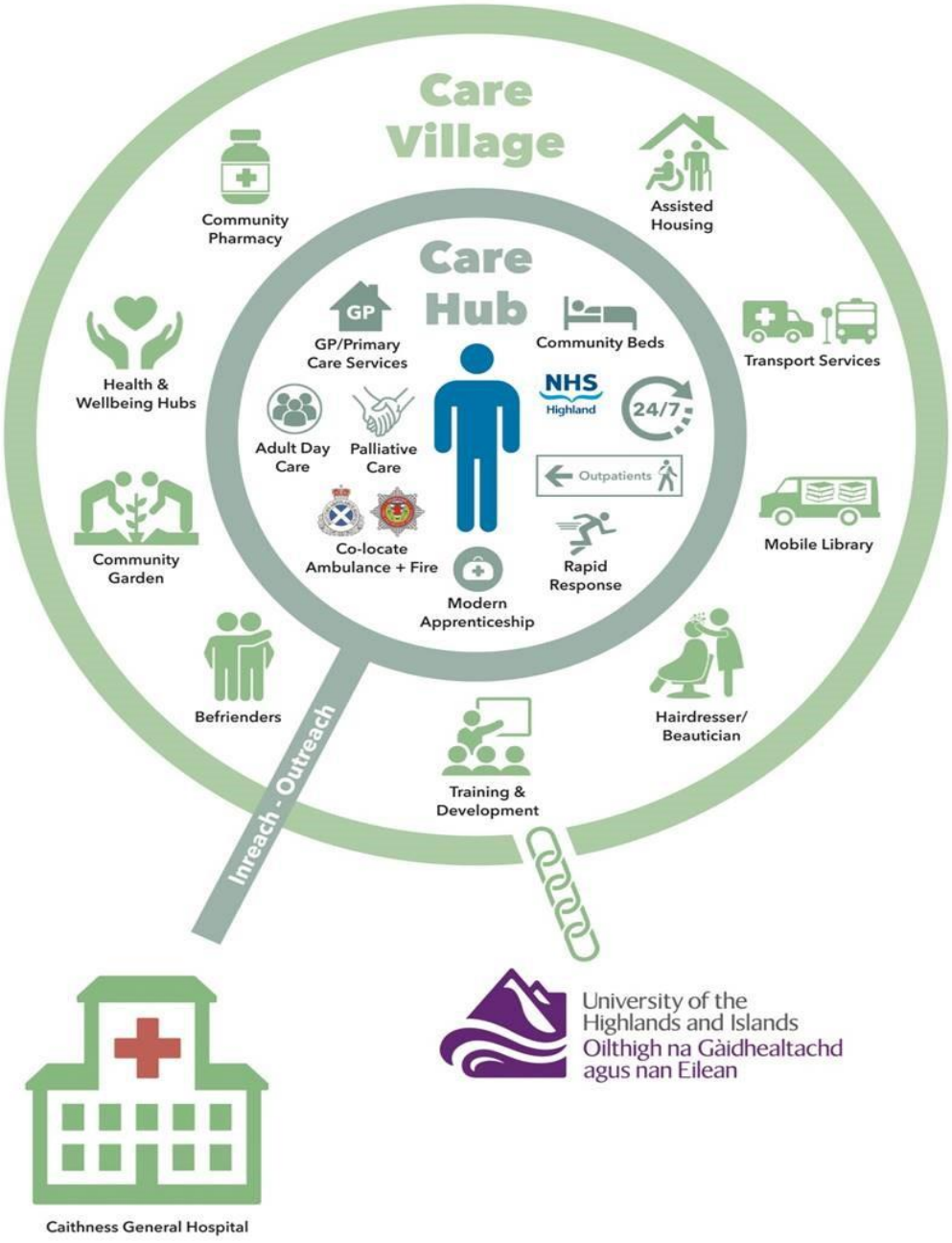
The Care Hub / Care Villages, also known as Health and Wellbeing Hubs, for Thurso and Wick would:

- Bring together, onto one campus, forty 24/7 Community Care Beds, Palliative and End-Of-Life Care, Respite Care, Day Care Services, NHS Near Me, Outpatients, the Community Integrated Team including Community Mental Health, Vocational Support, and other staff groups and NHS services as appropriate, delivering an expanded range of services;
- Have dual registration to provide nursing and residential care;
- Provide Primary Care services including NHS Highland salaried practices in each site, and possibly independent practice;
- Potentially include a Scottish Fire & Rescue Service base on both sites;
- Be slightly different in each location depending on local circumstances, needs, opportunities and constraints. The following services will be provided on the Thurso site only;
    - A Primary Care Emergency Centre (PCEC) (to be delivered from CGH in Wick);
    - Scottish Ambulance Service base (to be located at CGH in Wick);

    - Dental Services (in Wick the Public Dental Service is located in Lochshell Dental Clinic and at CGH);
- Provision of some Assisted Living Units as part of the Care Village element. These houses or flats would be designed to help people live independently for longer, built in conjunction with an independent provider.

Diagram 9 was used during the engagement sessions to illustrate what a Care Hub / Care Village could be anticipated to provide.

Diagram 9 - Care Village / Care Hub concept from Public Consultation Document



A reconfigured Caithness General Hospital, building on initial work funded by Scottish

Government in 2020/21, would provide:

- Inpatient acute admission, post-acute and rehab beds, with an increase in single room and en-suite provision to meet current guidance;
- An Emergency Department, Primary Care Emergency Centre (PCEC) and Clinical Decision Unit, expanded and reconfigured to better support patient flow;
- A Scottish Ambulance Service base co-located with Emergency Care teams allowing for greater co-ordination and sharing of skills;
- A surgical suite including day case and endoscopy;
- An ambulatory care unit with infusion suite and renal services;
- An expanded Outpatient Department and NHS Near Me services – complete in 2021;
- Pharmacy and on-site diagnostics with laboratory services and a radiology department with CT scanner, x-ray and ultrasound; and
- A Community Maternity Unit with delivery suite, outpatient, and ultrasound scanning – complete in 2021.

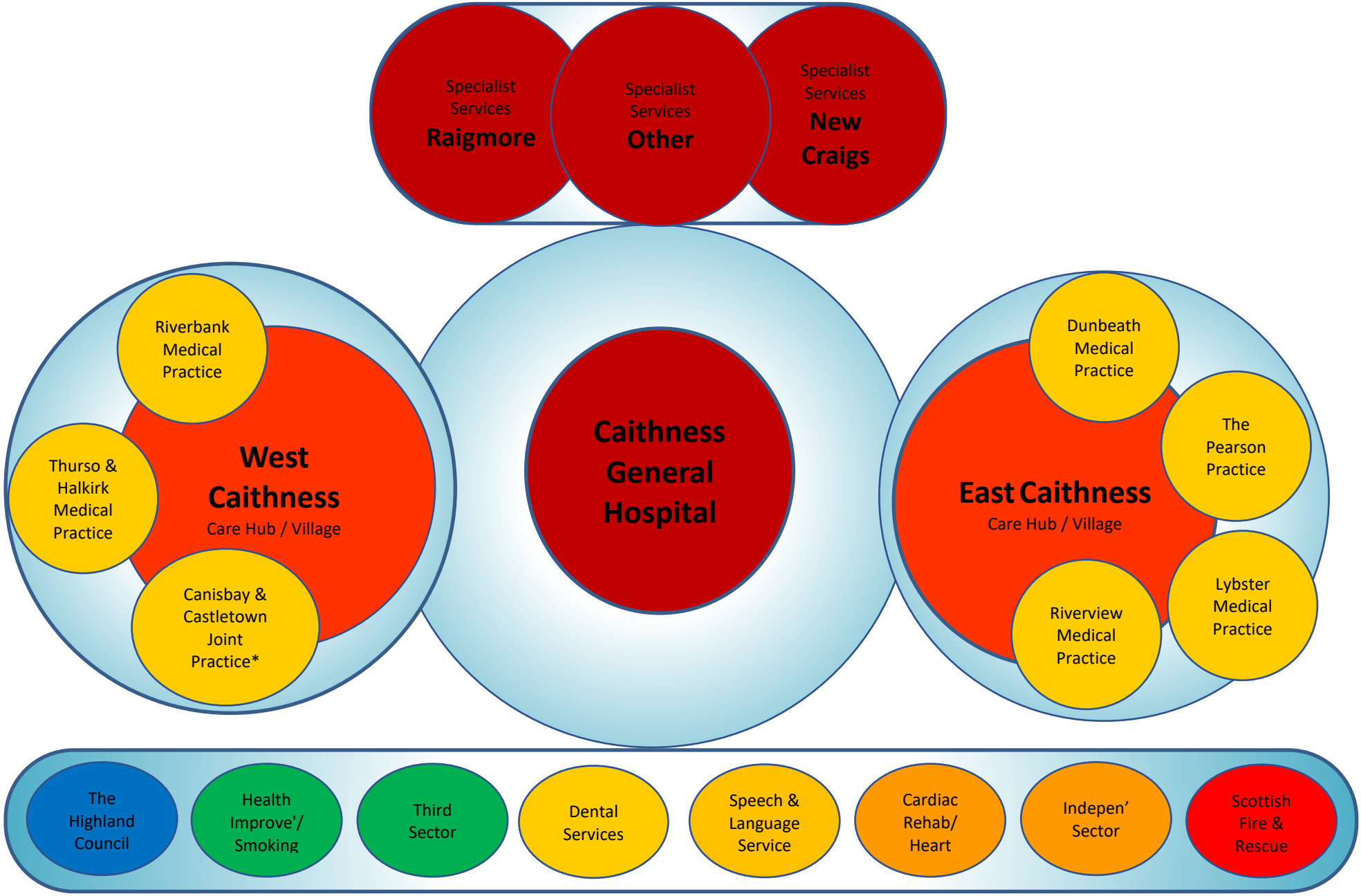
More specifically the care provided will be:

- Easily accessible through a Single Point of Access for Caithness;
- Multi - disciplinary in its delivery, ensuring that people have access to the right member(s) of the team who can best help with their care needs;
- In the person's own home or a homely setting, unless hospital care is necessary;
- Technology Enabled Care usage will be increased, to provide flexible solutions for individuals to stay at home for as long as possible and to reduce the need to travel for appointment;
- Anticipatory Care Planning will become the norm, to enable people to set out their wishes for future care and to guide healthcare professionals as they care for those nearing the end of life; and
- Based on shared decision making, reducing harm, waste and tackling unwarranted variation (realistic medicine).

An Equality Impact Assessment for the proposed redesign was completed in early 2021 to assess the potential impact of the proposed changes on groups with protected characteristics. This was ratified by the Project Team in March 2021 and is attached as **Appendix EC09.**

Diagram 10 overleaf shows what the proposed future model of care will look like, and the high-level health and care specification for the proposed future service model is attached at **Appendix EC10**. This was ratified by the Project Team in August 2021.

Diagram 10 – Proposed Future Model of Care



A summary comparison of the proposed solution and the "do nothing" option is outlined in **table EC04,** indicating some of the benefits of the proposed service change.

Table EC04 – Comparison of "Do Nothing" Option with Proposed Solution

STRATEGIC SCOPE:	DO NOTHING	PROPOSED SOLUTION

Service provision:	• 24/7 care across five sites
	  ○ CGH in Wick
	  ○ Dunbar Hospital, Thurso and Town & County Hospital, Wick
	  ○ Two NHS-run Care Homes; Pulteney House, Wick and Bayview, Thurso
	• Community integrated teams dispersed across multiple sites, not strategically located.
	• Primary care delivered from GP practices in multiple sites
		• 24/7 care across three sites
		  ○ CGH in Wick
		  ○ Care Hub / Village at Dunbar site, Thurso
		  ○ Care Hub / Village in Wick (site to be determined)
		• Community integrated teams co-located with bed-based services at Care Hubs
		• GP practices co-located with community services at Care Hubs
		• Third sector co-located with Care Hubs / Village

Service arrangements:	• NHS Highland lead agency for health and social care services. • Gaps in community service provision out of hours, putting pressure on hospital services. • Inpatient, Emergency Department, and some community services are stretched, evidenced by waiting times, waiting lists, bed occupancy and length of stay data. This has been exacerbated by COVID-19. • Over a third of Caithness residents are travelling long distances to access outpatient services	• NHS Highland lead agency for health and social care services. • Increased community service provision out of hours, supporting patients to stay at home • Reduced pressure on inpatient and emergency services as patients are given the right care in the right place at the right time. Reduction in waiting times, waiting lists, bed occupancy and length of stay. • Increased use of Near Me technology and increase in local outpatient service provision means less Caithness residents have to travel to access services
Service provider and workforce arrangements:	• 600 NHS Highland staff, half are over 50 years old • Difficulties in recruiting nurses and social care staff • Medical cover provided by Consultants, Rural Practitioners and GPs	• Improved recruitment of staff by promoting Caithness as a place to live and work • Increase in younger workforce, with more training and development opportunities locally

STRATEGIC SCOPE:	DO NOTHING	PROPOSED SOLUTION
	• Heavy reliance on locum and agency staff • Day services by NHS Highland and third sector • Contracts with third sector to support and deliver health and care services	• Reduced reliance on locum and agency staff to maintain services • Day services by NHSH and third sector • Closer working with third sector to support and deliver health and care services
Supporting assets:	• Medical equipment £3.6 million, 63% over 7 years old • Radiology equipment; one x-ray due replacement, two machines due within 5 years • IM&T equipment £500k,1 to 11 years old • Buildings dispersed, not strategically located, many in poor condition and quality and the majority are not functionally suited to the services that they support	• Reduction in older medical, radiology and IM&T equipment through investment in refurbished / new estate • Reduction in number of buildings, located in the right place, and functionally suitable to support the services delivered within them
Public and service user expectations:	• Continued local provision, better access, and reduced travel • Continuity of service provision and no service disruption – currently there are multiple single points of failure and service disruption (e.g., Dunbar out of hours)	• More local provision of services through use of Near Me and other technology, reduced travel • More sustainable local service with less service disruption

3.7 Indicative Costs

3.7.1 Accommodation Assumptions

To support this Initial Agreement, early accommodation schedules were developed to inform the site option appraisal exercise and allow development of indicative capital costs. These are based on high level assumptions, in line with the proposed solutions outlined above, and are purely for the purpose of informing indicative costs at this early stage. The final accommodation requirement will be fully developed at Outline Business Case stage in response to a detailed health and care specification.

The accommodation schedules are provided in **Appendix EC11**, with a summary of the estimated floor area associated with the relevant sites provided in **table EC05**.

Table EC05 – Floor Area estimates for each site

Sites (Wick)	Estimated Area (Build or Reconfiguration) m2
Caithness General Hospital	4,959
Wick Care Hub / Village (site to be determined)	6,457
Sites (Thurso)	
Thurso Care Hub / Village (Dunbar Hospital)	7,034
Total Accommodation m2	**18,450**

3.7.2 Indicative Costs for each of the Proposed Solutions

An estimated capital cost breakdown for each site option is provided in **Appendix EC12.** These are based on the accommodation schedules, feasibility sketches and assumptions outlined in the site option appraisal. A reminder of the proposed solution options is provided below.

- Option 1 – Do nothing
- Option 2 – Care Hub / Villages at Dunbar, Thurso and Town & County, Wick
- Option 3 – Care Hub / Villages at Dunbar, Thurso and Pulteney House, Wick
- Option 3a – Care Hub / Villages at Dunbar, Thurso and Noss, Wick

Table EC06 – Indicative Capital Costs of each option

Costs in £millions	Option 1	Option 2	Option 3	Option 3a
Capital Cost[17]	£5.1m	£64.9m	£68.7m	£64.1m
Whole of life capital cost[18]	£5.1m	£70.7m	£74.6m	£70.0m
Whole of life operating cost[19]	£823.6m	£844.4m	£844.7m	£844.5m
Estimated Net Present Value (NPV) of Costs[20]	£828.7m	£915.2m	£919.3m	£914.5m

Table EC06 indicates that Option 3 has a slightly higher capital and whole life capital cost than Options 2 and 3a. There is no significant difference between the estimated whole life operating costs for the three change options.

3.8 National Design Assessment Process

3.8.1 Achieving Excellence in Design Evaluation Toolkit (AEDET)

The existing NHS facilities were assessed by a multi-stakeholder group in January 2020 to establish a baseline. Two separate sessions were held, one for acute and one for community services, to correspond with the proposed new model of a reconfigured Caithness General Hospital and two Community Hub and Care Villages in Thurso and Wick. The relevant buildings and stakeholder groups involved are detailed in **table EC09**.

[17] Total estimated initial capital spend excluding VAT
[18] Discounted cashflows for capital spend (at NPV)
[19] 40-year cash outlays for operating and non-recurring revenue costs at NPV
[20] NPV of both capital and revenue cash flows

Table EC09 - Facilities and stakeholders involved in AEDET workshops[21]

EXISTING	PROPOSED	AEDET stakeholder group
Acute Services	Acute Services	- NHS staff (clinical, facilities, managerial and project) - Scottish Ambulance Service - Patient Council - Caithness Disabled Access Panel - Caithness Health Action Group
Caithness General Hospital	Caithness General Hospital	
Community Services	**Community Services**	- General Practice - Care Home - Day Services - Community Integrated Team - Mental Health - Allied Health Professionals - Health Improvement - Scottish Ambulance Service - Macmillan - Facilities, Estates, Management and Project staff - Caithness Voluntary Group - Highlands and Islands Enterprise - Patient representatives - Staff-side - Caithness Disabled Access Panel - Caithness Health Action Group
Wick Town & County Hospital	Wick Community Hub	
Pulteney House Care Home		
Old Wick Medical Centre (CGH site)		
Wick Medical Centre, Martha Terrace		
Dunbar Hospital	Thurso Community Hub	
Bayview Care Home		
Thor House day services		
Riverbank Medical Practice		
Davidson's Lane (closed and disposed of in April 2021)		

The resulting benchmark and target scores are detailed in **tables EC10 and EC11** below, and a description of each facility is provided in **Appendix EC13 (CGH)** & **Appendix EC14 (Hubs).** The benchmark AEDET scores support the need for investment, with existing facilities scoring poorly across all categories. Caithness General Hospital scored slightly better for build quality which supports the proposal for refurbishment and reconfiguration of the existing building.

Table EC10 – AEDET Benchmark and Target Scores, Caithness General Hospital

Descriptor		Benchmark	Target
Functionality	Use	1.7	4.3
	Access	1.2	4.4
	Space	1.9	4.4
Build Quality	Performance	3.0	4.4
	Engineering	3.3	3.8
	Construction	0.0 (N/A)	4.2
Impact	Character and Innovation	2.1	4.4
	Form and Materials	2.4	4.4
	Staff and Patient Environment	1.7	4.3
	Urban and Social Integration	2.7	4.5

[21] The AEDET workshop recorded a baseline of the facilities in use in January 2020. Some of these have changed in line with the "do minimum" described in section 3.1

Table EC11 – AEDET Benchmark and Target Scores, Care Hub and Villages

Descriptor		Benchmark	Target
Functionality	Use	1.5	4.3
	Access	1.6	4.4
	Space	2.2	4.4
Build Quality	Performance	1.8	4.4
	Engineering	1.6	3.0
	Construction	0.0 (N/A)	4.2
Impact	Character and Innovation	2.4	4.4
	Form and Materials	2.6	4.4
	Staff and Patient Environment	2.1	4.3
	Urban and Social Integration	2.7	4.5

3.8.2 Design Statements

The multi-stakeholder groups, detailed above, also developed and agreed non-negotiable design objectives for the proposed new facilities during workshops facilitated by Architecture and Design Scotland (A&DS). The full reports are attached at **Appendices EC15 and EC16**. The requirements for the facilities were viewed from the perspective of patients, staff, and visitors.

3.8.2.1 Caithness General Hospital

The Patient Perspective
There was consensus that the facility should be welcoming and not ostentatious, with clear intuitive wayfinding and shelter from the elements. Patients should be able to access help and support quickly on entering the building, only having to tell their story once. The facility should be accessible to people with a wide range of needs and support privacy and dignity.

The Staff Perspective
Staff were looking for the building to provide shared social space and separate non-public routes to allow them to come together informally and build good working relationships. The facility should have standardised room layouts and be designed to allow services to flex and change without the need to make physical alterations. Staff were keen for the building to support a friendly, lively, modern culture, enabling agile working. A key requirement is the provision of training facilities to enable closer links with further education providers such as University of Highlands and Islands and North Highland College, thus improving staff recruitment and retention and creating a more sustainable service.

The Visitor / Carer Perspective
Visitors, family, and carers would like to see a café near the main entrance and quiet spaces away from clinical areas to allow them to take time to themselves where needed.

Common themes for all groups were that it was very important for the building to have a strong Caithness identity with use of local materials and art. There should also be easy access to views, external space, daylight, and fresh air.

3.8.2.2 Community Care Hub and Villages

The Patients Perspective
For patients it is important that the building(s) and grounds are welcoming, homely, and safe, provide reassurance and invite you in. The facility should be an integral part of life in the town, with a non-clinical feel and positive connections to local amenities. It should be easy to use, with direct accessible routes and the internal and external areas should work well together.

The residential and day care areas should have their own distinct domestic identity which feels different from the public areas. Each resident must feel that their space is their own, as this is their home. The design should respect personal privacy and dignity and promote independence.

The Staff Perspective
Staff would like to have a facility that is easy and reliable to get to. The layout should support different staff groups to come together with shared ownership of the space to facilitate them to build working relationships. Spaces should be flexible in their use and working areas should be friendly, modern, and innovative. Social space should be away from the public areas to allow rest and relaxation when off duty, and the building should be zoned appropriately to support 24/7 and daytime use.

The Community Perspective
Family and friends of residents should be enabled to take part in their care and be supported in their own needs. Shared landscapes and amenities should have a public feel, encouraging all members of the community to access them.

A strong common theme was that the facility must be a community resource, integrated with daily life.

4 Commercial Case

4.1 Procurement Strategy

NHS Highland will lead on the procurement of the building solutions. The designated procurement vehicle for community health care projects exceeding £750k is the Scottish Futures Trust hub initiative, and for acute facilities it is Frameworks Scotland.

- The reconfiguration and refurbishment of Caithness General Hospital in Wick is proposed to be delivered by Frameworks Scotland as a design and build capital solution (Frameworks 3 contract).
- It is proposed to deliver the new Health and Wellbeing Hubs in Wick (new build) and Thurso (part refurbishment, part new build) as a single contract with hub North Scotland Ltd. This would be either a design and build capital scheme or a design, build, finance and maintain revenue funded solution, to be determined by availability of capital funding and NHS Scotland strategy at Outline Business Case.

Alternative procurement options for the Health and Wellbeing Hubs, to be fully explored at Outline Business Case are:

- Delivery of elements of the Care Village concept, such as Assisted Living Accommodation, in conjunction with an independent partner; and
- Potential for the Highland Council to lead through the Council Borrowing Powers, as these buildings have a significant social care element.

In finalising the procurement and funding options, NHS Highland will continue to work closely with our Community Planning Partners including the Highland Council, and Dounreay, to select the final agreed procurement and funding routes for the Care Hub / Villages.

In addition to the above permanent solutions which are dependent on approval of the Full Business Case, some interim work has already or is in the process of taking place:

- Funding of £800k was provided by Scottish Government to implement the first phase of reconfiguration work at Caithness General Hospital, as detailed earlier (section 2.2.2.2). The architectural design, project management and supervision for this work was provided in-house. The Community Maternity Unit construction contract was procured using a two-stage tender process, providing opportunity for local contractors to bid for the works, and a Caithness-based contractor was appointed. The alterations to Outpatients and the Emergency Department were more minor and carried out by our in-house team using local sub-contractors where necessary.
- A five-year lease of office premises commenced in 2020 to accommodate the Community Integrated Teams formerly based at Davidson's Lane, until the new Health and Wellbeing Hub in Thurso is ready. The old premises have been disposed of in accordance with the property transactions handbook.
- The Highland Council, through the Adult Social Care partnership, is funding and project managing changes to Pulteney House care home, to implement a test of change to provide two step-up beds. This will allow us to assess one of the elements of the proposed new Local Care Model, to provide focussed support to individuals over a short period of time with a view to them returning home and living independently. This preventative approach aims to avoid hospital admission and strengthen community services.

4.2 Procurement Timetable

A timetable confirming the key procurement stages is provided in **table CC01** below, with further detail in **Appendix CC01**.

Table CC01 – Key Business Case, Design Development and Procurement Milestones

Milestone	Date
Lease concluded of William Smith House, Thurso – West Caithness community teams. COMPLETE	Apr 2020
Caithness General Hospital (CGH) phase 1 – concept design. COMPLETE	Jul 2020
CGH phase 1 contractor appointed. COMPLETE	Feb 2021
CGH phase 1 construction. COMPLETE	Sep 2021
Initial Agreement approved by SGHD	Nov 2021
Engage development partners (Hubs and CGH)	Q4 2021/22
Concept design complete (Hubs and CGH)	Q2 2022/23
Outline Business Case approved by SGHD	Q4 2022/23
Detailed design complete (Hubs and CGH)	Q2 2023/24
Full Business Case approved by SGHD	Q3 2023/24
Contract close (Hubs and CGH)	Q4 2023/24
Construction starts	Q4 2023/24
Construction complete (Wick and Thurso Hubs)	Q2 2025/26
Disposal of surplus buildings	Q4 2025/26
Construction complete (CGH)	Q4 2025/26

These high-level milestones assume that construction at Caithness General Hospital will be completed on a phased basis and therefore likely to take longer overall, however the benefits will be achieved in line with the completion of each phase.

5 Financial Case

5.1 Affordability

5.1.1 Capital Costs

Full details of the estimated costs are contained in **Appendices EC10 to EC14** and **Appendix FC01**, and the capital cost per option is detailed in **table FC01**.

Table FC01 – Indicative capital costs

Cost £millions	Option 1	Option 2	Option 3	Option 3a
Construction / refurbishment / Backlog Costs	£5.1m	£40.8m	£43.8m	£41.1m
Fees, surveys, prelims, consultants, advisors	-	£8.1m	£8.4m	£7.4m
Land Purchase	-	£0.0m	£0.1m	£0.1m
Demolition costs	-	£0.6m	£0.3m	£0.3m
Equipment	-	£0.3m	£0.3m	£0.3m
NHSH Project Costs	-	£1.3m	£1.3m	£1.3m
Optimum Bias	-	£13.7m	£14.6m	£13.6m
Total	**£5.1m**	**£64.9m**	**£68.7m**	**£64.1m**
VAT	**£1.0m**	**£12.7m**	**£13.5m**	**£12.5m**
Total Capital Costs	**£6.1m**	**£77.6m**	**£82.2m**	**£76.6m**

5.1.2 Revenue Costs

5.1.2.1 Non-recurring revenue

Full details are contained in **Appendix FC02**, with a summary provided in **table FC02.**

Table FC02 – Indicative non-recurring revenue costs

Costs in £millions	Option 1	Option 2	Option 3	Option 3a
Pay Costs				
Decant/Redeployment costs	-	£0.2m	£0.2m	£0.2m
eHealth project resource	-	£0.7m	£0.7m	£0.7m
Non Pay Costs				
Equipment	-	£1.5m	£1.5m	£1.5m
Building related costs	-	£0.3m	£0.4m	£0.4m
Backlog maintenance	-	£0.0m	£0.0m	£0.0m
Total Non-Recurring Costs	**-**	**£2.7m**	**£2.8m**	**£2.8m**

5.1.2.2 Recurring Revenue

Indicative revenue costs are shown in **table FC03** with further detail attached (**Appendix FC03**). They include an assumed £750,000 investment in community care staff across all three change options.

Table FC03 – Indicative recurring revenue costs

Costs in £millions	Option 1	Option 2	Option 3	Option 3a
Pay Costs Secondary Care Staff Community Care Staff	 £12.8m £10.9m	 £12.6m £11.6m	 £12.6m £11.6m	 £12.6m £11.6m
Non Pay Costs Direct Clinical/Care Costs Non Direct Clinical/Care Costs	 £12.0m £1.0m	 £12.0m £1.0m	 £12.0m £1.0m	 £12.0m £1.0m
Building Occupancy / Running Costs	£0.9m	£1.1m	£1.2m	£1.1m
Income Contribution / Costs	(£0.4m)	(£0.6m)	(£0.6m)	(£0.6m)
Total Recurring Costs	**£37.2m**[22]	**£37.7m**	**£37.8m**	**£37.7m**
Depreciation Costs	**£0.6m**	**£2.2m**	**£2.3m**	**£2.2m**

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

- An optimum bias of 26.9% has been applied to 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;
- Demolitions costs have been included where appropriate;
- 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 guidance;
- Capital cost options are based on the accommodation schedules, feasibility sketches and assumptions outlined in the site option appraisal using Building Cost Information Service (BCIS) Tender Price Indices from 2025, as detailed in **Appendices EC10 to EC14**; and
- Revenue and capital costs for Option 1 are in line with current activity and bed numbers.

5.1.3 Statement of Affordability

Based on the capital costs and assumptions identified in above, the proposed solution is not currently deemed to be affordable within the existing capital resources available to NHS Highland as outlined in the Local Delivery Plan. NHS Highland would require additional capital support from Scottish Government, estimated at this stage to be £76-82 million. There is a significant contingency built into this to cover optimism bias, as is typical at this

[22] Current budget

early stage.

The proposed service change will require additional recurring revenue in the region of £0.5-0.6 million, plus an additional £2.2 – 2.3 million associated with the depreciation costs for the capital, which is currently not affordable within the Caithness £37.2 million budget. Non-recurring investment of £2.7-2.8 million would also be required from Scottish Government. There is likely to be double running of some services until the new local care model is fully bedded in. The detailed work to develop workforce and accommodation requirements (section 6.4) will inform more definitive costs and a clearer affordability position at Outline Business Case.

Currently the Highland Council part-fund Adult Social Care services; the care home buildings are owned by them and run and maintained by NHS Highland. Any consequences on social care as a result of the proposals would require to be agreed in partnership with The Highland Council at Outline Business Case stage.

It must be emphasised that should we fail to invest in community services to support individuals to stay at home and prevent unnecessary hospital admissions, this will lead to additional strain on already pressured hospital services. The revenue impact of increasing inpatient provision at Caithness General Hospital by an additional 17 beds (as projected in section 2.2.3.1) is estimated to be around £1.2 million if we recruit staff to substantive posts. The “status quo” would become increasingly unaffordable and unsustainable, with an increasing risk of further locum and agency spend, therefore the actual cost of additional beds is likely to be much higher. In addition to a recurring revenue impact there would also be non-recurring costs associated with building alterations to increase bed numbers, which is not accounted for in the capital costs presented for Option 1 in **table FC01**.

The challenges in recruitment outlined in section 2.2.1.5 have historically resulted in an overspend at Caithness General Hospital (£0.8 million in 2020/21) due to high locum and agency staff use. A separate piece of work is underway in Highland to address this and the figures presented in table FC02 for Option 1 assumes that this will be successful, but this will be very challenging to achieve without a wholescale redesign of the model of care.

In short, Option 1 is likely to present a greater affordability risk to the organisation than the change options, strengthening the case for change and underlining why action must be taken now.

5.2 Impact of Proposals on Existing Assets

Some NHS Highland owned buildings will be subject to disposal under the proposed changes, dependent on the final site chosen for the new hub in Wick. The details are outlined in **table FC04** and details of the change impact on leased buildings is provided in **table FC05**.

Table FC04 – Proposed Future Use of NHS Highland Owned Buildings

Building	Location	Proposed Action
Caithness General Hospital	CGH site	Reconfigure and refurbish
Old Medical Centre	CGH site	Demolish
Town & County Hospital	Wick	Disposal (Options 3 and 3a) Demolish and rebuild (Option 2)

Building	Location	Proposed Action
Martha Terrace	Wick	Potential use for teams who do not require to be in the Care Hub, or alternatively, disposal[23]. To be determined at Outline Business Case.
Dunbar Hospital	Thurso	Reconfigure and refurbish, some demolition and new build.
Davidsons Lane	Thurso	Disposed of April 2021

Table FC05 – Proposed Future Use of NHS Highland Leased Buildings

Building	Location	Proposed Action
Pulteney House	Wick	Remove from Adult Social Care agreement (Options 2 & 3a) Highland Council to determine future use
Bayview House	Thurso	Remove from Adult Social Care agreement Highland Council to determine future use
William Smith House	Thurso	Do not renew lease (term ends April 2025)
Riverbank Medical Practice	Thurso	Do not renew lease (term ends Feb 2031) – alternative use may need to be found in meantime as cost of buying out the lease likely to be equal to remaining rent, costs and dilapidations. Consider use as satellite GP surgery.
Thor House	Thurso	Remove day services area from Adult Social Care agreement Highland Council to determine future use of space

5.3 Suitability and availability of resources

5.3.1 Infrastructure changes

It is recognised that a programme of change of this magnitude, with the briefing, design and build of three facilities running in parallel, is a significant amount of work. Adequate resourcing is essential to ensure that the work is delivered in line with the agreed programme.

The following in-house resources are proposed to support delivery of the building elements of the project. This has been built into the capital cost outlined in section 5.1.1. Many of these individuals are already in post and have been supporting the redesign and development of this Initial Agreement for the past 2 years or more.

- Senior Project Manager – 0.75WTE (in post)
- Clinical Advisor / Healthcare Planner – 0.75WTE (in post)
- Project Manager – 2WTE (1 WTE in post, 1 WTE proposed)
- Project Administration – 0.25WTE (in post)

An indication of the relevant experience and capability of key project leads is provided in **Appendix FC04**. The allocated Senior Project Manager has over 10 years of NHS project management experience and has delivered Frameworks and hub projects in the context of major service change. The Project Manager has provided estates project management support to this redesign since its early stages, and more recently designed and managed

[23] Assumptions for costs in section 5.1 assume disposal

the Community Midwifery Unit project at Caithness General Hospital.

5.3.2 Digital transformation

The local care model outlined in section 2.2.2.1 requires a transformation in the way health care information is managed and shared across health and social care service providers. We recognised at an early stage that this is critical to the successful delivery of the Local Care Model Multidisciplinary Team approach and the Single Point of Access. Funding support (£0.7m per annum throughout project) is sought from Scottish Government for this.

- Senior Project Manager – 0.5WTE (proposed)
- Data Analyst – 1WTE (proposed)
- Training and Facilitation – 2WTE (proposed)

5.4 Capital and Revenue Constraints

Delivery of the proposed solution is dependent on an additional capital allocation from Scottish Government, over and above what is currently included in the Board's Local Delivery Plan. The total capital cost for the infrastructure changes is currently estimated at £76-82 million, depending on the final site chosen for the Wick hub. During Outline Business Case the Project Team will work closely with Community Planning Partners to explore other potential sources of funding, which could reduce the amount required from Scottish Government.

The change proposals must be delivered within NHS Highland's recurring revenue allocation. They must also be delivered in accordance with the organisation's Standing Financial Instructions.

5.5 Commitment from External Partners

The Care Hub / Care Villages will be truly joint health and social care buildings and funding packages will need to be agreed with partners. Some assumptions have been made in section 5.1 to allow indicative costs to be presented, however appropriate allocations will be agreed with partners for Capital and/ or Revenue cost contributions at Outline Business Case (OBC).

Table FC06 outlines the relevant partner organisations and the status of their commitment at Initial Agreement. All partners have been fully involved in the process from the outset. Commitment in principle has been sought for this Initial Agreement, pending detailed OBC work to determine how organisations will work together to deliver the service change proposals, how this translates to accommodation requirements, and a fuller understanding of the potential costs.

Table FC06 – List of external partners and status of commitment to project

Facility	Partner Organisation	Status
Caithness General Hospital, Wick	Scottish Ambulance Service (SAS)	Commitment in principle. SAS are a member of the Project Team.
Wick Care Hub / Village	Scottish Fire and Rescue Service (SFRS)	Commitment in principle.
	Laurandy Centre	Commitment in principle.
	Caithness Mental Health Support Group	Desire to explore this as an option, further discussion required at OBC.
	Pearson Practice	No decision taken by practice. Further discussion required at OBC.

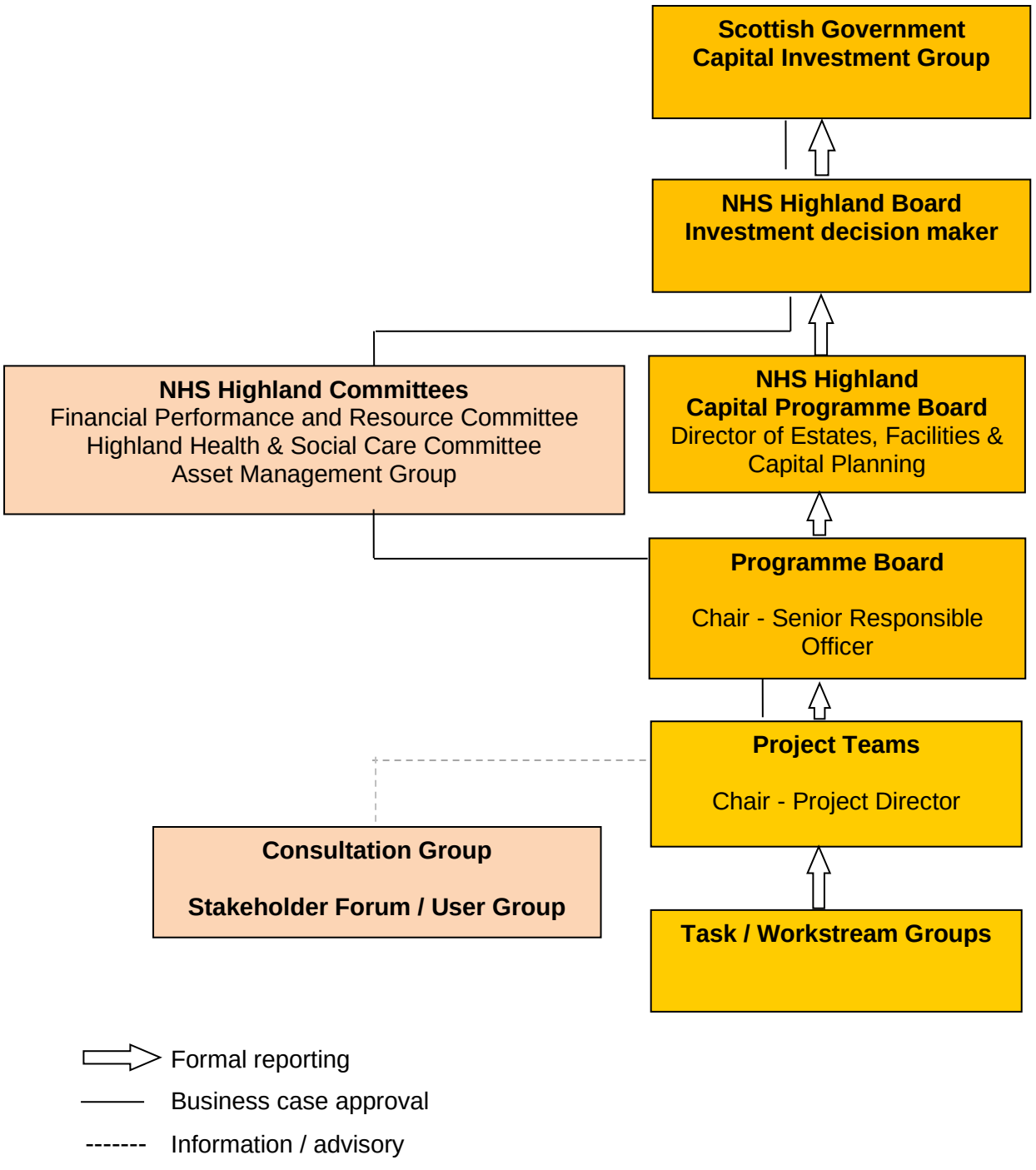
Facility	Partner Organisation	Status
Thurso Care Hub / Village	Thurso & Halkirk Medical Practice	Commitment in principle for Thurso practice to be co-located in the Care Hub.
	Scottish Ambulance Service (SAS)	Commitment in principle.
	Scottish Fire and Rescue Service (SFRS)	Commitment in principle.

6 Management Case

6.1 Governance Arrangements

Diagram 11 outlines the project's formal governance arrangements. The Programme Board was established in April 2020 with an agreed remit to provide governance to the Project Team delivering the service redesign and estates infrastructure elements. The Programme Board is chaired by the Senior Responsible Officer and the agreed role, remit and membership is attached at **Appendix MC01**.

Diagram 11 - Formal Governance Arrangements

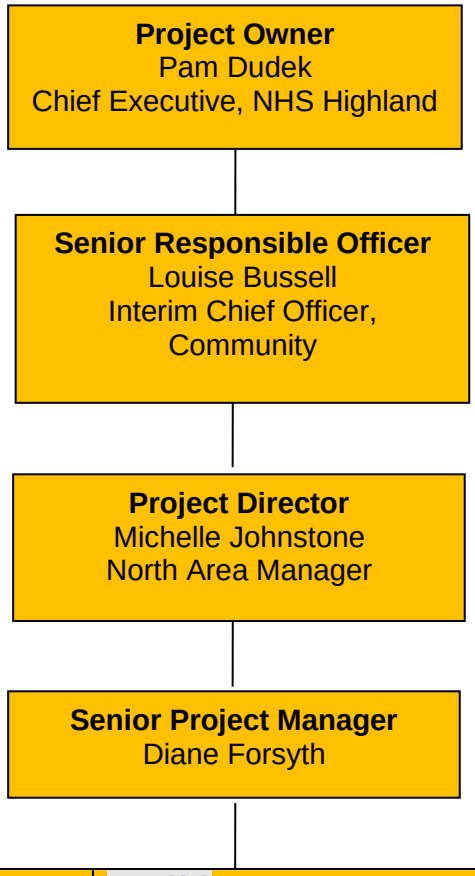


The remit of the Programme Board includes ensuring that the infrastructure elements of the project are delivered to agreed quality standards and this includes seeking assurance that the NHS Scotland Design Assessment Process (NDAP), NHS Assure and Sustainable Design and Construction (SDaC) guidance and processes are followed.

The Senior Responsible Officer for the project is Louise Bussell, Interim Chief Officer for Community Services. Project Director is Michelle Johnstone, Area Manager North. The Area Manager North is responsible for the provision of Health and Social Care services in Caithness and Sutherland. Senior Project Manager is Diane Forsyth. This post is responsible for supporting the Project Director to co-ordinate and manage all project activities and for development of the business case.

The Project Team meets monthly, chaired by the Project Director, and supported by the Senior Project Manager. An outline of the reporting structure is provided in diagram 12.

Diagram 12 – Caithness Redesign reporting structure



Workstream	Lead(s)	Project Manager
Supporting Services	Pam Garbe, RGH Manager	Kay Allan
Multidisciplinary Team (MDT)	Alison Brooks, GP Michelle Johnstone, Area Manager	Naomi Watson
Single Point of Access (SPOA)	Lesley Martin, Care at Home Manager	Morven Shone
Estates	Eric Green, Head of Estates	Zhen Ron Tan
Information Technology (IT)	Iain Ross, Head of eHealth	TBC
Workforce Development	Michelle Johnstone, Area Manager Christian Nicolson, District Manager	Morven Shone
Communications & Engagement	Christian Nicolson, District Manager	N/A

The leads and project managers for each project workstream are shown in diagram 12 and the capabilities and suitability of key project leads is provided in **Appendix FC04**.

The reporting structure will be subject to review as this programme of change moves forward. To mitigate the risk of insufficient resource to deliver infrastructure changes on three different sites in parallel, it is anticipated that the Estates workstream will separate in to two strands which could result in two separate but linked Outline Business Cases (to be determined). This is in line with our procurement strategy, with one workstream to deliver the alterations to Caithness General Hospital via the Frameworks Scotland process, and another to work with hub North Scotland Ltd to deliver the two Care Hub / Care Villages. This would have no impact on the overall governance structure and the two workstreams would report to the Project Team and Programme Board as outlined in diagrams 9 and 10.

Dedicated resource is required to support and deliver the Information Technology workstream, as outlined in section 5.3.2.

6.2 External Advisors

During the major service change consultation and Options Appraisal process (2018), facilitation and healthcare planning advice was provided by independent consultants Higher Ground Health Care Planning Ltd. Higher Ground also facilitated the multi-stakeholder benefits workshop in November 2019 and produced a draft Benefits Register for further development by the Project Team.

Service activity projections are reliant on robust modelling information, not only based on past trends, but to anticipate the impact of the new ways of working. External support was provided to NHS Highland's Planning and Performance team by specialist data analysts, Kurtosis, resulting in the output described in section 2.2.3.1.

An external consultant, ATOS, carried out a piece of work in early 2021 to start to develop the digital requirements for the local care model and inform the resources required to deliver the digital transformation.

As we move to Outline Business Case, we intend to seek external consultant support on the detailed work required for the GEM model for the economic case, as we recognise that we do not have these specialist skills in-house. This will also involve planning partners working on the ongoing Place-Based review.

Due to the transformational nature of the local care model, we feel it is crucial to ensure an appropriate degree of external support and challenge to refine and fully detail our health and care specification and the workforce and accommodation briefs that will flow from that. We propose to formally engage an external advisor as we move forward from Initial Agreement to Outline Business Case.

We anticipate appointing a consultant via the Frameworks 3 procurement route to project manage the contract for the design and reconfiguration of Caithness General Hospital. This is in line with our approach on previous Frameworks projects, and in recognition that our in-house capacity and experience is more limited in this area.

The expected costs for all anticipated external appointments are included in section 5.1.1.

6.3 Project Plan

The full project programme is outlined in **Appendix CC01** and a summary of high-level milestones provided in **table MC01**.

Table MC01 - High level project milestones

Milestone	Date
Service model (high level health & care specification) - complete	Jul 2021
Caithness General Hospital phase 1 construction complete	Sep 2021
Initial Agreement approved by SGHD	Nov 2021
Workforce plan	Nov 2021
Pulteney House step up beds operational	Q4 2021/22
Local Care Model MDT working in place	Q1 2022/23
Outline Business Case approved by SGHD	Q4 2022/23
Full Business Case approved by SGHD	Q3 2023/24
Construction starts	Q4 2023/24
Construction complete (Wick and Thurso Hubs)	Q2 2025/26
Disposal of surplus buildings	Q4 2025/26
Construction complete (CGH)	Q4 2025/26

6.4 Work needed to prepare Outline Business Case

To prepare for Outline Business Case (OBC), the immediate next step is to develop the high-level health and care specification (**Appendix EC10**) in sufficient detail to inform specific workforce requirements (the workforce plan) and accommodation requirements (the design brief). These will be developed by the workforce development and estates workstreams respectively.

The workforce plan will set out the current workforce arrangements against the future specification that will be required to deliver the agreed local model of care. This will include details of how we transition from one to the other, which forms the detail of the plan.

The design brief will comprise of a set of complex information including but not limited to;

- Proposed accommodation schedules for the two Care Hubs and Caithness General Hospital;
- Adjacency matrix for each of the facilities, setting out how departments and services inter-relate and work with each other;
- Service requirements;
- Design statements (Appendices EC15 & EC16);
- Relevant site information;
- Technical information outlining NHS Highland's requirements for compliance with relevant statutory and guidance documents; and
- Net zero carbon and energy strategies.

As stated in section 3.5.4.2, before we can issue a design brief for the Care Hub in Wick a further detailed technical and cost appraisal of the three site options is required for the NHS Highland Board to reach a final site selection decision.

Other prerequisites for the design brief are the development of an action plan in response to the NHS Assure IA Key Stage Assurance Review (KSAR) report (February 2022), and completion of an early OBC SDaC assessment as identified in the NDAP report (November 2021).

6.5 Summary of Governance Support

This Initial Agreement was submitted to all appropriate governance bodies within NHS Highland and planning partners as detailed in section 6.1, and then to the Scottish Government Capital Investment Group for consideration and approval.

Table MC02 sets out how members of the proposal's governance arrangements have been involved in its development and continue to support its current outcomes. Details of support from service users, the public, staff, and partner organisations were provided in section 3.2.

Table MC02 – Governance support for the proposals

Governance Group	Engagement taken place	Confirmed support for the proposal
Scottish Health Council (SHC)	NHS Highland (NHSH) first engaged with the SHC regarding proposals to redesign services in Caithness in January 2017. The SHC provided advice and support throughout this time, culminating in the formal public consultation process.	The SHC published a report on 18 January 2019 (**Appendix EC04**) confirming their view that: • NHSH has met national guidance, enabling local people to be informed about and give their opinions on the proposals; • NHSH demonstrated that it was listening and responding to views expressed during the process; and • The majority of people who took part had understood the case for change and it was clearly explained.
The Highland Council	• The Highland Council are fully supportive of the proposals and local councillors have been involved in their development since option appraisal stage. • Details of involvement at specific workshops and events are provided in **Appendices EC05-06**.	• The proposals received the unanimous backing of the full Highland Council at a meeting on 13 December 2018
Cabinet Secretary for Health & Sport	• The NHSH Board wrote to the Cabinet Secretary on 31 January 2019 seeking support for the proposals	• The proposed model of care and direction of travel was approved on 2 May 2019 (**Appendix EC01**)
Scottish Government Capital Investment Group (CIG)	• This Initial Agreement (IA) version 14.4 was submitted to CIG in October 2021 and presented to members at their meeting on 15 December 2021.	• Following discussion, CIG members recommended approval of this IA. • The Director-General for Health & Social Care wrote to NHSH on 16 February 2022 confirming approval of this IA.

Governance Group	Engagement taken place	Confirmed support for the proposal
NHS Scotland Design Assessment Process (NDAP)	• IA NDAP submission by NHSH on 18 October 2021. • Documentation updated and re-submitted on 15 December 2021.	• NDAP IA supported (unverified) status received 24 November 2021. • NDAP IA supported (verified) status confirmed on 16 December 2021.
NHS Assure	• IA KSAR submission by NHSH on 29 October 2021.	• IA KSAR report issued 10 February 2022 confirming support for the project.
NHS Highland Board	• The strategic context and case for change was presented to the NHSH Board on 24 July 2018. • The NHSH Board considered the outcome of the public consultation on 29 January 2019. • This IA (v14.4) was presented to the NHSH Board on 30 November 2021.	• Approval of option appraisal process and options to be consulted on (July 2018) • Endorsement of consultation process and recommendations (January 2019) • Endorsement of preferred way forward and next steps (January 2019) • The NHSH Board wrote to the Cabinet Secretary for Health and Sport on 31 January 2019 seeking approval of the proposals • The NHSH Board formally ratified the IA. The NHSH Chief Executive and Chair confirmed this in writing to CIG on 3 December 2021.
Highland Health & Social Care Committee (HHSCC)	• The outcome of the public consultation was presented to the HHSCC on 15 January 2019 • This IA (v14.3) was shared with HHSCC members for information	• Full endorsement of consultation process and the recommendations
Finance, Resources & Performance Committee (FRPC)	• This IA (v14.3) was presented to the FRPC on 21 October 2021	• The FRPC ratified the IA, subject to minor amendments to incorporate feedback
Asset Management Group (AMG)	• This IA (v14.3) was presented to the AMG on 27 October 2021	• The AMG ratified the IA
Programme Board	• This IA (v14.2) was presented to the Programme Board on 29 September 2021 and an updated version (14.3) issued for final ratification on 8 October 2021	• The Programme Board ratified the IA, subject to minor amendments to incorporate feedback

Governance Group	Engagement taken place	Confirmed support for the proposal
Project Team	• A draft of this IA was shared with the project team for comment • This IA (v14.1) was presented to the Project Team on 27 September 2021	• The Project Team ratified the IA, subject to minor amendments to incorporate feedback

6.6 Readiness to proceed

NHS Highland is in a strong position to progress these proposals to Outline Business Case, as indicated in the checklist below.

Table MC03 – Initial Agreement Checklist

Initial Agreement requirement	Response	Evidence
Is the reason made clear why this proposal needs to be done now?	Yes	Table SC16 in section 2.2.5
Is there a good strategic fit between this proposal, NHS Scotland's strategic priorities, national policies and the organisation's own strategies?	Yes	Section 2.2.4 and **Appendix SC13**
Have the main stakeholders been identified and are they supportive of the proposal?	Yes	Sections 3.2, 3.5.4.1 and 6.5.
Is it made clear what constitutes a successful outcome?	Yes	Benefits, section 2.3.2 and **Appendix SC15**
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	Benefits, section 2.3.2 and **Appendix SC15**
Have the main project risks been identified, including appropriate actions taken for mitigating against them?	Yes	Risk register, section 2.3.3 and **Appendix SC16**
Does the project delivery team have the right skills, experience, leadership and capability to achieve success?	Yes	Sections 5.3 and **Appendix FC02**
Are appropriate management controls explained?	Yes	Sections 5.4, 6.1 and 6.5
Has provision for the financial and other resources required been explained?	Yes	Sections 5 and 6.2

7 Conclusion

7.1 Is this proposal still a priority?

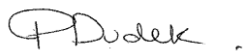
In revisiting the investment objectives outlined in section 2.3.1, it is clear from the case presented that the change proposals will deliver significant benefits. The priority scores are outlined in table C01 below.

Table C01 – Priority scores for investment objectives

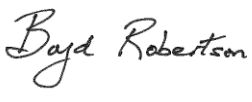
Investment Objectives	**Priority Score**
Improve user experience **(Person centred)**	4
Improve access to services and care **(Effective)**	5
Improve quality and effectiveness of accommodation **(Safe and effective)**	4
Improve safety of service delivery **(Safe)**	5
Make best use of resources **(Value and sustainability)**	5
TOTAL SCORE	**23**

7.2 Statement of Support

NHS Highland and its Community Planning Partners are absolutely committed to delivering the transformational service changes outlined in this Initial Agreement. With the additional pressures of COVID-19, the case for change is stronger than ever before. The organisation will provide the necessary resources and project workforce arrangements as outlined in this document to ensure successful delivery of the proposals and achievement of the much-needed benefits for the Caithness community.



Pamela Dudek
Chief Executive, NHS Highland



Boyd Robertson
Chair, NHS Highland