Local Workforce Plan

Lochaber Redesign Project

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Record of Changes

Date	Version	Page	Amendment	Responsible
17/05/2023	1		New document - Initial workforce plan developed to establish a baseline position for the Lochaber Redesign Programme, setting out early workforce assumptions to support future service and estate redesign.	G. Briggs
January 2024	2.4		Updated draft to reflect further development of service models, workforce assumptions and early financial considerations to support ongoing Lochaber Redesign work.	G. Briggs
March 2024	2.5		Refinement of workforce modelling and service assumptions, including additional detail on rehabilitation, facilities and staffing pressures, to inform emerging redesign options.	G. Briggs
November 2025	3.3		Substantially revised workforce plan following project pause and restart, incorporating refreshed policy context, demand analysis and workforce options to support Initial Agreement requirements and Outline Business Case development.	Membership of the Lochaber Redesign Service Delivery Workstream
March 2026	4		Amendments to reflect updated workforce impacts across Service options following Buchan's review, with consolidation and review of sections and appendices for consideration by the Lochaber Redesign Programme Board.	Emma Oates, Rural General Manager – Belford Hospital

Table of Contents

1.0 Executive Summary 5

2.0 Lochaber Redesign Workforce Plan 6

2.1 Workforce options 6

2.2 Service by service - Option Comparison 7

3.0 Policy Context for the Lochaber Redesign 8

Population Health Framework 9

Health and Social Care Renewal Framework (2025-2035) 9

Operational Improvement Plan (2025) 9

National Workforce Strategy for Health and Social Care 10

Ageing and Frailty—Standards for the Care of Older People 10

Urgent and Unscheduled Care Healthcare Standards 10

Fiscal and Demographic Considerations 10

Scottish Fiscal Commission Report (April 2025) 10

Joint Strategic Needs Assessment (Highland, 2024) 10

4.0 Defining the Plan 11

4.1 Introduction 11

4.2 Purpose of the Plan 12

4.3 The Scope of the Plan 12

4.4 Ownership of the Plan 13

4.5 Demand Analysis 15

4.5.1 Analysis of Hospital Activity 15

5.0 Benefits 17

5.1 Drivers for Change 17

5.2 Demographics 19

5.3 Challenges Identified 19

5.4 Environmental Sustainability 19

5.5 Barriers 20

5.6 Potential Working Models 20

5.7 Benefits Realisation 21

6.0 Required Workforce 22

6.1 Overview 22

6.2 Recruitment and Retention 22

7.0 Current Workforce 24

7.1 Wards and Departments 24

Emergency Department including Minor Injury (MIU) and Virtual Fracture Clinic (VFC) 25

GP Out of Hours 32
Advanced Nurse Practitioner (ANP) Team 34
Medical Staffing 39
Combined Assessment Unit (CAU) 44
Ward 1 – Rehabilitation Ward 49
Integrated Community Services 56
Outpatients and Infusions 59
Day Case and Pre-assessment 62
Theatres and Endoscopy 65
Endoscopy 68
Renal 72
Systemic Anti-Cancer Therapy (SACT) and Macmillan Cancer Support team 76
Midwifery and Obstetric Ultrasound 79
Radiology 84
Laboratory Services 89
Administrative services 93
Pharmacy 96
Facilities 102
Estates Department 107
8.0 Plan to Deliver 111
8.1 Medical Staffing 111
8.2 Frailty and Rehabilitation Services 111
8.3 New Roles Development 111
8.4 Facilities 111
9.0 Financial Overview 112
10.0 Action Plan 112
11.0 List of Appendices 112
Appendix 1 –Services aligned to each option.docx 112
Appendix 2- Options - Advantages and Disadvantages.docx 113
Appendix 3: Data packs 113
Appendix 4 –Population Demographics and Workforce Implications in Lochaber.docx 113
Appendix 5: Benefits Realisation Register 113
Appendix 6: Workforce Demographics 113

1.0 Executive Summary

Lochaber Rural General Hospital Redesign Workforce Plan

The Lochaber Rural General Hospital (RGH) Workforce Plan presents a comprehensive review of workforce and service redesign options for the new hospital development, addressing demographic shifts, healthcare delivery improvements, and alignment with Scottish Government policies.

Workforce and Service Model Options

Six workforce and service model options were developed to support the redesign of acute and community services in Lochaber. These range from maintaining current arrangements (Option 1: Do Minimum) to enhanced elective activity and ambulatory care models (Option 5). NHS Highland has not yet taken a final decision on the preferred service option. The workforce requirements of Options 1, 2, 3 and 4 are described in this plan. The preferred option decision will be informed by the Economic Case, which will bring together the non-financial assessment, capital and revenue cost estimates, whole-life costing, risk analysis and value-for-money considerations.

Financial Implications

The redesign also anticipates increased operational costs due to expanded facilities, extended hours, and modernised systems, but these are balanced by expected improvements in sustainability, workforce resilience, and patient outcomes. The impact on workforce changes on revenue pay budgets of the workforce requirements for each option is shown in the table below.

Policy Alignment

The redesign supports Scottish Government objectives for person-centered, locally delivered care, emphasizing prevention, early intervention, and integration across health and social care. It aligns with frameworks such as the Population Health Framework and the Health and Social Care Renewal Framework.

Demographic and Service Challenges

Lochaber faces an aging population, driving increased demand for healthcare, especially among older adults with complex conditions. The plan addresses these challenges by shifting toward community-based care and rehabilitation, expanding integrated working, hybrid roles, and stakeholder collaboration for workforce sustainability.

Key Service Redesigns

- **Emergency and Urgent Care:** Integration of Emergency Department (ED), Minor Injuries Unit (MIU), Virtual Fracture Clinic (VFC), and Same Day Emergency Care (SDEC) services, including a Place of Safety, to streamline patient flow and improve crisis management.
- **Advanced Nurse Practitioner (ANP) Expansion:** Extended ANP coverage to out-of-hours, new frailty ANP roles, and enhanced clinical leadership for patient safety and service resilience.
- **Medical Staffing:** Maintenance of consultant-led care increased Rural Emergency Physicians, and strengthened senior coverage and training.

- **Rehabilitation Services:** Intensive rehabilitation model in Ward 1 with increased Allied Health Professional (AHP) staffing and new support roles to reduce length of stay and promote independence.
- **Diagnostics and Support Services:** Expanded radiology, laboratory, pharmacy, and administrative services with extended hours, advanced roles, digital systems, and improved facilities.
- **Facilities and Estates:** Increased facilities staff and modern systems to support larger hospital footprint, environmental sustainability, and energy efficiency.

This workforce plan anticipates future demands, addresses current challenges, and supports the delivery of high-quality, sustainable health and care services in Lochaber, ensuring value for both patients and the health system through improved outcomes and cost efficiencies.

2.0 Lochaber Redesign Workforce Plan

2.1 Workforce options

Six workforce and service model options were developed to support the redesign of acute and community services in Lochaber, aligned to the proposed new hospital development. These options are intended to explore the full range of workforce and service model approaches available within the Lochaber area and to appraise both the financial and non-financial benefits associated with each. They span the continuum from a “do minimum” position through to options that involve increasing levels of service activity and workforce change. These are detailed in the table below:

Option	Descriptor
Option 1: Do Minimum	Maintain existing arrangements for the delivery of Rural General Hospital services in Lochaber. The assumption would be that demographic changes would drive demand growth (particularly in older age groups), but that the model of care would remain the same as presently delivered, with ongoing Business-As-Usual service improvement where possible.
Option 2: Core Rural General Hospital	This model focuses service provision within the proposed new development on the scope and range of services defined by clinical and operational colleagues in February 2022 and agreed across multiple RGHs within NHS Highland. It provides a range of ambulatory and inpatient services in a new RGH environment, complemented by community-based services delivered locally, with access to specialist acute services for residents hosted by Raigmore or, where clinically appropriate, by a tertiary centre in the central belt.
Option 3: Core Rural General Hospital with enhanced Intensive Rehabilitation provision	This option recognises local challenges in supporting the Health and Care system and builds on Option 2. Services will be designed to improve and support system-wide flow reflecting the unique challenges of delivering services in a rural geography. The focus will be on supporting patients' transition from hospital to home or a homely setting, with intensive rehabilitation input for complex rehabilitation pathways. Services will be designed to support patients who live locally to return home more quickly, and to support their continued improvement and reablement until their goals are achieved.
Option 4: Option 3 with increased elective activity, including	This option builds on the scope of services outlined in Option 3 by further broadening surgical and outpatient services in Lochaber, thereby reducing the need for travel to and activity on the Raigmore site. This option would aim to optimise the number of patients able to access treatment locally. Optimisation of operational processes for scheduling planned treatments should ensure that where local delivery is possible, patients are made aware of this choice.
Option 4a: Limited today-case surgery only	In line with NHSH Strategic transformation programmes of work, this option seeks to maintain specialist skills in surgical interventions locally in Lochaber and to ensure rapid access to more complex general surgical services requiring an inpatient admission in an appropriate alternative setting. Local surgical services in the RGH would operate under a comprehensive elective day case model.
Option 5: Ambulatory care services only	This option envisages a radical redesign of local services and a shift away from the RGH core services described in Option 2. It would do so by developing an ambulatory care centre in Lochaber, maximising services that can be delivered locally in community and ambulatory care settings. This option seeks to provide outpatient, minor injuries, and ambulatory care facilities, such as renal dialysis, chemotherapy, and medical investigations and day case surgery and endoscopy, locally in a new development. This will be supported by an optimised set of community and primary care-based services, in alignment with only the ambulatory aspects of the RGH core clinical model in option 2. This model would shift any acute-based inpatient services from Lochaber to the Raigmore hospital campus in Inverness or to Lorn and Islands hospital.

2.2 Service by service - Option Comparison

Appendix 1 sets out the specific service differences for each option, with the associated advantages and disadvantages detailed in Appendix 2. The table below provides a summary comparison of service delivery across the options.

Summary comparison of service model options

Symbol	Meaning	Interpretation
…	Included	Maintaining what we currently have
▲	Enhanced	More than baseline / expanded
◐	Limited	Reduced from current service offer
—	Removed	Not part of this option

Option	Urgent / ED	Inpatient beds	Diagnostics & lab	Theatres / elective	Specialist OP, renal & SACT	Rehab	Clinical workforce	Facilities & estates
Option 1 – Do minimum	…	…	▲	…	…	▲	▲	…
Option 2 – Core RGH	▲	▲	▲	…	▲	▲	▲▲	▲
Option 3 – Core RGH + intensive rehab	▲	▲	▲	…	▲	▲▲	▲	▲
Option 4 – + increased electives	▲	▲	▲	▲	▲	▲▲	▲	▲
Option 4a – Day surgery only	▲	▲	▲	◐	▲	▲▲	▲	▲
Option 5 – Ambulatory only	◐	—	◐	◐	…	—	◐	◐

3.0 Policy Context for the Lochaber Redesign

The Lochaber Redesign is closely aligned with current Scottish Government policy and guidance. For several years, the Scottish Government has emphasised the need to transform health and care delivery, advocating that services should be more person-centered and, whenever possible, provided locally. The overarching aim is to shift the balance of care away from dependence on acute hospitals and toward care delivered at or near home.

Recent policy documents, including the Operational Improvement Plan, Population Health Framework 2025-2035, and Health and Social Care Renewal Framework 2025-2035, reiterate these ambitions. They outline specific actions required to achieve a more sustainable, efficient, and accessible health and care system.

Population Health Framework

The Population Health Framework is built upon five key drivers for health and well-being. It emphasises resource allocation that supports prevention across health and other public services:

1. Prevention-focused system
2. Social and economic factors
3. Places and communities
4. Enabling healthy living
5. Equitable access to health and care

Health and Social Care Renewal Framework (2025-2035)

This ten-year framework is guided by five principles, each aiming to reshape service delivery and workforce development:

- Prevention Principle
- People Principle
- Community Principle
- Population Principle
- Digital Principle

The intention behind these principles is to enhance services that prevent disease, enable early detection, and manage long-term conditions effectively. The framework also seeks to deliver health and social care that is people-led and value-based, strengthen integration across the system, and improve access to community-based services and treatments.

For Lochaber, this means prioritising sustainability, efficiency, quality, and accessibility in the redesign. The framework calls for faster, fairer, and timelier access to care, new opportunities for staff, more collaborative and innovative working methods, hospital redesign to support community-based care, and increased use of digital technologies.

Staff and their representatives must be actively involved in shaping and developing services. Supporting individuals to manage their own care can help reduce demand on acute services.

Operational Improvement Plan (2025)

This plan outlines short-term commitments and actions to improve patient experiences. Its focus areas include:

- Improving access to treatment
- Shifting the balance of care
- Enhancing access to health and social care services through digital innovation
- Prevention, working proactively with people to prevent illness and meet needs

Implications for Lochaber's redesign include reducing waiting times, increasing diagnostic capacity (such as CT and endoscopy), improving patient flow, enabling early identification and intervention, growing community capacity, supporting Hospital at Home, addressing frailty, and implementing targeted interventions.

National Workforce Strategy for Health and Social Care

This strategy focuses on recovery, growth, and transformation of the health and care workforce. The reform program aims for coherence, sustainability, and improved outcomes through four core programs:

- Integrated planned care
- Unscheduled care
- Preventative and proactive care
- Place and wellbeing

It recognises changing service demands and describes the workforce journey through five pillars:

- Plan
- Attract
- Train
- Employ
- Nurture

Supporting, developing, and equipping staff are essential for long-term sustainability and staff well-being.

Ageing and Frailty—Standards for the Care of Older People

Given the population profile, the workforce must be shaped and skilled to implement these standards. Both the standards and NHS Highland's Frailty Strategy highlight the need for early identification, early intervention, comprehensive assessment, and an integrated response. Staff knowledge and skills are critical for supporting people to remain independent.

Urgent and Unscheduled Care Healthcare Standards

The Urgent and Unscheduled Care Collaborative aims to:

- Improve care pathways
- Ensure the right care is delivered in the right place and time
- Increase access to Hospital at Home services
- Optimise assessment and care in Emergency Departments by expanding same-day services
- Reduce hospital stays

Fiscal and Demographic Considerations

Scottish Fiscal Commission Report (April 2025)

The Scottish Fiscal Commission's report assesses the fiscal sustainability of government spending, with health being the largest budget item. The report notes rising demand and projected increases in health and social care funding needs, particularly for older age groups. Improvements in population health could help alleviate fiscal pressures, but current public spending trends are unsustainable, necessitating significant change.

Joint Strategic Needs Assessment (Highland, 2024)

A Joint Strategic Needs Assessment conducted for Highland Council and NHS Highland highlights an aging population: from 2003 to 2023, the over-65 population increased by 58.8%, while the working-age population rose by only 4.9%. Many older people live with multiple long-term conditions, and overall health declines with age, increasing future service demands. Meanwhile, birth rates and the number of children and young people are falling. The number of unpaid carers needing support and respite is rising, and unmet needs are growing. The assessment also points to a growing prevalence of mental health conditions, including dementia.

Current services are pressured. The Joint Strategic Needs Assessment advocates for a fundamental shift toward prevention and mitigation of underlying health determinants such as poverty and deprivation, especially in remote and rural areas. Consistent with other policy drivers, it calls for shifting the balance of care, with greater investment in prevention and early intervention.

The Lochaber Redesign is proposed within the broader context of these policies and guidance documents, all of which are relevant to workforce planning. There is a clear need for transformational change in the design and delivery of care, as well as in the training, development, organisation, and support of the workforce.

The Skills for Health Six Step methodology has been utilised to develop this plan.

4.0 Defining the Plan

4.1 Introduction

This plan forms part of a wider Lochaber health and care services redesign which includes a new Rural General Hospital (RGH) in Fort William. The aim is to design a sustainable workforce which meets the needs of Lochaber's Rural General Hospital, ensuring that the right people with the right skills are in the right place at the right time.

The RGH serves a role similar to that of a District General Hospital (DGH), providing acute care to a broad and geographically dispersed population in remote and rural areas. Despite being smaller in scale, the RGH delivers essential health services and demands a workforce with high levels of skill and competency to ensure the provision of high-quality, safe, and effective care.
Staff at the RGH are required to be multi-skilled generalists, as the support and maintenance of specialist roles are more challenging within a smaller workforce. The hospital offers flexible care options and variable facilities, accommodating the unique needs of rural communities. Significant distances in Highland rural areas present logistical challenges for both patients and staff when traveling for diagnostics or treatments. The Scottish Government's goal is to deliver care as close to home as possible, positioning the RGH as a key component in the broader network of care across the region.

To develop the workforce plan, a planning group was convened with an initial focus on acute services. The project experienced a pause by the Scottish Government in 2024, before being reinstated in 2025. While the initial emphasis was on acute services, the plan was expanded to encompass community services.

The planning process involved a series of workshops, discussion groups, and communications aimed at achieving a comprehensive understanding of staffing requirements. These activities were reviewed and updated in 2025/26 to ensure accuracy and relevance. Key priority areas identified for review included medical staffing, the Place of Safety, and Frailty and Rehabilitation services.

This workforce plan presents a snapshot of current staffing arrangements as well as the anticipated profile needed to achieve the ambitions of stakeholders and the aspirations of NHS Highland and the Scottish Government. The plan reflects the ongoing commitment to delivering effective health and care services across Lochaber, guided by national and local objectives.

4.2 Purpose of the Plan

The workforce plan aims to ensure that the staffing levels are appropriate, that staff are suitably trained, and that the organisation of the workforce maximises safety, effectiveness, and efficiency within the constraints of the available budget.

Within the Lochaber workforce plan, the funded workforce is identified in terms of whole time equivalent (WTE) posts. The plan also includes proposals for future service and workforce developments, which have been formulated with input from department heads and professional leads. This collaborative approach ensures that proposed changes are relevant and practical, drawing on the expertise of those most integrally involved in service delivery.

Each specialism and unit has been described in detail within the plan. However, there is recognition that crossover between departments and specialties is unavoidable. Such areas of overlap have been highlighted to avoid unnecessary duplication. The connections with community services and primary care are subject to ongoing review and development, which will be addressed through the business case process.

Key Principles Guiding the Workforce Plan

- Patient safety
- Staff safety
- Built-in sustainability
- Opportunities for learning and development
- Adherence to the agreed budget

Currently, the cost of the proposed developments exceeds the available budget. It is anticipated that this challenge can be mitigated through measures such as reducing waste within the system, changing roles, implementing continuous improvement processes, and adopting new models of care. Nonetheless, ongoing work will be required to ensure that the plan remains affordable and financially sustainable.

To underpin the workforce plan, there is a requirement for both a Learning and Development Plan and a People and Culture Plan. These supporting frameworks will help ensure staff are equipped with the necessary skills and that the organisational culture fosters development and positive engagement.

4.3 The Scope of the Plan

The initial focus of planning was on acute services, driven by the rationale for the new facility. This scope has now broadened to include community health and social care services, forging stronger connections with primary care and partner organisations. Such expansion aligns with prevailing policy, which calls for greater emphasis on prevention, early intervention, and less dependence on acute care.

To achieve integrated working methods, the development of 'hybrid' roles that cross traditional boundaries will be explored. Success depends on close collaboration among all professions and partners, utilising the experience, skills, and resources of everyone involved.

Building a sustainable workforce demands thoughtful planning and innovation, encouraging the creation of new roles and allowing time and support for teams to experiment with fresh ways of working. The outlined plan will pave the way for this future workforce, enabling changes to take root even before the new building opens. Over the next few years, these planned transformations require strong partnerships and cooperation with:

• Voluntary groups

• Acute and community health services

• Social services

• Staff groups

• Educational institutions

• Community representatives

• Patient and family organizations

• Political bodies

• Local employers

In the forthcoming 2–4 years, it is necessary to finalise staffing plans, evolve new working practices, initiate educational partnerships, reorganize services, and implement processes aimed at enhancing care and quality.

The new facility offers a significant chance to reshape service delivery, promote sustainability, and cultivate an inspiring workforce that sets standards across Highland and beyond. Lochaber's teams have previously shown adaptability and creativity and will continue shaping future services.

It is expected that the plan will strengthen local improvement efforts, supporting current staff by providing appealing and innovative opportunities that boost retention.

Targeted training and educational programs are vital for maintaining existing services and attracting high-calibre recruits.

As shown by prior experience, remote and rural services rely on mutual support, and this plan addresses the need to include all major service providers and partners.

4.4 Ownership of the Plan

Workforce activities have been undertaken across most services, engaging all relevant stakeholders through focus groups and workshops. These collaborative sessions emphasized the importance of developing new ways of working and consolidating staff and support groups wherever possible.

Service leads and clinicians have played a central role in both shaping and advancing the overall workforce plan and its ongoing developments. Their guidance and contributions have been integral to the process.

The plan has been crafted and reviewed by clinical teams and relevant clinical experts, ensuring that it is endorsed by individual teams and leadership. There has been broad consultation and approval through programme governance processes.

Core RGH Clinical Model

To support the clinical development elements, a series of two workshops were held with the aim of establishing a core RGH model. To achieve this, the groups were asked to "define the thresholds of safety and sustainability in delivery of services locally, compared to those requiring acute, centralised and specialist services" accessible in Raigmore or in Tertiary centres elsewhere.

The RGH Clinical Model describes the type and scope of care which can be provided safely and sustainably within an RGH including the level of complex care appropriate to an RGH. The multi-disciplinary teams involved in this work were drawn from across NHS Highland and ranged across clinical specialties and grades, including Consultant Clinicians from both Caithness and Lochaber.

The outcome was that the RGH could support Level 1 and Level 1+ as the "high end of complexity" and must be staffed accordingly. There are variations of opinion as to whether there should be an established and equipped HDU or that the levels of care described in the RGH Clinical Model provide the appropriate level of enhanced care (Level 1/1+) delivery for an RGH. The assumptions in this plan is that the workforce is built into the ward whole time equivalent`s and should not be identified as an additional cost.

Senior Staff who have been involved in agreeing and reviewing the plan

Radiology	Niall Lloyd
ED, MIU, VFC	Victoria Jackson/Aileen McLean/Elizabeth Baskerville
ANPS	Aileen McLean/Elizabeth Baskerville
GP OOH and community services	Karen Anne Wilson
OPD and Infusions	Veronica Walker- Armitage/Aileen McLean
CAU and Enhanced Care	Eilidh MacDonald/Aileen McLean
Day Case and Pre Assessment	Lesley Pow/Aileen McLean
Ward 1 Rehab	Liz Knox/Aileen McLean/Jo McBain/Karen Anne Wilson
Theatres and Endoscopy	Helen Cree/Aileen McLean
Pharmacy	Rhona Gunn
SACT	Derek McBride/Georgina Hough
Renal Unit	Heather Andrews/Aileen Mclean
Medical Staff	Duncan Scott/Bruce Tulloh
Maternity	Juliet Evans
Laboratory Services	Grace Cuthbertson
Admin Staff	Jamie Forrester/Klara Campbell
Facilities	Roslyn McLean/Allan Ross

Professional, clinical, and operational leadership have had oversight through the Service Delivery Group as per programme governance arrangements.

4.5 Demand Analysis

Appendix 3 contains activity information and analysis of this is given below.

Activity for each ward and department is contained in section 6 alongside current and projected workforce requirements.

4.5.1 Analysis of Hospital Activity

Between 2019 and 2024, Belford experienced a consistent rise in both occupied bed days and the average length of stay across its wards. This trend was particularly pronounced among older patients. For individuals aged over 65, the average length of stay increased from 2.8 days in 2019 to 4.1 days in 2024, a 46% rise. Even when excluding patients with delayed discharge, the increase remained significant at 38%.

Within the over 80 age group, the length of stay, adjusted to remove delayed discharge cases, saw a 49% increase, moving from 6.5 days in 2019 to 9.6 days in 2024. Additionally, the average length of stay in Ward 1 during 2024 reached 72.1 days.

Analysis of emergency admissions revealed that the longest stays, top 5%, were consistently associated with patients aged over 80. This cohort accounted for 66% of total bed day usage, which is notably higher than the Scottish average of 39%. Despite the extended hospital stays, the in-hospital mortality rate for these patients was relatively low at 18%. This suggests that most older patients eventually transition to home or alternate care facilities.

Patient flow patterns through the Combined Assessment Unit (CAU) have shifted in recent years. In 2019, 70% of emergency pathway patients were discharged directly from CAU. By 2024, this figure had dropped to 55%, and further decreased to 50% in 2025, indicating an increased need for ongoing care beyond initial assessment.

There has also been a marked rise in internal ward movements following emergency admissions. In 2019, 14% of emergency admissions required an internal transfer, compared to 29% in 2024.

The Day Case Unit continues to perform well, with 94% of patients not requiring admission. Elective transfers to CAU from the Day Case Unit decreased from 19% in 2019 to 6% in 2024. However, the Day Case Unit has increasingly been used as additional bed capacity when hospital occupancy is high, a practice that was rare in 2019 but has become more common in recent years.

This analysis underscores the importance of focusing efforts on rehabilitation and strategies to reduce length of stay, especially for older patients. Increased proactive pathway management has demonstrated a 30% reduction in length of stay in another area within NHS Highland, suggesting potential benefits if implemented locally.

Opportunities for efficiency are:

- Enhanced SDEC models offer the most significant opportunity for reducing emergency admissions and bed days.

- Theatre efficiency work (start-time discipline, gap time reduction, scheduling reform) could unlock elective capacity.
- Outpatient pathway redesign, including DNA reduction and return-activity management, can improve flow and compliance.
- Local diagnostic enhancements (OBUS in Belford, MRI docking plinth) could reduce Raigmore dependency and travel.
- Strengthening community and ambulatory pathways can mitigate acute presentation growth.

5.0 Benefits

5.1 Drivers for Change

The principal driver for this workforce plan development is the proposed new hospital facility in Fort William. However, the hospital will only be able to function properly as part of an integrated health and care system in the District, therefore a secondary is ensuring that the wider system is fit for the future and able to cope with the demands of an ageing population.
Figures 1 and 2 below outline driver considerations within the programme that have been considered within the proposed service redesign.

Figure 1. Key primary workforce drivers

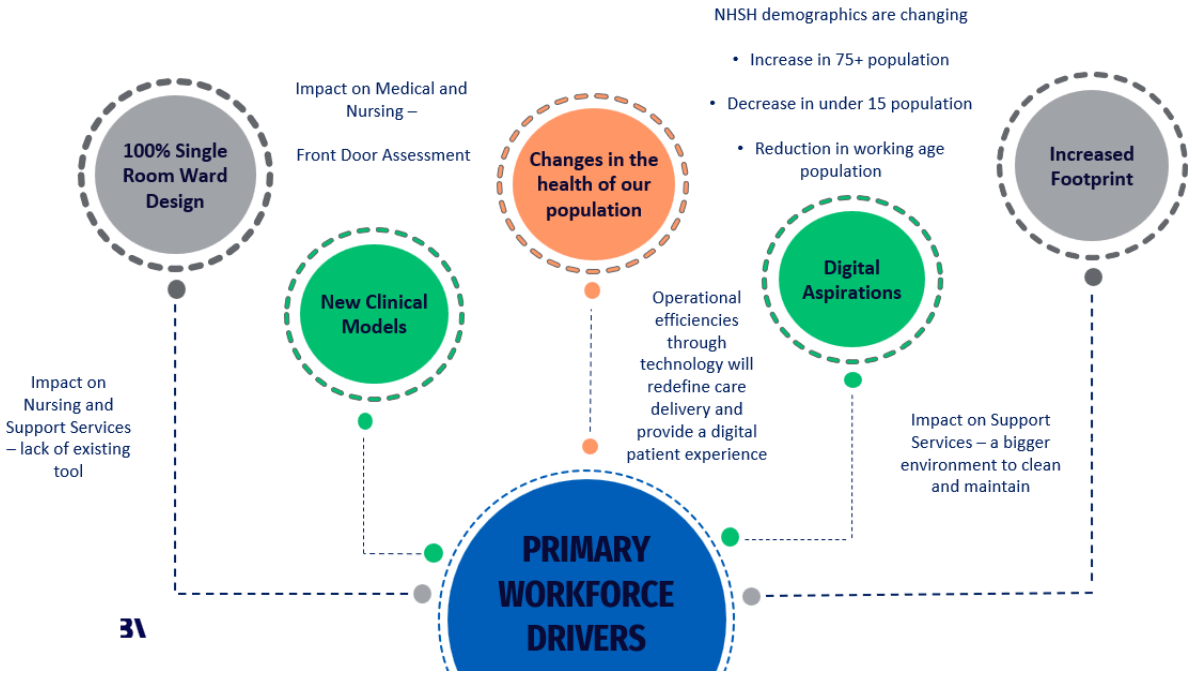
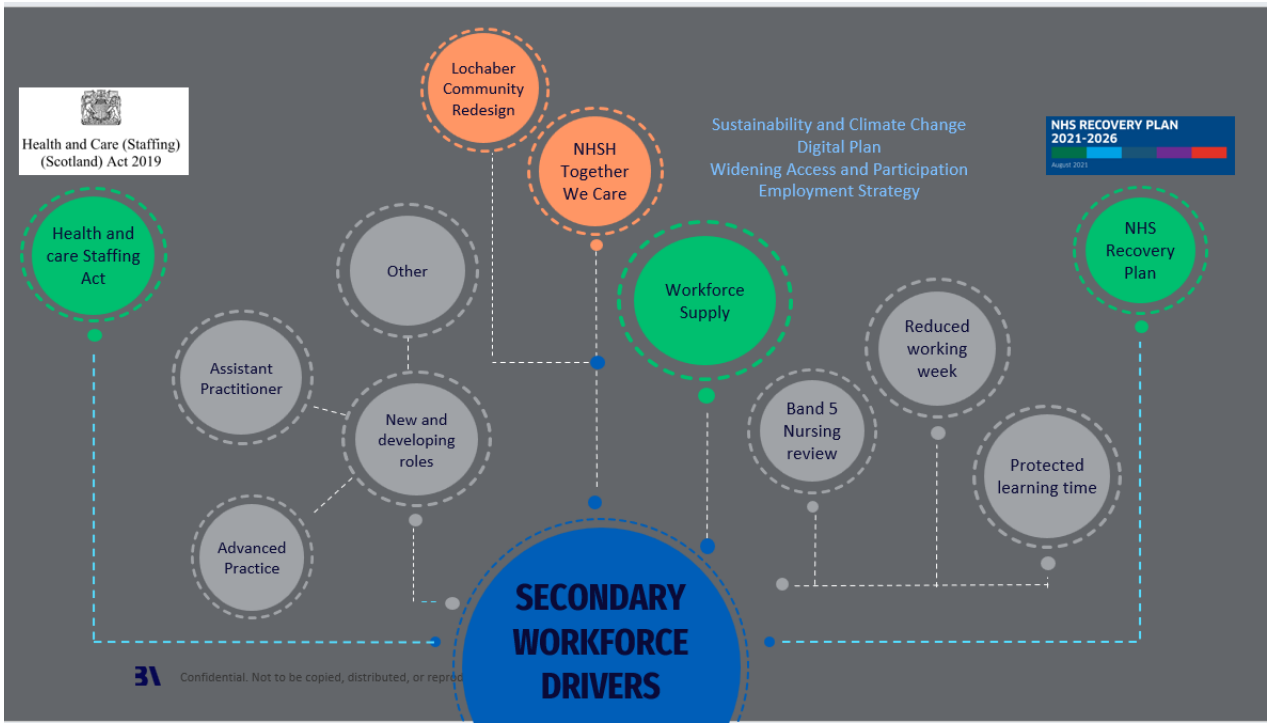


Figure 2. Secondary workforce drivers


Health and Care (Staffing) (Scotland) Act 2019
Lochaber Community Redesign
NHSH Together We Care
Sustainability and Climate Change
Digital Plan
Widening Access and Participation
Employment Strategy
NHS RECOVERY PLAN 2021-2026
Health and care Staffing Act
Other
Workforce Supply
NHS Recovery Plan
Assistant Practitioner
New and developing roles
Reduced working week
Band 5 Nursing review
Protected learning time
Advanced Practice
SECONDARY WORKFORCE DRIVERS
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5.2 Demographics

Lochaber is home to 20,042 residents. Although this figure is not anticipated to increase significantly in the coming years, the composition of the population necessitates careful consideration in workforce planning. Appendix 4 Population Demographics and Workforce Implications in Lochaber provides further context.

5.3 Challenges Identified

The teams have identified additional challenges currently driving the need for change:

- Recruitment and retention difficulties
- Limited career progression opportunities, including ANP and Specialist roles
- Numerous vacancies contributing to increased workload and staff burnout
- Slow and complex recruitment processes
- Insufficient flexibility and efficiency in decision-making regarding changes to post profiles aimed at attracting applicants
- Challenges related to rural location
- Unmet learning needs
- Inadequate availability of certain training placements and lack of backfill for training
- Scarcity of affordable accommodation for staff, particularly during peak summer months
- Limited accommodation options for patients willing to travel for procedures
- Age profile and retirement rates within the staff population
- Sickness absence, with particular impact on specialist areas such as renal, where cross-departmental support is limited
- Maternity leave gaps and obstacles in securing funding and recruiting suitable cover
- Cultural factors affecting workplace dynamics
- Staff morale concerns
- International candidate recruitment complications, including sponsorship and visa requirements
- Feelings of isolation arising from significant distances from Raigmore
- Managing stakeholder expectations
- Financial constraints impacting operational efficiency

5.4 Environmental Sustainability

Healthcare accounts for about 5% of global carbon emissions. The NHS aims for net-zero emissions by 2040, with an 80% reduction targeted between 2028–2032, covering all emission scopes including patient travel and home medicines.

Staff recruitment, retention, and well-being, along with public sector social responsibility, require ongoing attention to environmental sustainability in local health care. Encouraging local champions to join the NHS Leadership Academy's "Sustainability Leadership for Greener Health and Care" course is being supported.

Belford Hospital leads sustainability efforts through the Belford Environmental & Green Group (Bel-EGG) and the "Green Theatre" program.

NHS Highland and the Lochaber Redesign Project Team are actively pursuing national and local sustainability targets, aiming to be an "Anchor" organization in the area.

Sustainability needs to become a core organisational practice, with champions collaborating with staff to embed environmental initiatives into daily operations.

RGHs are expected to be innovative leaders, setting a model for NHS Highland's commitment to environmental improvement and quality of life.

5.5 Barriers

Financial constraints, recruitment challenges, and the need for support to implement fundamentally new service delivery methods are the primary obstacles to achieving this workforce plan.

5.6 Potential Working Models

The models proposed by the teams aim to shift away from dependence on traditional disciplines and titles, advancing towards a person-centred, responsive, flexible, multi-professional approach that crosses conventional role, managerial, and structural boundaries.

Developing multi-skilled, generic healthcare assistant staff will help minimise the number of contacts patients experience and promote enablement. This strategy is particularly significant in remote and rural areas, given the geographical distances involved and the necessity to optimise limited resources. These generic healthcare assistants will undergo extensive training to support all facets of patient care.

Further advancement of roles such as advanced nurse practitioners, senior allied health professionals (AHPs), and AHP practitioners will contribute to building a resilient and sustainable workforce, improve continuity of care, and provide enhanced career progression opportunities for expert clinical staff.

While it remains essential to maintain consultant-led services in this acute hospital setting, diverse roles can support, enhance, and sustain the overall model. Rural Emergency Practitioners already operate at a high level, and there are plans to expand this cohort.

Prioritising frailty syndromes through early identification and intervention is crucial for supporting older and vulnerable populations. There are opportunities to further develop the workforce and create specialist roles that enable both career advancement and greater focus on prevention, early identification, intervention, and promotion of independent living. Transitioning to a more integrated system, with staff working across acute and community settings, will reinforce the entire care system, facilitate avoidance of hospital admissions, and support timely discharge.

It is imperative to review current operational practices, assess their suitability for present and future needs, and refine and enhance existing service models. The period preceding the opening of the new facility presents an ideal window to perfect clinical models and strengthen partnership working. It is essential to build upon and advance existing facilities, skills, and competencies while actively exploring potential improvements.

The continued need for improved Frailty and Rehabilitation services is evident, with elements of future service models already emerging. Ward 1 currently serves as the rehabilitation ward, and steps have been taken to train all staff in enabling approaches, helping patients maximise independence and avoid debilitation during hospital stays. Extensive expertise and innovative ideas exist for further development to ensure that this ward functions effectively as a centre for rehabilitation.

Community teams are in the process of evaluating their operations to maximise resource utilisation and adequately address the needs of those requiring the most support. There is recognition of the importance of preventative strategies, early interventions, and more flexible, same-day urgent care solutions to prevent unnecessary hospital admissions.

Staff and local stakeholders aspire to create a state-of-the-art rehabilitation service. A staged, redesign-driven, and continuously improving approach is recommended to achieve this vision.

Frailty and Rehabilitation workshops have been conducted, to enhance integration, implement the Highland Frailty Strategy, and adhere to the Health Improvement Scotland Ageing and Frailty Standards.

The initiatives outlined are intended to reduce reliance on inpatient care. Resource transfer and transitional funding may be necessary to facilitate testing and demonstration of cost-effective reductions in inpatient stays.

5.7 Benefits Realisation

A benefits register has been developed and ranked and is included in the outline business case, this will inform post occupancy evaluation, this is shown in Appendix 5.

6.0 Required Workforce

6.1 Overview

Staffing requirements are identified by grade and by whole time equivalent. Where appropriate, these calculations incorporate 22% leave cover to ensure adequate resourcing across all shifts and operational periods.

Reducing agency costs and usage is a key requirement, with new staffing models proposed to address this challenge. The opening and management of surge beds continue to exert cost pressures, particularly as agency usage increases during winter and other key annual periods. To mitigate these pressures, there is a concerted effort to strengthen collaboration with community colleagues. The objective is to lessen reliance on supplementary hospital beds and staffing. By reducing the number and duration of delayed discharge cases, teams aim to achieve greater efficiency and improve patient flow across the system.

Work is ongoing at the interface with Allied Health Professionals to explore new or combined roles, such as enablement practitioners for rehabilitation. The development and review of Assistant Practitioners and Nurse Associates is underway, with the intention of expanding these roles to support ward and department staff. This approach aligns with similar role developments currently taking place in other NHSH sites.

6.2 Recruitment and Retention

The following principles underpin the approach to workforce development, ensuring a sustainable, skilled, and resilient workforce that meets the needs of both local services and the wider healthcare system:

- Growing our own staff
- Support for career progression
- Dedicated pathways for development
- Skills matrix for local services
- Local recruitment and retention
- Communication across the services
- Local learning opportunities

To build workforce sustainability and facilitate career progression, the following roles have been identified for development:

- Band 4 generic healthcare support workers
- Advanced Nurse Practitioners
- Lead Advanced Practitioner
- Frailty Practitioner
- Advanced Therapy roles
- Rural Emergency Practitioners

Models of care will be regularly reviewed to ensure better integration of acute and community services, with a patient-centred approach guiding all developments.

Innovative, values-based recruitment strategies, alongside the creation of engaging and well-supported positions, are essential for meeting both immediate and future workforce challenges. Recruitment processes must become more agile and adaptable, tailored to the specific requirements of each role to maintain service continuity and manage budgets effectively.

Providing opportunities for staff to undertake non-registered roles, with support from NHS Highland, and enabling progression into registered positions forms a core component of the workforce plan.

A sustained commitment to staff training and development, underpinned by organisational strategy clear vision, is necessary for building a learning organisation. Integrating both cultural and practical elements into this model will be fundamental in achieving workforce objectives and ensuring ongoing improvement.

7.0 Current Workforce

Appendix 6 provides an overview of current workforce demographics

7.1 Wards and Departments

Emergency Department including Minor Injury (MIU) and Virtual Fracture Clinic (VFC)

Current Service Position

The Emergency Department delivers urgent and emergency care, including assessment and stabilisation of patients with serious injuries or life-threatening conditions prior to transfer. It remains operational 24 hours a day providing around-the-clock care for Lochaber and its wider community, with increased activity during peak periods and comprehensive support for complex cases requiring stabilisation and timely transfer.

Lochaber, recognised as the outdoor capital of the UK, attracts substantial numbers of visitors annually, many of whom participate in various outdoor pursuits, some categorised as extreme. Activities such as mountaineering, skiing, mountain biking, kayaking, and white-water rafting, combined with a challenging road network prone to traffic incidents, contribute to high demand within the Emergency Department. As a result, the department must be prepared to manage multiple casualties concurrently.

The Minor Injuries Unit and Virtual Fracture clinic VFC are integrated with the Emergency Department.

The MIU is staffed by Advanced Nurse Practitioners who provide treatment for urgent yet non-life-threatening conditions such as fractures, dislocations and sprains, wounds and minor burns, foreign bodies etc. The unit operates seven days a week from 9:00am to 9:00pm.

The VFC is also ANP led, offering non-urgent orthopaedic services through remote review of patient X-rays and medical records to determine optimal treatment, which may include advice, early self-management guidance, or referral for further care. This model reduces unnecessary hospital attendance and supports prompt diagnosis and intervention. Service hours are Monday to Friday, 7:30am to 3:30pm.

Currently there is no Same Day Emergency Care service in Belford, however GP referrals and planned returns are managed by ED, OPD and CAU. There are no separate facilities to support the 6-10 attendees per day.

Belford is currently designated as a Place of Safety under The Mental Health (Care and Treatment) (Scotland) Act (2003) (the Act) – Section 298. In the existing environment there are challenges providing the necessary observation required, whilst maintaining privacy and dignity for all patients. The ability to provide a place of safety is currently documented on the Acute level 2 risk register.

Nursing and administrative staffing across the Emergency Department, MIU, and VFC totals 32.98 WTE. Decision making is led by additional medical staff detailed separately in this document.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Band 7 General acute nursing SCN	7	1
Band 7 General acute nursing ANPS for Minors and VCF and hospital at night	7	5.48
Band 6 General acute nursing	6	5.68
Band 5 General acute nursing	5	10.52
Band 3 General acute nursing HCSW	3	4.8
Band 2 Patient services ED receptionist	2	5.50
Total		**32.98**

Activity

Emergency Department attendances have shown steady year on year growth across the three-year period.

The overall pattern indicates a gradual and sustained increase in unscheduled care demand, consistent with wider system pressures and reflecting ongoing reliance on urgent and emergency pathways.

Year	Attendances	Minor Injuries	4h Performance %
2025	10112	6556	83.5
2024	9905	6714	82.6
2023	9723	7012	87.5

Modelling shows that an estimated 476.55 bed stays could be saved from implementing an SDEC model within the Emergency Department.

All patients presenting at the emergency department should be seen within 4 hours. Belford achieved 87.5% in 2023, reducing to 82.6% in 2024, before improving slightly to 83.5% in 2025. Although performance dipped in 2024, Belford remained above the NHS Highland average each year and significantly higher than the Scottish national level. (Appendix X Lochaber data pack)

Proposal for the future

It is proposed that:

- A Same Day Emergency Care service is developed, and this will sit within the Emergency Department.
- A dedicated purposed built Place of Safety is provided adjacent to the Emergency Department.
- Out of Hours Primary Care services are co-located to the Emergency Department
- Provision of the same high standard of Emergency Health Care that the Belford Hospital is renowned for within the Scottish Trauma Network is maintained.

Same Day Emergency Care

The proposed SDEC service combines rapid diagnostics and assessment with close links to community-based services to avoid unnecessary admission to hospital for stable patients with conditions such as deep vein thrombosis, low risk chest pain, respiratory infections, pneumonia, and cellulitis. Experienced clinical input is needed at the point of referral to direct suitable patients to SDEC. The service should be led by an experienced competent decision maker to ensure timely decision making. A multi-disciplinary team should make up the core staffing provision including Medical, Nursing, Allied Health Professional and Administrative staff. Developing closer relationships with community/primary and mental health services is essential. Robust inter-professional standards should be in place to support specialty in-reach into SDEC

Place of Safety

Section 298 of the Mental Health (Care and Treatment) (Scotland) Act (2003) authorises police personnel to transfer individuals from public areas to designated places of safety when there is reasonable belief that the individual has a mental disorder, requires immediate care and treatment, and that such intervention serves either their best interests or the protection of others.

Individuals may be held at a place of safety for up to 24 hours to enable medical evaluation and facilitate suitable care arrangements. In accordance with established local policies, police officers are required to remain with patients unless the lead clinician assesses and agrees that it is safe for the patient to stay within the department without police supervision.

Although detentions under this Act occur infrequently, averaging approximately three cases per year, the incidence of patients presenting the emergency department with psychiatric emergencies is notably higher, typically one or two each week. These individuals may also derive benefit from the supportive environment offered by a place of safety.

The recommended approach is to adopt standard operating procedures that will guide risk assessment and escalation processes. These procedures will enable flexible staffing arrangements, allowing staff from various departments across the hospital to be utilised as needed for patient supervision. This strategy avoids the need to create permanent roles specifically for this purpose, ensuring that resources are used efficiently while maintaining high standards of patient care and safety.

Ongoing multi-agency training led by the mental health team equips emergency department staff and nursing teams throughout the hospital, including healthcare support workers and medical professionals, to effectively manage individuals experiencing psychiatric emergencies. The development of multidisciplinary standard operating procedures, consistent with NHSH policy, will promote efficient management of this area while patients await assessment or transfer to specialised mental health units or other discharge routes.

Primary care out of hours service

GP led primary care out of hour services are currently delivered on a remote basis with appointments made via 111 service. This service will be co-located in the new facility, supporting the streaming of patients to appropriate service and providing security and support to lone working staff. This service is described in the GP OOH section of this plan.

How is the proposal different to what we have and why?

- Co-location of Emergency Department, Minor injuries unit and primary care out of hours service will allow us to quickly direct patients to the appropriate care service. Reducing patient wait times and speeds up diagnosis.
- The new facility will provide a high quality, modern environment for the provision of Acute & Unscheduled Care with adequate space to enable staff to work more efficiently and effectively, reducing patient waiting times.
- Facilities such as the multi-use plaster room will be located so that they can be accessed efficiently by the Emergency Department, Virtual Fracture Clinic & Outpatients Department.
- A compliant and comfortable Place of Safety for people requiring support with mental health care needs, as well as an enhanced environment for patients of all ages and their families and carers.
- Separate entrances for Ambulance & Self Presenting patients providing improved patient dignity.
- Central Administrative area which serves all the associated services within ED

Service Options presented at Initial Agreement impact on ED, MIU and VFC

Option 1 – Do minimum

Changes to the ED nursing team model are; Band 6 WTE is reduced by 0.2 WTE to remove SCN cover in the ED nurse staffing model, 22.5% on costs for backfill to B3 WTE has been applied. 1.81 WTE Band 7 has been removed to reflect current ANP team night cover, this is to offset against ANP site team detailed in the relevant section of this plan. 22.5% for Virtual Fracture Clinic Band 7 post is removed as will be backfilled by 8a ANP clinically in ANP site team model. This change would only be transacted on the basis of additional resources for an ANP team. With no change in resource there will be no change to ANP current model in terms of existing ANP night cover with a 22.5% uplift applied for backfill. This model requires recruitment and development of ENP to ANP

Band 4 nursing assistant roles are under consideration but not yet developed to include in this plan. Planned increases in Rural Emergency Practitioner and ANP leadership out of hours are business as usual service developments required to improve ED flow and resilience, as detailed elsewhere in this plan. GP out-of-hours may be co-located. The current workforce cannot support a staffed SDEC, nor is there space for a separate SDEC. There is a lack of sufficient waiting, monitoring areas, and gaps in the medical and Nursing workforce model, especially out-of-hours.

Option 2 – Core RGH Model

The Same Day Emergency Care (SDEC) service, in conjunction with a designated place of safety, will be introduced alongside emergency resuscitation, trauma management, minor injuries, and virtual fracture clinic services. The implementation of SDEC will require an increase in daytime nursing staff, which may be addressed by reallocating personnel from the GP referral unit (currently operated by CAU) to the Emergency Department. This adjustment includes a modest increase in band 6 nursing staff to 1.90 WTE to support SDEC with appropriate nursing input.

There are plans to add the band 6 SDEC role to the ED nursing rota, allowing staff cross-training and broader skill development. There is a further uplift of WTE for REs to provide an SDEC service 5 days a week, 52 weeks a year. The place of safety will adhere to NHSH protocols and will be supported by resources outlined within the broader workforce plan.

The core Emergency Department model will be complemented by multidisciplinary teams, including medical staff such as Rural Emergency Practitioners and Advanced Nurse Practitioners (ANPs), AHPs including pharmacy and diagnostics and therapy staff as described in other sections of the workforce plan. The GP Out-of-Hours (OOH) service will be co-located to facilitate improved streaming processes within the department, particularly directing patients to GP OOH where appropriate.

Standard operating procedures and comprehensive training for the use of Point of Care testing for rapid diagnostics will be established.

Other developments include a screen in resus to enable via Near Me access to consultant pediatrics, stroke, ortho review, ECG transmission to CCU, and integrating the OOH receptionist into Belford Admin services will be progressed.

Option 3 – RGH model + Intensive Rehab

There is no change to ED the workforce, the ED operating model, or impact on other NHSH sites from option 2 core RGH model.

Option 4- As option 3 but with increased elective activity

There is no change to ED the workforce, the ED operating model, or impact on other NHSH sites from option 2 core RGH model.

Projecting the Lochaber RGH Emergency Dept workforce requirements

Indicative plan as to how the workforce may change in terms of WTE to meet option 2 Core RGH model.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Band 7 General acute nursing SCN	7	1	1	1	1
Band 7 General acute nursing ANPS for Minors and VCF and hospital at night	7	5.48	3.67	3.67	3.67
Band 6 General acute nursing	6	5.68	5.33	5.33	7.23 (inc 1.90 SDEC band 6)
Band 5 General acute nursing	5	10.52	10.66	10.66	10.66
Band 3 General acute nursing HCSW	3	4.8	5.33	5.33	5.33 (difference is enhancements and 22.5% costed)
Band 2 Patient services ED receptionist	2	5.50	5.33	5.33	5.33
Total		**32.98**	**31.32**	**31.32**	**33.22**

GP Out of Hours

Current Service Position

The GP Out of Hours service for Lochaber is managed by Community Services and delivered from two centres, Fort William Health Centre and Acharacle Surgery.

The service is currently staffed by locum GPs supported by drivers and reception staff.

Current Funded Workforce Position

Agency Locum	GP	0.00
General Practioner	GP	0.00
Transport services	Band 2	3.63
Total		**3.63**

Total service budget is £926,473. Services are provided by an external agency with substantive driver staffing in post.

Activity

The table below indicates that the Emergency Department in Belford is being utilised at a higher rate than in other areas of Highland and conversely, the GP out of hours service is being utilised less than other areas.

Indicator	Count	Cluster rate	Health Board	Difference
A&E attendance	1779	79.5	54.7	+45.4
A&E over 65	484	97.3	67.9	+67.9
A&E GP referrals	84	4.7	8.0	-3.2
GP referrals over 65	34	7.0	10.8	-3.7
GP OOH	611	27.3	45.2	-39.6
GP OOH over 65	226	45.4	66.8	-32.0

Taken from Cluster Information October to December 2024

Proposal for the Future

Co-location of Emergency Department, Minor injuries unit and primary care out of hours service will allow us to quickly direct patients to the appropriate care service. Reducing patient wait times and speeds up diagnosis.

How is it different to whet we have now and why

The Out of Hours (OOH) GP-led service will be incorporated into the new facility alongside the Emergency Dept. A phased approach to co-location aims to ensure the continuity of service with the existing provider, while further work is required to establish a comprehensive action plan to develop the service covering the short, medium, and long term.

Office and clinic spaces will be utilised by the OOH service during evenings, nights, and weekends. There is potential to combine administrative and reception services within a single area, allowing for economies of scale and associated savings.

Co-location of the OOH GP-led service with Emergency Dept, Same day Emergency Care and Minor Injuries is expected to provide greater resilience for all teams. Additionally, it will improve patient pathways for individuals requiring onward acute treatment.

The intention is to further develop the service by moving towards a multi-professional model. This will be achieved by introducing Advanced Nurse Practitioners and Paramedic Practitioners, aligning with practices in other parts of Highland. Currently, this model is in its early governance stage through the Health and Social Care Partnership (HSCP) and is considered a business-as-usual service development. As such, it does not distinguish between options and is not included in the workforce plan at this stage. Any changes and impacts will be detailed during the Full Business Case stage.

Advanced Nurse Practitioner (ANP) Team

Current Service position

A senior ANP will lead this team, overseeing all ANPs with clinical, supervisory, managerial, and educational responsibilities, consistent with other MHSH sites. This practitioner will prescribe medications and assess, review, and discharge patients.

Building on the existing ANP workforce in minor injuries and virtual fracture clinic, the team will expand to cover night shifts, providing out-of-hours clinical resilience, improving flow, and taking on site management and Nurse in Charge duties. The team will also include a dedicated Frailty ANP working weekdays from 9am to 5pm; current funding for the Band 7 Frailty Practitioner is temporary, with efforts underway to secure further fixed term funding to fully evaluate the benefits of this approach.

Current Funded Workforce Position

ANP team

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Nil in post		
Total		**0**

Proposal for the future

- Increase band 7 ANP hours to cover the Out of hours period to provide clinical and operational resilience across the site
- Recruit to a substantive frailty ANP to lead implementation of the NHSH frailty strategy and frailty interventions within the RGH
- Provide ANP leadership to the existing ANP workforce

How is the proposal different to what we have and why?

At present, the site is experiencing a deficiency in nursing and operational leadership skills and experience during the out-of-hours (OOH) period. This shortfall poses notable risks to patients, staff, and overall site safety.

- During the OOH period, the nursing team primarily consists of junior staff members. Band 6 Registered Nurses (RNs) are designated as the nurse in charge, according to a planned departmental roster. In situations where there is an unexpected staffing shortfall, a Band 5 nurse may be required to assume this responsibility.
- Medical Staffing Arrangements, medical coverage out-of-hours is limited to a single resident doctor on site, who receives support from a non-resident, on-call consultant.
- Operational On-Call Support Monday to Thursday, operational on-call arrangements are provided remotely through a joint Belford and Caithness manager rota as part of wider NHSH on-call protocols. From Friday to Sunday, support during the OOH period is delivered by the NHSH site director on call, based at Raigmore.
- ANP leadership with ANP managerial and professional leadership is provided by the clinical nurse manager who also has management responsibility for all SCN staff. ANPs require different supervision and competency sign off arrangements, current management and professional leadership arrangements at Belford Hospital are not in line with other NHSH sites.
- Frailty is identified as a key area of concern in the Health inequality and Health equity assessments informing the Lochaber redesign programme. ANP provision has been successfully embedded in Raigmore and is a key enabler in the role of NHSH Frailty strategy.

Impact of each of the future Service Options including redesign on ANP workforce requirements.

Options 1- Do minimal

Implementing an Advanced Nurse Practitioner (ANP) team, led by Clinical ANP Leadership and including an ANP Frailty Practitioner, will enhance oversight, timely assessment, and support for inpatients. A dedicated Frailty ANP ensures prompt frailty recognition and intervention, collaborating with MDT and community partners This approach aims to lower admissions, readmissions, and length of stay, while enabling earlier discharge.

Lead ANP at band 8a would provide management, clinical leadership, and mentorship in a 60/40% split.

Out of hours staffing changes will increase patient and site safety, strengthen senior decision-making during high demand or staffing shortages, and bolster out-of-hours (OOH) resilience. With a proposed 5.43 WTE increase, OOH support requests to other sites are expected to decrease.

Training requirements and resources for ANP development would increase in options 1-4.

Option 2 – Core RGH Model

There is no change to the ANP workforce, the ANP operating model, or impact on other NHSH sites from option 1.

Option 3 – RGH model plus Intensive Rehab

There is no change to the ANP workforce, the ANP operating model, or impact on other NHSH sites from option 1, although the requirement for a frailty practitioner is important to underpin inpatient rehabilitation approaches as well as front door assessment.

Option 4- As option 3 with increased elective activity

There is no change to the ANP workforce, the ANP operating model, or impact on other NHSH sites from option 1.

Projecting the Lochaber RGH ANP workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
ANP	7	0	3.43	3.43	3.43
ANP Frailty	7	0	1	1	1
ANP Lead	8A	0	1	1	1
Total		5.43	5.43	5.43	5.43

Medical Staffing

Current Service Position

The medical staffing model at Belford Hospital provides consultant-led care, 24 hours a day. The hospital currently has 4.0 (WTE) Physicians and Surgeons, alongside 3.80 WTE Anesthetists established posts.

Each patient is overseen by a named consultant. Consultants are tasked with conducting reviews and assessments throughout the Emergency Department and hospital wards, as well as providing outpatient clinics and endoscopy services according to their specialties, such as general surgery or gastroenterology. Anesthetists manage airway care for trauma cases, deliver anesthesia for both elective and emergency surgeries, and perform pre-assessment reviews.

Recruitment and retention have been persistent challenges over several years, resulting in a recurring reliance on high-cost agency staff.

To address sustainability and mitigate the pressures associated with on-call duties, the consultant's establishment has been expanded in recent years. Rotational arrangements with Raigmore Hospital have been introduced into the Consultant Physician rota. Additionally, the hospital has implemented roles for Rural Emergency Physicians and Clinical Development Fellows. While these measures have largely been effective, ongoing adjustments are necessary to ensure long-term safety and sustainability of hospital services.

The Rural General Hospital (RGH) model is consultant led, and the current consultant complement will be maintained. The care model for all RGHs across NHS Highland necessitates the presence of core staff groups to deliver high-quality patient care and effective supervision. Senior decision-makers must be available at the hospital entrance, providing direct patient care and overseeing resident doctors, especially those early in their careers. At Belford Hospital, this role is carried out by Rural Emergency Physicians (REPs). At present, 2.0WTE REP posts are in establishment, resulting in staffing levels fluctuating during the week, which can result in inconsistent care and supervision for resident doctors.

The REP complement should be expanded to ensure continuous senior coverage for emergencies, support balanced shift patterns, and minimize the need for compensation for missed breaks. Funding from vacant Clinical Development Fellow posts could be redirected to facilitate this change.

Belford Hospital holds training hospital status, which is essential to maintain. Ensuring that resident doctors receive appropriate support and supervision is a fundamental requirement. This depends on the presence of consultants, other grades of medical staff, and senior nursing staff. The core RGH model offers NES resident doctors sustainable rotations with manageable out-of-hour demands. It is designed to foster a safe, high-quality learning environment that prepares doctors for primary and secondary care in Lochaber and Highland's rural communities. The medical rota is structured to balance direct and indirect supervision based on doctors' competency levels. It is recommended that Highland-based training with NHS Education for Scotland continue, particularly at Lochaber hospital, covering foundation, GPST level 1 and 2, emergency medicine, anesthetics, and general surgery to sustain the rural medical workforce.

Further details and rationale regarding the medical staffing model are available in the medical staffing model appendix.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Consultant medicine	Consultant	4.03 (0.03) spec Dr respiratory
Consultant surgical	Consultant	4.00
Consultant anaesthetics	Consultant	3.80
FY2	FY2	5.00
FY1	FY1	3.65
Specialty registrar	Specialty registrar	3.00
Rural Emergency Physician (REP)	Rural Emergency Physician (REP)	2.00
Total		**25.48**

Resident doctor non compliance costs are forecasting a full year spend of approx. £148 in 2025/2026.

Impact of each of the future Service Options including redesign on medical workforce requirements.

Option 1 – Do minimum

To provide a seven day a week REP rota an uplift of 1.5 WTE is required in the Do minimum option to provide an REP establishment of 3.5 WTE. REPs alongside the ANP service ensure consistent practice and adherence to standardised pathways, which can be challenging when resident doctors rotate frequently. The inclusion of ANP involvement out of hours and a frailty ANP is crucial and supports the delivery of the medical model; however, it does not reduce the requirement for doctors within the medical staffing model. ANPs cannot replace resident doctors on a rota at ST1 level or higher during out-of-hours periods.

The main risk is the ability to recruit Consultant medical staff for vacant positions; this is reflected in the risk register. Additionally, sustaining a suitable learning environment for resident doctors is challenging, especially without enough senior medical staff.

Option 2 – Core RGH Model

4.70 WTE REPS are needed to maintain consistent doctor coverage during SDEC hours. An electronic patient record system would enable seamless care transitions between hospitals and community settings. Combined with remote monitoring and imaging and test reporting, this approach would enhance care delivery in NHS Highland.

Experience at Caithness General Hospital highlights the importance of clear pathways between primary and secondary care in the ED, especially with seven-day REP coverage. It shows that patients should be directed to primary care, particularly out-of-hours services when appropriate, and that urgent care pathways must not develop in the ED if they belong in primary care.

Option 3 – RGH Model + Intensive Rehab

There is no change to the medical workforce, the medical operating model, or impact on other NHSH sites from option 2.

Option 4 – As Option 3 but with increased elective activity

This option increases surgical capacity by 1 PA to account for travel time required by visiting consultants and adds 2 PAs of anaesthetist time to support an additional surgical list. This option ensures an adequate number of PAs in the anaesthetic rota to facilitate recruitment to a substantive 10 PA post reducing reliance on high-cost agency locum use.

Projecting the Lochaber RGH medical workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Consultant medicine	Consultant	4.03	4.03	4.03	4.03
Consultant surgical	Consultant	4.00	4.00	4.00	4.00
Consultant anaesthetics	Consultant	3.80	3.80	3.80	3.80
FY2	FY2	5.00 NES banding supplement	5.00	5.00	5.00
FY1	FY1	3.65 NES banding supplement	*4.65	4.65	4.65
Spec reg		3.00 NES banding supplement	3.00	3.00	3.00
Clinical Fellow		4.00	4.00	4.00	4.00
GP/REP	REP	2.00	3.5	3.5	4.7
Medical assistant practitioner	Band 4		0.88	0.88	0.88
Total		**25.48**	**32.86**	**32.86**	**34.06**

- NES to confirm when increase in FY1 placement will commence
- REP model based on 13hr am-9am cover for 365 days per year with annal leave 4 hours SPA and 6 weeks study leave as per current NHSH REP contract. Roles would be part-time portfolio roles. Rota requires a headcount of 4.7wte staff in post for options 1-4.
- SDEC in 2029/30 is based on a 5 days per week, 6-hour shift requiring 1.2 WTE in line with Raigmore SDEC model

Combined Assessment Unit (CAU)
Current Service Position

The Combined Assessment Unit (CAU) offers short-term acute assessment, investigation, and treatment for medical and surgical patients, including those with general health conditions. It has 17 beds, with the ability to flex to 20, and operates 24/7. There is a daily consultant led medical and surgical ward rounds and multi-disciplinary input from a range of health care professionals to provide inpatient support.

Within the unit, there are two beds designated for enhanced care. Staff assigned to these beds possess specialised competencies to effectively meet the needs of patients requiring higher levels of care. These enhanced care beds are suitably equipped to support ventilated patients on a short-term basis when necessary, ensuring the unit can respond to acute clinical requirements.

The current CAU staffing budget is joint with Day case and preassessment. Organisational change is planned to split the two departments, for the purposes of this workforce plan, each department is presented separately.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Senior Charge Nurse	7	1
Senior staff nurse	6	2.74
Staff nurse	5	19.76
HCSW	3	11.62
HCSW	2	1.76
Housekeeper	2	0.8
Total		**37.69**

- It is anticipated that a high percentage of the band 5 staff nurses will have uplift to band 6 agreed before 2030. 2 have already started progressing paperwork.

- RWW – awaiting requested uplift 2.01 WTE

- 2024/25 establishment review demonstrated a required uplift in staffing to maintain safe levels of care, increasing funded establishment by 2.63 band 3. This has yet to be reflected in the budget

- No housekeeper cover at weekends charge nurse cover is Monday to Friday in hours.

Activity

Non elective admissions remain the main driver of acute bed use, with activity peaking in 2024.

General Medicine accounts for the majority of the emergency workload and shows steady year on year growth.

Rising emergency demand underscores continued system pressure and limited bed flexibility.

Activity Breakdown:

Year	Total	Gen Med	Gen Surg
2025	1269	876	393
2024	1355	891	464
2023	1209	820	389

From 2019 to 2024 there has been to be a steady increase in average length of stay in CAU. However, 2025 data to date shows an improvement with a reduction of 4.7 days in 2024 compared with 3.8 days in 2025.

In recent years, around 94% of Elective patients have been admitted to Day Case Unit and discharged home. Currently, only around 2 to 3% of patients are admitted to Day Case Unit and transferred to CAU before being discharged home. In 2019, such a ward sequence was much more common; 17.5%, indicating a decline in in inpatient elective admissions over this period.

Proposal for the Future

- 24 single rooms with en-suite WCs in one acute inpatient ward.
- Day Case (DC) unit will be separate and provided as part of the integrated theatres unit, reducing current conflicts in bed demand.
- Shared spaces, such as social and activity room space with the rehab unit to optimise use of resources.
- Consistent room design allows for flexibility between acute and rehabilitation ward as demand fluctuates.
- Ward layout is designed to optimise visibility and maximise the use of technology in patient monitoring.
- Patient accessible Wi-Fi.

How is it different to what we have now and why?

- When required, higher levels of observation and care will be delivered in single rooms, utilising monitoring technology and ensuring visibility rather than within a multi-bed unit. This will allow skilled clinical teams to provide the same level of enhanced care as currently delivered in a multi bed space, but with greater flexibility in room use as well as improved privacy and dignity for patients and families.
- An improved environment for patients, with single rooms providing increased privacy, dignity, and safety as well as flexibility for visiting family and less disrupted rest. These will be supplemented by high quality communal spaces and spaces for families, as well as right-sized, modern support spaces to help staff care for patients more effectively.
- MDT (Multidisciplinary Team) is available to provide full in-reach support. For example, physiotherapy, OT, Dietician all providing rapid 360-degree review.
- Single rooms provide a space to deliver treatment without the patient having to move repeatedly to prevent mixed sex breaches or infection prevention guidance.
- Elimination of shared toilet facilities improves infection prevention and control.

Service Options presented at Initial Agreement impact on CAU and enhanced care

Option 1 Do minimum

2024/2025 Nursing establishment review has helped address current workforce issues and safe staffing with the aims to reduce high-cost agency use due to recruitment of appropriately trained nurses remaining a significant challenge.

HEPMA and EPR will be utilised in line with NHSH to roll out timescales which should allow for streamlining and quicker/easier access to information.

Band 4 nurse roles are not currently in establishment; ongoing work with senior management around utilisation in an RGH model is planned.

Option 2 Core RGH Model

To support the new planned ward configuration based on the single room model and an occupancy rate of 85%, an increase of 3.86 WTE staff is required. This adjustment will ensure the ward is adequately staffed to meet the demands of the expanded bed capacity in this layout.

The increase in beds will have a positive effect on patient flow throughout the hospital, alleviating bottlenecks and facilitating more efficient admissions and discharges. The single room model is designed to minimise patient movement within the unit, particularly when accommodating single sex bays and isolation rooms. This approach is notably more efficient for staff, as it reduces the time spent planning moves and relocating patients and allows for a more streamlined workflow.

There are several benefits to patients and their families associated with the single room model. The reduction in unnecessary movement is less disruptive, contributing to a calmer environment and improving overall patient experience. Furthermore, this model reduces the risk of healthcare acquired infections (HAIs), as patients are less exposed to cross-contamination. The improved infection control results in fewer ward closures, thereby minimising the impact on the wider system when outbreaks occur. Ultimately, these changes are expected to lead to improved patient outcomes and experiences.

The increase in AHPs in these options would support wrap around AHP support for critically unwell patients and provide early AHP input for acute stroke patients.

‘Waiting well’ initiatives currently under development to allow patients who are waiting treatment/procedures to keep in better general health allowing for quicker recovery and less intervention overall.

Frailty ANP recruitment to embed frailty assessment and intervention across the site including joint work with community and primary care partners to reduce admission and shorten length of stay. ANP site management out of hours will have clinical and operational oversight of all areas which should facilitate flow and allow for more robust out of hours staffing/decision making and resilience.

Near Me already utilised but will be made easier and provide patient confidentiality in a single room model.

Option 3 - Core RGH model plus intensive rehab

As option 2 there is no CAU workforce impact/

Option 4 - As Option 3 plus increased elective activity

Increased elective activity will have minimal/no impact on the combined assessment unit. It is anticipated that a small number of surgical patients will be pre assessed as requiring an elective admission post operatively. This will likely be due to distance travelled (increasing number of out of area patients choosing surgery in Belford) or due to complexity (Enhanced care may be required therefore appropriate nurse to patient ratio essential). This option will ease pressure on partner hospitals, i.e. Raigmore and Lorne and Isles.

Projecting the Lochaber RGH CAU workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
SCN	7	1	1	1	1
SSN	6	2.74	2.74	2.74	5.33
SN	5	19.76	19.76	19.76	17.43
HCSW	3	11.62	11.62	11.62	15.99
HCSW	2	1.76	1.76	1.76	0
HK	2	0.8	0.8	0.8	1.16
Total		**37.69**	**37.69**	**37.96**	**41.55**

- 2025-2028 includes SDEC SN 1.23 WTE to be moved to new SDEC 29/30
- 3.85 WTE band 3 24/25 establishment review impact not showing in ledger until 26/27

Ward 1 – Rehabilitation Ward
Current Service Position

Ward 1 operates as a nurse-led rehabilitation unit, comprising 12 beds and providing continuous, around-the-clock care, seven days a week. The central aim of Ward 1 is to assist patients in regaining essential skills and independence following illness or injury, with the goal of restoring their baseline level of function.

Within Ward 1, approximately eight to ten patients typically require intensive therapy input and an enabling approach from all staff members. This collaborative effort is essential in helping patients achieve their maximum potential for functional recovery. The ward's multidisciplinary team works together to ensure that patients benefit from a comprehensive rehabilitation process.

Currently, high numbers of beds in Ward 1 are occupied by patients who are experiencing delays while awaiting home care or placement in a care home, home adaptation, or guardianship decisions. This ongoing situation underscores the persistent challenges faced in discharge planning and patient flow, which can impact the overall efficiency and effectiveness of the rehabilitation service.

The Lochaber redesign population health needs assessment, along with Health Impact Assessment (HIA) and Equality Impact Assessment (EQI), has identified frailty as a priority concern for the Lochaber area. The management and support of frailty have been recognised as significant issues by community stakeholders and staff teams. As a result, the development of workforce competency in frailty management across patient pathways, spanning both acute and community services, has become a central component in establishing an agreed service model.

The core principles underpinning the rehabilitation workforce are directed towards delivering consistent, person-centered, and multi-disciplinary rehabilitation services across acute, sub-acute, and community care environments. Central to this approach is the prioritisation of a strong home-first and enablement philosophy, which ensures that patients are provided with support tailored to their unique needs throughout every stage of their care journey. The multi-disciplinary team (MDT) responsible for delivering this care is comprised of a range of professionals working collaboratively to optimise patient outcomes.

- Physiotherapy
- Occupational Therapy
- Speech & Language Therapy (SLT)
- Dietetics
- Pharmacy, with a focus on medicines optimisation, is addressed separately within the pharmacy section.

Allied Health Professional (AHP) therapy and rehabilitation services within Ward 1 are currently delivered by community physiotherapy and occupational therapy teams. These teams provide an integrated approach, supporting patients through in-reach to the existing site. To maintain and support the current bed base, the combined capacity of AHP staff amounts to 4.4 WTE occupational therapy and physiotherapy posts.

The existing facility faces significant space constraints, with small rooms and a lack of en suite amenities. In addition, the physiotherapy gym is frequently closed due to roof leaks, which further complicates the delivery of care. Communication between community based therapy staff and the acute multidisciplinary team is also impeded by disconnected electronic patient record (EPR) systems, creating further operational challenges for the service.

Current Funded Workforce Position Allied Health Professional (AHP) Therapy and Rehabilitation Services

The community physiotherapy department currently operates with a total of 9.87 whole time equivalent (WTE) staff. In addition, the community establishment includes 6.34 WTE Occupational Therapists. 4.4WTE of the total establishment are aligned to support the delivery of therapy services at the Belford site.

It is important to note that the allocation of this workforce to the Belford site can fluctuate. Factors such as service pressures, short-notice sickness, and vacancies may impact the actual number of staff available at any given time. As such, staffing levels may vary, affecting the consistency and availability of therapy provision.

Current staffing level (WTEs)		
Job Family	(AfC Band or Medical Grade)	**Funded (WTE)**
Senior Physiotherapist	6	1
Physiotherapist	5	0.5
Physio assistant	3	0.3
Senior OT	6	1.6
OT Assistant	4	1
Dietetics	6	0.5
Speech and Language therapy	6	1 (inc community)
Total		**5.9**

Current Funded Workforce Position Ward 1 Nurse staffing

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Domestic - housekeeper	Band 2	0.73
Nursing – HCSW	Band 3	9.66
Nursing – RN	Band 5	10.15
Nursing – RN	Band 6	3.00
Nursing – RN	Band 7	1.00
Nursing - HCSW	Band 2	4.61
Total		**29.15**

Activity

Belford has the highest proportion of bed days taken by the 5% longest-stay patients, with this group occupying 66% of beds in 2024. Their average stay was 97 days, and their mean age remains around 81. In 2024, 18% (14 of 78) died in hospital, indicating slow but ongoing discharge for most.

Neurological/Stroke and Musculoskeletal/Orthopaedic/Fractures are the main diagnoses in this long stay cohort, averaging 14.7 (20%) and 13.7 (18%) cases annually from 2022–2024. Reducing stay average from 66% to the Scottish average (40%) by reducing the occupied bed days by 3033 days has the potential to save eight beds worth of activity.

Proposal for the future

- Increase in establishment of 0.9 WTE OT and 0.55 WTE physio and 0.2 WTE Dietitian
- Uplift 6.02 WTE band 3s Healthcare support workers to band 4 to develop generic rehab support worker roles
- Introduction of assistant physio, OT roles and a speech and language support worker roles
- Provision of consultant AHP clinical leadership to the rehabilitation service
- Provide an appropriate nursing model for a single room layout
- Medical cover provided as required within the current medical staffing model

Option 1 – Do minimum

Currently, there is a combined Allied Health Professional (AHP) capacity of 4.4 Whole Time Equivalent (WTE) occupational therapists and physiotherapists responsible for managing the present CAU and Ward 1 bed base. This falls short of the recommended benchmark, which stipulates 1 WTE occupational therapist and 1 WTE physiotherapist for every five beds. The existing staffing is below this standard, resulting in a deficit of 2.6 WTEs.

To address this gap and ensure that comprehensive therapy services, including full-day coverage for assessment and discharge planning, are available in both acute and rehabilitation settings, an increase of 0.9 WTE occupational therapists and 0.55 WTE physiotherapists is required under the 'do minimum' option. The current AHP staffing level does not meet these requirements, thereby limiting patient outcomes and constraining wider system benefits.

Acute-level medical staffing is not required within this model. Medical support, when necessary, will be provided through designated pathways. Only patients who do not require acute medical intervention should be admitted, which means the medical staffing model differs from traditional acute wards. Primary care or GP liaison may be involved as needed.

Daily discharge planning is conducted by the broader multidisciplinary team (MDT), including social work. Community supports such as housing services, third sector organisations, volunteers, advocacy groups, and carers are also integral to the process, ensuring holistic support for patients transitioning from hospital to home or community settings.

The nursing development plan centres on upskilling the existing workforce to strengthen rehabilitation support in the ward environment. Band 2 Healthcare Support Workers will undergo training to advance to band 3, thereby increasing their skill set and responsibilities. In addition, further development opportunities will be offered in the development of 6.03 WTE, Band 4, new generic rehabilitation, and nurse support roles, with the aim of facilitating consistent rehabilitation support for activities of daily living. As a result, patients will benefit from comprehensive rehabilitative assistance available around the clock, every day of the week.

To further enhance the ward environment, the plan includes the expansion of the housekeeper role, ensuring a seven-day service. This adjustment allows HCSWs to devote more time directly to patient care, thereby improving both the quality and continuity of rehabilitation support provided within the ward setting.

Option 2 – Core RGH Model

As Option 1 Do minimum

Option 3 – RGH model + Intensive Rehab.

An intensive rehabilitation model is characterised by the provision of high-intensity multidisciplinary team (MDT) input, the cultivation of a 24-hour rehabilitation culture, and the utilisation of purpose-built space. The workforce is specifically trained to deliver coordinated, goal-centred care targeting medically stable individuals who demonstrate potential for meaningful functional improvement. The model aims to enhance patient independence, decrease reliance on acute beds, and support efficient system flow, particularly within rural settings.

The proposed AHP workforce for the intensive rehabilitation model comprises 11.35 (WTE) staff, a 2.8 WTE uplift in staffing compared to the do minimum option. This figure is based on the delivery of full-day therapy across both the acute admission ward, which focuses on assessment and rapid discharge planning, and the enhanced rehabilitation approach. It is important to note that this does not include community or outpatient provision for either current or prospective

The Allied Health Professional (AHP) and Nurse Consultant post is proposed as the clinical lead for the rehabilitation service. Medical cover will be provided as needed, aligning with the existing staffing model.

Therapy will be delivered according to recommendations of 30 minutes to 2 hours per day per patient. This will be accompanied by a rehabilitation-informed approach to all aspects of care, ensuring a consistent enabling environment throughout the patient journey.

To further embed the enablement philosophy, Band 4 Assistant OT and physio and Band 3 Speech and language therapy posts will be developed. These practitioners will possess a range of skills and will be available across all shifts to maintain therapeutic input and reinforce enabling practice at all times. This approach is specifically designed to significantly reduce the length of patient stay by maximising functional potential, promoting independence, and preventing further debilitation or loss of function.

There is no change to the nursing model from option 1 do minimum.

The aim is to reduce length of stay and promote independence. Impact on other sites will include reduced delay in repatriation particularly on major and silver trauma, neuro, stroke, and vascular pathways from Raigmore to Belford for patients requiring rehab.

Option 4 – As Option 3, increasing day case elective

No change from option 3

Projecting the Lochaber RGH Ward 1 and rehabilitation workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Proposed Allied Health Professional (AHP) Therapy and Rehabilitation Services staffing

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
SLT	3				0.40
Band 3 physio	3	0.30	0.3	0.3	
Band 4 physio	4				0.55
Band 4 OT	4	1.00	1	1	2.00

Band 5 physio	5	0.50	2.2	2.2	2.20
Band 5 OT	5		0.9	0.9	0.90
Band 6 physio	6	1.00	1	1	1.00
Band 6 OT	6	1.60	1.6	1.6	1.60
Band 6 dietitian	6	0.50	0.5	0.5	0.70
SLT	6	(1.00)	1.00	1.00	1.00
Band 8b	8b				1.00
		5.9	**8.5**	**8.5**	**11.35 (Option 3)**

Proposed Nurse and nurse support worker staffing

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Domestic - housekeeper	Band 2	0.73	1.40	.1.40	1.40
Nursing – HCSW	Band 2	4.61	0	0	0
Nursing – HCSW	Band 3	9.66	5.33	5.33	5.33
Nursing – HCSW	Band 4	0	6.66	6.66	6.66
Nursing – RN	Band 5	10.15	8.00	8.00	8.00
Nursing – RN	Band 6	3.00	2.67	2.67	2.67
Nursing – RN	Band 7	1.00	1.00	1.00	1.00
Total		**29.15**	**25.05**	**25.05**	**25.05**

Integrated Community Services
Current Service Position

Lochaber Integrated teams consist of the following teams:

Community Nursing, Physiotherapy, Occupational therapy, Social Work, Care at Home and the following Care homes:

- Invernevis House – 32 bds, 5 short term community access
- Moss Park – 39 beds, 17 closed at present. 1 Failte bed
- Telford Centre, Fort Augustus – 9 beds, 1 respite care
- MacIntosh Centre, Mallaig – 6 beds
- Abbeyfield Ballachulish (Charity run)

The teams work to Integrated Team principals through the delivery of a local care model outlined below:



During 2022/23, Lochaber Community Teams conducted a community and staff engagement to find solutions for emerging healthcare challenges. Five main projects were developed:

<u>Project 1: Living and Waiting Well</u>

Supports individuals on waiting lists (e.g., physiotherapy, occupational therapy, hip/knee operations) to maintain health and prevent deterioration.

<u>Project 2: Multidisciplinary Workers</u>

Explores flexible roles for care workers in homes and care facilities. Legislative changes now allow crossover, with efforts underway for standardised job descriptions across NHS Highland.

Project 3: Single Point of Access

Introduced a single contact for all community services, streamlining referrals, and assessments. This has improved efficiency and reduced inappropriate referrals, though waitlists have grown.

Project 4: Frailty

Regular Geriatrician clinics and updated multidisciplinary meetings review long-term patients. A crisis team is planned; progress continues within the HSCP in line with the Lochaber redesign programme.

Project 5: Intermediate Care

Intermediate care beds, now called Community Access Beds (CAB), support citizens at home or in hospital. The project succeeded at Invernevis, with repurposed beds in other locations and future expansion pending Care Inspectorate approval.

Current Funded Workforce Position

Please see Appendix x for comprehensive details about the Community workforce.

Information about proposed changes to rehabilitation models relating to the rehab model impacting Community Physio and Occupational Therapy teams can be found in the Ward 1 section of this plan.

Proposal for the Future

- We plan to support care closer to home, improve outcomes, and improve the experience of everyone including volunteers and carers. Services and workforce will be about supporting people to stay in their community.
- Introduction of rehabilitation service to provide services more holistically to better meet the needs of people locally, making effective use of digital technology to maintain independence. We will continue to work with our primary care partners to improve the health of our community.
- Expansion of palliative care services out of Care Homes and include more outreach to the community to make the care more accessible.
- More engagement with 3rd sector and voluntary services to aid prevention and engage with Housing to look at innovative solutions for care closer to home.
- Engagement on the Joint Strategic Plan for the Highland Partnership so that communities can have their say on how services are provided.

How is it different to what we have now and why

- We will ensure our services work well together in an integrated way and are responsive to the needs of individuals. Care and support is aimed at supporting people to remain at home for as long as possible.
- Public services are facing financial pressure and there is growing demand for support. We will support people to make positive lifestyle choices and to listen and engage our workforce.
- A focus on a holistic rehabilitation approach where different services work together rather than on an individual service approach should ensure better person-centred care and treatment.
- Palliation and end of life care have always been provided in Care Homes: Invernevis House has been trailing a dedicated space for relatives and both in and outreach services to assist people dying at home or in a more homely environment.
- We aim to work with housing associations to look at better supporting those who need some level of care in the future.

Current Funded Workforce Position

Proposal for the future

Rehabilitation will be delivered on a continuum model from prevention, supportive self-management, and pre-habitation to specialist practitioner intervention to optimise physical, mental, and social wellbeing. We will work in partnership with people to support their needs using an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society.

Alongside the growth in community AHP support to enable the development of proposed intensive rehabilitation model in option 3. There is an aspiration to redesign GP Out of hours services to develop the existing and additional proposed rehab team as part of a multidisciplinary Advanced Nurse Practioner led, full response team. This team will consist of Advanced Practice nurses, Paramedic Practitioners, Advanced clinical practitioners, Occupational Therapy staff, Physiotherapists Practitioners, OT and Physio but multidisciplinary workers. Care at Home multidisciplinary workers to provide immediate and intermediate packages until SDS Options are in place (Direct payments or traditional care at home for example) or, the citizen does not require the assistance.

This proposal is in its initial stages, and arrangements for detention must be agreed upon to advance this model. The development of this workstream is considered business as usual and does not differentiate between the options outlined in this plan, except for where staffing requirements have been described for the rehabilitation model. The proposal will move through HSCP governance processes alongside the development of the preferred option during the full business case stage.

Outpatients and Infusions

Current service position

The Outpatient (OP) department provides support for locally based and visiting clinicians and is open Monday to Friday 9am to 5pm. Currently 17,000 patients travel from a Lochaber postcode to a Raigmore outpatient clinic annually. There is scope to support additional visiting specialists to reduce the need for patients to travel with the OP current workforce capacity.

The team also provide a day case infusion service for many types of treatment, including immunoglobulin, monoclonal antibodies, and iron, but excludes systemic anti-cancer therapies, which are delivered by the MacMillan team (see SACT and Macmillian section). This service was initially set up utilising space in the Renal Unit for one day per week, 8am to 4pm. However, demand has increased, and the team often supports an extra day when space permits in the outpatient department. If this service were not available, patients would have multiple trips to Raigmore on a regular basis. As treatment advances and people are living longer with long term conditions, demand for this local service is likely to grow.

Current workforce funding position

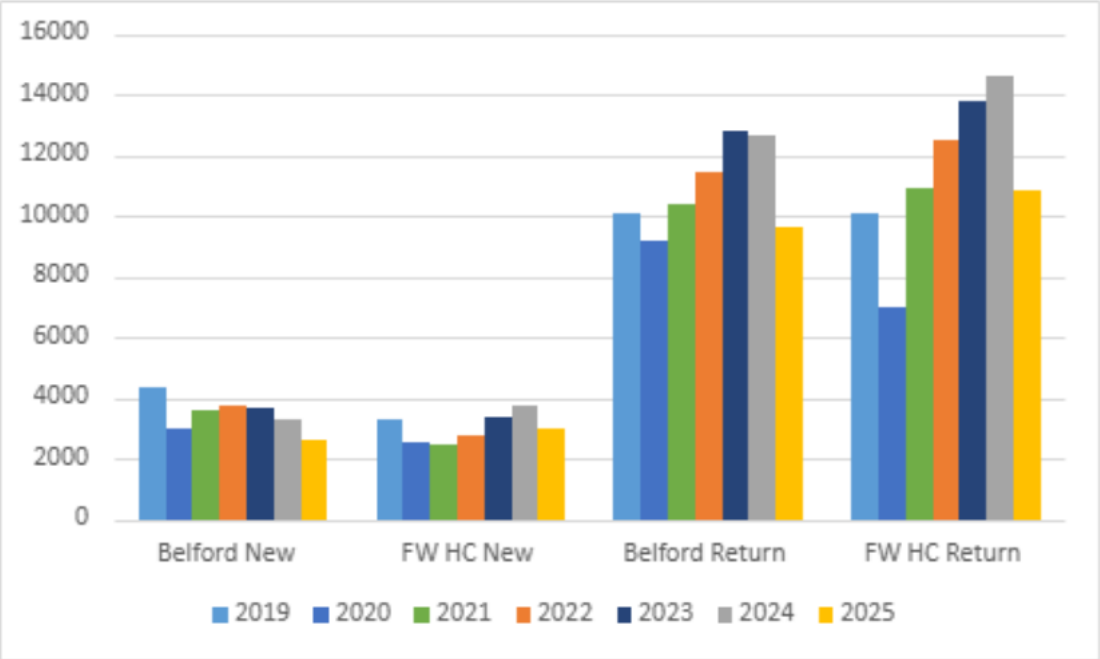
Current staffing level (WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)
Senior Health Care Support	3	3.01
Staff Nurse	5	2.12
Senior Staff Nurse	6	1.0
Senior Charge Nurse	7	1.0
Total		**7.13**

2 x Band 5 applied for band 5-6 uplift

Activity

- Return appointments continue to fall, driving the overall drop in outpatient activity; Belford new appointments also show decline.
- 12-week performance is slowly improving but remains below the desired standard; waiting-list compliance varies but is similar to NHSH averages.
- DNA rates remain a persistent pressure, limiting clinic efficiency.
- For Raigmore-delivered care, high-volume specialties (Orthopaedics, Oncology, Dermatology, Urology, ENT, Haematology, Neurology) account for most activity. Face-to-Face remains dominant (67%), generating over 1.52 million travel miles for Lochaber patients in 2025 and highlighting a strong case for local or virtual pathways.
- Near Me and Phone activity (≈33%) shows clear opportunity for expansion, especially for review-heavy specialties with repeated travel requirements.

- Combined trends emphasise sustained pressure on outpatient capacity and the need for targeted pathway redesign to improve flow, reduce DNAs and minimise avoidable travel.



Proposal for the Future

- Retaining a mixture of clinics, delivered by both resident and visiting Specialty Clinicians, for example a respiratory physician seeing a patient with asthma.
- Introduction of online booking will allow patients to book a time that suits them. Patient follow up appointments arranged flexibly around patient need/ condition and presentation.
- Concentration of all Outpatient level activity to one area within the hospital, featuring flexible use of clinical spaces alongside high-quality waiting areas.
- Hybrid Outpatient appointment approach, including virtual and telephone conversations, as well as face-to-face consultations.

How is it different and why?

- Physical capacity in terms of the type and number of rooms will be more closely aligned to demand.
- Enhanced environment for both patients and their relatives, for example waiting spaces with access to outside spaces and café.
- Flexible accommodation to support evolution of new services and treatments within a single outpatient department.
- Increased self-management and patient-initiated returns gives patients more control over their treatment.
- Optimal use of digital health systems and applications to support patient service access and information management/ communications.
- Due to increasing demand, staffing will be required to increase from 7.13 WTE to 8.85 WTE to staff for a third infusion session.

Service Options presented at Initial Agreement impact on Outpatient and infusion Department

Option 1 – Do minimum

No changes to the current service. Restricted potential to increase infusions in current space.

Option 2 Core RGH model

An uplift of 1.47 WTE is required at 0.67 band 3 and 0.8 band 6 to increase infusion capacity to meet demand.

Options 3 Core RGH plus intensive rehab

No change from option 2

Option 4 – Core RGH plus intensive rehab and increased elective activity

No change from option 2. WTE can support repatriated clinics

Projecting the Lochaber RGH Outpatient and infusion workforce requirements

Indicative plans as to how the workforce may change in terms of WTE

Current staffing level (WTEs)			Projected Staffing (Indicative WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)	2025/26	2027/28	2029/30
SHCSW	3	3.01	3.01	3.01	3.68
Staff Nurse	5	2.12	2.12	2.12	1.23
Senior Staff Nurse	6	1.0	1.0	1.0	2.70
Senior Charge Nurse	7	1.0	1.0	1.0	1.0
Total		7.13	7.13	7.13	8.60

Day Case and Pre-assessment

Current Service Position

Pre-assessment Service

The pre-assessment service is responsible for managing pre-assessment processes for all residents of Lochaber, irrespective of the surgical site location in Scotland. Additionally, the service undertakes pre-assessment for NHS Highland patients residing outside of Lochaber, provided their surgery is scheduled at Belford Hospital. In such cases, any necessary investigations or diagnostics are conducted at the hospital closest to the patient's home.

A dedicated nurse-led pre-assessment team evaluates patients' fitness for surgery. When cases are deemed more complex, they are referred to anesthetists for further review. The team decides the patient's suitability for surgery and determines whether the surgery should proceed at the RGH or if management at Raigmore is more appropriate. To support consistency and efficient sharing of information, the team utilises a software package called Synopsis.

With waiting lists managed centrally, patients are able to receive surgery dates prior to referral to pre-assessment. The service operates from Monday to Friday, between 09:00 and 17:00.

Day Case Unit

The Day Case Unit offers both pre-operative and post-operative care for patients undergoing elective surgical procedures that typically do not require an overnight stay, as well as those listed for endoscopic procedures. Additionally, the unit provides care for patients receiving transfusions and certain infusions.

On the day of surgery or endoscopy, patients proceed directly to the Day Case Unit, arriving from 08:00 at staggered intervals. Admission is managed by nursing staff, followed by reviews from the consultant surgeon and an anesthetist. After a brief recovery period within the unit, most patients are discharged on the same day. However, some patients may require an overnight stay; these individuals are transferred to a combined assessment unit (CAU) ward bed.

Staff in the Day Case Unit collaborate closely with colleagues in the CAU ward, which is immediately co-located. Currently, these teams are considered part of the overall ward staff complement, though there are plans to revise this arrangement in the future.

Current workforce funding position

Current Staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Senior Charge Nurse	7	0.71
Senior staff nurse	6	1.4
Staff nurse	5	4.61
HCSW	3	3.13
Total		**9.85**

***It is anticipated that a high percentage of the band 5 staff nurses will have an uplift to band 6 agreed before 2030. All band 5s have already started progressing paperwork.**

Proposal for the Future

- Integrated theatres and day case unit, independent of Inpatient facilities, encompassing elective day case activity and Endoscopy activity.
- Provision of a 8-space Day Case (DC) unit, separate from the inpatient ward, will reduce current conflicts in bed demand. This is supported by the seated discharge lounge.
- Integration of the team and flexible capacity within a state-of-the-art facility will allow a flexible patient-focused approach, better meeting demand.

How is it different to what we have now and why?

- There are 9-day case beds at present, and this will change to 7 beds and 5 chairs in the new facility.
- The Day Case Unit could be extended to provide care for patients requiring medical treatments on a same day basis.

Service Options presented at Initial Agreement impact on Daycase and Preassessment

Option 1 – Do minimum

No changes to the current service. Restricted potential to increase beds in current space.

Option 2 Core RGH model

No change form option 1

Options 3 Core RGH plus intensive rehab

No change from option 1

Option 4 – Core RGH plus intensive rehab and increased elective activity

An uplift of 0.94 WTE is required. There is potential to increase the day case service to five days per week, which would necessitate additional WTE to support an extra Friday list. To support this expansion, 0.2 Band 5, 0.2 Band 5, and 0.29 Band 7 positions are needed. The Band 7 role would enable the senior charge nurse to work full-time, reflecting operational requirements for a weekday service, and will also involve clinical duties to support the additional list. Additionally, 0.25 Band 5 is required for one additional day for preoperative assessment. Option 4a – As

Projecting the Lochaber RGH Daycase and preassessment workforce requirements

Indicative plans as to how the workforce may change in terms of WTE

Current staffing level (WTEs)			Projected Staffing (Indicative WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
SCN	7	0.71	0.71	0.71	1
SSN	6	1.4	1.4	1.4	1.4
SN	5	4.61	4.61	4.61	5.06
HCSW	3	3.13	3.13	3.13	3.33
Total		**9.85**	**9.85**	**9.85**	**10.79**

Theatres and Endoscopy
Current service position

The theatres at Belford Hospital are dedicated to providing safe, effective, and person-centred perioperative care, covering both scheduled and unscheduled procedures. As a standalone facility, Belford delivers surgical and endoscopy services primarily for residents of Lochaber, while also playing a vital role within the wider Highland network.

The theatre team manages a range of responsibilities including theatres, anaesthetics, recovery, and endoscopy. The team is composed of nursing staff, Operating Department Practitioners (ODPs), and Health Care Support Workers. Services are available five days a week, with an on-call team providing coverage during out-of-hours periods and weekends.

There are four established Consultant Surgeon posts at Belford Hospital. Although all positions are currently filled, not all consultants are full time or consistently present due to job plan arrangements and training needs, resulting in occasional gaps within theatre schedules. Visiting consultants also carry out uncomplicated procedures at Belford, and there is capacity to increase this activity. Efforts are ongoing to explore these opportunities further, and a central waiting list is recognised as a necessary step to optimise the use of available capacity.

Visiting surgical services are provided by a range of consultant surgeons who attend on a rotating sessional basis. These services are mainly focused on the Orthopaedics, Colorectal, and Gynaecology specialties. Specialty surgeons from Raigmore Hospital travel to Belford and operate on Mondays.

Endoscopy lists for Belford Hospital are organised by a centralised booking team based at Raigmore. For patients on a cancer pathway, pre-assessment staff monitor their waiting times to ensure appropriate care and timely intervention.

All Surgical and Endoscopy services in Lochaber are undertaken within Belford hospital. The current site has one operating theatre, with one anaesthetic room and one first stage recovery bed and one endoscopy procedure room; The day case unit has 1 multi-bedded bays of 4 beds and has additional 5 beds housed in the annex of a separate ward.

Current session plan

	Theatre 8 sessions		**Endoscopy 3 sessions**	
	am	**pm**	**am**	**pm**
Monday	Visiting surgeon	Visiting surgeon		Surgeon
Tuesday	General Surgery	General Surgery		
Wednesday	General Surgery	General Surgery	Physician	
Thursday	General Surgery	General Surgery		
Friday			Surgeon	

Current Funded workforce position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Nursing & Midwifery	Band 7	1
Nursing & Midwifery	Band 6	1.13
Nursing & Midwifery	Band 5	10.21
Nursing & Midwifery	Band 3	4.20
Nursing & Midwifery	Band 2	1.80
Healthcare Sciences (ODP)	Band 5	2.80
Total		**21.14**

Activity

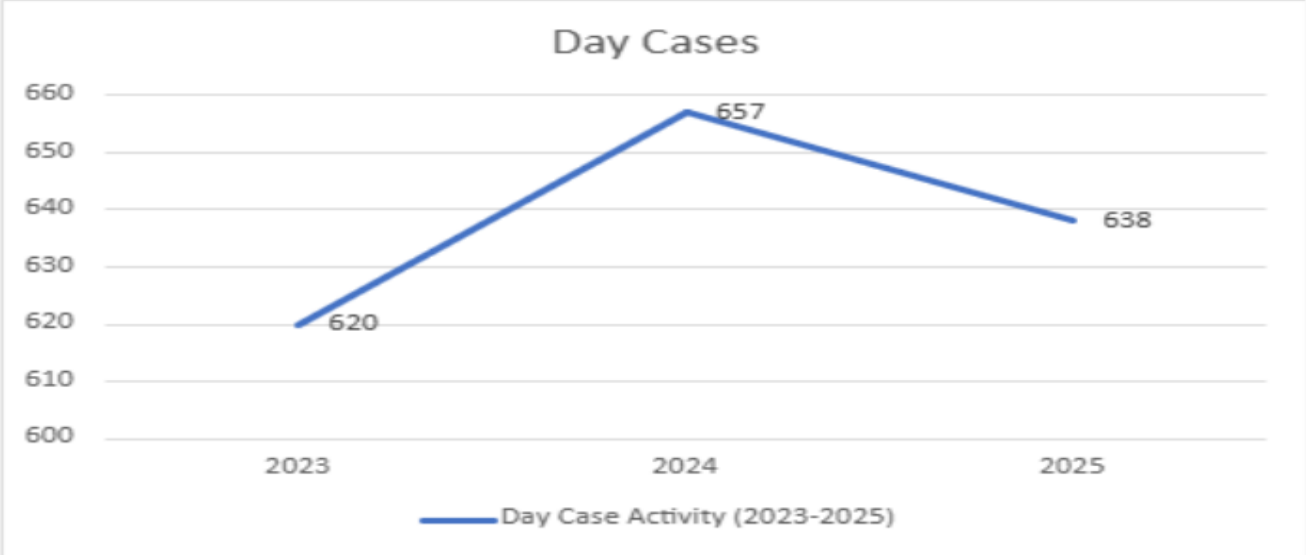
Day case activity has remained largely stable over the past three years, showing only minor annual fluctuations.

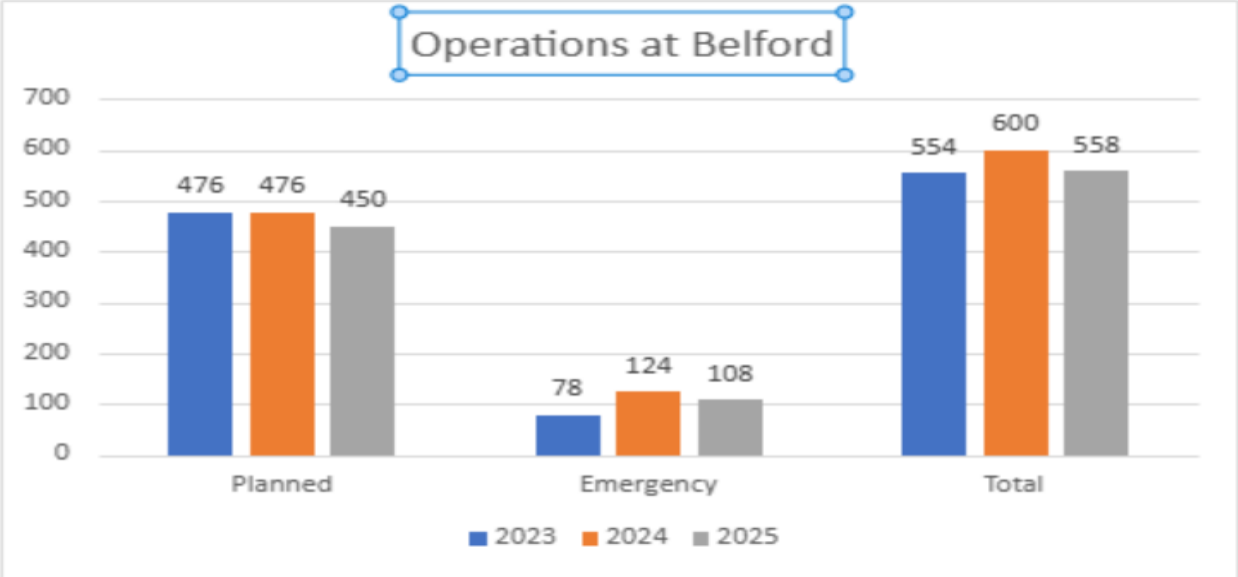
General Surgery continues to account for the majority of the workload, while Medicine provides a consistent, albeit smaller, contribution.

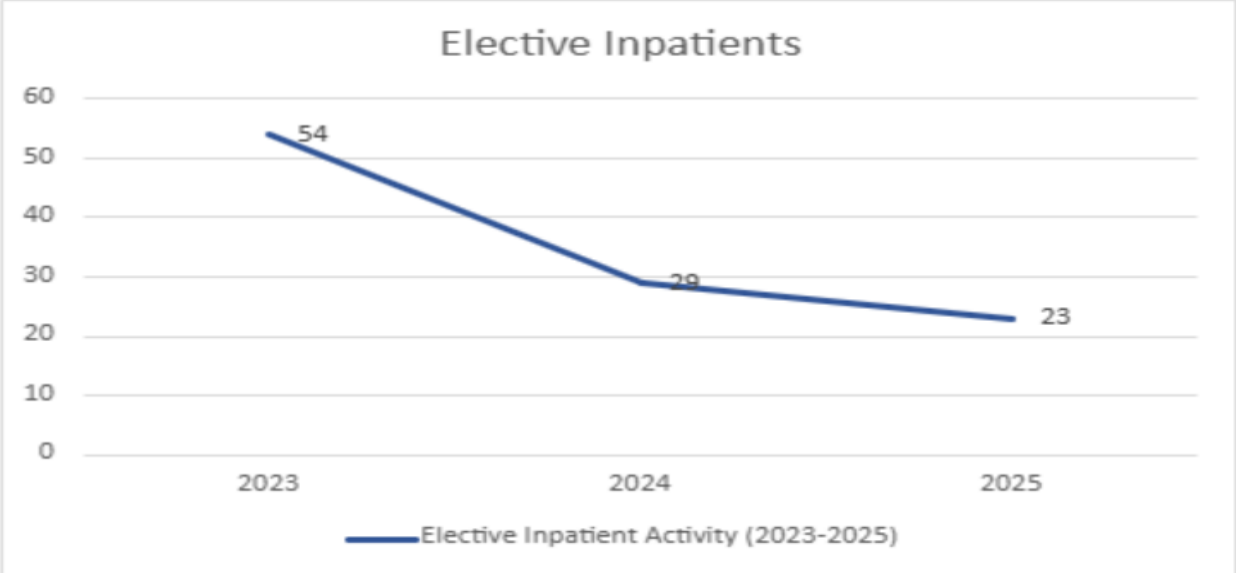
Elective inpatient activity is steadily declining, with volumes reduced by half between 2023 and 2025, most likely due to bed availability and need for HDU care post operatively.

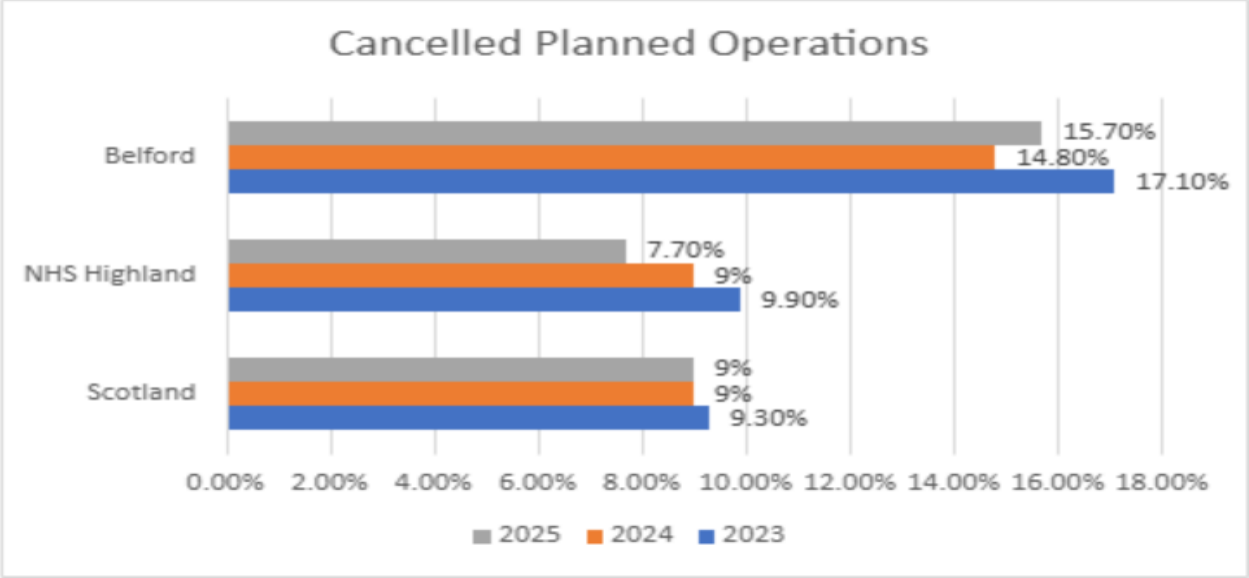
General Surgery remains the principal contributor but has experienced the most significant decrease.

This progression indicates limited capacity for planned care and an increased dependence on day surgery models. Cancellation rates exceed those observed in NHSH and across Scotland.


Day Cases
660
650
640
630
620
610
600
657
638
620
2023
2024
2025
Day Case Activity (2023-2025)


Operations at Belford
700
600
500
400
300
200
100
0
476
476
450
78
124
108
554
600
558
Planned
Emergency
Total
2023
2024
2025


Elective Inpatients
60
50
40
30
20
10
0
54
29
23
2023
2024
2025
Elective Inpatient Activity (2023-2025)



Endoscopy

From April 2023 to February 2026, Belford's diagnostic endoscopy performance shows sustained high compliance for Upper GI against the 6-week standard, with February recovering from a weaker January and returning towards the long-run trend. Flexi Sig and Colonoscopy demonstrate pronounced month-to-month percentage volatility due to very low throughput, with February activity at one patient in each stream, limiting interpretability. Where volumes are low, rolling averages and patient counts should be used alongside percentages to accurately reflect service performance.



Proposal for the Future

An increase from one to two fully compliant theatres, each with an anaesthetic room, will enable access for emergency surgical patients with minimal interrupting/ cancelling of elective (planned) lists.

Integrated theatres and day case unit, independent of inpatient facilities, encompassing elective day case activity and Endoscopy activity will reduce cancellation of the surgical programme.

Provision of an 8-space Day Case (DC) unit, separate from the inpatient ward, will reduce current conflicts in bed demand. This is supported by the seated discharge lounge.

Integration of the team and flexible capacity within a state-of-the-art facility will allow a flexible patient-focused approach, better meeting demand.

How is it different to what we have now and why?

- Increased theatre capacity would allow for more efficient use of the facilities and increased activity to be delivered locally.
- Ability to perform emergency surgery at the same time as elective, maximising the new layout for patient benefit reducing disruption to planned activity.
- Second theatre provides resilience under maintenance periods.

How is it different to what we have now and why?

- Increased theatre capacity would allow for more efficient use of the facilities and increased activity to be delivered locally.
- Ability to perform emergency surgery at the same time as elective, maximising the new layout for patient benefit reducing disruption to planned activity.
- Second theatre provides resilience under maintenance periods.

Service Options presented at Initial Agreement impact on Theatres

Option 1 – Do minimum

The establishment will be reduced to 17 WTE, to align to current session delivery of 8 elective surgery sessions and 3 endoscopy sessions. This supports 6 Belford/Lochaber activity sessions and 2 recovery plan sessions under the NHSH recovery plan, plus 3 endoscopy sessions. The nurse endoscopist initiative has been removed, as a medical/surgical consultant endoscopist is required onsite for all lists, which is currently not feasible.

Eye injections for macular degeneration treatment are scheduled to begin in summer 2026, taking place on Fridays in the theatre as this area meet ventilation requirements for the procedure. Visiting staff from Raigmore will be deliver the activity, supported by current Band 3 HCSW from Belford.

Option 2 Core RGH model

As per option 1. Eye injections will be delivered in outpatients in the new facility.

Options 3 Core RGH plus intensive rehab

As per option 1

Option 4 – Core RGH plus intensive rehab and increased elective activity

The establishment remains at 21.09 (WTE). The workforce supports a higher level of activity, with a total of 10 sessions scheduled per week. This includes an all-day operating list on Fridays and maintains three dedicated endoscopy sessions each week.

The operational approach features one elective theatre running full days, five days a week, providing consistent support for elective surgical activity. In addition, a second theatre is designated as an endoscopy room, used specifically to deliver three half-day endoscopy lists weekly. This arrangement ensures efficient use of available theatre space and aligns current funded establishment to projected increase in clinical activity.

Projecting the Lochaber RGH Theatres workforce requirements

Indicative plans as to how the workforce may change in terms of WTE

Current staffing level (WTEs)			Projected Staffing (Indicative WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)	2025/26	2027/28	2029/30
Nursing & Midwifery	Band 7	1	1	1	1
Nursing & Midwifery	Band 6	1.13	2.07	2.07	2.07
Nursing & Midwifery	Band 5	10.21	10.26	10.26	10.26
Nursing & Midwifery	Band 3	4.20	3.24	3,24	3.24
Nursing & Midwifery	Band 2	1.80	0.99	3.24	3.24
Total		**21.14**	**17.57**	**17.57**	**17.57**

Renal

Current Service Position

The renal dialysis unit located at Belford Hospital operates as a satellite facility of the Raigmore Hospital. At present, the service runs on a three-day schedule each week, providing dialysis on Monday, Wednesday, and Friday. This arrangement allows for dialysis of up to 12 patients within the unit.

The Renal unit is used to provide SACT and infusions on the remining days of the week.

The Belford dialysis unit also has the capacity to support patients from outside the Lochaber area, with particular reference to those from Argyll and Bute. These patients are regularly accepted into the unit, which helps reduce their need to travel longer distances, such as to Glasgow.

There are instances when certain patients require dialysis more than three times a week. Due to these limitations, some patients are compelled to travel to Raigmore Hospital to receive additional treatment. The existing staffing model, which necessitates working split days across the three operating days, has proven problematic to recruit to. There is potential to derive income from holiday renal patients, however in the current capacity it is not possible to capitalise on this, and patients holidaying in the area are unable to benefit from this service.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Nursing / General	3	1.84
	5	1.6
	6	0.8
	7	1
Total		**5.15**

Impact of establishment review 25/26 – 0.6 WTE Band 5 agreed but not in ledger

RWW – 6hrs /0.16 WTE hours per week

Activity

Proposal for the Future

- Dedicated separate spaces for both Renal and SACT (chemotherapy)
- Renal services to expand to a shorter day, 6 day a week service
- Patient led care planning promoting self-care with the ultimate aim to dialyse at home

- The expanded service will also be able to support visitors to the area for which funding can be sought from home Health Boards.

How is it different to what we do now?

- Dedicated space ensures flexibility to provide more treatments locally. Fewer patients required to travel from Lochaber to Raigmore Hospital or Argyll and Bute to Glasgow.
- Appropriate equipment storage and dedicated treatment preparation areas allows staff to work more effectively
- Enhanced purpose-built environment for patients

Option 1 – Do minimum

No change in current service. Service will not be able to expand its capacity. Uplift of 0.61 band 5 WTE increase from 24/25 establishment review. Band 5 to 6 uplift in process.

Option 2 Core RGH

To facilitate six-day short day working within the renal service, there will be an increase of 2.19 (WTE), comprising 0.68 WTE at Band 5 and 1.48 WTE at Band 6. This adjustment is designed to ensure adequate staffing levels for the expanded service model.

Recruitment into these roles is expected to be enhanced by the revised shift patterns and associated enhancements, making positions more attractive to prospective candidates.

Renal nursing requires specialised training. Nurses will begin developing core competencies after six months of training, equipping them with fundamental knowledge. Full competency as a Renal Nurse is typically achieved after at least one year of dedicated training.

The establishment of self-care stations supports government objectives to increase home haemodialysis. This initiative will enable all Lochaber patients to receive dialysis closer to home, promoting patient-centred care and greater convenience.

Option 3 – RGH model + Intensive Rehab

No change compared to Option 2

Option 4- As option 3 but with increased elective activity

The service has the potential to expand its catchment area, which would result in an increase in patient numbers. In order to accommodate this growth, it would be necessary to transfer additional resources to support an increase in Whole Time Equivalents.

By increasing capacity, the service would be able to serve a wider group of patients. This additional capacity would also help to alleviate pressures currently experienced within the acute hospital units, ensuring a more balanced distribution of patient care and supporting overall efficiency within the healthcare system.

Projecting the Lochaber RGH renal department workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Nursing	3	1.84	1.84	1.84	1.86
	5	1.6	1.6	1.6	2.28
	6	0.8	0.8	0.8	2.28
	7	1	1	1	1
Total		**5.24**	**5.24**	**5.24**	**7.43**

Systemic Anti-Cancer Therapy (SACT) and Macmillan Cancer Support team Current Service position

The Systemic Anti-Cancer Therapy (SACT) and Macmillan Nurse team operate and are managed within Community service, providing substantial advice and in-reach support to Belford hospital wards. Their responsibilities include administering the Systemic Anti-Cancer Therapy Service, ensuring that patients benefit from the expertise and guidance required throughout their treatment journey.

SACT nurses are highly specialised in the safe administration, coordination, and comprehensive support of systemic anti-cancer therapies. These treatments encompass chemotherapy, immunotherapy, targeted therapy, and other anti-tumour agents. The nurses play a pivotal role, safeguarding the effective and secure delivery of these therapies while providing holistic care to cancer patients at every stage of their treatment.

Presently, the SACT service is offered in the Renal Unit for one day each week, specifically on a day when dialysis is not scheduled. Plans for the new hospital design include the establishment of a dedicated SACT unit, which would facilitate the expansion of the service to an additional weekly session. This development would allow local patients to attend treatments on consecutive days, eliminating the need to travel between Raigmore and Belford hospitals, and thereby increasing local convenience and continuity of care.

Enabling patients to attend consecutive sessions at Belford would free up capacity at Raigmore Hospital, allowing more patients to be treated at Raigmore and optimising resource utilisation across both sites.

The expansion of SACT administration at Belford Hospital is inherently linked to the capabilities of the Aseptic Dispensing Unit (ADU) at Raigmore Hospital, which supplies intravenous SACT to North Highland. Currently, the ADU’s infrastructure limits its preparation capacity, with only two isolators available for SACT preparation. Any increase in SACT provision at Belford must therefore be carefully balanced with existing demands across North Highland to maintain safe and sustainable service delivery.

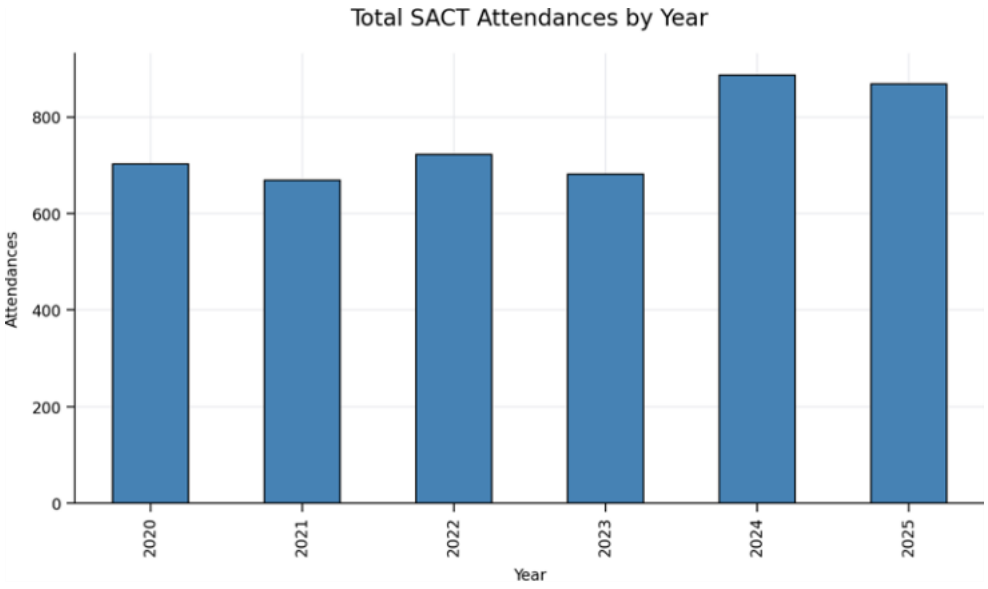
A capital bid has been submitted to establish a new ADU equipped with additional isolators, which would enhance aseptic preparation capacity and support future growth of SACT services. However, there is no current confirmation regarding funding approval or associated timescales. As such, it is not possible to assume any immediate increase in capacity, and expansion plans must remain provisional for further developments. Staffing for an additional clinic to meet existing demand is included in this plan.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)
Team lead	7	0.2
Macmillan Nurse specialist SACT	6	2.81
Macmillian Nurse	5	0.80
Macmillan support worker	3	0.72
Total		**4.53**

Activity

SACT activity remained broadly stable between 2020–2023, followed by a substantial rise in 2024 (+30%). This reflects increasing use of long-term targeted and immunotherapy treatments. Breast cancer remains the highest contributor to treatment volumes (30%), with growing demand from urology (19%) and gastrointestinal pathways (12%). The case-mix highlights a sustained need for pharmacy aseptic capacity, chair time, and specialist nursing support, given the predominance of multi-cycle regimens.



Proposal for the future

- Dedicated SACT and infusion unit, distinct from the renal department

How is it different and why?

- Doubled capacity for SACT clinic and SACT infusion, negating the need for patient travel to Raigmore and increasing capacity on the Raigmore site

Option 1 Do minimum

No impact unable to expand service on current site

Option 2 Core RGH model

This option would enable the increase of one session a week requiring 0.4 WTE Band 6 Registered nurses to provide the SACT clinic and infusion session required to enable local patients to attend both days of treatment consecutively, rather than having day one at Raigmore and day two at Belford. Consequently, this would create additional capacity at Raigmore for treating more patients.

Option 3 Core RGH plus intensive rehab

No change form option 2

Option 4 Core RGH plus intensive rehab and increase elective activity

No change from option 2.

Projecting the Lochaber RGH SACT workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
AFC Nursing	7	0.2	0.2	0.2	0.2
AFC Nursing	6	2.81	2.81	2.81	3.3 (plus 0.40 inc 22.5.%)
AFC Nursing	5	0.80	0.80	0.80	0.80
AFC HCSW	3	0.72	0.72	0.72	0.72
Total		**4.53**	**4.53**	**4,53**	**5.02**

Midwifery and Obstetric Ultrasound
Current service position

Midwifery

The midwifery service operates throughout the Lochaber region, encompassing both community-based care and the midwife-led community midwifery unit located in Belford Hospital. Governance and management of the service are overseen by the Women and Health Directorate based in Raigmore.

Recent analysis of activity and staffing demonstrates that the service is well resourced. This level of staffing is necessary to ensure coverage across the wide geographical area of Lochaber, considering the distances travelled by midwives. Additionally, there is a requirement for an on-call system to support labour and delivery, both at home and within the unit. To maintain the wellbeing of staff, compensatory rest is provided following call-outs, and the current staffing establishment is essential to accommodate these needs.

Although the birth rate within the region is declining and is expected to continue to decrease, it remains impractical to reduce the number of midwives on the rota. The nature of the service, including the geographical spread and on-call commitments, necessitates sustained staffing levels to ensure continuity of care.

The midwifery team benefits from low staff turnover, and recruitment has not posed significant challenges in recent years. However, it is noted that six members of the midwifery staff are over the age of 50, highlighting the need for robust succession planning to secure future service provision.

The team plays an active role in training future midwives by supervising students from both Robert Gordon University and Napier University. The experience gained in remote and rural placements is recognised as a valuable factor in supporting recruitment to the profession.

The staffing requirements for the midwifery service are expected to remain unchanged. Despite a projected decline in the birth rate, the combination of a wide geographical area and the necessity for on-call cover continues to underpin the need for the current workforce establishment.

Obstetric Ultrasound

Currently, there is no access to obstetric ultrasound services in Fort William. As a result, expectant mothers must travel to Inverness in order to undergo necessary ultrasound scans. This arrangement presents challenges for women and families, especially given the distances involved and the importance of timely access to early pregnancy care.

Recognising these concerns, the reintroduction of a locally provided obstetric ultrasound service has been identified as a priority and is actively under review. The preferred approach is to establish a midwife-led service, which aligns with the existing model of care in Lochaber. However, implementing this service will require addressing both training requirements and additional costs.

There is a nationwide shortage of obstetric sonographers, especially affecting northern Scotland. Recruitment for midwife/obstetric sonographer positions remains challenging, and Raigmore's obstetric ultrasound service is severely understaffed and operating below establishment. This is on the NHSH Risk Register.

The training pathway for sonographers spans 18 months and typically involves placements outside the immediate area. This requirement represents a significant barrier for local midwives who may wish to undertake the necessary training, as it could disrupt their professional and personal lives. While a visiting solution from Raigmore is possible, it is less efficient due to valuable sonographer time spent travelling. Considering the shortage, efforts to develop local services would benefit both the Lochaber and Raigmore sites by increasing capacity. The necessary resources for obstetric ultrasound are outlined in the service options, but delivering this service will involve significant challenges.

Current workforce funding arrangements

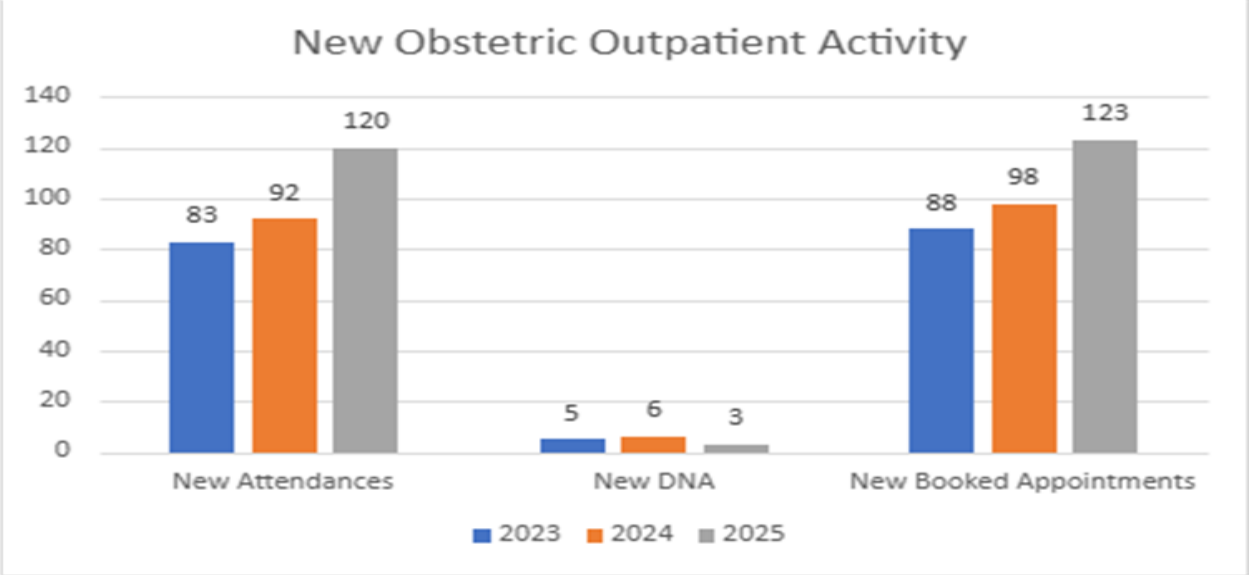
Current staffing level (WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)
Nursing and Midwifery	Band 7	1.0
Nursing and Midwifery	Band 6	7.79
Nursing and Midwifery	Band 4	0.73
Nursing and Midwifery	Band 3	1.0
Total		**10.52**

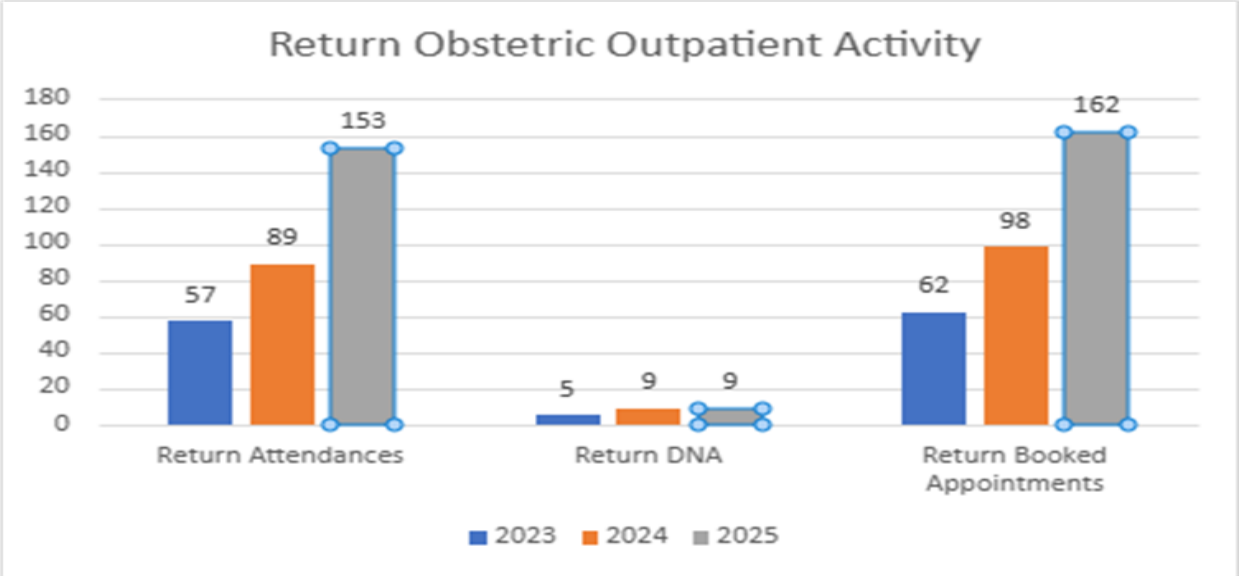
Activity

Outpatient obstetric activity has shown steady growth across the three-year period, with both new and return attendances rising year-on-year. In 2025, new attendances increased to 120, up from 92 in 2024 and 83 in 2023, while return attendances rose to 153, compared with 89 in 2024 and 57 in 2023. This upward movement suggests increasing demand for maternity outpatient services.

DNA rates remained low and stable across all years, with new DNAs ranging from 3–6 and return DNAs consistently at 9 or fewer. The proportion of attended versus booked appointments remained strong, with only small numbers of non-attenders, indicating good service engagement.

Overall, activity has increased substantially since 2023, reflecting rising caseloads and sustained utilisation of maternity outpatient pathways, supported by consistently low non-attendance rates that help maintain clinical continuity and service efficiency.





Obstetric Ultrasound Activity

Count of Lochaber Patient appointments for obstetric ultrasound at Raigmore 2019-2025 (Source RIS)

Hospital Year	Raigmore Inverness OBUS
2019	1329
2020	1139
2021	1219
2022	1029
2023	1186
2024	1162
2025	1109
Total	**8173**

Proposal for the Future

- Lochaber midwifery-led model of care will continue, working collaboratively with the wider NHS team whilst providing care within the hospital and care in community settings and people's own homes across Lochaber.
- The new hospital will provide an improved environment and experience for patients and families.
- Introduction of obstetric ultrasound scanning locally will improve the level of early pregnancy care provided locally.
- The new facility will provide space for parenting/ante natal classes, providing a sustainable and reliable service for new and expectant parents.

How is it different and why

Will meet modern specifications, offering enhanced privacy and dignity with a more relaxed parent/patient focused environment.

Scanning and obstetric clinics within the unit will provide immediate access to further investigations (e.g., CTG/BP, monitoring) and reduce the need for travel to Inverness, and the associated time and cost to families.

The new facility will enable the midwifery team to better deliver Best Start principles alongside the integrated care team in local community hubs

A local obstetric ultrasound service will require the appointment of a midwife sonographer, a trainee midwife sonographer, a screening midwife, and a healthcare support worker.

Service Options presented at Initial Agreement impact on Maternity services

Option 1 – Do minimum

Option 1 – increase in 0.6 WTE Band 7 midwife sonographer, 1 band 6 Trainee Midwife Sonographer, 0.5 band 3 HCSW

Option 2 Core RGH model

No change to workforce requirements from option 1

Options 3 Core RGH plus intensive rehab

No change to workforce requirements from option 1

Option 4 – Core RGH plus intensive rehab and increased elective activity

No change to workforce requirements from option 1

Projecting the Lochaber RGH Maternity workforce requirements

Indicative plans as to how the workforce may change in terms of WTE

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Midwife sonographer	Band 7	0	0	0.6	0.6
Trainee Midwife Sonographer	Band 6	0	0	1.0	1.0
Nursing and Midwifery	Band 7	1.0	1.0	1.0	1.0
Nursing and Midwifery	Band 6	7.79	7.79	8.19	8.19
Nursing and Midwifery	Band 4	0.73	0.73	0.73	0.73
Nursing and Midwifery	Band 3	1.0	1.0	1.5	1.5
Total		**10.52**	**10.52**	**13.02**	**13.02**

Radiology

Current service position

The Radiology Department at the Belford Hospital provides imaging services for the Lochaber region and supports the imaging deficits of Skye, Lochalsh and Western Ross through its CT and Ultrasound service and also supports MSK Ultrasound referrals from Argyll & Bute.

Consultant Radiology support is provided from Raigmore on a remote basis with no visiting Consultant Radiologist. An external tele-diagnostics company are also available for reporting out of hours.

Radiology services are essential in delivering round-the-clock diagnostic support to the Emergency Department, inpatient wards, and operating theatres. The department operates Monday through Friday from 9:00 AM to 9:00 PM, providing comprehensive diagnostics for both scheduled and unscheduled care. This includes computed tomography (CT), ultrasound, and plain imaging. For emergency unscheduled CT and plain imaging, an on-call service is available overnight, on weekends, and during public holidays. Notably, 64% of unscheduled care occurs outside of regular hours.

The introduction of 2 WTE band 5 additional staff to support the extension of core radiology hours will increase service capacity and operational resilience, by extending core hours to 7 days per week, while also enabling meaningful and sustainable career development within the Radiology Department. This workforce expansion will provide the capacity to develop and embed advanced and transformational roles, including Reporting Radiographers, which are critical to service transformation.

The radiology staff consists primarily of a younger demographic, with no retirements expected in the next ten years.

The department has redesigned its workflow to accommodate increased demand and meet the needs of clinical services. Imaging equipment utilisation currently ranges between 79% and 100% capacity. There is an anticipated further increase in demand, particularly for CT and ultrasound, driven by demographic changes, national guidance, surveillance, screening initiatives, and developments such as Same Day Emergency Care (SDEC).

To meet growing demand and maintain an adequate workforce, further redesign the service is necessary. Key recommendations include increasing staffing levels to lessen the burden of on-call duties and compensatory rest, introducing advanced practice models, promoting continuous improvement, and leveraging technology. The financial impact of these changes could be partially offset by realigning budgets, especially by reducing agency spending. Improved work-life balance, the creation of engaging positions, and enhanced recruitment and retention are expected outcomes.

NHS Highland covers Scotland’s largest health board area, where geographic remoteness and deprivation make access to healthcare challenging. Patients often face lengthy travel up to four hours, for brief diagnostic appointments, adding costs and barriers, especially for those relying on public transport or needing leave from work. Delays in diagnostic imaging like chest X-rays can complicate treatment and increase management costs.

To address this, the Belford service is pursuing community-based imaging, including mobile services, to bring diagnostics closer to patients and reduce inequalities.

Community imaging will minimally impact Radiology staffing, as expanded hours will accommodate increased activity. The addition of a Reporting Radiographer will enhance diagnostic turnaround, patient flow, and satisfaction, while reducing reliance on outsourcing and supporting workforce development.

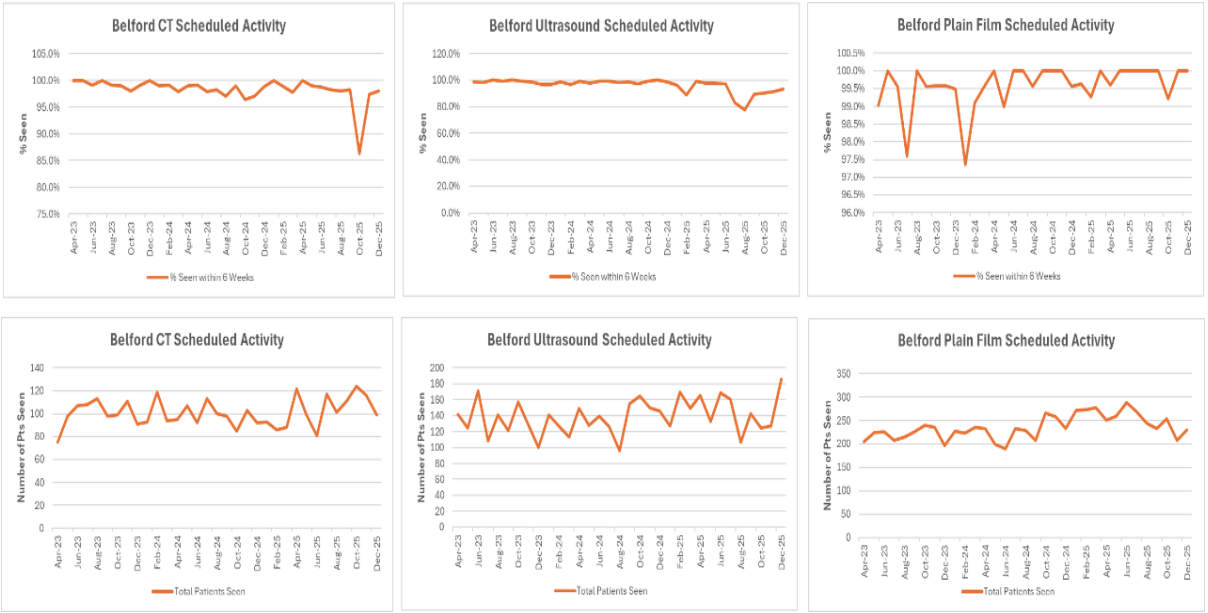
Implementation depends on funding, creation of Band 5 posts (planned for Year 29/30), and training at Raigmore and Oban. Outsourcing budget reallocations will help fund these changes, creating sustainable in-house reporting capacity and saving costs.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Radiology Service Manager	Band 8A	1
Sonographer	Band 7	1
Radiographers	Band 6	6
Assistant Practitioner	Band 4	0.93
Administrator/Booking Officer	Band 3	0.96
Clinical Support Worker	Band 2	1
Total		**10.89**

*RWW mitigations have been put in place with no increase to establishment

Activity



What are we proposing?

- An enhanced multi-disciplinary team model, including increased local input from the Consultant Radiologist service
- Extension of core hours which supports greater access to patients across a 24-hour period. At peak times for the emergency department, radiology can provide improved support and quicker diagnosis for patients
- Digitally enabled services. Allowing rapid diagnosis and information sharing allowing all clinicians to have immediate access to results, supporting improved patient care
- Utilisation of innovative technology to bring services into the community, for example, portable ultrasound scanner

How will this be different to what we have and why?

- Ability to offer more diagnostic services and host visiting services so fewer people will need to travel to Inverness or even to Fort William.
- All supported by the new digital infrastructure. giving clinicians greater access to digital diagnostic tools and results.
- Alignment of core working hours will support improved SDEC (Same Day Emergency Care) Service.

Option 1 – Do minimum

As an increasing proportion of activity occurs outside the traditional Monday–Friday, 9am–5pm model, working patterns in the existing site need to adapt. The introduction of an OOH GP service may necessitate/expedite the expansion of core working hours to reflect sustained changes in unscheduled care demand and support safe working practices in line with the Working Time Directive. Radiology services are experiencing a sustained shift away from traditional Monday–Friday, 09:00–17:00 working patterns, driven by increasing levels of unscheduled care. This reflects a structural change in demand rather than short-term pressure and requires an evolution in the radiology service delivery model.

Stage 1 of this redevelopment has been implemented, extending weekday core radiology hours to 21:00. This has improved service responsiveness and supported safe, timely patient care in line with current demand.

The primary purpose of the radiography on-call service is to provide urgent diagnostic imaging outside core hours for patients with suspected life- or limb-threatening conditions. It is not designed to support predictable, flow-based activity.

The proposed model also supports the growth of the ultrasound service through the training and development of new Sonographers, alongside targeted upskilling, and role development for existing staff. This strengthens service flexibility, resilience, and responsiveness across extended hours.

The plan supports succession planning, workforce retention, and long-term skills sustainability by offering clear progression pathways. It will reduce reliance on medical reporting capacity alone and strengthen multidisciplinary working across imaging services.

Option 2 – Core RGH Model

No change from option 1. The successful implementation of a Same Day Emergency Care (SDEC) unit relies on immediate access to diagnostic imaging to enable timely clinical decision-making, optimise patient flow, and avoid unnecessary admissions; this will necessitate service expansion where such capacity does not already exist.

Reporting Radiographers are a timely evolution of staff within a Radiography Department. It facilitates timely, real-time image interpretation and reporting, directly improving patient flow, clinical decision-making, and pathway efficiency. This is particularly important within Same Day Emergency Care (SDEC) and Unscheduled Care settings, where rapid access to diagnostics and reports reduces delays, avoids unnecessary admissions, and enhances the patient experience.

Overall, this investment ensures the radiology workforce is aligned with current and future service demands, supporting system-wide objectives in patient flow, operational efficiency, workforce wellbeing, and the delivery of high-quality, patient-centred care.

Option 3 – RGH Model + Intensive Rehab

No change from option 1.

Option 4 – As Option 3 but with increased elective activity

No change from option 1. No additional workforce requirements are anticipated however there may be impacted dependent on specific activity, for example the use of intra-operative Radiology services required for an orthopaedic procedure would have an impact on required establishment levels.

Projecting the Lochaber RGH Radiology Departments workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Radiology Service Manager	Band 8A	1	1	1	1
Sonographer	Band 7	1	1	1	1
Reporting Radiographer *	Band 7 *				1*
Radiographers	Band 6	6	6	6	5
Radiographers	Band 5			2**	2
Assistant Practitioner	Band 4	0.93	0.93	0.93	0.93
Administrator/Booking Officer	Band 3	0.96	0.96	0.96	0.96
Clinical Support Worker	Band 2	1	1	1	1
Total		**10.89**	**10.89**	**12.89**	**12.89**

** This date is dependent on when Stage 2 – extension of core hours actually occurs

Laboratory Services

Current service position

The laboratory at Belford Hospital is vital to its infrastructure, supporting diagnostic and transfusion services around the clock. It is integrated with other healthcare sectors community, primary care, and acute services offering 24-hour support for diagnostic testing, ensuring prompt delivery of essential patient information.

A non-residential, all-hours on-call service handles urgent needs and assists the A&E department, enabling swift response for critical cases.

Core Diagnostic Areas provided are:

- Biochemistry
- Haematology
- Transfusion
- Point of care testing: currently blood gases, troponin, blood glucose

To comply with Working Time Regulations and to maintain safe staffing levels, as well as meet Medicines and Healthcare Products Regulatory Agency (MHRA), United Kingdom Accreditation Service (UKAS), and Health and Care Professional Council regulatory requirements, the Belford Hospital laboratory requires a minimum of six Biomedical Scientists (BMS). This is essential to ensure both the continuity and safety of core services, particularly within the transfusion department, which must operate under strict legal guidelines.

Currently, only four BMS posts, including the Laboratory Manager, are substantively funded and available. This staffing gap has led to the long-term reliance on agency staff for over five years, creating ongoing cost pressures but ensuring that service delivery is maintained despite the shortfall. The Laboratory in Belford has a much lower staffing establishment than other Highland RGHs.

In response to these challenges, approval has recently been granted to appoint an additional 2 WTE Band 6 Biomedical Scientists on a fixed-term basis. This temporary measure is intended to establish rota compliance while alternative solutions are being explored through the STAG programme. Opportunities for closer collaboration with Lorn and Islands hospital laboratory services are under consideration, aiming to secure the rota and address persistent staffing issues within existing revenue budget.

The most significant risk currently facing the laboratory is the blood transfusion service. This risk is formally recognised on both the laboratory network risk register and the corporate risk register for Belford Hospital. It is crucial that workforce capacity accurately reflects the demands of the transfusion department, as this directly determines the level of service that can be delivered.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Blood Sciences Manager (Pan Highland)	8b	0.10
Laboratory Manager	8a	1.00
Senior Biomedical Scientist	7	2.00
Specialist Biomedical Scientist permanent	6	1.00
Specialist Biomedical Scientist fixed term 12-month contract	6	2.00
Medical Laboratory Assistant	3	0.46
Total		**6.56**

Activity

23/24 activity data total of 736,634 tests, blood science activity (biochemistry and haematology), microbiology activity 4,552.

Proposal for the future

- An improved lab environment which supports increased efficiency with additional space for personnel, meeting the requirements for modern lab standards.
- Both lab facilities and point of care testing facilities (POC – bedside diagnostics for example blood sugar testing) will be maintained/enhanced.
- Lab based services, maintaining routine blood sciences and transfusion activities including microbiology, supporting diagnostic management for patients.
- On call system remains in place, providing out of hours for transfusion, overdose, coagulation etc.

How is this different to what we have now and why?

- Better supported by digital health systems, allowing rapid diagnosis and information sharing allowing all clinicians to have immediate access to results, supporting improved patient care.
- Increased availability of POC testing. Right test in the right place at the right time to support clinical decision making and patient flow.
- Enhanced environment and introduction of POC testing will optimise sample transportation, meaning faster results.
- Supports increased same day emergency care activity due to being able to provide rapid diagnostic testing for patients.

Service Options presented at Initial Agreement impact on Laboratory

Option 1 – Do minimum

Service development to retain the existing fixed terms contracts as substantive staff at 2 WTE biomedical scientists is included in the Do minimum option. This will be removed should collaboration with pan-Highland STAG workstreams to review and rectify discrepancies in staffing models across Rural General Hospitals and /or exploration of opportunities to improve the efficiency of on-call arrangements, particularly focusing on Belford and Lorn and Islands hospital secures the rota.

There is an intention to explore opportunities for expanding Point of Care Testing (POCT) within the current site, aiming to enhance service delivery.

Consideration is being given to the introduction of the Band 4 practitioner role to assist in the day-to-day running of the laboratory and provide additional support to POCT services. This proposal forms part of a wider pan-Highland POCT business case as is not included in this workforce plan. There is also potential for remote validation of test results during on-call periods, with Band 4 practitioners responsible for physically running samples. However, it should be noted that this approach is untested and does not replace the current Band 6 role, which remains essential due to HCPC registration requirements.

Option 2 – Core Rural General Hospital (RGH) Model

Under Option 2, the model builds upon Option 1, with the addition of comprehensive implementation of Point of Care Testing (POCT) across the site. While the expansion of POCT services will not completely eliminate the workload within the laboratory nor remove the necessity for on-call services, it is anticipated to lessen the requirement for compensatory rest time. This, in turn, will contribute to higher laboratory quality standards and provide additional support during periods of analyser downtime. The increased use of POCT may also help to reduce costs associated with call-out charges.

The deployment of POCT will have some impact on Emergency Dept staff. However, the time difference compared to existing workflow systems is expected to be negligible.

The introduction of acute order communications will coincide with the completion of the new build, enhancing laboratory workflow efficiency. ICE requests are already operational for community testing. These technological advancements are not expected to have any impact on staffing levels.

There is also the potential for blood transfusion services to become more sophisticated through the adoption of systems such as electronic issue and automated smart blood fridges. While these enhancements could influence workforce requirements, they carry a high-cost impact and would require substantial eHealth support, which is currently unavailable.

Option 3 – RGH model + Intensive Rehab

As option 2.

Option 4 – RGH Model with Intensive Rehabilitation and Increased Elective Activity

The workforce model remains the same as option 2. The increase in elective activity is projected to result in a higher Laboratory workload due to a higher number of samples for pre-operative assessment and blood transfusion samples. This escalation brings a greater likelihood of encountering antibody sensitivities, influenced by an ageing population, evolving patient demographics, and increased patient throughput. Consequently, more samples may need to be transported to Raigmore Hospital, typically via taxi services.

The increased surgical procedures raise the risk and probability of major haemorrhage events, which will directly impact the usage and re-supply of emergency O Negative blood. To accommodate this, it may become necessary to increase the stock of blood held within the laboratory. Additionally, this scenario could lead to greater wastage of blood products, resulting in a potential cost impact. Despite these operational changes, there are no workforce implications beyond the continued requirement for a compliant rota.

Projecting the Lochaber RGH Laboratory workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			Projected Staffing (Indicative WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)	2025/26	2027/28	2029/30
Blood Sciences Manager	8b	0.10	0.10	0.10	0.10
Belford Laboratory Manager	8a	1.00	1.00	1.00	1.00
Senior Biomedical Scientist	7	1.00	2.00	2.00	2.00
Specialist Biomedical Scientist	6	1.00	3.00	3.00	3.00
Medical Laboratory Assistant	3	0.46	0.46	0.46	0.46
Total		**4.56**	**6.56**	**6.56**	**6.56**

Administrative services

Current Service Position

As part of the NHS Highland (NHSH) Transforming and Resilience of Admin (TARA) initiative, the administrative services previously managed within Belford Hospital have now been transferred to a central management function for NHSH Acute Services, based at Raigmore Hospital. This transition encompasses not only the budget but also the operational and professional line management responsibilities, thereby aligning Belford with the NHSH Acute Division model.

The primary objective of this transition is to adopt a centralised approach to administrative functions that support health and care services. By doing so, the initiative seeks to promote integration and ensure long-term sustainability of administrative operations.

Collaboration across various services is at the core of this process, with teams working together to develop and implement a new administrative model. This model is designed to optimise the utilisation of both resources and technology, ultimately delivering improvements that benefit both patients and staff.

Key components of this transformation include the implementation of an acute administration target operating model and a clear emphasis on digital transformation and innovation. Speech recognition, digital forms, robotic process automation (RPA), digital front door, EPR i.e. Order Comms, and MS365 are all examples of digital tools that should streamline administrative processes over the next 5 years. The evolving model places greater focus on patient-facing roles within administration, while reducing the emphasis on roles that are primarily concerned with managing patient records as an electronic patient record is introduced.

Local teams are testing the application of innovative technology to aid service delivery, including the implementation of speech recognition software. However, current findings suggest that, within a small team such as Belford’s, the anticipated time-saving benefits may not be sufficient to justify a reduction in staffing requirements.

Presently, the service is operating with a staffing level that is below the established threshold, resulting in an underspend. It is expected that this underspend will be utilised following the outcome of the wider Admin Services Review as part of this a proposal to introduce a B5 team leader has been proposed.

At Belford Hospital, administrative support, particularly at management support level has been assessed as inadequate for meeting service requirements. Consequently, a proposal has been made to reinstate a previous Business Manager post, which would be at Band 6, 0.5 Whole Time Equivalent (WTE). This position is not currently included in the workforce plan.

Radiology admin are managed by admin services with the budget remaining within Radiology. There is a proposal for management of ED reception to move to admin service line management arrangements to be aligned with main reception services. GP OOH admin has the potential to align with ED in a future reception model that will be confirmed at full business case.

Current Funded Workforce Position

Currrent staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Admin – Belford Medical Records	2	9.54
	3	1.86
	4	5.53
	6	1
Total		**17.93**

RWW will not have any impact on admin team, mitigations are in place

B5-6 uplifts do not apply

Proposed changes

- Collaborative Working Environment, co-locating multidisciplinary staff will foster teamwork and improve communication, supporting patient care and operational efficiency.
- Flexible Workspaces, hot desks in clinical areas will offer convenient workspaces for visiting staff, allowing closer collaboration with patients and teams.
- Modern Office Design with open-plan offices, meeting rooms, and breakout spaces provide flexible environments for both teamwork and confidential tasks.
- Transition to Electronic Patient Records aims to eliminate paperwork, streamline information sharing, and ease administrative workload.
- Education Facilities including a multi-use education room will facilitate training and development, optimize clinicians' time, and reduce use of external venues.
- Central administrative services will support the Emergency Department, improving consistency and efficiency.

How is it different and why?

- Hot desks within clinical areas allow staff and clinicians to be closer to patients.
- Co-location of all those using non-clinical based office environments in a centralised area, promoting collaboration as opposed to current segregated offices.
- Electronic records – will eliminate the need for a physical medical records store.
- Education facilities – improved utilisation to support ongoing staff development.

Option 1 Do minimum

No change to current service

Option 2 Core RGH model

No change to WTE

Option 3 Core RGH plus intensive rehab

No change to option 2

Option 4 Core RGH plus intensive rehab and increase elective activity

No change option 2. Repatriated Raigmore pt would be administered at Belford but anticipate can absorb activity. Potential for pan highland waiting list management to facilitate patient choice and theatre efficiency

Projecting the Lochaber RGH admin services workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			Projected Staffing (Indicative WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)	2025/26	2027/28	2029/30
Admin & medical records					
	B2	9.94	9.94	9.94	9.94
	B3	1.86	1.86	1.86	1.86
	B4	5.53	5.53	5.53	5.53
	B6	1	1	1	1
Total		17.93	17.93	17.93	17.93

Pharmacy

Current service position

The Pharmacy Department at Belford Hospital is responsible for delivering a comprehensive supply and clinical service to the hospital itself. Additionally, it extends certain supply and clinical support to Lochaber Locality and GP practices, as well as other non-hospital services such as Out of Hours provision and support for the Rural Support Team.

This Pharmacy also operates as a vaccine holding distribution centre, serving Lochaber, Argyll & Bute, and part of Skye. Its distribution responsibilities include driving and delivery, which, in some cases, are coordinated with existing transport services.

The Pharmacy operates during the core hours of Monday to Friday, from 08:00 to 16:00. Outside of core working hours, from 16:00 to 08:00, the Raigmore Pharmacy On-Call service provides support. On weekends and public holidays, the on-call service arrangement remains in place

Current demographics of staff are mixed, though there are none of immediate retirement age. Range from 30’s to 50’s.

Recruitment is challenging and locum staff have been needed. The aim is to build a team that would be self-sufficient and not require locums unless in extenuating circumstances.

There is an established post of Pharmacy Manager, Band 8B which has been difficult to fill. Service change undertaken in 24/25 has secured the recruitment of Band 8A Pharmacist with management and professional leadership provided from Raigmore and the Belford RGH manager.

Potential to develop and integrated acute/community service has been explored but will not be taken forward as part of the workforce redesign.

The current staff within the Pharmacy Department represent a diverse range of ages, predominantly spanning from their thirties to fifties. Notably, there are no employees who are of immediate retirement age, which provides stability in terms of workforce continuity.

Recruitment remains an ongoing challenge for the department. As a result, locum staff have occasionally been required to support service provision. The overarching objective is to establish a self-sufficient team that would only require locum assistance in exceptional situations.

The post of Pharmacy Manager, graded at Band 8B, is vacant following a retirement, this post has been reviewed and skill mixed. In response to these service changes implemented during 2024/25, a Band 8A Pharmacist has been successfully recruited. Management and professional leadership responsibilities are shared between Raigmore and the Belford RGH manager, ensuring continuity and oversight.

The possibility of developing an integrated acute and community pharmacy service was explored as part of workforce redesign discussions. However, this option will not be pursued further at this stage.

The use of Omnicell cabinets is being looked at to support wards and departments. This may have a positive effect on staff requirements out of hours but will also add workload at other times. The use of a “Robot” in the pharmacy is a well-known and tested system in larger general facilities. The use of such in a RGH will require a cost and volume assessment which is not viable at Belford or other RGH`s

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family	(AfC Band or Medical Grade)	Funded (WTE)
Team Lead Pharmacist	8B	1
Specialist Pharmacist	7	1
Deputy Team Manager	7	1
Pharmacy Technician (vaccine funded)	4	1 VTP funded
Pharmacy Support Worker	2	1 Plus 1.53 WTE VTP funded
Total		**6.53WTE**

Proposal for the future

- Improved team working as part of the wider NHS Highland Acute Pharmacy network. Working as collaborative partners across NHSH and RGHs in particular.
- Optimising use of diverse skill sets across various roles in the Pharmacy Team e.g. checking technician, medicines reconciliation, prescribing etc., RGH staff working to they ‘top of their licence’ and achieving optimal, cost-effective outcomes from medicines use. Providing a high level of pharmacy input for both in patients and outpatients.
- Undertake the distribution and supply activities of pharmacy for the RGH. Operate the vaccine centre for the region (Lochaber and Argyll and Bute)
- Optimising working as integrated MDT alongside acute colleagues and maximising use of staff time to support clinical value adding activities such as medication reviews.
- Flexible evolution of use of technology as expectations change.

How is different to what we have now and why?

- Service provision better matched to demand, with earlier involvement in the patient pathway, e.g. from ED onwards through to discharge providing the optimal level of value/input.
- Adequate purpose designed space will allow efficient storage and dispensing of medication. Timely medication supply (e.g. discharge planning at admission, near patient dispensing); access to prepack medication for supply out of hours.
- Identification and responding to medicines- related admissions; early discharge planning.
- Services delivered efficiently, making optimal use of diversified skill mix in the team, with all team members working at the topmost level of their clinical training.

Service Options presented at Initial Agreement impact on Pharmacy

Option 1 – Do minimum

Reducing the 8B Pharmacy Team Manager post and providing this oversight from Raigmore from within pharmacy may have an impact on the Belford Hospital Manager. However, this approach will have benefits in terms of quality, governance and resilience presenting a reduction of 0.39 WTE.

Leadership for pharmacy technicians is required at Band 6 level, this change will bring the service model in line with all other sites across Scotland, this will require organisational change.

The central supply model will be maximised, using robotics at Raigmore Hospital to manage stock where appropriate and improve efficiency. Top up supply will be supported via 0.2 WTE band 2 support from Raigmore

HEPMA (Hospital Electronic Prescribing and Medicines Administration) will be introduced at Belford Hospital. Once outpatient prescribing functionality is enabled, clinical checking of prescriptions can be undertaken remotely within the hospital. A pharmacist will still be required on site to maintain pharmacy operations; however, this will allow greater flexibility in how pharmacist time is deployed.

Prescription collection cabinets will be introduced to enable patients to collect medicines when the pharmacy is closed, improving convenience and access.

The current pharmacy skills mix is heavily influenced by vaccine service requirements. Demand for this service is expected to continue or increase. A move toward a hybrid vaccination delivery model involving GP services would increase logistical complexity.

Removal of vaccine funding would significantly misalign the current skills mix with service need, requiring a full-service review and organisational change.

Option 2 Core RGH model

No changes from option 1. Planned changes to the bed base in option 2 is expected to have minimal impact on pharmacy workload.

Options 3 Core RGH plus intensive rehab

No change from option 1

Option 4 – Core RGH plus intensive rehab and increased elective activity

No change from option 1. No impact on workforce anticipated. May require consideration of how discharge medicines are provided. A model using PGDs for discharge medicines should be considered. This will depend on the pathways for the surgery to be done.

Projecting the Lochaber RGH Pharmacy workforce requirements

Indicative plans as to how the workforce may change in terms of WTE

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Team Manager Pharmacist	8B	1	0.2	0.2	0.2
Lead Pharmacist	8A		1	1	1
Specialist Pharmacist	7	1	1	1	1
Deputy Pharmacy Manager	7	1			
Lead Pharmacy Technician	6		1	1	1
Specialist Pharmacy Technician	5			1	
Pharmacy Technician	4	1	1		
Pharmacy Support Worker	2	2.53	2.53	2.53	2.53
Raigmore based pharmacy support worker for direct ward top up	2		0.2	0.2	0.2
Total		**6.53**	**6.93**	**6.93**	**6.93**

Removal of deputy post may trigger pay protection impact

Facilities

Current Service Position

The Facilities workforce plan for Lochaber outlines the changes in workforce required to support the proposed Clinical & Non-Clinical services model in terms of domestic cleaning, catering, laundry, and portering.

The plan has been developed in line with the four separate workshops which have been held with all local teams to translate the high-level clinical and non-clinical model into a service-by-service plan.

The Facilities Assistant role which is currently in place throughout North West Highland will be continued in this plan, this role allows for staff members to carry out a variety of roles within Facilities and therefore provides a robust 7-day service. Staff training and development needs will be identified through this process, as will additional skills not available in the current workforce. A core work stream of this group will be the development of an action plan for the workforce plan with timescales and associated risk status.

Current funded workforce position

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Domestic Cleaning	Band 4	1.00
Domestic Cleaning	Band 3	0.87
Domestic Cleaning	Band 2	11.34
Catering & Retail	Band 3	0.87
Catering & Retail	Band 2	5.26
Laundrette	Band 3	0
Laundrette	Band 2	0.99
Porter	Band 3	0
Porter	Band 2	4.40
Management	Band 5	1.00
Total		**25.73**

Proposal for the Future

- The facilities plan shows a net increase in staffing of 14.09 WTE as a direct result of this redesign and the increase in size of the building
- The traditional Domestic, Catering and Laundry Assistants will be generic “Facilities Assistants” to increase flexibility in terms of the areas in which they work. All would be on a rotational contract.
- Production laundry in hospital for scrubs etc. Retention of Raigmore as central laundry for sheets etc.
- Improved area store's function, supported by Portering staff
- The catering Model will be a 100% delivered meal model using national contracted suppliers with a small percentage of defined in-house prepared fresh food. Direct meals service for in patients ensuring all nutritional needs are met. Increasing the ability to deliver meals to patients out with ‘service’ times when required, supporting freedom of choice.
- Defined range of freshly prepared food available for staff and visitors in a café environment.

Assumptions and co-dependencies

• Domestic staffing is calculated in line with the domestic workforce planner. For the purpose of this plan the staffing requirement assumes a building of 6203.6 smq2.This workforce plan is a working document and will continue to be refined.

• All establishments have been based on the hospital services being provided between 0700-2200, with no facilities overnight or on-call services.

• With links to the local schools & College, there would be a review to include work placement/apprenticeship opportunities would be created.

The increase is attributable to the inclusion of training and planned absence coverage hours within revenue budgets, which will mitigate the need for overtime and associated costs.

Staff will operate on a 5 out of 7 days schedule to provide greater workforce flexibility. The ward area requires coverage seven days per week from approximately 7am to 10pm, while most other unit areas will primarily be cleaned in the evenings between 5pm and 8pm.

Specialised positions such as the Cook role will remain, with these posts primarily supporting the community cafe. The catering model will be ward-based, utilising the regeneration kitchen located on the ward for direct service.

The catering department will operate from 08:00 to 19:00, Monday through Sunday.

The Community Cafe will operate from 08:30 to 16:00, Monday through Sunday.

The production laundry model assumes the local laundry will process only 20% of linen, with the remaining 80% transferred to the Central Laundry at Raigmore.

Portering services will be expanded to accommodate patient transfers necessitated by the distances between departments and the layout of the new facility.

Facilities Team Leaders/Supervisors will work on a rotational rota to ensure coverage across all facilities services over a seven-day period. This differs from the current model, where each department has a dedicated team leader covering a single facilities department. Current pay budgets do not include provisions for training or staff cover costs related to planned or unplanned leave.

How is it different to what we have now?

Public café allows visitors to access catering services and provides alternative waiting environments within the hospital. Enhancing environment and patient/public experience.

Direct meals service improves consistency of food quality and nutritional content, with increased range/choice of meals available and more options to manage specific dietary requirements. This also reduces food waste.

Ability to prepare small numbers of meals at ward level out with core service hours improves patient centred care and patients' choice, reflecting individual needs.

Separate flows/access routes throughout the hospital for FM services, avoiding the need to cross over with patients and visitors, improving privacy and dignity, and decreasing cross infection risks within the hospital.

Synbiotix Task Allocation System optimizes porter service efficiency and reporting.

Synbiotix CIS/Bedside Ordering ensures patients receive precise, nutritionally balanced meals and minimises food waste at the ward level.

Synbiotix Xclean Scheduler applies National Cleaning Specifications for direct cleaning guidance in all areas.

Synbiotix FMT digitises Facilities Monitoring, meeting Scottish Government benchmarks with improved auditing and streamlined reporting.

Desk Booking System enables non-clinical staff to reserve workspaces as needed, maximizing office space use.

Emerging technologies like UV cleaning automation, robotics, and digital booking are set to transform service delivery.

Current staffing level (WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**
Domestic Cleaning	Band 4	1.00
Domestic Cleaning	Band 3	0.87
Domestic Cleaning	Band 2	11.34
Catering & Retail	Band 3	0.87
Catering & Retail	Band 2	5.26
Laundrette	Band 3	0
Laundrette	Band 2	0.99
Porter	Band 3	0
Porter	Band 2	4.40
Management	Band 5	1.00
Total		**25.73**

Impact of options presented at initial agreement on Facilities workforce

Option 1 Do minimum

No changes to current WTE

Option 2 Core RGH model

Uplift of WTE required. Recruitment to begin 6-9 months prior to the opening of the new hospital to allow time for staff training and for the recruitment process to be completed before the opening data

Option 3 Core RGH plus intensive rehab

No change from option 2

Option 4 Core RGH plus intensive rehab and increase elective activity

No change from option 2.

Projecting the Lochaber RGH Facilities Dept workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			Projected Staffing (Indicative WTEs)		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Domestic Cleaning	Band 4	1.00	1.00	1.00	1.00
Domestic Cleaning	Band 3	0.87	0.87	1.20	1.20

Domestic Cleaning	Band 2	11.34	11.34	19.34	20.50
Catering & Retail	Band 3	0.87	0.87	1.87	1.87
Catering & Retail	Band 2	5.26	5.26	6.66	6.66
Laundrette	Band 3	0.00	0.00	0.60	0.60
Laundrette	Band 2	0.99	0.99	0.99	0.99
Porter	Band 3	0.00	0.00	0.60	0.60
Porter	Band 2	4.40	4.40	5.40	5.40
Management	Band 5	1.00	1.00	1.00	1.00
Total		**25.73**	**25.73**	**38.66**	**39.82**

Estates Department

Current Service arrangements

The Estates function in Lochaber encompasses the hospital as well as all community and social care facilities. This team is responsible for the onsite management of plant, equipment, and grounds, ensuring the smooth operation and upkeep of all assets within their remit.

Discussions are currently ongoing regarding the future configuration and boundaries of the existing Lochaber Estates team. The outcome of these discussions will shape how the team operates and interfaces with other areas in the future.

As new digital and innovative systems are implemented, such as modern Building Management Systems (BMS), advanced controls, smart emergency lighting, and remote temperature monitoring, the Estates team will require comprehensive handover procedures. This will involve in-depth training and familiarisation with the technologies being installed, ensuring that team members are fully equipped to manage and operate these systems effectively.

To support this transition, additional training and development opportunities will be provided. It is recommended that a couple of existing staff members, or new recruits, integrated during the build phase, are partially involved in the construction project. This integration will allow them to gain practical understanding and familiarity with the innovative technologies, facilitating a streamlined handover and ensuring that the operations team includes individuals already versed in the equipment and systems being introduced.

NHS Highland (NHSH) aims to implement appropriate technological innovations to alleviate pressure on the existing team and improve the traceability and usability of data from the various systems. Examples include smart emergency lighting and remote water temperature monitoring, though the Estates team is open to adopting any innovations that support high standards of maintenance. To ensure successful adoption, in-depth familiarisation, training, and development will be essential prior to handover, specifically regarding digital and innovative systems like the new BMS and controls.

The personnel identified for integration into the project will play a critical role in simplifying the soft landing and transition processes. As the technologies being introduced are unfamiliar to the current Estates team, involving selected individuals during the build phase will ensure a more effective and efficient service delivery after handover, as they will be equipped with the necessary expertise and understanding of the new systems.

With the opening of the new hospital, it is anticipated that there will initially be a decrease in reactive maintenance compared to the existing Belford facility. This reduction is expected because the assets in the new build will be in their early lifecycle, thus requiring less immediate attention. However, as these assets age, the volume of reactive maintenance will inevitably increase, particularly given the greater amount of new equipment installed within the new hospital. The additional labour required to manage and maintain this new equipment will be crucial in supporting future reactive maintenance tasks, which may have implications for clinical service delivery.

It is important to note that, despite previous new builds—such as the NTC, Aviemore, and Broadford—being constructed to high standards, the Estates team has continued to deal with a significant number of reactive maintenance issues. This experience should inform planning and expectations for the new hospital in Lochaber.

Considering the volume and type of equipment to be maintained in the new hospital, compared to the existing Belford, there may be a requirement for additional staffing to adequately support maintenance operations. As the hospital design is currently at RIBA stage 3, there is not yet a definitive list of equipment or detailed maintenance regimes, both of which will influence the final workforce requirements.

There is a potential need for an additional Band 5 and an additional Band 2 staff member to support the expanded maintenance workload. However, this requirement cannot be fully determined until the project progresses to RIBA stage 4, and as such, these roles have not been included in the current cost plan. Should additional labour be required and secured, there should be no adverse effect on service delivery at other sites within the Lochaber area.

Current Funded Workforce Position

Current staffing level (WTEs)		
Job Family – Estates.	(AfC Band or Medical Grade)	Funded (WTE)
Estates Multi Skilled Engineers	Band 5	3.0
Estates Painter	Band 4	1.0
Estates Maintenance Assistants	Band 2	3.8
Total		**7.8**

No impact with reduced working week, this is mitigated within current Team

Proposal for the future

- Maintaining Estates Hub based in the hospital covering the other Lochaber and NHS Highland sites.
- Modernise Building Management Systems to provide remote access to NHS Highland site services and self-monitoring capabilities including asset tracking. Supporting self-management by the local team.
- Enhancing staff roles with training in potential energy saving innovations.
- Modernisation of plant to meet current sustainability targets.
- Continue scheduled maintenance activity programme adapted to accommodate more building needs, therefore releasing more capital for patient care and not maintenance of the building.

How is it different and why?

- Access to modern building management systems (BMS) to provide remote self – monitoring and fault indication, Reduced time on routine inspection.
- Energy efficient plant and equipment will reduce carbon footprint

- Separate flows/access routes throughout the hospital for FM services, avoiding the need to cross over with patients and visitors, improving privacy and dignity, and decreasing cross infection risks within the hospital.

Service Options presented at Initial Agreement impact on Estates

Option 1 Do minimum

No changes to current WTE

Option 2 Core RGH model

Option 2- The increase in footprint of the new Hospital compared to the existing Belford may require additional resource to maintain. This will be reassessed and workforce requirements confirmed at RIBA stage 4.

Option 3 Core RGH plus intensive rehab

No change from option 2

Option 4 Core RGH plus intensive rehab and increase elective activity

No change from option 2.

Projecting the Lochaber RGH Estates workforce requirements

Indicative plans as to how the workforce may change in terms of WTE.

Current staffing level (WTEs)			**Projected Staffing (Indicative WTEs)**		
Job Family	**(AfC Band or Medical Grade)**	**Funded (WTE)**	**2025/26**	**2027/28**	**2029/30**
Multi-skilled Engineer	5	3.0	3.0	3.0	3.0
Estates Painter	4	1.0	3.0	3.0	3.0
Maintenance Assistants	2	3.8	3.0	3.0	3.0
Total		**7.8**	**7.8**	**7.8**	**7.8**

8.0 Plan to Deliver

There are four key areas within the current workforce profile that require significant change or a revised approach to effectively deliver the service and meet workforce plan projections. These changes are closely linked to the necessity of operating within budgetary constraints and the existing financial envelope.

8.1 Medical Staffing

- There is a consistent challenge in recruiting physicians, indicating an ongoing workforce gap in this area.
- The profile currently being offered to potential recruits no longer aligns with the expectations or demands of today's labor market.
- Gaps in resident medical staffing have become a routine issue, impacting day-to-day operations.
- Supervision of junior staff requires attention to ensure appropriate support and oversight.
- Staffing at the front door, particularly for urgent and emergency care, is a key consideration for service delivery.

8.2 Frailty and Rehabilitation Services

- Development of Ward 1 is underway as part of efforts to enhance frailty and rehabilitation services.
- Community services are also being developed, with an emphasis on providing wrap-around care to better support patients outside of hospital settings.
- Ensuring adequate Allied Health Professional (AHP) coverage for the service is critical, including the deployment of advanced practitioners.
- Recruitment and backfilling of posts remain ongoing priorities to maintain service levels.

8.3 New Roles Development

- Development of generic healthcare assistants, particularly at Band 4, is being pursued to enhance flexibility and service delivery.
- The expansion of Advanced Nurse Practitioners is planned to provide higher levels of clinical expertise.
- A dedicated Frailty Practitioner role is being developed to address the specific needs of frail patients.
- The creation of AHP Consultant positions will support advanced clinical leadership within teams.

8.4 Facilities

- An increase in square footage across facilities will necessitate additional cleaning and maintenance efforts.
- Corresponding increases in staffing to cover these expanded spaces are currently not accommodated within existing budgets.
- Changes in skill mix have been incorporated into the proposal to address operational needs within the financial constraints.

9.0 Financial Overview

Total recurring costs for Options 1 to 4 range from £37.1m to £40.2m per year with workforce numbers between 599 and 630 WTE, indicating similar service footprints. Non-pay costs have been adjusted for activity and footprint changes

	Current budget	Option 1	Option 2	Option 3	Option 4
Pay costs	33,790,642	34,877,876	36,238,420	36,437,484	36,758,259
Non pay costs	3,322,846	3,391,415	3,511,996	3,511,996	3,511,996
Total recurring costs	**37,113,488**	**38,269,292**	**39,750,415**	**39,949,479**	**40,270,255**

	Option 1 - Do Minimal		Option 2 - Core RGH Model		Option 3 - Core RGH Model and Intenstive Rehab		Option 4 - Core RGH Model, Intensive Rehab & Increased Elective	
	£s	wte	£s	wte	£s	wte	£s	wte
Current Funding	33,790,642	597.67	33,790,642	597.67	33,790,642	597.67	33,790,642	597.67
Required Funding	34,877,876	599.25	36,238,420	622.20	36,437,484	625.35	36,758,259	629.86
Funding Change	**1,087,234**	**1.58**	**2,447,777**	**24.53**	**2,646,842**	**27.68**	**2,967,617**	**32.19**

The current workforce budget includes a £325k Vacancy Factor credit and a £752k efficiency savings target. Costings are based on the 2024/25 ledgers and do not include the impact of a reduced working week in 2025/26 or the 2024/25 nursing establishment review.

There is a placeholder for non-recurring/transition costs (e.g., decant, training, start-up and project support), estimated as £409,908 across all options. Full financial summary is shown in Appendix 7.
Opportunity costs of £4,028,978 have been identified from repatriation, reduced admission and length of stay in each model. This is presented in the GEM model as part of the OBC.

10.0 Action Plan

The Programme Board will select the preferred option. Review periods will align with key stage assurance reviews throughout the project. The Service Delivery Group is responsible for owning and executing the plan.

11.0 List of Appendices

The following appendices are included:

Appendix 1 –Services aligned to each option.docx

Appendix 2- Options - Advantages and Disadvantages.docx

Appendix 3: Data pack - March 2026 - V1.docx

Appendix 4 –Population Demographics and Workforce Implications in Lochaber.docx

Appendix 5: Benefits Realisation RegisterLochaber Benefits Register 2.0 Client Issue - LIVE1.xlsx

Appendix 6: Workforce Demographics

Appendix 7 : Full Financial summary