



**Outline Business Case  
Mental Health 2 Ward DBFM Scheme  
V 12<sup>th</sup> June 2017**



## Contents

	Contents	2
	Appendix Reference	3
	Table Reference	4
	Figure Reference	5
1	Strategic Case Executive Summary & Revisiting the Strategic Case	6
	Current Arrangements	9
	Is the case for change still valid?	11
	Investment Objectives	12
	Is the choice of Preferred Service Solution still valid?	16
	Is this proposal still a good thing to do?	16
2	Economic Case	17
	Identifying a short-list of implementation options	17
	Identify and quantify monetary costs	18
	Non-monetary costs and benefits of options	19
	Identifying the preferred option	28
3	Commercial Case	29
	Procurement Route	29
	Proposed scope and services	29
	Risk allocation	31
	Payment structure	32
	Contractual arrangements	33
4	Financial Case	35
	Revenue Costs and Funding	35
	Value for money	43
5	Management Case	44
	Project Management	44
	High Level Project Plan	46
	Change management arrangements	46
	Stakeholder engagement and communication	47
	Benefits Realisation	52
	Risk Management	56
	Commissioning	65
	Project Evaluation	65
	Appendices	66

Appendix Reference	Title
Appendix 1	Report and Analysis from the Options Appraisal Event 27 <sup>th</sup> April 2017
Appendix 2	Stobhill Option Document - Keppie
Appendix 3	Individual Scoring Option Appraisal Exercise
Appendix 4	New Stobhill mental health inpatient facility: SCIM Design Statement (product of workshops 1 and 2)
Appendix 5	Project Programme
Appendix 6	Initial Agreement Letter Health & Social Care Directorates
Appendix 7 (a) & (b)	NHS Greater Glasgow & Clyde Clinical Output Specification
Appendix 8	Schedule of Accommodation
Appendix 9	Stobhill AEDET
Appendix 10	Stakeholder Letter of Support
Appendix 11	HAI Scribe

Table Reference	Title
1	Summary Project Programme
2	Need for Change Summary - Stobhill
3	Need for Change Summary – Birdston Care Home
4	Investment Objectives - Stobhill
5	Investment Objectives – Birdston Care Home
6	Initial Capital Costs
7	Revenue Cost Implications
8	Summary Benefit Criteria, Ranking and Weighting
9	Group Weighted Benefit Scores
10	Weighted Benefit Scores / results as percentage score
11	Equal weighting of the benefit Criteria
12	Score/results equal weighting benefit criteria
13	Weighting/Normalised Weight & Rank of Benefit Criteria
14	User & Carer Group scoring of options
15	NHS staff scoring of options
16	Non-financial Risks Appraisal
17	Net Present Value
18	Net Present Cost per weighted benefit score
19	Economic Appraisal and Risk Appraisal Ranking
20	Staff Numbers
21	Risk Allocation
22	Recurring Cost
23	Unitary Charge
24	Sources of Revenue Funding
25	Recurring Revenue Funding
26	Recurring Revenue Costs
27	Capital costs and associated funding for the projects
28	Non Recurring Revenue Costs
29	Current finance assumptions
30	Subordinated debt
31	Senior debt
32	Financial model key inputs and outputs
33	Governance Structure - Senior Responsible Owner
34	Governance Structure – Project Director
35	Governance Structure – Project Manager
36	Governance Structure – Project Board Members
37	Governance Structure – Independent Client Advisers
38	High Level Project Plan
39	Identified Stakeholders
40	Engagement with Stakeholders - Stobhill
41	Engagement with Stakeholders – Birdston Care Home
42	Benefits Realisation Plan
43	Risk Register

Figure Reference	Title
1	Graph of Group Weighted Benefit Scores
2	Graph of Scores/Results Equal Weighting Benefit Criteria
3	Graph of User & Carer Group Scoring of the Options
4	Graph of NHS Staff Scoring of the Options
5	Governance Reporting Structure

## Strategic Case

### 1 Executive Summary

#### 1.1 What is the proposal about?

##### Background

This Outline Business Case (OBC) identifies preferred option for the reconfiguration of mental health services in the North of Glasgow and assesses potential value for money (VFM), affordability and achievability.

Specifically this includes the Stobhill Hospital located ward that provides acute adult mental health services and the hospital based complex care ward for older people with mental health problems housed at Birdston Care Home. Although patients using these services have different needs the synergies between the services and economies of scale indicate a single preferred solution for both.

##### 1.1.2 Executive summary - Strategic case

This document presents the proposals and preferred option to resolve issues around the provision of Adult Acute Mental Health services provided from Stobhill Hospital and Elderly Mental Health services at Birdston. In brief the issues are as follows:

The inpatient services are committed to:

- Offering care and treatment that respects individual rights and allows treatment to occur in the least restrictive manner possible
  - Providing a service which is flexible and responsive and does not discriminate between individuals
  - Providing a high standard of treatment and care, respecting rights for privacy and dignity, in a safe and therapeutic environment for service users in the most acute and vulnerable stage of their illness
  - Ensuring all individuals needs are assessed and that an appropriate care plan is agreed, which includes the views of the service user and relevant carers and discharge planning arrangements
- Adult Acute Mental Health services at Stobhill Hospital

As part of the 2001 Health Board Modernising Mental Health Services Strategy there has been a drive to reduce both the dispersed nature of mental health in-patient ward sites and inpatient beds. This has led to moderated inpatient accommodation options on the Stobhill Hospital site where there are clinical concerns around the ability to deliver modern clinical models of care, the quality of accommodation of the adult acute patient inpatient ward and to a lesser extent its comparative separation. There are challenges both with the retention of staff and ensuring sufficient staff are available to cover any clinical incident which may arise. Critically the accommodation concerned at Stobhill Hospital is in poor condition and not fit for purpose.

• Birdston Care Home – Complex Elderly Mental Health Services

Elderly Mental Health services are provided from the Birdston Care Home. This is a privately owned facility with single bedrooms which is contracted by Greater Glasgow and Clyde Health Board. The facility is isolated from other mental health and acute diagnostic services therefore providing challenges in management of co-morbidities. An additional challenge is the increasing co-morbidity and incidence of dementia amongst the client group which is

staff intensive, particularly on an isolated site such as the Birdston Care Home, requiring self-sufficiency in staffing levels to deal with any medical emergencies.

Additionally the service is also reliant on a high cost private contract which expires June 2018. Discussions with the landlord have extended the existing contract short-term. Significant rise in contract costs is anticipated if longer term extension is required.

There is therefore a compelling case for change.

### 1.1.3 Executive Summary - Economic Case

In scoping the options, the Project Board has considered that the future model of service provision needs to be delivered from premises that are fit for purpose. The premises need to support the level of integrated working required to make a more positive impact to provide a safe environment for assessment, treatment and therapeutic work for a full spectrum of mental health conditions. These services form part of a planned and integrated whole system approach to care which is delivered in conjunction with the community services and is designed to promote recovery. Within the ward all aspects of physical health, social care needs and risks are jointly managed by a multi-disciplinary team.

The current facility at Stobhill has been assessed as not meeting the basic needs, so the “Do Nothing” option is not viable. The on-going maintenance and repair of the building mean that from a repairs perspective it is “money hungry”. There is a current maintenance backlog. The asbestos that is part of the building’s structure means that even relatively simple repairs require investigation prior to work and become costly as measures need to be put in place to protect staff, the public and contractors from the dangers of displaced asbestos fibres or dust. The accommodation at Birdston is an expensive contract which now does not meet the required specification for hospital based complex care. The preferred solution is therefore two new-build wards, to be delivered within an overall funding envelope of £10.6M.

The proposal optimises value for money.

### 1.1.4 Executive Summary - Commercial, Financial and Management Cases.

In discussions including with the Scottish Government and Scottish Futures Trust this Project will be developed based on the hub revenue financed model.

A summary of the key updated project dates is provided in the table below.

Table1 Summary Project Programme

Submission of Initial Agreement	October 2016
Submit Outline Business Case	June 2017
Submit Final Business Case	April 2018
Financial Close	May 2018
Construction	May 2018 – November 2019

Costs have been identified for each proposed solution to provide an indication if they are likely to present value for money, against the “Do Nothing Option” (see Economic Case).

The Governance and Project Management arrangements are based on previous Hub approved schemes, and experience from the developments such as Inverclyde (Greenock) and Maryhill will help us improve these areas (see Management Case).

The proposal is viable commercially, financially affordable and both achievable and deliverable.

#### 1.1.5 Executive Summary - Summary of objectives

The proposal is therefore vitally important in terms of:

- Offering care and treatment that respects individual rights and allows treatment to occur in the least restrictive manner possible
- Providing a service which is flexible and responsive and does not discriminate between individuals.
- Providing a high standard of treatment and care, respecting rights for privacy and dignity, in a safe and therapeutic environment for service users in the most acute and vulnerable stage of their illness.
- Ensuring all individuals needs are assessed and that an appropriate care plan is agreed, which includes the views of the service user and relevant carers and discharge planning arrangements.
- Tackling health inequalities, promoting supported recovery and self-management and fostering the principles of multi-disciplinary anticipatory approaches. This is to maximise the effectiveness in how we work with colleagues in the HSCP, across the mental health network and diagnostic and in-patient care in the physical acute sector.
- Also making a contribution to local economic generation and the wider Community Planning Partnership objectives of improving population health and valuing people by providing modern, well-equipped public spaces and buildings.

In developing specific objectives, that we would like to achieve by changing how and where we work if we are to meaningfully tackle the health inequalities that have characterised Glasgow for so long, five key themes emerged.

- i) Interagency and interdisciplinary working is central. The current wards do not support the extent of our ambition; therefore the first investment objective is to improve accommodation to allow users and carers to be better supported by interdisciplinary working in fit for purpose accommodation.
- ii) Related services are sometimes delivered out of different locations and awkward to get to locations and buildings meaning hospital transport and escorts for extended periods. Additionally there are bus, car or taxi journeys for service users and carers. This can be costly and time-consuming, therefore our second investment objective is to improve access for public and service users.
- iii) Our Clinical Services Review for Mental Health Services highlighted that improved service outcomes are sometimes achieved through visibly welcoming health service users and others clearly onto the care pathway. Supporting service users along with third sector and community planning partners will help improve care, preventative approaches and more appropriate referrals. Our third objective is therefore to enable speedier access to modernised mental health services.
- iv) There is a need to provide services that are “easy in and easy out”, with interventions providing “everything you need and nothing more”. This includes for patients with multiple morbidities receiving coordinated rather than fragmented care and care planning supporting personal outcome based progress towards recovery/living well with the condition. We also need to support continuous learning and development of clinical and non-clinical staff if we are to recruit and retain high-quality expertise into mental health services in the future. Replacement premises must have physical capacity for this, but in a way whereby the spatial arrangement of development space is logical in terms of the teams and relationships that need to be supported. Our

fourth objective is to have better integrated services for modernised therapeutic care and co-morbidities in keeping with the Mental Health Strategy 2017-2027 vision.

- v) As we look to the future, we are keen to reduce our carbon footprint in line with the Government's 2020 target. We also see the cost benefits of reducing energy bills, thereby freeing up resources towards clinical or support services. Our fifth objective is to improve the safety and effectiveness of our accommodation.

#### 1.1.6 Strategic Background

In considering new ways of working we have considered who is affected by our proposal and worked to engage their views at an early stage of the Clinical Services Review, throughout the process to date and in the more recent specific design work and option appraisal exercise. We have also considered how our objectives align with and help to deliver the wider strategic NHS priorities, both at national and NHSGGC levels. Finally, we have taken account of the key external factors that influence or are influenced by our proposal.

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

## 2 Current Arrangements

### 2.1 Stobhill Hospital (providing Acute Adult mental Health Services)

The Adult Acute Mental Health inpatient services within this proposal are as set out in the Initial Agreement, provided from an old designed acute admissions ward at Stobhill Hospital. The bed configuration is multi-occupancy bays with separate shower and toilet facilities. The catchment area for the service is the North East of Glasgow with some of the most deprived areas in Glasgow such as Easterhouse and Queenslie. The catchment area also includes the Maryhill area of Glasgow and the east area of East Dunbartonshire.

### 2.2 Birdston Care Home

Complex Elderly Mental Health services are as set out in the Initial Agreement, provided from the Birdston Care Home. This is a privately owned facility contracted by Greater Glasgow and Clyde Health Board. The direct patient care is provided by GG&C NHS staff while Facilities Management services (hard and soft) are provided by the Contractor for the Birdston Care Home. The Out of Hours medical care for patients is provided by GP's and NHS 24. The catchment area for the service includes East Dumbarton, North East Glasgow and the Maryhill corridor. The Birdston Care home sits towards the periphery of Dunbartonshire at the furthest point of the catchment area. The Home is geographically isolated with infrequent bus service (one bus per hour) and few local activities.

As the Birdston contract expires in June 2018, the arrangement has been extended. Slippage in the 2 x DBFM scheme will incur additional increase in charges from the accommodation provider.

### 2.3 Update on Design Quality Objectives

### 2.4 Procurement Route

During June 2016 an AEDET assessment of the existing Stobhill and Birdston was carried out and was facilitated by Andrew Baillie, Project Manager. The workshop was attended by staff, management, clinicians and public representatives facilitated by third sector user and

carer organisation Mental Health Network (Greater Glasgow and Clyde wide). The outcome of this was documented in an AEDET Assessment summary which was included in Appendix B of the Initial Agreement. The assessment highlighted the areas where the existing buildings worked well:

- Space that exists is flexible and also those areas where the building was seen as being inadequate
- Patient and staff environment
- Access to the health
- Energy performance
- Security and supervision
- Circulation spaces\travel distances for patients and staff

A follow-on workshop series was undertaken during June/July 2016 to develop a Design Statement for any new facility. This was facilitated by Heather Chapple from Architecture & Design Scotland, and was attended by broadly the same group of stakeholders who undertook the AEDET Assessment. The Design Statement was included in the Initial Agreement as an appendix, and formed a key part of the briefing documentation to hub and its design team for the site options appraisal and the development of design proposals. The workshop highlighted the key aspects of any new design to be:

- Location easy to find and access
- Welcome and Shelter
- Walking Routes short and Pleasant
- Flexible Space
- Encourage Integration of Services

Since then further design work has been undertaken in conjunction with feedback from the NHS Scotland Design Assessment Process (NDAP), Architecture & Design Scotland and Health facilities Scotland and additionally with a further AEDET assessment of the proposed accommodation. During May 2017 an AEDET assessment of the currently proposed accommodation was carried out and was again facilitated by Andrew Baillie, Project Manager. The process and workshop included NHS staff, management, clinicians and public representatives facilitated by third sector user and carer organisation Mental Health Network (Greater Glasgow and Clyde wide). The outcome of this was documented in an AEDET Assessment summary which is included as an Appendix9 of this Outline Business Case.

### 3 Is the Case for Change still valid?

#### 3.1 Need for change–Stobhill

The following table summarises the need for change.

Table 2 Need for Change Summary Stobhill

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
<i>Dislocated service – physically less integrated</i>	<i>Existing service arrangements leave the service more dislocated and vulnerable to risk</i>	<i>There is an opportunity to improve integration and access on this site at this point in time.</i>
<i>Service arrangements not person centred</i>	<i>Service is not meeting user requirements e.g. no access to single rooms with en-suite resulting in little privacy or ‘own space’ which is not conducive to providing a therapeutic environment and recovery. The topographic nature of the site is that the service is physically more remote from remaining services. The facilities are without proper outdoor space.</i>	<i>A service that isn’t meeting user requirements is unsustainable, even in the short term.</i>
<i>Accommodation with high levels of backlog maintenance and poor functionality</i>	<i>Increased safety risk from the old style design, outstanding maintenance and inefficient service performance to deliver basic care as well as therapeutic interventions.</i>	<i>Building condition, performance and associated risks will continue to deteriorate if action isn’t taken now.</i>
<i>Impact on staffing and additionally on out of hours</i>	<i>Increased safety risk due to the old style ward design. Impact on recruitment due to desirability of the ward and its less integrated location.</i>	<i>Service sustainability and retaining existing staff when other opportunities on site present will be at risk if this proposal isn’t implemented now</i>

### 3.2 Need for Change –Birdston

The following table summarises the need for change.

Table 3 Need for Change Summary Birdston

<b>What is the cause of the need for change?</b>	<b>What effect is it having or likely to have on the organisation?</b>	<b>Why action now :</b>
<i>Increasing co-morbidity and frailty of patients</i>	<i>Existing clinical isolation presents a challenge in managing co-morbidities.</i>	<i>Service sustainability will be at risk if this proposal isn't implemented now.</i>
<i>Facilities not fit for purpose</i>	<i>Challenges in: providing hospital level care in a Care Home; challenges in observation, maintaining patient dignity and privacy.</i>	<i>Facilities do not meet patient need</i>
<i>Geographical isolation and poor public transport</i>	<i>Causing difficulties for relatives and carers who wish to visit the facility, limited support groups or activities available in the vicinity for patients.</i>	<i>Facilities do not meet patient or carer/visitor needs</i>
<i>Reliance on an expensive private provider with significant rise in lease costs anticipated when contract expires in June 2018</i>	<i>Further challenge on the Board's revenue resources</i>	<i>Service continuation is at risk</i>
<i>Sustainability of Out of hours medical rota</i>	<i>Increasing expensive contribution to pressure on sustainability out of hours medical rota</i>	<i>Service financial pressure will continue to be exacerbated.</i>

### 3.3 Investment Objectives

The following describes these investment objectives in relation to the Adult Acute mental health services at Stobhill Hospital and then the Complex Elderly mental health services at Birdston Care Home.

#### 3.4 Investment objectives for Stobhill hospital services

The investment objectives for the Stobhill Hospital services are:

- 1) Improve Patient Environment and safety
  - i. Provide better conditions for patients with fit for purpose facilities by:
    - a. Providing single room with en-suite allowing patients a space of their own and privacy and dignity.
    - b. Reduce tension within mental health environment through design of physical environment through use of space and colour.
    - c. Access to safe and secure green outside space providing a quiet restful environment.
    - d. Provide a modern environment with WIFI throughout able to support the latest technology, for both staff using handheld devices to support them in providing health care and patient to access the internet where suitable.

- ii. Reduction of risk in dealing with medical emergencies as relocation alleviates the risks associated with clinical isolation providing improved links and access to other services and more medical /nursing expertise agencies.
- 2) Achieve service benefits of site location, including:
- i. Strengthen the care of patients with co-morbidities by being able to draw on other services and expertise more easily.
  - ii. Economies of scale, for example there will be a greater pool to draw staff from and more opportunities for staff having a larger range of service areas and therefore ability to build up and develop a range of skills.
  - iii. Address service variance in access and treatment
  - iv. Reduced negative impact on sustainability of the clinical Out of Hours Rota
- 3) Improve access for patients
- i. Improve therapeutic environment for patients by improving their access to safe outside green spaces to enjoy and relax in.
  - ii. Facility fully compliant
  - iii. Facilitate integration
- 4) Improve staff retention, recruitment and wellbeing
- i. Relocation will address the staff retention issues and staff sickness cover currently experienced in trying to maintain a service on the oddly dislocated topographic site location. There will be a greater stability of staffing and more opportunities for staff having a larger range of service ward areas and therefore ability to build up and develop a range of skills.
  - ii. Improve the working environment and access to developing physical health opportunities
- 5) Improve efficiency of estate
- i. Deliver a more energy efficient facility reducing CO2 emissions and improving sustainability of the estate.
  - ii. Enable access to modernised and fit for purpose Hospital environment and services.
  - iii. Meet statutory requirements and obligations for public buildings e.g. DDA compliance
- 6) Community Benefits
- i. The relocation of service will provide a bigger footfall for local services within the new location.
  - ii. New build options will provide opportunities for local businesses and workforce

Table4 Investment Objectives - Stobhill

Effect of the need for change on the organisation:	What needs to be achieved to overcome this need? (Investment Objectives)
The service is currently physically less integrated.	<i>Improve safety and effectiveness of service by reducing clinical and physical isolation.</i>
Challenges in sustainability of the medical Out of Hours Rota.	<i>Improve sustainability of service.</i>
Challenges in managing co-morbidities in an old design ward.	<i>Achieve service benefits of greater proximity with other mental health services and acute general services.</i>
Staff retention issues currently experienced in trying to maintain a service in a less desirable ward.	<i>Improve staff recruitment, retention and well-being.</i>
<i>Facilities are not meeting current or future user requirements.</i>	<i>Meet user requirements by improving the patient environment and safety.</i>
<i>Increased safety risk from outstanding maintenance and inefficient service performance.</i>	<i>Improve the efficiency of the estate and effectiveness of supporting accommodation.</i>

### 3.5 Investment objectives for Birdston Care Home services

The investment objectives for the Birdston Care Home services are:

1. Improve Patient Environment and safety
  - i. Improve ability to cope with medical emergencies or incidents and staff sickness as they become part of a bigger pool of staff from which to draw, means better able to cope with staff sickness at short notice.
  - ii. Improve out of hours medical cover and sustainability
  - iii. Achieve Fit for purpose older persons facilities, in more detail:
    - a. Achieve an older persons (including dementia friendly) environment that supports the long term care needs of more elderly patient group and their families.
    - b. Providing an environment that is calming, separating the visitor support services travel routes from the patient areas to reduce noise levels and disturbance.
    - c. Provide a modern environment with WIFI throughout able to support the latest technology.
2. Achieve benefits of co-location
  - i. Achieve co-locations with other mental health and acute services facilitating enhanced management of co-morbidities and close ties to the admissions ward for support and information exchange.

- ii. Improve transition for patients transferring from Acute Admissions into Elderly Hospital Based Complex Care. New admissions are referred from Acute Admissions and are therefore admissions are known in advance and patients are allocated a named nurse. Being on a site with other mental health services means that the named nurse can attend on site case conferences and visit the patient in the Acute Admissions ward and get to know patient before the move. This will allow an easier transition for the patient from Acute Admissions to hospital based complex care.
  - iii. Reduce disruption for patients attending physical acute diagnostic and other appointments by having such services on the same site.
3. Improve access for patients
- i. Relocate services so they are more central to the catchment area rather than being towards the periphery
  - ii. Relocate services to a site with better public services to allow better access for relatives and carers visiting.
4. Improve staff retention, recruitment and wellbeing
- i. Improve staff retention- address current difficulties of recruitment and retention due to site isolation.
  - ii. Improve staff access to training and learning opportunities - by having onsite training facilities available and access to a wide range of services.
5. Improve efficiency of estate
- i. Avoid reliance on a high cost contract.
6. Community Benefits
- i. The relocation of services will create a bigger mass of footfall for local shops and businesses.
  - ii. New build options will provide opportunities for local businesses and workforce.

Table 5 Investment Objectives Birdston

Effect of the need for change on the organisation:	What needs to be achieved to overcome this need?  (Investment Objectives)
Existing service clinically isolated	Co-locate with other mental health services including acute admissions and mental health intensive care services and also acute general services with provision of in house medical cover.
Existing service arrangements affect access and travel arrangements for patients/visitor and staff	Improve service access
Facility is not meeting current or future patient needs	Meet user needs
Patient environment is not therapeutic	Provide therapeutic environment
Community	<p>Improve access for the majority of visitors and carers by relocating services closer to the heart of the catchment area.</p> <p>Increased footfall will benefit local businesses.</p> <p>Preferred option to target providing opportunities for local employment, apprenticeships and opportunities for local small to medium businesses.</p>

No material changes have occurred and the drivers for change and investment objectives remain the same.

#### 4 Is the choice of preferred service solutions still valid?

The option to build two new mental health wards is the preferred solution for the adult acute admissions ward and elderly complex care ward. The preferred solution remains unchanged from the preferred way forward identified at the IA stage.

##### 4.1 Is this proposal still a good thing to do?

The current arrangements, need for change and investment objectives made at IA remain, confirming the need for change and the identified way forward.

The Initial Agreement was approved by SGHSCD; see Appendix 6 of this OBC. No specific conditions were outlined in the approval letter. Stakeholder involvement continues to be core to the Project.

## 5 Economic Case

### 5.1 Identifying a short-list of implementation options

A feasibility study was carried out to determine any suitable and available areas of land on the Stobhill site alongside the current mental health wards for the re-provision of accommodation required. As one of the two wards; 20 beds, provide NHS hospital based complex care to challenging behaviour dementia patients – a demanding and high risk care group, the ward needs to be evidence based dementia appropriate, including ground floor access to safe and stimulating external gardens.

In developing a short-list of options consideration of a Mental Health Campus to integrate as far as possible the new development with existing Mental Health facilities at Stobhill was prioritised. Doing so enables safer and better quality care to be delivered.

The existing Wards 43 and 44 are currently undergoing renovation works to provide interim accommodation and therefore given the timescales to commence construction, are unavailable options to house the two new wards.

The plot of land located adjacent to Mackinnon House and at the West end of Ward 44 were both unsuitable due to their small size, limited adjacency to other wards and because they would have likely resulted in a compromised piecemeal development.

Wards 22-25, the psychotherapy centre and Hillview Day Centre (currently unoccupied) are available sites as although this option involves demolition of existing buildings, these buildings have been categorised as 'having reached the end of their useful lives.

The site is bounded by roadways on the north and east, by the existing main car park to the south and by both roadway and MacKinnon House to the West. This particular plot offers a good sized site with good adjacency with MacKinnon House and would permit the new Mental Health Campus to be delivered as a whole. Additionally, in keeping with being dementia appropriate, the site offers fine views to the Campsies to the North and is well placed to benefit from daylight. There are a few existing mature trees which could also be retained.

No other sites are available as all other vacant plots on Stobhill are out with the Mental Health Campus and have been scheduled for disposal, with disposal dates to be confirmed. The potential for extended demolition programmes would be a risk and build delay into the mental health services development process. There would also be a potential risk to the bundling of the scheme in missing the timescale. Although this could be potentially overcome with further mitigation, bundling remains the preferred mechanism to progress the scheme.

As the only area identified as available remains to be Wards 22-25 at Stobhill, the short list of options explores different ways in which this area could be utilised, including:

- Do Nothing
- Refurb and Extend – Wards 22-25
- Single Building – On site of Wards 22 and 23. This requires costing to re-locate pharmacy
- Two new build wards – On site of Wards 22 and 23. This requires costing to re-locate pharmacy
- Two new build wards – On site of wards 22 and 25.

## 5.2 Identify and Quantify Monetary Costs and Benefits of Options

Tables below set out the initial capital and revenue cost inputs to the GEM model related to each option. They are expressed as an undiscounted annual recurring cost for each category.

Table 6 Initial Capital Costs

Initial Cost Implications:	Option 1: Do Nothing	Option 2: Refurb& Extend Wards 22-25	Option 3: Single Building On site of Wards 22 & 23 (& relocate Pharmacy)	Option 4: Two new build Wards On site of Wards 22 & 23 (& relocate Pharmacy)	Option 5: Two New Build Wards on site of Wards 22 & 25
	£'000	£'000	£'000	£'000	£'000
Initial Capital Costs	0	9,833	11,916	11,279	10,734

Table 7 Revenue Cost Implications

Revenue Cost Implications:	Option 1: Do Nothing	Option 2: Refurb& Extend Wards 22-25	Option 3: Single Building On site of Wards 22 & 23 (& relocate Pharmacy)	Option 4: Two new build Wards On site of Wards 22 & 23 (& relocate Pharmacy)	Option 5: Two New Build Wards on site of Wards 22 & 25
	£'000	£'000	£'000	£'000	£'000
Life Cycle Costs	1,120	█	█	█	█
Clinical Service Costs	N/A	N/A	N/A	N/A	N/A
Non-clinical Support Service Costs	1,120	1,812	1,812	1,812	1,812
Building Related Running Costs	2,264	4,136	4,136	4,136	4,136
Net Income Contribution	N/A	N/A	N/A	N/A	N/A
Revenue Costs of Embedded Accommodation	N/A	N/A	N/A	N/A	N/A
Displacement Costs	N/A	N/A	N/A	N/A	N/A
<b>Total recurring revenue cost implications</b>	<b>4,880</b>	█	█	█	█

### 5.3 Non-monetary costs and benefits of options

The results of the non-financial benefits appraisal exercise are presented in the table that follow:

### 5.4 Options Appraisal Workshop

A non-financial benefits option appraisal exercise was undertaken. The workshop was attended by a range of service user and carer representatives (identified by the local user and carer organisation Greater Glasgow and Clyde Mental Health Network). Additionally the workshop was attended by an NHS clinician and clinical services manager, an NHS operational service manager, an NHS capital procurement manager, an NHS patient & carer services manager.

The event used a systematic and structure process to identify a preferred option to provide two new fit for purpose, modernised mental health wards, one for adult acute admission and one for older adult hospital based complex care at Stobhill. Consideration was given to identifying alternative options and none were identified.

The option appraisal process had three main key stages 1) discussing and agreeing the criteria, 2) ranking the criteria and weighting the criteria and 3) scoring the options.

Each option was scored against the agreed criteria on a scale of 0-10 (including Do Nothing/Minimum). A score of 0 indicated that the option offered no benefits at all in terms of the criteria, while a score of 10 indicated that it presents some 'maximum' or 'ideal' level of performance.

The result of the workshop was a single weighted score for each option, which was used to indicate and compare the overall performance of the options in non-monetary terms.

The criteria below were identified during engagement with users and carers in preparation for the Initial Agreement that was submitted and approved by the Scottish Government. They were also used to brief the designs and options presented at the Options Appraisal event on 27<sup>th</sup> April 2017. The Option Appraisal event discussed and confirmed the criteria and ranked them as shown below.

After each criterion was ranked in order of importance it was then expressed as a weighting out of 100. The weightings were then scaled to a percentage. The service user and carer representatives agreed that patient environment and safety was the most important criterion and should be weighted 100. Thereafter each of the following criteria were ranked and weighted. It was understood differences between the values given to the weightings could be anything (in multiples of 10) from 10 to over 30 or more. Following discussion, particularly from user and carer representatives, each criterion was given a value of 10 less than the previous ranked criterion. The group felt this was reasonable, as at the end point community benefits (ranked least important) would be weighted as half as important as patient environment and safety (ranked most important).

To ensure the robustness of the views expressed the facilitator challenged the group suggesting that it was legitimate to attribute a broader range of values to the ranked weightings.

Following discussion the group confirmed that they preferred to keep the weighting values they had identified as follows.

1. Patient Environment and safety (Ranked 1 Weighting 100)
- 2) Service benefits of site location (Ranked 3 Weighting 80)
- 3) Good access for patients (Ranked 2 Weighting 90)
- 4) Staff retention, recruitment and wellbeing (Ranked 4 Weighting 70)
- 5) Efficiency of estate (Ranked 5 Weighting 60)
- 6) Community Benefits (Ranked 6 Weighting 50)

Table 8 Summary Benefit Criteria, Ranking and Weighting

Importance Weighting				
<i>Benefit Criteria</i>	<b>Weight</b>	<b>Normalised Weight</b>		<b>Rank</b>
Patient Environment and safety	<b>100</b>	<b>22</b>		<b>1</b>
Service benefits of site location	<b>80</b>	<b>18</b>		<b>3</b>
Good access for patients	<b>90</b>	<b>20</b>		<b>2</b>
Staff retention, recruitment and wellbeing	<b>70</b>	<b>16</b>		<b>4</b>
Efficiency of estate	<b>60</b>	<b>13</b>		<b>5</b>
Community Benefits	<b>50</b>	<b>11</b>		<b>6</b>
	<b>450</b>	<b>100</b>		

The options were identified to explore different ways in which the recognized area could be utilised, including:

- 1) Do Nothing (Baseline)
- 2) Refurb and Extend – Wards 22-25
- 3) Single Building – On site of Wards 22 and 23. This requires costing to re-locate pharmacy
- 4) Two new build wards – On site of Wards 22 and 23. This requires costing to re-locate pharmacy
- 5) Two new build wards – On site of wards 22 and 25

During the Option Appraisal exercise the group assessed the design of the two new wards for each of the options independently. Each option was given a score for each of the criteria (out of 10) based on how well they would achieve the agreed criteria.

### 5.5 Calculating the Weighted Scores

The Group discussed and scored each of the 5 options against the 6 benefit criteria. The group was asked to try to reach a consensus on a score out of 10 for each benefit criteria against each option. The results for the consensus score are set out in the table below. Along with the consensus scoring is also a score for an optimistic view and also a pessimistic view.

During the discussions for each of the options and each of the criteria if anyone present had a different view of the score for an option then their individual score was also recorded as more optimistic or pessimistic.

The group optimistic and group pessimistic scores represent the highest and lowest score given by any one of the attendees at the event. These results are also set out in the table below

### 5.6 Results of Scoring the Options

The Group scores for each of the options against each of the criteria are represented in the table and chart below.

Table9 Group Weighted Benefit Scores

Group	Weighted Benefits Score		
	Optimistic	Consensus	Pessimistic
1	316	218	156
2	593	469	456
3	596	536	536
4	649	618	587
5	816	796	707

Figure 1 – Graph of Table9 Group Weighted Benefit Scores

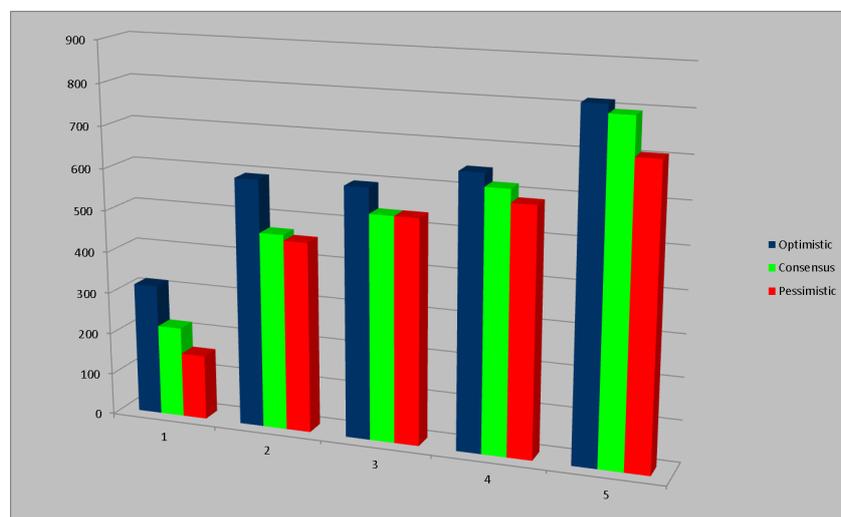


Table 9 and Figure 1 above demonstrate the results of the scoring and as identifying Option 5 “Two new build wards – On site of wards 22 and 25” as the preferred option, based on the non-financial benefits appraisal.

The weighted benefit scores and results from the table above have been recalculated below as a percentage score to produce a cost per benefit point under the Economic Case.

Table 10 Weighted Benefit Scores / results as Percentage Score

Benefit Criteria	Normalised Weight	Option 1 Do Nothing	Option 2 Refurb & Extend Wards 22 - 25	Option 3 Single Building On- site of Wards 22 & 23 ( & relocate Pharmacy Dept)	Option 4 Two New Build Wards on site of Wards 22 & 23 ( & relocate Pharmacy Dept)	Option 5 Two New Build Wards on site of Wards 22 & 25
Patient Environment and safety	22	2	2	9	11	20
Service benefits of site location	18	2	12	7	11	12
Good access for patients	20	6	10	8	12	16
Staff retention, recruitment and wellbeing	16	5	12	11	9	12
Efficiency of estate	13	3	5	12	12	12
Community Benefits	11	4	4	7	7	7
Total Weighted score as a Percentage %	100	22	47	54	62	80
Rank:		5	4	3	2	1

### 5.7 Testing the Sensitivity of the Results

It was important to examine how reactive the results of the weighted scoring exercise might be to different views, changes in the scores and the weights.

#### Equal Weighting of the Benefit Criteria

The methodology for the Group scores (Group consensus and group optimistic and group pessimistic scores representing the highest and lowest score given by anyone of the attendees at the event) was set out above. To test the sensitivity of the results these Group consensus, and the most optimistic and most pessimistic scores were applied to an equal ranking. The equal ranking is set out and the weighted scores using equal weighting was calculated and shown in Tables and the figure below:





Changing the scoring, using only the scoring from users and carers representatives, in this way tests for bias. The scores from Users and Carers alone don't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.

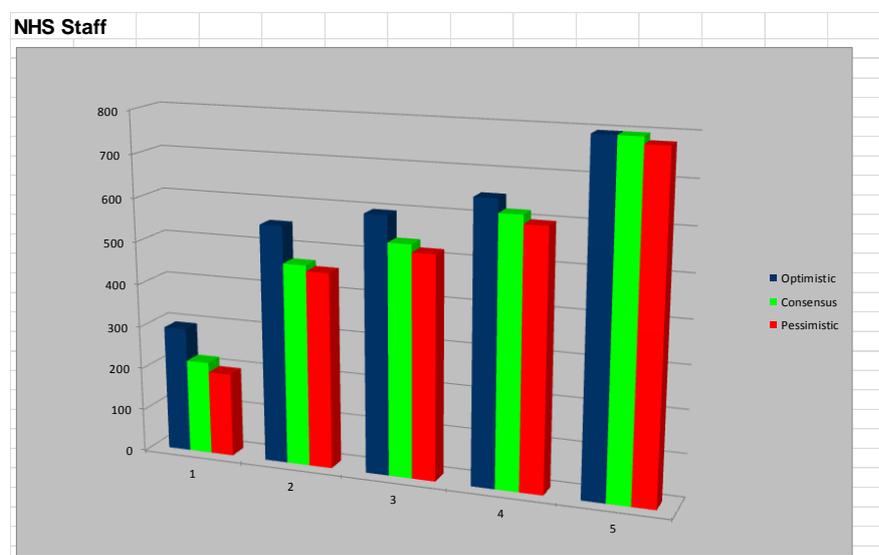
### 5.9 NHS Staff Scoring of the Options

The scores provided by the NHS staff were separated and the result re-tested with the original weightings, again to test for any bias in the overall scoring. The results of the NHS staff can be seen in Table and Figure 4 below.

**Table 15 NHS Staff Scoring of the Options**

NHS Staff			
	Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic
1	293	218	196
2	553	469	456
3	596	536	518
4	649	618	598
5	796	796	780

Figure 4 - Graph of Table 15 NHS Staff Scoring of the Options



Changing the scoring, using only the scoring from NHS representatives, in this way doesn't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.

### 5.10 User & Carer and NHS Staff Individual Scoring of the Options

The scores provided by the Users and carers and the NHS staff individually were separated and the result again re-tested with the original weightings, the results of which can be seen in the tables and graphs in Appendix 3.

Changing the scoring, using individual non-financial benefits appraisal scoring only from all the representatives in this way doesn't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.

### 5.11 Summary

The non-financial benefits appraisal scoring from the range of sensitivity analysis shows that Option 5 retained the preferred status when the changes were made in the scores (pessimistic and optimistic). The weights were changed to reflect different perspective as were the alternative User and Carer, NHS Staff and Individual scores. Therefore the identification of option 5 as the preferred option can be said to be robust and have been tested for sensitivity and risk of bias.

The report of the Option Appraisal event is at Appendix 1, the Options Report (Keppie) at Appendix 2 and the Individual Scores of the Option Appraisal participants is at Appendix 3.

### 5.12 Non-financial Risks Appraisal

Having tested with the Option Appraisal Group if alternative options were identifiable/ likely to maximise the desirable benefits from the project and weighted and scored the options, the DBFM Project Board considered the likelihood and impact of the risks identified drawn from the Option Appraisal Criteria, Benefits Realisation, Design Statements, Risk register and AEDET Workshops.

The discussion points on the risk scores reflected the issues raised throughout the design work to date, the design statements and included the following:

- ✓ accommodation being deemed no longer fit for purpose;
- ✓ storey ward requires a higher staffing ratio and can feel like a separated unit;
- ✓ double banked corridors promote institutional feeling and provides little natural daylight and observation;
- ✓ current limited flexibility due to existing layout and room proportions; buildings on development site are not fit for purpose;
- ✓ existing external fabric repairs and fit-out costs will be higher the longer the buildings are left to deteriorate;
- ✓ level access to the garden spaces is important;
- ✓ road realignment adds complexity;
- ✓ diversions to main service routes;
- ✓ access required for vehicles;
- ✓ potential for a clash of visitor, service and emergency traffic utilising the same access point;
- ✓ disconnection from Mackinnon House and other mental health wards;
- ✓ possible lack of privacy due to external garden space being located adjacent to main hospital traffic route;
- ✓ topography could compromise views; relocating pharmacy; adjacency to main hospital traffic route.

The table below shows the results of the non-financial risk appraisal and indicates Options 4 and 5 were considered considerably less risky than options 1, 2 and 3.

**Table 16 Non-financial Risks Appraisal**

	Likelihood ( 0 - 10 )				
	Option				
Risk	1	2	3	4	5
Incompatible with existing national & local strategies	8	6	2	2	2
Over/under estimating capacity to meet demand	2	2	2	2	2
Deliverability - availability & priority for sites; within timescales	7	4	7	7	2
Operational problems, staffing, H&S, HAI	8	7	3	2	2
Lack of flexibility to cope with change	7	7	5	2	2
Change in public transport arrangements	2	2	2	2	2
	Impact ( 0 - 10 )				
	Option				
Risk	1	2	3	4	5
Incompatible with existing national & local strategies	7	6	4	2	2
Over/under estimating capacity to meet demand	8	8	7	7	7
Deliverability - availability & priority for sites; within timescales	8	7	7	7	7
Operational problems, staffing, H&S, HAI	8	4	4	3	3
Lack of flexibility to cope with change	6	5	4	3	3
Change in public transport arrangements	4	3	3	3	3
	Risk Score				
	Option				
Risk	1	2	3	4	5
Incompatible with existing national & local strategies	56	36	8	4	4
Over/under estimating capacity to meet demand	16	16	14	14	14
Deliverability - availability & priority for sites; within timescales	56	28	49	49	14
Operational problems, staffing, H&S, HAI	64	28	12	6	6
Lack of flexibility to cope with change	42	35	20	6	6
Change in public transport arrangements	8	6	6	6	6
	243	151	112	89	55

Net Present Value

In line with the Optional Appraisal Guide, the NPV or NPC for each option can be calculated using discounted cash flow techniques on the capital and revenue costs associated with each option as entered into the GEM model. The outcomes of these calculations can be summarised in the exemplar table below:

Table 17 Net Present Value

	Option 1: Do Nothing	Option 2: Refurb& Extend Wards 22-25	Option 3: Single Building On site of Wards 22 & 23 (& relocate Pharmacy) £'000	Option 4: Two new build Wards On site of Wards 22 & 23 (& relocate Pharmacy) £'000	Option 5: Two New Build Wards on site of Wards 22 & 25 £'000
Net Present Value / Cost	19,593	14,486	16,569	15,932	15,387

### 5.13 Identifying the Preferred Option

Table 18 Net Present Cost per weighted benefit score

	Option 1: Do Nothing	Option 2: Refurb& Extend Wards 22-25	Option 3: Single Building On site of Wards 22 & 23 (& relocate Pharmacy)	Option 4: Two new build Wards On site of Wards 22 & 23 (& relocate Pharmacy)	Option 5: Two New Build Wards on site of Wards 22 & 25
	£	£	£	£	£
Net Present Cost per weighted benefit score	89,057	30,821	30,683	25,696	19,233

The combined NPC per weighted benefit score figures clearly identify Option 5 as the preferred option. Although Option 2 has the lowest Net Present Cost, it scores poorly in the quality factors and is not an option for the Board. Options 1,2 and 3 also score relatively poorly on the quality criteria compared to Option 5.

The table below shows the rankings of both the economic appraisal and of the risk appraisal exercise which has been undertaken for each of the options.

The table shows that the ranking of the options is the same under both the economic and risk appraisal with option 5 being ranked 1<sup>st</sup> and the Do Nothing Option 1, ranking last.

Table 19 Economic Appraisal and Risk Appraisal Ranking

Evaluation Results (out of 100)	Option 1: Do Nothing	Option 2: Refurb& Extend Wards 22-25	Option 3: Single Building On site of Wards 22 & 23 (& relocate Pharmacy)	Option 4: Two new build Wards On site of Wards 22 & 23 (& relocate Pharmacy)	Option 5: Two New Build Wards on site of Wards 22 & 25
	Rank	Rank	Rank	Rank	Rank
Economic Appraisal	5	4	3	2	1
Risk Appraisal	5	4	3	2	1

It is clear from the appraisal work undertaken that Option 5 is a preferred option that should be taken forward from the economic case and assessed under the commercial and financial cases.

Although the Net Present Costs of options 2, 3, 4 and 5 were similar areas where Option 5 scored highest more highly than other options included:

- Patient Environment and safety
- Service benefits of site location
- Good access for patients
- Staff retention, recruitment and wellbeing
- Efficiency of estate
- Community Benefits

## **6 Commercial Case**

### **6.1 Procurement Route**

The relocation of Mental Health Beds from Birdston Care Home to the Stobhill Hospital Site will follow the hub procurement initiative, as it is a community project, which is revenue funded, and the contract arrangement will Design Build, Finance Maintain. (DBFM).

#### **Procurement Plan**

The hub initiative has been established in Scotland to provide a strategic long-term programme approach in Scotland to the procurement of community-focused buildings that derive enhanced community benefit.

Stobhill Hospital is located within the West Territory. A Territory Partnering Agreement (TPA) was signed in 2012 to establish a framework for delivery of this programme and these benefits within the West Territory. The TPA was signed by a joint venture company, hub West Scotland Limited (hubco), local public sector Participants (which includes NHS GGC and GCC), Scottish Futures Trust (SFT) and a Private Sector Development Partner (PSDP).

The Stobhill Mental Health Facility project will be bundled with the New Greenock Health & Care Centre, and the New Clydebank Health & Care Centre - the purpose of this approach and the benefits are outlined in the stand-alone paper which accompanies this and the Greenock & Clydebank OBCs.

The TPA prescribes the stages of the procurement process including:

- New Project Request;
- Stage 1 (submission and approval process);
- Stage 2 (submission and approval process); and
- conclude DBFM Agreement (financial close)

Since this project includes design, construction and certain elements of hard Facilities Management services, the TPA requires that DBFMco (a special purpose company) enters into SFT's standard form Design, Build, Finance and Maintain Agreement for hub projects. The main Contractor appointed for this project by HUBco is BAM Construction

### **6.2 External Advisers**

The Procurement of External Advisers for this project and the two other projects which are part of this bundled group i.e. Greenock Health & Care Centre and Clydebank Health & Care Centre Projects, have been appointed, utilising the Public Contracts Scotland for procurement, and where applicable the OJEU process.

The Advisers Appointed is as follows:

- Technical Advisers – Currie & Brown
- Legal Advisers – CMS
- Financial Advisers – Caledonian Economics

### **6.3 Proposed scope and services**

#### **Existing Arrangements**

As part of the wider mental health services strategy for NHS Greater Glasgow & Clyde, we are planning to re-provide a 20 bed Adult Admissions Unit Facility ( AAU) that will replace the existing facilities located at Stobhill Hospital in the North East of Glasgow. This will be accompanied by a 20 bed Elderly Ward that will replace the bed capacity at Birdston Nursing Home.

## 6.4 The Site

The preferred site is located on the Stobhill Hospital site. The site is centrally located and adjacent to other Mental Health Units, most notably MacKinnon House. The Site is in the ownership of the “Scottish Ministers” and in the administration of NHS Greater Glasgow & Clyde.

A Schedule of Accommodation (SOA) has been arrived at following a number of meetings with the users and project team and totals a floor area of 2527.5m<sup>2</sup>. The design reports are included in Appendix 7 (a) and 7 (b) and a copy of the SOA is included as Appendix 8 which provides more detail on each of the two wards i.e. Acute Admissions Unit and Hospital Based Complex Clinical Care and the facilities provided.

## 6.5 Site Access, Constraints and Orientation

The site is currently occupied with three day units, two of which formed part of the original hospital master plan. These have been deemed unfit for purpose by NHSGG&C. Adjacent, is a landmark B listed Water & Clock Tower of significant local importance.

The site is enclosed by a busy car park to the south, the main access road between Balgrayhill Road, and the New Stobhill Ambulatory and Diagnostic Care Hospital to the east and secondary route to the north.

To support the proposed design, site investigations and topographical surveys have been undertaken by hub West to determine the full extent of the ground conditions and any possible contaminants on the site. Following the initial site investigations, the recorded methane levels the site was found to be a Characteristic Situation 1 site, while on the basis of the carbon dioxide levels the site was found to fall within Characteristic Situation 2. It is therefore considered that the overall site falls within Characteristic Situation 2 and there is a significant source, intact-pollutant linkages are present and therefore require remedial works. These works will be detailed during Stage 2.

## 6.6 Design Development

The Design was developed in conjunction with the Project Design Group which consisted of Keppie Architects, Hubwest, NHSGG&C Property & Capital Planning Team, and representatives from Stakeholder Groups i.e. Users and Staff. The Design's put forward was presented to and approved by the Development's Project Board on 14<sup>th</sup> June 2016.

## 6.7 NHS Scotland Design Assessment Process ( NDAP )

As part of the embedding of the design process in the various business case stages, the Scottish Government has, in addition to BREEAM assessments, advocated a formalised design process facilitated by Architecture and Design Scotland (A&DS) and Health Facilities Scotland (HFS). NHS GGC has taken steps to consult with A&DS in the development of the design of the new Health and Care Centre.

An initial Design Statement has been prepared on behalf of NHS GGC in conjunction with the project team, PSCP and their architects, and is included in this OBC as Appendix 4. This has been used as the key control document to measure the developing design against the project's design objectives.

## 6.8 HAI-Scribe

An HAI-Scribe Stage 1 infection control assessment of the preferred option site was carried out on 30<sup>th</sup> May 2017 with NHS GGC Infection Control. The Stage 1 Strategy and Risk Assessment was completed at this meeting and is included at Appendix 11.

## 6.9 Clinical and Design Brief

The Health Planner for the project has attended the Project Design Group meetings and met with various stakeholders to look at the operational policy documents provided by NHS GGC and to review the accommodation requested. A full report was produced by the Health Care Planner and presented to the Project Board for approval on 14<sup>th</sup> June 2016.

## 6.10 Staff to be accommodated in the new facility

The number of staff to be accommodated in the new facility is summarised in the table below:

**Table 20 – Staff numbers**

Services	Estimated No of Staff
Nursing (58 wte staff in total across two wards)	Approx 8 staff in acute ward on days 6 staff in OPMH Ward on days 4 staff per ward on nights
Medical Staff (in for 2-4hrs two to three x weekly) 11 in total in acute ward and two in OPMH ward	Approx 6 in acute ward Mon to Friday 1 in OPMH ward
Allied Health Professionals eg Physiotherapists, Dieticians, Podiatrist	In wards for approx. Two-four hours per week Mon to Frid
Occupational Therapists	3 across two wards for approx six hours per day Mon to Frid
Pharmacist/technician	1 for approx 2 hours per day
Hotel Services x12hrs daily	4 staff, 2 per ward for 12 hours day
Psychology / Psychotherapy	Approx 3 hrs x 2 per week

Other staffing groups are not permanently located in the new facility but will sessional or part-time input.

## 6.11 Surplus Estate

The OBC is predicated on the basis that in the case of the Birdston Residential Home the lease will be terminated prior to the move to the new facility.

## 6.12 Commercial Arrangements

Not Applicable

## 6.13 Risk Allocation

## 6.14 Transferred Risks

Inherent construction and operational risks are to be transferred to the Sub-hubco. These can be summarised as follows:

**Table 21 – Risk Allocation**

	Risk Category	Potential Allocation		
		Public	Private	Shared
1	Design risk		Yes	
2	Construction and development risk		Yes	
3	Transitional and implementation risk		Yes	
4	Availability and performance risk		Yes	
5	Operating risk			Yes
6	Variability of revenue risks		Yes	
7	Termination risks			Yes
8	Technology and obsolescence risks		Yes	
9	Control risks	Yes		
10	Residual value risks	Yes		
11	Financing risks		Yes	
12	Legislative risks			Yes

#### 6.15 Shared Risks

Operating risk is shared risk subject to NHS GGC and Sub-hubCo responsibilities under the Project Agreement and joint working arrangements within operational functionality.

Termination risk is shared risk within the Project Agreement with both parties being subject to events of default that can trigger termination.

While Sub-hubCo is responsible to comply with all laws and consents, the occurrence of relevant changes in law as defined in the Project Agreement can give rise to compensate Sub-hubCo.

#### 6.16 Payment Structure

NHS GGC will pay for the services in the form of an Annual Service Payment.

A standard contract form of Payment Mechanism will be adopted within the Project Agreement with specific amendments to reflect the relative size of the project, availability standards, core times, gross service units and a range of services specified in the Service Requirements.

NHS GGC will pay the Annual Service Payment to Sub-hubCo on a monthly basis, calculated subject to adjustments for previous over/under payments, deductions for availability and performance failures and other amounts due to Sub-hubCo.

The Annual Service Payment is subject to indexation as set out on the Project Agreement by reference to the Retail Price Index published by the Government's National Statistics Office. Indexation will be applied to the Annual Service Payment on an annual basis. The base date will be the date on which the project achieves Financial Close.

Costs such as utilities and operational insurance payments are to be treated as pass through costs and met by NHS GGC. In addition NHS GGC is directly responsible for arranging and paying all connection, line rental and usage telephone and broadband charges. Local Authority rates are being paid directly by NHS GGC.

## 6.17 Contractual Arrangements

The hub initiative in the West Territory is provided through a joint venture company bringing together local public sector participants, Scottish Futures Trust (SFT) and a Private Sector Development Partner (PSDP).

The hub initiative was established to provide a strategic long term programmed approach to the procurement of community based developments. To increase the value for money for this project it is intended that the Stobhill Mental Health Project will be bundled with the similarly timed new Greenock Health Centre, and the New Clydebank Health Centre.. This will be achieved under a single Project Agreement utilising SFT's standard "Design Build Finance and Maintain (DBFM) Agreement".

This bundled project will be developed by a DBFMco. DBFMco will be funded from a combination of senior and subordinated debt and supported by a 25 year contract to provide the bundled project facilities.

The senior debt is provided by a project funder that will be appointed following a funding competition and the subordinated debt by a combination of Private Sector, Scottish Futures Trust and Participant Investment.

DBFMco will be responsible for providing all aspects of design, construction, ongoing facilities management and finance through the course of the project term with the only service exceptions being wall decoration, floor and ceiling finishes.

Soft facilities management services (such as domestic, catering, portering and external grounds maintenance) are excluded from the Project Agreement.

Group 1 items of equipment, which are generally large items of permanent plant or equipment will be supplied, installed and maintained by DBFMco throughout the project term.

Group 2 items of equipment, which are items of equipment having implications in respect of space, construction and engineering services, will be supplied by NHS GGC, installed by DBFMco and maintained by NHS GGC.

Group 3 items of equipment are supplied, installed, maintained and replaced by NHS GGC. The agreement for New Stobhill Mental Health Facility will be based in the SFT's hub standard form Design Build Finance Maintain (DBFM) contract (the Project Agreement). The Project Agreement is signed at Financial Close. Any derogation to the standard form position must be agreed with SFT.

DBFMco will delegate the design and construction delivery obligations of the Project Agreement to its building contractor under a building contractor. A collateral warranty will be provided in terms of other sub-contractors having a design liability. DBFMCo will also enter into a separate agreement with a FM service provider to provide hard FM service provision.

The term will be for 25 years.

Termination of Contract – as the NHS will own the site; the building will remain in ownership of the NHS throughout the term, but be contracted to DBFMco. On expiry of the contract the facility remains with NHS GGC.

Service level specifications will detail the standard of output services required and the associated performance indicators. DBFMco will provide the services in accordance with its

method statements and quality plans which indicate the manner in which the services will be provided.

NHS GGC will not be responsible for the costs to DBFMCo of any additional maintenance and/or corrective measures if the design and/or construction of the facilities and/or components within the facilities do not meet the Authority Construction Requirements.

Not less than 2 years prior to the expiry date an inspection will be carried out to identify the works required to bring the facilities into line with the hand-back requirements which are set out in the Project Agreement.

DBFMCo will be entitled to an extension of time on the occurrence of a Delay Event and to an extension of time and compensation on the occurrence of Compensation Events. NHS GGC will set out its construction requirements in a series of documents. DBFMCo is contractually obliged to design and construct the facilities in accordance with the Authority's Construction Requirements.

NHS GGC has a monitoring role during the construction process and only by way of the agreed Review Procedure and/or the agreed Change Protocol will changes occur. Sub-hubCo will be entitled to an extension of time and additional money if NHS GGC requests a change.

NHS GGC and DBFMCo will jointly appoint an Independent Tester who will also perform an agreed scope of work that includes such tasks as undertaking regular inspections during the works, certifying completion, attending site progress and reporting on completion status, identifying non-compliant work and reviewing snagging.

NHS GGC will work closely with DBFMCo to ensure that the detailed design is completed prior to financial close. Any areas that do remain outstanding will, where relevant, be dealt with under the Reviewable Design Data and procedures as set out in the Review Procedure.

The Project Agreement details the respective responsibilities towards malicious damage or vandalism to the facilities during the operational terms. NHS GGC has an option to carry out a repair itself or instruct Sub-hubCo to carry out rectification.

Compensation on termination and refinancing provisions will follow the standard contract positions.

#### 6.18 Personnel Implications

As the NHS management of soft facilities management services will continue to be provided by NHS GGC there are no anticipated personnel implications for this contract. NHS Operational facilities have been part of the Project Board throughout the entire process. During negotiation on contract extension the current provider care home provider has confirmed that TUPE is not applicable for the facilities function and care home facilities staff.

Future plans for location include retaining NHS clinical and NHS facilities input. No care home provider staff will transfer and therefore the alternative standard contract provisions in relation to employee transfer (TUPE) have not been used.

## 7 Financial Case

It is proposed that the Mental Health 2 Ward DBFM Scheme will be one of three schemes contained within the Mental Health 2 Ward DBFM Scheme, Greenock & Clydebank DBFM bundle being procured through hub West Scotland by NHS Greater Glasgow & Clyde (NHSGG&C)

The financial case for the preferred option, option 5 New Build Mental Health 2 Ward DBFM Scheme on Stobhill Site sets out the following key features:

- Revenue Costs and associated funding
- Capital Costs and associated funding.
- Statement on overall affordability position
- Financing and subordinated debt.
- The financial model
- Risks
- The agreed accounting treatment

### 7.1 Revenue Costs & Funding

#### Revenue Costs and Associated Funding for the Project

The table below summarises the recurring revenue cost with regard to the Mental Health 2 Ward DBFM Scheme.

In addition to the revenue funding required for the project, capital investment will also be required for demolition of existing Wards £746.0k, equipment £611.3k and subordinated debt investment £86.2k. Details of all the revenue and capital elements of the project together with sources of funding are presented below:

#### **Recurring Revenue Costs**

**Table 22 Recurring Cost**

<b>First full year of operation</b>	<b>2020/21</b>
<b>Additional Recurring Costs</b>	<b>£'000</b>
Unitary Charge	████████
Depreciation on Equipment	61.1
IFRS – Depreciation	407.5
Heat, Light & Power, Rates & Domestic services	534.4
Client Facilities Management (FM) Costs	13.7
<b>Total Additional Recurring Costs</b>	████████

### 7.2 Unitary Charge.

The Unitary Charge (UC) is derived from both the hub West Scotland Stage 1 submission dated 28<sup>th</sup> April 2017 and the Financial Model Health Bundle 20170511 and represents the risk adjusted Predicted Maximum Unitary Charge of ██████ k pa based on a price base date of April 16.

The UC will be subject to variation annually in line with the actual Retail Price Index (RPI) which is estimated at 2.5% pa in the financial model. The current financial model includes a level of partial indexation ██████ and this will be optimised prior to financial close.

### 7.3 Depreciation

Depreciation of £61.1k relates to a 6% allowance assumed for capital equipment equating to £611.3k including VAT and is depreciated on a straight line basis over an assumed useful life of 10 years.

### 7.4 HL&P, Rates & Domestic Costs

HL&P costs are derived from existing inpatient ward costs and a rate of £27.00/m2 has been used.

Rates figures have been provided by external advisors and an allowance for water rates of £19.00/m2 has also been included.

Domestic costs are derived from existing MH Inpatient Units costs and a rate of £152.00/m2 has been used.

### 7.5 Client FM Costs

A rate of £5.29/m2 has been provided by the Boards technical advisors based on their knowledge of other existing PPP contracts.

### 7.6 Costs with regard to Services provided in new Wards

NHS staffing and non-pay costs associated with the running of the Wards are not expected to increase with regard to the transfer of services to the new facility.

### 7.7 Recurring Funding Requirements – Unitary Charge (UC)

**Table 23 Unitary Charge**

<b>UNITARY CHARGE</b>	<b>Unitary Charge £'000</b>	<b>NHSGGC Cost £'000</b>
Capexinc group1 equipment (Net)	█	█
Life cycle Costs	█	█
Hard FM	█	█
<b>Total Unitary Charge including Risk</b>	█	█
		<b>100%</b>

This project will be fully funded from Glasgow HSCP revenue budgets.

### 7.8 Sources of recurring revenue funding

The table below details the various streams of income and reinvestment of existing resource assumed for the project.

## 7.9 Sources of revenue funding

**Table 24 Sources of revenue funding**

<b>Glasgow HSCP</b>	<b>£'000</b>
Existing Revenue Funding	1,547.5
<b>Total Recurring Revenue Funding</b>	<b>1,547.5</b>

## 7.10 H, L & P, Rates & Domestic Costs

The patients are transferring from Birdston Care Home accommodation. The contract value includes HL&P and Domestic costs.

## 7.11 Additional Revenue Funding

N/A

## 7.12 Summary of revenue position

In summary the total revenue funding and costs associated with project are as follows:

**Table 25 Recurring Revenue Funding**

<b>Recurring Revenue Funding</b>	<b>£'000</b>
SGHD - IFRS Depreciation	407.5
Glasgow HSCP recurring funding per above	1,547.5
<b>Total Recurring Revenue Funding</b>	<b>1,955.0</b>

**Table26 Recurring Revenue Costs**

<b>Recurring Revenue Costs</b>	<b>£'000</b>
Total Unitary charge(service payments)	██████
Depreciation on Equipment	61.1
Facility running costs	548.1
IFRS - Depreciation	407.5
<b>Total Recurring Revenue Costs</b>	██████

<b>Net surplus at OBC stage</b>	<b>0</b>
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The above table highlights that at OBC and Stage 1 Submission stage, the project revenue funding is cost neutral. This will be reviewed during FBC stage.

### 7.13 Capital Costs & Funding

Although this project is intended to be funded as a DBFM project i.e. revenue funded, there are still requirements for the project to incur capital expenditure. This is detailed below:

**Table 27 Capital costs and associated funding for the project**

<b>Capital Costs</b>	<b>£'000</b>
Land purchase & Fees	0
Group 2& 3 equipment Including VAT	611.3
Sub debt Investment	86.2
<b>Total Capital cost</b>	<b>697.4</b>
<b>Sources of Funding</b>	
NHSGG&C Formula Capital	697.4
<b>Total Sources of Funding</b>	<b>697.4</b>

### 7.14 Land Purchase

The land is currently under the ownership of NHSGG&C.

### 7.15 Group 2 & 3 Equipment

An allowance of £611.3k including IT equipment and VAT has been assumed for the Mental Health 2 Ward DBFM Scheme Project. An equipment list is currently being developed which will also incorporate any assumed equipment transfers. It is therefore anticipated the current equipment allowance will reduce at FBC stage.

### 7.16 Sub Debt Investment

Sub Debt was reviewed after ESA10 and at this stage of the project it is assumed that the Board will be required to provide the full 10% investment. Confirmation will be requested from the other participants during the stage 2 process (the PSDP, SFTi and HCF). The value of investment assumed at OBC stage is £86.2k for which NHSGG&C has made provision in its capital programme.

### 7.17 Non Recurring Revenue Costs

There will be non-recurring revenue costs estimated below:

**Table 28 Non Recurring Revenue Costs**

<b>Non Recurring Revenue Costs</b>	<b>£'000</b>
Advisors Fees	51.0
Demolition	746.0
Decommissioning incl IT & Telecoms	60.0
Commissioning incl PPE	22.0
Security	0
<b>Total Non-Recurring Revenue Costs</b>	<b>879.0</b>

These non-recurring revenue expenses will be recognised in the Board's financial plans.

#### 7.18 Statement on Overall Affordability

The current financial implications of the project in both capital and revenue terms as presented in the above tables confirm the projects affordability. The position will continually be monitored and updated as we progress towards Full Business Case (FBC).

#### 7.19 Financing & Subordinated Debt

hub West Scotland (hWS) will finance the project through a combination of senior debt, subordinated debt and equity. The finance will be drawn down through a DBFMCo special purpose vehicle that will be set-up for the three projects.

The senior debt facility will be provided by either a bank or insurance company. It is likely they will provide up to 90% of the total costs of the projects. The remaining balance will be provided by hWS' shareholders in the form of subordinated debt (i.e. loan notes whose repayment terms are subordinate to that of the senior facility) and pin-point equity. It is currently intended that the subordinated debt will be provided to the sub-hubco directly by the relevant Member.

#### 7.20 Current finance assumptions

The table below details the current finance requirements from the different sources, as detailed in the Financial Model Health Bundle 20170511 submitted with hubco's Stage 1 submission.

**Table 29 Current finance assumptions**

	Mental Health 2 Ward DBFM Scheme
<b>Senior Debt (£000)</b>	9,909
<b>Sub debt (excl rolled up interest) (£000)</b>	862
<b>Equity (£000)</b>	0.01
<b>Total Funding</b>	10,771

The financing requirement will be settled at financial close as part of the financial model optimisation process.

#### 7.21 Subordinated debt

Our expectation is that subordinated debt will be provided in the following proportions: 60% private sector partners, [REDACTED], 10% NHS Greater Glasgow & Clyde and [REDACTED].

The value of the required sub debt investment is as follows:

**Table 30 Subordinated debt**

	NHS GG&C	SFT	HCF Investments	hubco	Total
<b>Proportion of sub debt</b>	10%	[REDACTED]	[REDACTED]	[REDACTED]	100%
<b>£ sub debt</b>	86,181	[REDACTED]	[REDACTED]	[REDACTED]	861,809

NHS Greater Glasgow & Clyde confirms that it has made provision for this investment within its capital programme.

It is assumed the sub-ordinated debt will be invested at financial close, and therefore there would be no senior debt bridging facility.

### 7.22 Senior Debt

hubco has assumed that the senior debt will be provided by NORD. hubco's review of the funding market has advised that NORD currently offers the best value long term debt for the projects. This is principally because of:

- NORD's knowledge and experience in the health sector
- NORD's appetite for long term lending to match the project term
- NORD's lower overall finance cost in terms of margins and fees
- NORD's reduced complexity of their lending documentation and due diligence requirements.

SFT tender funder opportunities annually and a best value appointment is made via a competitive process. The principal terms of the senior debt, which are included within the financial model, are as follows:

**Table 31 Senior debt**

Metric	Terms
Margin during construction	
Margin during operations	
Arrangement fee	
Commitment fee	
Maximum gearing	

Confirmation of NORD's terms have not yet been received from hubco, though NHS GG&C's financial advisors confirm that these terms modelled are in line with NORD's approach in the market currently.

### 7.23 Financial Model

The key inputs and outputs of the financial model are detailed below:

**Table 32 Financial model key inputs and outputs**

Output	Mental Health 2 Ward DBFM Scheme
Total Annual Service Payment (NPV)	
Nominal project return (Post Tax)	
Nominal blended equity return	
Gearing	
All-in cost of debt (including 0.5% buffer)	
Minimum ADSCR	
Minimum LLCR	

Annual Debt Service Cover Ratio: The ratio between operating cash flow and debt service during any one-year period. This ratio is used to determine a project's debt capacity and is a key area for the lender achieving security over the project

The all-in cost of senior debt includes an estimated swap rate of [REDACTED] and an interest rate buffer of [REDACTED]. The buffer protects against interest rate rises in the period to financial close. Recent swap rates for an average loan life of around 15 years were trading at around [REDACTED] therefore the interest rate buffer [REDACTED] of adverse movements, given the current model's average loan life of [REDACTED].

The financial model will be audited prior to financial close, as part of the funder's due diligence process.

#### 7.24 Financial efficiencies through project bundling

A separate paper has been provided that outlines the financial efficiencies through project bundling.

#### 7.25 Risks

The key scheme specific risks are set out in the Mental Health 2 Ward DBFM Scheme Health and Care Centre Risk Register, which is held at the Risk section to this OBC. This has been developed by joint risk workshops with hub West Scotland and totals £594,000. The risk register risks according to their likely impact (red, amber, green). It is anticipated that the majority of these risks will be fully mitigated, or mitigated to manageable levels in the period prior to FBC submission and financial close.

The unitary charge payment will not be confirmed until financial close. The risk that this will vary due to changes in the funding market (funding terms or interest rates) sits with NHS GG&C. This is mitigated by the funding mechanism for the Scottish Government revenue funding whereby Scottish Government's funding will vary depending on the funding package achieved at financial close.

A separate, but linked, risk is the risk that the preferred funder will withdraw its offer. This is a risk which needs to be considered when the funding market for revenue projects is difficult. This will be monitored by means of on-going review of the funding market by NHS GG&C's financial advisers and periodic updates from hubco and its funders of the deliverable funding terms (through the Funding Report). This will incorporate review of the preferred lender's commitment to the project as well. This will allow any remedial action to be taken as early in the process as possible, should this be required. hubco's financial model currently includes a small buffer in terms of the interest rate which also helps mitigate against this price risk adversely impacting on the affordability position.

At financial close, the agreed unitary charge figure will be subject to indexation, linked to the Retail Prices Index. This risk will remain with NHS GG&C over the contract's life for those elements which NHS GG&C has responsibility (100% hard FM, 50% lifecycle). NHS GG&C will address this risk through its committed funds allocated to the project.

The project team will continue to monitor these risks and assess their potential impact throughout the period to FBC and financial close.

#### 7.26 Accounting Treatment and ESA10

This section sets out the following:

- the accounting treatment for the Mental Health 2 Ward DBFM Scheme for the purposes of NHS GG&C's accounts, under International Financial Reporting standards as applied in the NHS; and
- how the scheme will be treated under the European System of Accounts 2010, which sets out the rules for accounting applying to national statistics.

## 7.27 Accounting treatment

The project will be delivered under a Design Build Finance Maintain (DBFM) service contract with a 25 year term. The assets will revert to NHS GG&C at the end of the term for no additional consideration.

The Scottish Future Trust's paper, "Guide to NHS Balance Sheet Treatment"<sup>1</sup> states: " under IFRS [International Financial Reporting Standards], which has a control based approach to asset classification, as the asset will be controlled by the NHS it will almost inevitably be regarded as on the public sector's balance sheet".

The DBFM contract is defined as a service concession arrangement under the International Financial Reporting Interpretation Committee Interpretation 12, which is the relevant standard for assessing PPP contracts. This position will be confirmed by NHS GGC's auditors before the Full Business Case is adopted. As such, the scheme will be "on balance sheet" for the purposes of NHS GG&C's financial statements.

NHS GG&C will recognise the cost, at fair value, of the property, plant and equipment underlying the service concession (25 year period) as a non-current fixed asset and will record a corresponding long term liability. The asset's carrying value will be determined in accordance with International Accounting Standard 16 (IAS16) subsequent to financial close, but is assumed to be the development costs for the purposes of internal planning. On expiry of the contract, the net book value of the asset will be equivalent to that as assessed under IAS16.

The lease rental on the long term liability will be derived from deducting all operating, lifecycle and facilities management costs from the unitary charge payable to the hubco. The lease rental will further be analysed between repayment of principal, interest payments and contingent rentals.

The overall annual charge to the Statement of Comprehensive Net Expenditure will comprise of the annual charges for operating, lifecycle and maintenance costs, contingent rentals, interest and depreciation.

The facility will appear on NHS GG&C's balance sheet, and as such, the building asset less service concession liability will incur annual capital charges. NHS GG&C anticipate it will receive an additional ODEL IFRS (Out-with Departmental Expenditure Limit) allocation from SGHD to cover this capital charge, thereby making the capital charge cost neutral.

## 7.28 ESA10 (European System of Accounts 2010)

As a condition of Scottish Government funding support, all DBFM projects, as revenue funded projects, need to meet the requirements of revenue funding. The key requirement is that they must be considered as a "non-government asset" under ESA10. Although Stobhill is being self-funded, it is important that the whole project structure remains a "non-government asset" under ESA10.

The standard form hub DBFM legal documentation has been drafted such that construction and availability risk are transferred to hubco. On this basis, it was expected that the Mental Health 2 Ward DBFM Scheme would be treated as a "non-government asset" for the purposes of ESA 10. Following clarification and the provision of guidance "A guide to the statistical treatment of PPPs" by EUROSTAT on 29 September 2016 SFT have engaged the various parties and made amendments to the standard documentation that allow hub schemes to be considered as a "non-government asset" under ESA10.

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<http://www.scottishfuturestrust.org.uk/publications/guide-to-nhs-balance-sheet-treatment/>

### 7.29 Value for Money

The Predicted Maximum Cost provided by Hubco in their Stage 1 submission has been reviewed by external advisers and validated as representing value for money.

The costs have been compared against other similar comparators with adjustment to reflect specific circumstances and industry benchmarks, compliance with method statements and individual cost rates where appropriate.

For Stage 2, Hubco are expected to achieve further value for money through market testing.

### 7.30 Composite Tax Treatment

In line with other hub DBFM projects, composite trade tax treatment has been applied in the financial model, where a combined trade of the development, construction, financing and maintenance of the asset is undertaken. This is accepted practice by HMRC and will not require an advanced clearance.

As with other DBFM projects, the Financial Model assumes hWS will charge VAT on the Service Payment and will reclaim VAT incurred in its own development and operational costs.

### 7.31 Confirming Stakeholder(s) Support

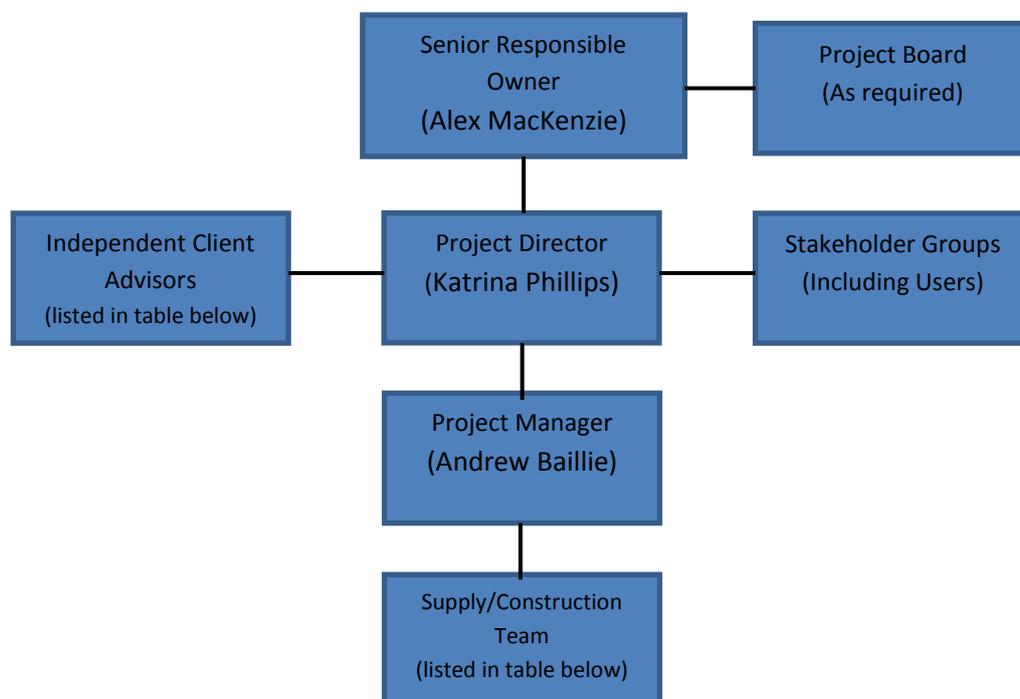
Agreement in principle exists between the NHS Greater Glasgow and Clyde and Glasgow City Health and Social Care Partnership as the two bodies involved in the Mental Health 2 Ward DBFM Scheme. A written record of the agreement is included in the Appendix 10.

## 8 Management Case

### 8.1 Project Management - Reporting structure and governance arrangements

The governance arrangements are set out in the Figure 5 and Tables 33 to 37 below.

Figure 5 - Reporting Structure



### 8.2 Key Roles and Responsibilities

Table 33

Senior Responsible Owner: Alex MacKenzie		
<b>Main Responsibilities:</b>	The business sponsor who has ultimate responsibility at Board level for delivery of the project's benefits and the appropriate allocation of resources to ensure its success.	
<b>Experience and suitability for the role:</b>	<b>Skillset Expected:</b>	<b>Skillset of Individual:</b>
Development Management:	Previous involvement	Experienced
Governance:	Expert	Experienced
Commercial Acumen:	Experienced	Experienced
Project Management:	Experienced	Experienced
Stakeholder Management:	Experienced	Experienced
Procurement Management:	Experienced	Experienced
Contract Management:	Previous Involvement	Experienced
Resource Commitment:	Experienced	Experienced

**Table 34**

<b>Project Director: Head of Adult Services NE Glasgow City HSCP</b>		
<b>Main Responsibilities:</b>	Responsible for the ongoing day to day management and decision making on behalf of the SRO to ensure that the desired project objectives are delivered. They are also responsible for the development, maintenance, progress, and reporting of the business case to the SRO.	
<b>Experience and suitability for the role:</b>	<b>Skillset Expected:</b>	<b>Skillset of Individual:</b>
Development Management:	Previous involvement	Experienced
Governance:	Expert	Experienced
Commercial Acumen:	Experienced	Experienced
Project Management:	Experienced	Experienced
Stakeholder Management:	Experienced	Experienced
Procurement Management:	Experienced	Experienced
Contract Management:	Previous Involvement	Experienced
Resource Commitment:	Experienced	Experienced

**Table 35**

<b>Project Manager: Andrew Baillie</b>		
<b>Main Responsibilities:</b>	Responsible for leading, managing and coordinating the integrated project team on a day-to-day basis.	
<b>Experience and suitability for the role:</b>	<b>Skillset Expected:</b>	<b>Skillset of Individual:</b>
Development Management:	Experienced	Experienced
Governance:	Previous Involvement	Experienced
Commercial Acumen:	Experienced	Experienced
Project Management:	Experienced	Experienced
Stakeholder Management:	Experienced	Experienced
Procurement Management:	Experienced	Experienced
Contract Management:	Experienced	Experienced
Resource Commitment:	Experienced	Experienced

**Table 36**

<b>Project Board Members:</b>		
<b>Project Role &amp; Main Responsibilities:</b>	<b>Named person:</b>	<b>Experience of similar project roles:</b>
<b>Organisation's senior business/finance representative –</b> Representing the organisation's business & financial interests	Marion Speirs	Experienced
<b>Senior service representative –</b> Representing the end user interests	Mary O'Donnell and Lesley Donnelly	Experienced Experienced
<b>Senior Technical/Estates/Facilities representative –</b> Representing the technical aspects of the project	Andrew Baillie	Experienced
<b>Stakeholder representatives –</b> Representing stakeholders' interests	Architecture & Design Scotland Mental Health Network	Experienced

**Table 37**

Independent Client Advisors:	
<b>Project Role:</b>	<b>Organisation &amp; Named lead:</b>
<b>Project Manager</b>	Andrew Baillie
<b>Business Case author</b>	David Harley
<b>Private Sector Development Partner – Project Manager</b>	Euan MacKenzie (hub West Scotland)
<b>Clinical / service lead</b>	Head of Adult Services NE Glasgow City HSCP
<b>Technical advisor</b>	Currie and Brown
<b>Financial advisor</b>	Caledonian Economics
<b>Legal advisor</b>	CMS Cameron McKenna Nabarro Olswang LLP
<b>IM&amp;T advisor</b>	David Daly
<b>Civil/ Structural Adviser</b>	MSPS
<b>M&amp;E Adviser</b>	RSP
<b>Architectural Adviser</b>	Keppie
<b>Medical equipment advisor</b>	Lesley Donnelly
<b>Commissioning advisor</b>	Andrew Baillie
<b>Other advisors</b>	Austin Smith Lord (Landscape Architects)

(SUPPLY/CONSTRUCTION TEAM DETAILS SHOULD BE INCLUDED WITHIN THE COMMERCIAL CASE)

### 8.3 Project recruitment needs

No project recruitment needs have been identified at this stage.

### 8.4 High Level Project Plan

**Table 38 High Level Project Plan**

OBC Consideration\Approval	June\July 2017
Stage 2	February\March 2018
FBC Consideration\Approval	April\May 2018
Financial Close	May\June 2018
Completion date	December 2019
Services Commencement	February 2020

Project Programme attached at Appendix 5.

### 8.5 Change Management Arrangements

### 8.6 Operational and service

Potential impact of the proposed change on the NHS Greater Glasgow and Clyde's operational and service activities, processes and people has been assessed. Mary O'Donnell - In-patient Service Manager, North East Sector (Glasgow City HSCP), Lesley Donnelly - Operations Co-ordinator, Mental Health and Head of Adult Services NE Glasgow City HSCP also deliver the existing function for the two wards affected by the proposed

service change. No additional resources are needed to implement the plan. Staff partnership representatives have been involved in the transfer of staff and are managed in accordance with existing arrangements. Structure and governance arrangements will remain the same.

### 8.7 Facilities

Similarly, due to continuity in senior management of the service, NHS facility services will remain as they are at present. NHS Operational facilities have been part of the Project Board throughout the entire process. During negotiation on contract extension the current provider care home provider has confirmed that TUPE is not applicable for the facilities function and staff. Future plans for location include retaining NHS clinical and NHS facilities input.

### 8.8 Stakeholder engagement and communication

#### 8.9 Identification of Stakeholders

The following list of stakeholders has been identified for the ward currently located at Stobhill:

**Table 39 Identified Stakeholders**

- Patients / service users
- NHSGG+C
- Glasgow City HSCP
- Head of Mental Health Services
- Clinicians
- Nurses
- AHP
- Facilities Management
- Occupational therapists
- Therapeutic activity nurses
- Dieticians
- Practice Development nurse
- Secretarial staff
- Community Councils
- Community Transport Glasgow
- Pharmacy
- Patient Affairs (funding/finance)
- Medical records
- Out of Hours service
- Psychiatric Liaison
- Addiction Teams
- General Public
- Community GP's
- Community Mental Health Teams
- Public Partnership Forum
- Patient Services (service user and carer engagement)

### 8.10 Engagement with Stakeholders

#### a) Stobhill Hospital

The following table summarises the stakeholder engagement that has taken place regarding acute adult mental health inpatient services delivered from Stobhill Hospital.

**Table 40 Engagement with Stakeholders - Stobhill**

Stobhill Hospital Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Patients / service users	<p>Patients and service users affected by this proposal include multiple public engagements as part of the Clinical Services Review events over the past three years. Their involvement in its development includes representation at Mental Health Care Group Forum meetings and specific design meetings including with Design Scotland and Architect for the proposals. The impact that this had on the proposal's development includes the space utilisation, feel and material of the design materials and the aspect of the openness and access to the ward. User and carer representation was facilitated and delivered as a key part of the Option Appraisal exercise</p>	<p><i>Patient / service user groups were consulted on the final version of this Initial Agreement by meeting with the Public Fora and Patient Involvement Group over the last three years and most recently on 9th August 2016. Their feedback was supportive and consistent with the feedback on the overall Strategy development over which has been incorporated into this proposal. Additionally further work with service user and carer representatives on improving transport access generally is being progressed. User and Carer representation delivered the Option Appraisal as a key part of the exercise.</i></p>
Organisation	<p>NHSGGC is fully supportive of this proposal with Director Operations Glasgow City HSCP taking the lead role in its development.</p> <p>Board members approved this proposal at the Board meeting held on 19<sup>th</sup> April 2016.</p>	<p>The Initial Agreement was approved at the Health Board Meeting on 18<sup>th</sup> October 2016</p>
Service or Department	<p>The Head of service is the project sponsor and the Director Operations Glasgow City HSCP is the lead for the Programme Board</p>	<p>The proposals for relocation of the service was approved by the Project Board on 9<sup>th</sup> September 2016</p> <p>The Initial Agreement was approved by the Programme Sponsor on behalf of the Project Board on 23<sup>rd</sup> September 2016.</p>
Staff / Resources	<p>Staff affected by the proposal are as follows:</p> <ul style="list-style-type: none"> <li>• Clinicians</li> <li>• Nurses</li> <li>• AHP</li> <li>• Facilities Management</li> <li>• Occupational therapists</li> </ul>	<p><i>Staff representatives have participated in Mental Health Services Redesign Engagement Group on an on-going basis for the previous three years.</i></p> <p><i>Staff representatives were involved in the development of the new solution including contributing to the scope, schedule of accommodation, design</i></p>

Stobhill Hospital Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
	<ul style="list-style-type: none"> <li>• Therapeutic activity nurses</li> <li>• Dieticians</li> <li>• Practice Development nurse</li> <li>• Secretarial staff</li> <li>• Pharmacy</li> <li>• Patient Affairs (funding/finance)</li> <li>• Patient Services (service user and carer engagement)</li> <li>• Medical records</li> <li>• Out of Hours service</li> <li>• Psychiatric Liaison</li> <li>• Addiction Teams</li> </ul>	<p><i>of the build and communicating with the wider staff.</i></p>
General public	<p>The general public will be affected by this proposal by improved service pathway and change of the ward location on site at Stobhill in closer proximity to with other acute adult mental health services. A range of public consultation events took place in relation to the broader Clinical Services Review over a number of years and specifically direct engagement with the current service user and carer representatives is on-going.</p>	<p>Outcomes from the public consultation events have influenced this proposal by development of the proposed more modern accommodation for this acute ward on the Stobhill mental health campus.</p>
Other key stakeholder Groups	<p>Community GP's Community Mental Health Teams PPF</p>	<p><i>The Initial Agreement was well received and supported by the PPF when it was presented at its meeting on 13<sup>th</sup> October 2016.</i></p>
<i>Other key stakeholders</i>	<p>Other key stakeholders identified for this proposal includes community councils and Community Transport Glasgow. Their involvement in the development of this proposal includes individual meetings to</p>	<p><i>Confirmed support for this proposal has been gained through the individual meetings undertaken by the Head of Service over the previous year's development of the Clinical Services Review.</i></p>

Stobhill Hospital Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
	discuss the development the proposed new acute ward on the Stobhill site.	

b) Stakeholder engagement – Birdston Care Home.

The following list of stakeholders has been identified for the ward currently located at Birdston:

- Patients / service users
- General public
- Clinicians
- Nurses
- AHP
- Private Accommodation Provider
- Community Transport Glasgow

The following table summarises the stakeholder engagement that has taken place regarding the proposal to relocate the complex elderly mental health services from Birdston Care Home.

**Table 41 Engagement with Stakeholders – Birdston**

Birdston Care Home Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Patients / service users	Patients and service users affected by this proposal include the current Birdston catchment and carer cohort. Their involvement in its development includes highlighting where any transport issues may occur for people who might live next to the current location. The impact that this has had on the proposal's development includes commitment to transport mitigation where carers are affected at the time of transfer. User and carer representation was facilitated and delivered as a key part of the Option Appraisal exercise	Patient / service user groups were consulted on the final version of this Initial Agreement by meeting with the Public Fora and Patient Involvement Group over the last three years and most recently on 9 <sup>th</sup> August 2016. It was approved subject to final comments received by 31 August 2016. Their feedback was supportive and consistent with the feedback on the overall Strategy development over which has been incorporated into this proposal. Additionally further work with service user and carer representatives on improving transport access generally is being progressed. <i>User and Carer representation delivered the Option Appraisal as a key part of the exercise.</i>

General public	<p>The general public will be affected by this proposal by improved service pathway and change in location of service for older peoples Hospital Based Complex Care from private nursing home at the perimeter of the catchment geography to more centralised location co-located with other mental health services. This was subject to a range of public consultation events in relation to the broader Clinical Services Review over a number of years and specifically direct engagement with the current service user cohort. This specific engagement will also continue during the period of design and construction.</p>	<i>See above Patients / service users</i>
Staff / Resources	<p>Staff affected by the proposal are as follows:</p> <ul style="list-style-type: none"> <li>• Clinicians</li> <li>• Nurses</li> <li>• AHP</li> </ul>	<p><i>Staff representatives have participated in Mental Health Services Redesign Engagement Group on an on-going basis for the previous three years.</i></p> <p><i>Staff representatives were involved in the development of the new solution including contributing to the scope, schedule of accommodation, design of the build and communicating with the wider staff.</i></p>
Support Groups and services	<p>Support groups and services who provide support, company and friendship to the patients are as follows:</p> <ul style="list-style-type: none"> <li>• Private Accommodation Provider</li> </ul>	<i>The proposals have been shared with the current accommodation provider and a joint approach is being adopted for the proposals.</i>
Other key stakeholders	<p>General support for the overall Clinical Services Review</p> <p>Community Transport Glasgow. Their involvement in the development of this proposal includes individual meetings to discuss the development of improved transport options in support of the proposed new ward</p>	<p><i>Confirmed support for this proposal gained through general engagement on the Clinical Services review. The current cohort of service users/carers are also discussing the development during specific review meeting with Clinical ward staff. These discussions will be on-going during the period of the project to keep people informed and to address any service user admissions and discharges.</i></p>

## 8.11 Benefits Realisation

The following benefits realisation plan builds on the investment objectives and option appraisal benefit criteria set out earlier in the Outline Business Case.

**Table 42 Benefits Realisation**

Main Benefit	Financial- Non Financial	As Measured by	Baseline Measure	Target Measure
1 Medical Practitioner day and night cover increased 100% on site	Non-Financial	Medical Rota	Medical Staffing Audit  6 months pre-opening	6 months post opening
2 Increased use of anticipatory care planning	Non-Financial	Average length of stay for ward (acute)	Average length of stay 6 months pre-opening	Average length of stay 6 months post-opening
3 Increased use of anticipatory care planning	Non-Financial	Hospital based complex care HBCC	Years 2015/16 and 2016/17	12-24 months post opening
4 Better bed mix for older people	Non-Financial	Number of functional and dementia older beds affected by project	Number of functional and dementia beds Birdston/Tate 2015/2016	Number of functional and dementia beds Stobhill/Tate on opening
5 Improve functional suitability of Mental Health estate	Non-Financial	Number of single en-suite bedrooms on wards	Percentage six months prior to opening	Percentage on opening
6 Reduction in people waiting more than 14 days to be discharged into more appropriate care setting	Non-Financial	Number of acute bed days lost to delayed discharged including AWI	12 months prior to opening	12 months post opening
7 Reduction in people waiting more than 14 days to be discharged	Non-Financial	Number of hospital beds based on complex care days lost to	12 months prior to opening	12 months post opening

<b>Main Benefit</b>	<b>Financial- Non Financial</b>	<b>As Measured by</b>	<b>Baseline Measure</b>	<b>Target Measure</b>
into more appropriate care setting		delayed discharge including AWI		
8 Improve financial performance	Financial	Reduced running costs due to more energy efficient wards	To be confirmed 6 months prior to opening	To be confirmed 6 months post opening
9 Improved diagnostic service	Non-Financial	Increase in referral for diagnostic assessments on site	12 months pre move	12 months post move
10 More efficient use of staffing resource	Financial	Reduction in nursing costs including bank and escorts	Acute ward 12 months prior to opening	12 months post opening
11 More efficient use of staffing resource	Financial	Reduction in nursing costs including bank and escorts	As above for HBCC ward	12 months post opening
12 New models of care for new wards	Non-financial	Numbers of internal transfers out with North sector (Acute)	12 months pre-opening	12 months post opening
13 New models of care for new wards	Non-financial	As above for HBCC ward	12 months pre-opening	12 months post opening
14 Community Integration	Non-financial	Increased menu of activities including community activity in reach	6 months prior to opening	6-12 months post move
15 Reduce sickness absence rates amongst staff	Financial and non-financial	Sickness absence rates for the wards	Rates 2016/2017	Rates 12 months post opening
16 Improved staff recruitment	Non-financial	Reduced vacancy rates	Rates 2016/17	Rates 12 months post opening

<b>Main Benefit</b>	<b>Financial- Non Financial</b>	<b>As Measured by</b>	<b>Baseline Measure</b>	<b>Target Measure</b>
17 Improved retention of staff	Non-financial	Reduced staff turn over	Rate 2016/17	Rates 12 months post opening
18 Improved ward environment	Non-financial	Acute ward. Number of specific environmental concerns raised by MWC and patient feedback	No of specific concerns raised 2015/16 and 2016/17	12 months post opening
19 Improved ward environment	Non-financial	HBCC (as above)	No of specific concerns raised 2015/16 and 2016/17	12 months post opening
20 Improved patient support	Non-financial	5% decrease in absconsions	No in year 12 months prior to opening	Number 12 months post opening
21 Improved service user well being	Non- financial	Reduced incidents aggression	No of DATIX reported incidents 12 months prior to move	No of DATIX reported incidents 6-18 months post opening
22 Improved service user socialisation	Non-financial	Service user rating service available as good	Service users survey 12 months prior to move	Service users survey 12 months after
23 Improved key adjacencies on wards	Non-financial	Minimum 80% delivered as specified in clinical brief	Reviews of clinical brief	Comparison to building post opening
24 Safer HBCC accommodation	Non-financial	Number of reported trips and falls of service users	12 months reporting on DATIX prior to move	12 months reporting on DATIX prior to move
25 Improved access to natural daylight/natural sunlight	Non-financial	Personal & public accessible spaces adjacent to and within ward area as per SCIM design statement	Audit of service user opinion/carer opinion prior to opening	Audit of service user opinion/carer opinion post opening

<b>Main Benefit</b>	<b>Financial- Non Financial</b>	<b>As Measured by</b>	<b>Baseline Measure</b>	<b>Target Measure</b>
26 Improved flexibility and functionality of building	Financial	Flexibility of design of development will reduce need for major adaptations £50K in 10 years	Adaptations costs circa 10 years prior to move	Decade post move
27 Improved compliance with building guidance	Non-financial	Compliance with current building guidance and space standards	Room audit % of compliance with current building guidance and space standards prior to move	Room audit % of compliance with current building guidance and space standards post move.
28 Improved confidentiality, privacy and dignity for service users	Non-financial	Complaints regarding breach of values	Number of complaints where accommodation limitations contributes to breach of values 12 months prior to move	Number of complaints where accommodation limitations contributes to breach of values 12 months prior to move
29 Improved equity and access to ward	Non-financial	Number of service users admission refused due to gender	12 months prior to move	12 months post move
30 Improved Infection Control	Non-financial	Infection control audits indicate measurable improvements	12 months pre move	12 months post move
31 Improved working environment	Non-financial	Staff survey on working environment (as below)	12 months prior to move	12 months post move
32 Improved comfort ambiance and atmosphere of the wards for some	Non-financial	Service user and care survey whereby by majority of these	Pre move timescales TBC	Post move timescales TBC

Main Benefit	Financial- Non Financial	As Measured by	Baseline Measure	Target Measure
users/carers and visitors		surveyed who experienced the same service at pervious ward voice a measurable improvement in the new ward		
33 Improved catchment access. HBCC wards	Non-financial	Percentage reduction in  1 service users home to ward distance  2 main carer/visitor home to ward distance	12 months pre move based on catchment address on administration  Survey TBC	12 Months post move based on catchment address on admission.  Survey TBC

### 8.12 Risk Management

The Risk Management registered is a living report which is reviewed and updated as required at each monthly Project Group meeting. The Risk Register (Table 43 below) incorporates HUB process and service risks.

Table 43 Risk Register

Stobhill MH New-Build DBFM													£420,000		hub		
Ref	Date Raised	Summary Description of Risk			Stage	PRE-CONTROL			Costed Risk Allowances	Impacts (Time & Cost)	Mitigation/Management/Transfer Strategy	Managed	Owned	Last Reviewed/Comments	Next Action	Forecast stage 2 status	
		Cause of Risk	Risk Description	Effect of Risk		Likelihood	Impact - Time	Impact - Cost (£)									Risk Score
<b>GENERAL RISKS</b>																	
G1	01/08/2016	A&DS & HFS Approvals	Stage 2 design review results in further design changes		1.2	2	3	5	10	£35,000	Change to design may be necessary- impacting time and cost	Proactive engagement to purify during Stage 2.	hWS (KD)	NHS	24 Jan 2017; Allowance increased on basis of 90m2 GIFA increase and additional fee estimate. 13 Feb 2017; Allowance decreased based on indicative 80m2 increase to GIFA at £2200/m2. 23rd February 2017; Allowance reduced to £80k based on increase GIFA of 16m2 based on revised layout plans but potential increase to envelope costs at corners. 17th March 2017 - Allowance removed as costed in revised Cost Plan. 24th April 2017; Allowance added to address any comments received during Stage 2 development. 4th May 2017; Allowance increased to £35k.	NHS GGC to arrange review aligned with programme requirements	Closed
G2	01/08/2016	Approvals by NHS Fire Officer, Infection Control	Approval process results in new requirements		1.2	2	3	4	8		Change to design may be necessary- note costed risk item G9 intended to cover this item aswell	Engage with stakeholders including HFS and purify during Stage 2	NHS	NHS	17 Nov 2016; Assume engagement will allow most issues to be resolved - make small allowance for changes in design. 17 Jan 2017; Allowance reduced. Dialogue ongoing with Infection Control and majority of Fire Engineering risk covered under allowance relating to Building Control. 13 Feb 2017; Allowance removed as Infection Control requirements generally costed and allowance within Item G9.	NHS to schedule engagement	Closed
G3	01/08/2016	Project bundling	Greenock, clydebank and Stobhill programmes for bundled projects fail to align		1.2	5	4	4	20		Unable to achieve FC as programmed	Monitor all three projects to ensure no programme slippage and alignment at key stages. Potential for Stobhill works to be suspended in advance of market testing if programme significantly ahead of Health Centre projects	hWS	NHS	17 Nov 2016; Assume project slips into 3rd Quarter 2018. 17 Jan 2017; Key project risk but unquantifiable, allowance removed.	hWS to initiate programme review prior commencement Stage 2	Closed
G5	19/10/2016	Additional Planning requirements including Masterplan	Change to design required			2	4	3	12	£50,000	Additional cost and time implications	Early engagement with Planning Dept. to clarify requirements	hWS (KD)	NHS	17 Jan 2017 Cost allowance increased; initial planning feedback noted concerns regarding design and site suitability. 22 March 2017; Agreed to reduce to £30k following initial meeting. 19 April 2017; Noted that this allowance should cover any additional acoustic requirements in relation to roof top plant and the generator. 24th April 2017; Allowance increased by £5k. 4 May 2017; NHS advised no formal masterplan planning approval required and thus no anticipated dependency. 4th May 2017; Allowance increased to £50k.	KD to schedule engagement	Closed

G6	21/09/2016	Reduced-ligature requirements	Stage 2 design refinement results in increased cost		1.2		3	4	3	12	£35,000	Revised overall scoping agreed during Stage 1. Early Stage 2 engagement with Stakeholders and clarification regarding NHS requirements with associated Risk Assessment required.	hWS (KD & RSP)	NHS	17 Nov 2016; Assume engagement will allow most issues to be resolved - make an allowance for potential additions to design. 24 Jan 2017; Allowance included in Cost Plan based on Inverclyde with uplift in relation to windows / doors requirements. Allowance of £25k per Unit deemed suitable in advance of confirmation of requirements through design development. 22 March 2017; Agreed to reduce to £40k. 19 Apr 2017; Agreed to reduce allowance to £30k. 4th May 2017; Allowance increased to £35k.	KD to schedule engagement	Closed	
G9	01/08/2016	Building control approvals	Additional measures to achieve compliance requested				2	3	4	12	£50,000	Change to design may be necessary	hWS (KD)	hWS	17 Nov 2016; Assume engagement will allow most issues to be resolved. Allowance for some changes in design requested by building Standards. 17 Jan 2017; Allowance increased. 22 March 2017; Agreed to reduce to £50k	KD to schedule engagement	Closed	
G10	01/08/2016	New wayleaves	New Wayleaves may be required for new services to site- specifically SP-routed from north of site	Impact on programme	2.post FC		2	3	2	6		Impact on programme and or assumed scope of hWS work	Wayleaves may be required but no significant issues anticipated. Early engagement required.	NHS	NHS	17 Nov 2016; Assume project slips into 3rd Quarter 2018. 17 Jan 2017; Site confirmed as being under complete ownership of NHS GG&C, cost allowance removed.	NHS to issue Schedule part 5	NHS
G11	01/08/2016	Title conditions and reserved rights	Title conditions and any reserved rights prejudice design or execution of the works		1.2		2	3	3	6		Impact on programme and or assumed scope of hWS work	Obtain Schedule part 5 at inception of Stage 2 and assess for design impact. Noted that legal engagement is already in progress with verbal assurance of clean title	NHS	NHS	17 Nov 2016; Assume project slips into 3rd Quarter 2018. Allow for additional works resulting from land ownership issues. 17 Jan 2017; Site confirmed as being under complete ownership of NHS GG&C, cost allowance removed.	NHS to issue Schedule part 5	Closed

SITE SPECIFIC RISKS															
SS3	01/08/2016	Pre-Construction Demolition and Service Diversion Works	Potential delays to availability of site for Phase 2 Site Investigation (providing insufficient time to investigate and cost associated works) and construction activities, potential for scope gaps between Demolition and New-Build Contract scopes (incl. removal of existing substructures / services within redline boundary).	1.2	4	5	5	20	Significant potential programme/cost impact	Demolition/services diversion required scoping advised to NHS GG&C. Ongoing engagement and close monitoring of programme and progress required with NHS Demolition Team / Contractor. Noted that any Asbestos survey / removal works would be undertaken by NHS GG&C. Programme implications of Stage 2 Site Investigations now overlapping with market testing and Stage 2 milestones to be considered.	NHS	NHS	17 Nov 2016; Assume project slips into 3rd Quarter 2018. Allow for additional works resulting from breaking out works/remediation works; Allow for extended time on site dealing with issues. 30 Nov 2016; NHS to obtain warranty in relation to Graham Construction works. 17 Jan 2017; Significant project risk but not quantifiable, allowance removed. Score reduced as service diversions will be undertaken by the Demolition Team and existing connections utilised with the exception of SP 03 May 2017; redrafted to incorporate Risk SS2	NHS to confirm hWS Demolition requirements will be met (is this Schedule Part 5)? Establish 'modus operandi' for close tracking and reporting	Closed
SS4	19/10/2016	Proximity to existing buildings	Noise / dust impact	Construction	2	2	3	6	Programme impact	Contractor to develop methodology and logistics strategy. Additional Planning requirements may be required.	BAM	BAM	17 Nov 2016; Assume Contractor will take into account the surrounding environment and initiate such measures to ensure minimum disturbance.	BAM methodology	Transferred to DBFMCo stepped down to BAM
SS5	01/08/2016	Service Connection issues	Risk of either capacity or other technical complications arising following NHS demolition/diversion works	1.2	3	5	5	15	Change in scope/design/ programme	Noted that GPRS completed. Known service diversions, disconnections and strip out required within the redline boundary now included in demolition scope. Impact of services at existing switchroom unlikely due to confirmed requirement for new SP supply from adjacent site/building.	hWS	BAM	17 Jan 2017; Cost allowance reduced as anticipated required diversion works will be undertaken by Demolition Team. 24 Jan 2017; Small allowance included for any further requirements identified. 25th Jan 2017; Wording changed to service connection issues. 22 March 2017; Agreed to increase to £30k.	Commission and sequence any additional surveys required	Closed or transferred to DBFMCo stepped down to BAM
SS6	21/09/2016	Connection issues identified with existing drainage routes	Additional works required to resolve existing issues	1.2	3	3	3	9	Programme / cost / design impact	Exposure of areas of concern identified in CCTV survey / potential by-pass through design	hWS	BAM	17 Nov 2016; Allow additional costs to by-pass connection issue. 17 Jan 2017; Cost allowance increased.	Commission and sequence any additional surveys required	Closed or transferred to DBFMCo stepped down to BAM
SS10	01/08/2016	Timing and Outcome of Phase 2 SI	Slippage of Demolition programme leading to delayed SI and insufficient time for risk transfer Ground Contamination - under existing buildings or possible asbestos arising from Demolition project Ground water subject to pollutants- requiring increased SUDS	1.2	3	5	5	15	Change in scope of works and design/programme slippage	Reliance on NHS meeting hWS 'Demolition and Service diversion Requirements' and agreed programme for completion October 2017 with phased earlier SI access for hWS. Phase 2 SI will identify any further requirements. Late access for Phase 2 Site Investigation will leave insufficient time for investigation and costing of any remedial works and the associated planned risk transfer. Proactively monitor and track NHS works. SI will identify any Ground Water requirements. Currently awaiting GW monitoring results.	hWS	NHS	17 Nov 2016; Allowance made. 30 Nov 2016; Further S.I results to follow. 17 Jan 2017; Cost allowance increase, potential contamination issue following Phase 2 Site Investigation. 24 Jan 2017; £25k in Cost Plan to address any issues, further £25k allowance deemed suitable in relation to Phase 2 SI risk. 22 March 2017; Agreed to remove allowance from Cost Plan and increase allowance. 18th Apr 2017; Agreed with NHS GG&C TA to remove £50k allowance for 'Dark Ground' and £25k for Ground Water. 03 May 2017; redrafted to encompass Phase 2 SI outcome and including former risk SS11 Ground Water	Formalise NHS commitment to Demolition programme and SI access sequence	Transferred to DBFMCo stepped down to BAM or remain with NHS

SS15	19/10/2016	Additional measures to obtain specified BREEAM targets	Loss of available credits and impact on ability to achieve excellent rating		1.2	3	3	9	£40,000	Design / BREEAM	Early engagement with demolition team and agreement regarding associated responsibilities / targets. Noted that fee proposals obtain in relation to Pre-Demolition Audit and Pre-Demolition Ecology Survey as not being undertaken by the Demolition Team. Track with interim BREEAM assessments and monitoring	hWS	NHS	17 Nov 2016; Allow for additional facilities to increase credits. 17 Jan 2017; Cost allowance increased. Concern noted in relation to associated Demolition Programme responsibilities and the potential loss of targeted credits. 18th Apr 2017; Allowance reduced to £30k. 24th April 2017; Allowance increased by £5k. 4th May 2017; Allowance increased to £40k.	Formalise obligation of NHS to deliver Demolition project related BREEAM credits including potential Relief Event for DBFMCo if not delivered.	Closed or transferred to DBFMCo stepped down to BAM
SS16	18/01/2017	Revision of finalised ACR's following significant design development and compilation of initial cost estimates	Stage 1 costed design does not include all requirements detailed within the latest ACR's issued.		1.2	3	2	9	£40,000		Early Stage 2 review of ACR v5 by the project team following issue on 06 Feb 2017 and clarification regarding any associated queries	hWS	NHS	18 Jan 2017; Cost allowance added to cover any additional design requirements detailed in the ACR's but not captured within initial cost estimates or design. 13 Feb 2017; Cost allowance reduced due to ACR issue and partial query close-out. 18th Apr 2017; Allowance reduced to £40k. 27th April 2017 - Allowance reduced to £34,500. 4th May 2017; Allowance increased to £40k.	Project team review at kick off of Stage 2	Closed
SS18	22/03/2017	Solar shading requirements	Potential for additional requirements relating to solar shading		1.2	3	2	9	£40,000	Design / Cost	Early Stage 2 design review and associated modelling to determine requirements	hWS	hWS	22 March 2017; Agreed to add allowance to address any later requirements identified. 24th April 2017; Allowance increased by £10k.	RSPK to initiate modelling	Closed
SS20	18/04/2017	Substructure/ foundation scope	Additional requirements identified in relation to substructure / foundation requirements due to variations from Phase 1 Site Investigation information impacting on amount of mass fill, etc.		Stage 1 & 2	3	4	12	£40,000	Cost Plan includes for current design but additional allowance required to cover further requirements identified	Design to be developed throughout Stage 2 with early access to be provided if possible following Phase 2 Site Investigation	hWS	hWS	18th Apr 2017; Agreed with NHS GG&C Technical Advisor that allowance of £40k should be transferred from Cost Plan to Risk Register	BH Stage 2 design programme	Closed
SS20	18/04/2017	Additional requirements relating to obstructions / soft spots identified during construction	Cost Plan assumes majority will be completed through demolition programme but additional allowance prudent		Construction	4	3	12	£40,000	Design / Cost	Phase 1 Site Investigation has not identified any issues, early access for Phase 2 Site Investigation to be arranged if possible. Possible additional survey works to be considered	BAM	BAM	18th Apr 2017; Agreed with NHS GG&C Technical Advisor that allowance of £20k should be transferred from Cost Plan to Risk Register. 24th April 2017; Allowance increased by £5k. 4th May 2017; Allowance increased to £40k.	BAM to commission and programme any required additional surveys	Transferred to DBFMCo stepped down to BAM
SS21	19/04/2017	Additional works identified following Transport Engineer Input / Assessment	Cost Plan does not include for any requirements outwith the redline boundary		2	3	3	12			Engagement with Roads Dept. required. Allowance included in Cost Plan for potential pedestrianisation of adjacent access road. Traffic Engineer / Transport Assessment to be undertaken during Stage 2. Risk relates to any additional works required outwith the site boundary.	hWS	NHS	19 April 2017; Agreed prudent to incorporate risk. Agreed no allowance should be included as any requirements are likely to be out with the site boundary and part of the wider campus requirements. Could include traffic calming, layby's and the like.	Commission and programme Transport Assessment	Closed
SS22	19/04/2017	Availability of Site Compound	Risk that agreed site compound on adjacent NHS car park zone becomes unavailable or proves unacceptable		2,Construction	3	3	12		Programme and cost impact	Purify during Stage 2 Design process by formal agreement with NHS	hWS	NHS	April 2017; Agreed basis for Stage 1 submission is use of adjacent car park area for site compound	Formalise access to area outwith Site red line boundary- Ancillary Rights? Schedule Part 5?	Closed

SERVICE RISKS not updated at Stage 1 and not considered relevant to Stage 2 Construction/Procurement													
S1	30/11/2016	Older People's service demand	Actual demand does not match the projected demand levels.	20 bedded ward for Patient safety/ functionality / cost of boarding out	Post Construction	1	5	5			Carry out sensitivity testing of assumptions behind service demand projections to understand and manage any underlying risks. This includes functional and organic mix of demand.	NHS	Service numbers to be monitored including functional and organic mix.
S2	30/11/2016	Adverse publicity occurs due to patients moving location	Patients and Carers unhappy regarding communication on moves and on actual moves / locations.	Moves delayed / design / programme timetable delayed	Stage 1 & Stage 2 & Construction	1	4	1	4		Review on-going operational arrangements associated with the project and moves. Communication letter to be sent. Meetings with workers/carers and clinicians.	NHS	Operational Change plan to be developed as part of OBC process. Individual discussions and letters completed. To be repeated for the next stage.
S3	30/11/2016	Poor stakeholder involvement	A lack of stakeholder support for the project.	Moves delayed / design / programme timetable delayed	Stage 1 & Stage 2 & Construction	1	4	1	4		On-going development and implementation of project communication which includes engaging with all appropriate stakeholders at appropriate stages of the project	NHS	Engagement plan to be updated and monitored as part of OBC process
S4	30/11/2016	Scope of service alterations associated with programme not being clearly understood	Unrealistic expectations of what the project will deliver.	Change in scope/design/ programme. Unsuitable accommodation realised	Stage 1 & Stage 2 & Construction & FC	1	4	1	4		Clear objectives for the project set out as part of the Initial Agreement, linking them to clearly defined & measurable benefits and outcomes	NHS	Initial Agreement submitted to SCIG for approval. Objectives to be confirmed again at OBC stage.
S5	30/11/2016	Missing the dates of the Board meetings and the subsequent impact on the completion date of the new builds	The OBC is required to be submitted by March 2017. A delay in this would result in subsequent delays in submitting the FBC and would also impact negatively on Construction timeframes.	Programme / Cost	Stage 1 & Stage 2 & Construction & FC	1	5	1	5		Submission of IA to be completed by October 2016 to allow OBC to be completed by March 2017	NHS	To be updated following SCIG feedback from submission of IA
S6	30/11/2016	Missing the dates of the Board meetings and the subsequent impact on the completion date of the new builds	The FBC is required to be submitted by November 2017. A delay in this would result in subsequent delays in construction and would affect the financial close, currently planned for December 2017.	Programme / Cost	Stage 2 & Construction & FC	1	5	5	5		Submission of OBC to be completed by March 2017 to prevent subsequent delays from occurring	NHS	To be updated following submission of OBC. FBC to be submitted by November 2017.

S7	30/11/2016	The anticipated benefits from the project are not achieved following project completion	Benefits of change are not delivered.	Scope and Design/programme.	Construction & FC	1	1	1		Set out a realistically achievable benefits realisation plan as part of the Initial Agreement. Further engagement with stakeholders during process	NHS	Benefits plan to be reconfirmed and updated as part of OBC process	
S8	30/11/2016	The outline business case requires an option appraisal to take place. Confirmation is required as to whether this option appraisal would re-visit the options of building a new build, refurb or doing nothing or if this would be an option appraisal of various site locations for the new build wards.	In order to progress with design with HubWest Scotland, a high level of commitment to the preferred option is required. In order to achieve the completion dates outlined in the OBC and in the IA, the design work must be an ongoing process throughout the SCIG approval process.	Scope and Design/programme.	Stage 1 & Stage 2 & Construction & FC	3	5	15		Capital Projects Team will lead in discussions with the Chair of SCIG to confirm an agreed way forward with the option appraisal.	NHS	Update to be given once discussion has taken place between capital planning and the chair of SCIG.	
S9	30/11/2016	The Initial Agreement was discussed at SCIG meeting on 22.11.16. Formal comments awaited. Approval of the Initial Agreement is required in order to submit the NPR to HubWest Scotland. This NPR is due on the 31.11.16.	A delay in submitting the NPR would result in Hub not being able to initiate the next stage of their works.	Delay to design work / cost/ programme	Stage 1 & Stage 2 & Construction & FC	4	1	4		Capital Projects Team to lead in discussion with the chair of SCIG to receive formal feedback and to enquire as to the timescales for the formal response to be issued.	NHS	Update to be provided as soon as a response from SCIG is received.	
S10	05/12/2016	The current contract at Birdston is due to expire at the end of June 2018. There is a one year notice period NHSGG+C are required to formally note their intentions to end or extend the contract. Initial discussions have taken place regarding the possibility and likely costs of extending the contract for a period of 12 months. Birdston Directors stated that this would be the longest period of time they would be willing to extend the contract by. If such a potential option were to go ahead, this would extend the contract until the end of June 2019. The new DBFM ward is currently programmed to be completed by August 2019, this creates a potential gap in accommodation of two months following the completion of the extended Birdston contract.	The costs for extending the Birdston contract for a period of 12 - 20 months can be managed within the existing budget. However the costs of extending the contract on a rolling monthly basis beyond June 2019 will incur charges.	Impact on cost and the number of patient moves that may be required.	Financial Close and Construction	5	3	15		Project Director received exact costs of penalty charges from Birdston Directors and Project Director in discussion with Programme Sponsor confirmed extension as preferred way forward. The timescale and bundling with other schemes will be closely monitored for early warning of potential slippage in programme.	NHS	Monthly monitoring and report on financial impact of any change to project build completion and vacation of Birdston care Home accommodation.	

G7	21/09/2016	Building Regulation requirements for sprinklers	Additional design / works to achieve compliance	Programme / cost / design impact	Stage 1 & 2	4	2	3	12				Early review of required Building Standards to clarify requirements. Cost allowance to be included in Cost Plan	Keppie / RSP	17 Nov 2016; assume cost of sprinklers not in cost (client preference). Based on internal storage tank, gravity fed. 30 Nov 2016; Outcome of Fire Strategy Meeting on 06/12 awaited. 17 Jan 2017; Allowance added to cover potential requirement for sprinkler system. 24 Jan 2017; Allowance based on appropriate m2 rate and potentially increased GIFA. 22 March 2017; Agreed to reduce to £100k to cover eith options to maintain open plan day spaces. 30 Marh 2017; Allowance removed as strategy costed.	Closed at Stage 1 with solution agreed and allowance included within Stage 1 Cost
G8	01/08/2016	Development Programme delay	Delay in development programme pre FC and tied approvals risks FC movement to next quarter.	Impact on programme and cost	Stage 1 and Stage 2	4	3	3	12				Close monitoring of design development programme to be undertaken. Meet / accelerate development programme where necessary to achieve programme requirements.	NHS GG&/hWS	17 Nov 2016; Assume project slips into 3rd Quarter 2018. 17 Jan 2017; Cost allowance removed.	Closed at stage 1 since individual programme risks now all separately identified
SS1	01/08/2016	Statutory approvals required	Traffic infrastructure works may be necessary for roads surrounding the site	Change to design and or scope of work may be necessary	Stage 1, Stage 2	2	3	5	10				Engagement with Roads Dept. required. Allowance included in Cost Plan for potential pedestrianisation of adjacent access road.	NHS GG&/Keppie / MSPS	17 Nov 2016; Assume creating new road to by-pass buildings. 30 Nov 2016; Unlikely this will be required, potential impact on site strategy to be considered. 17 Jan 2017; Extensive requirements / works unlikely, allowance reduced. 24 Jan 2017; Noted that allowance could cover potential land grab from adjacent road (and associated works) to mitigate site size constraints and associated design issues. 13 Feb 2017; Allowance agreed following discussions, reasonable allowance now within Cost Plan.	Closed at stage 1 as costed allowances now included and residual risks covered under Risk SS21
SS2	01/08/2016	Delays relating to service connection / diversion works	Delays relating to associated approvals and lead-in times	Impact on programme	Stage 1 & Stage 2 and post FC	2	3	4	8				Early engagement required where necessary. Noted that new power supply only new supply anticipated. All other supplies to utilise existing supplies. SP engagement has commenced.	NHS GG&/RSP	17 Nov 2016; Assume an eight week delay on site. 17 Jan 2017; Significant project risk but not quantifiable, allowance removed. Score reduced as service diversions will be undertaken by the Demolition Team and existing connections utilised with the exception of SP.	Closed at Stage 1 as now incorporated in Risks SS3 and SS5- as NHS tackling utilities and demolition as a single contract and thus single dependency risk
SS7	21/09/2016	Challenges relating to bedroom model (interlocking) and safe / secure access to services	Finalised design creates risk to Patient group and / or challenges regarding access for maintenance	Patient Safety / Design	Stage 1 & 2	2	2	3	6				Early review of other projects with interlocking bedroom model and same Patient group	Keppie / RSP	17 Nov 2016; Allow additional costs per bedroom. 17 Jan 2017; Allowance removed as issue will be addressed as part of ongoing design development.	Closed at Stage 1 since layout design signed off by Participant
SS9	21/09/2016	Challenges relating to building escape resulting from significant level issues	Additional works required to form means of escape due to significant level changes and specific Patient group requirements	Design / Cost	Stage 1 & 2	2	2	3	6				Early clarification of escape strategy and associated design requirements. Review of management of escape with Stakeholder Group.	Keppie / MSPS / ASL	17 Nov 2016; Make allowance for measures to create ramps or bridges to exits. 17 Jan 2017; Minor reduction to allowance following Fire Strategy Meeting. 24 Jan 2017; Still potential risk until revised layout agreed and fire engineering strategy confirmed. 22 March 2017; Agreed to omit allowance as covered under G9.	Closed at Stage 1 with current design and noted that residual risk with building control covered by allowance under G9

SS11	19/10/2016	Ground water subject to pollutants (identified during Phase 2 Site Investigation)	Increased SUDS requirements	Design / Cost	Stage 2	3	3	4	12			SI will identify requirements. Currently awaiting GW monitoring results.	NHS GG&C / MSPS	17 Nov 2016; Allow for further treatment. 24 Jan 2017; Allowance increased following MSPS / QS feedback. 18th Apr 2017; Agreed with NHS GG&C TA to remove £25k allowance	Closed at Stage 1 as combined with SS10
SS12	01/08/2016	Gas Venting	Gas venting may be required for ground gases given historical industrial use of site	Change in assumed hWS scope of work	Stage 1 and Stage 2	3	2	4	12			SI surveys to be progressed at Stage 1	MSPS	17 Nov 2017; Allowance for gas venting and membrane. 24 Jan 2017; £60k allowance deemed suitable following MSPS / QS feedback in relation to gas pressure relief pathways. 13 Feb 2017; Allowance removed as gas venting measures costed.	Closed at Stage 1 since requirements clear and included within cost plan
SS13	19/10/2016	Corridor Service Zones	Insufficient corridor width may result in stacking of services and and compromise future access for maintenance	Design / Cost / Functionality	Stage 1 & Stage 2 & Post FC	2	3	4	8			Early identification of service requirements and space limitations	RSP / Keppie	17 Nov 2017; Allowance for creating additional space. 17 Jan 2017; Cost allowance removed, part of ongoing design development process.	Closed at Stage 1 as now embraced within signed off Stage 1 Design
SS14	19/10/2016	Required access to elevated areas	Specialist equipment required to access elevated areas	Design / Cost	Stage 1 & 2	2	3	4	8			Early development of design requirements. Requirements to be detailed in Access Strategy Document. Potential access for inspection and maintenance of PV panels noted if applicable.	Keppie / RSP	17 Nov 2016; Plant access to be considered and designed in; allowance made at present. 24 Jan 2017; Possible cost increases relating to additional platforms, access ladders, etc. 13 Feb 2017; Allowance removed as agreed, roof access requirements generally incl. in Cost Plan	Closed at stage 1 as measures incorporated in costed Stage 1 Design
SS17	22/02/2017	Potential for additional works to existing retaining walls due to the proximity of buildings to the site perimeter.	Current Cost Plan does not include any works to existing retaining walls	Design / Cost	Stage 1	4	2	3	12			Early review of building locations and impact on existing retaining walls.	MSPS	22 February 2017; Review of building layouts and likely impact on existing retaining walls to be confirmed. 17th March 2017; Allowance removed as now costed in revised Cost Plan.	Closed at Stage 1 with solution agreed and allowance included within Stage 1 Cost
SS19	22/03/2017	Additional requirements relating to access to roof plant or relocation of plant to low level plant room	Cost Plan includes for ladder access but full access stair may be required	Design / Cost / H&S	Stage 1 & 2	3	3	3	9			Early engagement with PD / FM Contractor to define access requirements. Access and maintenance strategy to be developed.	RSP / Keppie / FES	22 March 2017; Agreed to add allowance for potential improvements to roof access or alternative location for roof plant. 19 Apr 2017; Agreed to omit allowance following FES FM acceptance of companionway ladder solution.	Closed at Stage 1 with solution agreed and allowance included within Stage 1 Cost

### 8.13 Commissioning

The NHSGG&C Property & Capital Planning Project Manager will be responsible in overseeing the final stages of the project including all training needs for the new building and final commissioning certificates. They will liaise with the Main Contractor and other specialist contractors, along with the Commissioning Group to ensure a smooth transition to the New Facility.

### 8.14 Non-Technical Commissioning

A Transition and Commissioning Group will be established during the construction stage with membership from the various stakeholders in the project including, amongst others, Clinical User representation, Non Clinical User representation, IT, Telecoms, Estates, Procurement, Facilities Management, Estates and input from Infection Control. The Group will be led by the in-house Commissioning Team drawing on experience of previous new builds including the Queen Elizabeth University Hospital to develop an agreed Commissioning programme in conjunction with users.

The group will also be responsible for the development of a migration programme for the service move to the new facility and co-ordination of all the service teams to achieve the migration timescale, in line with the contract programme.

### 8.15 Project Evaluation

Post Project Evaluation will be undertaken in line with the SCIM guidelines to determine the project's success and identify lessons to be learnt.

During Construction the project will be monitored with regards to time, cost, the procurement process contractors performance, and any initial lessons learnt.

Six to twelve months after commissioning of the facility a more wide ranging evaluation (Stage 3) will take place. This will assess, amongst other factors:- how well the project objectives were achieved; was the project completed on time, within budget and according to specification; whether the project delivered value for money; how satisfied patients, staff and other stakeholders are with the project results and the lessons learnt about the way the project was developed, organised and implemented. A key focus will be sharing the information gathered so that the lessons to be learned is made available to others

Longer term outcomes (Stage 4) will be evaluated 2 to 5 years post migration to the new facility as by this stage the full effects of the project will have materialised. The evaluation will be undertaken by the in-house Post Project Evaluation team and both quantitative and qualitative data will be collected during stages 3 and 4 evaluation through the use of questionnaires and workshops.

## List of Appendices

Appendix 1 Report and Analysis from the Options Appraisal Event 27<sup>th</sup> April 2017

*Appendix 2 Stobhill Option Document Keppie*

*Appendix 3 Individual Scoring Option Appraisal Exercise*

Appendix 4 New Stobhill mental health inpatient facility: SCIM Design Statement (product of workshops 1 and 2)

*Appendix 5 Project Programme*

*Appendix 6 Initial Agreement Letter Health & Social Care Directorates*

Appendix 7 (a) & (b) NHS Greater Glasgow & Clyde Clinical Output Specification

Appendix 8 Schedule of Accommodation

Appendix 9 Stobhill AEDET

Appendix 10 Stakeholder Letter of Support

Appendix 11 HAI Scribe

## **Report and Analysis from the Options Appraisal Event 27<sup>th</sup> April 2017**

### **Purpose**

This report describes the results from an option appraisal exercise that was undertaken at a workshop event in April 2017. The workshop was attended by a wide range of nine service user and carer representatives (identified by the local user and carer organisation Greater Glasgow and Clyde Mental Health Network). Additionally the workshop was attended by an NHS clinician and clinical services manager, an NHS operational service manager, an NHS capital procurement manager, an NHS patient & carer services manager. The event was also attended by an Architect.

The purpose of the event was to use a systematic and structure process to identify a preferred option to provide two new fit for purpose, modernised mental health wards, one for adult acute admission and one for older adult hospital based complex care at Stobhill.

The report has been prepared by David Harley, Planning and Strategy who facilitated the option appraisal workshop and provided guidance to ensure that the process adopted was compatible with the Scottish Government's current guidance on non-financial benefit option appraisal in the NHS, that opinions were probed and a consensus reached as a group and that prejudice was avoided.

### **Process**

Guidance on the weighted scoring method approach is the preferred methodology for Scottish Government Health and Social Care Directorates (SGHSCD). It involved identification of all the non-monetary factors that were relevant to the project. The rationale for the identified options was briefly discussed and confirmed by the people attending the workshop. Brief consideration was given to identifying alternative options and none were identified.

The option appraisal process then had three key stages:

**i. Discuss and Agree the Criteria**

In accordance with the guidance, the process developed a number of measures to enable options to be compared.

**ii. Rank the Criteria and Weight the Criteria**

*Agree which criteria are most important to the group and the relative importance of the criteria. Each criterion was expressed as a weighting out of 100. The weightings were then scaled to a percentage.*

**iii. Score the Options**

*Each option will be scored against the agreed criteria on a scale of 0-10 ((including Do Nothing/Minimum). A score of 0 will indicate that the option offers no benefits at all in terms of the criteria, while a score of 10 will indicate that it presents some 'maximum' or 'ideal' level of performance. Rationale for scoring should also be recorded.*

## **Criteria**

*The criteria listed were derived from the benefit criteria agreed during stakeholder engagement that has guided the design process to date and also as part of the approved Initial Agreement document.*

The following criteria were identified during engagement with users and carers in preparation for the Initial Agreement that was submitted and approved by the Scottish Government. They were also used to brief the designs and options presented at the Options Appraisal event on 27<sup>th</sup> April 2017. The Option Appraisal event discussed and confirmed the criteria.

1. Patient environment and safety (Ranked 1)
2. Service benefits of site location (Ranked 3)
3. Good access for patients (Ranked 2)
4. Staff retention, recruitment and wellbeing (Ranked 4)
5. Efficiency of estate (Ranked 5)
6. Community Benefits (Ranked 6)

### **Rank and Weight the Criteria**

*The group agreed which criteria were most important to the group and the relative importance of the criteria. Each criterion was ranked in order of importance and then expressed as a weighting out of 100. The weightings were then scaled to a percentage. Justification for the agreed weights was that all service user and carer representatives agreed that patient environment and safety was the most important criterion and should be weighted 100. Thereafter each of the following criteria were ranked and weighted. It was understood differences between the values given to the weightings could be anything (in multiples of 10) from 10 to over 30 or more. Following discussion, particularly from user and carer representatives, each criterion was given a value of 10 less than the previous ranked criterion. The group felt this was reasonable, as at the end point community benefits (ranked least important) would be weighted as half as important as patient environment and safety (ranked most important). The NHS staff concurred with the views of the service user and carer representatives regarding the weightings. To ensure the robustness of the views expressed the facilitator challenged the group suggesting that it was legitimate to attribute a broader range of values to the ranked weightings. Following discussion the group confirmed that they preferred to keep the weighting values they had identified.*

#### **2. Patient Environment and safety (Ranked 1 Weighting 100))**

- a. Single room accommodation with en-suite facilities allowing patients a space of their own and privacy and dignity.
- b. Calm environment within mental health environment through design of physical environment with use of space and colour.
- c. Access to safe and secure green outside space providing a quiet restful environment.
- d. A modern environment with WIFI throughout able to support the latest technology. Both for staff using handheld devices to support provision of health care and for patients to access the internet where suitable.

#### **7) Service benefits of site location (Ranked 3 Weighting 80)**

- a. Strengthened care of patients with co-morbidities by being able to draw on other services and expertise more easily.
- b. Greater pool to draw staff from and more opportunities for staff having a larger range of service areas and therefore ability to build up and develop a range of skills.

- c. Address service variance in access and treatment
- d. Sustainability of the clinical Out of Hours Rota.

**8) Good access for patients (Ranked 2 Weighting 90)**

- a. Therapeutic environment for patients by facilitating access to safe outside green spaces to enjoy and relax in
- b. Fully compliant and accessible facilities

**9) Staff retention, recruitment and wellbeing (Ranked 4 Weighting 70)**

- a. Staff retention and stability from more opportunities for staff to build up and develop a range of skills.
- b. Quality of the working environment and access to developing physical health opportunities

**10) Efficiency of estate (Ranked 5 Weighting 60)**

- a. Achieve an energy efficient facility reducing CO2 emissions and contributing to improved sustainability of the estate.
- b. Enable access to modernised and fit for purpose Hospital environment and services.
- c. Meet statutory requirements and obligations for public buildings e.g. DDA compliance

**11) Community Benefits (Ranked 6 Weighting 50)**

- a. The relocation of an adult acute admission ward and older adult complex continuing care ward to Stobhill will provide a bigger footfall for local services within the new location.
- b. Opportunities created for local businesses and workforce

Table 1 Summary Benefit Criteria, Ranking and Weighting

Importance Weighting				
Benefit Criteria	Weight	Normalised Weight		Rank
Patient Environment and safety	100	22		1
Service benefits of site location	80	18		3
Good access for patients	90	20		2
Staff retention, recruitment and wellbeing	70	16		4
Efficiency of estate	60	13		5
Community Benefits	50	11		6
	450	100		

**Score the Options**

*Each option was discussed and then scored against the agreed criteria on a scale of 0-10 ((including Do Nothing/Minimum). A score of 0 indicated that the option offered no benefits at all in terms of the criteria, while a score of 10 indicated that it presented a ‘maximum’ or ‘ideal’ level of performance.*

## **Options**

*A briefing on the Mental Health Strategy covering Adult Acute and Older Adult Hospital Based Complex Care Services for North Glasgow' provided background information on how the available location evolved. It also detailed the mental health strategies that support this piece of work. This included a previous feasibility study which informed subsequent thinking for the identified options outlined below.*

Available land identified is located at Wards 22-25 at Stobhill see Appendix 1 report by Keppie Architect. The NHS GG&C Capital Projects professional and the Architect from Keppie presented the options. Discussion by the group highlighted some of the pros and cons of each of the options. These have been incorporated into the summary report by Keppie at Appendix 1. Along with the design statement (as set in the Initial Agreement [see appendix 3]) the pros and cons were raised and discussed during discussion on scoring each of the options.

The options below were identified to explore different ways in which the recognized area could be utilised, including:

- **Do Nothing (Baseline)**
- **Refurb and Extend – Wards 22-25**
- **Single Building – On site of Wards 22 and 23. This requires costing to re-locate pharmacy**
- **Two new build wards – On site of Wards 22 and 23. This requires costing to re-locate pharmacy**
- **Two new build wards – On site of wards 22 and 25**

During the Option Appraisal exercise the group assessed the design of the two new wards for each of the options independently and gave each option a score out of 10 based on how well they would achieve the agreed criteria.

## ***Calculating the Weighted Scores***

*The Group discussed and scored each of the 5 options against the 6 benefit criteria. The group was asked to try to reach a consensus on a score out of 10 for each benefit criteria against each option. The results for the consensus score are set out in table 2 below.*

*Along with the consensus scoring is also a score for an optimistic view and also a pessimistic view.*

*During the discussions for each of the options and each of the criteria if anyone present had a different view of the score for an option then their individual score was also recorded as more optimistic or pessimistic.*

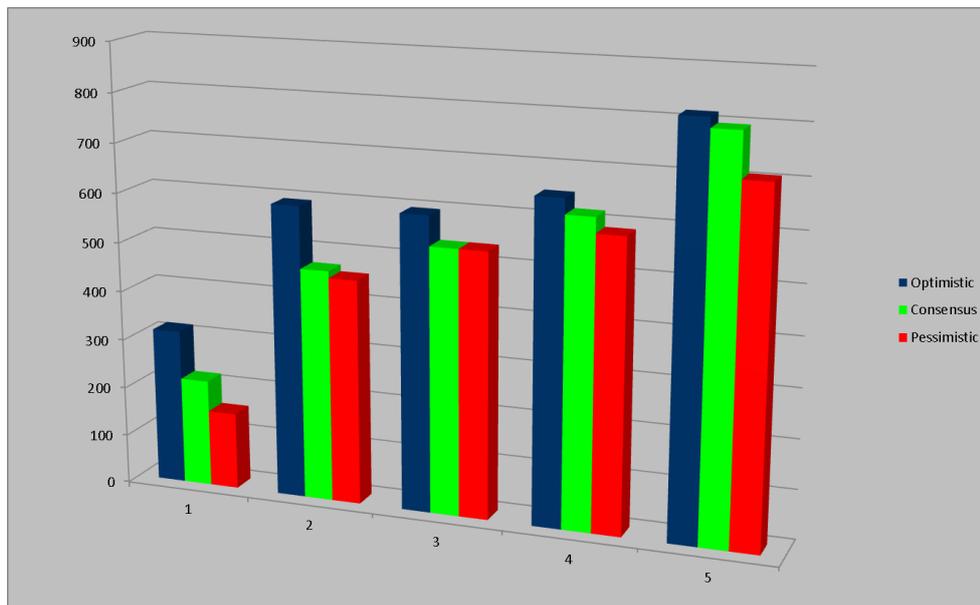
The group optimistic and group pessimistic scores represent the highest and lowest score given by any one of the attendees at the event. These results are also set out in table 2. (Neither the Architect nor the event facilitator gave a score for any of scoring exercises.)

**Results of Scoring the Options**

The Group scores for each of the options against each of the criteria are represented in the table and graph below.

Table 2

Group	Weighted Benefits Score		
	Optimistic	Consensus	Pessimistic
1	316	218	156
2	593	469	456
3	596	536	536
4	649	618	587
5	816	796	707



The table and chart demonstrate the results of the scoring and as identifying Option 5 “Two new build wards – On site of wards 22 and 25” as the preferred option, based on the non-financial benefits appraisal.

## Testing the Strength of the Results

It is important to examine how reactive the results of the weighted scoring exercise are to changes in the scores and the weights.

### Equal Weighting of the Benefit Criteria

The methodology for the Group scores (Group consensus and group optimistic and group pessimistic scores representing the highest and lowest score given by anyone of the attendees at the event) was set out above. To test the strength of the results these Group consensus, and the most optimistic and most pessimistic scores were applied to an equal ranking. The equal ranking is set out and the weighted scores using equal weighting was calculated and shown in Tables 3A, 3B and the chart below:

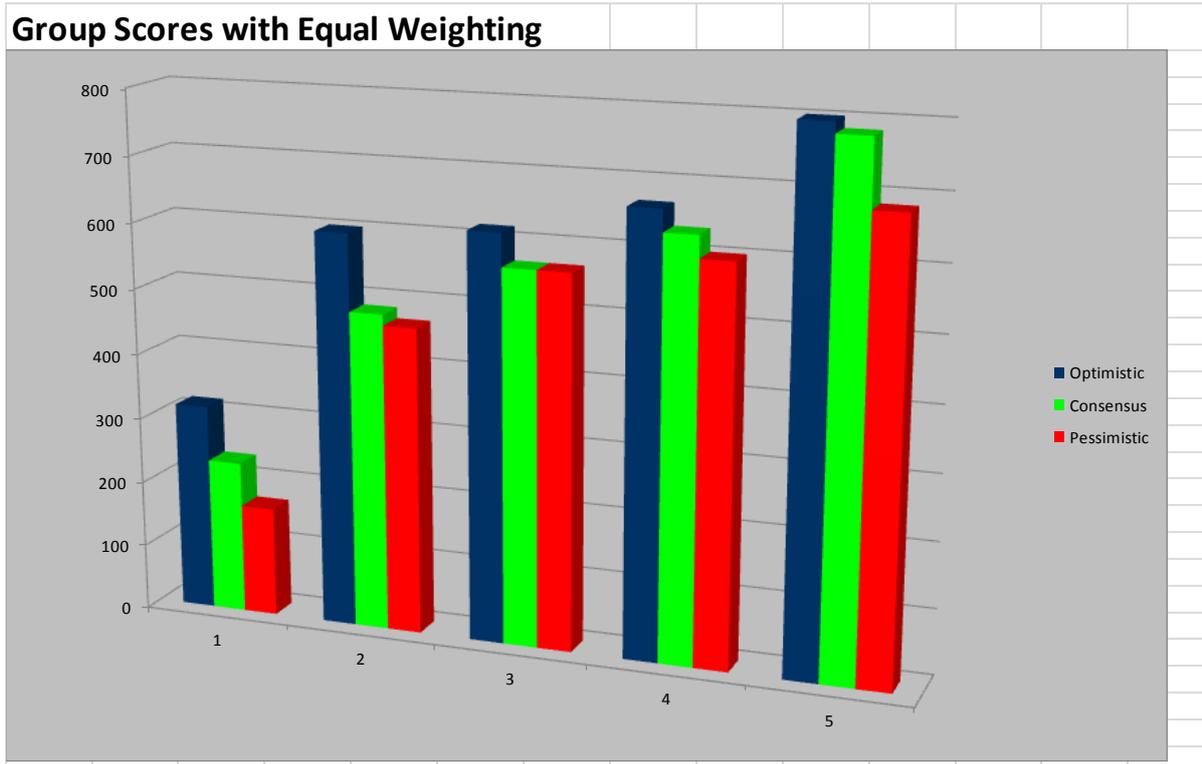
**Table 3A**

#### Equal Weighting

Importance Weighting		
Benefit Criteria	Weight	Normalised Weight
Patient Environment and safety	100	17
Service benefits of site location	100	17
Good access for patients	100	17
Staff retention, recruitment and wellbeing	100	17
Efficiency of estate	100	17
Community Benefits	100	17
	600	100

**Table 3B**

Group Scores with Equal Weighting			
	Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic
1	317	233	167
2	600	483	467
3	617	567	567
4	667	633	600
5	800	783	683



Having tested the results in this way demonstrates that changing the weighting in this way doesn't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.

### User & Carer Group and NHS Staff Scoring of the Options

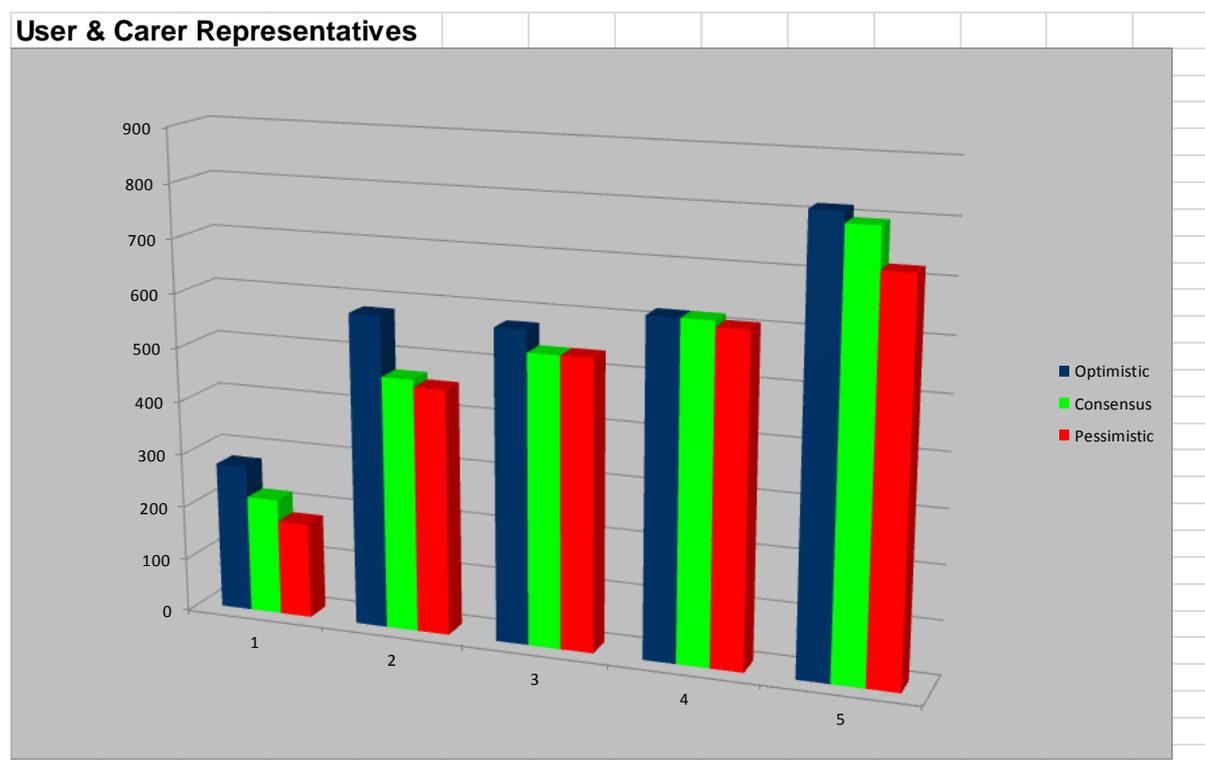
To further test the robustness of the option appraisal and to test for any bias the scores provided by Users and Carers and the NHS staff were separated and the result re-tested with the original weightings, the results of which can be seen in the Tables 4A, 4B and the graph below.

**Table 4A**

Original Importance Weighting			
Benefit Criteria	Weight	Normalised Weight	Rank
Patient Environment and safety	100	22	1
Service benefits of site location	80	18	3
Good access for patients	90	20	2
Staff retention, recruitment and wellbeing	70	16	4
Efficiency of estate	60	13	5
Community Benefits	50	11	6
	450	100	

**Table 4B User & Carer Group Scoring of the Options**

User & Carer Representatives			
	Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic
1	276	218	178
2	580	469	456
3	576	536	536
4	618	618	607
5	816	796	722



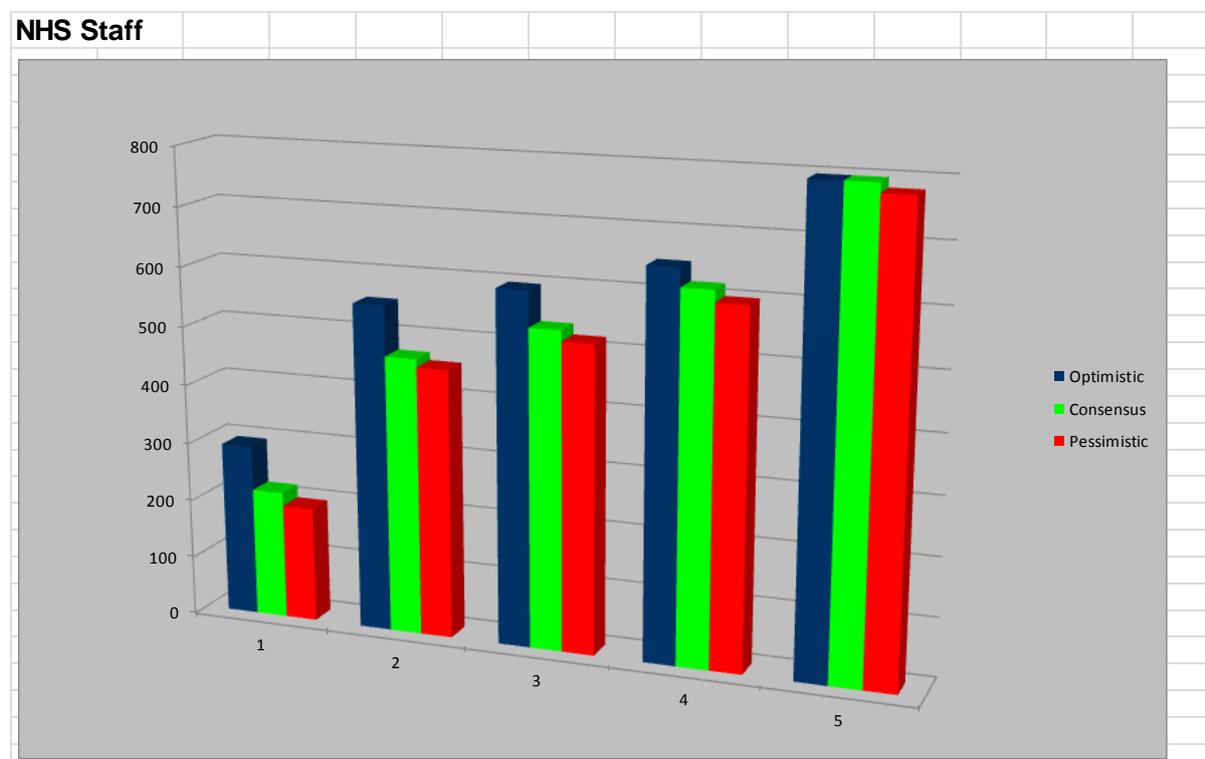
*Changing the scoring, using only the scoring from users and carers representatives, in this way tests for bias. The scores from Users and Carers alone don't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.*

## NHS Staff Scoring of the Options

The scores provided by the NHS staff were separated and the result re-tested with the original weightings, again to test for any bias in the overall scoring. The results of the NHS staff can be seen in Table 5 and graph below.

**Table 5**

NHS Staff			
	Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic
1	293	218	196
2	553	469	456
3	596	536	518
4	649	618	598
5	796	796	780



Changing the scoring, using only the scoring from NHS representatives, in this way doesn't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.

## ***User & Carer and NHS Staff Individual Scoring of the Options***

*The scores provided by the Users and carers and the NHS staff individually were separated and the result again re-tested with the original weightings, the results of which can be seen in the tables and graphs in Appendix 2.*

*Changing the scoring, using individual non-financial benefits appraisal scoring only from all the representatives in this way doesn't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.*

### ***Summary***

*The non-financial benefits appraisal scoring from the range of sensitivity analysis shows that Option 5 retained the preferred status when the changes were made in the scores (pessimistic and optimistic). The weights were changed to reflect different perspective as were the alternative User and Carer, NHS Staff and Individual scores. Therefore the identification of option 5 as the preferred option can be said to be robust and have been tested for bias.*

*David Harley  
Planning & Strategy*



MENTAL HEALTH ESTATE  
STOBHILL HOSPITAL  
OPTIONS APPRAISAL MAY 2017



#### DESIGN TEAM

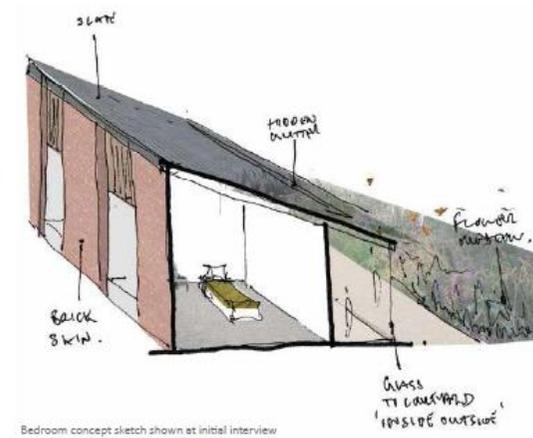
hub West Scotland - Project Managers  
NHS Greater Glasgow + Clyde - Participant  
Keppie Design Ltd - Architecture, Interior Design  
Armours - Cost Consultant

## CONTENTS

0.0	Introduction	6.1	Option 1
1.0	Site Location	6.2	Option 2
2.0	Context + Views	6.3	Option 3
3.0	Site Opportunities	6.4	Option 4
4.0	Accessibility	6.5	Option 5
5.0	Brief + Schedule of Accommodation		

### Appendices

Cost Report



Bedroom concept sketch shown at initial interview

## 0.0 INTRODUCTION

The service providing mainstream mental health in-patient services for the North of Glasgow has evolved over the years and been delivered from a range of sites. There has been a long standing commitment to fulfil the delivery of admission services on no more than two sites for the North of Glasgow; Gartnavel Royal and Stobhill, rather than multiple sites.

As part of their wider mental health services strategy, NHS Greater Glasgow and Clyde (NHS GG+C) are proposing to re-provide a 20-bed adult facility (AAU) that will replace existing facilities at Parkhead Hospital and a 20-bed elderly ward (CCC) that will replace an element of the bed capacity at Birdston Nursing Home, along with associated staff and clinical support facilities.

These new units are to be provided at Stobhill Hospital, Glasgow.

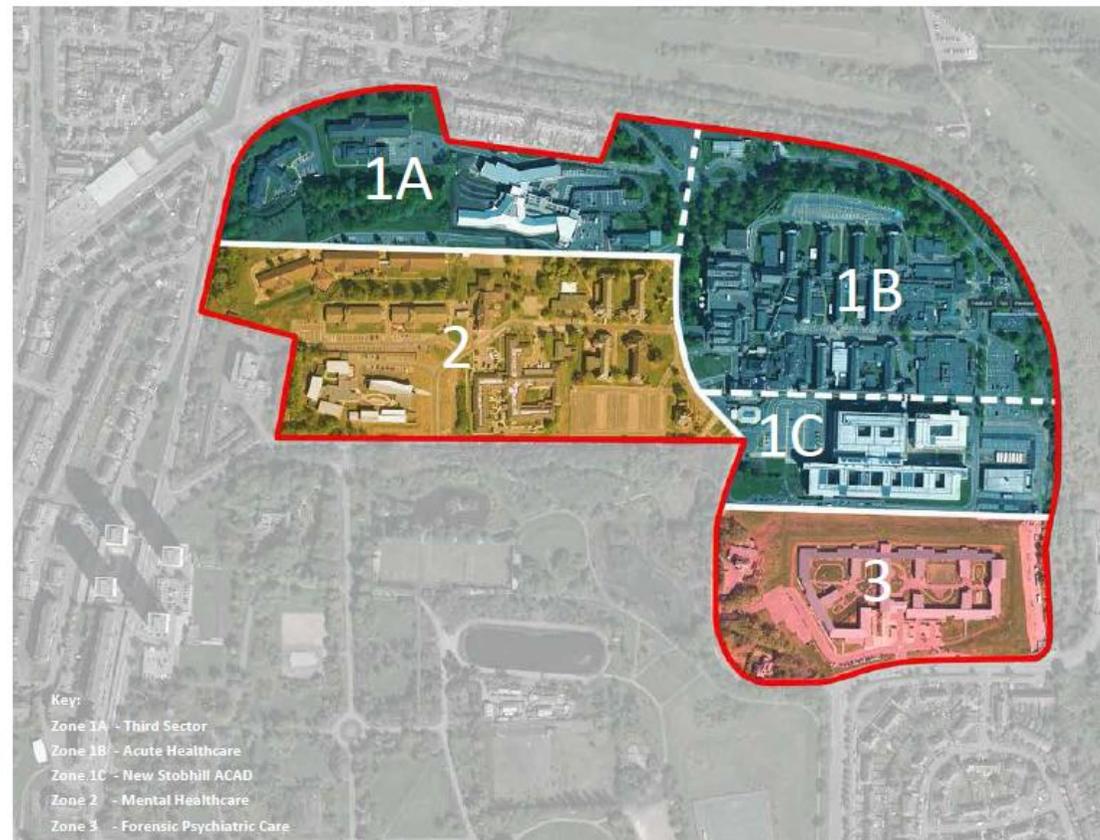
A feasibility study was carried out to determine any suitable and available areas of land on the Stobhill site alongside the current mental health wards for the re-provision of accommodation required. As one of the two wards; 20 beds, provide NHS Hospital Based Continuing Care to challenging behaviour Dementia patients – a demanding and high risk care group, the ward needs to be evidence based dementia appropriate, including ground floor access to safe and stimulating external gardens.

The existing Stobhill Hospital campus is effectively split into 3 zones.

- Acute Healthcare Zone
- Mental Health Zone
- Forensic Psychiatric Zone

In line with the current zoning of the hospital campus, these two new inpatient facilities are to be built within the Mental Health Zone adjacent to the existing mental health facilities. The proximity to existing facilities allows for staffing efficiencies and keeps response times to a minimum.

This document is a collation and explanation of the option appraisals exercise carried out to determine the most appropriate location for the new unit(s) within the Mental Health zone.



## 1.0 SITE LOCATION

For this exercise, we have investigated the appropriateness of 5 different site permutations. The options are based around either the retention of existing facilities or the future demolition of a number of existing buildings currently situated in these locations:

- Option 1 - Do nothing
- Option 2 - Refurb & Extension of Wards 22 and 25
- Option 3 - New Build (Single Building) on site of existing Wards 22 and 23
- Option 4 - New Build (Separate Buildings) on site of existing Wards 22 and 23
- Option 5 - New Build (Separate Buildings) on site of existing Wards 22 and 25

All site permutations are centrally located in the Stobhill Hospital grounds and adjacent to other Mental Health units, most notably Mackinnon House to the left.

Currently, the site is occupied by existing buildings, most of which formed part of the original hospital masterplan. These have been deemed unfit for purpose by the NHS.

Adjacent is a landmark B listed water + clock tower of significant local importance.

The site is enclosed by a busy car park to the south, the main access road between Balgrayhill Road and the New Stobhill Hospital to the east and a secondary route to the north.



Site Plan showing buildings as existing NTS.  
Potential buildings for future demolition/ refurbishment in red.

## 2.0 CONTEXT + VIEWS



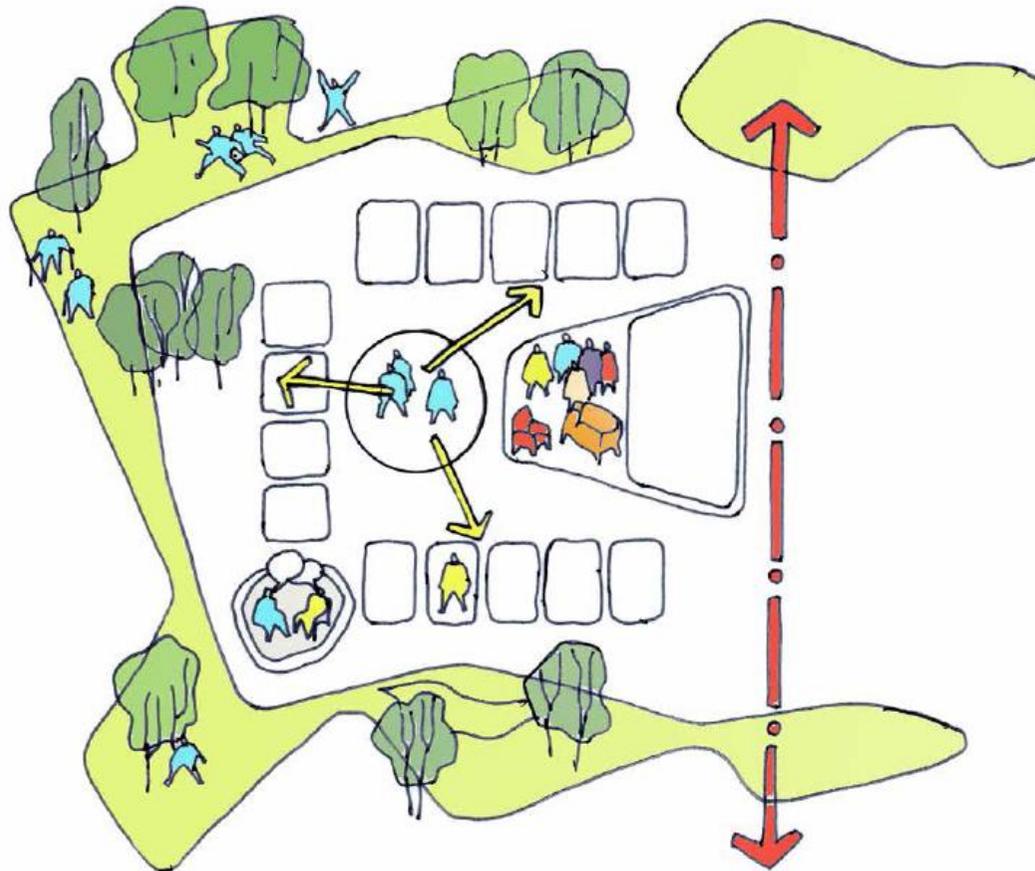
Site views as existing

### 3.0 SITE OPPORTUNITIES

The prominent site affords good opportunity for the design of the new units to become a positive, welcoming and therapeutic addition to the campus, instead of being hidden like so many mental health facilities.

The design should exploit the surrounding context to focus on connection with outside space. The overriding design driver is to facilitate key stakeholder requirements such as a feeling of openness and light throughout the facility, views of green space and easy, safe access to therapeutic external spaces.

The necessary observation required for the function of both units is enhanced by planning scheduled accommodation around courtyards which become pivotal to the design in terms of light ingress, access to secure and protected amenity space and utilising nature to evoke a calming environment.



Early concept sketch

## 4.0 ACCESSIBILITY

The site is well served by public buses to the surrounding area and the city centre of Glasgow. Plentiful parking and taxi provisions are in place. The design of the new units should fully integrate with the existing NHS travel plan for the hospital site.



## 5.0 BRIEF + SCHEDULE OF ACCOMMODATION

The briefed Schedule of Accommodation referred to within the NPR identifies a baseline GIFA figure of 2572m<sup>2</sup> which has been used for the purposes of this exercise.

Total GIFA for AAU + CCC: 2,572.3 m<sup>2</sup>

### ELDERLY HOSPITAL BASED COMPLEX CLINICAL CARE (CCC)

Briefed Schedule of Accommodation	hub Stage 0 As Drawn Total m2
<b>ENTRANCE HUB</b>	
Draught Lobby	6.0
Entrance Vestibule	9.3
WC (Disabled)	4.5
<b>Sub-total</b>	<b>19.8</b>

<b>PATIENT DAY AREAS</b>	
Servery	16.0
Dining Room	42.5
Sitting Room(s)	48.0
Quiet room	20.0
Activity Room	22.0
Store	4.5
2 no. WC (Disabled)	9.0
<b>Sub-total</b>	<b>162.0</b>

<b>PATIENT BEDROOM AREAS</b>	
20 no. Single Bedrooms	310.0
20 no. En-suites (Dual Access)	90.0
2 no. Touch Down Bases	4.0
Assisted Bathroom with WC + WHB	16.0
<b>Sub-total</b>	<b>420.0</b>

<b>LOCAL CLINICAL SUPPORT AREAS</b>	
Office: 1 staff	10.5
Office: 3 Place (hot desk)	15.6
Duty Room	14.0
Interview Room	10.0
Clean Utility / Treatment Room	16.5
Disposal / Sluice / Test Room	12.0
3 no. General + Equipment Store	30.0
Linen Store	6.0
DSR	10.0
Service Entrance Lobby	6.0
Disposal Hold	10.0
2 no. Switch Cupboards	4.5
<b>Sub-total</b>	<b>145.1</b>

<b>STAFF AREAS</b>	
Staff Room + Kitchenette	18.0
2 no. Changing Cubicle	12.6
2 no. Shower (Ambulant)	5.2
2 no. Staff WC	4.0
Foot Locker Area	0.0
<b>Sub-total</b>	<b>39.8</b>

<b>SUB TOTAL</b>	<b>786.7</b>
Internal Walls + Planning	80.8
Circulation	319.6
Circulation % of SUB TOTAL	40.6

<b>TOTAL</b>	<b>1187.1</b>
m2 over 1143	44.1
% over 1143	3.9
<b>TOTAL plus Central Plant</b>	<b>1282.1</b>
<b>GRAND TOTAL CCC + AAU</b>	<b>2572.3</b>

### ACUTE ADMISSIONS UNIT (AAU)

Briefed Schedule of Accommodation	hub Stage 0 As Drawn Total m2
<b>ENTRANCE HUB</b>	
Draught Lobby	6.0
Entrance Vestibule	14.9
WC (Disabled)	4.5
<b>Sub-total</b>	<b>25.4</b>

<b>PATIENT DAY AREAS</b>	
Servery	16.0
Dining Room	36.0
Sitting Room(s)	37.5
Quiet room	18.0
Female Only Day Room	10.0
Activity Room	22.0
Store	4.2
Patients' Pantry	10.0
Patients' Utility	10.0
<b>Sub-total</b>	<b>163.7</b>

<b>PATIENT BEDROOM AREAS</b>	
20 no. Single Bedrooms	310.0
20 no. En-suites (Dual Access)	90.0
Assisted Bathroom/Shower	0.0
2 no. Touch Down Bases	4.0
<b>Sub-total</b>	<b>404.0</b>

<b>LOCAL CLINICAL SUPPORT AREAS</b>	
3 no. Interview Rooms	30.0
Office: 1 staff	10.5
Office: 3 Place (hot desk)	13.5
Duty Room	14.0
MDT Room	18.0
Nurses' Station / Staff "Hub"	6.3
Clean Utility / Treatment Room	16.5
Disposal / Sluice / Test Room	12.0
General + Equipment Store	16.0
Patient's Personal Belongings / Clothing Store	8.0
Linen Store	6.0
DSR	10.0
Service Entrance Lobby	3.3
Disposal Hold	10.0
2 no. Switch Cupboards	4.0
<b>Sub-total</b>	<b>178.1</b>

<b>STAFF AREAS</b>	
Staff Room + Kitchenette	18.0
2 no. Changing Cubicle	12.6
2 no. Shower (Ambulant)	5.2
2 no. Staff WC	4.0
2 no. Foot Locker Area	0.0
<b>Sub-total</b>	<b>39.8</b>

<b>SUB TOTAL</b>	<b>811.0</b>
Internal Walls + Planning	85.3
Circulation	298.3

<b>TOTAL</b>	<b>1194.6</b>
<b>TOTAL plus Central Plant</b>	<b>1290.2</b>
<b>GRAND TOTAL AAU + CCC</b>	<b>2572.3</b>

# 5.0 AAU BRIEF + SCHEDULE OF ACCOMMODATION

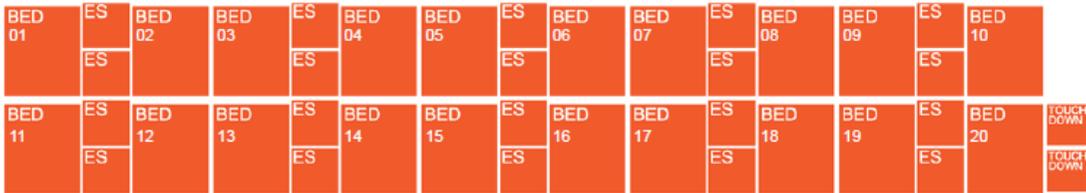
The brief for the AAU has been directed by the Healthcare Planner and been further developed through Stakeholder engagement.

As the scheme has evolved the schedule of accommodation has developed to include larger bedroom and en-suite facilities to ensure future flexibility of the unit.

The graphical brief highlights the five primary functions of these spaces; entrance hub, day areas, local clinical support, staff areas and bedroom areas.

Total GIFA for AAU: 1,290.2 m<sup>2</sup>

### PATIENT BEDROOM AREAS



### LOCAL CLINICAL SUPPORT AREAS



### PATIENT DAY AREAS



### ENTRANCE HUB



### STAFF AREAS



- Key
- EN en-suite
- DSR domestic service room
- SH shower
- 10

Graphic schedule of accommodation

## 5.0 CCC BRIEF + SCHEDULE OF ACCOMMODATION

The brief for the CCC has been directed by the Healthcare Planner and been further developed through Stakeholder engagement.

The graphical brief highlights the five primary functions of these spaces; entrance hub, day areas, local clinical support, staff areas and bedroom areas.

Total GIFA for CCC: 1,282.1 m<sup>2</sup>

### PATIENT BEDROOM AREAS



### LOCAL CLINICAL SUPPORT AREAS



### PATIENT DAY AREAS



### ENTRANCE HUB



### STAFF AREAS



- Key**
- EN en-suite
  - DSR domestic service room
  - SH shower

Graphic schedule of accommodation

## 6.0 DEVELOPMENT OPTIONS

On the following pages we have illustrated five different site permutations. The options are based around either the retention of existing facilities or the future demolition of a number existing buildings currently situated in these locations:

- Option 1 - Do nothing
- Option 2 - Refurb & Extension of Wards 22 and 25
- Option 3 - New Build (Single Building) on site of existing Wards 22 and 23
- Option 4 - New Build (Separate Buildings) on site of existing Wards 22 and 23
- Option 5 - New Build (Separate Buildings) on site of existing Wards 22 and 25

## 6.1 OPTION 1 - DO NOTHING

In this option, elderly services would remain at Birdston Nursing Home, and adult mental health services would move from Parkhead into a refurbished ward on the Stobhill campus. None of the buildings on the aforementioned development site would be demolished or refurbished, and all would remain as they currently stand.

Discussions have concluded the following:

### Pros

No immediate cost associated with the fit-out or demolishing of the buildings on site.

### Cons - Service

Birdston Nursing Home has been deemed no longer fit for purpose.

Refurbishing a 2 storey ward will require a higher staffing ratio and each storey will feel like a separate unit.

Double banked corridors promote institutional feeling and provides little natural daylight and observation. [1.1](#), [1.5](#), [2.3](#)

Limited flexibility due to existing layout and room proportions. [1.6](#), [2.2](#), [2.7](#)

Abundance of excess accommodation due to inappropriateness of existing spaces.

### Cons - Development Site

Buildings on development site are not fit for purpose, with some standing vacant.

Assets are of no benefit to NHS GG+C or service users.

Does not meet any of the aims and objectives of NHS GG+C wider mental health service strategy.

External fabric repairs and fit-out costs will be higher the longer the buildings are left to deteriorate.

**This option does not meet any of the non-negotiable performance objectives outlined in the SCIM Design Statement.**



Birdston Nursing Home

## 6.2 OPTION 2 - REFURB & EXTENSION OF WARDS 22 AND 25

Option 2 is designed to test the feasibility of carrying out extensive refurbishment and extension of the 2 existing buildings on this site, Ward 22 and Ward 25. Both these 2 storey buildings were constructed circa 1904 as part of the original campus, albeit with subsequent modifications over the following century. Both buildings are very similar in existing layout, however Ward 25 has a significant 2 storey brick extension to the West. The buildings (site) are centrally located in the Stobhill Hospital grounds within the mental health zone and adjacent to other Mental Health units, most notably Mackinnon House to the West.

Currently, both Wards 22A/B (Alba House) and Wards 25A/25B are vacant.

With Option 2 being the refurbishment of 2no existing buildings, the site topography is of lesser significance due to the land already being formed at the appropriate levels.

Small changes to the perimeter external levels would be required to ensure level access at all access / egress points.

Additionally, small changes to site topography to garden areas of each building may be required especially to the East of Ward 22 where the sloping site is at its most steep.



Long section looking North NTS.

Discussions have concluded the following:

Orange text refers to SCIM Design Statement references.

**Pros**

Limited groundwork alterations required.

**Cons**

2 storey buildings require higher staffing ratio and each storey will feel like a separate unit.

Double banked corridors promote institutional feeling and provides little natural daylight and observation. 1.1, 1.5, 2.3

Limited flexibility due to existing layout and room proportions. 1.6, 2.2, 2.7

Abundance of excess accommodation due to inappropriateness of existing spaces.

Available external space predominantly favours Ward 22. 1.5



KEY					
<span style="color: red;">■</span>	PATIENT BEDROOM AREAS	<span style="color: lightblue;">■</span>	LOCAL CLINICAL SUPPORT AREAS	<span style="color: yellow;">■</span>	ENTRANCE
<span style="color: orange;">■</span>	PATIENT DAY AREAS	<span style="color: blue;">■</span>	STAFF AREAS	<span style="color: lightgreen;">■</span>	PATIENT GARDENS

Option 2 diagram NTS.

### 6.3 OPTION 3 - NEW BUILD (SINGLE BUILDING) ON SITE OF EXISTING WARDS 22 AND 23

Option 3 is designed to test the feasibility of construction of a single, new build unit, built on land vacated by the demolition of 2no existing buildings, Ward 22 and Ward 23.

The site is centrally located in the Stobhill Hospital grounds and adjacent to other Mental Health units, most notably Mackinnon House to the West. Currently, the site is occupied by Wards 22A/B and Wards 23A/B. Both these 2 storey buildings were constructed circa 1904 as part of the original campus, albeit with subsequent modifications over the following century. Both buildings are very similar in existing layout however Ward 23 has a significant plant room built immediately adjacent to the West.

Currently, Wards 22A/B (Alba House) are vacant, and Wards 23A/23B house two Regional Services.

On the ground floor, Pharmacy Regional Quality Assurance Service – Pharmacy equipment, laboratory service, aseptic unit, pharmacy administration. This service occupies the whole of the ground floor in Ward 23 and is heavily used and occupied.

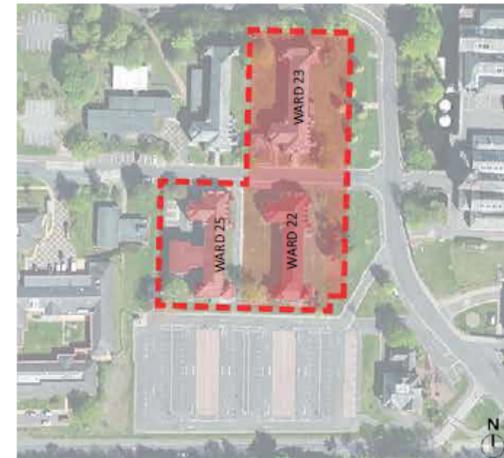
On the upper floor, Weight Management Services – Weight management offices, psychology offices, group therapy room. This service has recently centralised at WGACH on the Yorkhill Site and occupies half of the upper level of Ward 23. With only one room in use it appeared very under occupied.

Large open plan area with supporting offices - Open area which could accommodate 20 to 25 staff with 3 support offices on the periphery which would house 5 to 6 people. This area is currently empty.

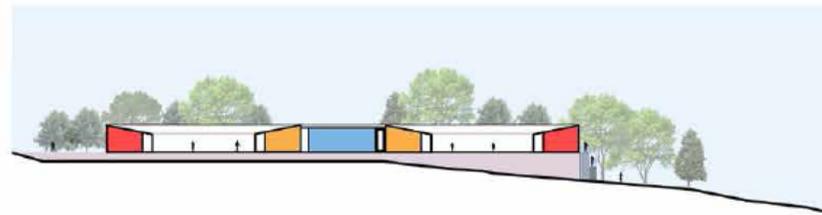
This ward is in a poor state of repair with old rotting windows, severe dampness on the walls and evidence of a leaking roof.

With Option 3 being the provision of a single new build spanning across a site currently occupied by 2 separate existing buildings (both at different formation levels), significant changes to topography would be required. This is due to a variety of reasons:

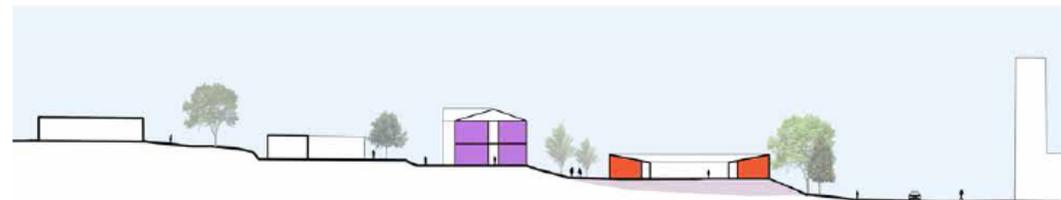
- The clinical requirement to provide single storey, level access building;
- Varying formation levels of the existing buildings;
- The existing site slopes both West to East and South to North, particularly to the Northern and Eastern edges;
- The removal of the existing access road running between both sites.



Location diagram



Cross section looking West NTS.



Long section looking North NTS.

Discussions have concluded the following:

Orange text refers to SCIM Design Statement references.

**Pros**

Opportunity to seek efficiency of accommodation through shared services etc.

Single building promotes staffing efficiency and response times. 2.2, 2.6

Entrance to West and terminating spine road creates 'campus' feel. 1.1

Single banked corridors provide potential for natural daylight and good observation to both units. 1.5, 1.6

Limited groundwork alterations required.

Can be designed to briefed GIFA. 2.7

Provision of secure courtyard external spaces as well as perimeter gardens. 1.5

**Cons**

Topography dictates buildings will be significantly elevated to North and East. This will not allow level access to the garden and stairs / lift will be required. 1.5

Removal of existing sub-station required.

Road realignment required. Likely diversions to main service route running underneath spine road, which also houses an asbestos lined service duct.

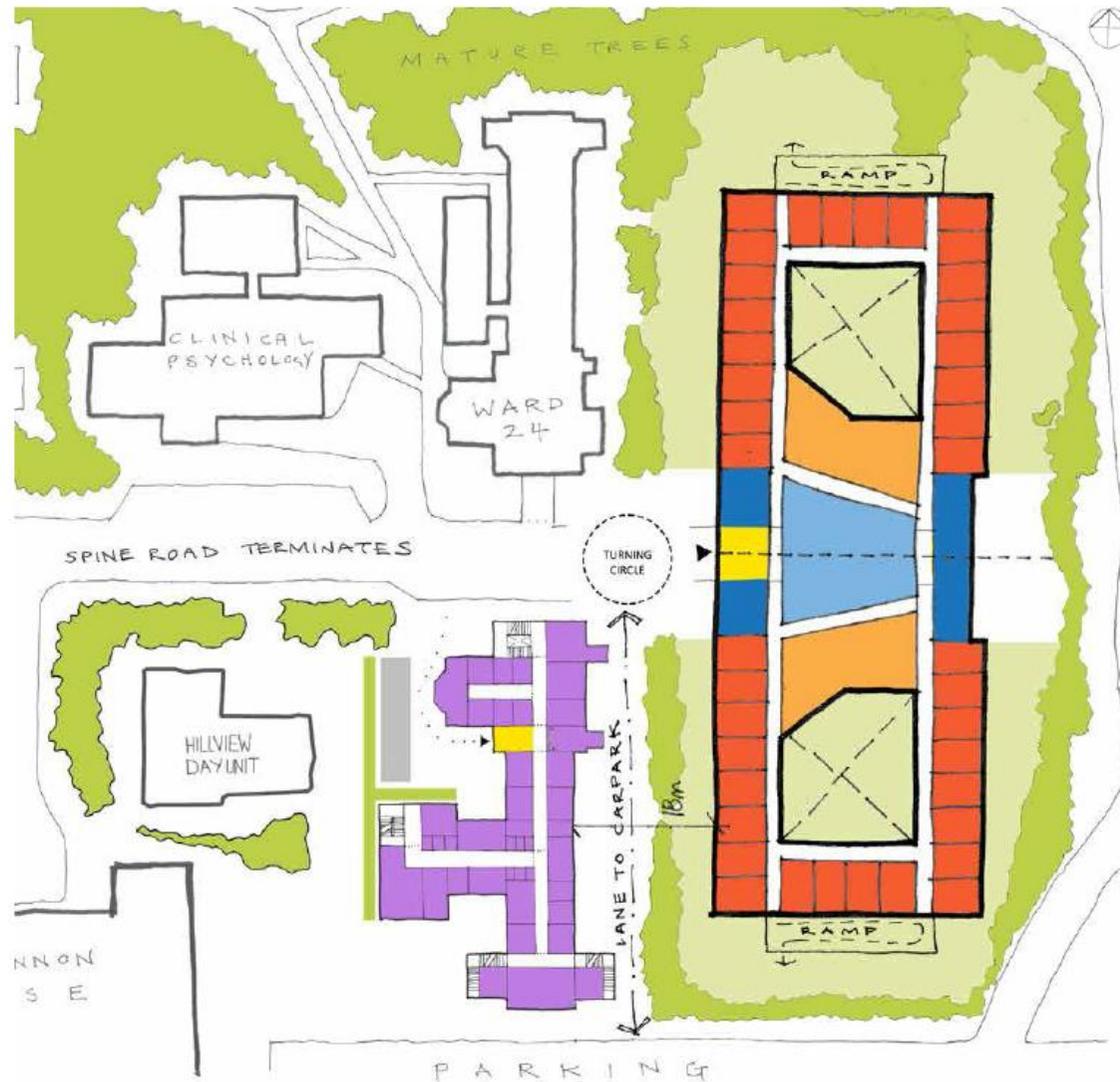
Turning circle or similar required for vehicle access. Potentially costly, and minimal space available. Potential clash of visitor, service and emergency traffic utilising the same access point. 1.2, 3.5

Disconnection from Mackinnon House and other mental health wards. 2.6

Possible lack of privacy due to external garden space being located adjacent to main hospital traffic route. 1.5

Compromised views from West facing bedrooms due to topography sloping East. 1.8

Fit-out of Ward 25 required to accommodate Pharmacy previously housed in Ward 23. If only 1 storey of accommodation is required (as currently) another use and subsequent costs will need to be defined for the rest of the building.



Option 3 diagram NTS.

## 6.4 OPTION 4 - NEW BUILD (SEPARATE BUILDINGS) ON SITE OF WARDS 22 AND 23

Option 4 is identical to Option 3, with the exception that it is designed to test the feasibility of construction of two separate new build units, built on land vacated by the demolition of 2no existing buildings, Ward 22 and Ward 23.

With Option 4 being identical to Option 3, with the exception that it is for two separate new build units, the challenges are slightly less. The main design influences would be:

The levels of both buildings can react independently to respective site constraints.

Levels will primarily be dictated by the levels of the existing access road running through the site.

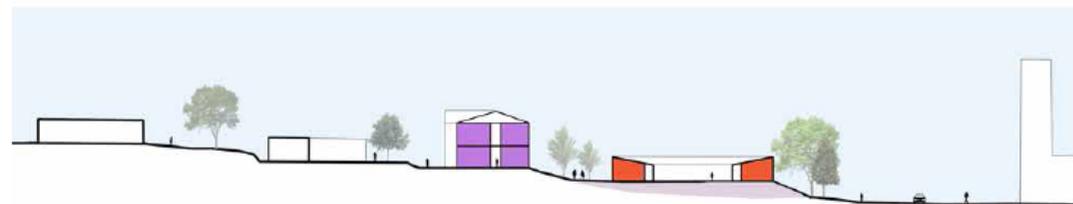
The significant slopes on both sites, particularly to the Northern and Eastern edges which will affect both buildings independently;



Location diagram



Cross section looking West NTS.



Long section looking North NTS.

Discussions have concluded the following:

Orange text refers to SCIM Design Statement references.

**Pros**

Each unit has own access and identity. 1.1, 1.2, 1.3

Individual buildings allow for sloping topography to be considered.

Single banked corridors provide potential for natural daylight and good observation to both units. 1.5, 1.6

Each unit can be designed to briefed GIFA. 2.7

Provision of secure courtyard external spaces as well as perimeter gardens. 1.5

**Cons**

Topography dictates buildings will be significantly elevated to North and East. This will not allow level access to the garden and stairs / lift will be required. 1.5

Both units are located next to main thoroughfare to the ACAD.

Removal of existing sub-station required.

Possible lack of privacy due to external garden space being located adjacent to main hospital traffic route. 1.5

Fit-out of Ward 25 required to accommodate Pharmacy previously housed in Ward 23. If only 1 storey of accommodation is required (as currently) another use and subsequent costs will need to be defined for the rest of the building.



Option 4 diagram NTS.

## 6.5 OPTION 5 - NEW BUILD (SEPARATE BUILDINGS) ON SITE OF EXISTING WARDS 22 AND 25

The site is centrally located in the Stobhill Hospital grounds and adjacent to other Mental Health units, most notably Mackinnon House immediately adjacent to the West.

Currently, the site is occupied by Wards 22A/B, Wards 25A/B and Hillview Day Centre. Both Wards 22 & 25 are 2 storey buildings constructed circa 1904 as part of the original campus, albeit with subsequent modifications over the following century. Both buildings are very similar in existing layout however Ward 25 has a significant 2 storey brick extension to the West. The site also contains a smaller single storey brick building that formerly housed the Hillview Day Centre.

Currently, Wards 22A/B (Alba House) and Wards 25A/25B are vacant.

With Option 5 being the provision of two separate new build units on a site currently occupied by 3 separate existing buildings, significant changes to topography may be required. This may be limited however due to the fact that the site slopes generally in only one direction, West to East and therefore we can potentially mitigate this change in level with the separation of both buildings.

Particular challenges may exist at the existing retaining wall beside Mackinnon House and around the perimeter of the site. The design of the new units must also ensure the users of Mackinnon House cannot overlook the public spaces or bedrooms. Service user privacy and dignity must be maintained through the design of an appropriate boundary treatment to the perimeter of the site.



Location diagram



Long section looking North NTS.

Discussions have concluded the following:

Orange text refers to SCIM Design Statement references.

**Pros**

Each unit has own access and identity. 1.1, 1.2, 1.3

The units have excellent proximity to Mackinnon House. 2.2, 2.6

Individual buildings allow for sloping topography to be considered.

Single banked corridors provide potential for natural daylight and good observation to both units. 1.5, 1.6

Each unit can be designed to briefed GIFA. 2.7

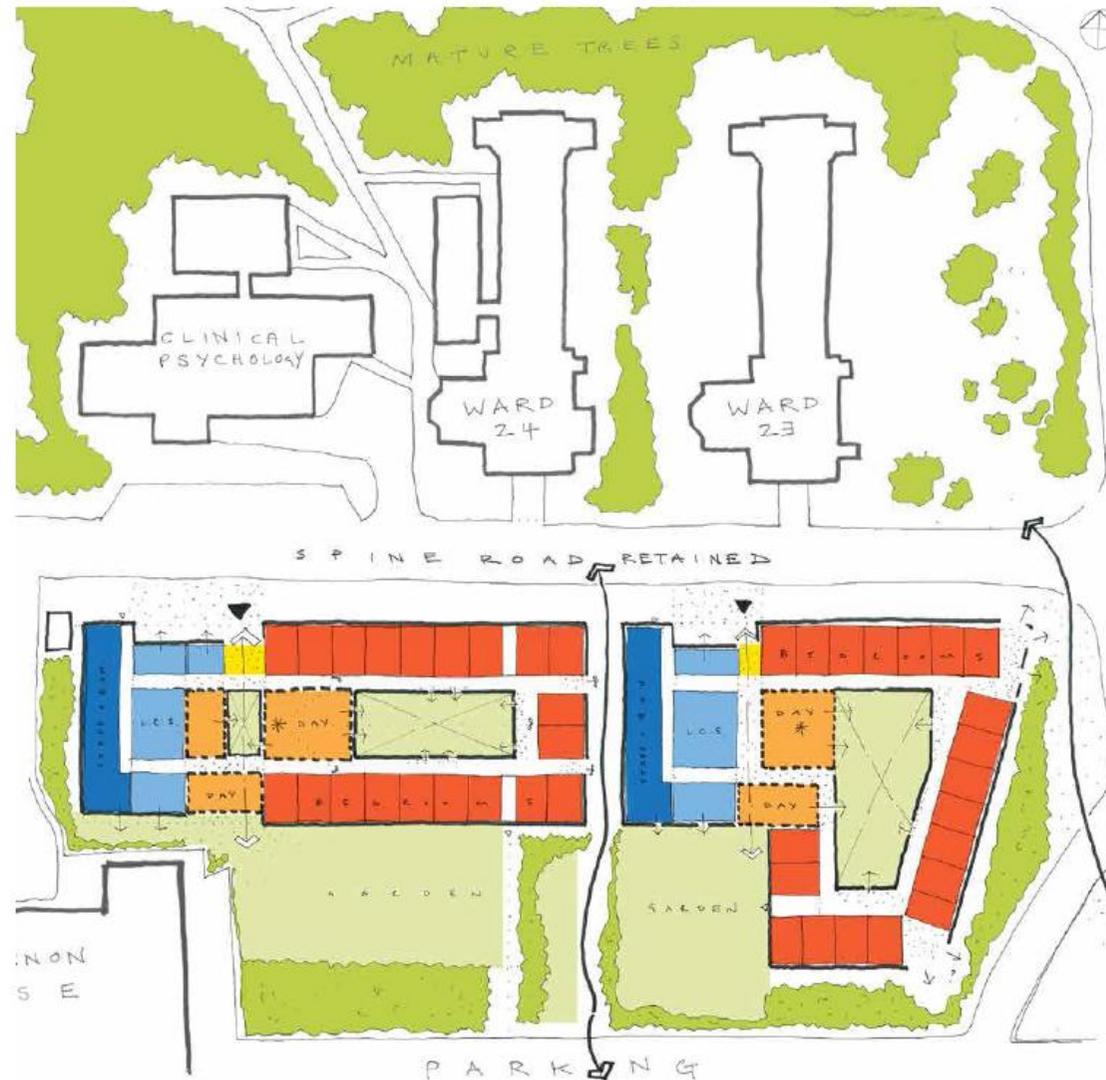
Provision of secure courtyard external spaces as well as large and level South facing gardens. Perimeter planting helps to provide privacy and pleasant views. 1.5, 1.8

**Cons**

Topography dictates buildings will be significantly elevated to North and East.

Removal of existing sub-station required.

One unit is located adjacent to the main hospital traffic route.



Option 5 diagram NTS.

## Appendix 3

### Individual Scoring Option Appraisal Exercise

Stephen McGuire	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
<b>Scoring of Options</b>															
<i>Benefit Criteria</i>	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic
Patient Environment and safety	1	1	1	1	2	1	4	4	4	5	5	5	9	9	9
Service benefits of site location	1	3	1	7	7	7	4	5	4	6	6	6	7	7	7
Good access for patients	3	3	3	5	5	5	4	4	4	6	6	6	8	8	7
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	6	6	8	8	8
Efficiency of estate	2	2	2	4	4	4	9	9	9	9	9	9	9	9	5
Community Benefits	4	4	4	4	5	4	6	6	6	6	6	5	6	6	6
Andrew Baillie	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
<b>Scoring of Options</b>															
<i>Benefit Criteria</i>	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic
Patient Environment and safety	1	1	1	1	2	1	4	5	4	5	5	5	9	9	9
Service benefits of site location	1	3	1	7	8	7	4	5	4	6	6	6	7	7	7
Good access for patients	3	3	3	5	6	5	4	5	4	6	6	5	8	8	8
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	8	6	8	8	7
Efficiency of estate	2	2	2	4	5	4	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	2	4	5	4	6	6	6	6	6	6	6	6	6
George Brown	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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<i>Benefit Criteria</i>	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic
Patient Environment and safety	1	1	1	1	1	1	4	4	4	5	5	5	9	9	9
Service benefits of site location	1	1	1	7	7	7	4	4	4	6	6	6	7	7	7
Good access for patients	3	3	3	5	5	5	4	4	3	6	6	6	8	8	8
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	6	6	8	8	8
Efficiency of estate	2	2	2	4	4	4	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	4	4	5	4	6	6	6	6	6	6	6	6	6
Mary O'Donnell	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Patient Environment and safety	1	1	1	1	1	1	4	4	4	5	5	5	9	9	9
Service benefits of site location	1	1	1	7	7	7	4	4	4	6	6	6	7	7	7
Good access for patients	3	5	3	5	5	5	4	4	4	6	6	6	8	8	8
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	6	6	8	8	8
Efficiency of estate	2	2	2	4	4	4	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	2	4	4	4	6	6	6	6	6	6	6	6	6

Mary Hanratty	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Patient Environment and safety	1	2	1	1	2	2	4	4	4	5	5	5	9	9	9
Service benefits of site location	1	2	1	7	8	8	4	4	4	6	6	6	7	7	7
Good access for patients	3	3	1	5	5	5	4	4	4	6	6	6	8	8	8
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	6	6	8	8	8
Efficiency of estate	2	2	2	4	4	3	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6
Ronnie Sharp	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Patient Environment and safety	1	1	1	1	1	1	4	4	4	5	5	5	9	9	9
Service benefits of site location	1	1	1	7	7	7	4	4	4	6	6	6	7	7	7
Good access for patients	3	3	3	5	5	5	4	4	4	6	6	6	8	8	8
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Efficiency of estate	2	2	2	4	4	4	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6
Elisabeth Lucas	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6
Elisabeth Cruickshanks	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6

<b>Billy Kilpatrick</b>	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6
<b>Liz Borland</b>	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6
<b>Jeanette Whitelaw</b>	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
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Patient Environment and safety	1	1	1	1	1	1	4	4	4	5	5	5	9	9	9
Service benefits of site location	1	1	1	7	7	7	4	4	4	6	6	6	7	7	7
Good access for patients	3	3	3	5	5	5	4	4	4	6	6	6	8	8	8
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	6	6	8	8	8
Efficiency of estate	2	2	2	4	4	4	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6
<b>Sharon Moore</b>	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
<b>Scoring of Options</b>															
<b>Benefit Criteria</b>	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic
Patient Environment and safety	1	1	1	1	1	1	4	5	4	5	5	5	9	9	9
Service benefits of site location	1	1	1	7	7	7	4	4	4	6	6	6	7	7	7
Good access for patients	3	3	3	5	8	5	4	4	4	6	6	6	8	9	8
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	6	6	8	8	8
Efficiency of estate	2	2	2	4	4	4	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6
<b>Lesley Donnelly</b>	Option 1 Do Nothing			Option 2 Refurb & Extend Wards 22 - 25			Option 3 Single Building On-site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 4 Two New Build Wards on site of Wards 22 & 23 (& relocate Pharmacy Dept)			Option 5 Two New Build Wards on site of Wards 22 & 25		
<b>Scoring of Options</b>															
<b>Benefit Criteria</b>	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic
Patient Environment and safety	1	1	1	1	1	1	4	4	4	5	5	5	9	9	9
Service benefits of site location	1	1	1	7	7	7	4	4	3	6	6	6	7	7	7
Good access for patients	3	3	3	5	5	5	4	4	4	6	6	6	8	8	8
Staff retention, recruitment and wellbeing	3	3	3	8	8	8	7	7	7	6	6	6	8	8	8
Efficiency of estate	2	2	2	4	4	3	9	9	9	9	9	9	9	9	9
Community Benefits	4	4	4	4	4	4	6	6	6	6	6	6	6	6	6



Mary O'Donnell		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	258	218	196	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

Mary Hanratty		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	258	218	178	
2	509	469	496	
3	536	536	536	
4	618	618	618	
5	796	796	796	

Ronnie Sharp		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

Elisabeth Lucas		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

Elisabeth Cruickshanks		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

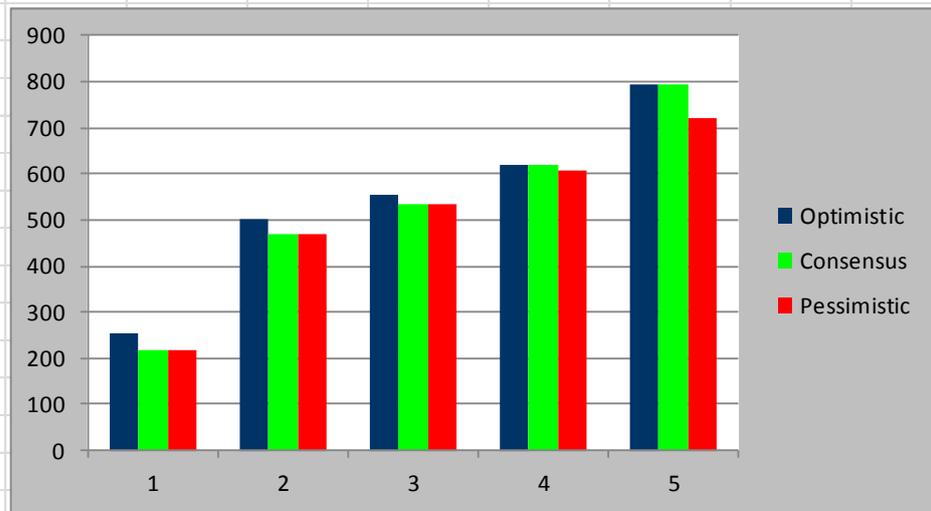
Billy Kilpatrick		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	178	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

Liz Borland		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	469	469	469	
3	553	536	536	
4	618	618	618	
5	796	796	796	

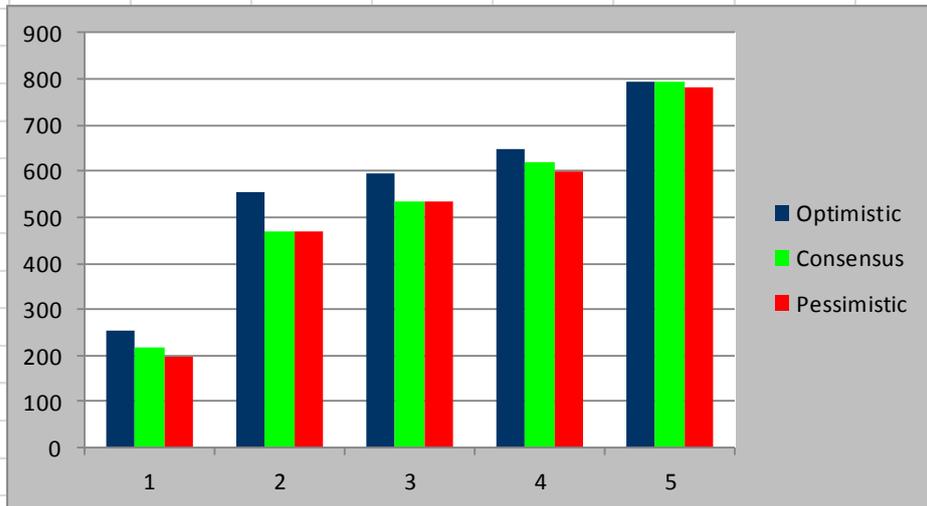
Jeanette Whitelaw		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

Sharon Moore		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	529	469	469	
3	558	536	536	
4	618	618	618	
5	816	796	796	

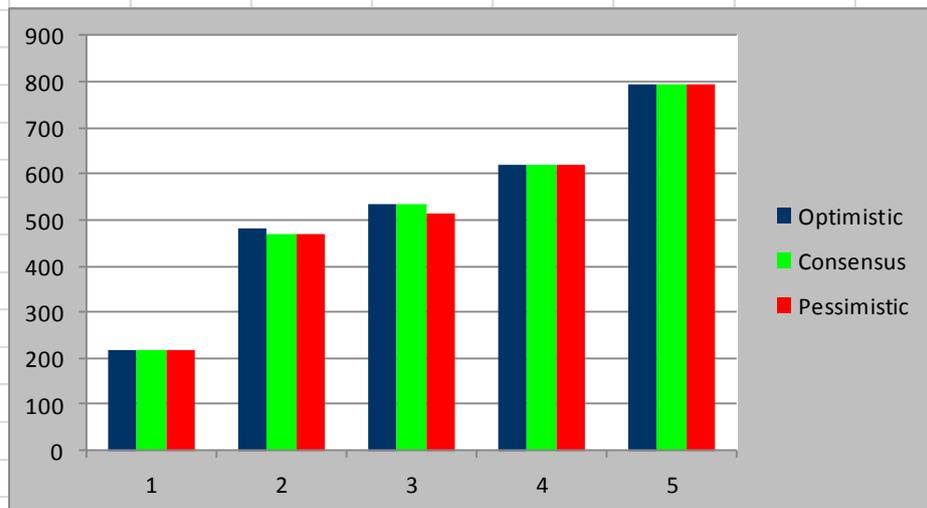
Stephen McGuire



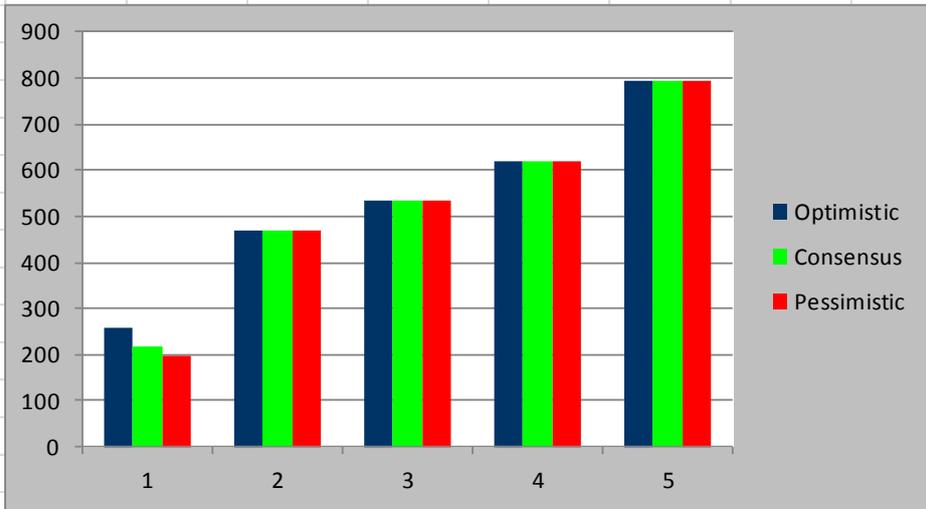
Andrew Baillie



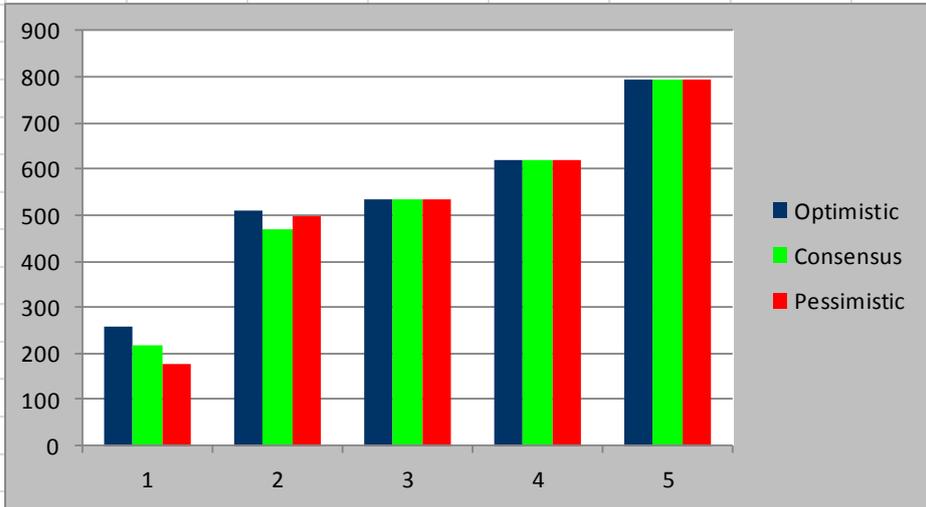
George Brown



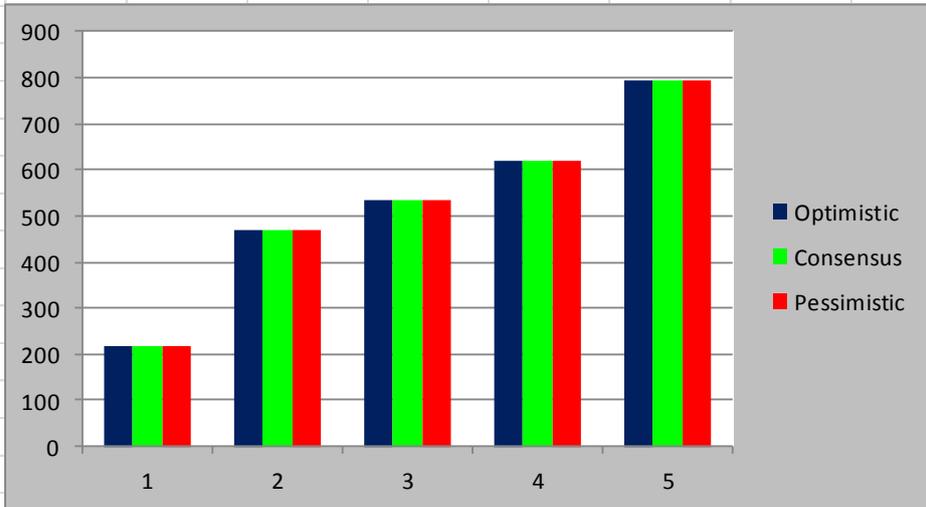
Mary O'Donnell



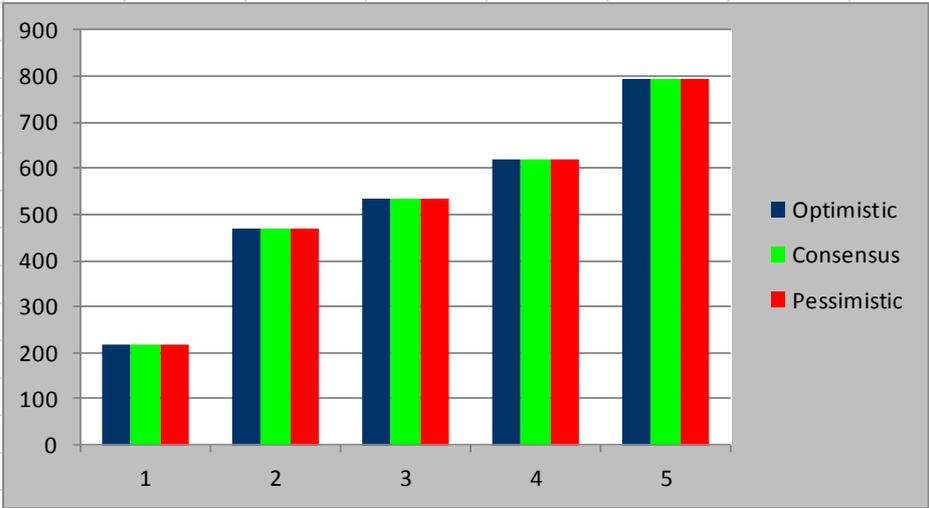
Mary Hanratty



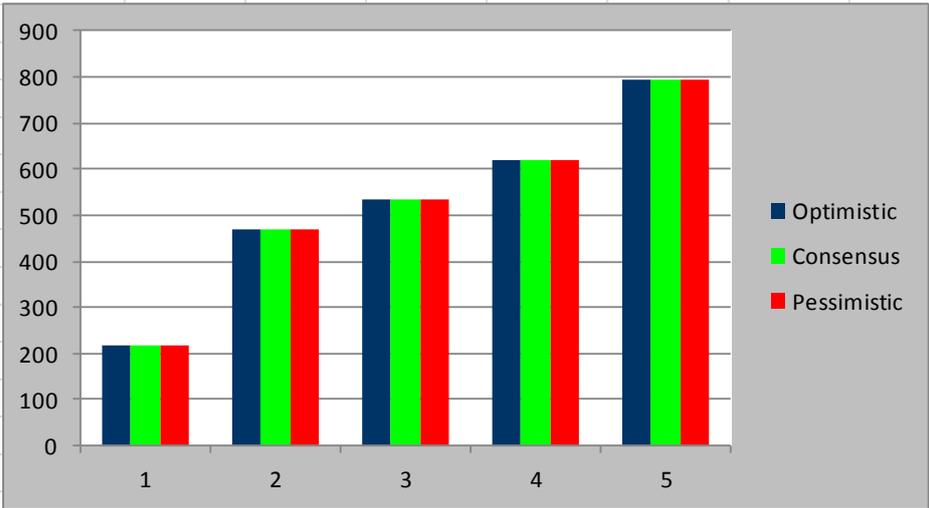
Ronnie Sharp



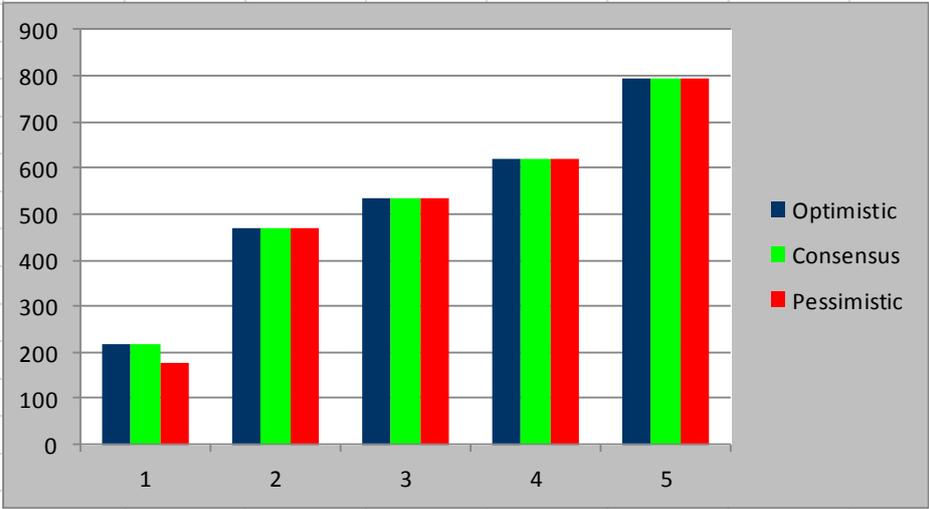
Elisabeth Lucas



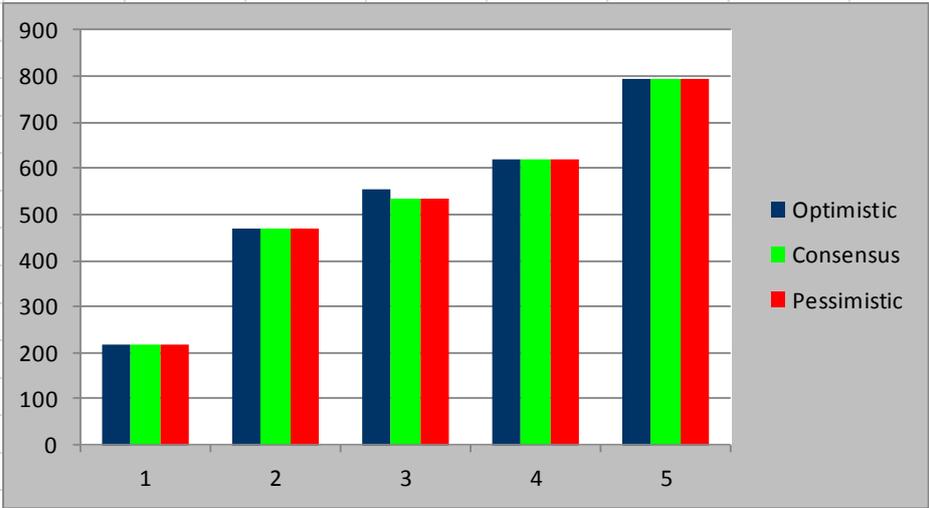
Elisabeth Cruickshanks



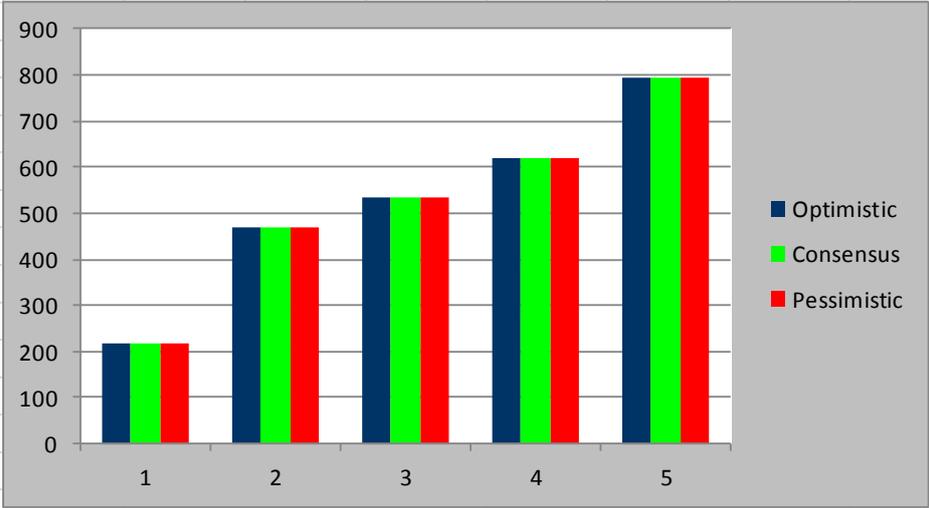
Billy Kilpatrick



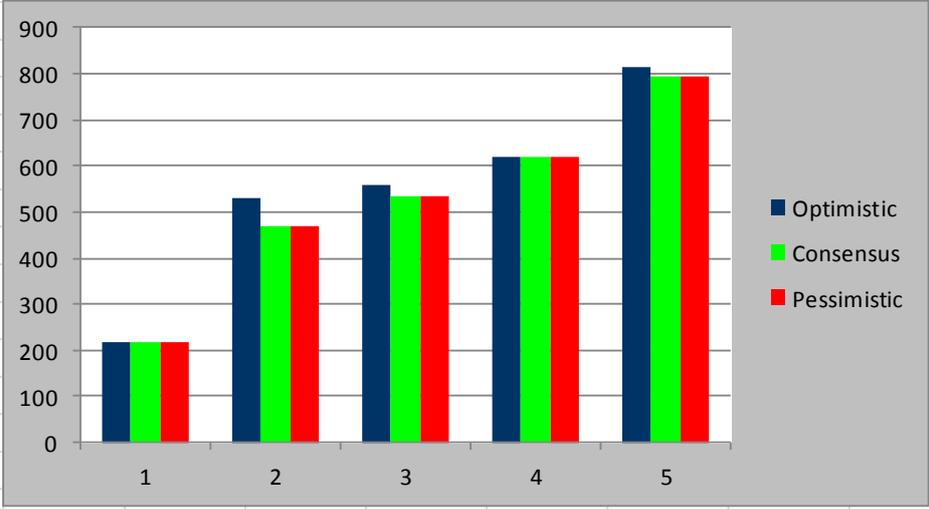
Liz Borland

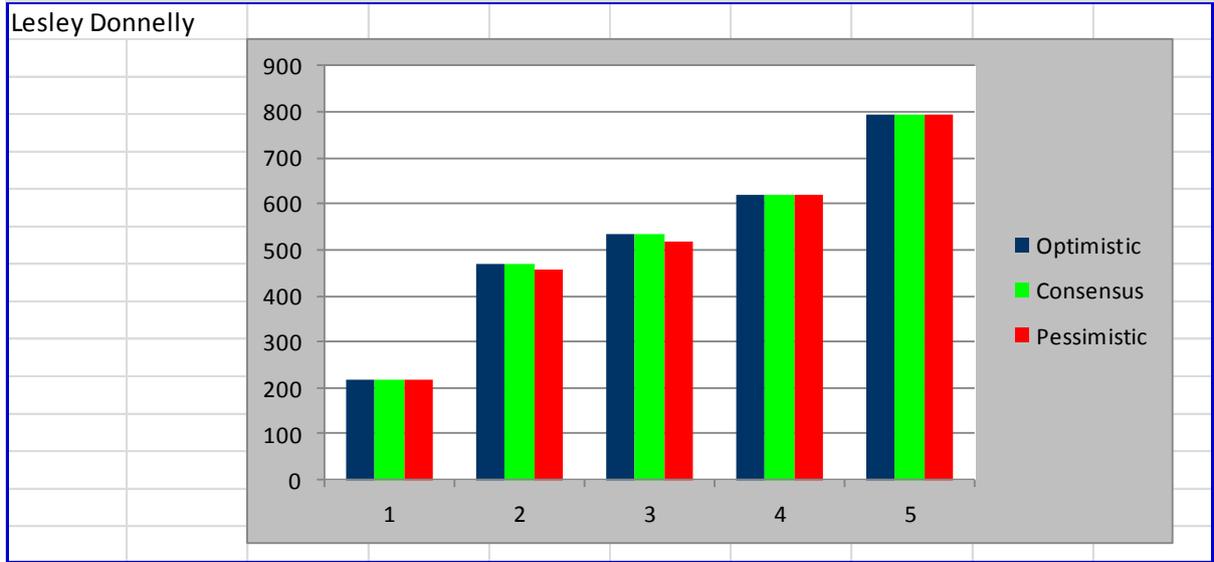


Jeanette Whitelaw



Sharon Moore





## Appendix 4

### New Stobhill mental health inpatient facility: SCIM Design Statement (product of workshops 1 and 2)

The business objectives for the facility are: (refer to section 3.2). Therefore, in order to meet these, the development must possess the following attributes.

#### 1 Non Negotiable for Patients

<b>Non-Negotiable Performance Objectives</b> <i>What the design of the facility must enable</i>	<b>Benchmarks</b> <i>The physical characteristics expected and/or some views of what success might look like</i>
<p>1.1 Almost all service users arrive accompanied and by car/taxi or other vehicle, therefore the first key experience is the approach (see 3.1 below for driver's needs) which must be reassuring. The facility must not be/feel hidden, but be a positive part of the site like facilities for any other service. It must not look austere or institutional but more homely/natural/therapeutic/hopeful.</p>	<p>The building must be visible from a main route around/through the site. There must be something (in the building design or landscape or art) that is visible from the main route that has a clear identity you can direct people by ..."look out for the....."</p> 
<p>1.2 The spaces between the road and the entrance must be designed to feel safe, reassuring and to normalise and make as easy/pleasant as possible the arrival experience for those coming voluntarily/through negotiation. The entrance must feel open, welcoming and draw you in. There must be a discrete route of entry for those arriving in a distressed condition.</p>	<p>The entrance must be visible from parking and within an agreed distance. The route from parking to the entrance must be well lit, observed from staff areas, but visually screened from main public routes and inpatient areas so that it doesn't feel like a goldfish bowl. There should be a place to stop/rest before entering if further negotiation/reassurance is needed, but the space must not be cluttered so that people can move quickly through it as a group if needed.</p>



1.3 The first internal space must provide immediate welcome, be a breather space before entering the ward, and give easy quick access to a private space for assessment or admission.

Initial space should feel like any other public space. It should be intimate in scale to accommodate a small group of people, with a social feel, distraction (daylight and views to green space) and information.

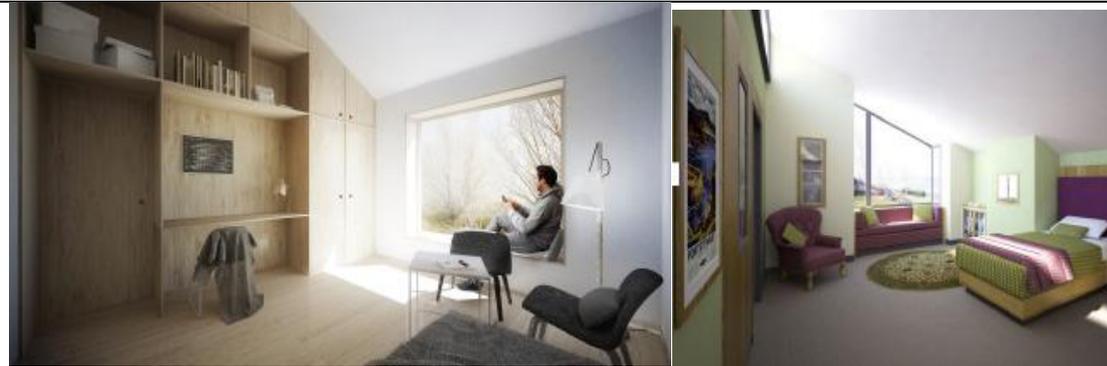


It may also be a space to sit or spend some time off ward as a stepping stone to the wider campus.

The space must be immediately adjacent to wards to allow staff to come out and greet you, and be aware of people in/using the space. There should be no formal reception of other clinical elements in this space.

<p>1.4 Entry to the wards must allow security and arrival to be managed discretely and respecting the needs/wishes of individuals.</p>	<p>Locks and keypads to be discrete and low noise. Arrival into the ward must not be directly into a day or social space, but allow people to go directly to their room or settle into a smaller space before joining a larger group. The routes and will be the first impression of the ward and so must provide a positive environment with views to social areas and the outside.</p> 
<p>1.5 Throughout the facility, patient spaces/rooms must give a feeling of openness and light, not closed in and claustrophobic. There must be views of green space and easy, safe access to therapeutic external spaces for respite/exercise/green therapies etc and places to let off steam in safety. Routes and connections to other services must encourage trips out for those who can.</p>	<p>Secure green spaces accessed directly from social areas to enable use without permission being needed, these spaces designed to provide the range of experiences, including shelter, quiet respite, wander routes, green activities etc to meet the needs of residents. Space you can feel like you're outdoors even if you're not allowed outside. The landscape design to connect to well-lit walking routes to other facilities on the site and nearby landscapes for longer walks.</p>  <p>There must be no hidden corners or dead ends where you might feel trapped or unsafe. There's evidence that sunlight – particularly morning light - improves recovery rates: design should ensure every patient has access to morning light within the facility as part routine.</p>

<p>1.6 The design of the ward must allow personal choice in environment, interaction, activities to give normal life experiences. The spaces must be designed to demonstrate the values of the service and people, being hopeful, optimistic and humane.</p>	<p>Social spaces must give people options on where to be, what activities to engage in, places to be quiet, and places to be alone or talk discretely. There must be a place for patients to make their own refreshments.</p>  <p>These spaces and places must have good daylight, views and positive distractions and a good use of colour and art.</p>
<p>1.7 The facility must help people to stay in touch with family and friends. (see also section 3)</p>	<ul style="list-style-type: none"> <li>• Safe IT access to be provided to promote opportunities to keep in touch.</li> <li>• Bedrooms, social and shared spaces, and rooms for reviews, must provide space for visitors to sit and talk with patients and staff.</li> <li>• External spaces to be designed to allow pets to visit and places for visiting children to play.</li> <li>• The design and location of initial interview/review rooms must allow staff to have appropriate conversations with family members/carers etc without the patient's feeling they're being discussed 'behind their back'.</li> </ul>
<p>1.8 The facility must provide a safe place for people to manage their own wellbeing, respecting their privacy and belongings.</p>	<p>Bedrooms must feel a safe and comfortable space and allow people to control their own environment, including lighting levels, ventilation, temperature and to open a window. Space outside the window must provide privacy, peace and a positive view.</p> <p>The doorway should form a threshold of control where other people need permission to enter (though not a barrier to staff access if needed).</p> <p>From your room you must be able to contact staff discretely and from the doorway have a visual connection to social areas (internal or external) to encourage you out of your room.</p>



There must be secure storage on site (in bedroom plus potentially additional store for items that can't be left in the bedroom) for personal belongings.

See also publication on bedrooms in mental health

<http://www.ads.org.uk/personal-space-interior-design-approaches-to-mental-health-bedrooms/>

1.9 Spaces for eating must feel relaxed and be able to deal with different needs and preferences. The sensory experiences of food and eating (smell etc) must be

Bright and airy spaces, with a variety of venues (sizes of tables and groupings within the space) to allow some to eat and chat in a more social/communal environment, and others to be more private area if needed due to anxiety or dignity (if people need help eating). The spaces must also be adaptable for other uses (social gatherings and smaller more intimate groupings) at other times.



## 2 Non Negotiables for Staff

The majority of working areas are patient areas listed above. The sections below cover the additional aspects needed to support staff in their role and own wellbeing. Aspects of technical standards to support safe practices, such as anti-ligature design, are not covered as these are detailed in guidance.

<b>Non-Negotiable Performance Objectives</b> <i>What the design of the facility must enable</i>	<b>Benchmarks</b> <i>The physical characteristics expected and/or some views of what success might look like</i>
2.1 there must be reliable, safe access for staff working shift patterns and those attending from other facilities/bases for routine and emergency contacts.	Site-wide parking/travel strategy to provide parking and green travel options for shift workers with max / mins walk to parking/bus stops and cycle stores/showers on well-lit route. Reliable parking within m of entrance for 'essential users', such as out of hours emergency.
2.2 The layout of routes and spaces must not separate staff and patients, marking them as different, but bring them together.	<ul style="list-style-type: none"> <li>• Staff routes into and around the building to be the same as patient routes.</li> <li>• Ward layout to minimise staff only areas and visible separations such as reception desks etc, however there must be a place within 10m of general ward areas to do confidential calls, brief colleagues, complete records etc.</li> </ul>
2.3 The facility must allow aspects of patient safety to be dealt with unobtrusively and discretely.	Clear lines of observation from staff/social areas to other patient spaces including circulation/external/bedrooms.
2.4 Staff's personal and emotional needs must be met on site.	<p>There must be secure storage for personal belongings (coats/bags) away from patient areas. There must be a place where staff can go 24/7 for rest, refreshments, socialise or have a quiet moment apart.</p>  <p>There should be an easy route from staff rest areas to external space and or wider walking routes to encourage staff to get a breath of fresh air and some exercise during breaks.</p>

<p>2.5 Facilities management must be able to happen without impacting on the nature of patient areas, or staff rest areas.</p>	<p>Discrete servicing and bin stores/ meals Any needs on maintenance or linen etc</p>
<p>2.6 The layout and design of the facility must help staff come together to share learning.</p>	<p>Staff areas for rest and learning to be sited so that they're accessible by all and designed to encourage use. They must not be located so they're the territory of any one group.</p>
<p>2.7 Flexibility in use: flexibility must be built into the accommodation to respond to challenges thrown up by changes in the patient group, new and emerging models of care in response to changes in policy, legislation and evolution of evidence based practice.</p>	<p>Create a central hub area where all rooms are bookable spaces. Enable gender specific allocation to a room(s). All areas are dementia friendly.</p> <p>Future proof monitoring system to support new technologies including equipment.</p>

### 3 Non Negotiables for Visitors

<p><b>Non-Negotiable Performance Objectives</b></p> <p><i>What the design of the facility must enable</i></p>	<p><b>Benchmarks</b></p> <p><i>The physical characteristics expected and/or some views of what success might look like</i></p>
<p>3.1 The layout must help those bringing in patients to do so easily and calmly.</p>	<ul style="list-style-type: none"> <li>• Good information on routes/access at the point it is agreed someone will come in.</li> <li>• Clear signage from main route through the site</li> <li>• Parking etc spaces as section 1 above</li> </ul>
<p>The design of the facility must help and encourage family and friends to visit, and to feel comfortable (psychological comfort, safe and able to deal with the social environment they are in) when visiting.</p>	<p>The initial entrance and arrival spaces (including first interview spaces) to have a family friendly feel. It must be possible for family (children or other vulnerable people) to visit and use these spaces (including external areas noted in 1.7 above) without entering the main ward environment.</p> 

### 4 Alignment of Investment with Policy

<p><b>Non-negotiable performance specification</b></p>	<p><b>Benchmark - criteria to be met or some views of what success might look like</b></p>
<p><b>4.1 The development, through its location and design, must be a positive part of the regeneration of the area.</b></p>	<p><b>Please refer to Section 1.1</b></p> <p>Good regeneration development practices provide a healthy, self-perpetuating cycle, these will include: early, wide and continuous <b>Community Engagement</b>; incorporation of <b>Health Promoting Health Service (HPHS)</b> principles, enabling healthy decisions, e.g. stair visibility, food outlet standards or usable gardens/ courtyards. Build on wider <b>Green Infrastructure</b> locally, to encourage physical activity and biodiversity, e.g. alternative travel routes; trees to reduce energy + CO<sup>2</sup>, add to well being, or provide growing spaces; i.e. enable further community engagement</p>

<p><b>4.2 Anything on Extension space/adaptability for growing/aging/changing population?</b></p>	<p>The <b>Building</b> design and construction will enable adaptation &amp; flexibility, for example: ‘repeatable rooms and standard components’; ‘loose fit’; a modular grid; ‘soft spaces’ built in. <b>Safety, Accessibility &amp; Equality</b> will be at the foundation of our design and operations. Collaborative workshops are required at key stages e.g. HAI Scribe, Dementia Design, for a holistic approach to delivering above goals.</p>
<p><b>4.3. Sustainability.</b></p>	<p>Promote health, social, environment and economic sustainability by delivering whole life value from investment. Collaborative workshops using current <b>BREEAM</b> are required at key stages, for a holistic approach to delivering above goals. Early NDAP reviews will allow a pragmatic approach to ensure principles above applied. For example, target for new build is: 2014 NC ‘Excellent’ rating. Minimum criteria include: Man03: Considerate construction; Man04: Building user guide; Man05: 2yrs seasonal commissioning; Ene01: 6credits; Ene02: sub-meter; Wat01: 1credit; Wat02 + Mat03: Criteria1 only; HEA04: 3credits; and target operational energy consumption <math>\leq 200\text{kWhr/m}^2</math> (To verify evidence of above, the proposed/ actual dynamic simulation model (DSM) issued at key NDAP review stages, plus annual DEC or equivalent energy reporting issued for 3yrs or FM contract period, whichever greater.)</p>
<p><b>4.4 Anything about perceptions of CHP in the community - Good corporate citizenship.</b></p>	<p>The building will be part of the regeneration of Stobhill and will be a facility that our neighbors and service users are proud to have in their community. The building should be iconic and stand out within the site.</p>

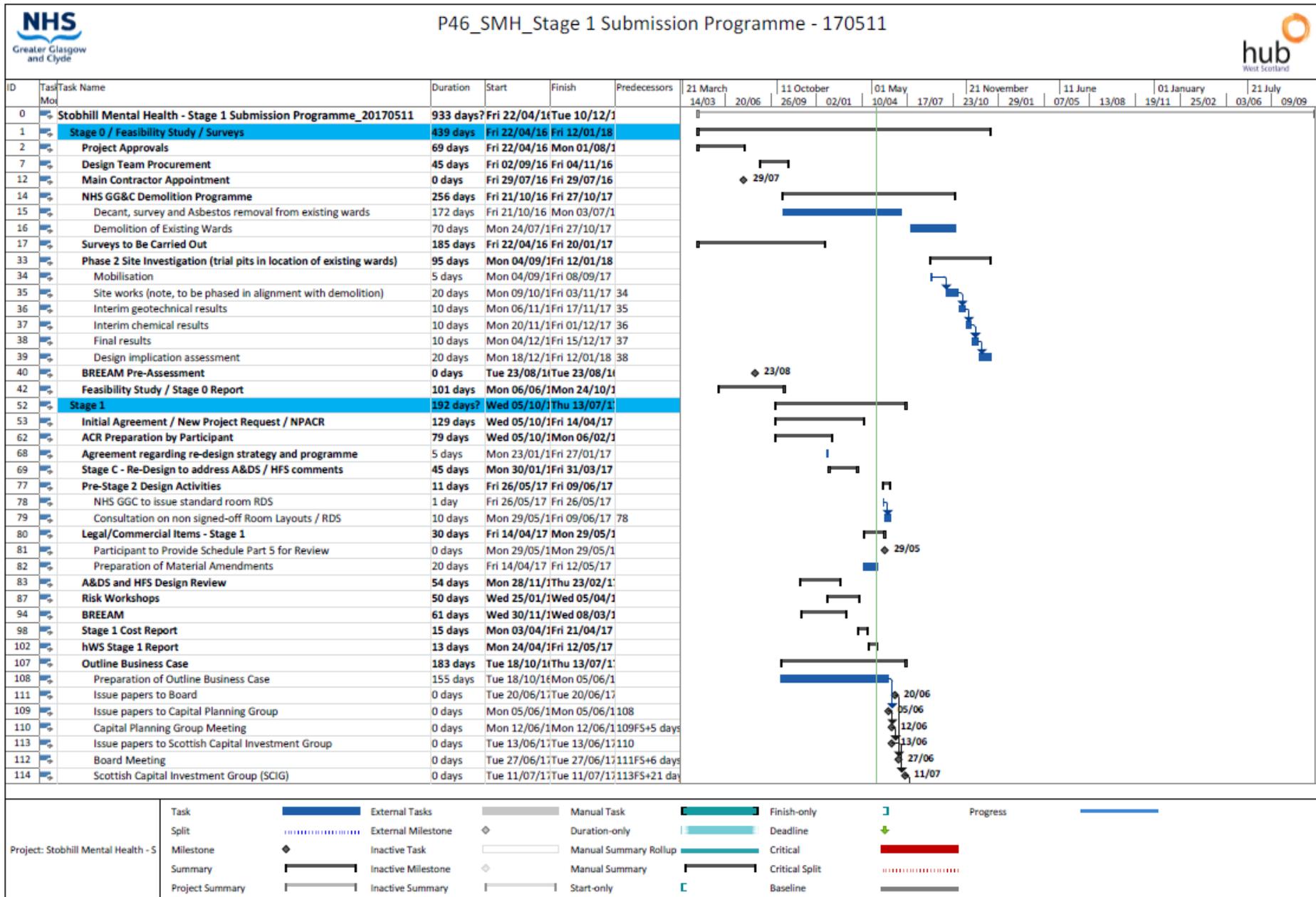
## **Stakeholders involved in preparation of the design statement**

David McCrae	- Head of Mental Health North East Sector
David Harley	- Planning and Performance Manager
Russell Hosie	- Consultant Psychiatrist
Ruth Ward	- Consultant Psychiatrist
Mary O'Donnell	- In-patient Service Manager
Alison Paterson	- Lead Nurse
Lesley Donnelly	- Operations Co-coordinator
Dorothy Rae	- Care Group Lead O.T North East & East Dun
Catherine Wilson	- Ward Manager
Yvette Wilson	- Ward Manager
Amanda McCrone	- Senior Charge Nurse
Susan Campbell	- Senior Charge Nurse
Gordon McInnes	- Mental Health Network (Greater Glasgow and Clyde)
Shona Mackie	- Mental Health Network (Greater Glasgow and Clyde)
Ms Diane Fraser	- Project Manager
Mr Andrew Baillie	- Project Manager
Mr John Donnelly	- Head of Capital Planning

## 5 Self-Assessment Process

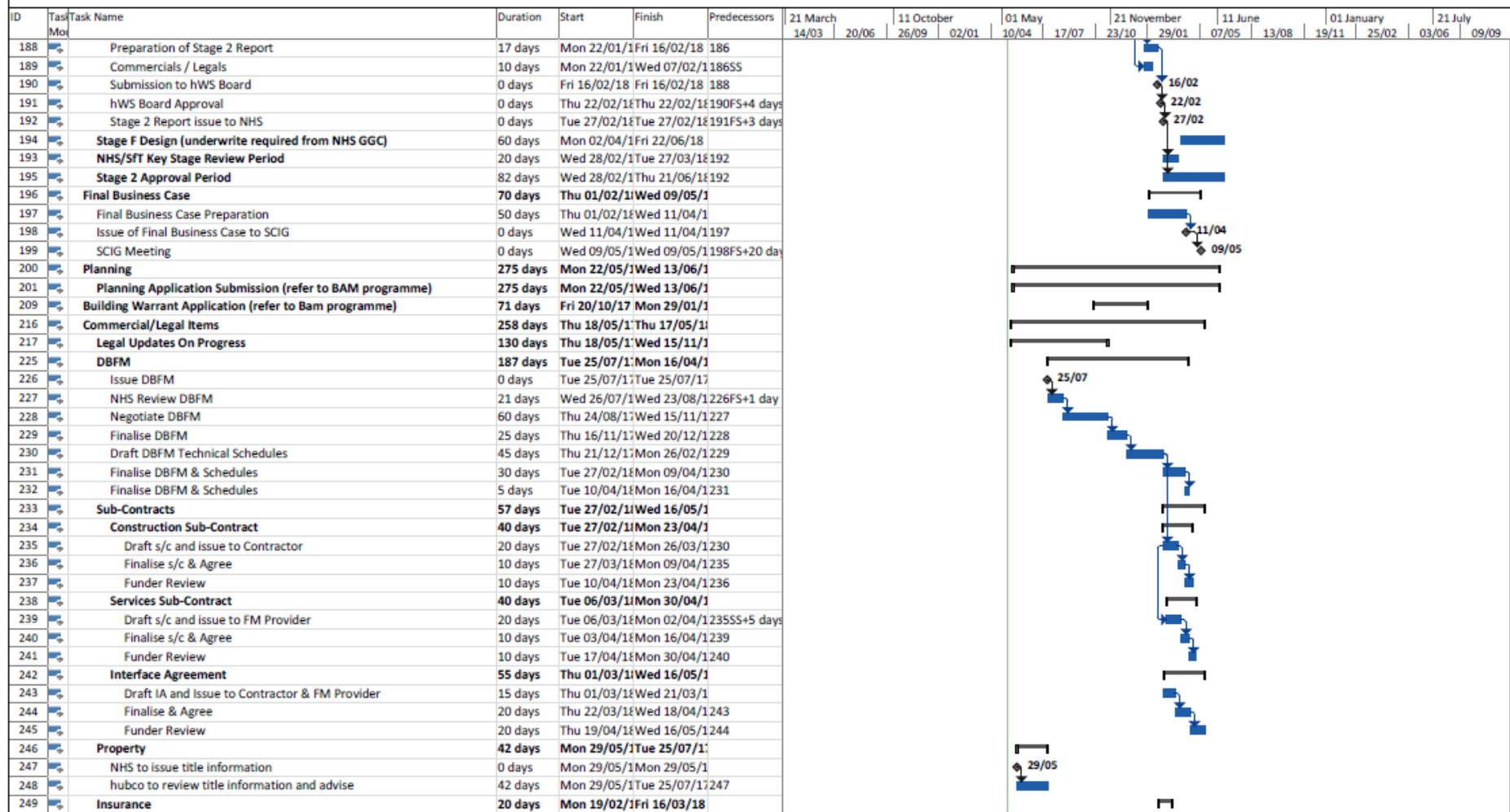
Decision Point	Authority of Decision	Additional Skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information needed to allow evaluation.
Selection of early design concept from options developed	Decision by Health Board with advice from Project Board	Comment to be sought from NDAP	Stakeholder assessment of options using AEDET or other methodology to evaluate the likelihood of the options delivering a development that meets the criteria above	Sketch proposals developed to RIBA Stage C coloured to distinguish the main use types (bedrooms, day space, circulation treatment, staff facilities, usable external space). Rough Model
Approval of Design prior to Planning submission	Decision by Health Board with advice from Project Board	Report & support to be sought from NDAP	Stakeholder assessment of options using AEDET or other methodology to evaluate the likelihood of the proposals delivering a development that meets the criteria above	
Approval of Detailed Design proposals to allow construction	Decision by Health Board with advice from Project Board	Report & support to be sought from NDAP	Stakeholder assessment of options using AEDET or other methodology to evaluate the likelihood of the proposals delivering a development that meets the criteria above	
Post Occupancy Evaluations	Consideration by Health Board – lesson fed to SGHSCD		Stakeholder assessment of options using AEDET or other methodology to evaluate completed development delivering the above criteria and business goals they set	

Appendix 5 Project Programme



ID	Task Name	Duration	Start	Finish	Predecessors	21 March 14/03	20/06	11 October 26/09	02/01	01 May 10/04	17/07	21 November 23/10	29/01	11 June 07/05	13/08	01 January 19/11	25/02	21 July 03/06	09/09
115	Scottish Capital Investment Group (SCIG) Stage 1 Approval	0 days	Thu 13/07/17	Thu 13/07/17	114FS+2 days						13/07								
116	Stage 1 Approval Period	45 days?	Fri 12/05/17	Thu 13/07/17															
117	NHS/SFT Key Stage Review Period	45 days?	Fri 12/05/17	Thu 13/07/17															
119	NHS GGC Stage 1 Approval	45 days?	Fri 12/05/17	Thu 13/07/17															
118	NHS / SFT Key Stage Review Period	11 days	Fri 12/05/17	Fri 26/05/17	106														
120	Stage 2 Design Fee underwrite received from NHS GGC	0 days	Fri 26/05/17	Fri 26/05/17	118						26/05								
121	Stage 2	277 days	Mon 29/05/17	Fri 22/06/18															
122	Stage D Design (refer to BAM programme)	40 days	Mon 29/05/17	Fri 21/07/17															
132	Authority Construction Requirements Development	40 days	Mon 29/05/17	Fri 21/07/17															
133	Issue of revised ACR's to reflect agreed V.E Items	10 days	Mon 29/05/17	Fri 09/06/17															
134	ACR to be reviewed by Design Team and Incorporated into design	10 days	Mon 12/06/17	Fri 23/06/17	133														
135	ACR to be updated to reflect Designs	10 days	Mon 26/06/17	Fri 07/07/17	134														
136	Issue of Finalised ACR	10 days	Mon 10/07/17	Fri 21/07/17	135														
137	Develop Room Data Sheets / Room Layouts (1:50) (refer to BAM programme)	35 days	Mon 29/05/17	Fri 14/07/17															
146	A&DS and HFS Design Review	10 days	Fri 14/07/17	Thu 27/07/17															
147	Issue Stage D Information to A&DS and HFS	0 days	Fri 14/07/17	Fri 14/07/17							14/07								
148	Review of plans and meeting to be held	5 days	Fri 14/07/17	Thu 20/07/17	147														
149	Review and Update of Drawings	5 days	Fri 21/07/17	Thu 27/07/17	148														
150	Stage D Cost Plan	15 days	Mon 17/07/17	Fri 04/08/17															
155	NHS GGC Stage D Design Approval	0 days	Fri 04/08/17	Fri 04/08/17							04/08								
151	Review of Outline Scheme Design	5 days	Mon 17/07/17	Fri 21/07/17	131FS-5 days														
152	Preparation of Stage D Cost Plan	5 days	Mon 24/07/17	Fri 28/07/17	151														
153	Stage D Cost Plan issue to hWS	0 days	Fri 28/07/17	Fri 28/07/17	152						28/07								
154	hWS and NHS Review of Stage D Cost Plan	5 days	Mon 31/07/17	Fri 04/08/17	153														
156	Risk Workshops (Stage D)	30 days	Wed 14/06/17	Wed 26/07/17															
157	Risk Workshop 1	0 days	Wed 14/06/17	Wed 14/06/17							14/06								
158	Risk Workshop 2	0 days	Wed 28/06/17	Wed 28/06/17							28/06								
159	Risk Workshop 3	0 days	Wed 12/07/17	Wed 12/07/17							12/07								
160	Risk Workshop 4	0 days	Wed 26/07/17	Wed 26/07/17							26/07								
161	Stage E Design and NBS (refer to BAM programme)	40 days	Mon 07/08/17	Fri 29/09/17															
176	Stage E Cost Plan	14 days	Mon 02/10/17	Thu 19/10/17															
177	Stage E Cost Plan Prepared	9 days	Mon 02/10/17	Thu 12/10/17	175														
178	Participant Review and Approval of Stage E	5 days	Fri 13/10/17	Thu 19/10/17	177														
179	A&DS and HFS Design Review	10 days	Fri 29/09/17	Thu 12/10/17															
180	Issue Stage E Information to A&DS and HFS	0 days	Fri 29/09/17	Fri 29/09/17	175														
181	Review of plans and meeting to be held	5 days	Fri 29/09/17	Thu 05/10/17	180SS-1 day														
182	Review and Update of Drawings	5 days	Fri 06/10/17	Thu 12/10/17	181														
183	Market Testing Period (refer to BAM programme)	110 days	Mon 21/08/17	Fri 19/01/18															
184	Market Testing Period	100 days	Mon 21/08/17	Fri 05/01/18															
185	Submission of CPS and Final Price to hWS	5 days	Mon 08/01/17	Fri 12/01/18	184														
186	Participant Review of CPs and Final Price	5 days	Mon 15/01/17	Fri 19/01/18	185														
187	hWS Stage 2 Report	24 days	Mon 22/01/17	Tue 27/02/17															

Project: Stobhill Mental Health - S	Task		External Tasks		Manual Task		Finish-only		Progress		Critical
	Split		External Milestone		Duration-only		Deadline				Critical Split
	Milestone		Inactive Task		Manual Summary Rollup						
	Summary		Inactive Milestone		Manual Summary						
	Project Summary		Inactive Summary		Start-only						Baseline



Project: Stobhill Mental Health - S	Task		External Tasks		Manual Task		Finish-only		Progress	
	Split		External Milestone		Duration-only		Deadline			
	Milestone		Inactive Task		Manual Summary Rollup		Critical			
	Summary		Inactive Milestone		Manual Summary		Critical Split			
	Project Summary		Inactive Summary		Start-only		Baseline			

ID	Task Name	Duration	Start	Finish	Predecessors	21 March 14/03	20/06	11 October 26/09	02/01	01 May 10/04	17/07	21 November 23/10	29/01	11 June 07/05	13/08	01 January 19/11	25/02	03/06	21 July 09/09		
250	hWS appoint Insurance Advisor	10 days	Mon 19/02/18	Fri 02/03/18																	
251	Review Insurance and Agree	10 days	Mon 05/03/18	Fri 16/03/18	250																
252	<b>Funding &amp; Finance</b>	<b>88 days</b>	<b>Thu 21/12/17</b>	<b>Thu 26/04/18</b>																	
253	Appoint Due Diligence Team	20 days	Thu 21/12/17	Wed 17/01/18																	
254	<b>Legal Due Diligence</b>	<b>25 days</b>	<b>Thu 01/03/18</b>	<b>Wed 04/04/18</b>																	
255	Funder Review of DBFM and Sub-Contracts	10 days	Thu 01/03/18	Wed 14/03/18																	
256	Issue Ancillary Finance Documents	5 days	Thu 08/03/18	Wed 14/03/18																	
257	Finalise Loan Agreement	10 days	Thu 08/03/18	Wed 21/03/18																	
258	Incorporate Model Schedules in Loan Agreement	5 days	Thu 22/03/18	Wed 28/03/18	257																
259	Finalise Ancillary Finance Documents	10 days	Thu 22/03/18	Wed 04/04/18	257																
260	Draft Subordinated Loan Agreement	5 days	Thu 22/03/18	Wed 28/03/18	257																
261	Finalise Subordinated Loan Agreement	5 days	Thu 29/03/18	Wed 04/04/18	260																
262	<b>Technical Due Diligence</b>	<b>12 days</b>	<b>Thu 18/01/18</b>	<b>Wed 07/02/18</b>																	
263	TA to Issue Requirements List	4 days	Thu 18/01/18	Wed 24/01/18																	
264	Provide TA Information & Finalise Report	8 days	Thu 25/01/18	Wed 07/02/18	263																
265	<b>Modelling</b>	<b>59 days</b>	<b>Mon 05/02/18</b>	<b>Thu 26/04/18</b>																	
266	Finalise Cost Plan	5 days	Mon 05/02/18	Fri 09/02/18																	
267	Update Financial Model (for Stage 2 Submission)	9 days	Mon 12/02/18	Thu 22/02/18	266																
268	NHS Review Model & Agree	10 days	Fri 23/02/18	Thu 08/03/18	267																
269	Model Audit - Q&A	10 days	Fri 09/03/18	Thu 22/03/18	268																
270	Financial Model Audit Conclusion	5 days	Fri 23/03/18	Thu 29/03/18	269																
271	Funder Valuation	20 days	Fri 30/03/18	Thu 26/04/18	270																
272	<b>Investor Approvals</b>	<b>12 days</b>	<b>Fri 27/04/18</b>	<b>Mon 14/05/18</b>																	
273	Issue Draft Investment Report	5 days	Fri 27/04/18	Thu 03/05/18																	
274	Issue Final Investment Report	5 days	Fri 04/05/18	Thu 10/05/18	273																
275	Shareholder Approval	2 days	Fri 11/05/18	Mon 14/05/18	274																
276	<b>Sub-Hubco Approvals</b>	<b>5 days</b>	<b>Fri 11/05/18</b>	<b>Thu 17/05/18</b>																	
277	Board Approvals	5 days	Fri 11/05/18	Thu 17/05/18	276																
278	<b>Financial Close</b>	<b>29 days</b>	<b>Fri 18/05/18</b>	<b>Wed 27/06/18</b>																	
281	Funder's Lawyers Confirm CP's Satisfied	1 day	Fri 18/05/18	Fri 18/05/18																	
282	Credit Committee	10 days	Tue 12/06/18	Mon 25/06/18																	
284	Place Insurances	0 days	Wed 27/06/18	Wed 27/06/18																	
279	Assemble Docs in Closing Room	2 days	Tue 26/06/18	Wed 27/06/18	284, 275																
280	Document Signing	0 days	Wed 27/06/18	Wed 27/06/18	279																
283	FC Model	3 days	Mon 21/05/18	Wed 23/05/18	281																
285	Financial Close	1 day	Wed 27/06/18	Wed 27/06/18																	
286	<b>Construction Period (refer to BAM programme)</b>	<b>462 days</b>	<b>Mon 05/03/18</b>	<b>Tue 10/12/18</b>																	
287	Long lead-in procurement by BAM (underwrite required from NHS GGC). Items to be scoped and quantified during Satage 2.	10 wks	Mon 05/03/18	Fri 11/05/18																	
288	Mobilisation Period (incl. Stage F Design) (TBA - to be Confirmed by MC)	8 wks	Wed 27/06/18	Tue 21/08/18																	
289	Construction Period (TBA - to be Confirmed by MC)	68 wks	Wed 22/08/18	Tue 10/12/18	288																

Project: Stobhill Mental Health - S	Task		External Tasks		Manual Task		Finish-only		Progress	
	Split		External Milestone		Duration-only		Deadline			
	Milestone		Inactive Task		Manual Summary Rollup		Critical			
	Summary		Inactive Milestone		Manual Summary		Critical Split			
	Project Summary		Inactive Summary		Start-only		Baseline			

## Appendix 6

### Initial Agreement Letter Health & Social Care Directorates

**Director-General Health & Social Care and  
Chief Executive NHSScotland**  
Paul Gray



Scottish Government  
Riaghaltas na h-Alba  
gov.scot

T: 0131-244 2410 F: 0131-244 2162  
E: [dghsc@gov.scot](mailto:dghsc@gov.scot)

Robert Calderwood  
Chief Executive  
NHS Greater Glasgow & Clyde  
J B Russell House  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow  
G12 0XH

16 December 2016

Dear Robert,

#### **Mental Health 2 Ward DBFM Scheme - Initial Agreement**

The above Initial Agreement was considered by the Health Directorate's Capital Investment Group (CIG) at its meeting of 22 November 2016. Since then CIG members have been in contact with your project team to obtain some additional information. As this has now been received, the CIG has now recommended approval. I am therefore pleased to inform you that I have accepted that recommendation and now invite you to submit an Outline Business Case.

A public version of the document should be sent to Colin Wilson ([colin.wilson@gov.scot](mailto:colin.wilson@gov.scot)) within one month of receiving this approval letter, for submission to the Scottish Parliament Information Centre (SPICe). It is a compulsory requirement within SCIM, **for schemes in excess of £5m**, that NHS Boards set up a section of their website dedicated specifically to such projects. The approved Business Case should be placed there, together with as much relevant documentation and information as appropriate. Further information can be found at [http://www.scim.scot.nhs.uk/Approvals/Pub\\_BC\\_C.htm](http://www.scim.scot.nhs.uk/Approvals/Pub_BC_C.htm).

I would ask that if any publicity is planned regarding the approval of the business case that NHS Greater Glasgow & Clyde liaise with SG Communications colleagues regarding handling.

As always, CIG members will be happy to engage with your team as the project progresses and to discuss any concerns which may arise. In the meantime, if you have any queries regarding the above please contact Alan Morrison on 0131 244 2363 or e-mail [Alan.Morrison@gov.scot](mailto:Alan.Morrison@gov.scot).

Yours sincerely

**PAUL GRAY**

St Andrew's House, Regent Road, Edinburgh EH1 3DG  
[www.scotland.gov.uk](http://www.scotland.gov.uk)





## APPENDIX

### Stobhill Acute Admissions Unit (AAU)

### High-Level Clinical Output Specification

Document History			
Version	Date	Author	Comments
1	16/5/16	N Sutherland (HG)	First full client issue draft as a component of a “whole facility” brief.
2	20/5/16	N Sutherland (HG)	Minor corrections to text and diagrams re: large bedroom sizes
3	7/6/16	N Sutherland (HG)	Page by page review & amendment by clinical team
4	2/8/16	N Sutherland (HG)	General update based on discussions to date

**Final Sign Off by Group:**

**Approved by:**

# 1. WHAT DO WE HAVE? (BASELINE SERVICES & FACILITIES)

## 1.1 COS Overview

This Clinical Output Specification (COS) relates to that element of NHSGG&C's mental health acute admissions service currently located in wards at Stobhill Hospital, Glasgow.

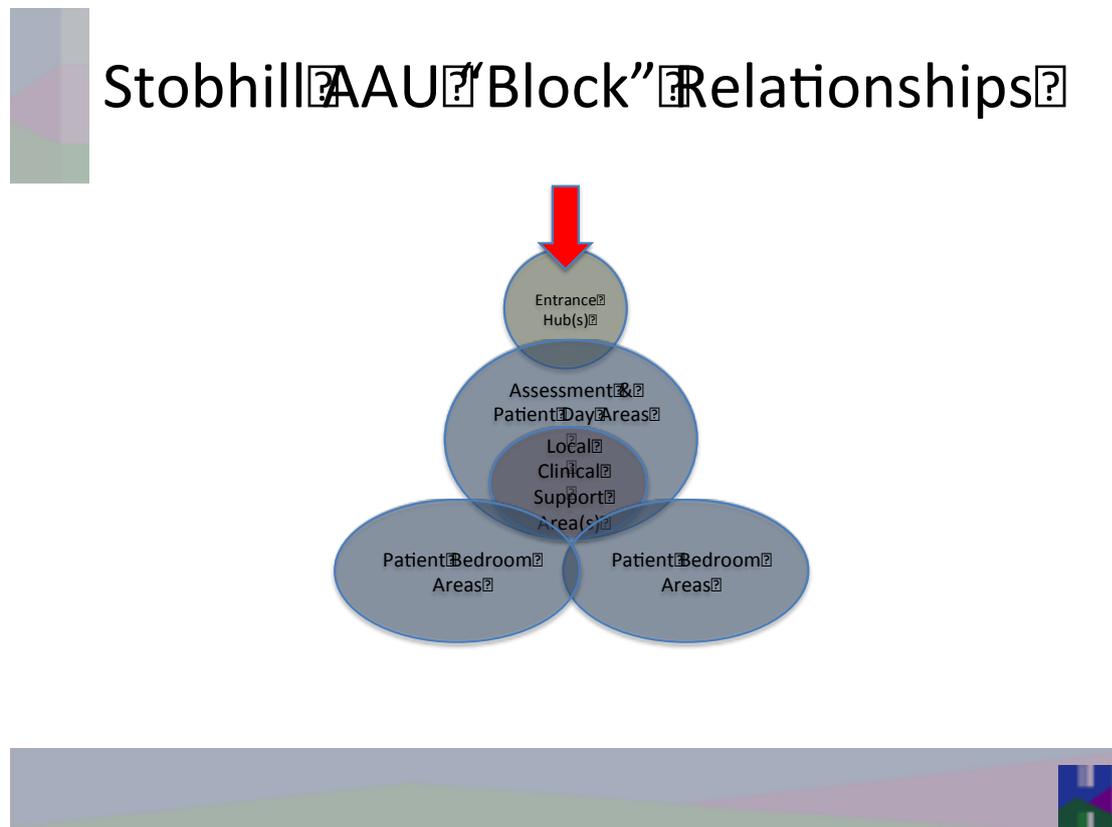
Specifically it describes the 20 bed Acute Admission Unit (AAU) to be located at Stobhill Hospital that will replace these.

The main areas within this development include:

- A small entrance hub
- Patient day & activity areas
- Patient bedroom areas
- Local clinical support areas (Including interview rooms supporting the admission & assessment function)
- Staff and clinical support spaces shared with the adjacent Elderly development (as identified in the relevant separate COS document)

These areas are as scheduled in the relevant project Schedule of Accommodation under the tabs entitled "Stobhill AAU" and "Stobhill Shared".

The concept of how AAU areas relate to each other is shown in Diag. 1. (Below)



**Diag. 1. Stobhill AAU: Concept Layout**

This document should be read in conjunction with the COS relating to Elderly Unit provision on the same site and the brief “Introduction & Overview” document that describes how these two units (the AAU described here and elderly unit) relate to each other.

## **1.2 Departmental Function & Overview**

The purpose of the unit will be to provide acute inpatient mental health care, including an assessment and admission function, to a large part of the NHS Greater Glasgow & Clyde catchment area as a component of the Board’s overall mental health services strategy.

Patients seen within the unit will predominantly be between the ages of 16 and 65, although older adults with functional mental illness may also need to be admitted on occasions. They will primarily come from Dunbartonshire & Glasgow City, North

People under the age of 16 will be admitted to the ward only under exceptional circumstances – and for the minimum amount of time required.

## **1.3 Baseline Configuration & Physical Capacity**

Existing AAU services/facilities are configured on a geographical basis with multiple separate units covering the Greater Glasgow and Clyde area. These are being rationalised into a smaller number of centres through the Board’s mental health services strategy.

The existing Acute Admissions Unit/service being re-located at Stobhill is currently based in wards 43 and 44 at Stobhill Hospital. These were reviewed and retrospectively scheduled as a component of the healthcare planning process. In summary they (each) include:

- 2 x interview rooms (supporting admission & assessment)
- 4 x 4 bed “wards” with associated WC, WHB and separate shower (Bed area circa 54m<sup>2</sup>, WC/WHB and separate shower circa 9.5m<sup>2</sup> including circulation)NB each “4 bed bay” includes the area associated with 6 historical bed spaces as bed numbers were reduced to increase spacing in line with control of infection recommendations
- 6 x single rooms with en-suite WC’s and WHB’s but no showers (Bedroom circa 10.5m<sup>2</sup> and en-suite circa 4m<sup>2</sup>)
- Dining Area
- Day room/Social area
- Support spaces

## **1.4 Assessment & Admission Criteria**

Everyone admitted to the unit comes through either Community Mental Health or Crisis teams following an appropriate initial assessment.

Primary referrers include:

- GP's
- CMHT's
- OOH (Crisis) Teams
- A&E Liaison services

## **1.5 Baseline Activity Metrics, Utilisation & Performance**

This data has not been provided or reviewed at this time.

## **1.6 Staffing**

It is anticipated that staff supporting the unit will include:

- Visiting consultants
- Visiting therapy and support staff (Social work, volunteers, etc.)
- A maximum of 10 nursing staff per shift (Including trained staff and students)

## **1.7 Negative Elements of Baseline Configuration/Risks**

Negative elements associated with existing service provision and the facilities used to deliver this (in no particular order) include:

- There is a gap in service between liaison teams finishing at 1700hrs and OOH's teams commencing at 2000 – this can lead to delayed assessment/admission
- Global in-patient bed capacity is a challenge – meaning that occupancy levels can be high and patients need to be admitted where capacity exists rather than where would be ideal
- The existing AAU is located in temporary accommodation Wards 43 and 44 at Stobhill Hospital. These are two on the Hospital site leading to relative isolation.
- The existing facility in a poor state of repair and has very limited parking.
- The units look/feel more like a “general hospital ward” (Multi-bed bays, corridor configuration, layout, etc.)
- Observation is challenging due to poor design
- There is in-sufficient space to effectively support unit function
- The units do not include a Female only day room which can lead to Female patients feeling vulnerable and requires operational solutions that restrict other areas of service delivery
- The unit is upstairs, a considerable distance from the main entrance causing problems for out of hours assessments and making it difficult for patients to access

external areas (The OOH assessment model involves ringing a buzzer at the main entrance, door being opened remotely, making their way to the ward and being let through an additional door there under direct vision)

- Whilst some attempts have been made to address ligature concerns, e.g. curtain rails, many remaining fixtures and fittings are ligature risks that are very difficult to address due to the original design and age of the facility (A number of the ceilings in patient areas are suspended)
- The unit is still primarily made up of multi-bed bays meaning that it is inflexible, inefficient, challenges privacy/dignity issues and arguably heightens infection control risks despite attempts to increase bed spacing through reducing bed numbers from 6 to 4 in multi-bed bays
- Windows/vision panels are obscured by curtains inside rooms meaning that nurses need to enter rooms on occasions to check on patients. This can be disturbing at night. (The operational model is to request that patients leave curtains open after they are dressed in night attire)
- Visiting areas are well into the ward – requiring relatives and visitors to enter further into the ward than should be necessary
- The two existing wards have to share a dining room that doubles as a visiting area with a consequential negative impact on all patients and a requirement for scheduled meal and visiting times

These elements must all be addressed through updated processes and the new facilities provided.

## **1.8 Positive Elements of Baseline Configuration/Opportunities**

Positive elements associated with existing service provision and the facilities used to deliver this (in no particular order) include that:

- Services are provided by dedicated and highly trained staff
- Staff based within the unit are supported by visits from key professionals such as physiotherapists
- Nursing staff within the unit manage the patients who are resident there whilst also supporting the acute assessment and admission function
- Areas used for assessment (Interview rooms) are located at the entrance to wards. This minimises disruption to the day-to-day management of the ward associated with assessment and means that patients who are not subsequently admitted do not have to enter any further into the ward than is necessary.
- Single bedrooms (where provided) have an inter-locking configuration – providing ready observation and the other benefits associated with this bedroom model
- En-suites, where provided include WC, WHB & shower
- There is a reasonable separation of “day” and “night” areas
- Most fittings are ant-ligature

These positive elements should all be retained, irrespective of how processes change, and must be deliverable by the new facilities provided. Specific opportunities for overall service change identified that will be taken forward by the service include those related to:

- Reviewing the overall model of AAU provision and assessment across GG&C
- Clearly articulating the impact this model will have on AAU and global in-patient bed provision by location
- Addressing gaps in existing service provision – most notably between liaison teams finishing at 1700hrs and OOH's teams commencing at 2000
- Planning for undertaking all required assessment activity (physical and mental health related) in a dedicated, co-located space at the entrance to the AAU prior to admission
- Supporting strategic planning that recognises the specific role of the Stobhill AAU and how it relates to the other facilities and services that support/are supported by it;

## **2. WHAT DO WE WANT? (TO REALISE PROJECT & WIDER OBJECTIVES)**

### **2.1 Philosophy of Care**

The philosophy of care within the Stobhill AAU will be explicitly user focused and supported by a robust systematic approach to clinical governance.

An important element of the philosophy will be to capitalise on the clinical expertise associated with staff who work between the AAU ward and assessment areas (and the economies of scale associated with this) whilst keeping the two functions (assessment and in-patient care) otherwise separate. Notably, patients will not be admitted to the ward element of the AAU until/unless the assessment process has deemed this necessary and it should therefore be possible for a patient to undergo assessment without having to enter the “main” in-patient areas of the AAU ward.

The objective of the “assessment” role of the unit will be to support the safe, effective and timely assessment of patients referred to it by community based mental health teams and other mental health professionals. This will in turn lead to decisions being taken regarding a requirement to admit these patients to the adjacent ward or to manage their required support in some other way that falls short of admission.

The objective of the “ward” or “in-patient” role of the unit will be to provide safe and effective acute in-patient mental health care to those patients who have undergone the required assessment process and been deemed to require admission. It will provide a range of therapeutic interventions which are planned, co-ordinated and provided from a multi-disciplinary and user/carer perspective, based on comprehensive on-going assessment. A key aim will be to provide a platform for social inclusion.

Working towards rehabilitation/discharge/recovery will be the underpinning objective at all times within the ward in order to prevent inappropriate lengths of stay and promote independence and self-reliance. Effective integrated working and communication with community based health services and other agencies will also be a key service objective.

All interventions undertaken will be evidenced-based or based on national consensus good practice and will be under-pinned by national standards and clinical guidelines.

Normally patients will stay within for the AAU for no more than 28 days before they are either discharged or transferred to a more appropriate longer-term in-patient area.

### **2.2 Model of Care**

In future, patients who it is deemed may require admission to in-patient mental health beds will all be referred to the appropriate Acute Admissions Unit. (AAU) These will be appropriately geographically distributed to support patient needs based on existing community infrastructure and Community Mental Health Teams. This established system means that a consistency is maintained between CMHT's and the specific acute admission facilities that they relate to, improving overall patient caseload management; reducing admissions/re-admissions; reducing length of stay; and smoothing out the discharge process.

Although geographical referral boundaries will be maintained as much as possible, it may be necessary on occasions for individual AAU's to accept referrals for assessment and potential

admission from different CMHT localities in order to make best use of the global resources available. The incidence and impact of such situations will be mitigated through:

- Recognising global in-patient capacity requirements but planning for appropriate capacity in local areas
- Appropriately locating facilities for optimal/easy access
- Ensuring common approaches to all assessment, admission and management processes
- Adopting recognisable, common layouts and key design elements across facilities with similar functions

### **2.3 The Operational Environment**

The operational environment will seek to implement this philosophy of care through:

- Involving patients as active participants in their care, contributing in a meaningful way to treatment decisions;
- Providing access to information on the service and their care package which will promote the greatest degree of self-determination, informed choice and equity;
- Respecting the individual and recognising their full rights and responsibilities as a citizen;
- Presenting a culture of support in which staff actively promote a sense of hope, well-being and self-esteem in their patients;
- Acknowledging that therapeutic interventions, social and recreational activities all play a part in the overall patient experience;
- Validating and affirming each patient's individuality supported by a structure of person-centred care;
- Focusing on active discharge planning and minimising lengths of stay in-keeping with the principles of shifting the balance of care;
- Providing innovative, evidence based treatment and care to individuals and their families underpinned by a strong values base;
- Identifying, containing and controlling potentially dangerous behaviours through consistent staff practices that assist patients to moderate their behaviour and develop internal coping and control skills;
- Providing security and observation at the least restrictive level, appropriate to the patients needs;
- Aligning it with relevant national drivers for example: QIS standards, HEAT targets, etc.

### **2.4 The Physical Environment (Key Design Statement Elements)**

The physical environment created should seek to support this philosophy and model of care through providing fixed assets that are capable of supporting its operationalisation. Specifically through:

- Recognising strategic context, the specific role of the Stobhill AAU and how it relates to the other facilities and services that support/are supported by it;
- Delivering the optimal configuration of scheduled accommodation on a single level without ramps/steps;
- Providing an assessment unit that is able to support effective assessment and clinical screening (including BP check, urinalysis, etc.) prior to admission and without undue impact on the remainder of the ward;
- Balancing the need to keep staff in a single area as far as possible whilst recognising at least 3 distinct internal activity "zones". (Assessment, day spaces and bedroom areas);
- Providing identified visitor accommodation that does not require visitors to travel any

further into the unit than is required;

- Ensuring the safety and security of staff, patients and visitors alike;
- Providing an environment that is “calming”;
- Appropriately balancing the need for safety and security with the provision of a therapeutic environment;
- Minimising observational “black spots”;
- Recognising that the therapeutic environment and ambience of the ward is a crucial element in how service users experience their in-patient stay and how they benefit from it;
- Recognising the importance of ready access to safe external areas that include spaces able to meet NHS GG&C’s policy on e-cigarettes and areas of shade;
- Meeting all required standards and guidelines regarding the built environment;
- Ensuring that the new build component “works” optimally in the context of the existing estate and defined areas shared with the proposed Elderly Unit and balance of the site

## **2.5 Key planning guidance, SHPN’s technical guidance, whole hospital policies, etc.**

Developing the required AAU at Stobhill is consistent with NHS GG&C’s mental health services strategy and quality strategy.

Attention is also drawn to the specific design guidance contained in the following documents:

- **SHPN 35 Accommodation for People With Mental Illness (Part 1)**
- **SHPN 35 Accommodation for People With Mental Illness (Part 2)**
- **SHPN 04 Adult In-patient Facilities**
- **Do The Right Thing: How To Judge A Good Ward (2011) The Royal College of Psychiatrists**
- **HBN 03-01 (Which has the status of “best practice” guidance in NHS Scotland)**

In addition, attention is drawn to a number of additional documents that include:

- **“MHS-21. Mental Health Services Policy For Locking Doors on Open Wards” (2016) NHS Greater Glasgow & Clyde**
- **“CR78. Safety For Trainees in Psychiatry: Report of the Collegiate Trainees’ Committee Working Party on the Safety of Trainees” (1999) London. Royal College of Psychiatrists.**

**The relevant schedule of accommodation has been developed based on this guidance with modifications as appropriate. It should be regarded as the primary document for all indications of activity space requirements associated with the accommodation briefed.**

## **2.6 Environmental and Services Requirements**

Environmental and service requirements should correspond to the standards described in the relevant technical documentation related to this project (SHPN’s and SHTM’s) in particular SHPN 35 (Part 1 and 2) regarding design/configuration issues.

### **3. WHAT IS CHANGING? (THAT WE NEED TO CONSIDER)**

#### **3.1 Planning Assumptions: Assumed changes in need/demand**

Although no data has been supplied or reviewed in this regard by HGHCP, main anticipated changes in future will arise as a result of a range of “future impact factors”. These are likely to fall under a number of categories that include:

- Demographic change elements.
- Clinical performance elements
- Corporate performance elements
- Financial performance elements and targets

Demographic elements include population and epidemiological factors that are wholly out with the influence of the NHS Board. They can be considered to reflect a shifting baseline over time that other changes/inputs will deviate from.

Clinical performance elements represent the potential impact of changes in clinical practice/re-design on future capacity requirements.

Corporate performance elements represent potential changes/improvements in patient management that could have an immediate and lasting effect on capacity requirements if implemented and managed appropriately.

Financial performance elements and targets reflect the frequent requirement to set specific targets that push services and practice closer to where clinical negotiation and modelling may indicate they could be. They also reflect the potential impact of improved “whole system” financial and service planning along with clarity around the requirement and options for resource transfer and service “buy in”.

Specific examples of “future impact factors” discussed informally thus far in the context of this development include:

- Increasing elderly population (Demographic)
- Investment in new facilities with 100% single rooms (Clinical performance)
- Increase in acute admissions with co-morbid addictions problems (Demographic)
- Increase in patients displaying more challenging behaviours (Demographic)
- The long-term impact of “legal highs” (Demographic)
- Reduced length of stay (Corporate performance)
- Increased bed occupancy (Corporate performance)

- Rationalisation of the overall AAU assessment model

### **3.2 Planning Assumptions: Assumed changes in delivery/supply**

In the absence of data, no assumptions have been made regarding changes to delivery or supply capacity.

### **3.3 Anticipated Impact On Global Physical Capacity Requirements**

In the absence of data it is not possible/appropriate to predict the anticipated impact on global (whole system) capacity of this development.

### **3.4 Anticipated Impact On Project-Specific Physical Capacity Requirements**

In the absence of access to data it should be assumed that all project-specific physical capacity requirements are as stated.

### **3.5 Any Other Longer Term Considerations Regarding Future Services/Activity**

N/K

## 4. WHAT DO WE THEREFORE REQUIRE?

### 4.1 The Proposed Facilities: Overview

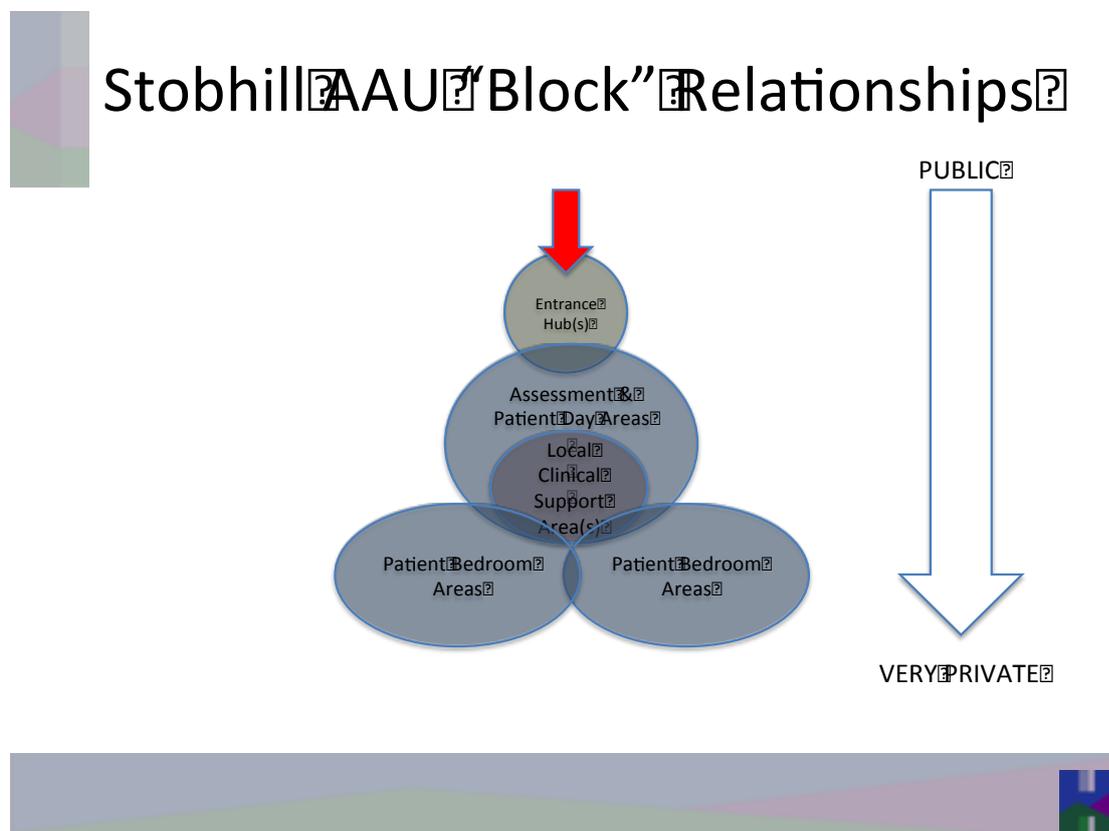
All of the accommodation within the proposed facilities is as specified in the attached Schedule of Accommodation which should be considered as the primary reference document relating to areas required. (Appendix 3)

In reflection of the requirements of clients, service users and the services themselves the care environment should, in overview:

- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- Create a calm and restful atmosphere throughout and an environment which is non-threatening;
- Optimise staff observation/monitoring of patients at all times (Specifically, minimise the opportunities for patients to engage in activities/behaviours that may place themselves/others at harm/risk whilst out with the direct vision/supervision of staff)
- Afford no undue separation of staff from patients;
- Provide a range of central clinical and shared spaces to support both informal socialisation as well as structured one to one and wider group activity
- Provide opportunities for exercise, leisure and education;
- Include easily maintained/accessed outdoor spaces;
- Be sensitive to the needs of physically disabled patients, visitors and staff;
- Be “operationally flexible” enough (on a day to day basis) to:
  - meet the changing care needs of individuals throughout their episode of care, e.g. through the movement/removal of furniture, ability to “lock off en-suites”, control observation levels and movement, etc.)
  - provide an equality sensitive service, e.g. Through identifying gender-specific areas with “gender-flexible” spaces between to support changing gender-mix
  - Ensure that all accommodation allows conversations at normal levels to take place in privacy but also allows raised voices/shouting to be overheard from adjacent rooms/areas;
  - Provide sufficient telephone access and IT infrastructure for patients and staff. (Specifically, in consideration of a move towards electronic health records, it should be assumed that an IT connection will be required everywhere that a clinical interaction may take place)
  - Provide areas suitable for social dining
  - Consider the needs of staff and the impact that the working environment has on job satisfaction, recruitment and retention.
  - Address gender, cultural and religious diversity whilst meeting the needs of relatives, carers and visitors
  - Conform to the requirements of the Disability Discrimination Act 2005 including wheelchair access into rooms, provision for those who have hearing or visual impairments and for obese patients.

## 4.2 The Proposed Facilities: Configuration

The ward should be laid out so that a clear progression can be identified from public areas (outside) to increasingly private areas upon entering the facility. Key “zones” within the ward are as identified in the relevant “bubbles” in Diag. 2. (Below)



**Diag. 2. Stobhill AAU: Block Relationships & Flow from Public to Private Space**

These key “zones” are:

- The entrance hub
- The assessment area
- Patient day/activity areas
- Patient bedroom areas
- Local clinical support areas
- External (garden) areas

### 4.2.1 The Entrance Hub

The entrance hub includes only minimal scheduled areas. It is intended to act purely as an entrance/airlock to the ward, small waiting area and also to be the location of the single disabled toilet for visitor use. As it is in an “uncontrolled area” this toilet will be lockable and accessible only through the use of a key/code or some other secure means only accessible in agreement with ward staff.

The “waiting area” has been included to allow the short-term waiting of small numbers of visitors who arrive before scheduled visiting times have begun.

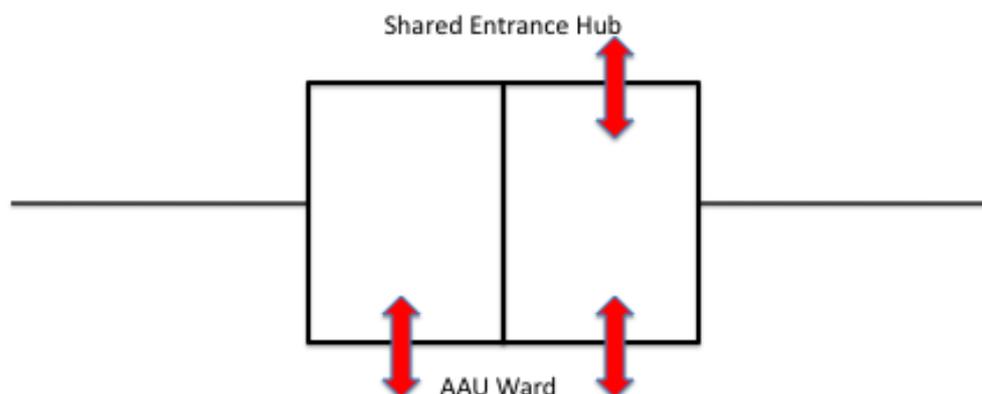
The entrance hub will be connected to the ward by a locked door with entry buzzer and video link that it will be possible to open remotely.

#### 4.2.2 The Assessment Area

Although not scheduled separately, the assessment function will be undertaken primarily through access to the 3 interview rooms scheduled in the “Local Clinical Support Areas” component of the S of A, supported by access to the clean utility/treatment, disposal/slucice/test room and other clinical support areas as required. Consequently “Assessment” should be seen as taking place in a notional zone between the “entrance hub” and patient day areas with ready access to the required clinical support spaces. (Clean utility, dirty utility and patient pantry)

It is noted separately here, as a key design challenge identified is: “ensuring that assessments can take place utilising staff based within the unit, without disrupting the day to day operation of the ward”. i.e. It should be possible to conduct an assessment without the patient being assessed having to enter the “main part of the ward”, the staff involved in assessment having to leave the “main part of the ward” and relatives being able to be provided with the support/hospitality they require, e.g. Tea and coffee.

Interview rooms are identified as providing a crucial interface between patient assessment and admission and should consequently be located/configured such that they are able to function as both a conceptual and physical entrance point to the ward in recognition of the anticipated patient flow. Specifically it is noted that these rooms are where initial assessment will take place that could result in admission and consequently may also be thought of as having a “airlock-like” function with entrances/exits from both the shared hub lobby and ward environment in at least one. (Diag. 3. Below)



**Diag. 3. The Interview Room as A Controlled Access Point To The Ward Following A “Decision to Admit” Following The Assessment Process**

#### 4.2.3 Patient Day/Activity Areas

Patient day/activity areas should be close to the entrance of the unit and distal to the bedrooms both to support appropriate social interaction and aid the operational control/observation of access to/from bedrooms and hierarchy of zones that reflects

increasing levels of privacy with travel into the unit.

These areas include a mixture of sitting, dining, activity and quiet areas intended to provide alternative options for daytime activities and patient separation where required.

They also include a patient pantry with access to tea/coffee/hot drinks by patients and utility room for self-care domestic activities including washing, drying and ironing clothes.

No WC's are included in day areas as the preferred model sees patients accessing their own en-suite WC.

In addition, the dining room will also double as the defined "visitor area" with visitors restricted to this area during agreed visiting times. (Visitors will not be allowed into any other patient areas and certainly not the bedroom wings so this should also be close to the main entrance)

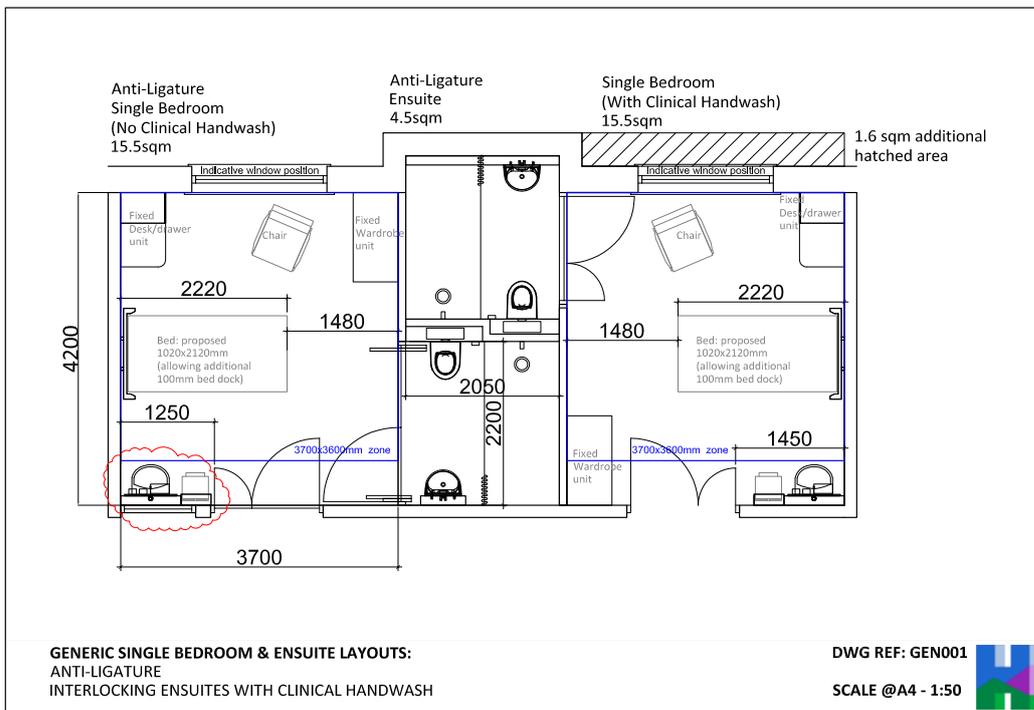
#### **4.2.4 Patient Bedroom Areas**

The Board notes that SHPN 35 is now over 15 years old and does not reflect the requirements for modern healthcare provision within acute mental health areas and affords NO future flexibility around change of use. Specifically, they note that the 11.5m<sup>2</sup> bedrooms specified in SHPN 35:

- Do not meet the minimum clear space around beds required to support any physical intervention
- Would therefore only ever be suitable for physically able patients groups
- Are incapable of supporting the preferred interlocking en-suite model utilising the HBN 00-02 model
- Are not therefore capable of supporting the long-term demographic and service delivery changes anticipated

Whilst SHPN 04, which reflects a minimum requirement for 19m<sup>2</sup> (not including en-suite facilities), is capable of meeting all of these requirements this is deemed excessive – with 16m<sup>2</sup> agreed as the optimum area required to deliver appropriate "clear space" around beds in those rooms where physical assistance may be required.

Consequently, the AAU Ward will include 20 beds in single rooms with associated en-suite toilet, shower and WC facilities. Sixteen of the bedrooms in the ward have been scheduled at 13,5m<sup>2</sup> with 4m<sup>2</sup> en-suites in line with the recently completed AAU facilities at Leverndale Hospital (that have been very well received in terms of bedroom design) whilst four of the bedrooms will be larger (16m<sup>2</sup>) to allow appropriate support of independent wheelchair users, bariatric patients or those with other special needs that require additional floor space. These larger bedrooms will also incorporate 5m<sup>2</sup> en-suites that comply with HBN 00-02 to ensure dual assistance can be provided in all larger bedrooms. (See Diag. 4, overleaf)



**Diag. 4. The Inter-locking Bedroom Model: For Illustrative Purposes Only**

The inter-locking bedroom model is mandated for these 4 larger bedrooms/en-suites within the AAU as:

- The position of en-suites must not compromise the observation of bedrooms
- The physical needs of patients demands that all scheduled bedroom area be available to support clinical activity
- These larger bedrooms require to be optimally shaped and ensure a minimum of 3.6m x 3.7m uninterrupted space around beds for patient management as per relevant guidance
- The 5m<sup>2</sup> en-suites associated with the larger bedrooms should all be sufficiently sized and configured so as to be able to provide “dual assistance” when required

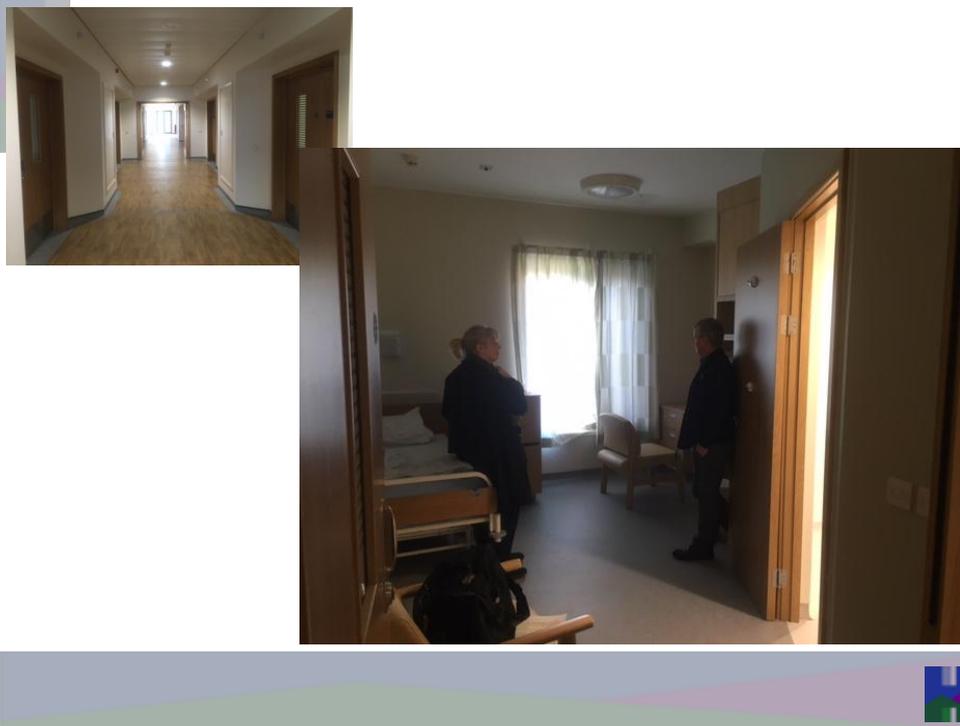
In addition:

- 1 of the larger sized bedrooms/en-suites within the unit should be identified as being suitable for bariatric use with the necessary fixed equipment.

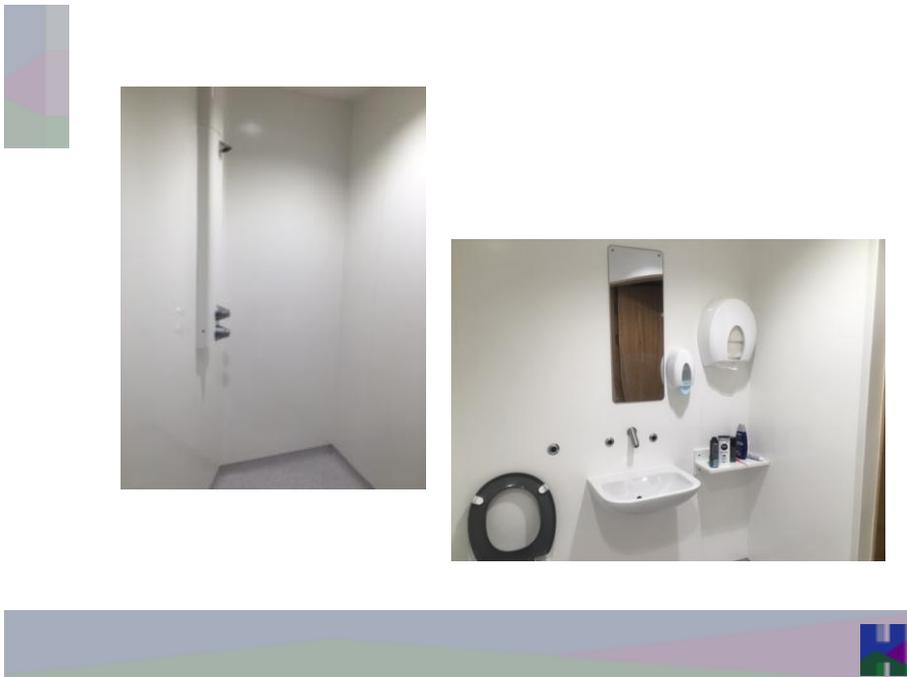
The preferred bedroom model for the balance of bedrooms is an in-board configuration – specifically EXACTLY as currently in use in the new build AAU at Leverdale. This is desirable to the Board as:

- It presents a good balance between patient privacy and ready observation
- The detailed design and use of fixed eqpt. addresses normal concerns related to “hidden areas” within the bedroom
- The “castellated” internal corridor model that results is chamfered to prevent injury/damage and makes the spaces more “interesting”
- It makes estates maintenance of en-suites and services easier

- It represents an economy of scope as the detailed design and equipping information is already available
- It has proven itself to be effective in operation and is liked by patients and staff



**Diag. 5. The In-board En-suite Bedroom Model at the New Leverndale AAU**



**Diag. 6. The In-board En-suite Bedroom Model at the New Leverndale AAU**

**Overall, bedrooms within the ward should be configured in 2 or more smaller identifiable “groupings” to support the appropriate separation of patient groups by gender or on a condition-specific basis as/when required and recognise the comments made by the Royal College of Psychiatrists regarding optimal unit sizes. (Do The Right Thing: How To Judge A Good Ward (2011) The Royal College of Psychiatrists)**

This should include the identification of a notional future Female and Male “end” in order to provide an operational separation of men and women with centrally located bedrooms that can flex between men and women in response to operational needs. The notional Female end of the ward would also be where the designated “Female only day room” is located.

Where provided, “women only” and “men only” areas should be accessible from the appropriate “end” of the bedroom areas – specifically without having to pass bedrooms/other areas likely to be occupied by the opposite sex as per Diag. 2. (Below)



#### **Diag.7. Gender Separation vs. Operational Flexibility: Layout Concept**

In addition, all bedrooms should have natural light via a large window and ideally a pleasant view to external soft landscaped areas or attractive spaces beyond.

Where ward design requires bedroom views to overlook courtyards, the courtyard dimensions and shape must be taken into consideration in order to optimise privacy.

Specifically, it should not be possible to look directly into bedrooms from outside areas.

Consideration should also be given as to how good passive observation levels can be achieved from corridors and staff bases.

As regards environmental control, it is important that all services (including power and water) can be isolated from outside bedrooms.

#### 4.2.5 Local Clinical Support Areas

**Although frequently used support rooms, such as dirty and clean utilities and disposal holds should be as near as possible to the clinical areas served, in general clinical support space may be used to create “buffer zones” between other scheduled spaces as required or to enhance overall design and functionality.**

The Charge Nurses office and other staff areas (such as the MDT room) should be close to day spaces and the entrance to wards to maximise observational opportunities, support

appropriate access control and ensure that staff are never far from patient areas – even when engaged in non-direct activities, e.g. Meetings, administration, etc.

Areas requiring FM access/servicing such as the clean utility, dirty utility, linen room, etc.) should be close to the defined FM entrance to reduce the distances travelled with fresh stores/dirty items. In addition defined clean/dirty “routes” should be identified that minimise all travel distances whilst maintaining an appropriate separation between “clean” and “dirty” goods/services.

#### **4.2.6 External (Garden) Areas**

Therapeutic external space that is readily accessible from shared day spaces is an essential element of the overall unit. This external space must:

- Maintain the same level of patient safety as within internal areas, e.g. Anti-ligature
- Maintain the same level of “anti-pass” as within internal areas, e.g. It should not be possible to pass, throw or otherwise supply any goods/substances to patients whilst they are using/accessing external areas
- Maintain the sense of calmness within the unit, particularly related to passive noise
- Deliver the same level of security (discouraging attempts to leave) without appearing overly oppressive
- Include areas of shade
- Provide spaces that comply with NHS GG&C’s policy on e-cigarettes
- Be easily maintained and accessible with any tools required to support maintenance

The unit will also require access to at least 2 pick-up/drop off spaces located immediately adjacent to the main entrance as a significant amount of patient transport is managed through a taxi service.

#### **4.3 The Proposed Facilities: Specialist Technical Infrastructure**

Although the specifics of the technical infrastructure required will vary according to the delivery systems identified, the following specific issues must be addressed:

- It should be possible to “lock down” the entire facility as/when required with all entry systems security controlled and remotely operable (Out of hours entry will be controlled through the single entry point in the central hub area)
- Security entry systems with video and audio intercoms should feature at all entrances
- It must be possible to activate a personal alarm anywhere within the scheduled areas in order to receive immediate assistance from more than one clinical area
- It must be possible for all patients/visitors to summon staff assistance from within all patient areas via an appropriate nurse-call system
- “Slow door systems” should be used where appropriate
- IT access should be available everywhere that a clinical interaction is likely to take place (wireless connectivity would be preferred for this functionality)

- Patient internet access should be provided at designated locations in day/activity spaces
- It should be possible for patients to control the lighting levels within individual bedrooms from within the room
- All patient areas should have “anti-ligature” fixtures, fitting and infrastructure as far as possible with any areas potentially compromising this directive identified to the Board during the design process for approval
- All doors in patient areas should be “anti-barricade”
- All windows in patient areas should be “anti-pass”

It is noted that there is NO requirement for any piped gas within the facility and that O2 will only feature on emergency trolleys/grab bags.

#### **4.4 The Proposed Facilities: Access, Door & Corridor Requirements**

**Patients and relatives will require to access the facility throughout an extended day as will other members of the clinical team; this poses particular challenges and should be considered within the design/location of the facility. The hospital-wide security policy should inform access control requirements for the areas out of hours.**

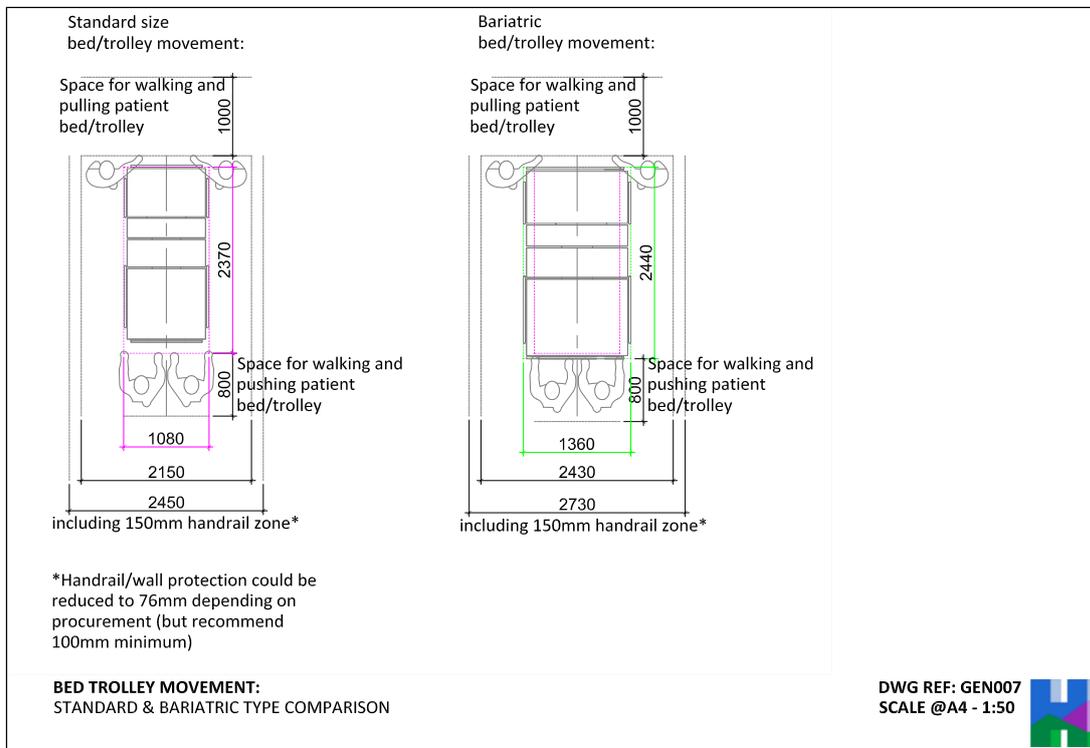
**In hours all patient and visitor access should be through a main entrance door that will be locked on the outside and only operable by staff with the appropriate access or remotely from inside the ward.**

**FM access will be via a separate dedicated FM entrance that will also be locked and require specific access privileges.**

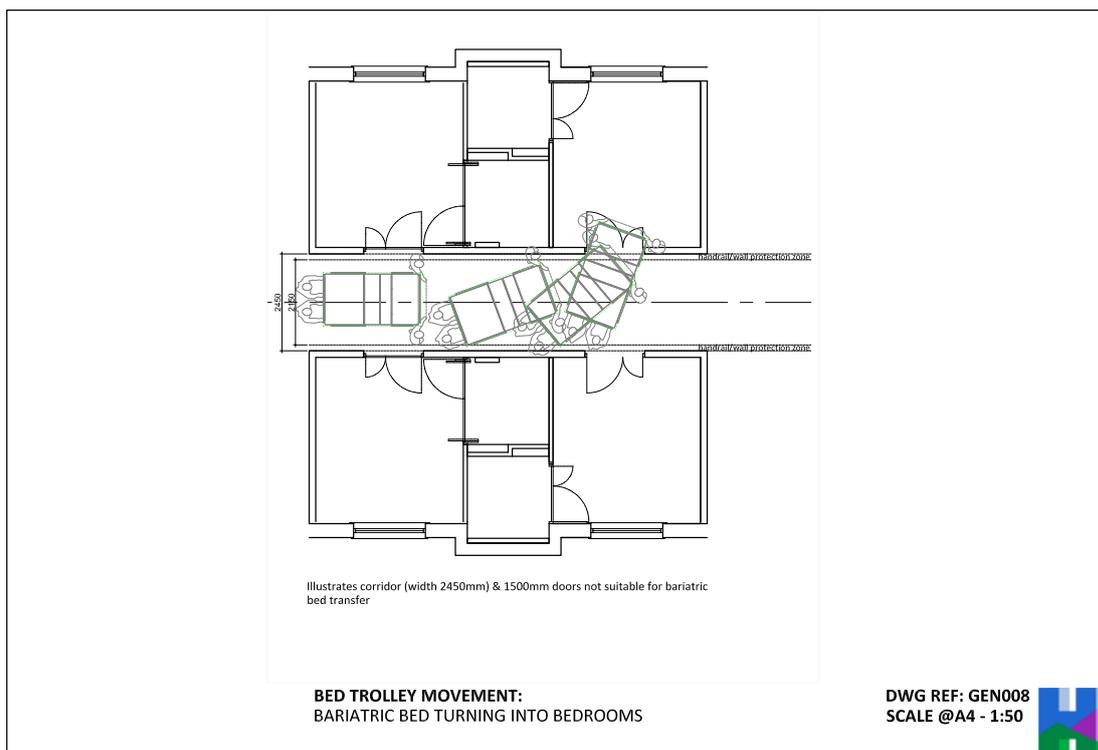
**Regarding corridor sizes:**

- **A minimum of 2.15m clear width is required in all clinical corridors - taking into account wall protection and any other obstacles. This will include all corridors in patient day/bedroom areas and access routes to/from that are required for bed supply/change**
- **Additional corridor width may be required to allow entry of a bariatric bed without requirement for disassembly into identified bariatric bedrooms as per Diag. 9 (Overleaf)**
- **A minimum of 1.5m clear width is required in all “staff only” corridors - taking into account wall protection and any other obstacles**
- **Anti-barricade penny-farthing type doors will be required on all bedrooms to allow access for infrequent bed movement (Primarily change/repair/replacement). These doors should be 1500mm in standard bedrooms and 1900mm in bariatric bedrooms although this larger door opening could be reduced if corridor/bed turning space allows) as per Diag. 10. (Overleaf)**
- **All corridors should be kept free of obstacles with essential items, e.g. Fire extinguishers fully recessed**

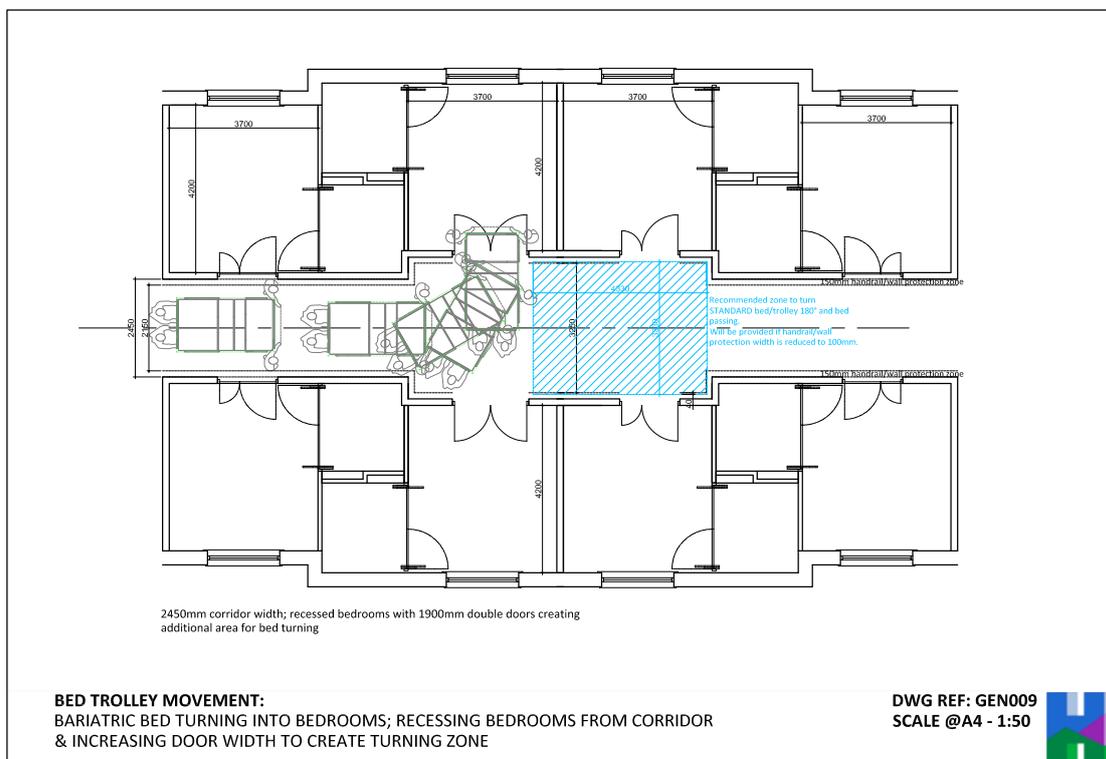
It is noted that the requirement for anti-barricade doors extends throughout the clinical areas. In addition, all doors will require to be lockable. If electronic systems are used (to minimise manual key requirements – which is desirable) these should be compatible with systems used on related facilities elsewhere on the site.



**Diag. 8. Standard & Bariatric Bed Dimensions For Comparison**



**Diag. 9. Entering A 1500mm Door Set With An Assembled Bariatric Bed**



**Diag. 10. Entering A 1900mm Door Set With An Assembled Bariatric Bed Making Use of Additional Corridor Width**

#### 4.5 The Proposed Facilities: Hours of Service & Work Patterns

The AAU ward will operate 24 hours/day, 365 days/year. AAU assessments will also take place 24 hours per day.

As administrative areas are unlikely to be staffed out with office hours the implications of this should also be considered within the design. Specifically this should allow for these areas to be locked when un-staffed with a separate provision for out of hours visitors to make contact with ward/clinical staff before being allowed access to clinical areas.

#### 4.6 The Proposed Facilities: Soft FM Considerations

All aspects of Hotel Services provision to the new facilities will be based on an integrated services model that will be provided via NHS Greater Glasgow & Clyde's Facilities. This includes the provision of:

- Core cleaning/housekeeping services
- Patient personal clothing laundry (where scheduled)
- Catering services including patient meal/dish wash
- Linen services
- Portering/messenger services
- Grounds maintenance
- Etc.

These services will be designed and delivered in conjunction with clinical service users in order to ensure that they complement direct patient care. Key considerations that will impact upon the effectiveness of these services that must be taken into consideration throughout the design process include:

- Overall site layout/configuration
- Defined internal and external FM delivery routes
- External landscaping
- Access in/out of facilities for FM service delivery
- Room layouts/relationships
- Environmental finishes

#### **4.6.1 Core Cleaning/Housekeeping Services**

Environmental Cleaning Services must be compliant with NQIS HAI Standards and the National Cleaning Services Specification, 2004 (revised 2009). Cleaning outcomes will be monitored and reported in line with the National Monitoring Framework (2006) requirements.

Specific infrastructure requirements include; the provision of dedicated Domestic Services Rooms (DSR's or "cleaner's rooms") within all areas as identified in SHFN 30; the provision of adequate separated waste storage areas; the provision of defined accessible entrance/exit routes for stores deliveries and waste collection.

#### **4.6.2 Patient's Personal Clothing Laundry**

Patients within the unit will primarily be responsible for undertaking their own laundry including washing; drying and ironing. A patient utility room has been scheduled for this purpose.

#### **4.6.3 Catering Services**

The NHSGGC Catering Strategy introduced a cook-freeze/cook-chill regeneration model in April 2010.

Specific infrastructure requirements that all new facilities will require in order to support this model include; the provision of a servery that is able to accommodate deep freeze and refrigerated storage, regeneration trolley, dry goods storage and dishwashing facilities; the provision of defined accessible entrance/exit routes for meal delivery/collection.

All catering services must be compliant with NQIS Food Fluid and Nutritional Care Standards.

#### **4.6.4 Linen Services**

Flat linen including sheets, pillowslips, blankets, counterpanes and towels will be provided via the central laundry facility at Hillingdon.

Required supply will be calculated to best match demand on the basis of local bed changing practice and bed occupancy projections/trends, however twice weekly deliveries are currently made to other wards on the site.

Specific infrastructure requirements include; storage areas for clean linen; storage areas for dirty linen; the provision of defined entrance/exit routes for clean/dirty linen.

It is noted that laundry-holding arrangements require to be accessible for the central laundry delivery/uplift service model and facilitate health and safety manual handling criteria.

#### **4.6.5 Porterage / Messenger Service**

The services provided are designed around specified/scheduled tasks that include; waste removal, food trolley delivery/collection; stores delivery; pharmacy delivery; specimen uplift; mail delivery/uplift; etc.

In so far as these activities reflect the requirements of those services already identified they present no further specific infrastructure requirements related to these facilities. They do however underline the requirement for clearly defined and accessible collection/delivery routes that are capable of supporting all service elements and accommodating established delivery methods, vehicles, delivery routes, etc.

#### **4.6.6 Grounds Maintenance**

Arrangements for season specific grounds maintenance and proactive winter pre gritting and snow clearance are already in place on the site that would be extended to include the new facilities.

Specific infrastructure requirements include; the provision of external winter grit storage bins; the provision of easily maintained external areas where these are provided, e.g. Gardens, where specified, should be "low maintenance".

It is noted that any "internal" garden model presents specific garden maintenance challenges and that consequently any such area should be manageable through the use of hand tools only that can be safely transported through the ward as required.

### **4.7 Specific Technical Requirements**

#### **4.7.1 Information Technology Requirements**

IT is seen as fundamental to the efficient functioning of the new unit and must be considered at every stage of the design process. In particular the use of IT to reduce workload, repetition and errors is key, as is its ability to support the safety & security of patients, staff and visitors.

Access to all relevant IT networks is essential for clinicians to carry out their duties. This access should extend to all clinical areas, office areas and treatment/interview rooms.

Specifically, in consideration of a move towards electronic health records, it should be assumed that an IT connection will be required everywhere that a clinical interaction may take place. i.e. everywhere that a patient and a clinician may need to interact and/or everywhere a clinician may need to interact with another clinician.

In addition, patients rely more and more on electronic contacts with other people via social networking, email etc. Whilst in hospital they may not have access to this facility. The provision of a public wireless network where they could connect their own devices is essential in helping them maintain their social contacts.

Many staff will be moving to new facilities from more traditional style wards (multi-bed bays) with technology seen as crucial to supporting their clinical observation of patients in a 100% single room model. Specifically, the IT network should therefore include an infrastructure for telemetry facilities for each ward, with the receiver at the main staff base and the capacity for telemetry to be used on any patient within the ward. Ideally telemetry information should also be capable of being relayed to staff throughout the ward in recognition of the desire to move away from a centralised nursing station.

Telemetry facilities shall enhance the case-specific monitoring of individual patients/groups who are confused, at risk of harm to themselves or others and/or who may try to leave their bedroom/ward unassisted and/or without permission.

Overall, IT networks should be flexible and assignable, thereby allowing decisions on future hardware requirements to be unencumbered by the need to have access to hard-wired connections – except as a back-up. They should also not restrict the Board's future procurement decisions unduly, meet all required technical specifications and be extendable to other parts of the facility at a later date if required.

#### **4.7.2 Acoustic Requirements**

SHTM 08-01 has been written for healthcare professionals to understand acoustic requirements and to help those involved in the development of healthcare facilities.

Acoustic design is fundamental to the quality of healthcare buildings as sound affects us both physiologically and psychologically through the introduction of unwanted noise and also, beneficially, e.g. the effect of music.

Good acoustic conditions improve patient privacy and dignity as well as promoting essential sleep patterns. Such conditions are key to healing. It also brings other benefits in terms of patient and staff comfort and morale, as well as improved efficiency and usability of equipment.

The relevant acoustic design parameters and the standards to be achieved are set down in SHTM 08-01 with the parameters most relevant to this unit:

- Noise levels in rooms – both from mechanical services within the building and from noise coming from outside. It is important to create an acoustic environment that allows rooms to be used for resting, sleeping, treatment, consultation and concentration. There are also statutory limits for noise levels that individuals can be exposed to whilst working; which should be adhered to;
- External noise levels – noise created by the healthcare building and operation shall not unduly affect those that live and work around it, including those utilising garden spaces;

- Sound insulation between rooms – allows rooms to exist side by side. Noisy activities shall not interfere with the requirements of adjacent rooms, and private conversations should not be overheard outside the room. It shall however be possible to hear raised voices/shouting from an adjacent room and this is seen as an important security/observation requirement.
- Impact sound insulation – prevents footfall noise of people walking over rooms interfering with the use of rooms below;
- Room acoustics – guidance is given on quantities of acoustically- absorbent material to provide a comfortable acoustic environment;
- Audio systems – announcements to patients, visitors and staff shall be intelligible;
- Vibration caused by plant, medical equipment and activities shall not affect the use of the building. Some medical equipment is sensitive to vibration, and so are people.

### 4.7.3 Security Considerations

Providing a safe and secure environment for patients, staff and visitors is integral to the provision of clinical care, with security determined to have three interdependent domains in the clinical context:

- Physical security: the internal and external perimeters, security mechanisms and technologies (e.g. manual/electronic lock systems, CCTV) and other physical barriers (e.g. airlocks) that exist in the unit and the service as a whole.
- Relational security: the understanding and use of knowledge about individual patients, the environment and the population dynamic
- Procedural security: the timely, correct and consistent application of effective operational procedures and policies

It is essential that the three domains are developed and managed jointly, can withstand physical or behavioural challenge and are used to inform decisions about individual/population care.

The balance in emphasis between each domain will change given the operational needs of the unit as a whole, or the needs of a particular patient and/or group of patients, and the setting in which the service is provided. The following comments describe some of the required security measures:

- Spaces where service users may not be continually supervised by staff (for example in bedrooms, toilets, day and activity areas should be designed, constructed and furnished to make self-harm or ligature as difficult as possible. All fixtures and fittings in these areas should be anti-ligature.
- Spaces that are expected to be continually supervised by staff shall be comfortable and therapeutic. They encourage service users to participate in life on the ward and actively engage with staff, but minimise the risk of self-harm or injury to others.
- Security measures and considerations shall also extend into (and be considered in the context of) external areas, corridors and communication spaces including the requirement for fences, walls and/or other barriers to prevent both ingress to and egress from secure areas.

The National Patient Safety Agency launched the Preventing Suicide Toolkit in

2008. The toolkit has a set of national standards regarding the acute mental health in-patient unit that shall be applied throughout this facility.

As noted elsewhere in this document, the requirements for all areas to be “anti-ligature” is emphasised once again as is the requirement for anti-barricade doors in all patient areas.

#### **4.7.4 Staff Call/Alert Requirements**

A comprehensive staff call system shall be required at all clinical service delivery locations (including but not restricted to bedrooms, en-suites, treatment areas and consultation spaces) as well as all other areas frequented by patients. The system must be addressable and capable of emitting both audible and/or visual warnings for the following situations:

- to summon a nurse (“Patient to Clinician”); and
- to highlight a medical/staff emergency (“Clinician to Clinician”)

Both visual and audible warnings should be sited in positions that enable the appropriate staff to respond to the exact location of the call both efficiently and effectively and shall ideally be relayed to individual staff members remotely. Warnings, both visible and audible, shall be specific to the type of emergency and must be consistent throughout all areas of the facilities. In the event of an emergency they shall also repeat to all wards within the same “cluster” to ensure that sufficient additional assistance is summoned efficiently.

There is a requirement to ensure that the staff call system meets the needs of all of the patient groups that may be required to use the facilities recognising that they may have cognitive problems or have difficulties with mobility. In addition, it must fully comply with the requirements of relevant SHTM's and SHBN's and interface fully with the information technology system to enable on-screen alerts at assignable locations.

In addition, from a clinical perspective:

- Security entry systems with video and audio intercoms shall feature at all entrances
- It must be possible to activate a personal alarm anywhere within the scheduled areas in order to receive immediate assistance from more than one clinical area
- It must be possible for all patients/visitors to summon staff assistance from within all patient areas via an appropriate nurse-call system
- “Slow door systems” shall be used where appropriate
- A safe should be provided in each bedroom for the personal use of patients

#### **4.7.5 Future Flexibility**

Throughout all of the planning, modelling and design work undertaken thus far, the key priority identified has always been future flexibility. Specifically, it is acknowledged that many variables exist that may have an impact on actual future facility requirements and, that as a result of this, facilities must be flexible enough to manage any patient group in the future with the minimal of cost/disruption/changes to contractual arrangements.

Future flexibility is therefore seen as a key design challenge with the following planning elements already factored in that shall be considered essential/non-negotiable unless more effective alternatives can be offered:

- 100% single rooms with en-suites
- An inter-locking en-suite model as far as possible – providing brighter, more flexible rooms that are a better shape than offered by the alternatives
- A slightly larger size of rooms than required by current SHPN guidance

In addition, a physical expansion strategy should be developed alongside any design that recognises building options for future development/growth/expansion of the facility or the co-location of an additional ward(s).

Future flexibility must remain at the forefront of all design activity and the facility MUST be able to demonstrate how function can change/develop over time with zero/minimum impact on services, costs and contracts.

NB. To ensure optimal future flexibility, the Board would ideally like to increase the size of all bedrooms and en-suites to 16m<sup>2</sup> and 5m<sup>2</sup> respectively. If this is realised, then all bedrooms should be inter-locking with accessible en-suites.

#### **4.8 Functional Relationships & Adjacencies**

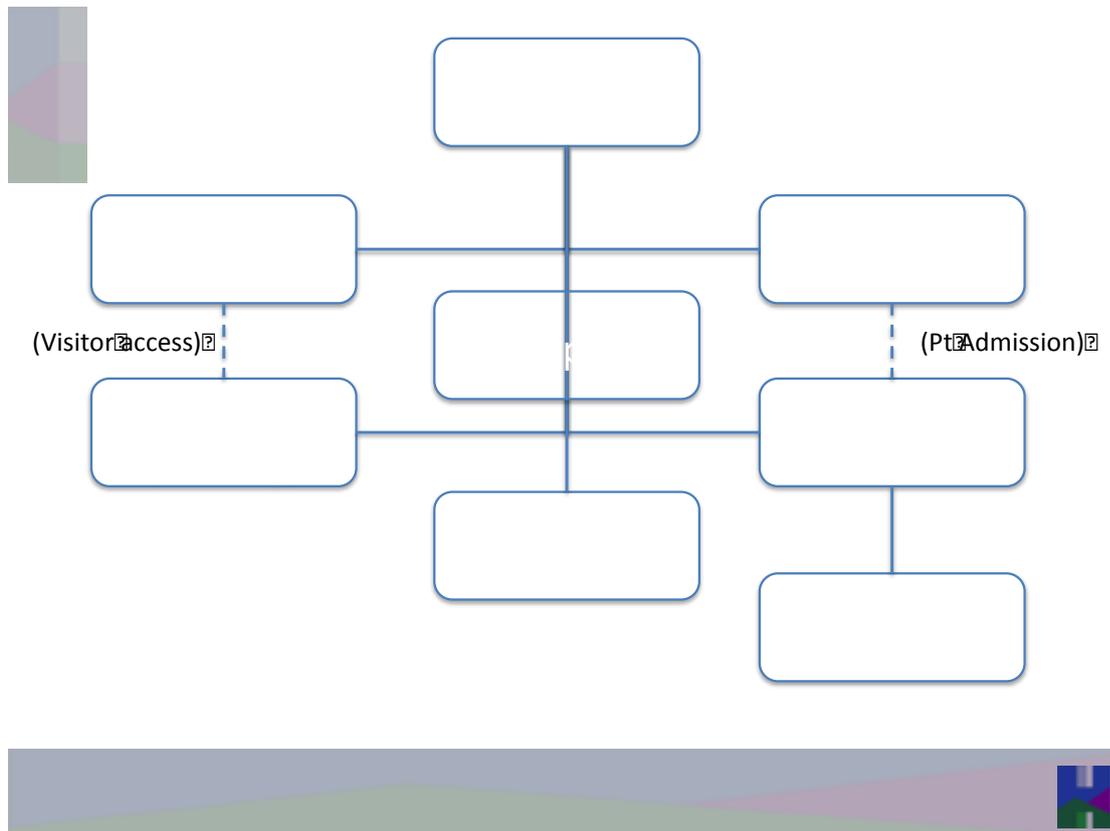
Throughout the planning process to date, the new development has been planned as an isolated facility on an identified site at Stobhill. Consequently only internal relationships and the impact of services not available locally have been considered.

Attention is however drawn to the links to other services identified throughout this document in consideration of the impact these will have on local infrastructure including pavements, cycle routes, parking, vehicular access and delivery routes.

#### **4.9 Patient/Process Flow Through The Proposed Facilities**

The physical environment should take into consideration the anticipated patient flows described elsewhere in this document, reflecting this in both the design and configuration of the scheduled areas.

A high-level overview of key patient/visitor flows is presented in Diag. 11. (Below).



**Diag. 11. Key Flows Within The AAU**

A patient vignette describing “A day in the life” of a patient in the AAU is also provided as Appendix A to this document. This is intended to help describe how the scheduled accommodation and associated spaces may be used in practice as a further aid to design development.

#### **4.10 Detailed Accommodation Requirements**

The following list of rooms is intended to provide an overview of unusual/non-standard rooms only, not all scheduled spaces. These descriptions are provided to aid design development only, especially relating to; functionality; shape; configuration; relationship to other spaces; and equipment requirements.

This information will be refined further through the on-going design development process and generation of appropriate room data sheets.

- **Servery/pantry**

A staff only pantry area where re-generation trolleys will be located and food served. This area will include a number of white goods including refrigerators and an industrial dishwasher. It will also have a sink with drainer and hand washbasin.

This area is likely to generate significant heat and it should ideally therefor be located on an external wall.

- **Dining Room**

A standard dining room area with tables and chairs immediately adjacent to the servery and ideally close to other day/activity spaces.

Dining areas will also double as activity areas when not being used for dining and will act as defined visiting areas in the AAU. Because of this, the AAU dining area should be as close to the main entrance as possible – to prevent visitors having to enter any further into the ward than is necessary.

- **Sitting Room (Day room)**

A pleasant sitting room environment, generally with a mixture of comfortable chairs and patient entertainment system, including television.

This room should have ready access to external spaces.

- **Quiet Room (10 persons)**

An alternative to the sitting room but still featuring comfortable chairs and furnishings. This room will not have a television.

- **Female Only Day Room (5 persons)**

A further alternative to the sitting room also featuring comfortable chairs and furnishings. This room will provide women with a separate safe sitting area and will include the same entertainment system and television as the main sitting room. As this is a Female only area it should be located such that women can access it from their bedrooms without having to go past the bedrooms of men or the main day spaces.

- **Activity Room**

A room intended to support a range of therapeutic interventions within the ward environment including group work, painting sessions, music therapy, etc.

This room will feature “hard” chairs and foldable tables and should include a sink with drainer and optimal cupboard space for material storage.

The room is associated with a small store cupboard that should be en-suite to it for the further storage of materials or the fold away tables when they are not required.

- **Patient Pantry**

This is essentially a small kitchen that is for the use of patients. It should feature a hot water boiler and include a fridge, dishwasher, sink with drainer and optimal high and low-level cupboard space and work surfaces.

- **Patient Utility**

This is essentially a patients laundry room and should feature 2 x washing machines, 2 x dryers and sink with drainer. It should have space for an ironing board and clothes airer along with storage for relevant materials.

- **Single Bedroom (13.5m<sup>2</sup>) & Associated En-suite (4m<sup>2</sup>)**

A single bedroom with associated en-suite. Any lockers or furniture required within this room should be fixed for safety.

En-suites should be “wet rooms” with shower, WC and HWB. It should be possible to lock en-suites to prevent them being used by patients.

It is important that en-suites effectively prevent the escape of water into bedrooms which is a common problem in existing areas due to poor drainage and insufficient wet-room floor run-off.

The preferred configuration for these smaller sized bedrooms/en-suites, as noted elsewhere in this document, is an alternative in-board model to the same design, configuration and specification as those bedrooms/en-suites in the recently completed AAU at Leverdale Hospital with the same eqpt. (Including personal safes for patient use in all bedrooms)

A key factor in bedroom design must be the ability to be able to observe all activity within the main bedroom area through either a window/vision panel/other means (without needing to enter the room) and, whilst it should be possible for clients to choose privacy this should not negate the option for clinical staff to override their decisions on occasion for safety reasons. I.e. open vision panels from outside the room using a key.

- **Single Bedroom (16m<sup>2</sup>) & Associated En-suite (5m<sup>2</sup>)**

A uniformly shaped bedroom with no intrusions that is able to deliver a minimum of 3.6m x 3.7m of clear space around the centrally located bed. These rooms are likely to include a CHWB and should have ready access to the associated en-suite through large doors that support dual nurse assistance through allowing the “borrowing of space” from the bedroom when required. Any lockers or furniture required within this room should be fixed for safety.

En-suites should be “wet rooms” with shower, WC and HWB that conform to HBN 00-02. It should be possible to lock en-suites to prevent them being used by patients.

The en-suite model for all 16m<sup>2</sup> bedrooms should be “inter-locking”.

As noted previously, it is important that en-suites effectively prevent the escape of water into bedrooms which is a common problem in existing areas due to poor drainage and insufficient wet-room floor run-off.

One 20m<sup>2</sup> bedroom with the AAU will be equipped for bariatric use.

The same point about visibility into the room, as noted previously, is equally valid here.

- **Interview Room**

A room with 3-4 comfortable seats and low table used for admission and assessment as well as a range of interview related activities including discussions with relatives and members of staff.

As noted elsewhere in this document the location of these rooms is critical to strike an appropriate balance between keeping staff close together when working in the ward and AAU whilst keeping ward patients and those being assessed for potential admission completely separate.

For reasons of safety and security, in line with Royal College of Psychiatry guidelines:

- Interview rooms should be situated close to main staff areas
- All interview rooms should have readily accessible panic buttons or an emergency call system
- The exit to all interview rooms should be unimpeded. Doors should not require a key to exit and should ideally open outwards
- Interview rooms should not be “cluttered” and should ideally have an inspection window to permit viewing when the room is occupied

- **Duty Room**

Effectively a small meeting/work room with desk and space for stand up briefings and other essential staff communication.

- **MDT Room**

Essentially a meeting room within the ward environment for local meetings, specifically extensive daily multi-disciplinary team review meetings.

- **Clean Utility/Treatment**

A large clean utility room that, as well as performing the normal role of a C/U, also includes a chair where patients can have blood samples taken, recordings done, receive medication, etc. This area should be contained by a curtain rail to provide additional privacy when required.

This room should be close to the interview rooms – in order to support the assessment function if required - and will also feature multiple high and low level cupboards, sink with drainer, CHWB, drug trolley storage and emergency equipment “grab bag”.

- **Patients Personal Belongings/Clothing Store**

This is an additional storage area that has been provided for the specific storage of patients belongings and clothing. It recognises that the service currently supports homeless patients.

This area should have optimal shelf storage to ensure that sufficient linear storage space is provided.

#### **4.11 Schedule of Accommodation**

The current S of A is attached as Appendix 3. This should be seen as the primary reference document regarding all required areas.

It is important to note that:

- Every opportunity to appropriately rationalise scheduled areas through design should be identified
- Accommodation should be as flexible as possible

Document ends.

## APPENDIX A

### A “Day In The Life” of A Patient in an Acute Admission Unit (AAU)

Mr A has been assessed by the community mental health team. From their assessment and referral on to the crisis resolution team it was decided that a short admission to an acute adult mental health ward may be necessary for a period of assessment and development of a collaborative treatment plan to aid his recovery process.

Mr A is consequently referred to the Acute Admissions Unit.

Mr A is accompanied to the AAU by his family; he is greeted at the entrance to the AAU by a registered nurse who is supporting the assessment process. The RN leads Mr A into a safe consulting room environment whilst asking his family to remain within the external waiting area. (This has access to toilets that are accessible using a key that is available from the ward).

The interview room that Mr A is taken to for the assessment process is also just off the main waiting area, at the entrance to – but not inside – the adjacent ward. It is anti-ligature with anti-barricade door and includes comfortable chairs and a low table. It is configured as per best practice guidelines with staff members always positioned closest to the door to aid exit and includes “staff-call” and emergency buzzers. These are essential to be able to quickly summon assistance from the adjacent ward if required.

A doctor and other members of the MDT are involved in the assessment process.

Following the assessment process and a brief MDT discussion and consultation with his family it is agreed that Mr A should be admitted to the unit. The reasons for this decision are shared with Mr A who agrees that it is the best course of action. Had Mr A disagreed with this decision, then he may have required to be detained in line with the Mental Health Act.

Following the decision to admit, the process of what happens next is explained to Mr A. He is then escorted to the adjacent ward and introduced to the person who has been allocated as his named nurse. This will ideally be the same nurse who supported his assessment prior to admission.

The RN and Doctor will speak with the family to obtain their views and any additional information required.

The admitting Medic/RN will also carry out a full physical examination in addition to the routine bloods etc. that have been taken by the named nurse.

The named nurse will orientate Mr A to the AAU ward environment and offer a clear explanation of what will happen during his time here – as well as an indication of how long this is likely to be and where he will go thereafter. The named nurse remains with Mr A and Family and gives an explanation as to the admission process, the aims of admission and offers information as to the ward and contact details.

Mr A's family are offered a tea or a coffee in the defined visiting area (ward dining room) and told that all visiting is restricted to this area while Mr A is escorted through to his room where his named nurse will go through the admission procedure with him using a hand-held electronic device, checking the details already held from his assessment and involvement with the CMHT. The Consultant Psychiatrist will have been alerted to Mr A's admission. A

clear treatment and management plan will be developed in collaboration with Mr A including risk assessment which will be discussed in his presence and his views sought.

Mr A will be orientated to the ward, shown his en-suite toilet/shower and how to access the free Wi-Fi should he wish to do so. The model of care based on therapeutic activity will be described to him and initial discussions entered into re his anticipated activity programme and the members of the wider Multi Disciplinary Team that he can expect to be involved in his care. He will be introduced to the other staff on shift and an explanation given as to how he can summon assistance from staff should he require to do so.

Mr A will be shown the personal laundry, the smaller quiet sitting room as well as the larger sitting room and the outside garden space surrounding the ward with tables/chairs and decorative planting and features.

He will also be shown those areas of the ward that he is not allowed to enter, including the Female only day area and some of the bedroom areas as well as being informed regarding any other advice that is specific to the environment or his treatment goals.

Mr A will be offered a meal as he has not had the chance to eat at home prior to admission and given the opportunity to make himself some tea and toast. His named nurse will describe the likely events of the next 24-48 hours and agree specific times that she will see Mr A on a one-to-one basis to further develop his therapeutic care plan and activity programme.

Mr A will be observed by nursing staff at the least restrictive level in a calm, therapeutic, safe and ligature free environment which will encourage and engage his journey of recovery. This will include engaging in various therapies including an art group, lifestyle sessions, individual psychosocial sessions, ADL assessment and relaxation within the designated activity rooms within and out with the ward and also in the therapeutic garden area.

Mr A is offered a choice of having his meals in a shared dining area or within his own room. Throughout the day he will have access to ward based area where he can prepare tea, coffee and cold drinks or access drinking water.

The staff who have come on shift for night shift introduce themselves to Mr A and again remind him of how he can request assistance from staff should he have any concerns and explain that they will look into his room from time-to-time overnight using the viewmatic panels on the window of his bedroom door to check on his well-being.

Mr A retires to the bed for the evening, feeling safe, calmer, hopeful for his future and assured that he has been listened to and his views are crucial in how he will be assisted to recover from the recent stresses and pressures in his life.

Within his room Mr A will have access to a control panel to adjust lighting to allow him to read when the lighting is dimmed at night to promote restful sleep.

He will remain within the AAU for the minimum amount of time required before being discharged to community based care or transferred to a more appropriate longer-term in-patient environment. Mr A will ideally not remain with the AAU area for any more than 7 days.



## APPENDIX

### Stobhill 20 Bed Elderly Unit

## High-Level Clinical Output Specification

Document History			
Version	Date	Author	Comments
1	16/5/16	N Sutherland (HG)	First full client issue draft as a component of a “whole facility” brief.
2	20/5/16	N Sutherland (HG)	Minor corrections to text and diagrams re: large bedroom sizes
3	7/6/16	N Sutherland (HG)	Page by page review & amendment by clinical team
4	2/8/16	N Sutherland (HG)	General update based on discussions to date

**Final Sign Off by Group:**

**Approved by:**

# 1. WHAT DO WE HAVE? (BASELINE SERVICES & FACILITIES)

## 1.2 COS Overview

This Clinical Output Specification (COS) relates to an element of NHSGG&C's existing elderly "continuing care" mental health service provision that is currently delivered through a contract with a private provider at Birdston Nursing Home, Birdston Road, Kirkintilloch.

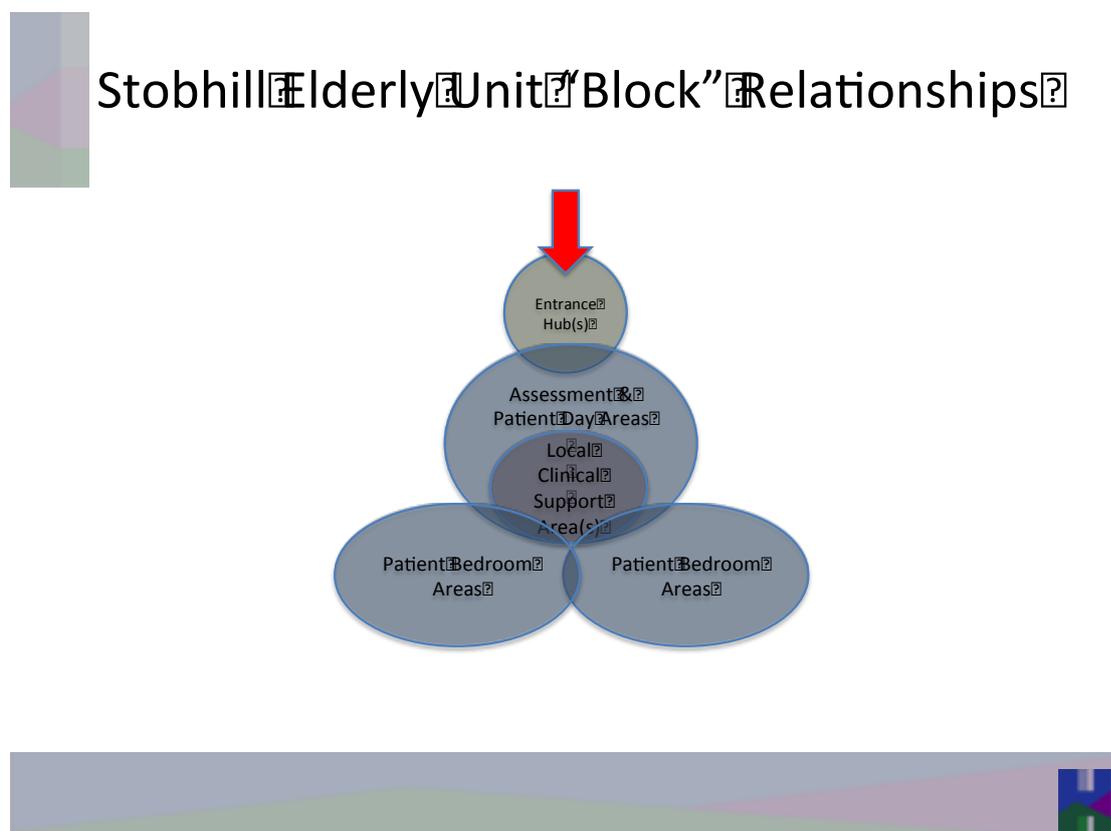
Specifically it describes the 20 bed ward to be located at Stobhill Hospital that will replace the Birdston complex for those patients who meet the definition of NHS "Hospital Based Complex Clinical Care" as defined in Scottish Govt. letter DL(2015)11.

The main areas within this development include:

- A small entrance hub
- Patient day areas
- Patient bedroom areas
- Local clinical support areas
- Staff and clinical support spaces shared with the adjacent AAU development (as identified in the relevant separate COS document)

These areas are as scheduled in the relevant project Schedule of Accommodation under the tabs entitled "Stobhill Elderly" and "Stobhill Shared".

The concept of how Elderly Unit areas relate to each other is shown in Diag. 1. (Below)



**Diag. 1. Stobhill Elderly Unit: Concept Layout**

This document should be read in conjunction with the COS relating to AAU provision on the same site and the brief “Introduction & Overview” document that describes how these two units (the Elderly unit described here and AAU) relate to each other.

### **1.3 Departmental Function & Overview**

The purpose of this unit will be to provide safe and effective care to the patient demographic currently accommodated at Birdston Nursing Home who meet the criteria for Hospital Based Complex Clinical Care.

Patients within the unit will predominantly be over the age of 65, although on occasions younger patients may be admitted with dementia.

People under the age of 16 will never be admitted to the unit.

### **1.3 Baseline Configuration & Physical Capacity**

Existing services are delivered at Birdston Care Home. This was reviewed and retrospectively scheduled as a component of the healthcare planning process. In summary it includes:

- A small reception/waiting area
- 60 x single bedrooms in 5 separate “wings” with en-suite WC and WHB but no showers. (Bedroom circa 12.8m<sup>2</sup> and en-suite circa 2.8m<sup>2</sup>)
- Dining areas
- Dayrooms
- Kitchen
- Laundry
- Admin & additional clinical support areas

It is important to note that, although the unit includes 60 beds overall, only 30 of these are commissioned by NHSGG&C. 25 of these beds occupied when the review was undertaken.

### **1.4 Assessment & Admission Criteria**

Everyone admitted to the unit will have come through an extensive assessment process that is likely to have involved multiple previous admissions to acute facilities, multidisciplinary team assessment in an Acute Elderly Medical Ward and a rigorous assessment of on-going clinical needs.

A key element of admission criteria to the unit will be the extensively documented agreement - in conjunction with relatives, carers and significant others - that a patient meets all of the criteria for “Hospital Based Complex Care” as identified in relevant national and local guidance and that consequently their longer-term care can “only be managed appropriately within a hospital environment”.

### **1.5 Baseline Activity Metrics, Utilisation & Performance**

This data has not been provided or reviewed at this time.

### **1.6 Staffing**

It is anticipated that staff supporting the unit will include:

- Visiting consultants
- Visiting therapy and support staff (Social work, volunteers, etc.)
- A maximum of 8 nursing staff per shift (Including trained staff and students)

## 1.7 Negative Elements of Baseline Configuration/Risks

Negative elements associated with existing service provision and the facilities used to deliver this (in no particular order) include:

- The service is currently commissioned from a private provider, with a consequential revenue cost
- The service still supports an NHS Continuing Care philosophy – which must be replaced with a HBCCC based philosophy
- Existing facilities are a “best fit” in an existing care home
- Current construction looks/feels a little too domestic, e.g. floors creak when walking on them
- Significant space is wasted within the area currently commissioned as it is too distal to main day areas
- Bedrooms are too small at circa. 12.8m<sup>2</sup> and do not therefore allow sufficient clear space around the bed area to support the clinical management of this complex patient group. (Minimum 3.6 x 3.7m recommended)
- Existing en-suites do not include showers and are too small to be used by the patient group in question. As a result most are not used, rendering them superfluous.
- There are no vision panels in doors or walls – bedroom doors have to be opened to view inside which can cause distress/disturb sleeping patient
- Peripheral day areas associated with bedroom wings are not used as they are too remote for this patient group who require constant supervision
- Although it incorporates “dementia friendly” elements, the unit lacks the specific value adding elements associated with dementia friendly design for this complex patient group

These elements must all be addressed through updated processes and the new facilities provided.

## 1.8 Positive Elements of Baseline Configuration/Opportunities

Positive elements associated with existing service provision and the facilities used to deliver this (in no particular order) include that:

- Services are provided by dedicated and highly trained staff
- Staff based within the unit are supported by visits from key professionals such as physiotherapists
- The facility is “bright and airy”
- Patients have access to external garden areas that also include identified “wander routes”
- The facility includes a clear separate FM entrance that keeps FM/goods delivery separate from clinical/patient areas
- The unit is 100% single rooms
- There are a number of large day/activity areas located central that provide the required social, dining and activity space whilst also allowing patient separation as/when required

These positive elements should all be retained, irrespective of how processes change, and must be deliverable by the new facilities provided. Specific opportunities for overall service change identified that will be taken forward by the service include those related to:

- Reviewing assessment processes and aligning to the principles and ethos of HBCCC
- Reviewing the balance between NHS bed requirements and commissioned services appropriately
- Realising the objectives of new HBCCC guidance. Specifically to:
  - Promote a consistent basis for the provision of Hospital Based Complex Clinical Care
  - Provide simplification and transparency to the current system
  - Maintain clinical decision making as part of a multi-disciplinary process

- Ensure entitlement is based on the main eligibility question “can this individual’s care needs be properly met in any setting other than a hospital?”
  - Ensure a formal record is kept of each step of the decision process.
  - Ensure that patients, their families and their carers have access to relevant and understandable information (particularly if the individual does not need to be in hospital but rather an alternative setting in the community).
- Supporting strategic planning that recognises the specific role of the Stobhill Elderly Unit and how it relates to the other facilities and services that support/are supported by it

## 2. WHAT DO WE WANT? (TO REALISE PROJECT & WIDER OBJECTIVES)

### 2.1 Philosophy of Care

The philosophy of care within the Stobhill Elderly Unit will be explicitly user focused and supported by a robust systematic approach to clinical governance.

The objective of clinical services will be to provide a range of therapeutic interventions which are planned, co-ordinated and provided from multi-disciplinary and user/carer perspective, based on comprehensive on-going assessment. A key aim will be to realise the objectives of new HBCCC guidance. Specifically to:

- Promote a consistent basis for the provision of Hospital Based Complex Clinical Care
- Provide simplification and transparency to the current system
- Maintain clinical decision making as part of a multi-disciplinary process
- Ensure entitlement is based on the main eligibility question “can this individual’s care needs be properly met in any setting other than a hospital?”
- Ensure a formal record is kept of each step of the decision process
- Ensure that patients, their families and their carers have access to relevant and understandable information (particularly if the individual does not need to be in hospital but rather an alternative setting in the community)

All interventions undertaken will be evidenced-based or based on national consensus good practice and will be under-pinned by national standards and clinical guidelines.

In addition the unit will aspire to be a “specialist dementia unit demonstrator site” as defined in the Quality and Excellence in Specialist Dementia Care (QESDC) improvement programme:

- Able to demonstrate compelling reasons why their unit should be chosen as a demonstrator site from an operational and physical perspective;
- With commitment and support for this work at all levels of the organisation, including executive level support, operational management and those working at the front line in the specialist dementia unit;
- With identified practical support from within the locality including access to special dedicated staff;
- Committed to the meaningful involvement of patients and carers throughout this work; and demonstrating a
- Willingness to share the learning from this work with other units.

### 2.2 Model of Care

In future, only patients who meet the criteria for HBCCC will remain in an NHS hospital environment. All other patients will be cared for in the environment that best meets their specific continually assessed needs. This is likely to include acute mental health facilities, elderly in-patient mental health facilities, care homes, community facilities or at “home” with appropriate support.

This will mean considerably fewer patients remaining within NHS facilities long-term and the end of traditional NHS “continuing care” in line with HBCCC principles.

Whilst the number of patients who meet the criteria for HBCCC is likely to be reduced, at least initially – before any demographic change is realised – those patients requiring HBCCC will represent the most challenging patients currently receiving NHS continuing care. These patients are likely to have complex physical and mental health needs, will be prone to displaying extremely challenging behaviours and will consequently require sustained, comprehensive NHS investment to support.

Within NHS GG&C, this challenging patient group will be cared for in the Elderly Unit at Stobhill described here in. This unit will:

- Be the main facility providing Hospital Based Complex Clinical Care
- Support assessment and clinical decision making on HBCCC as part of the multi-disciplinary process, including supporting patient assessment and evaluation
- Act as the local “specialist dementia unit” as noted previously

### 2.3 The Operational Environment

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The operational environment will seek to implement this philosophy of care through:

- Involving patients, families and significant others as active participants in their care, contributing in a meaningful way to treatment decisions;
- Providing access to information on the service and their care package which will promote the greatest degree of self-determination, informed choice and equity;
- Respecting the individual and recognising their full rights and responsibilities as a citizen;
- Presenting a culture of support in which staff actively promote a sense of hope, well-being and self-esteem in their patients;
- Acknowledging that therapeutic interventions, social and recreational activities all play a part in the overall patient experience;
- Validating and affirming each patient's individuality supported by a structure of person-centred care;
- Focusing on the principles of HBCCC, including continual assessment to ensure that hospital based care remains the only alternative;
- Providing innovative, evidence based treatment and care to individuals and their families underpinned by a strong values base;
- Striving to be recognised as a centre of excellence for dementia care;
- Identifying, containing and controlling potentially dangerous behaviours through consistent staff practices that assist patients to moderate their behaviour and develop internal coping and control skills;
- Providing security and observation at the least restrictive level, appropriate to the patients needs;
- Aligning it with relevant national drivers for example: QIS standards, etc.

#### **2.4 The Physical Environment (Key Design Statement Elements)**

The physical environment created should seek to support this philosophy and model of care through providing fixed assets that are capable of supporting its operationalisation. Specifically through:

- Recognising strategic context, the specific role of the Stobhill Elderly Unit and how it relates to the other facilities and services that support/are supported by it;
- Delivering the optimal configuration of scheduled accommodation on a single level without ramps/steps;
- Recognising the importance of ready access to safe external areas that include defined "wander routes" and areas of shade;
- Ensuring the safety and security of staff, patients and visitors alike;
- Creating a "dementia friendly" environment that supports the long term care needs of an extremely complex elderly client group and their families;
- Providing an environment that is "calming";
- Appropriately balancing the need for safety and security with the provision of a therapeutic environment;
- Minimising observational "black spots";
- Recognising that the therapeutic environment and ambience of the ward is a crucial element in how service users experience their in-patient stay and how they benefit from it;
- Meeting all required standards and guidelines regarding the built environment;
- Ensuring that the new build component "works" optimally in the context of the existing estate and defined areas shared with the proposed AAU and balance of the site

#### **2.5 Key planning guidance, SHPN's technical guidance, whole hospital policies, etc.**

Developing the required Elderly Unit at Stobhill is consistent with NHSGG&C's mental health services strategy and quality strategy as well as NHS Scotland's guidance on Hospital Based Complex Clinical Care.

Attention is also drawn to the specific design guidance contained in the following documents:

- **SHPN 35 Accommodation for People With Mental Illness (Part 1)**
- **SHPN 35 Accommodation for People With Mental Illness (Part 2)**
- **SHPN 04 Adult In-patient Facilities**
- **Do The Right Thing: How To Judge A Good Ward (2011) The Royal College of Psychiatrists**
- **HBN 03-01 (Which has the status of “best practice” guidance in NHS Scotland)**
- **Good Practice In the Design Of Homes and Living Spaces for People With Dementia and Sight Loss (University of Stirling dementia Centre)**  
[http://dementia.stir.ac.uk/system/files/filedepot/12/good\\_practice\\_in\\_the\\_design\\_of\\_homes\\_and\\_living\\_spaces\\_for\\_people\\_living\\_with\\_dementia\\_and\\_sight\\_loss\\_final.pdf](http://dementia.stir.ac.uk/system/files/filedepot/12/good_practice_in_the_design_of_homes_and_living_spaces_for_people_living_with_dementia_and_sight_loss_final.pdf)

The relevant schedule of accommodation has been developed based on this guidance with modifications as appropriate to reflect local issues and best current practice. It should be regarded as the primary document for all indications of activity space requirements associated with the accommodation briefed.

## **2.6 Environmental and Services Requirements**

Environmental and service requirements should correspond to the standards described in the relevant technical documentation related to this project (SHPN's and SHTM's) in particular SHPN 35 (Part 1 and 2) regarding design/configuration issues.

### **3. WHAT IS CHANGING? (THAT WE NEED TO CONSIDER)**

#### **3.1 Planning Assumptions: Assumed changes in need/demand**

Although no data has been supplied or reviewed in this regard by HGHCP, main anticipated changes in future will arise as a result of a range of “future impact factors”. These are likely to fall under a number of categories that include:

- Demographic change elements.
- Clinical performance elements
- Corporate performance elements
- Financial performance elements and targets

Demographic elements include population and epidemiological factors that are wholly out with the influence of the NHS Board. They can be considered to reflect a shifting baseline over time that other changes/inputs will deviate from.

Clinical performance elements represent the potential impact of changes in clinical practice/re-design on future capacity requirements.

Corporate performance elements represent potential changes/improvements in patient management that could have an immediate and lasting effect on capacity requirements if implemented and managed appropriately.

Financial performance elements and targets reflect the frequent requirement to set specific targets that push services and practice closer to where clinical negotiation and modelling may indicate they could be. They also reflect the potential impact of improved “whole system” financial and service planning along with clarity around the requirement and options for resource transfer and service “buy in”.

Specific examples of “future impact factors” discussed informally thus far in the context of this development include:

- Increasing elderly population (Demographic)
- The move to HBCCC (Clinical performance)
- Investment in new facilities (Clinical performance)
- Increase in acute admissions with co-morbid addictions problems (Demographic)
- Increase in patients displaying more challenging behaviours (Demographic)
- The long-term impact of “legal highs” (Demographic)
- Reduced length of stay (Corporate performance)
- Increased bed occupancy (Corporate performance)

#### **3.2 Planning Assumptions: Assumed changes in delivery/supply**

In the absence of data, no assumptions have been made regarding changes to delivery or supply capacity.

#### **3.3 Anticipated Impact On Global Physical Capacity Requirements**

In the absence of data it is not possible/appropriate to predict the anticipated impact on global (whole system) capacity of this development.

#### **3.4 Anticipated Impact On Project-Specific Physical Capacity Requirements**

In the absence of access to data it should be assumed that all project-specific physical capacity requirements are as stated.

#### **3.5 Any Other Longer Term Considerations Regarding Future Services/Activity**

N/K

## **4. WHAT DO WE THEREFORE REQUIRE?**

### **4.1 The Proposed Facilities: Overview**

All of the accommodation within the proposed facilities is as specified in the attached Schedule of Accommodation which should be considered as the primary reference document relating to areas required. (Appendix 3)

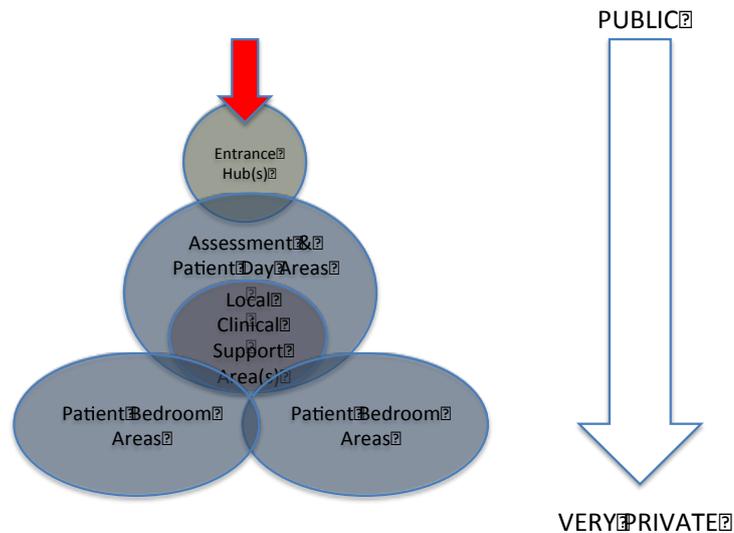
In reflection of the requirements of clients, service users and the services themselves the care environment should, in overview:

- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Be capable of meeting dementia design standards;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- Create a calm and restful atmosphere throughout and an environment which is non-threatening;
- Optimise staff observation/monitoring of patients at all times (Specifically, minimise the opportunities for patients to engage in activities/behaviours that may place themselves/others at harm/risk whilst out with the direct vision/supervision of staff)
- Afford no undue separation of staff from patients;
- Provide opportunities for exercise, leisure and education;
- Include easily maintained/accessed outdoor spaces;
- Be sensitive to the needs of physically disabled patients, visitors and staff;
- Be “operationally flexible” enough (on a day to day basis) to:
  - meet the changing care needs of individuals throughout their episode of care, e.g. Through the movement/removal of furniture, ability to “lock off en-suites”, control observation levels and movement, etc.
  - provide an equality sensitive service, e.g. Through identifying gender-specific areas with “gender-flexible” spaces between to support a changing gender-mix
  - Ensure that all accommodation allows conversations at normal levels to take place in privacy but also allows raised voices/shouting to be overheard from adjacent rooms/areas;
  - Provide sufficient telephone access and IT infrastructure for patients and staff. (Specifically, in consideration of a move towards electronic health records, it should be assumed that an IT connection will be required everywhere that a clinical interaction may take place)
  - Consider the needs of staff and the impact that the working environment has on job satisfaction, recruitment and retention.
  - Address gender, cultural and religious diversity whilst meeting the needs of relatives, carers and visitors
  - Conform to the requirements of the Disability Discrimination Act 2005 including wheelchair access into rooms, provision for those who have hearing or visual impairments and for obese patients.

### **4.2 The Proposed Facilities: Configuration**

The ward should be laid out so that a clear progression can be identified from public areas (outside) to increasingly private areas upon entering the facility. Key “zones” within the ward are as identified in the relevant “bubbles” in Diag. 2. (Overleaf)

# Stobhill Elderly Unit “Block” Relationships



**Diag. 2. Stobhill Elderly Unit: Block Relationships & Flow from Public to Private Space**

These key “zones” are:

- The entrance hub
- Patient day areas
- Patient bedroom areas
- Local clinical support areas
- External (garden) areas

## 4.2.1 The Entrance Hub

The entrance hub includes only minimal scheduled areas. It is intended to act purely as an entrance/airlock to the ward although it will also contain a single disabled toilet for visitor use. As it is in an “uncontrolled area” this toilet will be lockable and accessible only through the use of a key/code or some other secure means only accessible in agreement with ward staff.

No “waiting area” has been included external to the ward area due to the “open visiting” policy adopted and agreement that consequently there should never be a requirement for anyone to wait outside the unit.

A key principle of the unit will be that, whilst visitors will be allowed to see patients in their bedrooms, it should not be necessary for anyone to travel any further into the ward than is required.

The entrance hub will be connected to the ward by a locked door with entry buzzer and video link that it will be possible to open remotely.

#### **4.2.2 Patient Day Areas**

Patient day areas should be close to the entrance of the unit and distal to the bedrooms both to support appropriate social interaction and aid the operational control/observation of access to/from bedrooms and hierarchy of zones that reflects increasing levels of privacy with travel into the unit.

These areas include a mixture of sitting, dining and quiet areas intended to provide alternative options for daytime activities and patient separation where required. They also include disabled WC's to prevent patients from having to return/be taken back to bedrooms to use the toilet. It is important that these toilets can be seen from day areas (in line with dementia design guidance) but do not open directly on to it for reasons of modesty and odour management.

Given the patient group who will be using the unit day spaces should not be widely distributed.

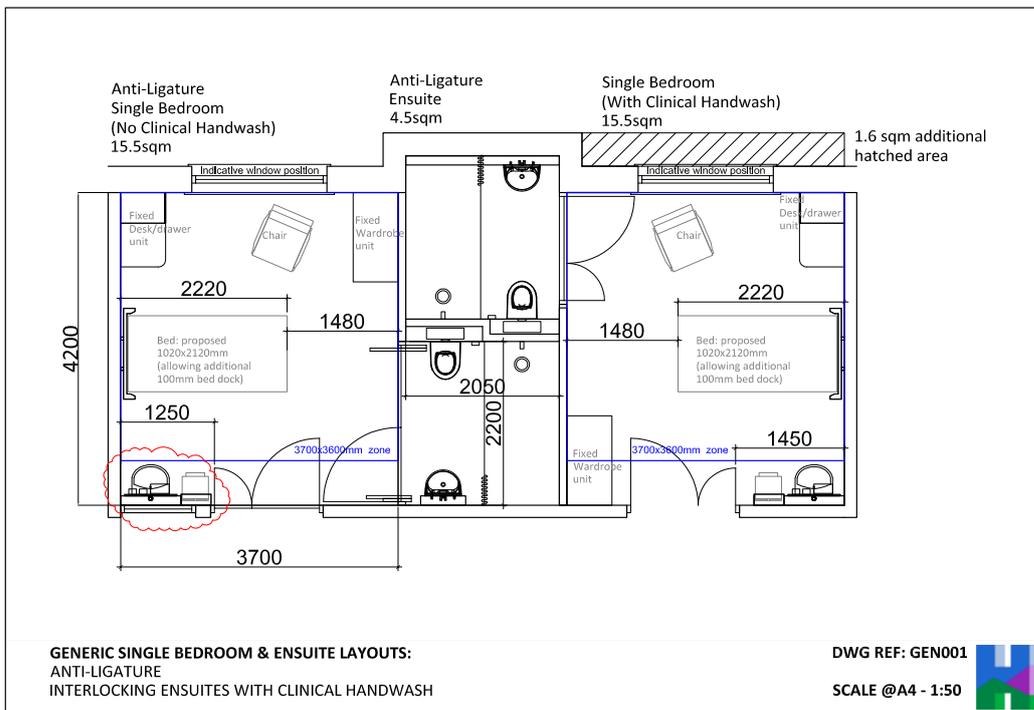
#### **4.2.3 Patient Bedroom Areas**

The Board notes that SHPN 35 is now over 15 years old and does not reflect the requirements for modern healthcare provision within acute mental health areas and affords NO future flexibility around change of use. Specifically, they note that the 11.5m<sup>2</sup> bedrooms specified in SHPN 35:

- Do not meet the minimum clear space around beds required to support any physical intervention
- Would therefore only ever be suitable for physically able patients groups
- Are incapable of supporting the preferred interlocking en-suite model utilising the HBN 00-02 model
- Are not therefore capable of supporting the long-term demographic and service delivery changes anticipated – and certainly not of meeting the needs of this particularly challenging patient group.

Whilst SHPN 04, which reflects a minimum requirement for 19m<sup>2</sup> (not including en-suite facilities), is capable of meeting all of these requirements this is deemed excessive – with 16m<sup>2</sup> agreed as the optimum area required to deliver appropriate "clear space" around beds whilst affording options for future change of use and the inclusion of a Clinical Wash Hand Basin if/where required in the majority of bedrooms.

Consequently, the elderly ward will include 20 beds in single rooms at 16m<sup>2</sup>. All rooms should be planned with en-suite showers, WC's and Wash Hand Basins as per the Schedule of Accommodation (S of A). All en-suites have been scheduled at 5m<sup>2</sup> to comply with HBN 00-02 in order to ensure dual assistance can be provided in all areas when incorporated in the preferred "inter-locking" en-suite bedroom model. (See Diag. 3, overleaf)



**Diag. 3. The Inter-locking Bedroom Model: For Illustrative Purposes Only**

The inter-locking bedroom model is mandated within the Elderly Unit as:

- The position of en-suites must not compromise the observation of bedrooms
- The physical needs of patients demands that all scheduled bedroom area be available to support clinical activity
- Bedrooms should be optimally shaped and ensure a minimum of 3.6m x 3.7m uninterrupted space around beds for patient management as per relevant guidance
- En-suites should all be sufficiently sized and configured so as to be able to provide “dual assistance” when required

In addition:

- 1 bedroom within the unit should be identified as being suitable for bariatric use with the necessary fixed equipment.

Overall, bedrooms within the ward should be configured in 2 or more smaller identifiable “groupings” to support the appropriate separation of patient groups by gender or on a condition-specific basis as/when required and recognise the comments made by the Royal College of Psychiatrists regarding optimal unit sizes. (Do The Right Thing: How To Judge A Good Ward (2011) The Royal College of Psychiatrists)

In addition, all bedrooms should have natural light via a large window and ideally a pleasant view to external soft landscaped areas or attractive spaces beyond.

Where ward design requires bedroom views to overlook courtyards, the courtyard dimensions and shape must be taken into consideration in order to optimise privacy.

Specifically, it should not be possible to look directly into bedrooms from outside areas.

Consideration should also be given as to how good passive observation levels can be achieved from corridors and staff bases.

As regards environmental control, it is important that all services (including power and water) can be isolated from outside bedrooms.

#### **4.2.4 Local Clinical Support Areas**

Although frequently used support rooms, such as dirty and clean utilities and disposal holds should be as near as possible to the clinical areas served, in general clinical support space may be used to create “buffer zones” between other scheduled spaces as required or to enhance overall design and functionality.

The Charge Nurses office and other staff areas (such as the duty room) should be close to day spaces and the entrance to wards to maximise observational opportunities, support appropriate access control and ensure that staff are never far from patient areas – even when engaged in non-direct activities, e.g. Meetings, administration, etc.

Areas requiring FM access/servicing such as the clean utility, dirty utility, linen room, etc.) should be close to the defined FM entrance to reduce the distances travelled with fresh stores/dirty items. In addition defined clean/dirty “routes” should be identified that minimise all travel distances whilst maintaining an appropriate separation between “clean” and “dirty” goods/services.

#### **4.2.5 External (Garden) Areas**

Therapeutic external space that is readily accessible from shared day spaces is an essential element of the overall unit. This external space must:

- Maintain the same level of patient safety as within internal areas, e.g. Anti-ligature
- Maintain the sense of calmness within the unit, particularly related to passive noise
- Deliver the same level of passive security (discouraging attempts to leave) without appearing overly oppressive
- Include areas of shade
- Deliver safe “wander routes” as described in the relevant dementia friendly guidance
- Provide spaces that comply with NHS GG&C’s policy on e-cigarettes
- Be easily maintained and accessible with any tools required to support maintenance

The following text is therefore provided primarily to support design considerations (rather than challenge in any way the scheduled spaces)

### **4.3 The Proposed Facilities: Specialist Technical Infrastructure**

Although the specifics of the technical infrastructure required will vary according to the delivery systems identified, the following specific issues must be addressed:

- It should be possible to “lock down” the entire facility as/when required with all entry systems security controlled and remotely operable (Out of hours entry will be controlled through the single entry point in the central hub area)
- Security entry systems with video and audio intercoms should feature at all entrances

- It must be possible to activate a personal alarm anywhere within the scheduled areas in order to receive immediate assistance from more than one clinical area
- It must be possible for all patients/visitors to summon staff assistance from within all patient areas via an appropriate nurse-call system
- “Slow door systems” should be used where appropriate
- IT access should be available everywhere that a clinical interaction is likely to take place (wireless connectivity would be preferred for this functionality)
- Patient internet access should be provided at designated locations in day/activity spaces
- It should be possible for patients to control the lighting levels within individual bedrooms from within the room
- All patient areas should have “anti-ligature” fixtures, fitting and infrastructure as far as possible with any areas potentially compromising this directive identified to the Board during the design process for approval
- All doors in patient areas should be “anti-barricade”
- All windows in patient areas should be “anti-pass”

It is noted that there is NO requirement for any piped gas within the facility and that O2 will only feature on emergency trolleys/grab bags.

#### **4.4 The Proposed Facilities: Access, Door & Corridor Requirements**

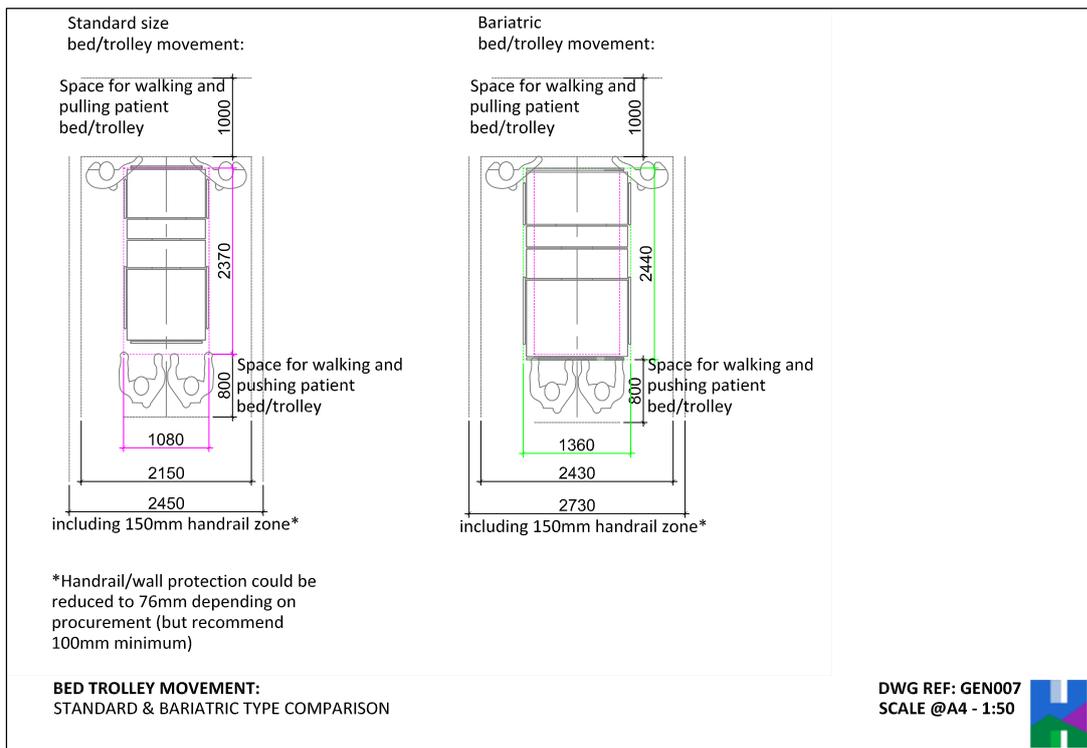
Patients and relatives will require to access the facility throughout an extended day as will other members of the clinical team; this poses particular challenges and should be considered within the design/location of the facility. The hospital-wide security policy should inform access control requirements for the areas out of hours.

In hours all patient and visitor access should be through a main entrance door that will be locked on the outside and only operable by staff with the appropriate access or remotely from inside the ward.

FM access will be via a separate dedicated FM entrance that will also be locked and require specific access privileges.

Regarding corridor sizes:

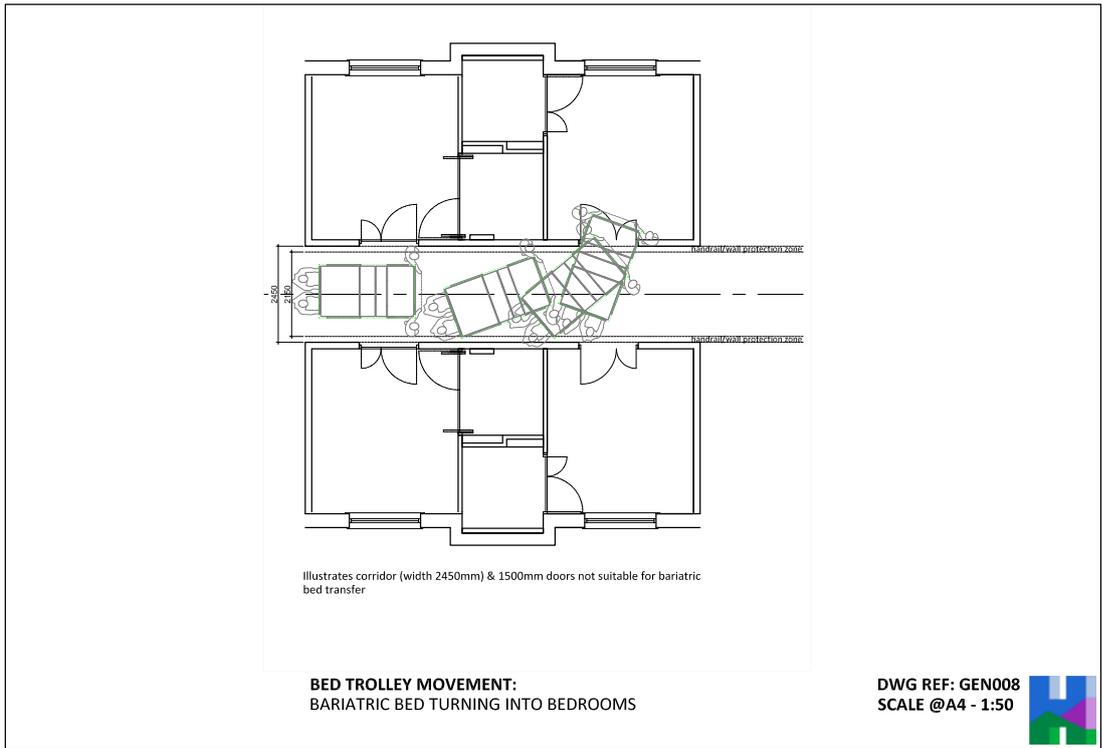
- A minimum of 2.15m clear width is required in all clinical corridors - taking into account wall protection and any other obstacles. This will include all corridors in patient day/bedroom areas and access routes to/from that are required for bed supply/change



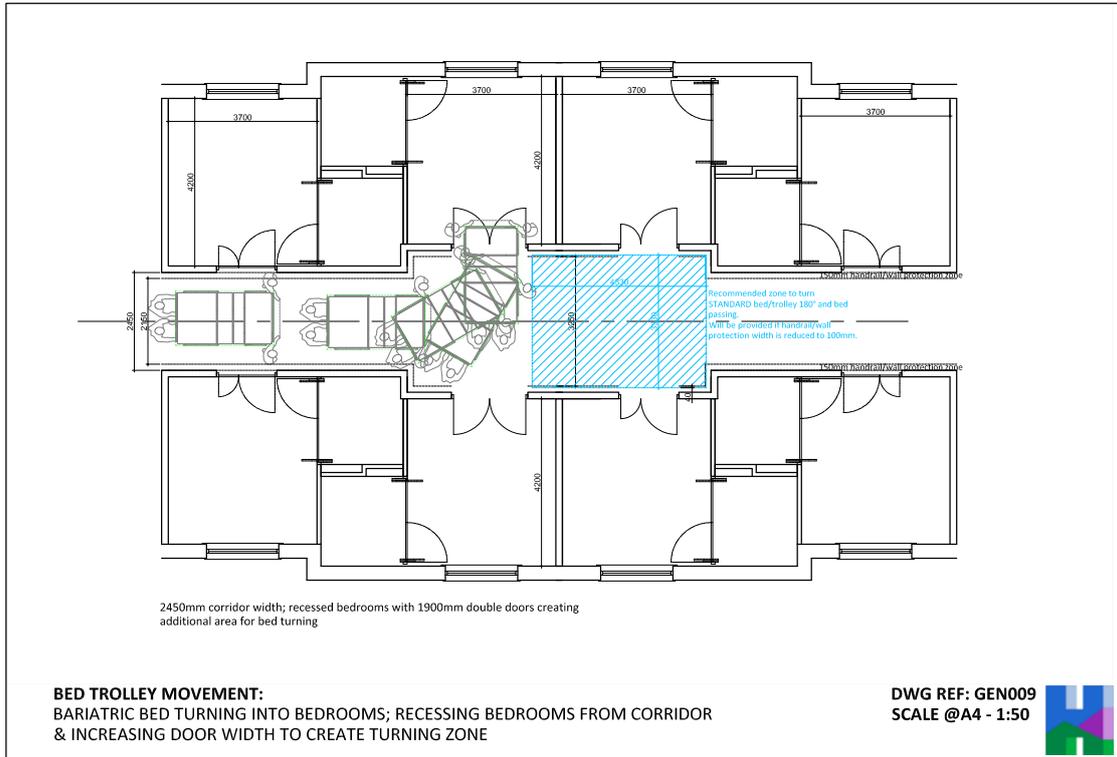
**Diag. 4. Standard & Bariatric Bed Dimensions For Comparison**

- Additional corridor width may be required to allow entry of a bariatric bed without requirement for disassembly into identified bariatric bedrooms as per Diag. 5 (Overleaf)
- A minimum of 1.5m clear width is required in all “staff only” corridors - taking into account wall protection and any other obstacles
- Anti-barricade penny-farthing type doors will be required on all bedrooms to allow access for infrequent bed movement (Primarily change/repair/replacement). These doors should be 1500mm in standard bedrooms and 1900mm in bariatric bedrooms although this larger door opening could be reduced if corridor/bed turning space allows) as per Diag. 6. (Overleaf)
- All corridors should be kept free of obstacles with essential items, e.g. Fire extinguishers fully recessed

It is noted that the requirement for anti-barricade doors extends throughout the clinical areas. In addition, all doors will require to be lockable. If electronic systems are used (to minimise manual key requirements – which is desirable) these should be compatible with systems used on related facilities elsewhere on the site.



**Diag. 5. Entering A 1500mm Door Set With An Assembled Bariatric Bed**



**Diag. 6. Entering A 1900mm Door Set With An Assembled Bariatric Bed Making Use of Additional Corridor Width**

#### **4.5 The Proposed Facilities: Hours of Service & Work Patterns**

The elderly ward will operate 24 hours/day, 365 days/year.

Although the majority of activity will be in day spaces throughout the day, bedrooms will be in use 24 hours.

#### **4.6 The Proposed Facilities: Soft FM Considerations**

All aspects of Hotel Services provision to the new facilities will be based on an integrated services model that will be provided via NHS Greater Glasgow & Clyde's Facilities. This includes the provision of:

- Core cleaning/housekeeping services
- Patient personal clothing laundry (where scheduled)
- Catering services including patient meal/dish wash
- Linen services
- Porter/messenger services
- Grounds maintenance
- Etc.

These services will be designed and delivered in conjunction with clinical service users in order to ensure that they complement direct patient care. Key considerations that will impact upon the effectiveness of these services that must be taken into consideration throughout the design process include:

- Overall site layout/configuration
- Defined internal and external FM delivery routes
- External landscaping
- Access in/out of facilities for FM service delivery
- Room layouts/relationships
- Environmental finishes

##### **4.6.1 Core Cleaning/Housekeeping Services**

Environmental Cleaning Services must be compliant with NQIS HAI Standards and the National Cleaning Services Specification, 2004 (revised 2009). Cleaning outcomes will be monitored and reported in line with the National Monitoring Framework (2006) requirements.

Specific infrastructure requirements include; the provision of dedicated Domestic Services Rooms (DSR's or "cleaner's rooms") within all areas as identified in SHFN 30; the provision of adequate separated waste storage areas; the provision of defined accessible entrance/exit routes for stores deliveries and waste collection.

##### **4.6.2 Patient's Personal Clothing Laundry**

Any patient clothing requiring laundry will be collected locally prior to transfer to a main laundry site for cleaning and ironing before being returned with regular laundry for use.

### **4.6.3 Catering Services**

The NHSGGC Catering Strategy introduced a cook-freeze/cook-chill regeneration model in April 2010.

Specific infrastructure requirements that all new facilities will require in order to support this model include; the provision of a servery that is able to accommodate deep freeze and refrigerated storage, regeneration trolley, dry goods storage and dishwashing facilities; the provision of defined accessible entrance/exit routes for meal delivery/collection.

All catering services must be compliant with NQIS Food Fluid and Nutritional Care Standards.

### **4.6.4 Linen Services**

Flat linen including sheets, pillowslips, blankets, counterpanes and towels will be provided via the central laundry facility at Hillingdon.

Required supply will be calculated to best match demand on the basis of local bed changing practice and bed occupancy projections/trends, however twice weekly deliveries are currently made to other wards on the site.

Specific infrastructure requirements include; storage areas for clean linen; storage areas for dirty linen; the provision of defined entrance/exit routes for clean/dirty linen.

It is noted that laundry-holding arrangements require to be accessible for the central laundry delivery/uplift service model and facilitate health and safety manual handling criteria.

### **4.6.5 Porterage / Messenger Service**

The services provided are designed around specified/scheduled tasks that include; waste removal, food trolley delivery/collection; stores delivery; pharmacy delivery; specimen uplift; mail delivery/uplift; etc.

In so far as these activities reflect the requirements of those services already identified they present no further specific infrastructure requirements related to these facilities. They do however underline the requirement for clearly defined and accessible collection/delivery routes that are capable of supporting all service elements and accommodating established delivery methods, vehicles, delivery routes, etc.

### **4.6.6 Grounds Maintenance**

Arrangements for season specific grounds maintenance and proactive winter pre gritting and snow clearance are already in place on the site that would be extended to include the new facilities.

Specific infrastructure requirements include; the provision of external winter grit storage bins; the provision of easily maintained external areas where these are provided, e.g. Gardens, where specified, should be "low maintenance".

It is noted that any "internal" garden model presents specific garden maintenance challenges and that consequently any such area should be manageable through the use of hand tools only that can be safely transported through the ward as required.

## **4.7 Specific Technical Requirements**

### **4.7.1 Information Technology Requirements**

IT is seen as fundamental to the efficient functioning of the new unit and must be considered at every stage of the design process. In particular the use of IT to reduce workload, repetition and errors is key, as is its ability to support the safety & security of patients, staff and visitors.

Access to all relevant IT networks is essential for clinicians to carry out their duties. This access should extend to all clinical areas, office areas and treatment/interview rooms.

Specifically, in consideration of a move towards electronic health records, it should be assumed that an IT connection will be required everywhere that a clinical interaction may take place. i.e. Everywhere that a patient and a clinician may need to interact and/or everywhere a clinician may need to interact with another clinician.

In addition, patients rely more and more on electronic contacts with other people via social networking, email etc. Whilst in hospital they may not have access to this facility. The provision of a public wireless network where they could connect their own devices is essential in helping them maintain their social contacts.

Many staff will be moving to new facilities from more traditional style wards (multi-bed bays) with technology seen as crucial to supporting their clinical observation of patients in a 100% single room model. Specifically, the IT network should therefore include an infrastructure for telemetry facilities for each ward, with the receiver at the main staff base and the capacity for telemetry to be used on any patient within the ward. Ideally telemetry information should also be capable of being relayed to staff throughout the ward in recognition of the desire to move away from a centralised nursing station.

Telemetry facilities shall enhance the case-specific monitoring of individual patients/groups who are confused, at risk of harm to themselves or others and/or who may try to leave their bedroom/ward unassisted and/or without permission.

Overall, IT networks should be flexible and assignable, thereby allowing decisions on future hardware requirements to be unencumbered by the need to have access to hard-wired connections – except as a back-up. They should also not restrict the Board's future procurement decisions unduly, meet all required technical specifications and be extendable to other parts of the facility at a later date if required.

### **4.7.2 Acoustic Requirements**

SHTM 08-01 has been written for healthcare professionals to understand acoustic requirements and to help those involved in the development of healthcare facilities.

Acoustic design is fundamental to the quality of healthcare buildings as sound affects us both physiologically and psychologically through the introduction of unwanted noise and also, beneficially, e.g. the effect of music.

Good acoustic conditions improve patient privacy and dignity as well as promoting essential sleep patterns. Such conditions are key to healing. It also brings other benefits in terms of patient and staff comfort and morale, as well as improved efficiency and usability of equipment.

The relevant acoustic design parameters and the standards to be achieved are set down in SHTM 08-01 with the parameters most relevant to this unit:

- Noise levels in rooms – both from mechanical services within the building and from noise coming from outside. It is important to create an acoustic environment that allows rooms to be used for resting, sleeping, treatment, consultation and concentration. There are also statutory limits for noise levels that individuals can be exposed to whilst working; which should be adhered to;
- External noise levels – noise created by the healthcare building and operation shall not unduly affect those that live and work around it, including those utilising garden spaces;
- Sound insulation between rooms – allows rooms to exist side by side. Noisy activities shall not interfere with the requirements of adjacent rooms, and private conversations should not be overheard outside the room. It shall however be possible to hear raised voices/shouting from an adjacent room and this is seen as an important security/observation requirement.
- Impact sound insulation – prevents footfall noise of people walking over rooms interfering with the use of rooms below;
- Room acoustics – guidance is given on quantities of acoustically- absorbent material to provide a comfortable acoustic environment;
- Audio systems – announcements to patients, visitors and staff shall be intelligible;
- Vibration caused by plant, medical equipment and activities shall not affect the use of the building. Some medical equipment is sensitive to vibration, and so are people.

#### **4.7.3 Security Considerations**

Providing a safe and secure environment for patients, staff and visitors is integral to the provision of clinical care, with security determined to have three interdependent domains in the clinical context:

- Physical security: the internal and external perimeters, security mechanisms and technologies (e.g. manual/electronic lock systems, CCTV) and other physical barriers (e.g. airlocks) that exist in the unit and the service as a whole.
- Relational security: the understanding and use of knowledge about individual patients, the environment and the population dynamic
- Procedural security: the timely, correct and consistent application of effective operational procedures and policies

It is essential that the three domains are developed and managed jointly, can withstand physical or behavioural challenge and are used to inform decisions about individual/population care.

The balance in emphasis between each domain will change given the operational needs of the unit as a whole, or the needs of a particular patient and/or group of patients, and the setting in which the service is provided. The following comments describe some of the required security measures:

- Spaces where service users may not be continually supervised by staff (for example in bedrooms, toilets, day and activity areas should be designed, constructed and furnished to make self-harm or ligature as difficult as possible. All fixtures and fittings in these areas should be anti-ligature.

- Spaces that are expected to be continually supervised by staff shall be comfortable and therapeutic. They encourage service users to participate in life on the ward and actively engage with staff, but minimise the risk of self-harm or injury to others.
- Security measures and considerations shall also extend into (and be considered in the context of) external areas, corridors and communication spaces including the requirement for fences, walls and/or other barriers to prevent both ingress to and egress from secure areas.

The National Patient Safety Agency launched the Preventing Suicide Toolkit in

2008. The toolkit has a set of national standards regarding the acute mental health in-patient unit that shall be applied throughout this facility.

As noted elsewhere in this document, the requirements for all areas to be “anti-ligature” is emphasised once again as is the requirement for anti-barricade doors in all patient areas.

#### **4.7.4 Staff Call/Alert Requirements**

A comprehensive staff call system shall be required at all clinical service delivery locations (including but not restricted to bedrooms, en-suites, treatment areas and consultation spaces) as well as all other areas frequented by patients. The system must be addressable and capable of emitting both audible and/or visual warnings for the following situations:

- to summon a nurse (“Patient to Clinician”); and
- to highlight a medical/staff emergency (“Clinician to Clinician”)

Both visual and audible warnings should be sited in positions that enable the appropriate staff to respond to the exact location of the call both efficiently and effectively and shall ideally be relayed to individual staff members remotely. Warnings, both visible and audible, shall be specific to the type of emergency and must be consistent throughout all areas of the facilities. In the event of an emergency they shall also repeat to all wards within the same “cluster” to ensure that sufficient additional assistance is summoned efficiently.

There is a requirement to ensure that the staff call system meets the needs of all of the patient groups that may be required to use the facilities recognising that they may have cognitive problems or have difficulties with mobility. In addition, it must fully comply with the requirements of relevant SHTM's and SHBN's and interface fully with the information technology system to enable on-screen alerts at assignable locations.

In addition, from a clinical perspective:

- Security entry systems with video and audio intercoms shall feature at all entrances
- It must be possible to activate a personal alarm anywhere within the scheduled areas in order to receive immediate assistance from more than one clinical area
- It must be possible for all patients/visitors to summon staff assistance from within all patient areas via an appropriate nurse-call system
- “Slow door systems” shall be used where appropriate
- A safe should be provided in each bedroom for the personal use of patients

#### **4.7.5 Overhead Tracking**

Overhead tracking MAY be required in specific areas although client feedback is currently awaited on this issue.

#### **4.7.6 Future Flexibility**

Throughout all of the planning, modelling and design work undertaken thus far, the key priority identified has always been future flexibility. Specifically, it is acknowledged that many variables exist that may have an impact on actual future facility requirements and, that as a result of this, facilities must be flexible enough to manage any patient group in the future with the minimal of cost/disruption/changes to contractual arrangements.

Future flexibility is therefore seen as a key design challenge with the following planning elements already factored in that shall be considered essential/non-negotiable unless more effective alternatives can be offered:

- 100% single rooms with en-suites
- An inter-locking en-suite model as far as possible – providing brighter, more flexible rooms that are a better shape than offered by the alternatives
- A slightly larger size of rooms than required by current SHPN guidance

In addition, a physical expansion strategy should be developed alongside any design that recognises building options for future development/growth/expansion of the facility or the co-location of an additional ward(s).

Future flexibility must remain at the forefront of all design activity and the facility MUST be able to demonstrate how function can change/develop over time with zero/minimum impact on services, costs and contracts.

#### **4.8 Functional Relationships & Adjacencies**

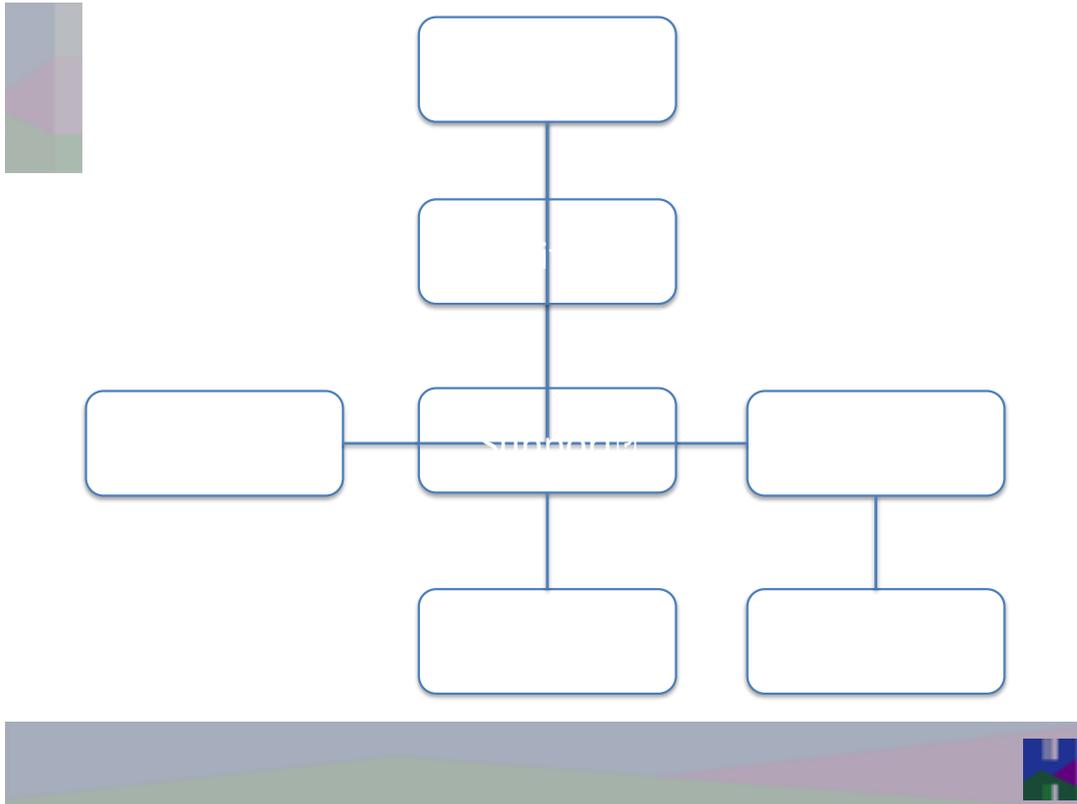
Throughout the planning process to date, the new development has been planned as an isolated facility on an identified site at Stobhill. Consequently only internal relationships and the impact of services not available locally have been considered.

Attention is however drawn to the links to other services identified throughout this document in consideration of the impact these will have on local infrastructure including pavements, cycle routes, parking, vehicular access and delivery routes.

#### **4.9 Patient/Process Flow Through The Proposed Facilities**

The physical environment should take into consideration the anticipated patient flows described elsewhere in this document, reflecting this in both the design and configuration of the scheduled areas.

A high-level overview of key patient/visitor flows is presented in Diag. 7. (Overleaf).



**Diag. 7. Key Flows Within The Elderly Ward**

A patient vignette describing “A day in the life” of a patient in the Hospital Based Complex Care (Elderly) Ward is also provided as Appendix A to this document. This is intended to help describe how the scheduled accommodation and associated spaces may be used in practice as a further aid to design development.

#### **4.10 Detailed Accommodation Requirements**

The following list of rooms is intended to provide an overview of unusual/non-standard rooms only, not all scheduled spaces. These descriptions are provided to aid design development only, especially relating to; functionality; shape; configuration; relationship to other spaces; and equipment requirements.

This information will be refined further through the on-going design development process and generation of appropriate room data sheets.

- **Servery/pantry**

A staff only pantry area where re-generation trolleys will be located and food served. This area will include a number of white goods including refrigerators and an industrial dishwasher. It will also have a sink with drainer and hand washbasin.

This area is likely to generate significant heat and it should ideally therefor be located on an external wall.

- **Dining Room**

A standard dining room area with tables and chairs immediately adjacent to the servery and ideally close to other day/activity spaces.

- **Sitting Room**

A pleasant sitting room environment, generally with a mixture of comfortable chairs and patient entertainment system, including television. This room should have ready access to external spaces.

- **Quiet Room**

An alternative to the sitting room but still featuring comfortable chairs and furnishings. This room will not have a television.

- **Single Bedroom (16m<sup>2</sup>) & Associated En-suite (5m<sup>2</sup>)**

A uniformly shaped bedroom with no intrusions that is able to deliver a minimum of 3.6m x 3.7m of clear space around the centrally located bed. These rooms are likely to include a CHWB and should have ready access to the associated en-suite through large doors that support dual nurse assistance through allowing the “borrowing of space” from the bedroom when required. Any lockers or furniture required within this room should be fixed for safety.

En-suites should be “wet rooms” with shower, WC and HWB that conform to HBN 00-02.

The en-suite model for all 20m<sup>2</sup> bedrooms should be “inter-locking”. It should be possible to lock en-suites to prevent them being used by patients.

It is important that en-suites effectively prevent the escape of water into bedrooms which is a common problem in existing areas due to poor drainage and insufficient wet-room floor run-off.

One 20m<sup>2</sup> bedroom with the Elderly Unit will be equipped for bariatric use.

A key factor in bedroom design must be the ability to be able to observe all activity within the main bedroom area through either a window/vision panel/other means (without needing to enter the room) and, whilst it should be possible for clients to choose privacy this should not negate the option for clinical staff to override their decisions on occasion for safety reasons. I.e. Open vision panels from outside the room using a key.

- **Assisted Bathroom with WC and WHB**

A large assisted bathroom with centrally located mechanical bath accessible on all sides, WC and WHB.

Two of these rooms have been scheduled in the elderly ward and consequently they should be appropriately distributed in bedroom areas. (Each bathroom serving 10 bedrooms)

- **Duty Room**

Effectively a small meeting/work room with desk and space for stand up briefings and other essential staff communication.

- **Interview Room**

A room with 3-4 comfortable seats and low table used for a range of interview related activities including discussions with relatives and members of staff.

For reasons of safety and security, in line with Royal College of Psychiatry guidelines:

- Interview rooms should be situated close to main staff areas

- All interview rooms should have readily accessible panic buttons or an emergency call system
- The exit to all interview rooms should be unimpeded. Doors should not require a key to exit and should ideally open outwards
- Interview rooms should not be “cluttered” and should ideally have an inspection window to permit viewing when the room is occupied

#### **4.11 Schedule of Accommodation**

The current S of A is attached as Appendix 3. This should be seen as the primary reference document regarding all required areas.

It is important to note that:

- Every opportunity to appropriately rationalise scheduled areas through design should be identified
- Accommodation should be as flexible as possible

Document ends.

## APPENDIX A

### **A “Day In The Life” of A Patient in the Hospital Based Complex Care Ward Elderly Ward**

Following admission after a period of deterioration in physical health and mobility at home, as well as many years of intermittent admission to acute mental health facilities, Mrs. B was assessed by the multidisciplinary team in an Acute Elderly Medical Ward. Mrs. B has been diagnosed with a range of conditions that require acute medical care as well as a long and enduring mental illness and dementia. She has been identified as having highly challenging needs, can become agitated and aggressive easily, is dis-inhibited and resistant to medication.

It was agreed between the multidisciplinary team and her family, in line with the transparent decision-making and clinical imperatives required by the latest guidance on Hospital Based Clinical Care that Mrs. B can “only be managed appropriately within a hospital environment” and it was therefore arranged that she be transferred to the elderly dementia admissions ward at Stobhill.

Following an extensive assessment process it was further identified that Mrs. B could not be cared for in anything other than a hospital environment long-term and she was consequently transferred to the Hospital Based Complex Care Ward for long-term care following a careful explanation of what this meant with her family. It was also explained however that her physical condition and mental state would be continually re-assessed and that she would be transferred to a non-hospital environment if/when it was agreed that she no longer benefitted from hospital based care.

Mrs. B was transferred to the ward by ambulance and, although her family wasn't present - primarily to help minimise further confusion and disorientation for Mrs. B - arrangements had been made for her daughter to attend the unit to be present for her mother's arrival.

At the door Mrs. B was welcomed to the unit by her daughter and nursing staff who introduced themselves before escorting her to her bedroom where she would be admitted by the nurse and clerked in by the ward Doctor.

During the admission procedure several risk assessments would be carried out for the benefit of Mrs. B's comfort and safety. Her activities of daily living were also assessed and care plans developed accordingly in partnership with Mrs. B and her daughter. Mrs. B requires assistance with transfers using overhead tracking hoist and two members of staff and to undertake other tasks such as personal cleansing/dressing, elimination, and eating/drinking.

At this time, Mrs. B's daughter is asked to review a copy of a local booklet that describes her life and history and asked to update this on behalf of her mother. (This booklet was commenced upon Mrs. B's initial assessment by community mental health teams but is kept updated throughout her care journey) It provides nursing staff with invaluable information about Mrs. B, such as her life and work history, her likes and dislikes, her current dementia care needs etc.

Nursing staff explained to Mrs. B and her daughter that ward staff deliver a varied programme of therapeutic activities which are organised on a daily basis. An activities

programme was shown to Mrs. B and her daughter and it was explained that patients are encouraged to participate in any activity they may be interested in within the programme e.g. quizzes, chair exercises, bowling, bingo, singing etc. Mrs. B would be asked her preferences, likes/dislikes in relation to hobbies and activities when creating an individualised therapeutic care plan. In addition to activities led by ward nurses, it was also explained that the OT staff covering the ward also supported individual and group work.

Mrs. B and her daughter were shown around the ward including the dining area and sitting room where they were introduced to other patients.

Mrs. B was assisted by the nursing staff to unpack her clothes, and personal belongings. Mrs. B had family photographs which were placed on the bedside furniture next to her bed. Mrs. B and her daughter went to sit in the quiet room to have a quiet/calm hour, following the busy transfer period which Mrs B had found unsettling, before returning to the dining room for lunch.

Mrs.B and her daughter were joined by Mrs. B's husband in the sitting room for afternoon visiting, although the unit operates an open visiting policy – including during mealtime – when relatives often attend to interact and assist with feeding. Staff assisted Mrs. B into a wheelchair as her family wanted to take her for a walk in the enclosed garden outside the ward where they were able to sit for a while on the patio in the quiet shaded area. When she felt physically fit enough, the ward and garden environment also provided a “wander route” that Mrs. B could follow that would always take her back to the familiar surroundings of the day room area

Mr. B took his wife to the dining room for afternoon tea before helping settle her back in the ward at the end of visiting time.

(Other patients within the ward had not felt so well that day and a number had remained in their beds much or all of the day, including for meals.)

After her evening meal Mrs. B stayed in the sitting room and spent time chatting to other patients in the ward. As she had no evening visitors and appeared tired and drowsy the nursing staff offered for her to return to her room to watch television and to have an early night.

Mrs. B was assisted by nursing staff to use the toilet, get undressed and washed before being transferred into bed and settled down for the night, with her nurse call buzzer to hand and the fall sensor mat in place next to her bed.

Mrs. B, like many of the patients in the ward, does not have the cognitive skills to independently use a buzzer – although these are still provided for those who can – so the use of monitoring technology such as local telemetry monitoring patient location (in bed, in bedroom, in ward) is important to ensure she remains safe.

## Appendix 8 Schedule of Accommodation

### Stobhill AAU & HBCCC Schedule of Accommodation

#### STOBHILL OVERALL SUMMARY

Ref.	Activity Space		Net	Gross	Comments
			m2	m2	

STOBHILL					
	Stobhill HBCCC Unit		815.0	1159.0	
	Stobhill AAU		831.0	1181.3	
	<b>Sub-total</b>			<b>2340.2</b>	

Total Net					
	<b>Add Communication</b>	0%		0.0	Now assumes separate buildings
	<b>Sub-total</b>			2340.2	
	<b>Add Central Plant</b>	8%		187.2	Estimate
	<b>Total Estimated Building Area</b>			<b>2527.5</b>	

#### NOTES:

This version generated by client discussion 7/6/16

Excludes External Areas

Central plant area requires engineer involvement to confirm

Now assumes separate buildings

Circulation allowances are as per relevant SHPN's and require drawings to confirm

#### Elderly Hospital Based Complex Clinical Care In-patient Unit (1 x 20 bed ward)

Ref.	Activity Space	Qty	Area	Total	Comments
		No.	m2	m2	

ENTRANCE HUB					
	Draught lobby	1	6	6.0	
	Entrance Foyer	1	8	8.0	With 4 waiting places and intercom to elderly ward.
	WC (Disabled)	1	4.5	4.5	Lockable with key. For use by visitors.
	<b>Sub-total</b>			<b>18.5</b>	

Total Net					
	Planning allowance	5%		0.9	
	<b>Sub-total</b>			<b>19.4</b>	
	Engineering Allowance	3%		0.6	
	Circulation	25%		4.9	
	<b>Total</b>			<b>24.9</b>	

PATIENT DAY AREAS					
3.19	Servery	1	16	16.0	On an outside wall with window
3.12	Dining room: 20 persons	1	40	40.0	Also for visiting/activities
3.11	Sitting room(s) (Older People)	1	48	48.0	
3.13	Quiet room	1	20	20.0	
	Activity Room	1	22	22.0	Equivalent of a 10 person group room with space for a sink and drainer
	Store	1	4	4.0	En-suite to Activity Room
	WC (Disabled)	2	4.5	9.0	Visible from day areas
	<b>Sub-total</b>			<b>159.0</b>	

PATIENT BEDROOM AREAS					
3.2	Single bedroom	20	16	320.0	
	En-suite (Dual Access)	20	5	100.0	As per HBN 00-02
	Touch Down Bases	2	2	4.0	As per HBN 00-02 One to be associated with each bedroom "wing"
3.10	Assisted bathroom with WC & WHB	2	16	32.0	With accessible bath
	<b>Sub-total</b>			<b>456.0</b>	

LOCAL CLINICAL SUPPORT AREAS					
	Office: 1 staff	1	10.5	10.5	Ward Manager
	Office: 3 Place ("hot desk")	3	4.5	13.5	4.5m <sup>2</sup> /desk
	Duty room	1	14.0	14.0	
3.33	Interview room	1	10	10.0	For relatives, MDT, etc
	Clean Utility/Treatment	1	16.5	16.5	C/U with patient access for bloods, recordings, etc
3.17	Disposal/sluice/test room	1	12	12.0	No macerator required
3.28	General & eqpt store	3	10	30.0	Includes personal storage
3.28	Linen store	1	6	6.0	
3.21	DSR	1	10	10.0	Subject to FM model
	Service entrance lobby	1	6	6.0	Included at request of architect
	Disposal hold	1	10	10.0	Subject to FM model
	Switch cupboard	2	2	4.0	Subject to Engineer review.
	<b>Sub-total</b>			<b>142.5</b>	

<b>Total Net</b>				<b>757.5</b>	
Planning allowance	5%			37.9	
Sub-total				795.4	
Engineering Allowance	3%			23.9	
Circulation	33%			262.5	
<b>Total</b>				<b>1081.7</b>	

STAFF AREAS					
	Staff Room With Kitchenette	1	18	18.0	

Changing Cubicle	2	4.0	8.0	
Shower: Ambulant (Staff)	2	2.5	5.0	
Staff WC (Staff)	2	2.0	4.0	
Foot Locker Area	1	4.0	4.0	Shared between changing cubicles
<b>Sub-total</b>			<b>39.0</b>	

<b>Total Net</b>			<b>39.0</b>	
Planning allowance	5%		2.0	
<b>Sub-total</b>			<b>41.0</b>	
Engineering Allowance	3%		1.2	
Circulation	25%		10.2	
<b>Total</b>			<b>52.4</b>	

<b>GROSS TOTAL</b>			<b>1159.0</b>	
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**Comments:**

Based primarily on Modified SHPN 35 & HBN 03-01  
Does not include communication spaces, external areas or central plant  
This version generated by client discussion 7/6/16

**Stobhill AAU (1 x 20 bed ward)**

Ref.	Activity Space	Qty	Area	Total	Comments
		No.	m2	m2	

<b>ENTRANCE HUB</b>					
	Draught Lobby	1	6	6.0	
	Entrance Foyer	1	15	15.0	With waiting and intercom to ward.
	WC (Disabled)	1	4.5	4.5	Lockable with key. For use by visitors.
	<b>Sub-total</b>			<b>25.5</b>	

<b>Total Net</b>				<b>25.5</b>	
Planning allowance	5%			1.3	
<b>Sub-total</b>				<b>26.8</b>	
Engineering Allowance	3%			0.8	
Circulation	25%			6.7	
<b>Total</b>				<b>34.3</b>	

<b>PATIENT DAY/ACTIVITY AREAS</b>					
3.19	Servery	1	16	16.0	On an outside wall with window
3.12	Dining room	1	36	36.0	Also for visiting
3.11	Sitting room(s) (Day room)	1	36	36.0	
	Quiet room (10 persons)	1	18	18.0	

	Female only day room (5 persons)	1	10	10.0	
	Activity Room	1	22	22.0	Equivalent of a 10 person group room with space for a sink and drainer
	Store	1	4	4.0	En-suite to Activity Room
	Patient pantry	1	10	10.0	Includes HWB
3.18	Patients' utility	1	10	10.0	Includes area for ironing
	<b>Sub-total</b>			<b>162.0</b>	

PATIENT BEDROOM AREAS					
	Single bedroom (Accessible)	20	16	320.0	In 2 or more "clusters"
	En-suite (Dual Access)	20	5	100.0	As per HBN 00-02. (Associated with accessible bedrooms)
	Touch Down Bases	2	2	4.0	As per HBN 00-02
	<b>Sub-total</b>			<b>424.0</b>	

LOCAL CLINICAL SUPPORT AREAS					
3.33	Interview room	3	10	30.0	At the immediate entrance - just inside entrance hub to support admission activity.
	Office: 1 staff	1	10.5	10.5	Ward Manager
	Office: 3 Place ("hot desk")	1	13.5	13.5	4.5m2/desk
	Duty room	1	14.0	14.0	
	MDT Room	1	18.0	18.0	For max of 10 persons
3.24	Nurses' station/staff "hub"	1	6.0	6.0	ADB Ref T0109
	Clean Utility/Treatment	1	16.5	16.5	C/U with patient access for bloods, recordings, etc
3.17	Disposal/sluice/test room	1	12	12.0	No macerator required
3.28	General & eqpt store	1	16	16.0	
	Patients Personal Belongings/Clothing Store	1	8	8.0	Recognising homeless needs currently managed at Parkhead
3.28	Linen store	1	6	6.0	
3.21	DSR	1	10	10.0	Subject to FM model
	Service entrance lobby	1	6	6.0	Included at request of architect
	Disposal hold	1	10	10.0	Subject to FM model
	Switch cupboard	2	2	4.0	Subject to Engineer review.
	<b>Sub-total</b>			<b>180.5</b>	

	<b>Total Net</b>			<b>766.5</b>	
	Planning allowance	5%		38.3	
	<b>Sub-total</b>			<b>804.8</b>	
	Engineering Allowance	3%		24.1	
	Circulation	33%		265.6	
	<b>Total</b>			<b>1094.6</b>	

<b>STAFF AREAS</b>				
Staff Room With Kitchenette	1	18	18.0	
Changing Cubicle	2	4.0	8.0	
Shower: Ambulant (Staff)	2	2.5	5.0	
Staff WC (Staff)	2	2.0	4.0	
Foot Locker Area	2	2.0	4.0	
<b>Sub-total</b>			<b>39.0</b>	

<b>Total Net</b>			<b>39.0</b>	
Planning allowance	5%		2.0	
Sub-total			41.0	
Engineering Allowance	3%		1.2	
Circulation	25%		10.2	
<b>Total</b>			<b>52.4</b>	

<b>GROSS TOTAL</b>			<b>1181.3</b>	
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**Comments:**

Based primarily on Modified SHPN 35 & HBN 03-01

Does not include communication spaces, external areas or central plant

This version generated by client discussion 7/6/16

## Appendix 9

### Stobhill AEDET form

#### Functionality

Use	Weight	Score	Notes
A.01 The prime functional requirements of the brief are satisfied	1	4	
A.02 The design facilitates the care model	1	5	
A.03 Overall the design is capable of handling the projected throughput	1	4	
A.04 Work flows and logistics are arranged optimally	1	5	
A.05 The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1	4	
A.06 Where possible spaces are standardised and flexible in use patterns	1	5	
A.07 The design facilitates both security and supervision	1	4	
A.08 The design facilitates health promotion and equality for staff, patients and local community	1	5	
A.09 The design is sufficiently adaptable to external changes e.g. Climate, Technology	1	3	
A.10 The benchmarks in the Design Statement in relation to building USE are met	2	4	

Access	Weight	Score	Notes
B.01 There is good access from available public transport including any on- site roads	1	3	
B.02 There is adequate parking for visitors/ staff cars/ disabled people	1	5	
B.03 The approach and access for ambulances is appropriately provided	1	6	
B.04 Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	5	
B.05 Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	4	
B.06 Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps et	1	4	
B.07 Active travel is encouraged and connections to local green routes and spaces enhanced	1	3	
B.08 Car parking should not visually dominate entrances or green routes	1	5	
B.09 The benchmarks in the Design Statement in relation to building ACCESS are met	2	4	

Space	Weight	Score	Notes
C.01 The design achieves appropriate space standards	1	5	
C.02 The ratio of usable space to total area is good	1	5	
C.03 The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	4	
C.04 Any necessary isolation and segregation of spaces is achieved	1	5	
C.05 The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	4	
C.06 There is adequate storage space	1	5	
C.07 The grounds provided spaces for informal/ formal therapeutic health activities	1	5	
C.08 The relationships between internal spaces and the outdoor environment work well	1	4	
C.09 The benchmarks in the Design Statement in relation to building SPACE are met	2	4	

## Build Quality

### Performance

	Weight	Score	Notes
D.01 The building and grounds are easy to operate	1	3	
D.02 The building and grounds are easy to clean	1	4	
D.03 The building and grounds have appropriately durable finishes	1	5	
D.04 The building and grounds will weather and age well	1	5	
D.05 Access to daylight, views of nature and outdoor space are robustly detailed	1	5	
D.06 The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	5	
D.07 The design minimises maintenance and simplifies this where it will be required	1	5	
D.08 The benchmarks in the Design Statement in relation to PERFORMANCE are met	2	5	

### Engineering

	Weight	Score	Notes
E.01 The engineering systems are well designed, flexible and efficient in use	1	4	
E.02 The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	3	
E.03 The engineering systems are energy efficient	1	4	
E.04 There are emergency backup systems that are designed to minimise disruption	1	5	
E.05 During construction disruption to essential services is minimised	1	5	
E.06 During maintenance disruption to essential healthcare services is minimised	1	5	
	1		

### Construction

	Weight	Score	Notes
F.01 If phased planning and construction are necessary the various stages are well organised	1		
F.02 Temporary construction work is minimised	1	5	
F.03 The impact of the building process on continuing healthcare provision is minimised	1	5	
F.04 The building and grounds can be readily maintained	1	4	
F.05 The construction is robust	1	5	
F.06 Construction allows easy access to engineering systems for maintenance, replacement & expansion	1	5	
F.07 The construction exploits opportunities from standardisation and prefabrication where relevant	1	5	
F.08 The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1	5	
F.09 The construction contributes to being a good neighbour	1	4	
F.10 Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1	4	

## Impact

Character and Innovation			
	Weight	Score	Notes
G.01 There are clear ideas behind the design of the building and grounds	1	5	
G.02 The building and grounds are interesting to look at and move around in	1	4	
G.03 The building, grounds and arts design contribute to the local setting	1	4	
G.04 The design appropriately expresses the values of the NHS	1	5	
G.05 The project is likely to influence future designs	1	4	
G.06 The design provides a clear strategy for future adaptation and expansion	1	4	
G.07 The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	4	
G.08 The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2	4	

Form and Materials			
	Weight	Score	Notes
H.01 The design has a human scale and feels welcoming	1	5	
H.02 The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	5	
H.03 Entrances are obvious and logical in relation to likely points of arrival on site	1	4	
H.04 The external materials and detailing appear to be of high quality and are maintainable	1	4	
H.05 The external colours and textures seem appropriate and attractive for the local setting	1	4	
H.06 The design maximises the site opportunities and enhances a sense of place	1	5	
H.07 The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2	4	

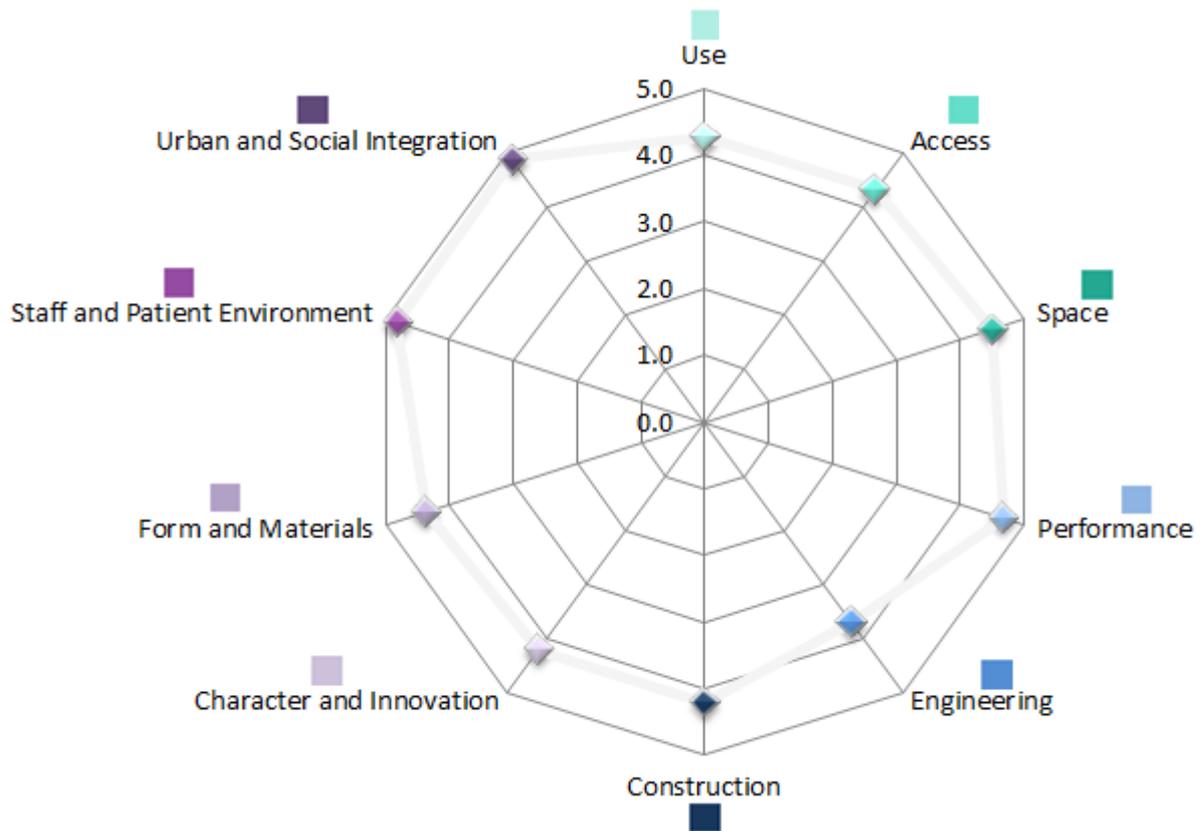
Staff and Patient Environment			
	Weight	Score	Notes
I.01 The design reflects the dignity of patients and allows for appropriate levels of privacy	1	5	
I.02 The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	5	
I.03 The design maximises the opportunities for access to usable outdoor space	1	5	
I.04 There are high levels of both comfort and control of comfort	1	4	
I.05 The design is clearly understandable and wayfinding is intuitive	1	5	
I.06 The interior of the building is attractive in appearance	1	4	
I.07 There are good bath/ toilet and other facilities for patients	1	5	
I.08 There are good facilities for staff with convenient places to work and relax without being on demand	1	5	
I.09 There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	5	
I.10 The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENT are met	2	5	

Urban and Social Integration			
	Weight	Score	Notes
J.01 The height, volume and skyline of the building relate well to the surrounding environment	1	5	
J.02 The facility contributes positively to its locality	1	4	
J.03 The hard and soft landscape contribute positively to the locality	1	5	
J.04 The design contributes to being a good neighbour and is sensitive to neighbours and passers-by	1	5	
J.05 There is a clear vision behind the design, its setting and outdoor spaces	1	5	
J.06 The benchmarks in the Design Statement in relation to INTEGRATION are met	2	5	

Ref	Note
A.01	
A.02	design at present would great help to facilitate the care model
A.03	Design meets the 20bed per ward requirments
A.04	
A.05	
A.06	
A.07	
A.08	
A.09	More information required
A.10	
B.01	Site is better than birdston and no worse for stobhill
B.02	
B.03	
B.04	
B.05	
B.06	
B.07	
B.08	
B.09	
C.01	
C.02	Very economical use of space to ensure value for money
C.03	
C.04	
C.05	
C.06	Good storage for the type of facility
C.07	
C.08	
C.09	
D.01	More information required
D.02	
D.03	
D.04	
D.05	very good access to good quality dayling provided through the design
D.06	
D.07	
D.08	
E.01	More information required
E.02	
E.03	
E.04	You would expect this from a new build
E.05	
E.06	
E.07	
F.01	
F.02	
F.03	The impact on the overall site has been well considered
F.04	
F.05	
F.06	
F.07	
F.08	
F.09	
F.10	HAI SCRIBE are satisfied it this stage of the design
G.01	Design meets the requirements of being prominent on the site
G.02	
G.03	
G.04	Design meeting the values of the NHS and will provide a good caring enviroment
G.05	
G.06	
G.07	
G.08	
H.01	
H.02	
H.03	
H.04	
H.05	
H.06	
H.07	The from and material choice will help to enhance the enviroment

I.01	
I.02	The design provided loads of access to safe external space.
I.03	
I.04	
I.05	
I.06	
I.07	Good spread of facilities for all.
I.08	
I.09	
I.10	
J.01	
J.02	
J.03	The building and landscaping design will enhance this area of the site
J.04	
J.05	
J.06	

**AEDET Refresh OBC Summary**



Target		Progress	
		Prev	Curr
0.0	Use	0.0	4.3
0.0	Access	0.0	4.3
0.0	Space	0.0	4.5
0.0	Performance	0.0	4.7
0.0	Engineering	0.0	3.7
0.0	Construction	0.0	4.2
0.0	Character and Innovation	0.0	4.2
0.0	Form and Materials	0.0	4.4
0.0	Staff and Patient Environment	0.0	4.8
0.0	Urban and Social Integration	0.0	4.9

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

## Appendix 10 Stakeholder Letter of Support



Chief Officer  
David Williams  
MA (Hons) COSW

Glasgow City Health and Social Care Partnership  
Commonwealth House  
32 Albion Street  
Glasgow  
G1 1L4

[www.glasgow.gov.uk](http://www.glasgow.gov.uk)  
[www.ghsccp.org.uk](http://www.ghsccp.org.uk)

Jane Grant  
Chief Executive Officer  
J B Russell House,  
Gartnavel Royal Hospital Campus  
1055 Great Western Road  
Glasgow  
G12 0XH

18<sup>th</sup> September 2017

Dear Jane,

### Greater Glasgow Health Board

#### Outline Business Case Mental Health: 2 Wards - Design Build Finance & Maintain Scheme

Greater Glasgow Health Board and Glasgow City Health & Social Care Partnership have been actively involved in developing the proposals for the above project through its various stages.

There has been engagement with the relevant stakeholders throughout the development process including representation from service users, staff, and management.

There is jointly confirmed acceptance of the strategic aims and investment objectives of the scheme, its functional content, size and services. The details of these are clearly set out in the business cases.

This letter is confirmation that the financial costs of the scheme can be contained within the agreed and available budget and a willingness and ability to pay for the services at the specified contribution level. The Outline Business Case has been presented to both Integrated Joint Board and Health Board meeting.

In the unlikely event that the scheme's costs breach the agreed funding ceiling, joint support would require to be re-validated.



# Appendix 11 HAI Scribe

AEDET Worksheet for Stobhill DBFM Rev A  
Project Title: AEDET Refresh v1.1 Feb 2018

Functionality	Build Quality	Impact
<p><b>Functionality</b></p> <p>A.01 The primary functional requirements of the brief are satisfied</p> <p>A.02 The design fulfils the care model</p> <p>A.03 Overall the design is capable of handling the projected throughput</p> <p>A.04 Work flows and logistics are arranged optimally</p> <p>A.05 The design is sufficiently flexible to respond to clinical/service change and to enable expansion</p> <p>A.06 Where possible spaces are standardised and flexible to use patterns</p> <p>A.07 The design fulfils both security and supervision</p> <p>A.08 The design fulfils health promotion and equality for staff, patients and local community</p> <p>A.09 The design is sufficiently adaptable to external changes e.g. Climate, Technology</p> <p>A.10 The benchmarks in the Design Statement in relation to building USE are met</p>	<p><b>Build Quality</b></p> <p>B.01 The building and grounds are easy to operate</p> <p>B.02 The building and grounds are easy to clean</p> <p>B.03 The building and grounds have appropriate durable finishes</p> <p>B.04 The building and grounds will weather and age well</p> <p>B.05 Access to daylight, views of nature and outdoor space are robustly detailed</p> <p>B.06 The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity</p> <p>B.07 The design minimises maintenance and disruption this where it will be required</p> <p>B.08 The benchmarks in the Design Statement in relation to PERFORMANCE are met</p>	<p><b>Impact</b></p> <p>I.01 There are clear ideas behind the design of the building and grounds</p> <p>I.02 The building and grounds are intended to look at and move around in</p> <p>I.03 The building, grounds and arts design contribute to the local setting</p> <p>I.04 The design appropriately expresses the values of the NHS</p> <p>I.05 The project is likely to influence future designs</p> <p>I.06 The design provides a clear strategy for future adaptation and expansion</p> <p>I.07 The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy</p> <p>I.08 The benchmarks in the Design Statement in relation to CONNECT &amp; INNOVATION are met</p>
<p><b>Form</b></p> <p>F.01 There is good access from available public transport including any on-street</p> <p>F.02 There is adequate parking for visitors/staff/ disabled people</p> <p>F.03 The approach and access for ambulances is appropriately provided</p> <p>F.04 Service vehicle circulation is well considered and does not inappropriately impact on users and staff</p> <p>F.05 Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired/ sight patients</p> <p>F.06 Outdoor space elements appropriate are usable, with safe lighting including paths, terraces, steps etc.</p> <p>F.07 Active travel is encouraged and convenient to local green routes and open spaces</p> <p>F.08 Car parking should not adversely dominate entrance or green route</p> <p>F.09 The benchmarks in the Design Statement in relation to building ACCESS are met</p>	<p><b>Environment</b></p> <p>E.01 If plant planning and construction are necessary the various stages are well organised</p> <p>E.02 Temporary construction work is minimised</p> <p>E.03 The impact of the building process on continuing healthcare provision is minimised</p> <p>E.04 The building and grounds can be readily maintained</p> <p>E.05 The construction is robust</p> <p>E.06 Construction allows easy access to engineering systems for maintenance, replacement &amp; expansion</p> <p>E.07 The construction exploits opportunities from standardisation and prefabrication where relevant</p> <p>E.08 The construction maximises the opportunities for sustainability e.g. waste and traffic reduction</p> <p>E.09 The construction contributes to being a good neighbour</p> <p>E.10 Infection control risk for options, design and construction recorded/ minimised using the Scribe</p>	<p><b>Form and Materials</b></p> <p>FM.01 The design has a human scale and fresh welcoming</p> <p>FM.02 The design contributes to local microclimate, matching sunlight and shelter from prevailing winds</p> <p>FM.03 Entrances are obvious and logical in relation to likely points of arrival on site</p> <p>FM.04 The external materials and detailing appear to be high quality and low-maintenance</p> <p>FM.05 The external colours and textures seen are appropriate and attractive for the local setting</p> <p>FM.06 The design maximises the site opportunities and enhances a sense of place</p> <p>FM.07 The benchmarks in the Design Statement in relation to FORM &amp; MATERIALS are met</p>
<p><b>Space</b></p> <p>S.01 The design achieves appropriate space residents</p> <p>S.02 The ratio of usable space to total area is good</p> <p>S.03 The circulation distances travelled by staff, patients and visitors is minimised by the layout</p> <p>S.04 Any necessary isolation and segregation of spaces is achieved</p> <p>S.05 The design maximises opportunities for space to encourage informal social interaction &amp; wellbeing</p> <p>S.06 There is adequate storage space</p> <p>S.07 The grounds provided spaces for informal/ formal therapeutic health activities</p> <p>S.08 The relationship between internal space and the outdoor environment work well</p> <p>S.09 The benchmarks in the Design Statement in relation to building SPACE are met</p>	<p><b>Staff and Patient Environment</b></p> <p>SPE.01 The design reflects the dignity of patients and allows for appropriate levels of privacy</p> <p>SPE.02 The design maximises the opportunities for daylight/ views of green natural landscape or elements</p> <p>SPE.03 The design maximises the opportunities for access to usable outdoor space</p> <p>SPE.04 There are high levels of both comfort and control of comfort</p> <p>SPE.05 The design is clearly understandable and wayfinding is intuitive</p> <p>SPE.06 The interior of the building is attractive in appearance</p> <p>SPE.07 There are good bath/ toilet and other facilities for patients</p> <p>SPE.08 There are good facilities for staff with convenient places to work and relax without being on demand</p> <p>SPE.09 There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax</p> <p>SPE.10 The benchmarks in the Design Statement in relation to STAFF &amp; PATIENT ENVIRONMENT are met</p>	<p><b>Urban and Social Integration</b></p> <p>USI.01 The building, volume and appearance of the building relate well to the surrounding environment</p> <p>USI.02 The facility contributes positively to its locality</p> <p>USI.03 The hard and soft landscape contributes positively to the locality</p> <p>USI.04 The design contributes to being a good neighbour and is sensitive to neighbour and pass-by</p> <p>USI.05 There is a clear vision behind the design, its setting and outdoor spaces</p> <p>USI.06 The benchmarks in the Design Statement in relation to INTEGRATION are met</p>

**AEDET Refresh OBC Summary**

Target	Weighting	Score	Cost
Use	0.0	0.0	4.3
Access	0.0	0.0	4.3
Space	0.0	0.0	4.7
Performance	0.0	0.0	4.7
Engineering	0.0	0.0	3.7
Construction	0.0	0.0	4.1
Character and Innovation	0.0	0.0	4.2
Form and Materials	0.0	0.0	4.4
Staff and Patient Environment	0.0	0.0	4.3
Urban and Social Integration	0.0	0.0	4.3

Weighting      Target

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1      2      3 - 4

0      <      3

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