

**FULL BUSINESS CASE**

**Mental Health 2 Ward DBFM Scheme**

**August 2018**



## Contents

1. Executive Summary
2. Strategic Case
3. Economic Case
4. Commercial Case
5. Financial Case
6. Management Case
7. Conclusion
  
8. Appendices
  1. Report and Analysis from the Options Appraisal Event 27th April 2017
  2. Stobhill Option Document Keppie
  3. Individual Scoring Option Appraisal Exercise
  4. SCIM Design Statement
  5. Project Programme
  6. Initial Agreement Letter Health & Social Care Directorates
  7. NHS Greater Glasgow & Clyde Clinical Output Specification
  8. IA Schedule of Accommodation
  9. FBC Schedules of Accommodation
  10. Stobhill AEDET form
  11. Stakeholder Letter of Support
  12. HAI Scribe
  13. Commissioning Requirement Brief
  14. Draft Commissioning Program
  15. Project Monitoring Report
  16. Planning Consent
  17. Risk Register
  18. OBC Letter Health & Social Care Directorates

## 1. Executive Summary

Glasgow City HSCP formally became operational in February 2016. The HSCP covers the geographical area of Glasgow City Council, a population of 593,245 and services within the HSCP are delivered in 3 geographical localities:

- North West Glasgow with a population of 206,483
- North East Glasgow with a population of 167,518
- South Glasgow with a population of 219,244

Glasgow City HSCP has an annual revenue budget of approximately £1.13 billion, with a staffing complement of approximately 9,000 staff.

The integration of health and social care services within the new facility will represent a visible demonstration of the commitment to integrated working consistent with the ambitions and priorities set out by Glasgow City HSCP's Integration Joint Board within its Strategic Plan for 2016-19 including:-

- Improving outcomes and reducing inequalities
- Person-centred care, providing greater self-determination and choice
- Early intervention, prevention and harm reduction
- Shifting the balance of care to better support people in the community
- Enabling independent living for longer and promoting recovery
- Public Protection to ensure people are kept safe and risks are managed appropriately

NHS GGC is the largest NHS Board in Scotland and covers a population of 1.2 million people. The Board's annual budget is £3.1 billion and employs over 40,000 staff. Services are planned and provided through the Acute Division and six Health and Social Care Partnerships (HSCPs), working with six partner Local Authorities.

### 1.1. Strategic Case

The Full Business Case Strategic Case for Change has not changed materially from the Outline Business Case.

The case presented in the OBC summarised a review of the historic and projected pressures on the current local capacity of mental health beds.

In the time that has passed since the submission of the OBC for this proposal, revisiting the principles of the strategic/ service solution identified has confirmed that no change is required at FBC.

It remains true that the provision of capacity for mental health estate is both essential and urgently required. This will protect services locally.

The proposed works will not fundamentally affect service change but will further enhance the capacity for flexible working across the mental health services within patient appropriate modern facilities and as such will also enhance patient and staff environment, experience, and outcome. This is in keeping with achieving the same level of access to services and the same efforts to improve standards, infrastructure and staffing in mental health as physical healthcare:-

- National 2017 – 2027 Mental Health Strategy;

- Local Greater Glasgow and Clyde wide “Moving Forward Together” vision and the
- Glasgow City HSCP Mental Health Strategy and Primary Care Improvement Plan development proposals.

## 1.2. Economic Case

The FBC’s preferred option of providing an additional two wards at Stobhill remains valid and as set out in the OBC submission. In achieving service delivery across the North of GG&C area and retaining the economic approach to construction through the detailed design stage the preferred option described in the OBC has been amended to take account of the needs of older people with functional mental health issues from the previously designated ward use for older people with mental health dementia.

Since completion of the OBC, work has progressed on developing the design and costs associated with the preferred option of:

- two inpatient wards on the Stobhill site on the area formally occupied by Wards 22 & 25, (now vacated and demolished). One ward is for \*adult acute inpatient care and one for \*\*older adults with functional mental health issues.

\*transferring within the site mental health campus which is managed and owned by NHS GG&C.

\*\*transferring from Birdston Nursing home site. The facility accommodation and facilities management is contracted/leased from a Nursing Home provider.

As detailed further within the Financial Case, the FBC has identified no overall increase in capital equivalent costs associated with the scheme.

The changes since Outline Business Case to the FBC are marginal in terms of square metres, and can be summarised as remaining within the identified footprint at OBC.

Total area of the building confirmed at 2543 m<sup>2</sup> based upon an agreed schedule of accommodation.(2543 m<sup>2</sup> at OBC design stage).

Final area and configuration of the site has been agreed and reflected in the stage E proposals. Design is improved for people’s personal bedrooms and en suite facilities.

Cost position – Capital build costs have not changed materially from OBC cost ceiling of £10.6m capital equivalent. There is a revenue reduction due to more favourable funding terms being provided by Nord.

The Affordability Cap of £10.6m was set taking account of inflationary uplift, technical changes to the project, further design development and site issues. The figures remain supported by SFT and the Boards technical advisors, reflecting the true cost of the proposed works. The overall unitary charge cost position remains within the ceiling for the project. The capital cost remains within the HSCP’s affordability cap of £10.6m, with consequential reduction of the unitary charge.

There is a remediation strategy being put in place. Scottish Government has offered to provide additional funding support (£287,418) to address the remediation matter to ensure that the bundle (Stobhill Mental Health, Greenock HC and Clydebank HC) can be delivered to the programme.

#### Benefits Criteria:

The benefits criteria articulated in this document are all desirable outcomes for the project that can be achieved by the preferred solution. Further details on the investment objectives and benefits for the project are included in the sections Strategic Case, Economic Case and Management Case.

#### Critical Success Factors:

The critical success factors were subject to workshop discussion at the early stages of the project and set out within the OBC. These have been revalidated as part of the preparation of this FBC and are outlined in the Section – Economic Case.

#### Sustainability Case:

The stage 2 report highlights that the Stage 2 design is on track to achieve a target BREEAM score of Excellent. The 'current' (fully validated) score is 73.85%. The requirement is to achieve BREEAM 'Very Good' which requires a score of up to 70% which is below the achieved score.

### **1.3. Commercial Case**

#### Procurement Route:

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

Stobhill 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) and Scottish Futures Trust (SFT)

The mental health 2 ward DBFM scheme project will be bundled with the new Clydebank and Greenock Health Centre projects - the purpose of this approach and the benefits were outlined in the bundling paper which accompanied this and the Clydebank and Greenock Health Centre OBCs and which has been updated to accompany submission to the Scottish Capital Investment Group with this FBC.

#### Risk Allocation:

Having identified the risks relating to the project and quantifying each, a review of the appropriate allocation of each was undertaken prior to agreement of the Guaranteed Maximum Price. In accordance with the hub process a total of 1% risk is allowed at the construction stage. This equates to £91,309 which is included within the GMP.

#### Agreed Contractual arrangements and charging mechanisms

The agreement for mental health 2 ward DBFM scheme is based on the SFT's hub current standard form Design Build Finance and Maintain (DBFM) Agreement. The TPA and SFT require that SFT's standard form agreement is entered into by NHS

GGC and DBFM Co with only amendments of a project specific nature being made. Therefore, the DBFM Agreement for this project (as bundled with Clydebank and Greenock Health Centre) contains minimal changes when compared against the standard form. Glasgow City HSCP/NHS GGC will pay for the services in the form of an Annual Service Payment.

Means of testing that the works provide the required scope included an FBC National Design Assessment Process (NDAP) submission; an FBC Achieving Excellence Design Evaluation Toolkit (AEDET) review; continuous update of the BREEAM pre-assessment information and the on-going utilisation of BIM level 2 protocols.

Is the Project Financially Viable:

The funding assumption contained within the OBC was that revenue funding from Glasgow City HSCP would be available to support this project. This has not changed and remains the case at FBC.

Output	Option 5
Capital Expenditure (capex & development costs)	£10,599,976
Remediation Strategy	£ 287,418
Annual Service Payment	

The approach to securing the site, demonstrates the benefits from GCC HSCP NHS and NHS GG&C proactively working together to their mutual benefit, in managing their estates efficiently and in securing the optimum outcome for service delivery to the public.

Stakeholder Support & sign-off:

The Glasgow City Health and Social Care Partnership and NHS Greater Glasgow and Clyde have been actively involved in developing and approving the Mental Health 2 Ward DBFM scheme through its various stages and this also additionally incorporates representation in West of Scotland Regional Planning and planning process. The financial costs of the scheme are contained within the agreed and available budget via the Design Build Fund and Maintain (DBFM) route. The Stakeholder sign-off letter is additionally contained in the Appendix.

#### **1.4. Management Case**

Project Management Arrangements:

The project will be managed by a Project Board chaired by Katrina Phillips, Head of Adult Services North East Glasgow, Glasgow City HSCP.

The Project Board will comprise representatives of NHSGGC Senior Management Team and key stakeholders from the Mental Health PFPI/User Group; and appropriate representation of the hub West Scotland Ltd Consortium. The Project Board will be expected to represent the wider ownership interests of the project and maintain co-ordination of the development.

The project will also be supported by a series of sub groups as required. The project management and governance arrangements are set out in greater detail in Section 6.

#### Change Management Arrangements:

The detail of change management arrangements can also be located in Section 6 of this FBC but in broad terms there is no anticipated change to the operational, service or facilities management arrangements stated within the OBC. The key stakeholders for operating the facility will remain as stated in the OBC, GC HSCP / NHSGGC.

The project has been developed to provide replacement capacity of mental health inpatient beds to replace an old model of accommodation contract arrangement and existing accommodation that does not offer single room accommodation for people and which despite best efforts does not meet modern standards of mental health inpatient accommodation. At this FBC submission there is no anticipated change to how the service will be delivered, with the focus on ensuring that the Glasgow City HSCP deploys NHSGGC employed and retained staff with the right skills and of the appropriate number, working in a multi-disciplinary and multi-agency way to ensure the right culture is fostered and patient centred care is at the foundation of the service delivery.

#### Benefits Realisation Plan:

The core benefits included in the provided Benefits Realisation Plan have remained in place from inception at Strategic Assessment. The Benefits Realisation Plan has however been expanded from that included in the OBC to provide a baseline measurement and a target outcome to ensure there is a clear ability to monitor progress and quantify success through subsequent project monitoring and evaluation.

Additionally, softer benefits have been included as a result of on-going discussion with the users through the detailed design period, and these will be included in the monitoring and evaluation process.

Evaluation of all benefits will be led by the NHSGGC Post Project Review Manager with the assistance of the Project Board; Project Delivery Group, and where necessary stakeholder representatives from staff, patients and visitors' groups.

#### Project Risk Register:

A risk register was established at the project initiation stage and has been subject to workshops and review to ensure it is appropriate to the project stage. At each stage through to submission of this FBC, a risk register review has formed part of the agenda for a range of core meetings and project board meetings. Contents are regularly reviewed and updated by appropriate stakeholders at these forums. This has included review in conjunction with the joint cost advisor, hub West Scotland Ltd and NHSGGC and been analysed and subsequently approved by all relevant parties using agreed methodology.

General risk review will continue to form part of regular meeting agendas through the construction stage, including progress meetings and project board meetings. Review and reporting on risks will be carried out collaboratively through engagement with the hub West Scotland Ltd, appointed consultants and the client team forming the core group with escalation procedures in place as per the governance arrangements for the project.

### Commissioning Master Plan:

The Commissioning arrangements for the project are provided within section 6 of this FBC submission, detailing:

- the reporting structure and governance arrangements
- the lead persons for both technical and non- technical commissioning
- the key stages and timescales within the process

A detailed Commissioning Requirements Brief (inclusive of Equipping Matrix) and Commissioning Master Plan are included within Appendix 13.

### Monitoring and Evaluation Plan:

Project Monitoring and Evaluation plans and methodologies have been developing throughout the OBC and FBC process in line with SCIM guidance. This has been achieved through engagement and collaboration with NHSGGC representatives, the appointed hub West Scotland Ltd and the core user and stakeholder groups to ensure plans, methods, timescales and means of engagement forming the monitoring and evaluation process have been agreed by all parties. This has culminated in the availability of the detailed Project Monitoring and Service Evaluation Plans included in Section 14. These show what will be assessed, when it will be done and the overall approach to delivery. Monitoring and Evaluation will continue throughout the construction and commissioning stages of the project, with a Project Monitoring Report being provided to SGHSCD shortly after DBFM Completion incorporating:

- An updated DBFM Cost Monitoring Form
- A Programme Monitoring Form
- Summary of significant scope changes
- Summary of Health and Safety performance
- An overview of achievement of the project design objectives
- A review of the management of risk throughout the project development

A comprehensive service benefits evaluation will place take from 12 months post occupancy, the focus of the evaluation involving:

- Assessment of whether and to what extent the project has realised its expected benefits
- Gaining feedback from users and other stakeholders on the project outcomes i.e. how stakeholder expectations have been met
- Reviewing the impact of any service change on operational activities, processes and people
- Understanding of how well the project has impacted on service activity and performance.
- Reflection of what went well and what could have been improved to provide learning to be passed on to other similar projects.



## 2. Strategic Case

The main purpose of the Strategic Case at FBC stage is to confirm or update the case for investment outlined within the OBC.

Strategic Case	Question	Response
	Has the strategic case for investment altered?	Confirm or update case for investment

### 2.1. Has the Strategic Case for Investment altered?

The Full Business Case has not changed materially from the Outline Business Case.

This Full Business Case (FBC) identifies the preferred option for the reconfiguration of mental health services in the North of Glasgow and confirms 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 clinical 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.

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

#### 2.1.1. Adult Acute Mental Health services at Stobhill Hospital

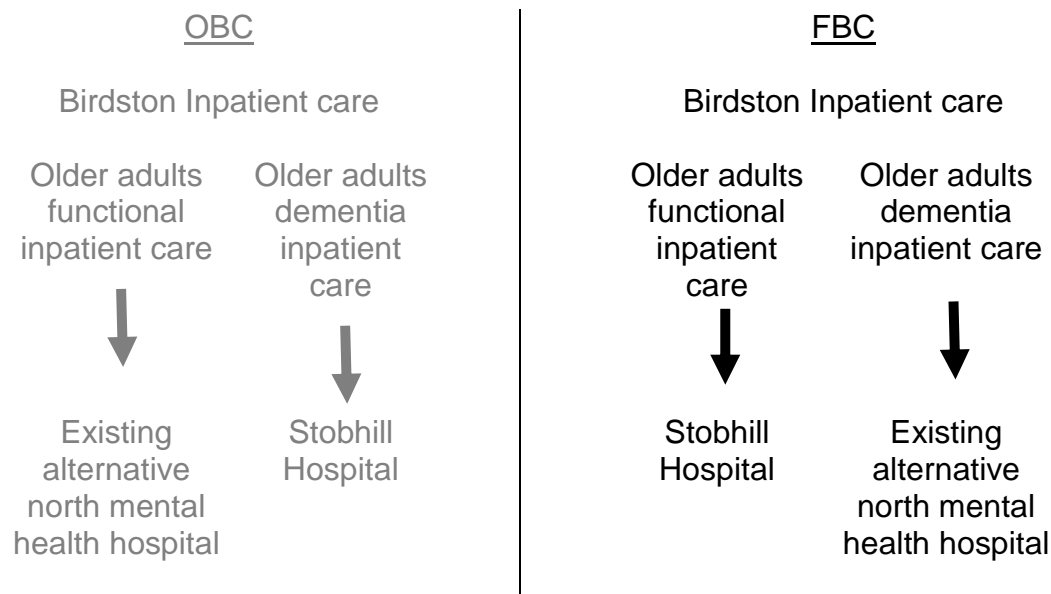
As part of the 2001 Health Board Modernising Mental Health Services Strategy there has been a drive to reduce both the dispersed nature of mental health in-patient ward sites and inpatient beds. This has led to moderated inpatient accommodation options on the Stobhill Hospital site where there are clinical 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 historical 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 of an old design, does not deliver sufficient single room accommodation to everyone, has required expenditure work (over a number of years) to keep it up to an acceptable standard and is not fit for purpose as a future modern inpatient ward.

### **2.1.2. 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 has been the on-going sustained need for older people with longer term functional mental ill health in addition to co-morbidity and incidence of dementia amongst the client group. This has been 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 expired June 2018. Discussions with the landlord have extended the existing functional mental ill health contract short-term. Significant rise in contract costs had been indicated if longer term extension was required. Latterly the landlord additionally specified during discussion the medium term intention to change the use of the accommodation.

The needs and expectations of the service users remain as set out in the Outline Business Case. Initially Birdston older adult's in-patient care was being directed to two future locations, dementia inpatient care at Stobhill and functional inpatient care to an alternative north mental health hospital location. Older adult's functional inpatient care will now be relocated on the Stobhill site and older adults dementia inpatient care accommodated on the existing alternative north mental health hospital location.

The figure below summarises the interchange from OBC to FBC.



The policy direction for better integrated services for modernised therapeutic care and co-morbidities remain in harmony with the Mental Health Strategy 2017-2027 vision. Local HSCP and the Health Board developing strategy “Moving Forward Together” continue to support the strategic direction and the continuation of the project. Outline Business Case assessment of the existing ward assets and services continue to support investment in inpatient ward accommodation. The scope of the project has not changed. Design objectives and engineering had been directed at ensuring ward design met specific ward use requirements whilst future proofing wards for different use. The adult mental health ward design remains single room accommodation that would be useable for other care groups. Likewise the older adult’s mental health ward retains the ability to meet the fundamental requirements for functionally ill older adults or for an alternative purpose such as older adults with dementia, without further major investment. Service models retain the objective of caring for older adults with functional illness separately from older adults with dementia. In discussion with HfS (Health Facilities Scotland) Capital Procurement colleague sit has been agreed the BREEAM (Building Research Establishment Environment Assessment Methodology) target for the two new build wards will be to achieved as a minimum, a “Very Good” rating. The expected benefits of the investment, risks and costs to the project have also not changed.

There remains therefore a compelling strategic case for change.

### 2.1.3. Need for Change

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 remains not viable. The on-going upkeep, maintenance and repair of the building mean that from a repairs or adaptation perspective it is “money hungry”. There has been a maintenance backlog and the asbestos that is part of the building’s structure has meant that even relatively simple repairs require investigation prior to work and become comparatively 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. Over a number of years the ward has been made presentable and pragmatically viable for immediate use but it does not represent a sustainable facility for the future that meets current standards for modern mental health in-patient accommodation. The accommodation at Birdston is an expensive contract which now does not meet the required specification for hospital based complex clinical care. The preferred solution is therefore two new-build wards, to be delivered within an overall “capital equivalent” funding envelope of £10.6M.

The proposal optimises value for money.

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	July / Aug 2017
Submit Final Business Case	October 2018
Financial Close	November 2018
Construction	November 2018 – April 2020

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 Orchard View (Greenock) and Maryhill will help us improve these areas (see Management Case).

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

The proposal remains 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 within 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 previous and current developing mental health services and Moving Forward Together Strategy 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.

## **2.2. 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 previous strategies and the developing the mental health and Moving Forward Together strategy. This has continued throughout the process to date and in the more recent specific design work and the option appraisal exercise. We have also considered how our objectives align with and help to deliver the wider strategic HSCP and NHS priorities, including at local HSCP, Greater Glasgow and Clyde wide and national levels. Finally, we have taken account of the key external factors that influence or are influenced by our proposal.

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

### **2.2.1. Current Arrangements**

#### **2.2.1.1. Stobhill Hospital (providing Acute Adult mental Health Services)**

The Adult Acute Mental Health inpatient services within this proposal are as set out in the OBC, provided from an old designed acute admissions ward at Stobhill Hospital. The bed configuration is mainly multi-occupancy bays with communally available shower and toilet facilities. The catchment area for the service is the North East of Glasgow with some most deprived areas in Glasgow. The catchment area also included the east area of East Dunbartonshire. The Maryhill catchment area of Glasgow, as an element of the extant wider strategy, relocated away from the Stobhill site to maximise the benefits and use of improved single room accommodation.

#### **2.2.1.2. Birdston Care Home**

Complex Elderly Mental Health services for people with functional illness are 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 Glasgow City HSCP GG&C NHS employed 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 Dunbarton, 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 expired in June 2018, the arrangement was temporarily extended. Slippage in the 2 x DBFM scheme will incur additional increase in charges from the accommodation provider.

### **2.2.2. Update on Design Quality Objectives**

During the design stage Architecture & Design Scotland recommended improved social (including individual) seating and linkages to external space and opened up external aspects. The design changed to include less regimented layout and reconfigured internal design to improve light and external access. The new updated design also adopted creating an external plant room in the undercroft of the building to improve the quality of the user approach and ensure no detrimental impact on building security and public safety.

#### **2.2.2.1. Procurement Route**

An AEDET (Achieving Excellence Design Evaluation Toolkit) 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 the OBC. 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 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. In May 2017 an AEDET assessment of the proposed accommodation was carried out and facilitated by Andrew Baillie, Project Manager. During June 2018 a further AEDET assessment of the currently proposed accommodation was carried out and was again facilitated by Andrew Baillie, Project Manager. The process was facilitated by third sector user and carer organisation Mental Health Network (Greater Glasgow and Clyde wide) and the workshop included service users, NHS staff, clinicians and management. The outcome of this was documented in an AEDET Assessment summary which is included as an Appendix of this Full Business Case.



## 2.2.3. The Case for Change remains valid

### 2.2.3.1. 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. lack of 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>

### 2.2.3.2. Need for Change –Birdston

The following table summarises the need for change.

Table 3 Need for Change Summary Birdston

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>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 expired 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>

### 2.2.4. 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.

#### 2.2.4.1. 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 adjacencies.
- 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

Table 4 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>

#### 2.2.4.2. 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 for any future use that requires to be able to be dementia friendly with minimal change) 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.

### 2.2.5. 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 hospital based complex clinical care ward. The preferred solution remains unchanged from the preferred way forward identified at the OBC stage.

### **2.2.6. Is this proposal still a good thing to do?**

The current arrangements, need for change and investment objectives made at IA and OBC remain, confirming the need for change and the identified way forward. The OBC was approved by SGHSCD. No specific conditions were outlined in the approval letter. Stakeholder involvement continues to be core to the Project.

### 3. Economic Case

The purpose of the Economic Case at Full Business Case stage is to demonstrate that the preferred option identified at OBC stage remains valid. It will do this by responding to the following question:

	Question	Response
Economic Case	Does the OBC's preferred option remain valid?	Confirm or update OBC preferred option

#### 3.1. Does the OBC's preferred option remain valid?

The preferred option identified in the Outline Business Case remains valid and has not changed. The equivalent capital cost and revenue costs remain within the funding ceiling as set out in the OBC. Consideration of this has taken place through the Program Board, through engagement with the Mental Health Patient Focus and Public Involvement Group and via the design work and AEDET involvement processes, which included users and carer input.

#### 3.2. Background

##### 3.2.1. 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 functionally ill patients – a demanding and high risk care group, the ward needs to be evidence based functionally ill 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 (Nairn and Munro) previously named Wards 43 and 44) have recently undergone renovation works and remain to provide interim accommodation. The renovation work also identified a range of longer term challenges that would likely require demolition to bring up to single room standard and present a restricted location that would also challenge the area requirements for single room accommodation. Therefore given the timescales to commence construction, the



current occupancy, and the identified restricted footprint they remaining attainable 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 (previously unoccupied and now demolished) are available sites as although this option involved demolition of existing buildings, these buildings had 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 opposite for older people's mental health conditions, 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. The only area still identified as available remains Wards 22-25 at Stobhill, the short list of options explored 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.

### **3.2.2. Identify and Quantify Monetary Costs and Benefits of Options**

As there has been no significant cost since OBC the detailed analysis is the Outline Business Case still stands.

The overall cost position remains the same since OBC stage. There has been a minimal decrease in Unitary Charge since the OBC due to improved funding terms being provided. The overall costs have been examined by the Projects Technical and Financial Advisers who have confirmed that the costs represent value for

money.

### **3.2.3. Non-monetary costs and benefits of options**

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

### **3.2.4. 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 HSCP / NHS clinician and clinical services manager, an HSCP / NHS operational service manager, an NHS capital procurement manager, an HSCP / NHS patient & carer services manager.

The event used a systematic and structured 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 6 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.

### 3.2.5. 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

### 3.2.6. 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.

Table 7 Group Weighted Benefit Scores

Group	Weighted Benefits Score		
Option	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 Table 7 Group Weighted Benefit Scores

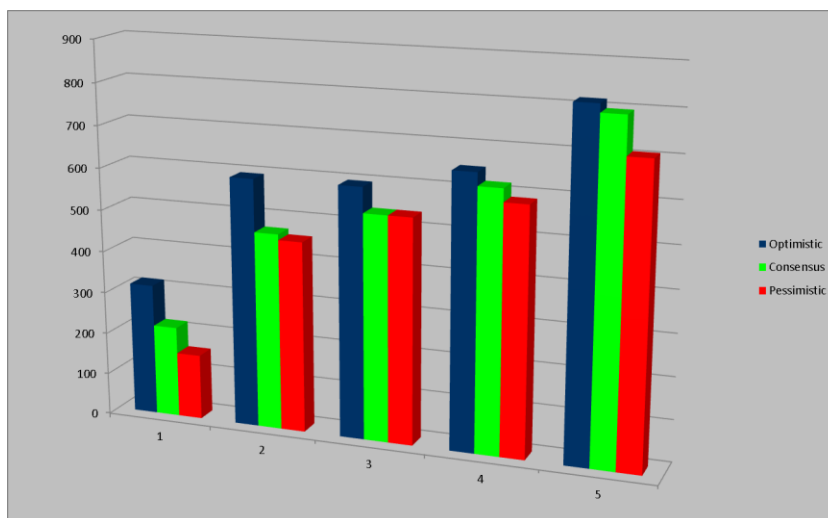
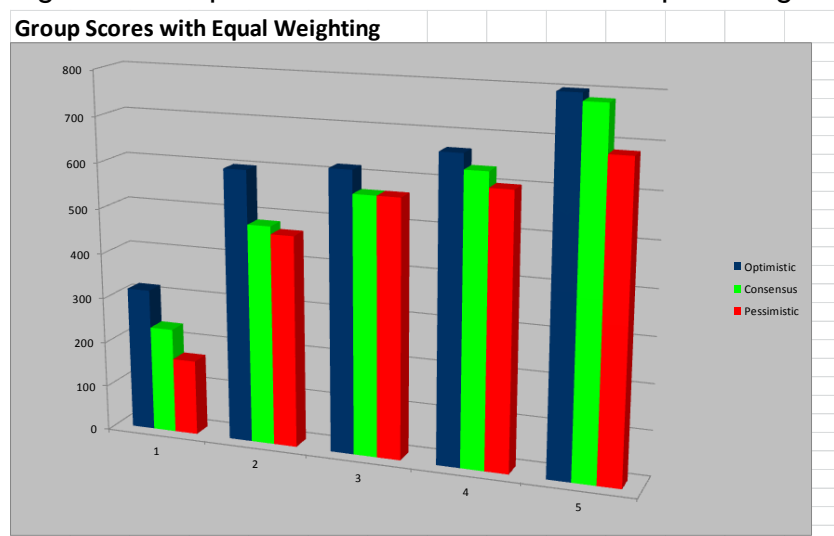




Figure 2 - Graph of Table 9 Scores/Results Equal Weighting Benefit Criteria



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.

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

To further test the robustness and sensitivity of the option appraisal and to test for risk of 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 13, 14 and the Figure3 below.

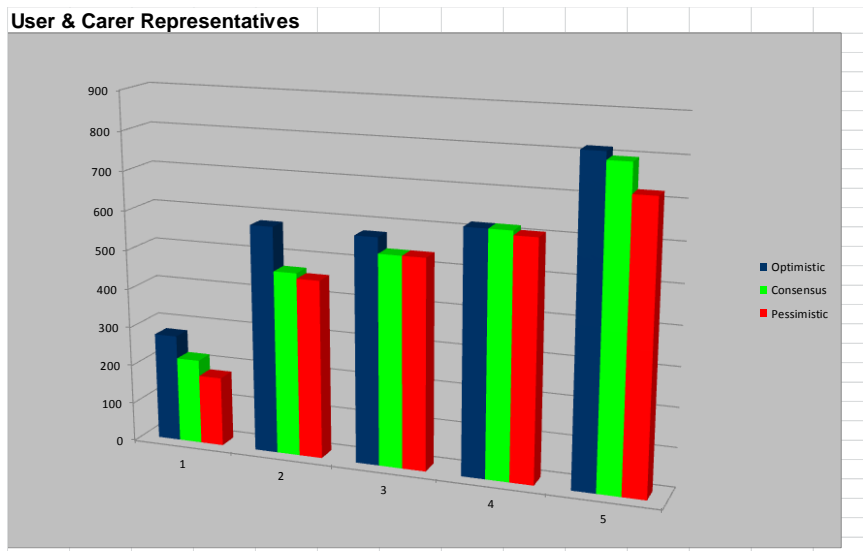
Table 10

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 11 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

Figure 3 – Graph of Table 11 User & Carer Group Scoring of the Options



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.

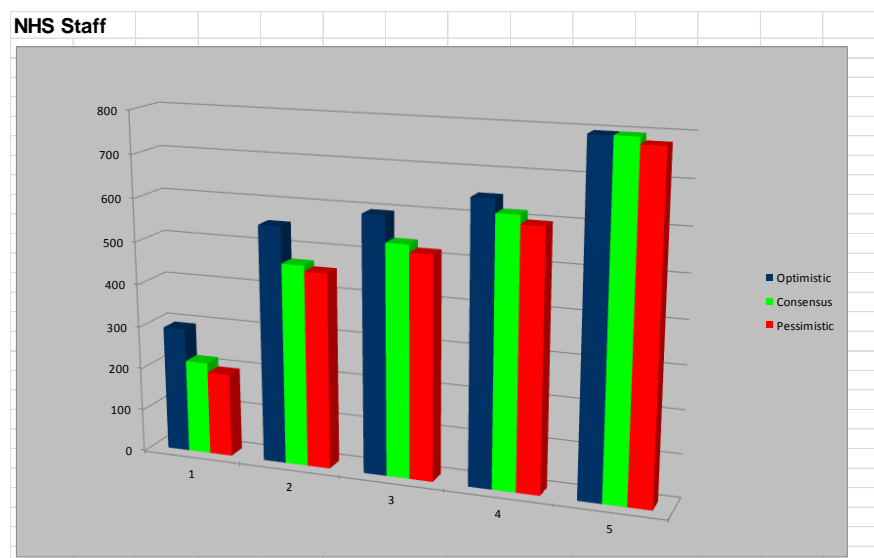
### 3.2.9. NHS Staff Scoring of the Options

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 12 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 12 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.

### 3.2.10. 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.

### 3.2.11. 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.

### 3.2.12. 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 13 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

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 14 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

### 3.14 Design Development of the Preferred Option from OBC to FBC

The High Level Clinical Specification has not changed from the OBC and the NDAP & Design Statement for Capital Investment has also not changed from the OBC. Since the OBC the schedule of accommodation has developed to meet further the requirements of the NHS Scotland Design Assessment Process and financial ceiling for the project.

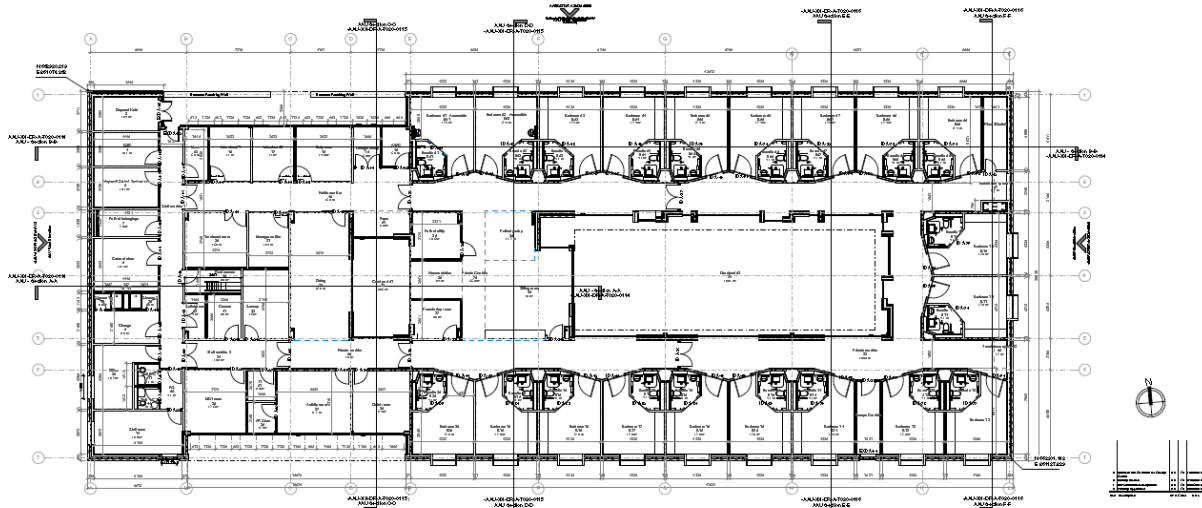
The schedule of change has altered as follows:-

Department	Number	Name	Area	Briefed Area	Area Difference	Comments
CCC	3	Disposal Hold	10 m <sup>2</sup>	10 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	4	DSR	10 m <sup>2</sup>	10 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	5	Disposal/ Sluice/ Test room	12 m <sup>2</sup>	12 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	6	General store	9.9 m <sup>2</sup>	10 m <sup>2</sup>	-0.1 m <sup>2</sup>	
CCC	7	Patient belongings	9.9 m <sup>2</sup>	10 m <sup>2</sup>	-0.1 m <sup>2</sup>	
CCC	8	Change	9.9 m <sup>2</sup>	8 m <sup>2</sup>	1.9 m <sup>2</sup>	
CCC	10	Shower 2	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	11	Staff WC 1	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
CCC	14	Staff room	18.2 m <sup>2</sup>	18 m <sup>2</sup>	0.2 m <sup>2</sup>	
CCC	15	Staff corridor 1	33 m <sup>2</sup>			
CCC	16	Interview 01	9.5 m <sup>2</sup>	10 m <sup>2</sup>	-0.5 m <sup>2</sup>	
CCC	18	Duty room	14 m <sup>2</sup>	14 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	19	Draught lobby	5.9 m <sup>2</sup>	6 m <sup>2</sup>	-0.1 m <sup>2</sup>	
CCC	20	Managers office	10.3 m <sup>2</sup>	10.5 m <sup>2</sup>	-0.2 m <sup>2</sup>	
CCC	23	Servery	16.3 m <sup>2</sup>	16 m <sup>2</sup>	0.3 m <sup>2</sup>	
CCC	24	Private Corridor	15.1 m <sup>2</sup>			
CCC	26	Office	13.7 m <sup>2</sup>	13.5 m <sup>2</sup>	0.2 m <sup>2</sup>	
CCC	27	Activity room	21.4 m <sup>2</sup>	22 m <sup>2</sup>	-0.6 m <sup>2</sup>	
CCC	28	AR store	3.7 m <sup>2</sup>	4 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	29	Quiet room	19.7 m <sup>2</sup>	20 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	31	Dining	36.6 m <sup>2</sup>	40 m <sup>2</sup>	-3.4 m <sup>2</sup>	
CCC	33	Public corridor	30 m <sup>2</sup>			
CCC	40	Public corridor	52.6 m <sup>2</sup>			
CCC	42	Switch room	4.1 m <sup>2</sup>	2 m <sup>2</sup>	2.1 m <sup>2</sup>	
CCC	43	Shower 1	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	44	Staff WC 2	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
CCC	45	Comms	6.9 m <sup>2</sup>	5 m <sup>2</sup>	1.9 m <sup>2</sup>	
CCC	49	Patient Utility	10.5 m <sup>2</sup>	4.5 m <sup>2</sup>	6 m <sup>2</sup>	
CCC	50	IVS	4.3 m <sup>2</sup>			
CCC	51	IT	3.1 m <sup>2</sup>	5 m <sup>2</sup>	-1.9 m <sup>2</sup>	
CCC	52	Roof access	6.2 m <sup>2</sup>			
CCC	53	Foyer	6.1 m <sup>2</sup>	8 m <sup>2</sup>	-1.9 m <sup>2</sup>	
CCC	57	Touchdown 02	4.9 m <sup>2</sup>			
CCC	74	Touchdown 01	2.7 m <sup>2</sup>			
CCC	75	Patient Pantry	11.3 m <sup>2</sup>			
CCC	92	Nurse Station	7.4 m <sup>2</sup>	6 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	93	AWC	5.2 m <sup>2</sup>	4.5 m <sup>2</sup>	0.7 m <sup>2</sup>	
CCC	95	Treatment Room	14.5 m <sup>2</sup>	16.5 m <sup>2</sup>	-2 m <sup>2</sup>	
CCC	96	Assisted bathroom	16 m <sup>2</sup>	16 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	97	Sitting Room	42.9 m <sup>2</sup>	48 m <sup>2</sup>	-5.1 m <sup>2</sup>	
CCC	98	Office	14.9 m <sup>2</sup>	13.5 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	101	Corridor	15.9 m <sup>2</sup>			
CCC	103	Private Corridor	54.5 m <sup>2</sup>			
CCC	142	Private Corridor	123.4 m <sup>2</sup>			
CCC	801	Bedroom 01 - Assisted	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
CCC	802	Bedroom 02 - Assisted	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
CCC	803	Bedroom 03 - Partially Assisted	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	804	Bedroom 04 - Partially Assisted	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	805	Bedroom 05	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	806	Bedroom 06	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	807	Bedroom 07	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	808	Bedroom 08	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	809	Bedroom 09	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	810	Bedroom 10	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	811	Bedroom 11	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	812	Bedroom 12	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	813	Bedroom 13	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	814	Bedroom 14	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
CCC	815	Bedroom 15	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	816	Bedroom 16	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	817	Bedroom 17	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	818	Bedroom 18	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	819	Bedroom 19	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	820	Bedroom 20	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	E01	Ensuite 01	4.2 m <sup>2</sup>	5 m <sup>2</sup>	-0.8 m <sup>2</sup>	
CCC	E02	Ensuite 02	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E03	Ensuite 03	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E04	Ensuite 04	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E05	Ensuite 05	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E06	Ensuite 06	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E07	Ensuite 07	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E08	Ensuite 08	4 m <sup>2</sup>			
CCC	E09	Ensuite 09	4.1 m <sup>2</sup>			
CCC	E10	Ensuite 10	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E11	Ensuite 11	4.1 m <sup>2</sup>			
CCC	E12	Ensuite 12	4.1 m <sup>2</sup>			
CCC	E13	Ensuite 13	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E14	Ensuite 14	4.1 m <sup>2</sup>			
CCC	E15	Ensuite 15	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E16	Ensuite 16	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E17	Ensuite 17	4 m <sup>2</sup>	5 m <sup>2</sup>	-1 m <sup>2</sup>	
CCC	E18	Ensuite 18	4 m <sup>2</sup>	5 m <sup>2</sup>	-1 m <sup>2</sup>	
CCC	E19	Ensuite 19	4.1 m <sup>2</sup>			
CCC	E20	Ensuite 20	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	

Departm	Number	Name	Area	Briefed A	Area diff	Commen
AAU	3	Disposal Hold	10.4 m <sup>2</sup>	10 m <sup>2</sup>	0.4 m <sup>2</sup>	
AAU	4	DSR	10.1 m <sup>2</sup>	10 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	5	Disposal/ Sluice/ Test room	12.1 m <sup>2</sup>	12 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	6	General store	16.1 m <sup>2</sup>	16 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	7	Patient belongings	7.6 m <sup>2</sup>	8 m <sup>2</sup>	-0.4 m <sup>2</sup>	
AAU	8	Change	9.8 m <sup>2</sup>	8 m <sup>2</sup>	1.8 m <sup>2</sup>	
AAU	10	Shower 2	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	11	Staff WC 1	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	14	Staff room	18.2 m <sup>2</sup>	18 m <sup>2</sup>	0.2 m <sup>2</sup>	
AAU	15	Staff corridor 1	25.2 m <sup>2</sup>			
AAU	16	Interview 01	11 m <sup>2</sup>	10 m <sup>2</sup>	1 m <sup>2</sup>	
AAU	17	Interview 02	11 m <sup>2</sup>	10 m <sup>2</sup>	1 m <sup>2</sup>	
AAU	18	Duty room	14.8 m <sup>2</sup>	14 m <sup>2</sup>	0.8 m <sup>2</sup>	
AAU	19	Draught lobby	5.2 m <sup>2</sup>	6 m <sup>2</sup>	-0.8 m <sup>2</sup>	
AAU	20	Treatment room	15.9 m <sup>2</sup>	16.5 m <sup>2</sup>	-0.6 m <sup>2</sup>	
AAU	21	Managers office	10.4 m <sup>2</sup>	10.5 m <sup>2</sup>	-0.1 m <sup>2</sup>	
AAU	23	Servery	15 m <sup>2</sup>	16 m <sup>2</sup>	-1 m <sup>2</sup>	
AAU	24	Staff corridor 2	13.9 m <sup>2</sup>			
AAU	25	MDT room	17.5 m <sup>2</sup>	18 m <sup>2</sup>	-0.5 m <sup>2</sup>	
AAU	26	Office	13.7 m <sup>2</sup>	10.5 m <sup>2</sup>	3.2 m <sup>2</sup>	
AAU	27	Activity room	21.1 m <sup>2</sup>	22 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	28	AR Store	3.7 m <sup>2</sup>	4 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	29	Quiet room	16.4 m <sup>2</sup>	18 m <sup>2</sup>	-1.6 m <sup>2</sup>	
AAU	31	Dining	35.8 m <sup>2</sup>	36 m <sup>2</sup>	-0.2 m <sup>2</sup>	
AAU	33	Private corridor	120.6 m <sup>2</sup>			
AAU	35	Patient utility	10.5 m <sup>2</sup>	10 m <sup>2</sup>	0.5 m <sup>2</sup>	
AAU	36	Nurses station	9.4 m <sup>2</sup>	6 m <sup>2</sup>	3.4 m <sup>2</sup>	
AAU	37	Female day room	8.6 m <sup>2</sup>	10 m <sup>2</sup>	-1.4 m <sup>2</sup>	
AAU	38	Sitting room	33 m <sup>2</sup>	36 m <sup>2</sup>	-3 m <sup>2</sup>	
AAU	39	Patient pantry	11.7 m <sup>2</sup>	10 m <sup>2</sup>	1.7 m <sup>2</sup>	
AAU	40	Public corridor	35.3 m <sup>2</sup>			
AAU	41	Comms	6.9 m <sup>2</sup>	5 m <sup>2</sup>	1.9 m <sup>2</sup>	
AAU	42	Switch room	4 m <sup>2</sup>	2 m <sup>2</sup>	2 m <sup>2</sup>	
AAU	43	Shower 1	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	44	Staff WC 2	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	45	Roof access	6.2 m <sup>2</sup>			
AAU	47	Riser 2/Switch	8 m <sup>2</sup>			
AAU	49	AWC	5.3 m <sup>2</sup>	4.5 m <sup>2</sup>	0.8 m <sup>2</sup>	
AAU	50	JVS	4.1 m <sup>2</sup>			
AAU	51	IT	3.9 m <sup>2</sup>	5 m <sup>2</sup>	-1.1 m <sup>2</sup>	
AAU	52	Linen	5.8 m <sup>2</sup>	6 m <sup>2</sup>	-0.2 m <sup>2</sup>	
AAU	54	Foyer	6.2 m <sup>2</sup>	15 m <sup>2</sup>	-8.8 m <sup>2</sup>	
AAU	57	Touchdown space 01	1.7 m <sup>2</sup>	2 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	65	Switch Room	21.5 m <sup>2</sup>			
AAU	66	Touchdown space 02	1.7 m <sup>2</sup>	2 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	68	Private corridor	16 m <sup>2</sup>			
AAU	69	Escape Corridor	8.1 m <sup>2</sup>			
AAU	70	Private Corridor	55.6 m <sup>2</sup>			
AAU	B01	Bedroom 01 - Accessible	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B02	Bedroom 02 - Accessible	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
AAU	B03	Bedroom 03	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B04	Bedroom 04	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B05	Bedroom 05	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B06	Bedroom 06	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B07	Bedroom 07	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B08	Bedroom 08	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B09	Bedroom 09	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B10	Bedroom 10	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B11	Bedroom 11	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B12	Bedroom 12	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
AAU	B13	Bedroom 13	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B14	Bedroom 14	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B15	Bedroom 15	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B16	Bedroom 16	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B17	Bedroom 17	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B18	Bedroom 18	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B19	Bedroom 19	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B20	Bedroom 20	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	E01	Ensuite 01	4 m <sup>2</sup>	5 m <sup>2</sup>	-1 m <sup>2</sup>	
AAU	E02	Ensuite 02	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E03	Ensuite 03	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E04	Ensuite 04	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E05	Ensuite 05	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E06	Ensuite 06	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E07	Ensuite 07	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E08	Ensuite 08	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E09	Ensuite 09	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E10	Ensuite 10	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E11	Ensuite 11	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E12	Ensuite 12	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E13	Ensuite 13	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E14	Ensuite 14	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E15	Ensuite 15	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E16	Ensuite 16	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E17	Ensuite 17	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E18	Ensuite 18	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E19	Ensuite 19	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E20	Ensuite 20	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	

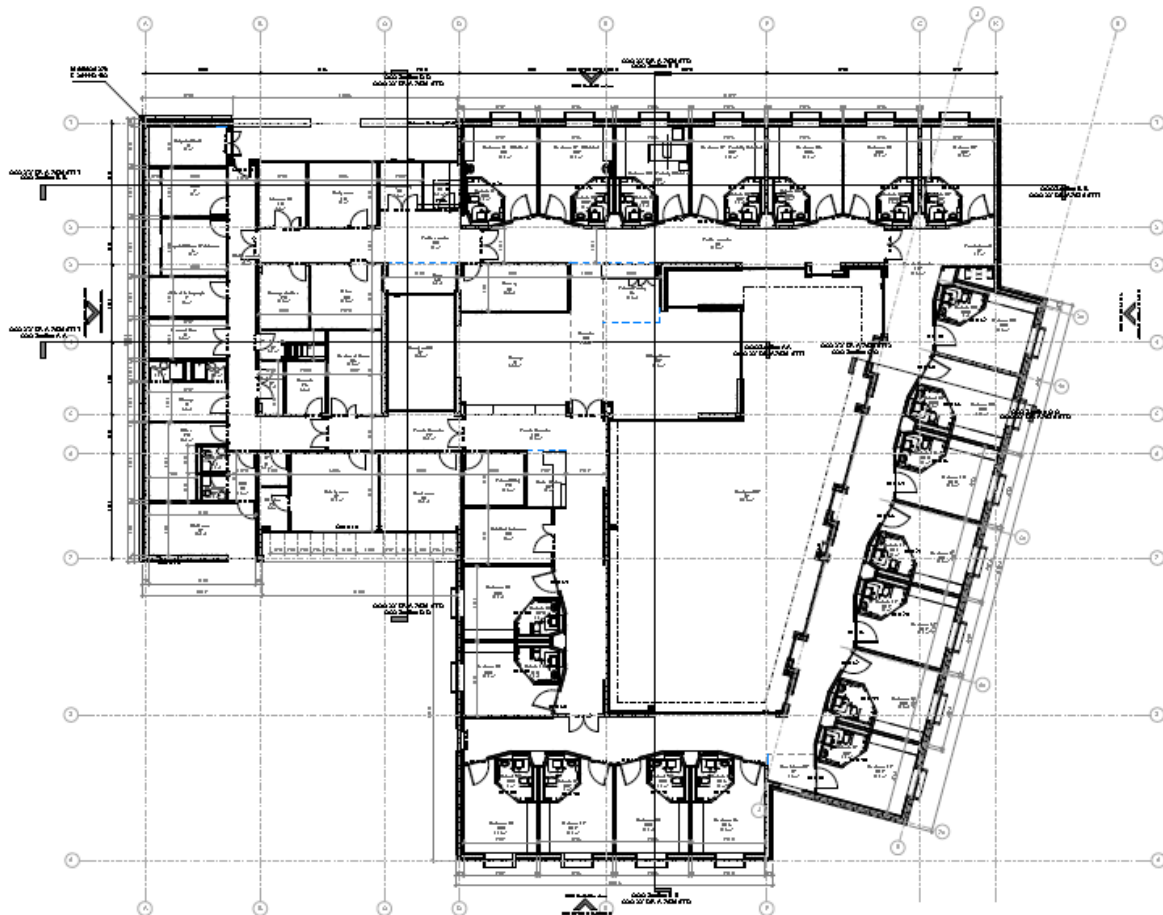
Overall a better design has been achieved with slightly increased areas for en suite bedrooms overall and slightly reconfigured and compacted public and back of

house areas. The overall layout has also changed to improve the outlook and patient requirements for security and privacy following design engagement with HfS and also with the Design User Group. Each ward has a staff base and staff room with an external staff terrace. The Staff room was designed to incorporate a small kitchen and computer workstations. The layout and design of the facility helps staff come together to share learning”, building on the business objective of improved staff co-working/efficiency/learning. This is in addition to bringing all the mental health services on to the single campus.



A&I Ground Floor Plan  
600-11-00

keppie



Hospital Based Complex Clinical Care Ground Floor

The Good Practice In the Design Of Homes and Living Spaces for People With Dementia and Sight Loss (University of Stirling Dementia Centre) have also continued to inform the ward design, even though the client group for older people will be people with functional illness and not people with dementia.

This has resulted in a change to lighting and the number of hoists being installed. The design remains however flexible in retaining four ceiling hoists in each of the new wards and the ability to deploy mobile hoists as required. Significant re-design has also gone in to the heating system and additionally the doors for people's en suite shower and toilet. The heating system involved major examination of heating systems deploying either ceiling panels and under floor heating. Whilst ward staff were thoughtful about the heat provided by ceiling panels, experience was also reported that under floor heating puts a strain physically on staff. The design has also prioritised management of ligature risks in bathrooms and although no environment can deliver 100% risk free environment the door design improves management of this risk. Reduced en suite ligature doors have been identified with a safe hinge and stable door design. This followed GG&C wide Health and Safety and Environmental Design Group input. The doors are light in construction, provide privacy and reduce ligature risks. The doors also have reduced risk of being deployed as a weapon, being of foam construction.

In addition to the additional improvements referred to, further user and carer input was provided from the North East of Glasgow. User input was sought for the Achieving Excellence Design Evaluation Toolkit (healthcare) which resulted in a further review and improved score for the design. The AEDET score report is at Appendix 10 and indicates a further improvement on the AEDET scores at OBC stage.

Additionally an internet a Linked article was publicised via the mental health user and carer network: <http://www.scottishconstructionnow.com/24707/keppie-designed-mental-health-facility-north-glasgow-submitted-planning/>



The Mental Health Network reported 416 people reached and directed to the article with web/facebook responses which included:

- “What is wrong with a V shaped roof? Flat roofs are notorious, for flooding and numerous problems in Scotland. We don't have the climate for flat roofs.”
- “I like the look of the place but of course it is what goes on inside that matters, however a complementary building is always welcome.”
- “When will this be open?”
- “Too difficult for visitors to get to Stobhill. Need to get 2 buses.”



During the AEDET process the design was confirmed as not having a flat roof. The roof has an angle of 12.5 degrees and maximises sunlight whilst maintaining privacy. The reference to bus access although not related to the specific design, highlights future work will be required with local transport planning to maximise increased public transport access to the site. However direct bus transport has also been put on from the north east Glasgow Parkhead area to the Stobhill site by the local mental health service for users and carers, and which staff can also use.

## 4. Commercial Case

### 4.1. Procurement Route

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 (Hws), local public sector Participants (which includes NHS GGC and GCC), Scottish Futures Trust (SFT) and a Private Sector Development Partner (PSDP).

The Stobhill 2 Mental Health Wards project will be bundled with the New Clydebank Health & Care Centre, and the New Greenock Health & Care Centre Facility – the purpose of this approach and the benefits are outlined in the stand-alone paper which accompanies this and the Clydebank & Greenock FBCs.

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 Hws is BAM Construction, this contractor is also appointed on the Clydebank and Greenock projects.

Stage 2 has been completed, and reviewed and challenged from an NHS perspective. The FBC is based upon the Stage 2.

The Stage 2 has been reviewed by the Board's external advisers who have confirmed its compliance with the TPA. The reports can be provided if required.

### 4.2. External Advisers

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

- The Advisers appointed are:
- Technical Advisers – Currie & Brown
- Legal Advisers – CMS
- Financial Advisers – Caledonian Economics

Awareness of the need to clearly manage quality control during the construction phase of projects has been heightened by the recent publication of the Cole Report (Edinburgh Schools). In addition to the quality management responsibilities of DBFMCo, a Building Monitor is being appointed by NHS GGC to provide an independent opinion of the quality of construction.

### **4.3. 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.

#### **4.4. 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 2543m<sup>2</sup>. The NHS Greater Glasgow & Clyde Clinical Output Specification is included in Appendix 7 (a) and 7 (b) and a copy of both original and current SOA is included as Appendix 8 & 9 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.

#### **4.5. Site Access, Constraints and Orientation**

The site was 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 demolitions pockets of Asbestos have been identified on the site and a Remediation Plan has been developed, and agreed with the Pollution Officer.

#### **4.6. 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.

#### **4.7. 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 and HFS in the development of the design of the new wards to ensure best practice is achieved and lessons from past projects has been integrated.

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

#### **4.8. HAI-Scribe**

An HAI-Scribe Stage 2 infection control assessment of the preferred option site was carried out on 20<sup>th</sup> August 2018 with NHS GGC Infection Control, Facilities and the Senior Charge Nurse. The Stage 2 Strategy and Risk Assessment was completed at this meeting and is included in Appendix 12.

#### **4.9. Clinical and Design Brief**

The Health Planner for the project has attended the Delivery 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 and approved by the Project Board.

#### **4.10. 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 15 – Staff numbers

<b>Services</b>	<b>Estimated No of Staff</b>
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  3 across two wards for approx six

Occupational Therapists	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.

#### 4.11. Surplus Estate

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

#### 4.12. Commercial Arrangements

The purpose of this section is to confirm that the scope and content of works and services included within the recommended procured offer(s) meets the project requirements set out in the OBC, and that they are sufficient and capable of delivering a successful outcome for the project.

#### 4.13. AEDET

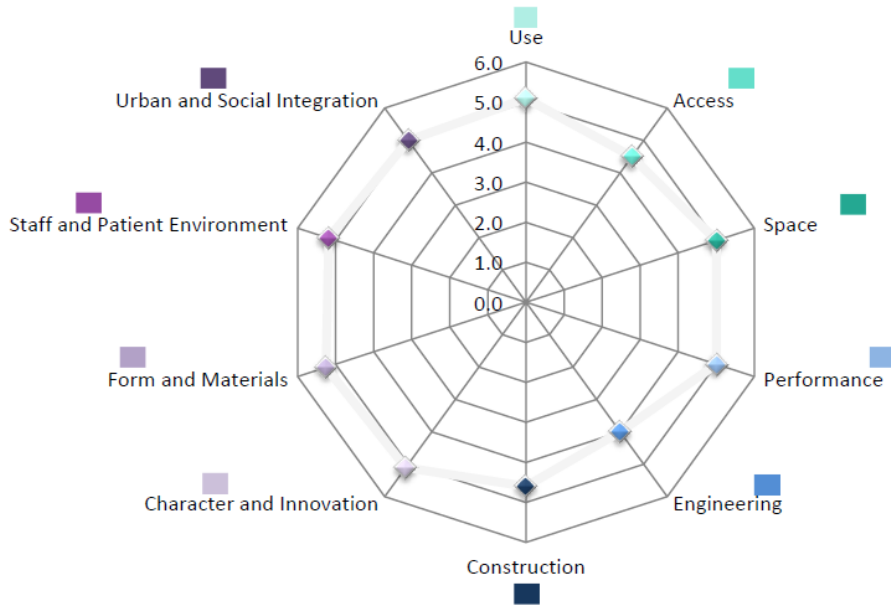
Throughout the planning process AEDET workshop have been carried out to create a baseline, at OBC development stage and a further meeting with key users for FBC stage on 4th June 2018. The summary scores from this workshop can be viewed below:

Diagram 01: Summary of FBC AEDET

Target		Progress	
		Prev	Curr
5.0	Use	4.3	5.1
5.0	Access	4.3	4.5
5.0	Space	4.5	5.0
5.0	Performance	4.7	5.0
4.3	Engineering	3.7	4.0
5.0	Construction	4.2	4.6
5.0	Character and Innovation	4.2	5.1
5.0	Form and Materials	4.4	5.3
5.0	Staff and Patient Environment	4.8	5.2
5.0	Urban and Social Integration	4.9	5.0

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

AEDET Refresh FBC Summary



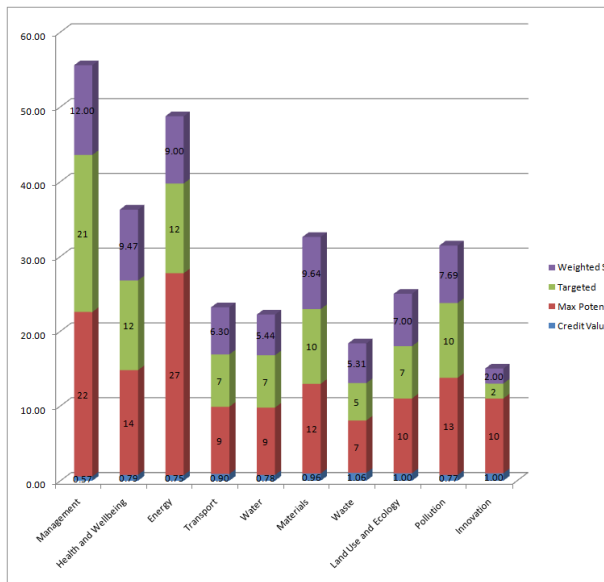
Scoring has been maintained or improved across all categories from the previous evaluation and it is anticipated that this would be the case post completion where it will be possible to provide a score establishing if the benchmarks set out in the design statement have been achieved. A post-completion AEDET will be undertaken to complete the assessment process once the construction works are complete and the new facility is occupied.

#### 4.14. BREEAM

BREEAM is the Building Research Establishment Environmental Assessment Method. BREEAM assessment evaluates the procurement, design, construction and operation of a development against a range of targets based on performance benchmarks.

It focuses on sustainable value across Energy, Land Use and Ecology, Water, Health and Wellbeing, Pollution, Transport, Materials, Waste and Management.

Each category focusses on the most influential factors, including reduced carbon emissions, low impact design, adaption to climate change, ecological value and biodiversity protection. Whilst the project has always identified a target BREEAM score of 'excellent', ongoing dialogue with HFS has noted that a score of 'very good' is the most likely outcome for the project. The project team continues to work towards 'excellent' whilst providing a balance against the affordability limit for the works. At the FBC NDAP submission stage the score is noted as 73.85 % (excellent) with the breakdown as follows:



Section	Credit Value	Max Potential	Targeted	Weighted Score
Management	0.57	22	21	12.00
Health and Wellbeing	0.79	14	12	9.47
Energy	0.75	27	12	9.00
Transport	0.90	9	7	6.30
Water	0.78	9	7	5.44
Materials	0.96	12	10	9.64
Waste	1.06	7	5	5.31
Land Use and Ecology	1.00	10	7	7.00
Pollution	0.77	13	10	7.69
Innovation	1.00	10	2	2.00
<b>Total Score</b>				<b>73.85</b>

BREEAM Rating table	
Pass	30%
Good	45%
Very Good	55%
Excellent	70%
Outstanding	85%

## 4.15. Risk Allocation

### 4.15.1. Transferred Risks

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

Table 15 – 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

#### **4.15.2. 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 DBFM Co is responsible for complying with all laws and consents, the occurrence of relevant changes in law as defined in the Project Agreement can give rise to compensate DBFM Co

#### **4.16. Payment Structure**

Glasgow City HSCP and NHS Greater Glasgow and Clyde will fund and 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.

Glasgow City HSCP and 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.

#### **4.17. 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". Flexibility in approach will support asymmetric project timetabling within the bundling 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.

#### **4.18. 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 Glasgow City HSCP / 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.

## 5. Financial Case

The purpose of the Financial Case at FBC stage is to explain in detail the financial implications to the organisation of the recommended procured offer or service, and to confirm its affordability.

	Question	Response
Financial Case	Is the project financially viable?	Confirm: <ul style="list-style-type: none"><li>• Project affordability</li><li>• Stakeholder support &amp; sign-off</li></ul>

### 5.1. Is the project affordable?

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

The overall unitary charge cost position remains within the ceiling for the project. The capital cost remains within the HSCP's affordability cap of £10.6m, with consequential reduction of the unitary charge.

There is a remediation strategy being put in place. Scottish Government has offered to provide additional funding support (£287,418) to address the remediation matter to ensure that the bundle can be delivered to the programme.

### 5.2. 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 equipment £611.3k and subordinated debt investment £88.4k. Details of all the revenue and capital elements of the project together with sources of funding are presented below:

## Recurring Revenue Costs

Table 16 Recurring Cost – at Base Date

<b>Additional Recurring Costs</b>	<b>£'000</b>
Unitary Charge	
Depreciation on Equipment	61.1
IFRS – Depreciation	422.3
Heat, Light & Power, Rates & Domestic services	572.5
Client Facilities Management (FM) Costs	13.4
<b>Total Additional Recurring Costs</b>	

### 5.3. Unitary Charge.

The Unitary Charge (UC) is derived from both the hub West Scotland Stage 2 submission dated 2<sup>nd</sup> August 2018 and the Financial Model Health Bundle 20180712 and represents the risk adjusted Predicted Maximum Unitary Charge of [REDACTED] 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 ([REDACTED]) and this will be optimised prior to financial close.

### 5.4. 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.

### 5.5. HL&P, Rates & Domestic Costs

HL&P costs are derived from existing inpatient ward costs and a rate of £36.76/m<sup>2</sup> has been used.

Rates figures have been provided by external advisors and an allowance for water rates of £19.00/m<sup>2</sup> has also been included.

Domestic costs are derived from existing MH Inpatient Units costs and a rate of £176.92/m<sup>2</sup> has been used.

### 5.6. Client FM Costs

A rate of £5.29/m<sup>2</sup> has been provided by the Boards technical advisors based on their knowledge of other existing PPP contracts.

### 5.7. 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.

## 5.8. Recurring Funding Requirements – Unitary Charge (UC)

Table 17 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>Annual Unitary Charge at Base Date</b>	██████	██████
		<b>100%</b>

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

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

### Sources of revenue funding

Table 18 Sources of revenue funding

<b>Glasgow HSCP</b>	<b>£'000</b>
Existing Revenue Funding	██████
<b>Total Recurring Revenue Funding</b>	██████

## 5.9. H, L & P, Rates & Domestic Costs

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

### 5.10. Additional Revenue Funding

N/A

### 5.11. Summary of revenue position

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

Table 19 Recurring Revenue Funding

<b>Recurring Revenue Funding</b>	<b>£'000</b>
SGHD - IFRS Depreciation	422.3
Glasgow HSCP recurring funding per above	██████
<b>Total Recurring Revenue Funding</b>	██████

**Table 20 Recurring Revenue Costs**

<b>Recurring Revenue Costs</b>	<b>£'000</b>
Total Unitary charge(service payments)	
Depreciation on Equipment	61.1
Facility running costs	585.9
IFRS - Depreciation	422.3
<b>Total Recurring Revenue Costs</b>	
<b>Net surplus at FBC stage</b>	<b>0</b>

The above table highlights that at FBC and Stage 2 Submission stage, the project revenue funding is cost neutral.

### **5.12. 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 21 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	88.4
<b>Total Capital cost</b>	<b>699.7</b>
<b>Sources of Funding</b>	
NHSGG&C Formula Capital	699.7
<b>Total Sources of Funding</b>	<b>699.7</b>

### **5.13. Land Purchase**

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

### **5.14. 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.

### **5.15. 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 FBC stage is £88.4k for which NHSGG&C has made provision in its capital programme.

### **5.16. Non Recurring Revenue Costs**

There will be non-recurring revenue costs estimated below:

**Table 22 Non Recurring Revenue Costs**

Non Recurring Revenue Costs	£'000
Advisors Fees	51
Demolition& Service Diversion	1.400
Decommissioning incl IT & Telecoms	60
Commissioning incl PPE	22
Security	0
<b>Total Non-Recurring Revenue Costs</b>	<b>1,533</b>

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

### 5.17. 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).

### 5.18. 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.

### 5.19. Current finance assumptions

The current financial implications of the project in both capital and revenue terms as presented in the above tables confirm the projects affordability. There should be no changes between FBC and Financial Close apart from any change in swap rates.

**Table 23 Current finance assumptions**

	Mental Health 2 Ward DBFM Scheme
<b>Senior Debt (£000)</b>	10,177
<b>Sub debt (excl rolled up interest) (£000)</b>	884
<b>Equity (£000)</b>	0.01
<b>Total Funding</b>	<b>11,061</b>

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

### 5.20. Subordinated debt

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

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

**Table 24 Subordinated debt**

	NHS GG&C				Total
<b>Proportion of sub debt</b>	10%				100%
<b>£ sub debt</b>	88,395				883,949

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.

### 5.21. Senior Debt

The senior debt facility will be provided by either Nord LB, an experienced lender in the Scottish DBFM market. They will provide up to 92% 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.

**Table 25 Senior debt**

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

### 5.22. Financial Model

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

**Table 26 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 1.63% and an interest rate buffer of 0.50%. The buffer protects against interest rate rises in the period to financial close.

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

### **5.23. Financial efficiencies through project bundling**

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

### **5.24. Risks**

The key scheme specific risks are set out in the Risk Register, which is held at Appendix 17 to this FBC. This has been developed by joint risk workshops with hub West Scotland and totals zero. The risk register risks according to their likely impact (red, amber, green). All risks have been fully mitigated, or mitigated to manageable levels in the period prior to 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 financial close.

### **5.25. 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.

## **5.26. 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 NHSGG&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 NHSGG&C's balance sheet, and as such, the building asset less service concession liability will incur annual capital charges. NHSGG&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.

## **5.27. 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.

---

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

## **5.28. 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.

## **5.29. 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.

## **5.30. 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 11

## 6. Management Case

### 6.1. Management Case

The main purpose of the Management Case at FBC stage is to confirm that the organisation is ready and capable of proceeding to contract award and project implementation.

	Question	Response
Management Case	Is the organisation ready to proceed to contract award and implementation?	<p>Confirm:</p> <ul style="list-style-type: none"><li>• Project management arrangements</li><li>• Change management arrangements</li><li>• Benefits realisation plan</li><li>• Project risk register</li><li>• Commissioning Master Plan</li><li>• Monitoring &amp; evaluation plan</li><li>• Project Monitoring report</li></ul>

The FBC confirms that:

- Project management arrangements are in place to ensure its successful implementation.
- All necessary change management arrangements are in place to ensure the smooth transition of services into a new facility; and that the organisation's existing activities (including health, care & facilities services), processes and people are not unnecessarily affected by the project.
- A comprehensive benefits realisation plan is available; including baseline data and details of how each benefit will be monitored and evaluated.
- A comprehensive and up to date project risk register is available; including details of appropriate control measures and individual risk owners.
- A Commissioning Master Plan is available which sets out how the planning and commissioning process will be managed and carried out.
- A Full Project Monitoring and Service Benefits Evaluation plan is available, which sets out how project progress will be monitored, and how its successful outcome will be identified and evaluated.
- A Project Monitoring Report has been completed covering the development of the technical aspects of the project from Initial Agreement through to FBC.

### 6.2. Confirm Project Management arrangements

This section provides an update of the project management arrangements shown in the OBC with the focus shifted from the procurement phase to the detailed arrangements in support of the design, build, implementation, and commissioning phases.

### 6.2.1. Project Programme

A programme for the project has been developed. A summary of the identified target dates is provided as follows.

#### High Level Project Plan

**Table 27 High Level Project Plan**

OBC Consideration\Approval	July/August 2017
Stage 2	July 2018
FBC Consideration\Approval	August\October 2018
Financial Close	November 2018
Completion date	April 2020
Services Commencement	May 2020

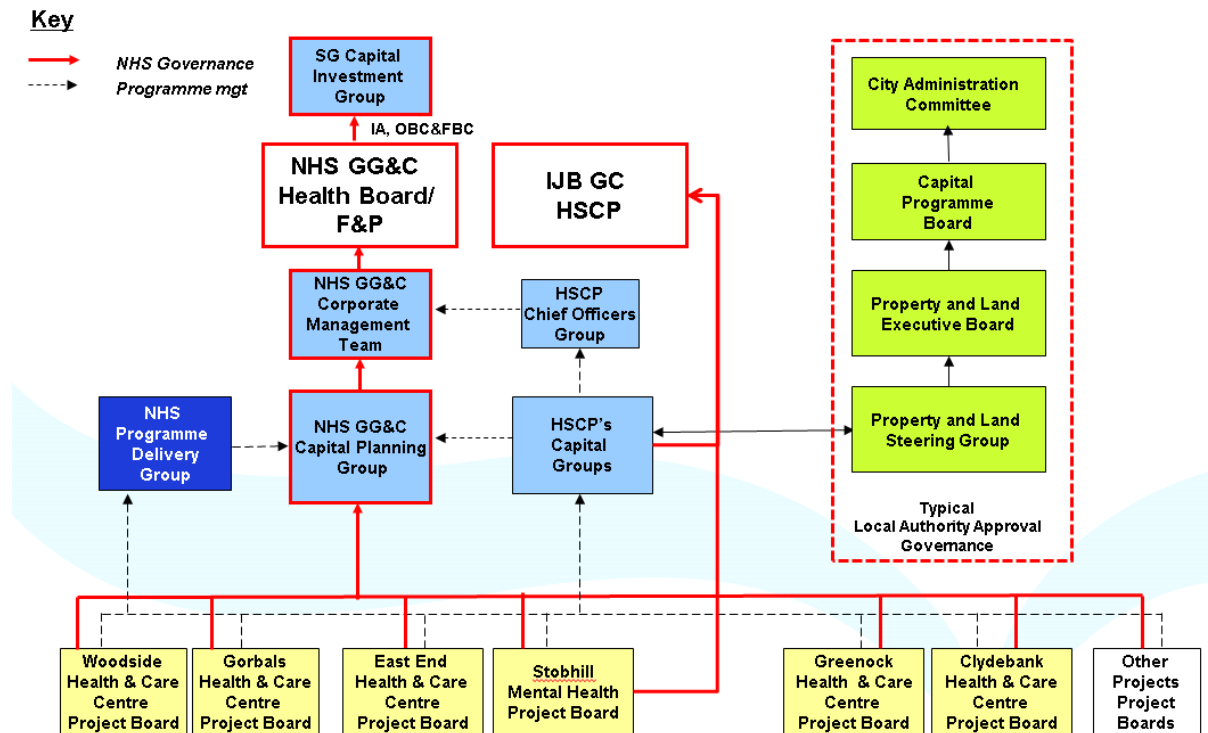
A detailed project programme is attached at Appendix 5.

### 6.2.2. Project Management Arrangements

The approach to the management and methodology of the project is based on the overriding principles of the “hubco” initiative where NHS GGC, GCC and Glasgow City HSCP will work in partnership with the appointed Private Sector Development Partner to support the delivery of the project in a collaborative environment that the “Territory *Partnering Agreement*”, and “*DBFM Agreement*” creates.

### 6.2.3. hub Governance and Reporting Arrangements

The hub Project Steering Group has governance and reporting structure which impacts on this project is:



A Project Board has been established and is chaired by the North East Locality Head of Adult Services of Glasgow City HSCP who will act on behalf of the Glasgow City HSCP Assistant Chief Officer Corporate Services who is the identified the Project Sponsor.

The Project Board comprises representatives from the:

- Senior Management Team of the North East Sector, Glasgow City HSCP
- Service leads, including links to Greater Glasgow and Clyde user and carer representation group
- PPF
- NHSGGC Capital Planning team.
- Hub West

The Project Board will be expected to represent the wider ownership interests of the project and maintain co-ordination of the development proposal. The Project Board reports to a range of governance arrangements, including the NHSGGC Programme Delivery Group, which oversees the delivery of all NHSGGC hub projects. This Group is chaired by a Chief Officer of an HSCP and includes representative from other Project Boards within NHSGGC, Capital Planning, Facilities, Finance, hub Territory and Hubco.

The project is also supported by a series of sub groups / task teams as required and identified in the Guide to Framework Scotland published by Health Facilities Scotland. These task teams include Design User Group; Commercial; IM&T; Equipment; Commissioning and Public Involvement.

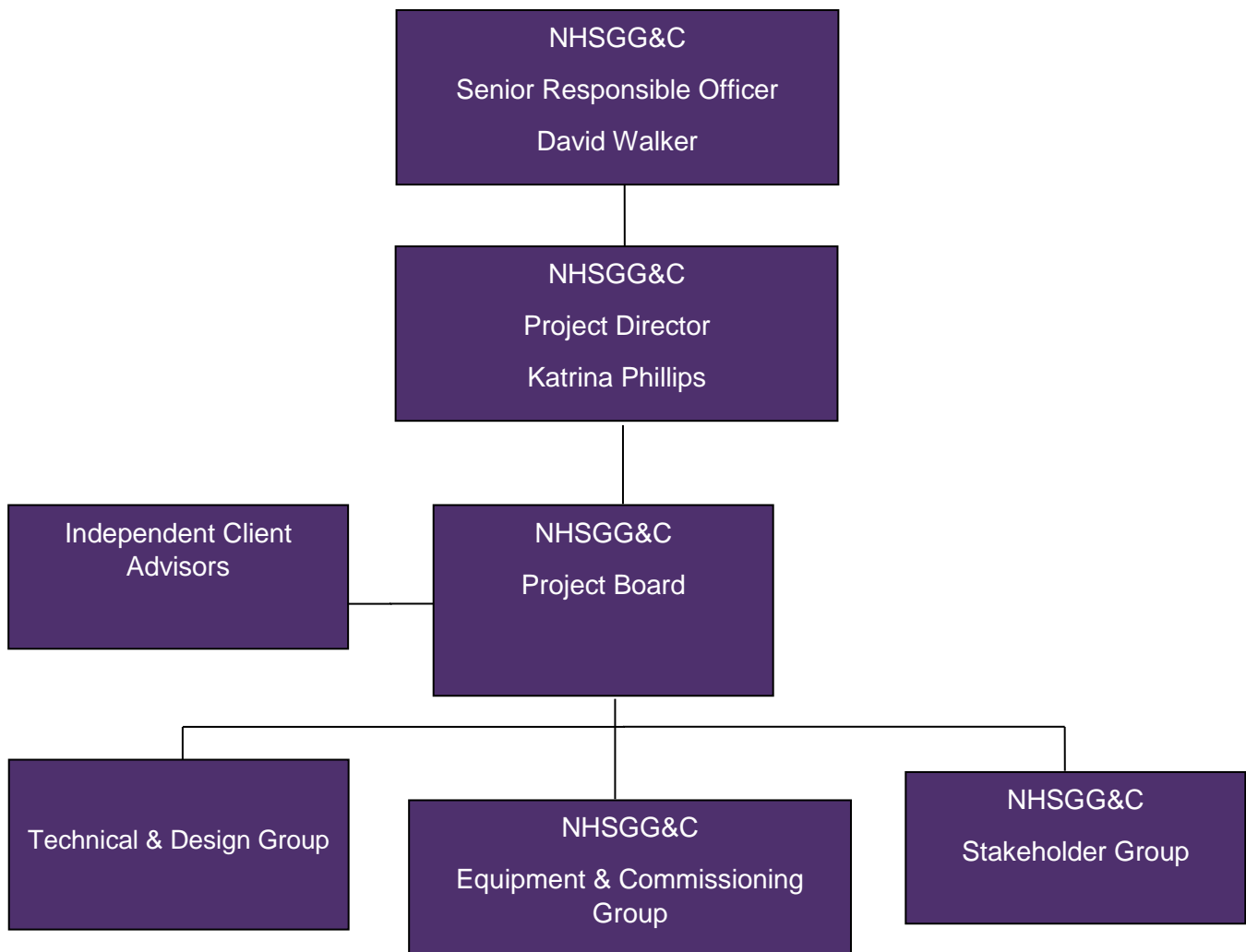
The following key appointments will be responsible for the management of the project.

Project	Mental Health 2 Ward DBFM Scheme	NHS GGC GCC HSCP Hubco
Parties	NHS Greater Glasgow & Clyde Glasgow City HSCP Hub West Scotland	NHS GGC GCC HSCP Hubco
Project Sponsor	David Walker	GCC HSCP
Project Director	Katrina Phillips	GCC HSCP
Project Manager	Andrew Baillie	NHS GG&C
Finance Manager	Marion Speirs	NHS GG&C
Planning Manager Mental Health	David Harley	GCC HSCP
Private Sector Development Partner – Project Manager	Ewen MacKenzie	hubco
Private Sector Development Partner - Tier 1 contractor	Principal Supply Chain Member (Lead) – BAM	BAM
Legal	CMS	CMS
Financial	Caledonian Economics	Caledonian Economics
Technical	Currie & Brown	Currie & Brown

#### 6.2.4. Project Organisational Structure Diagram

The following diagram represents the NHSGGC project organisation structure. The diagram has been updated from OBC stage to include the NHSGGC commissioning team linked to the Lead Project Manager, Service Lead and Stakeholder Group. An explanation of roles, responsibilities and suitability is provided in subsequent sections for all roles now identified:

## Diagram: Organisational Structure



The Project Board also reports to the NHSGGC Capital Planning Group, which oversees the delivery of all NHSGGC projects and the Glasgow City HSCP Capital Planning Group which oversees all Glasgow City HSCP funded projects. Arrangements have been confirmed via the West of Scotland Regional Planning Group.

The project will be sponsored by Mr David Walker, Associate Chief Officer Corporate Services (Glasgow City HSCP), supported and managed by a Project Board chaired by Mrs Katrina Phillips, Adult Services Manager for North East Glasgow incorporating the mental health inpatient services provided from Stobhill Hospital site.

The Project Board comprises of representatives of Glasgow City HSCP Senior Management and key stakeholders from the Mental Health PFPI/User Group; and appropriate representation of hub West Scotland (hWS) and the DBFM consortium. The Project Board will be expected to represent the wider ownership interests of the project and maintain co-ordination of the development.



## 6.2.5. Named Persons for each Key Role identified

**Table 28: Named Persons**

Key Roles:		
Role:	Named person:	Role Description:
Senior Responsible Officer	David Walker	<p>David is Glasgow City Health and Social Care Partnerships Associate Director Corporate Services and will chair the project board and lead on communication with those groups forming part of the governance process. Communication will include: Greater Glasgow and Clyde Mental Health Care Groups Forum and Regional Planning representatives as well and internal communication with those groups forming part of the full NHS GG&amp;C governance process: Senior Management Group, Capital Forum, Corporate Management Team and the Finance &amp; Planning Committee.</p> <p>David has extensive and direct experience of leading projects and overseeing works to improve the health of local people and the service they receive.</p> <p>Through this experience David is able to provide expertise related to the projects development management, governance and stakeholder management.</p>
Project Director	Katrina Phillips	<p>Katrina is a Senior General Manager within the Glasgow City HSCP and it is her role to manage and deliver on the capital plan for adult services the North East of Glasgow City HSCP.</p> <p>Delivering the North East of Glasgow City HSCP plan means Katrina is directly involved with a large number of projects at any one time, at varying stages of development and that vary greatly in complexity and value.</p> <p>Through this role Katrina has gained knowledge of all the key competencies required to deliver a project.</p>

		<p>Therefore, Katrina will provide expertise in development, contract, procurement, stakeholder and procurement management and be able to assist the SRO with project governance and commercial acumen.</p>
<p>Lead Project Manager &amp; Client Representative</p>	<p>Andrew Baillie</p>	<p>Andrew is a senior project manager within the Capital Planning &amp; Property Department forming part of Capital Procurement team tasked with delivering the boards' capital plan.</p> <p>In this role Andrew is directly involved in the project management of numerous projects forming part of the capital plan with varying complexity and value at any one time.</p> <p>Experience gained in this role and through working closely with Department, Andrew will also be able to provide expertise in contract, procurement, stakeholder and project management.</p> <p>His role in this project will be to lead, manage and co-ordinate the project team and he will be the day to day contact for the NHSGGC project team, the appointed client advisors and hub West Scotland. As a result he will provide expertise in development, contract, procurement, stakeholder and procurement management and be able to assist the SRO with project governance and commercial acumen.</p>
<p>Commissioning Manager</p>	<p>Heather Griffin</p>	<p>Heather is a Senior General Manager within the Capital Planning &amp; Property Department and it is her role to lead on all of the boards commissioning, decommissioning accommodation and migration projects as well as post project evaluations.</p> <p>In this role Heather has led on numerous commissioning projects, including secure mental health facilities and including projects with Andrew. It is her experience in DBFM Commissioning and existing relationships that will be utilised for this</p>

		project.
Project Monitoring Manager	Frances Wrath	<p>Frances is the designated Post Project Evaluation Manager within the Capital Planning &amp; Property Department.</p> <p>For this project Frances has assisted on developing the Benefits Realisation and Evaluation Plan, has drawn up the post project review plan; ensuring its compliance with latest SCIM guidelines for this project and will lead on all aspects of the post project review process.</p> <p>As Full Time Post Project Review Manager Frances has undertaken this role on a number of projects of various sizes over the last two years and is conversant with all SCIM requirements in respect of Post Project Evaluation.</p>
Project Finance	Marion Speirs	<p>Marion is a senior project management accountant within the Finance Department of NHS GG&amp;C forming part of team tasked with delivering the boards' capital plan. Marion has acted as Financial Lead on all NHSGGC hub projects to date. These have included completed projects (Maryhill H&amp;CC and Eastwood H&amp;CC), projects currently on site (Orchard View Mental Health Wards, Woodside H&amp;CC and Gorbals H&amp;CC) and projects currently in development (Greenock H&amp;CC and Clydebank H&amp;CC)</p> <p>In this role Marion is directly involved in the financial project management of numerous projects forming part of the capital plan with varying complexity and value at any one time.</p> <p>Experience gained in this role and through working closely with Departments and HSCPs, Marion will also be able to expertise in financial bundling and project management.</p> <p>Her role in this project will be to lead, manage and co-ordinate the financial input to the project and he will be the day to day financial input for the NHSGGC project team, the appointed</p>

		client advisors and hub West Scotland. As a result she will provide expertise in financial management and be able to assist the SRO with project governance and commercial acumen.
--	--	--

David, Katrina, Andrew, and Marion have been involved with the project from before submission of the Outline Business so have a detailed understanding of the project objectives and the process of delivery. All have confirmed capacity to continue in their roles ensuring continuity of knowledge and the required skills. Heather, through her existing relationships with Andrew and Katrina is aware of the projects resource requirements and timescales and has capacity to deliver the DBFM Commissioning. Similarly, Frances has an existing relationship with Heather, Andrew, Katrina and Marion and has developed a good awareness of the project through the OBC and FBC processes. Through this engagement there is a sound basis of planning for project monitoring criteria including and ensuring time for resource planning to undertake the monitoring required.

Those individuals detailed above will be supported both internally and by those appointed as client advisors and hub West Scotland. Expertise of the key roles and key competencies is described above but further expertise on commercial acumen is achieved through NHSGGC Head of Capital Finance Alan McCubbin and Chief Finance Officer for Glasgow City HSCP Sharon Wearing. Both Alan and Sharon are members of the Health Boards' Capital Planning Group and their shared experience ensures that the project has appropriate commercial expertise. This expertise together with that identified in the above table demonstrates that the project structure contains the required skill set to successfully deliver the project with no gaps in the required skills present.

#### 6.2.6. Project recruitment needs

No project recruitment needs have been identified at this stage.

#### High Level Project Plan

**Table 29 High Level Project Plan**

OBC Consideration\Approval	June\July 2017
Stage 2	July 2018
FBC Consideration\Approval	August\October 2018
Financial Close	November 2018
Completion date	April 2020
Services Commencement	May 2020

Project Programme attached at Appendix 5.

### **6.2.7. Change Management Arrangements**

To achieve successful change management outcomes key staff will continue to be involved in a process of developing detailed operational policies and service commissioning plans that will be incorporated into the benefits realisation plan

### **6.3. 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 Katrina Phillips 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.

#### **6.3.1. 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.

### **6.4. Communications and Engagement**

In terms of the development of the project to date, the OBC and FBC have been developed through consultations with the following internal and external stakeholders.

#### **6.4.1. Stakeholder engagement and communication**

#### **6.4.2. 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
- Community Councils
- Community Transport Glasgow

- Glasgow City HSCP
- Head of Mental Health Services
- Clinicians
- Nurses
- AHP
- Facilities Management
- Occupational therapists
- Therapeutic activity nurses
- Dieticians
- Practice Development nurse
- Secretarial staff
- 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)

### 6.4.3. 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 30 Engagement with Stakeholders - Stobhill**

<b>Stobhill Hospital Stakeholder Group:</b>	<b>Engagement that has taken place</b>	<b>Confirmed support for the proposal</b>
Patients / service users	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	<i>Patient / service user groups were consulted on the final version the Initial Agreement by meeting with the Public Fora and Patient Involvement Group over the last four years and most recently with input via the Mental health Network facilitated events on option appraisal and design work. Their feedback was supportive and consistent</i>

Stobhill Hospital Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
	<p>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 and the design work.</p>	<p><i>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 in addition to the design work including AEDET.</i></p>
<p>Organisation</p>	<p>NHSGGC is fully supportive of this proposal with the lead Director Strategy 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. The OBC was approved by NHS GG&amp;C Health Board 12<sup>th</sup> June 2017.</p>
<p>Service or Department</p>	<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 September 2016</p> <p>The OBC was approved by the by the Project Board May 2017.</p> <p>The FBC was approved by the by the Project Board on 31<sup>st</sup> July 2018.</p>
<p>Staff /</p>	<p>Staff affected by the</p>	<p><i>Staff representatives have</i></p>

Stobhill Hospital Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Resources	<p>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> <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>participated in Mental Health Services Redesign Engagement Group on an on-going basis for the previous four 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, option appraisal, AEDET 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</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. This in later stages has included input to design meeting,</p>



Stobhill Hospital Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
	broader Clinical Services Review over a number of years and specifically direct engagement with the current service user and carer representatives is on-going.	NDAP review, Option Appraisal and AEDET processes.
Other key stakeholder Groups	Community GP's Community Mental Health Teams PPF	<i>The Initial Agreement was well received and supported by the PPF when it was presented at its meeting October 2016.</i>
<i>Other key stakeholders</i>	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 discuss the development the proposed new acute ward on the Stobhill site.	<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>

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 31 Engagement with Stakeholders – Birdston**

<b>Birdston Care Home Stakeholder Group:</b>	<b>Engagement that has taken place</b>	<b>Confirmed support for the proposal</b>
Patients / service users	<p>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</p>	<p><i>Patient / service user groups were consulted on the final version of the Initial Agreement by meeting with the Public Fora and Patient Involvement Group over the last four years and most recently with input via the Mental health Network facilitated events on option appraisal and design work. 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 specific service user and carer cohort on transport access is being progressed and will continue to be reviewed to May 2018. User and Carer representation delivered the Option Appraisal as a key part of the exercise in addition to the design work including AEDET.</i></p>
General public	<p>The general public will be affected by this proposal by improved service pathway</p>	<p>The Initial Agreement was approved at the Health Board Meeting on 18<sup>th</sup></p>

	<p>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>	<p>October 2016. The OBC was approved by NHS GG&amp;C Health Board 12<sup>th</sup> June 2017.</p>
<p>Staff / Resources</p>	<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>Staff have participated in services redesign on an on-going basis throughout the development and presentation of Initial Agreement, OBC and FBC. Staff representatives have been involved in the development of the new solution including contributing to the scope, design, schedule of accommodation and communicating with wider staff. The proposals for relocation of the service was approved by the Project Board September 2016</p> <p>The OBC was approved by the by the Project Board May 2017.</p> <p>The FBC was approved by</p>

		the by the Project Board on 31 <sup>st</sup> July 2018.
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>	<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>

#### **6.4.4. Benefits Realization**

The Benefits Realisation Plan provided (below) in this FBC has been reviewed and confirmed as both appropriate and viable for the stage. Whilst the core benefits have remained in place from the Strategic Assessment, the Plan has been expanded upon from that included in the OBC to provide a baseline measurement and a target outcome to ensure there is a clear ability to monitor progress and quantify success through subsequent project evaluation.

Softer qualitative benefits have also been included within the Benefits Realisation Plan. These will be included in any monitoring and evaluation through the construction, commissioning and post occupancy phases.

Evaluation of all benefits will be led by the NHSGGC Post Project Review Manager with the assistance of the Project Board; Project Delivery Group, and where necessary stakeholder representatives from staff, patients and visitors' groups.

### Benefits Realisation Plan

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<p><b>1. Enable speedy access to, modernised, Adult and older peoples continuing care (mental health services), that achieves national standards. Development of fit for purpose healthcare facilities suitable for needs of the service in accordance with modern standards.</b></p>							
	<p>1 Medical Practitioner day and night cover increased 100% on site</p>			<p>Medical Rotas</p>	<p>Medical Staffing Audit  Medical on-call currently provided by non-mental health psychiatry General Medical Practitioner contract</p>	<p>Medical on-call for Older adult hospital based complex clinical care provided as an element of and by mental health psychiatry on-call system</p>	<p>12 months post opening</p>

### Benefits Realisation Plan

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
	2 Increased use of anticipatory care planning			Average length of stay for ward (acute)	Average length of stay 6 months pre-opening. Average length of stay 12 months to April 2017 is 43.1 days for the equivalent ward	Comparison to the average length of stay for all adult acute wards	12months post-opening

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
	3 Increased use of anticipatory care planning			Hospital based complex care HBCC	4 admissions 12 months to April 2017 for the location.		12months post opening
	4 Better bed mix for older people			Number of functional and dementia older beds affected by project	<p>Number of hospital based complex clinical care beds and older adult acute short stay beds Birdston</p> <p>20 functional hospital based complex clinical care beds @ April 2018. Nil older adult acute beds at site @ April 2018</p>	<p>Number of functional and dementia beds Stobhill on opening – anticipated 20 older adult hospital based complex clinical care beds on opening co-located with 24 functional and 20 dementia older adult acute beds</p>	



	5 Improve functional suitability of Mental Health estate			Number of single en-suite bedrooms on wards	Percentage six months prior to opening. 0% en suite single rooms at Birdston (currently single rooms with toilet and wash hand basin.)  Equivalent adult acute ward on Stobhill site has 30% single en suite rooms	Anticipated increase – range up to 100% of rooms en suite for two new DBFM builds	
	6 Reduction in people waiting to be discharged into more appropriate care setting			Number of adults(average) delayed discharges	12 months prior to opening  Average 5 Glasgow City North East Adult delays June 2017 – May 2018	Reduction in average number Glasgow City North East Adult delays for a calendar year	12 months post opening

	7 Reduction in people waiting to be discharged into more appropriate care setting			Number of older adults (average) delayed discharges	12 months prior to opening  Average 3 Glasgow City North East Older adult delays June 2017 – May 2018	Reduction in average number Glasgow City North East Adult delays for a calendar year	12 months post opening
	29 Improved equity and access to ward			Number of service users admission refused due to gender	12 months prior to move  NIL (anecdotally - not a data system item to prove / evidence - may ultimately need to exclude		12 months post move

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<b>2. Improve and maintain recruitment and retention of staff; improvement in staff satisfaction</b>							
	10 More efficient use of staffing resource			Reduction in nursing in-post	Acute ward 12 months to 01/03/2018  Average 32.58 wte		12 months post opening
	11 More efficient use of staffing resource			Reduction in nursing in post	HBCC ward 12 months to 01/03/2018  Average 23 wte		12 months post opening
	15 Reduce sickness absence rates amongst staff			Sickness absence rates for the wards	Rates 2016/2017  Equivalent HBCCC Ward 12.4%  Equivalent Adult Acute Ward 7.0%		12 months post opening
	16 Improved Staff recruitment			Reduced bank staff use for vacancies	Rates 2017/2018 (Jul – Jun)		12 months post

					Equivalent HBCCC Ward 4,431 hours		opening
					Equivalent Adult Acute Ward 4,310 hours		
	17 Improved staff retention			Reduced bank staff use for vacancies	Rates 2017/2018 (Jul – Jun)	Rates	12 months post opening
					Equivalent HBCCC Ward 4,431 hours		
					Equivalent Adult Acute Ward 4,310 hours		
	31 Improved working environment			Staff survey on working environment & absence rates	Rates 2016/2017		12 months post move
					Equivalent HBCCC Ward 12.4%		
					Equivalent Adult Acute Ward 7.0%		

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<b>3. Improved Service User satisfaction</b>							
	20 Improved patient support			5% decrease in absconsions	No of Datix reported in year 12 months 2017/18  Adult acute one ward equivalent 38 absconding / missing per year  HBCCC average 1 absconding / missing per year	Number of Datix reported 12 months post opening	12 months post opening
	21 Improved service user well being			Reduced incidents aggression	No of Datix reported in year 12 months 2017/18  Adult acute one ward	No of DATIX reported incidents 12 months post opening	12 months post opening

					<p>equivalent 69 incidents of violence and aggression per year</p> <p>HBCCC one ward equivalent 45 incidents of violence and aggression per year</p>		
	22 Improved service user socialisation			Service user rating service available as good	<p>Service users survey 12 months prior to move</p> <p>Ward Discussions take place minimum twice per annum – summary of discussions issues</p>	<p>Service users survey 12 months after</p> <p>Ward Discussions take place minimum twice per annum – summary of discussions issues</p>	12 months post opening
	24 Safer HBCC accommodation			Number of reported trips and falls of	No of Datix reported in 12 months	12 months reporting on DATIX post	12 months post

				service users	2017/18  Adult acute one ward equivalent 20 incidents of trips, slips and falls per year  HBCCC one ward equivalent 46 incidents of trips, slips and falls per year	opening	opening
	28 Improved confidentiality, privacy and dignity for service users			Complaints regarding breach of values	Nil Number of complaints where accommodation limitations contributes to breach of values prior to move 2017/2018 (MH Clinical Governance & Quality Group Report).	Number of complaints where accommodation limitations contributes to breach of values 12 months post move (MH Clinical Governance & Quality Group Report).	12 months post opening

					Ward Discussions take place minimum twice per annum – summary of discussions issues includes people would like improved external space		
	32 Improved comfort ambiance and atmosphere of the wards for some users/carers and visitors			Service user and care survey whereby by majority of these surveyed who experienced the same service at pervious ward voice a measurable improvement in the new ward	Ward Discussions take place minimum twice per annum – summary of discussions issues and design discussions includes people would like improved reception and visitor spaces	Post move timescales TBC	12/18 months post opening



Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<b>4. Improved Catchment for service users</b>							
	33 Improved catchment access. HBCC wards			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	12 Months post move based on catchment address on admission.  Survey	12 months post opening

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<b>5. Deliver a more energy efficient building within NHSGG&amp;C estate, reducing CO2 emissions and contributing to a reduction in whole life Costs through achievement of BREEAM excellence rating.</b>							
Deliver a more energy efficient building within the NHSGGC estate reducing CO2 emissions and contributing to a reduction in whole life costs.	Sustainability  Increase capacity and adaption of facilities in which services delivered and based	Capital Planning/ Facilities leads within NHSGGC		CO2 emissions and energy consumption rate.	Assessed upon facility becoming operational	Meeting the sustainability standards as detailed in the Authority Construction Requirements (ACRs)	Review after 1 year of facility being operational
Achieve a BREEAM Healthcare rating of "Excellent"	Sustainability	Capital Planning/ Facilities leads within NHSGGC		Independent assessment by BREEAM accredited assessor	Assessed upon facility becoming operational	BREEAM score of 70 or over. Securing BREEAM Healthcare Rating of Excellent	Review after 6 months of facility being operational

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<p><b>6. Achieve a high design quality in accordance with the Board Design Action Plan and Guidance Available from Architecture and Design Scotland.. The creation of an environment people want to come and work in and feel safe in and that preserves the dignity and privacy of vulnerable people whilst maintaining their safety and security</b></p>							
Achieve a high design quality in accordance with the Board's Design Action plan and guidance available from A+DS	Improve patient experience/good working environment for staff, carry out an AEDET with Delivery Group	Capital Planning/ Facilities leads within NHSGGC		Use of quality design and materials to create a pleasant environment for patients and staff  HAI cleaning audits (regular NHSGGC process  Completed building	Assessed upon facility becoming operational	Secure a joint statement of support from A+DS and HFS via the NHS Scotland Design Process (NDAP)	Review after 6 months of facility being operational
	12 New models of care for new			Numbers of internal transfers	12 months pre-	12 months	

	wards			out with North East sector (Acute)	opening Occupied bed days boarding from equivalent ward – average 2017  70 occupied bed days per month	post opening Occupied bed days boarding from equivalent ward – average occupied bed days per month reduced target (40 occupied bed days potential)	
	13 New models of care for new wards			Older people HBCCC wards increased flow indicated by admissions discharges and occupancy average increased all hospitals	Older people HBCCC wards Feb – May 2018 admissions 44, discharges 52 and average occupancy 81.7% all HBCCC hospitals	12 months post opening	
	25 Improved access to natural daylight/natural			Personal & public accessible	Audit of service user opinion/carer	Audit of service user opinion/carer	

	sunlight, environment			spaces adjacent to and within ward area as per SCIM design statement	opinion prior to opening  Ward Discussions take place minimum twice per annum – summary of discussions issues – previously identified outdoor space as needing to be improved.	opinion post opening	
	26 Improved flexibility and functionality of building			Flexibility of design of development will reduce need for major adaptations of £50K in 10 years	Adaptations costs circa 10 years prior to move  £2.1m adult acute ward  £1.13m HBCCC		Decade post move
	30 Improved Infection Control			Infection control audits indicate measurable	12 months pre move		12 months post

				improvements			move
	23 Improved key adjacencies on wards			Minimum 80% delivered as specified in clinical brief	Reviews of clinical brief	Comparison to building post opening	

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<b>7. Meet statutory requirements and obligations for public buildings e.g. with regard to Equalities Act</b>							
Meet statutory requirement and obligations for public buildings e.g. with regards to DDA	Improve Access, Carry out Survey with I	Capital Planning/ Facilities leads within NHSGGC		Carry out DDA audit and EQIA of building:  Engagement with local groups to ensure building is welcoming	Assessed upon facility becoming operational	Compliance with Disability Discrimination Act, building Control Standards and NHS SHTMs.	Review after 1 month of facility being operational

8. Achieve a high design quality in accordance with the Board Design Action Plan and Guidance Available from Architecture and Design Scotland.. The create

Main Benefit	Investment Objective	Objective Owner	Dependencies	As Measured by	Baseline	Target (details required)	Timetable
<b>8. Contribute to physical and social regeneration of the area</b>							
14 Community Integration				Increased menu of activities including community activity in reach	6 months prior to opening	Increase in activities	6-12 months post move
				Work experience building contractor placements	Nil	Build phase 4	Build phase
				Building Contractor Employment Opportunities	Nil	Build phase 3	Build phase
				Building Contractor Apprenticeship Employment Opportunities	Nil	Build phase 1	Build phase



### 6.4.5. Risk Management

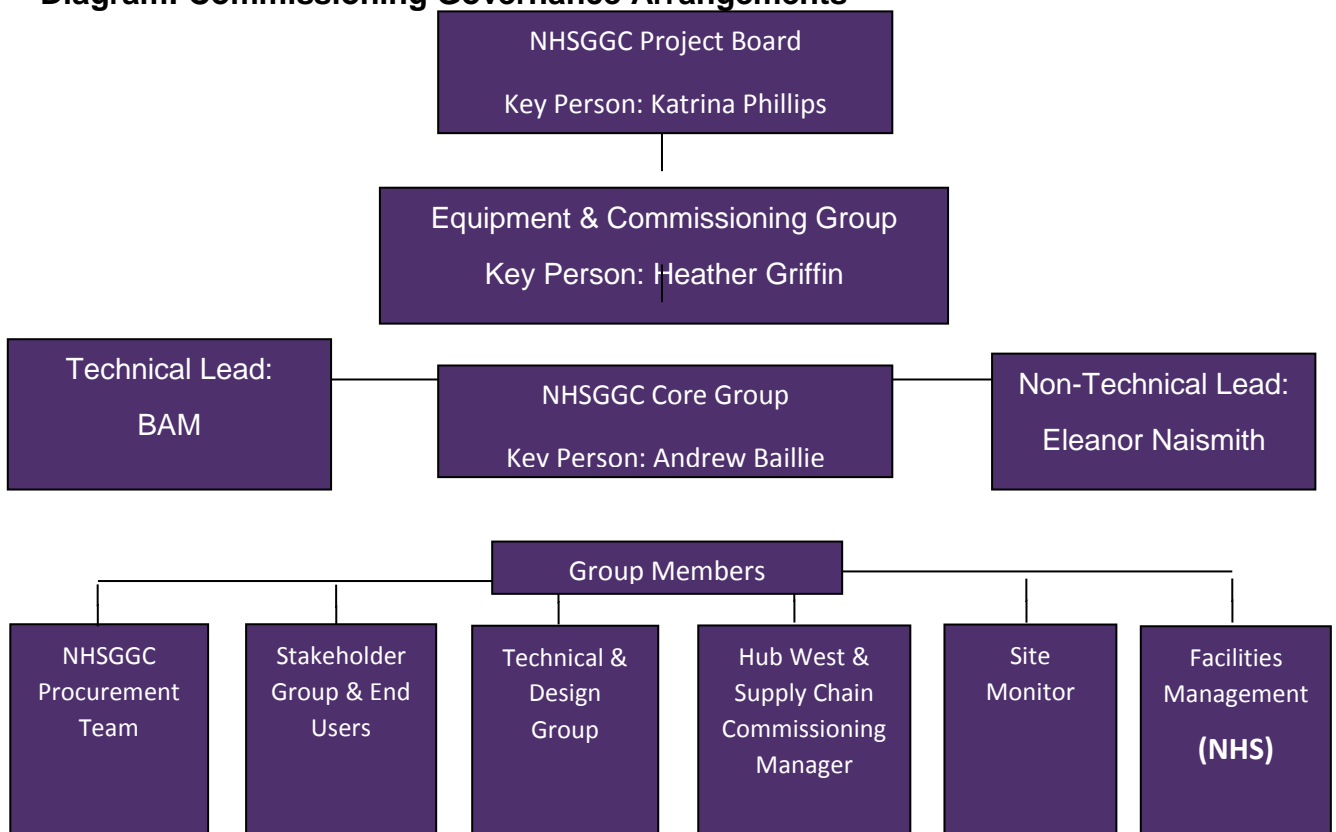
The Risk Management Register is a living report which is reviewed and updated as required at each monthly Project Group meeting. The Risk Register (see appendix) incorporates HUB process and service risks. The risk register has been reviewed over the course of Stage 2 to validate the Risk position. The current risk allowance within the final price is £91,309 which represents 1% of the Prime Cost and Preliminaries. This aligns with the maximum agreed Stage 2 risk cap. The main project risks and mitigation factors are identified at a high level at the OBC stage. As the project has developed through the FBC stages a more detailed and quantified risk register has been prepared. The main risks at this stage are highlighted in the appendix.

### 6.4.6. 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.

### Commissioning Governance Structure

Diagram: Commissioning Governance Arrangements



Senior General Manager Planning and Resources, has been identified as the key NHSGGC person for commissioning and will lead and chair the Equipment & Commissioning Group. Commissioning for the project will include both Technical and Non- Technical elements and, as noted in the structure above has a lead named person identified for each element. Project Manager Commissioning is identified as the Non- Technical lead. Project Manager Commissioning works as part of the non-technical commissioning team and has experience of both leading and assisting on the non-technical elements of DBFM Commissioning. Both the Senior General Manager and Project Manager Commissioning have confirmed resource ensuring suitability and availability to perform the roles.

Identified in the governance structure above is that the Equipment & Commissioning group lead and technical and non-technical leads all link with the Capital Planning Project Manager. Through their involvement in the project from the outset the Project Manager has been noted in the above structure as he will be able to support all commissioning leads through his established relationships with identified group members, working with the existing communications strategy and sharing of live project information. Working in this way, with the Project Manager's involvement, key stages of the commissioning process have been established to ensure the design and construction process is managed in such a way to reach all required milestones.

Examples of milestones reached relating to DBFM Commissioning, through the design process include:

- Design freeze
- Signed- off Fixtures, Furniture & Equipment (FF&E) schedule including grouping
- Establishing procurement streams
- Surveys for design and construction interfaces
- Establishing areas for closure during construction & duration of closures
- Access protocols
- Engagement protocols
- Construction completion date
- Technical testing and commissioning programme

The current Commissioning Requirements Brief (CRB) is provided in Appendix. The approach described for both Technical & Non- Technical commissioning below has provided input to the CMP and CRB and also a basis for the governance and reporting structure.

**Technical Commissioning** (BAM) will lead on the technical commissioning, and the Independent Tester appointed will sign off prior to NHS taking possession of the building.

#### **Non-Technical Commissioning**

Through development of the FBC, the Senior General Manager was identified as Commissioning Manager for NHSGGC as well as the lead for the Non- Technical commissioning element. Led by the project manager, the project has seen completion of room data and component sheets and the full schedule of FF&E components. Completion of this process has meant all components have been identified; their procurement route has been established and identified as either DBFMCo or direct by NHSGGC.

Within the governance structure, a stakeholder and end user group is identified. This group comprises all parties impacted through and beyond the commissioning process: staff, clinical and non- clinical staff members, and patient representation as

well as services representing IT, infection control and telecoms. It has also been agreed that through the process further members may be identified and included as required.

Through identification of the non-technical items for commissioning the following has been established and has been used for the development of the Commissioning Master Plan and Commissioning Requirements Brief:

- Agreed procurement routes for items including understanding if existing routes and supply chains exist or if new routes are required.
- Implementing routes to tendering carried out in accordance with NHSGGC standing financial instructions.
- Established protocols for stakeholder engagement and review periods to finalise items for procurement and commissioning.
- Established timescales for item commissioning reviewed and agreed in line with overall project programme. Timescales now include engagement and review periods, lead in, install and testing, commissioning and training required.
- Established if item commissioning requires Contractor input regarding any preparatory or install works. Contractor works have taken cognisance of such work identified which now forms part of the construction and installation works.
- Overall works and commissioning programme and construction contract agreed in such a way to provide beneficial access agreed through the construction contract.

#### **6.4.7. Finalise the Project Monitoring and Service Evaluation Plans**

This section will provide firm details of the Project Monitoring and Service Benefits Evaluation Plan previously outlined at OBC stage.

Project Monitoring plans and methodologies have been developing throughout the OBC and FBC process. This has been achieved through engagement and collaboration with Frances Wrath, Andrew Baillie, the appointed DBFM Co and the core user and stakeholder groups to ensure plans, methods, timescales and means of engagement forming part of the monitoring and evaluation process have been agreed by all parties.

The following provides an explanation of monitoring undertaken for the various components of the project. Evident here is how key the function of the core group is. Reporting carried out through the core group is not only related to output required for project monitoring but is also a requirement within the contractual arrangements in place with the appointed DBFM Co.

As described in the current Project Execution Plan (see Section 6.4 and Appendix 5), a variety of meeting types are in place to ensure appropriate monitoring and compliance with the contractual arrangements. A summary of the approach, including the key core group, is presented below and further described in the Project Monitoring and Evaluation Plan (Table ???) below:

- Project Board meetings will be held every 4 weeks with key elements of monitoring forming part of the agenda.
- Affordability Assessment: Monitoring overall project affordability will be carried out through the joint cost advisor role with representation and input by costs advisors. Assessment will be against baseline costs presented in the FBC.
- Works Delivery Costs: A project spend profile has been developed to include the Target Price and all project related costs. The joint cost advisors will review and report spend against the profile highlighting any issues.
- Project Programme: Monitoring will be in accordance with the requirements of the DBFM contract. An updated programme will therefore be provided every 4 weeks or as required / requested through the contract allowing ongoing up to date monitoring.
- Project Scope Changes: Changes, either through client or DBFM Co requirements, will be discussed and follow the established Change Control and Governance Procedures.
- Health & Safety Performance: All have a role in monitoring performance. Formal reporting will be provided by the DBFM Co with input and review from the appointed CDM Advisor.
- Risk Management Issues: Full review of current project Risk Register by Project Board.
- Design & Technical: Update from designers will be provided along with any request for stakeholder engagement in line with agreed contract protocols.
- Construction Quality: Achieving required quality is the responsibility of the DBFM Co. Quality monitored and reported on at Project Board by Site Monitor through site visits, both planned and ad- hoc.
- Design & technical meetings will be held as DBFM Co feels appropriate, alternating frequency with the core group, or as required. Discussions requiring stakeholder engagement will be arranged in accordance with the engagement protocols in place to ensure required representation.
- Stakeholder Engagement. Stakeholders will be represented at the core group meeting and be engaged for design and technical discussion and any elements of change. Stakeholders are identified in the PEP, with the most appropriate representatives forming part of the monitoring and evaluation process. Further detail on how stakeholders will be kept engaged is provided in the communication plan provided in section 6.
- As described in section 6. Risk review will be an ongoing process and form part of all project meeting agendas.

## 6.5. Monitoring & Evaluation Plan: Project Monitoring Programme

Table 32: Project Monitoring Programme

What will be assessed	When it will be carried out		How it will be done (approach)
	Milestone Date	Report submission	
<b>Project Monitoring stage:</b>			
Affordability Assessment	As part of the FBC approval. Ongoing assessment at Project Board meetings as part of change management and cost reporting.	Commercial report provided for each Project Board meeting. Final assessment report as part of Outturn Cost Report by financial close )	Affordability will largely be assessed as part of the FBC submission. On approval and construction commencing the Financial Close information will form the baseline for reporting. An Addendum to the FBC will be produced and forwarded to SGHSCD. Ongoing affordability will be assessed during the implementation stage through the change management process as part of the regular Project Board meetings. Costs will be assessed against the approved capital spend.
Outturn Capital Costs	November 2018	By financial close	Comparison between FBC&FC . The report will provide a detailed breakdown of any cost changes

			and impact of risks realised or mitigated.
Outturn Revenue Costs	December 2021 (18 months after occupation)	December 2021 (18 months after occupation)	The revenue costs will be assessed against the baseline and the target reductions identified within the FBC and benefits register.  The resulting report will provide a breakdown of the actual costs against forecast.
Stakeholder Support	Minimum 4 Weekly Project Board during implementation.	Recorded as part of meeting minutes published within 5 working days of each meeting.	Signed stakeholder support letters to be provided as part of the FBC submission.  Regular Project Board meetings throughout the project to maintain support and direction from project SRO. Key project information to be passed to those forming Stakeholder support.
Stakeholder Engagement	Monthly Progress Meetings during implementation with stakeholder representation.  Stakeholder engagement meetings as required through project.	Monthly from construction phase start November 2018	Pre- Start, progress and Commissioning meetings will be held throughout implementation to ensure continued stakeholder engagement as outlined within the PEP.  Part of the Service Benefits Evaluation Report undertaken after 18 months of occupation will seek

			stakeholder feedback on engagement through the project.
Project Programme	Minimum monthly during implementation	Report provided for each Delivery Group/ progress meeting, by Independent Tester.	Programme status contained on monthly DBFMCo& PM Reports.  Comparison between contract completion dates and planned completion dates reviewed: identify slippage or otherwise.
Project Scope Changes	4 Weekly Project Board during implementation  OR  As required for urgent emerging issues	Recorded as part of Delivery / progress/ design & technical meeting minutes published within 5 working days of each meeting	Significant changes in project scope are reviewed at the Project Board to ensure stakeholder and SRO support.  Change management discussed at Delivery group on a monthly basis to review changes to the works.
Health & Safety Performance	Ongoing through project.	Report provided for each Delivery Group meeting.  Report as required by any party in event of emergency.	Health & Safety issues captured and reviewed on the monthly Main Contractor Advisor report and DBFMCo Reports.
Construction Quality	Ongoing through construction and	DBFM Completion date and on completion of Commissioning	Provision of quality to the required standard is the responsibility of the DBFMCo.

	commissioning.	and Soft landings process. Concluded through issue of Independent Tester defects certificate.	Monitoring of quality will be carried out and reported on by the DBFMCo, Independent Tester and Principal Designer. DBFMCo target is zero snagging and defects at completion.
Design & Technical Aspects	Monthly during of Delivery / progress/ design & technical meeting or as required for specific issues	Recorded as part of meeting minutes published within 5 working days of each meeting	Technical design meetings are to be held every four weeks involving the Delivery Group and if required external stakeholders. This provides the opportunity to review the delivery of the design and agree on new design solutions or clarifications during implementation.
Risk Management Issues	Monthly as part of Project Board meetings	Report and risk register review as part of each project board meeting. Risk review meeting held as required.	Monthly Project Board meetings during implementation to review mitigate and add risks as required. Shared risks are avoided in order to reduce any potential for lack of ownership. Designated client risks are defined in the contract with all other risks passed to the DBFMCo at Financial Close.
Community Benefits	Quarterly as part of Delivery group/ progress	DBFMCo will provide monthly reports at the	DBFMCo have agreed a community benefits plan that exceeds baseline targets for a



	meetings.	<p>DeliveryGroup/ progress meetings.</p> <p>Targets were agreed on DBFMCo appointment and updates on achieving targets or otherwise will be provided through the project.</p>	<p>project of this size.</p> <p>An updated community benefits tracker has been developed at FBC detailing progress to this stage.</p> <p>Many benefits will be realised through the construction stage and a final report on those achieved will be provided on completion of the commissioning and soft landings process.</p>
--	-----------	---	--

A Project Monitoring Report will be provided to SGHSCD shortly after DBFM Completion incorporating:

- An updated DBFM Cost Monitoring Form
- A Programme Monitoring Form
- Summary of significant scope changes
- Summary of Health and Safety performance
- An overview of achievement of the project design objectives
- A review of the management of risk throughout the project development

### **6.5.1. Monitoring & Evaluation Plan: Service Benefits Evaluation**

Provided within section 6.11 is the project Benefits Realisation plan comprising core benefits identified and developed from the Strategic Assessment. As an addition, softer benefits have been developed post OBC, which have now been included in this FBC. For both core and additional benefits, on-going development has included the addition of Baselines and Targets which will form the basis of the evaluation of the service benefits.

Further details on the approach and engagement through the evaluation process are provided in the 'Monitoring & Evaluation Plan – Service Benefits Evaluation' table below. The table also contains information on the approach to gaining overall feedback on the project from the stakeholder group.

Initial review and evaluation will be undertaken within 3 months of occupation and will provide a final project monitoring report to be submitted to SGHSCD.

A further evaluation will take place 18 months post occupancy which allows for reasonable bedding in period following the occupation of the new facility. The main focus of the evaluation will involve:

- Assessment of whether and to what extent the project has realised its expected benefits
- Gaining feedback from users and other stakeholders on the project outcomes i.e. how stakeholder expectations have been met
- Reviewing the impact of any service change on operational activities, processes and people
- Understanding of how well the project has impacted on service activity and performance.
- Reflection of what went well and what could have been improved to provide learning to be passed on to other similar projects.

**Table 33: Service Benefits Evaluation Programme**

What will be assessed	When it will be carried out		How it will be done (approach)
	Milestone Date	Report submission	
<b>Service Benefits Evaluation stage:</b>			
Expected benefits	onwards within a 6 – 24-month timeframe depending on the benefit being evaluated	6 – 24 months following completion depending on the benefit being evaluated	Benefits register completed and endorsed by Object Owners. Evaluation to be completed against the agreed target/ baseline and within the specified 6 – 24-month timescale. A detailed breakdown per expected benefit is provided below.
<b>9.</b> Enable speedy access to, modernised, Adult and older peoples continuing care (mental health services), that achieves national standards. Development of fit for purpose healthcare facilities suitable for needs of the service in accordance with modern standards.	18 months after occupation	18-24 months after occupation	An assessment will be carried out against a baseline taken on August 2018 to review medical staff rotas; average length of stay per ward; use of anticipatory care planning; delayed discharges; increased referral for diagnostic assessment.
<b>10.</b> Improve and maintain recruitment and retention of staff; improvement in staff satisfaction	18 months after occupation	18 months after occupation	An assessment will be carried out against a baseline taken on August 2018 to review more efficient use of staffing resources; sickness/absence

			rates; staff recruitment; staff retention; staff satisfaction survey as part of POE review
<b>11.</b> Improved Service User satisfaction	18 months after occupation	18 months after occupation	<i>An assessment will be carried out against an August 2018 baseline to review patient absconsions; incidents of patient aggression; number of patient trips, slips and falls  As part of the service benefits Evaluation report (POE) undertaken 18 months after occupation workshops, surveys and 1-1 interviews will be undertaken to capture feedback from staff, patients and visitors.</i>
<b>12.</b> Improved Catchment for service users	12months after occupation	12months after occupation	<i>An assessment will be carried out against an August 2018 baseline to review service user catchment address on admission.</i>
<b>13.</b> Deliver a more energy efficient building within the NHSGGC estate reducing C02 emissions and contributing to a reduction in whole life costs.	12months after occupation	12months after occupation	Will be assessed during first year of occupation on how facility meets the sustainability standards as detailed in (ACRs)
<b>14.</b> Achieve a BREEAM Healthcare rating of	6 months after	6 months after occupation	Independent assessment by BREEAM accredited

"Excellent"	occupation		assessor
<p><b>15.</b> Achieve a high design quality in accordance with the Board Design Action Plan and Guidance Available from Architecture and Design Scotland.. The creation of an environment people want to come and work in and feel safe in and that preserves the dignity and privacy of vulnerable people whilst maintaining their safety and security</p>	<p>6 months after occupation</p> <p>18 months after occupation</p>	<p>6 months after occupation</p> <p>18-24 months after occupation</p>	<p>AEDET assessment and joint supporting statement from A+DS and HFS</p> <p>An assessment will be carried out against a baseline taken on August 2018 to review new models of care for new wards.</p>
<p><b>16.</b> Meet statutory requirement and obligations for public buildings e.g. with regards to DDA</p>	<p>1 month post occupation</p>	<p>1 month post occupation</p>	<p>DDA audit and EQIA of facility involving local disability groups with different types of disability</p>
<p><b>17.</b> Contribute to physical and social regeneration of the area</p>	<p>12months after occupation</p>	<p>12months after occupation</p>	<p>As part of the Service Benefits Evaluation Plan (POE) undertaken after 18 months of occupation a review of the activities available to service users, including community activity in reach</p>
<p>Stakeholder expectations</p>	<p>(18mths after occupation)</p>	<p>18 months after occupation</p>	<p>As part of the Service Benefits Evaluation Report undertaken after 18 months of occupation. This will assess how well the project achieved its objectives with feedback direct from the stakeholders as</p>

			part of the Project Board.
Impact of service change	(18mths after occupation)	18 months after occupation	A Service Benefits Evaluation Report will be undertaken 18 months after occupation and will capture feedback from staff patient and carer surveys.
Service activity & performance	(18mths after occupation)	18 months after occupation	In line with the benefits register the service activity and performance will be evaluated as part of the Service Benefits Evaluation Report.

## 7. Conclusion

Providing the 2 x DBFM wards would fulfil the need for change identified within the Strategic Case at Initial Agreement and Outline Business Case and which still remains a requirement at this FBC submission, providing a solution:

- 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.
- and 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.

The preferred option will also contribute to the 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:

- i) Interagency and interdisciplinary working. The new wards will support the extent of our ambition; to improve accommodation to allow users and carers to be better supported by interdisciplinary working in fit for purpose accommodation.
- ii) Improve access for public and service users. 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.
- iii) Enable speedier access to modernised mental health services.
- iv) Have better integrated services for modernised therapeutic care and co-morbidities in keeping with the Mental Health Strategy 2017-2027 vision. 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. The replacement premises 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.

- v) Improve the safety and effectiveness of our accommodation. 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.

Additionally parts of the service are also reliant on a high cost private contract which expires between now and May 2019.

Approval of this FBC will ensure that the project can move at pace towards the construction and commissioning phase of this critical project.



**Appendix 1 - Report and Analysis from the Options Appraisal Event  
27th April 2017**

# 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.*

1. **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.
- 3) **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.

**4) 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

**5) 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

**6) 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

**7) 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

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

**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 stored 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.

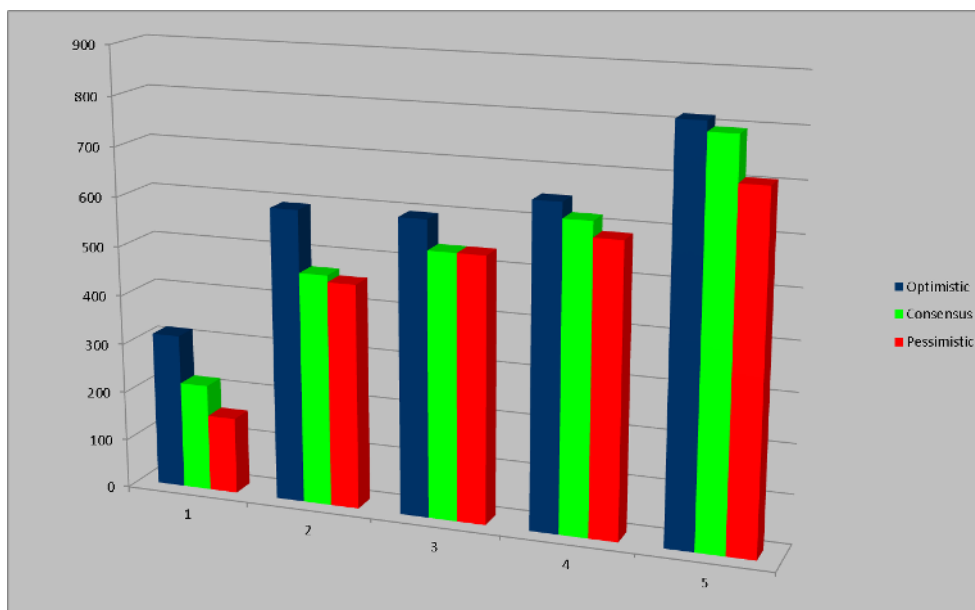
The group optimistic and group pessimistic scores represent the highest and lowest score given by any one of the attendees at the event. These results are also set out in table 2. (Neither the Architect nor the event facilitator gave a score for any of scoring exercises.)

**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:

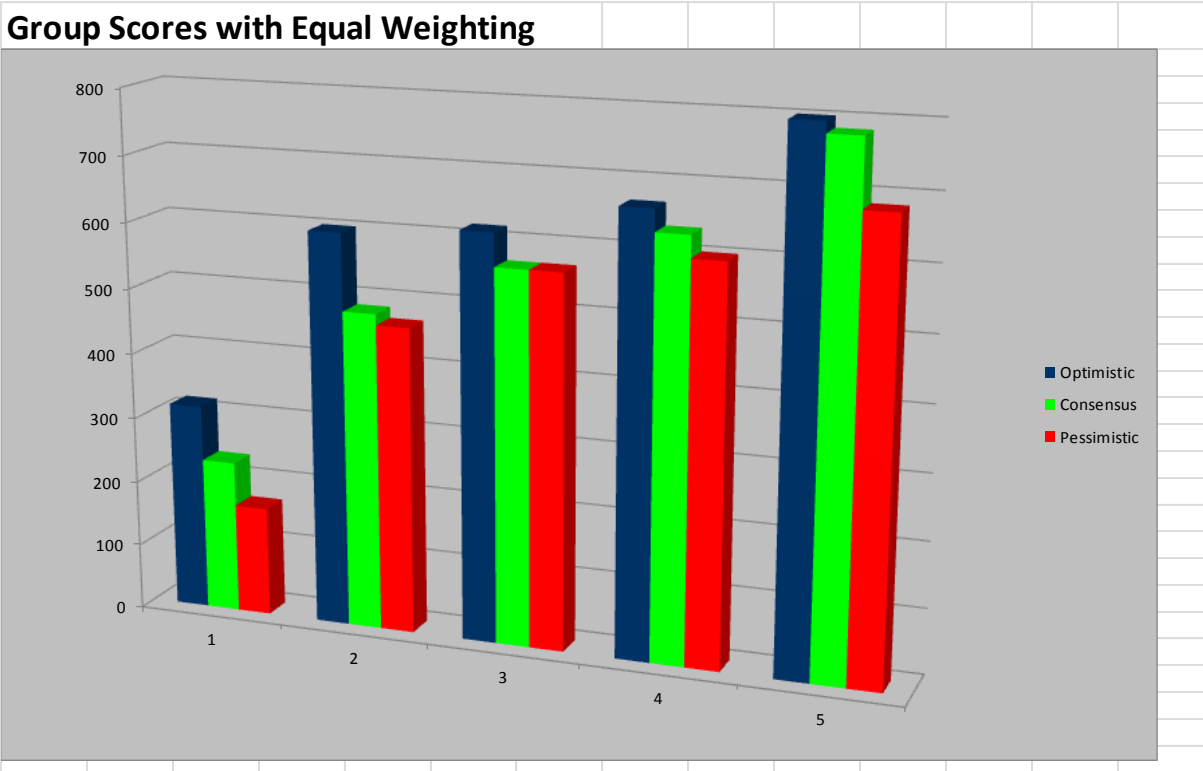
**Table 3A**

#### 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**

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



*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.*

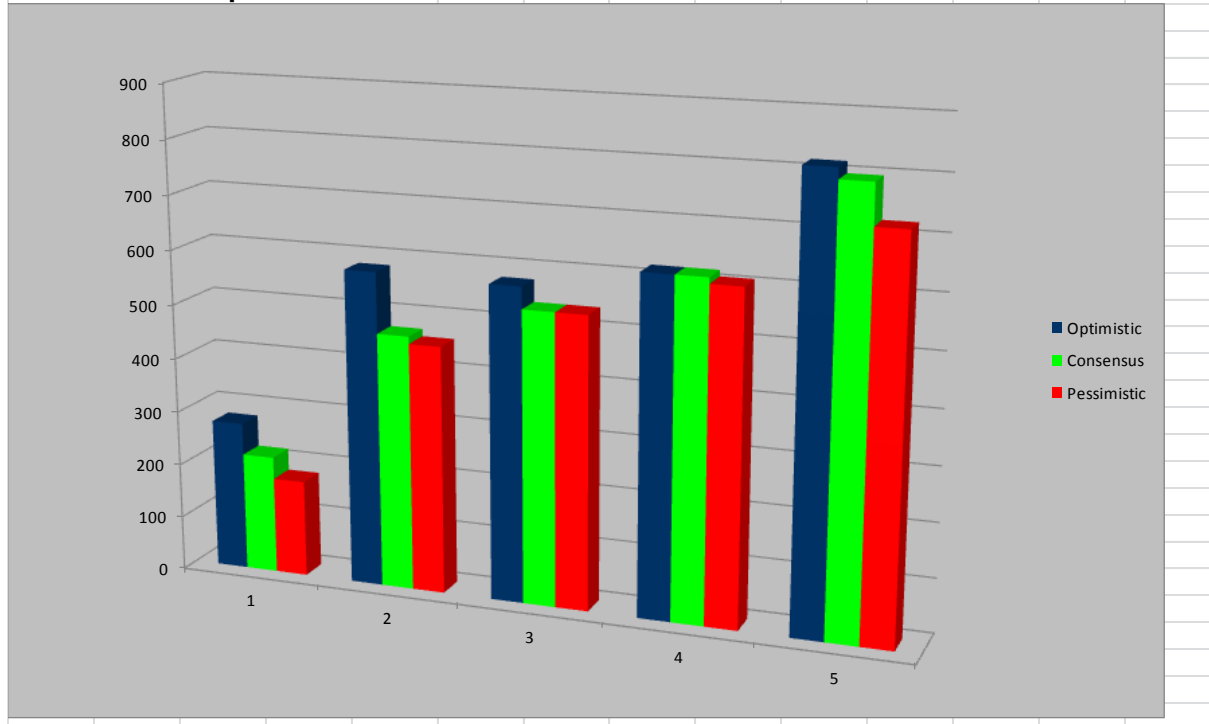
**User & Carer Group and NHS Staff Scoring of the Options**

*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.*





## User & Carer Representatives



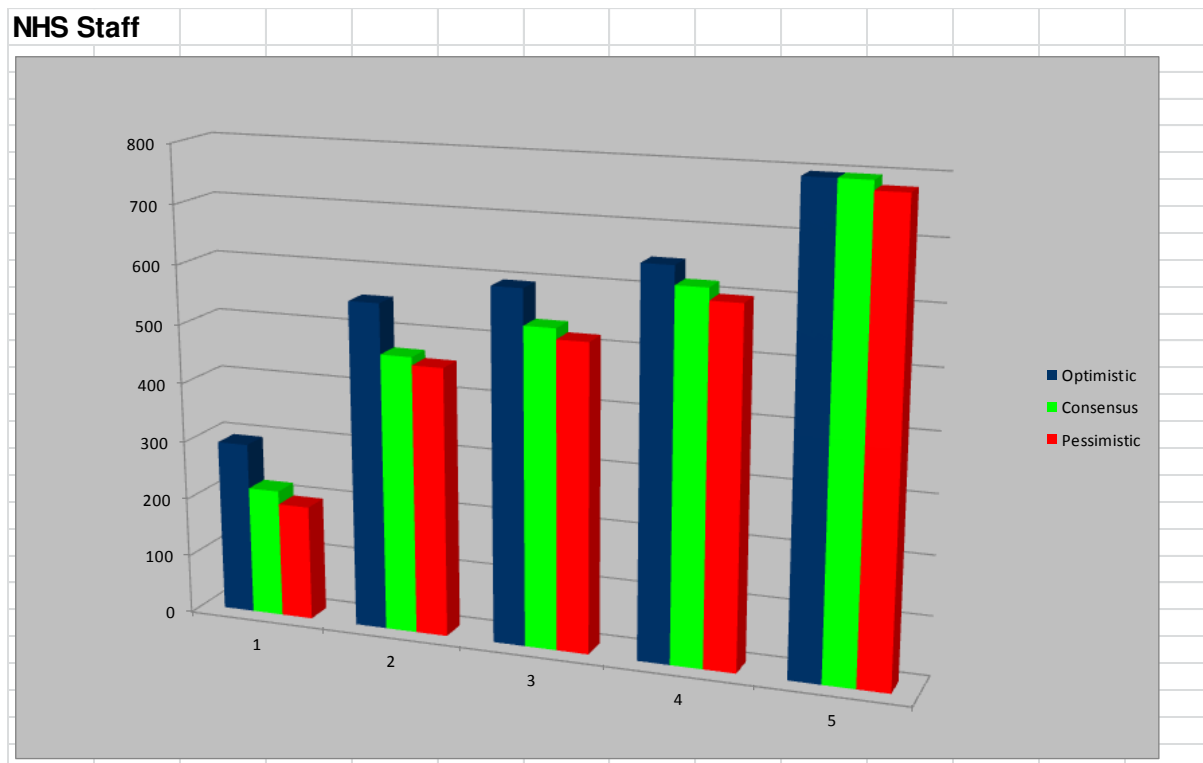
*Changing the scoring, using only the scoring from users and carers representatives, in this way tests for bias. The scores from Users and Carers alone don't alter the relative result of the options under the consensus, optimistic or pessimistic scenario.*

## 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 Table5 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*

## **Appendix 2 - Stobhill Option Document Keppie**

## Stobhill Option Document Keppie



keppie



#### 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.

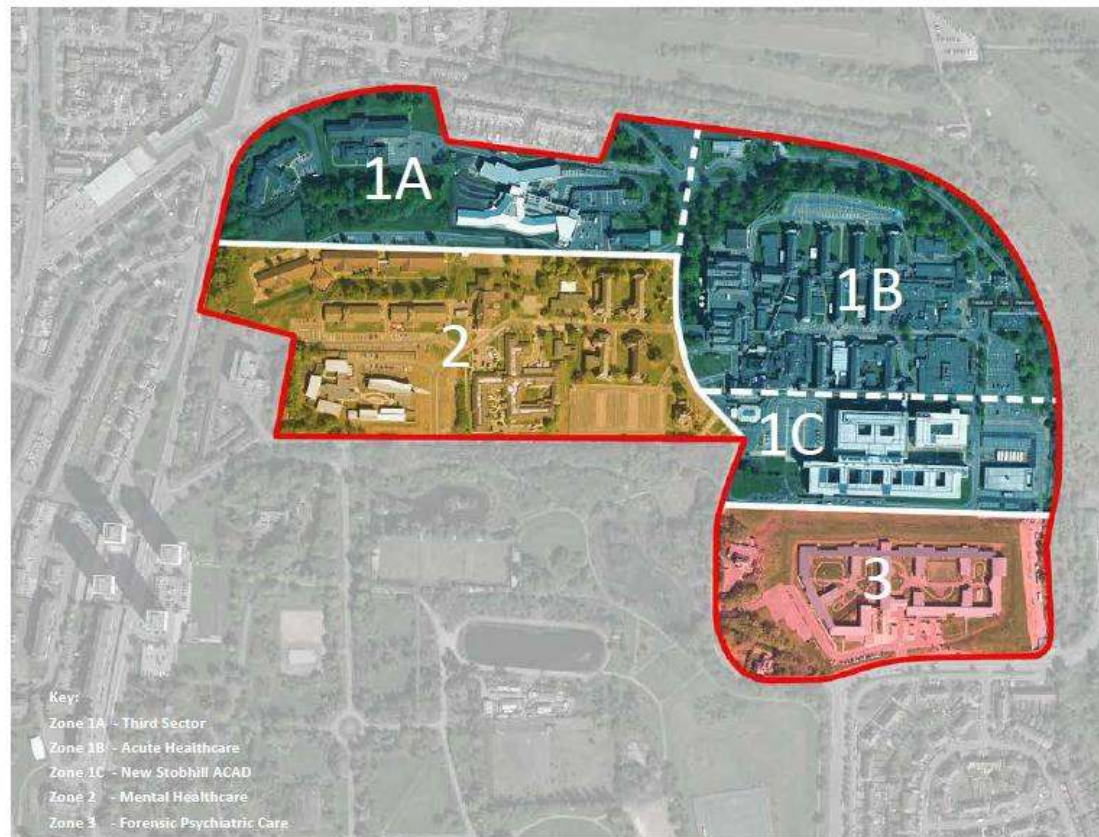
A feasibility study was carried out to determine any suitable and available areas of land on the Stobhill site alongside the current mental health wards for the re-provision of accommodation required. As one of the two wards; 20 beds, provide NHS Hospital Based Continuing Care to challenging behaviour 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:

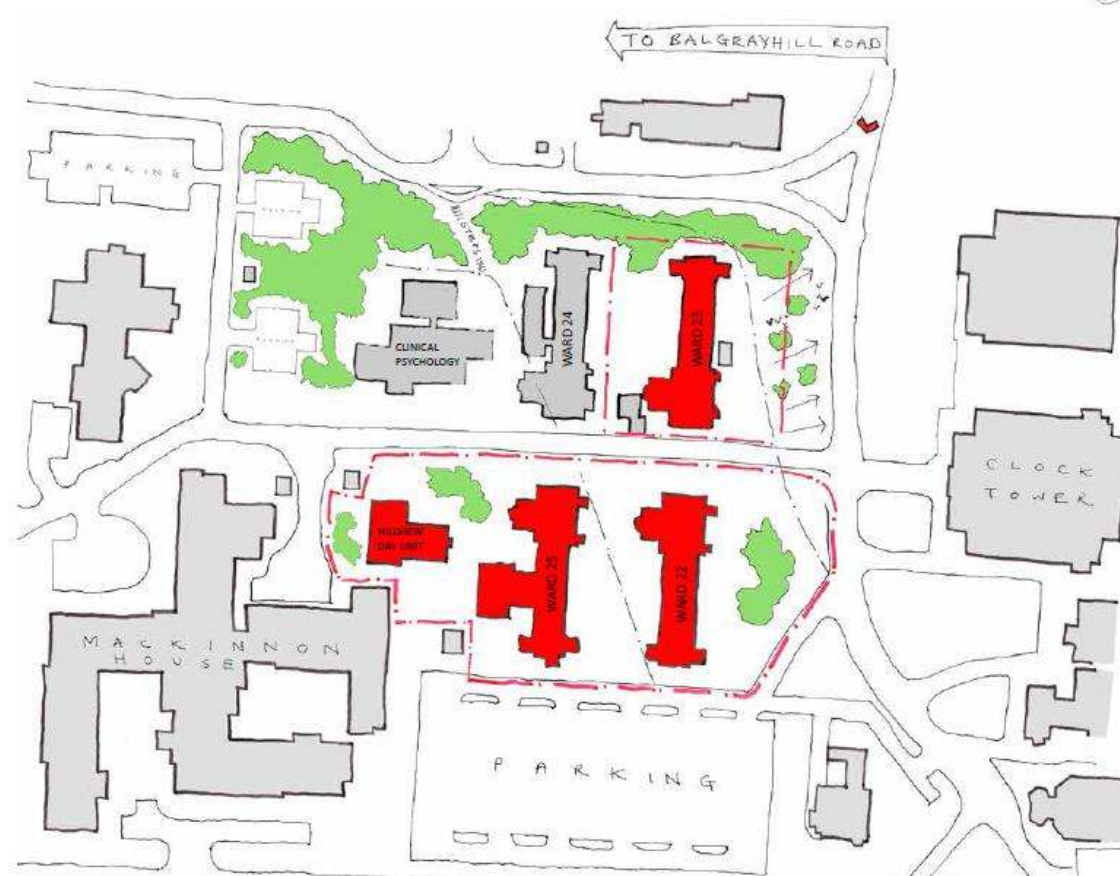
- Option 1 - Do nothing
- Option 2 - Refurb & Extension of Wards 22 and 25
- Option 3 - New Build (Single Building) on site of existing Wards 22 and 23
- Option 4 - New Build (Separate Buildings) on site of existing Wards 22 and 23
- Option 5 - New Build (Separate Buildings) on site of existing Wards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



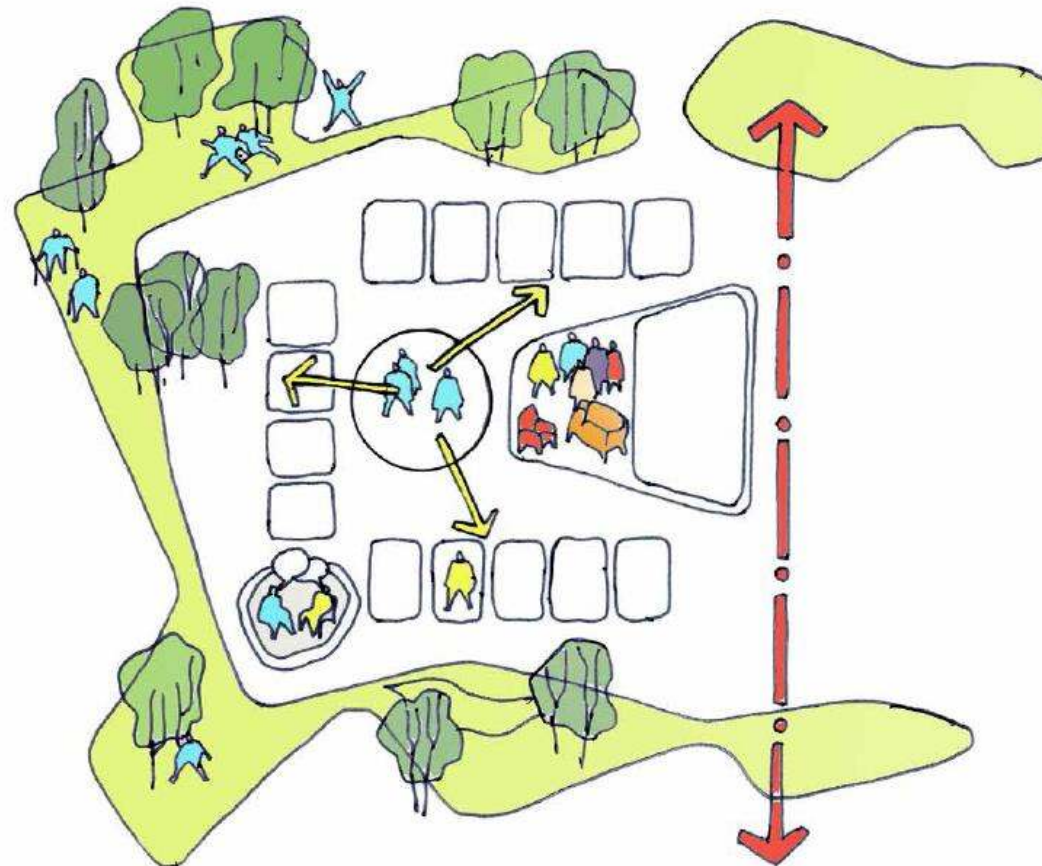
Site views as existing

### 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.

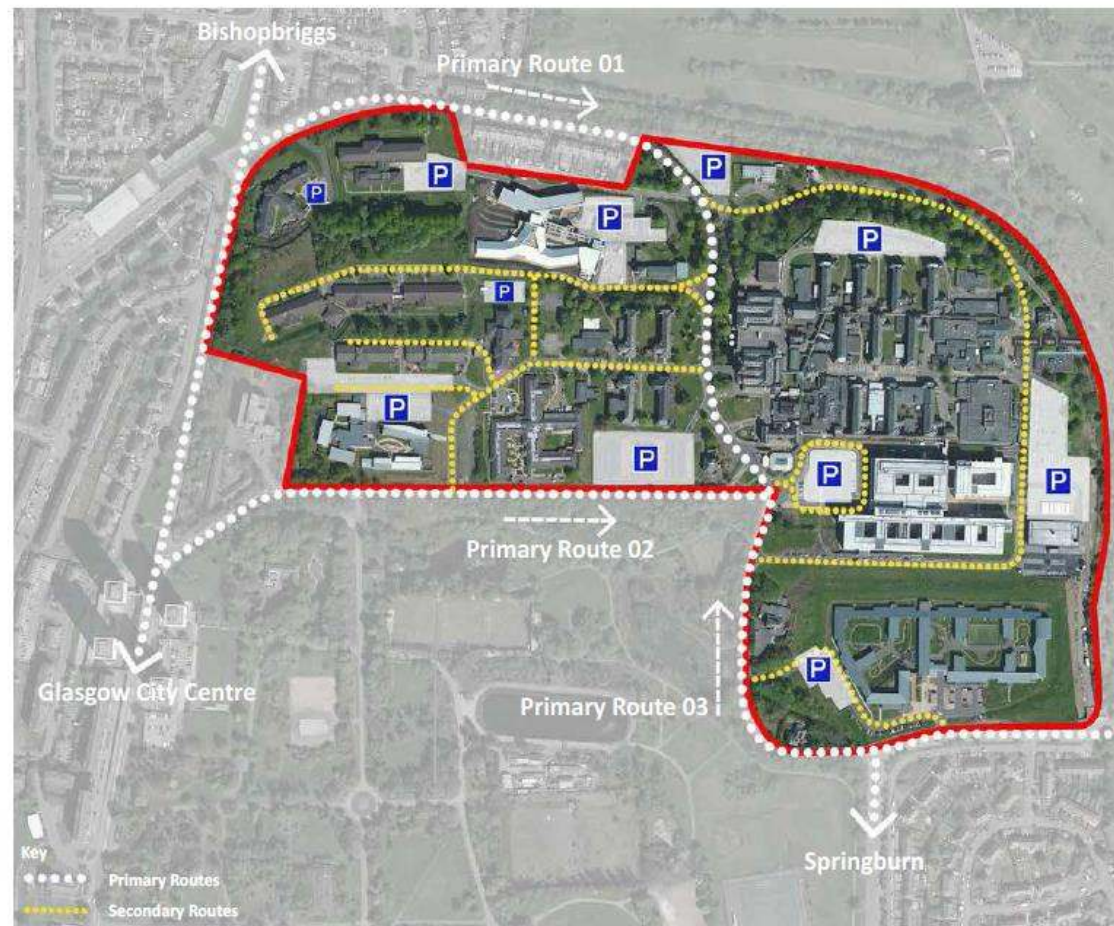
The necessary observation required for the function of both units is enhanced by planning scheduled accommodation around courtyards which become pivotal to the design in terms of light ingress, access to secure and protected amenity space and utilising nature to evoke a calming environment.



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
<b>Circulation</b>	<b>319.6</b>
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
<b>Circulation</b>	<b>298.3</b>

<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

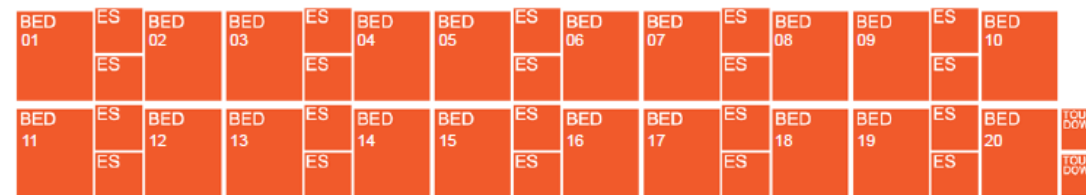
The brief for the AAU has been directed by the Healthcare Planner and been further developed through Stakeholder engagement.

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.

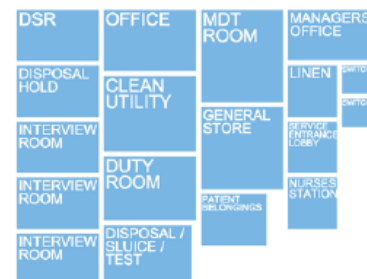
The graphical brief highlights the five primary functions of these spaces; entrance hub, day areas, local clinical support, staff areas and bedroom areas.

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

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

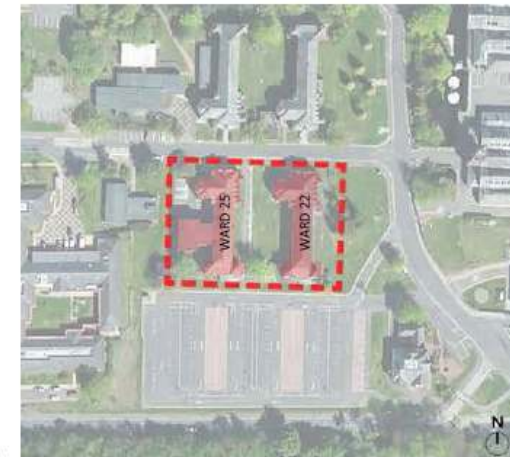
Option 2 is designed to test the feasibility of carrying out extensive refurbishment and extension of the 2 existing buildings on this site, Ward 22 and Ward 25. Both these 2 storey buildings were constructed circa 1904 as part of the original campus, albeit with subsequent modifications over the following 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.



Location diagram



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: blue;">■</span>	LOCAL CLINICAL SUPPORT AREAS
<span style="color: yellow;">■</span>	ENTRANCE
<span style="color: orange;">■</span>	PATIENT DAY AREAS
<span style="color: darkblue;">■</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.

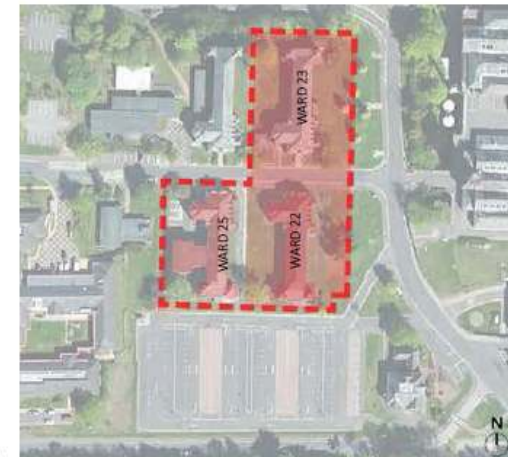
On the upper floor, Weight Management Services – Weight management offices, psychology offices, group therapy room. This service has recently centralised at WGACH on the Yorkhill Site and occupies half of the upper level of Ward 23. With only one room in use it appeared very under occupied.

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.

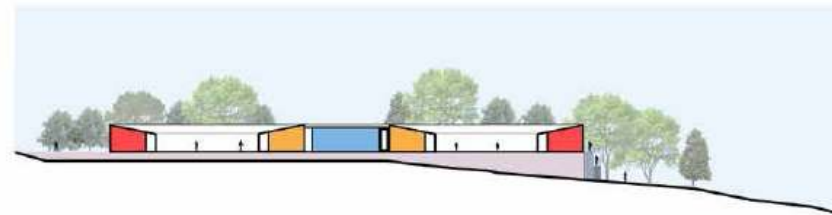
This ward is in a poor state of repair with old rotting windows, severe dampness on the walls and evidence of a leaking roof.

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

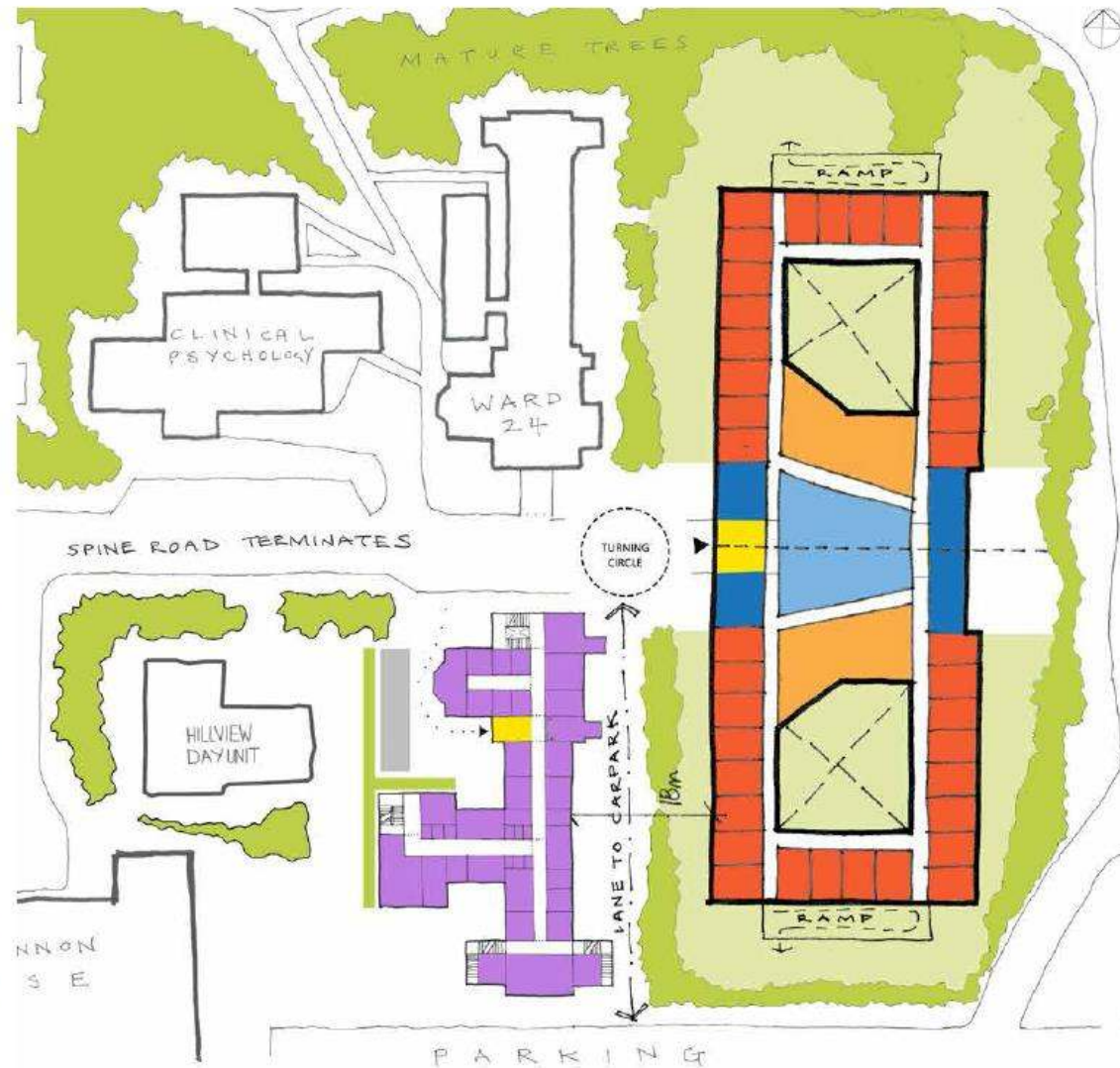
Possible lack of privacy due to external garden space being located adjacent to main hospital traffic route. 1.5

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.

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
	<span style="color: purple;">■</span> PHARMACY	



Option 3 diagram NTS.

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

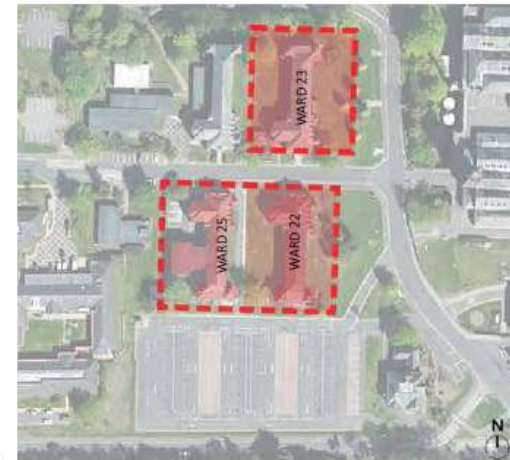
Option 4 is identical to Option 3, with the exception that it is designed to test the feasibility of construction of two separate new build units, built on land vacated by the demolition of two existing buildings, Ward 22 and Ward 23.

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**

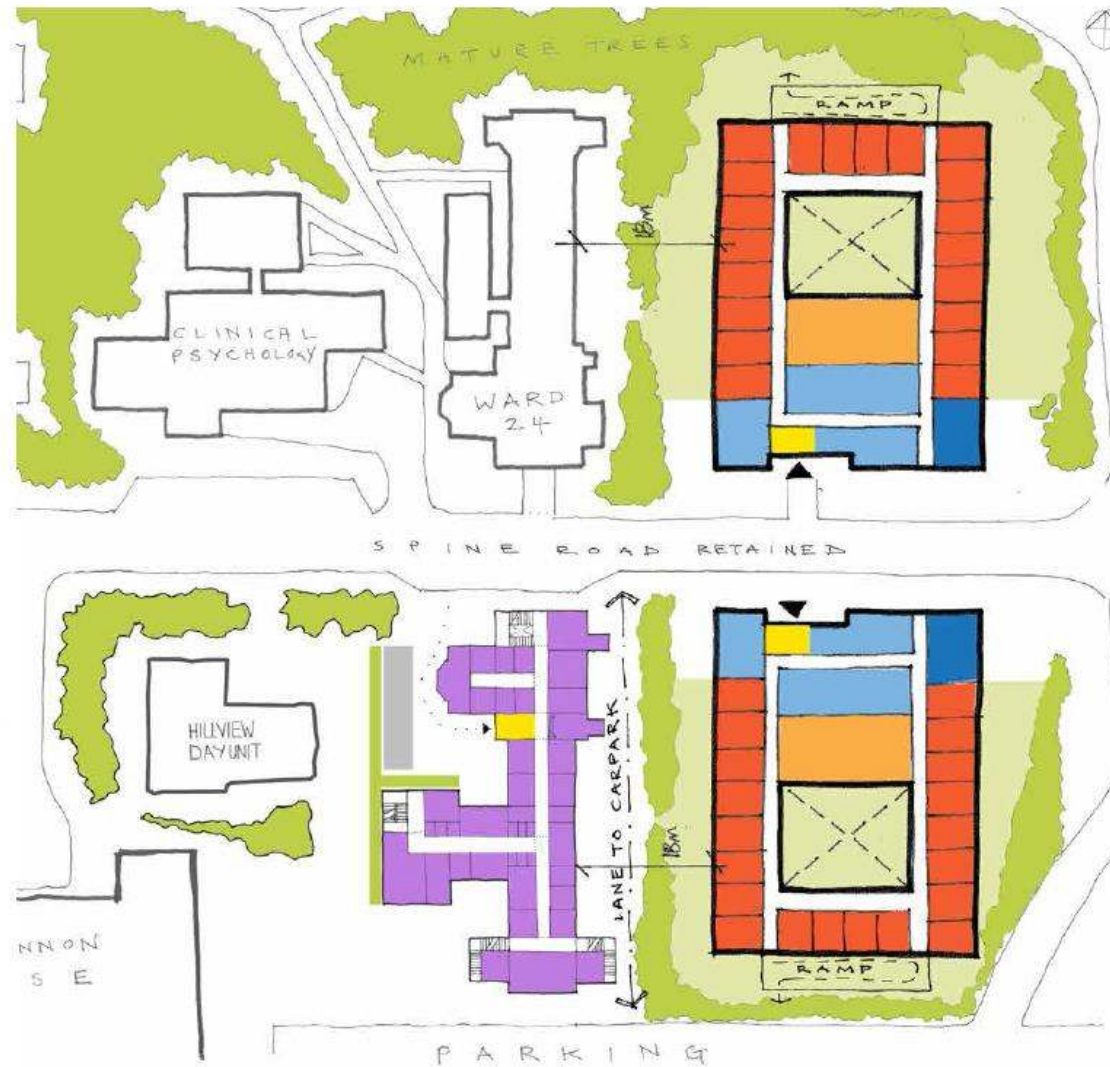
Topography dictates buildings will be significantly elevated to North and East. This will not allow level access to the garden and stairs / lift will be required. 1.5

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.

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



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

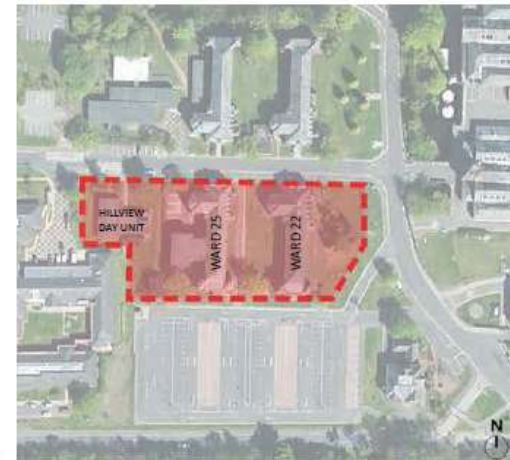
The site is centrally located in the Stobhill Hospital grounds and adjacent to other Mental Health units, most notably Mackinnon House immediately adjacent to the West.

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.

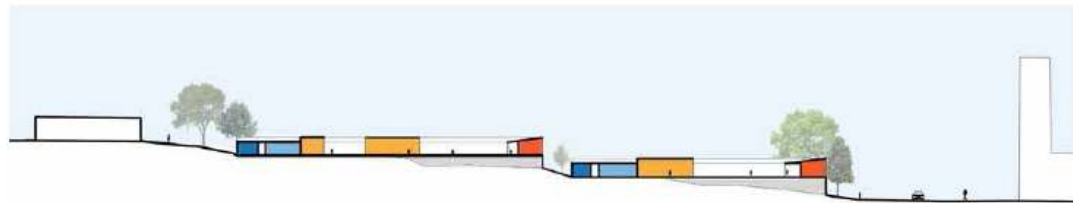
Currently, Wards 22A/B (Alba House) and Wards 25A/25B are vacant.

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**





Billy Kilpatrick	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	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	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
Liz Borland	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	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	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
Jeanette Whitelaw	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	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
Sharon Moore	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
Lesley Donnelly	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

Stephen McGuire		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	253	218	218	
2	502	469	469	
3	553	536	536	
4	618	618	607	
5	796	796	722	

Andrew Baillie		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	253	218	196	
2	553	469	469	
3	596	536	536	
4	649	618	598	
5	796	796	780	

George Brown		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	480	469	469	
3	536	536	516	
4	618	618	618	
5	796	796	796	

Lesley Donnelly		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	469	469	456	
3	536	536	518	
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	

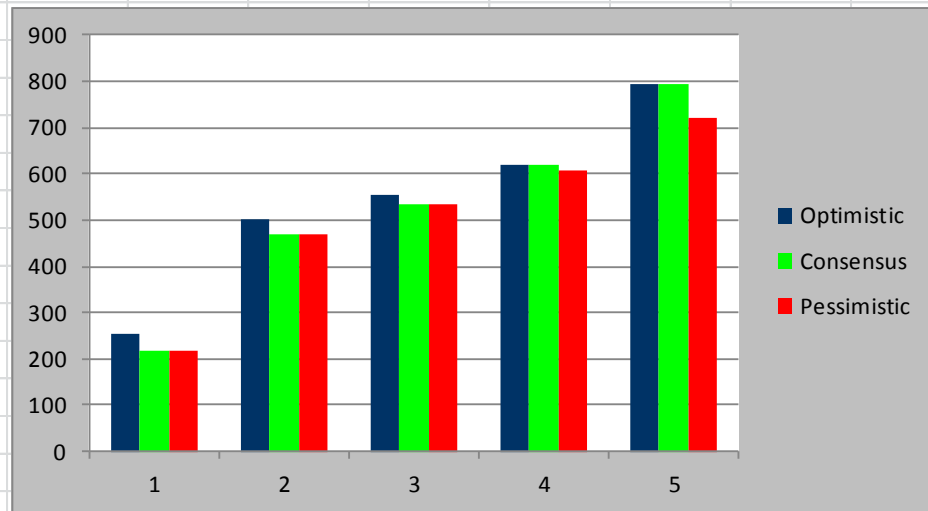
Billy Kilpatrick		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	178	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

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	

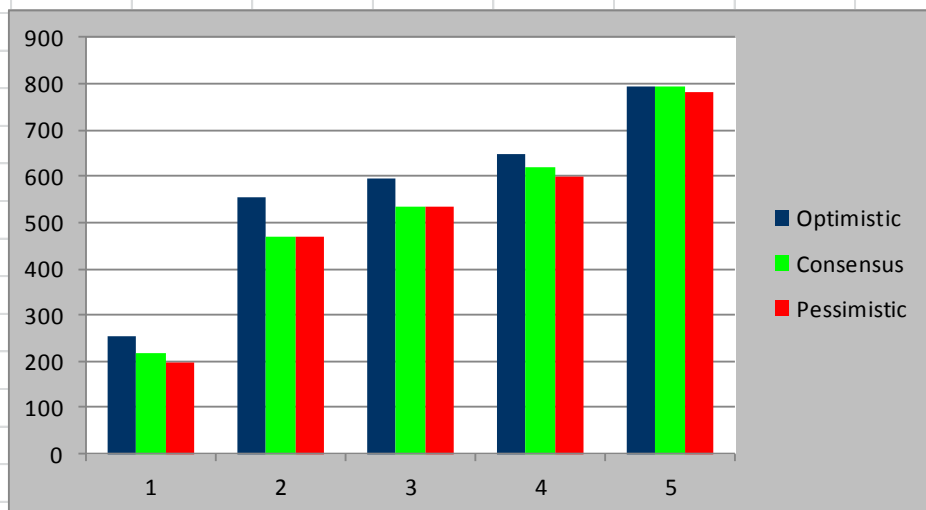
Jeanette Whitelaw		Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic	
1	218	218	218	
2	469	469	469	
3	536	536	536	
4	618	618	618	
5	796	796	796	

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	

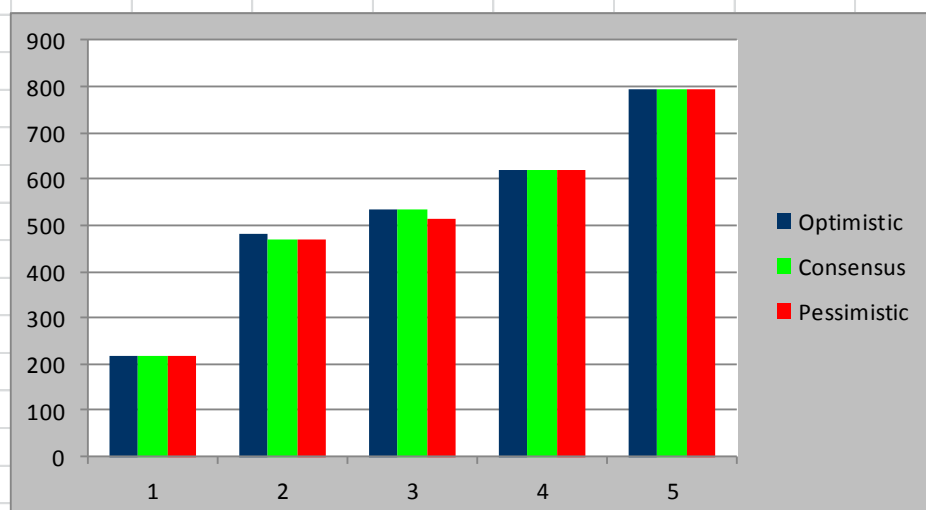
Stephen McGuire



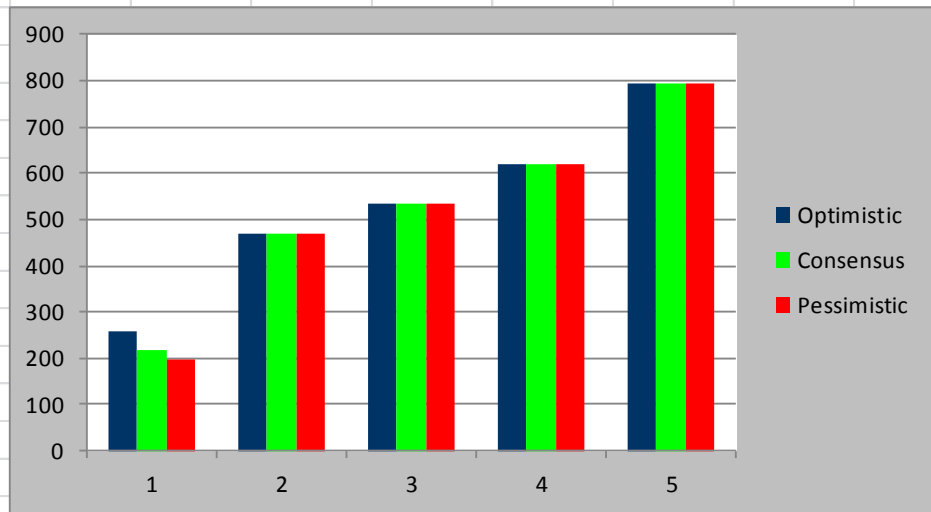
Andrew Baillie



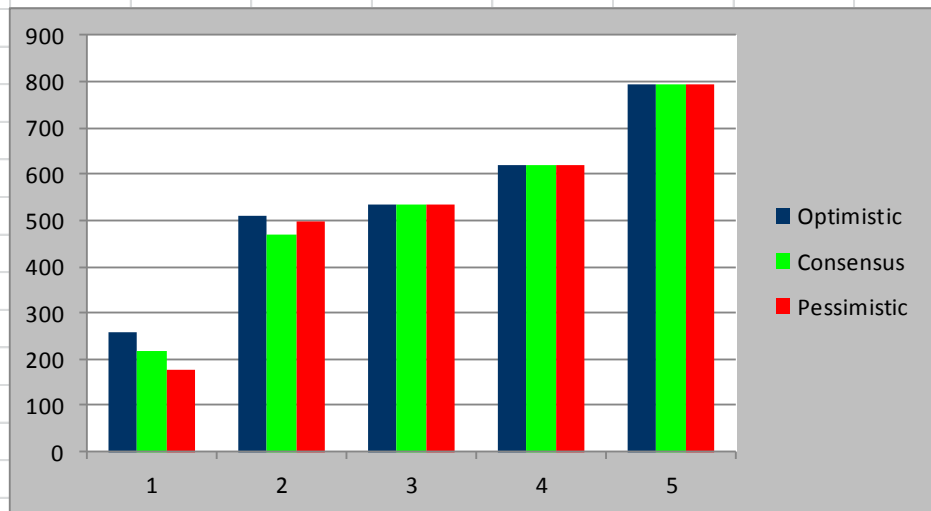
George Brown



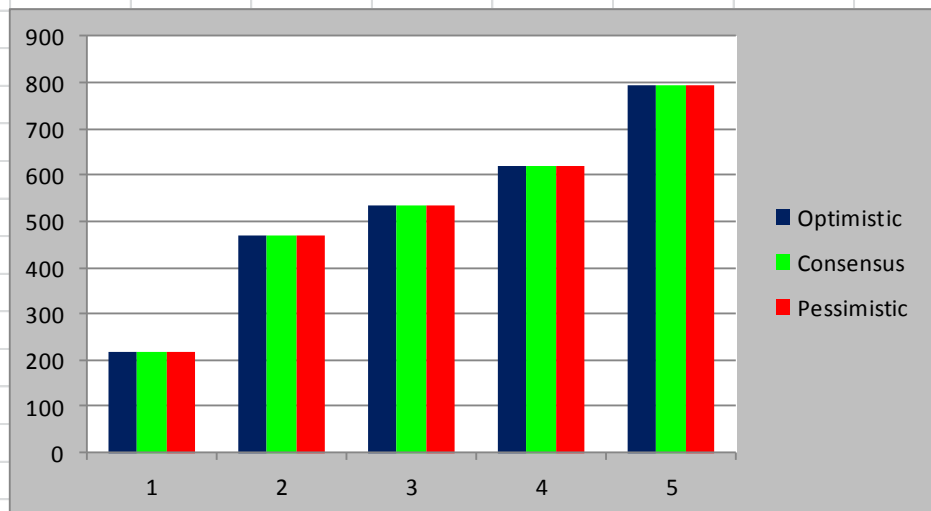
Mary O'Donnell



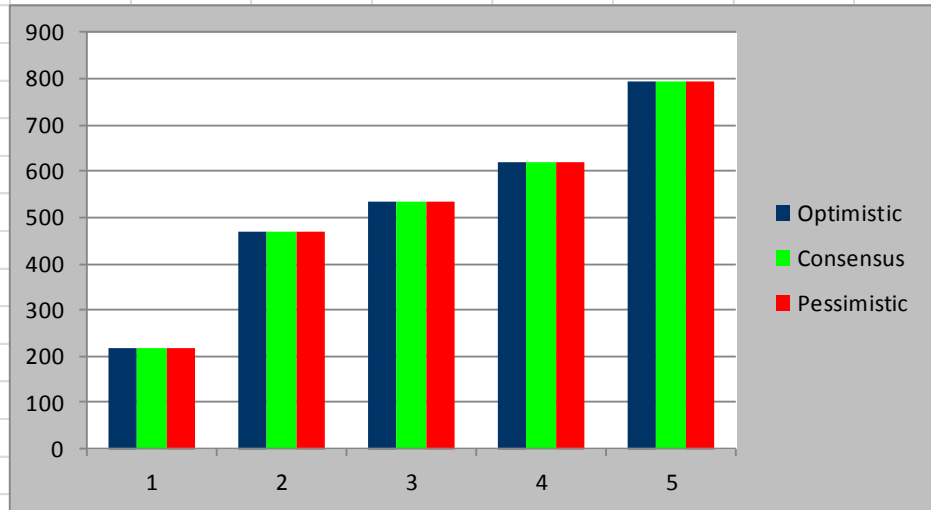
Mary Hanratty



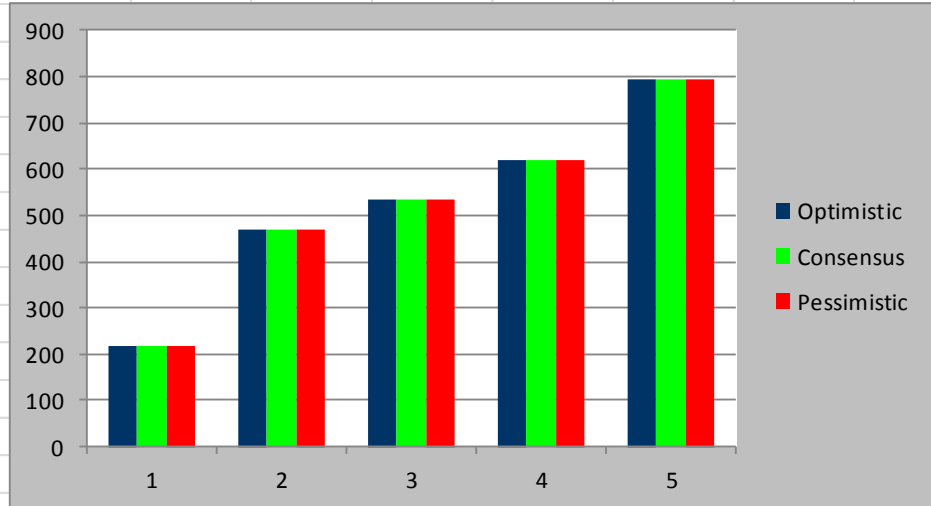
Ronnie Sharp



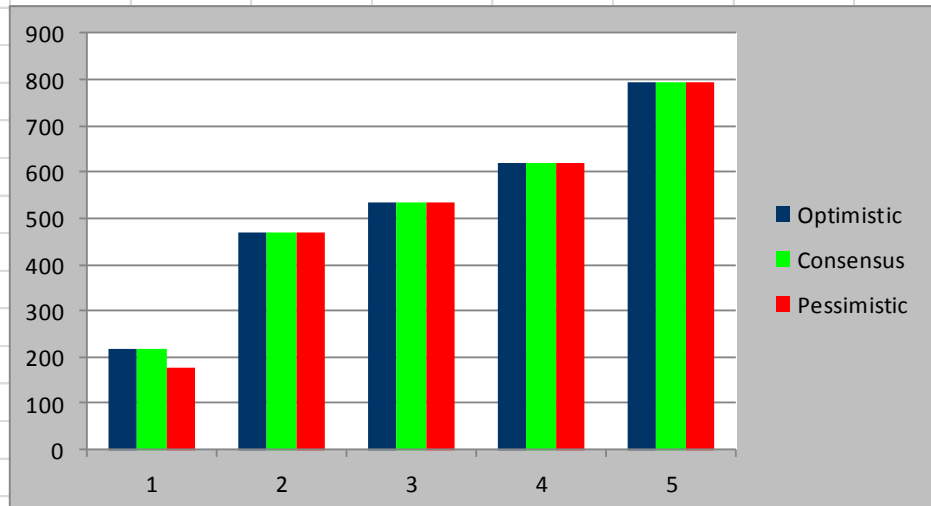
Elisabeth Lucas



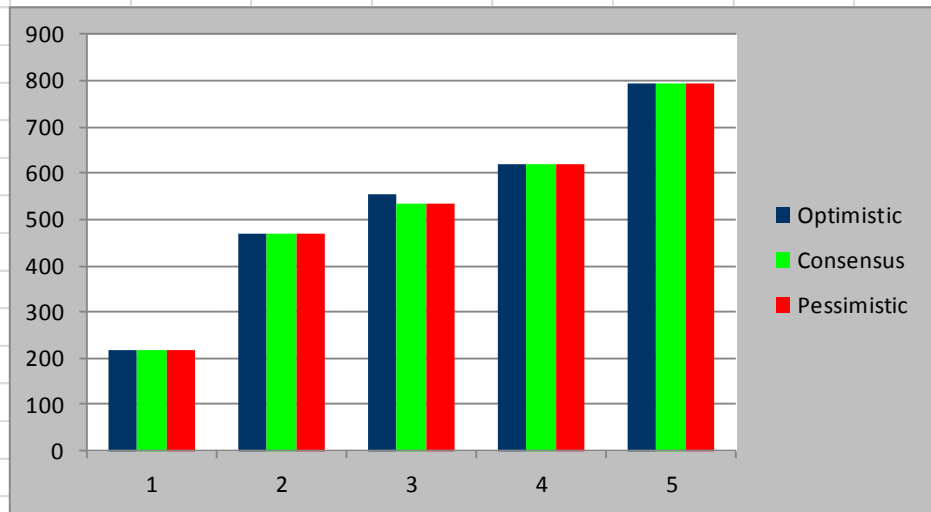
Elisabeth Cruickshanks



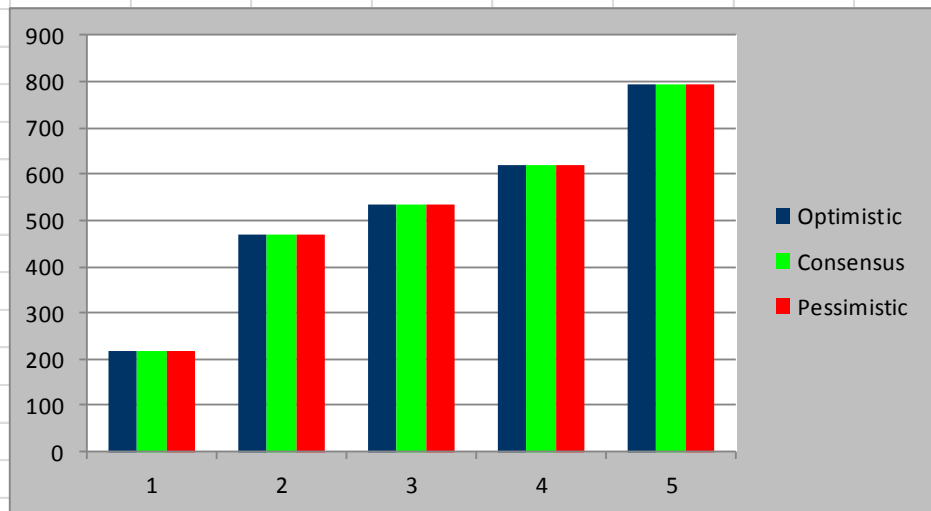
Billy Kilpatrick



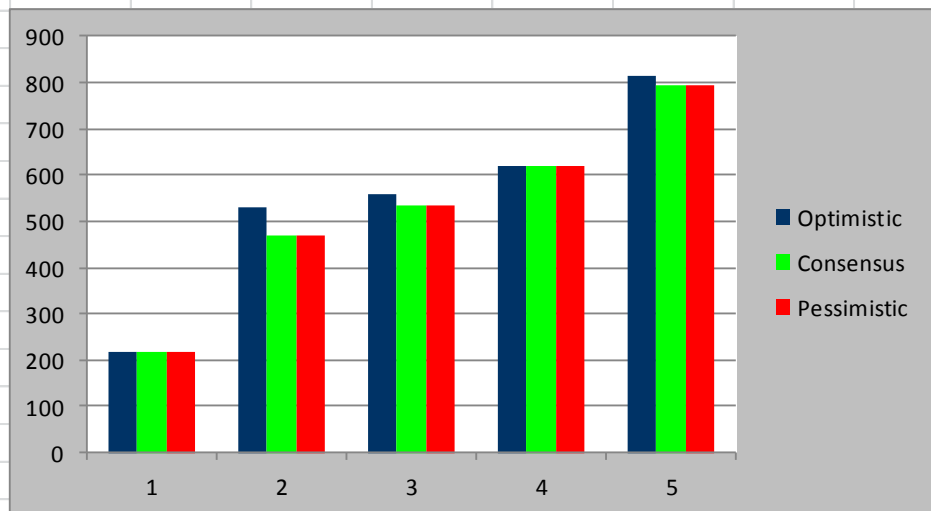
Liz Borland



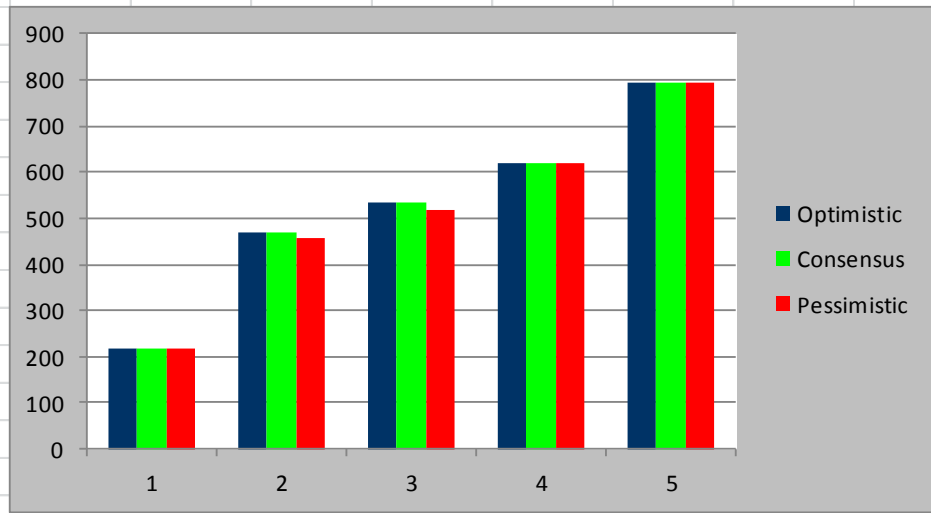
Jeanette Whitelaw



Sharon Moore



Lesley Donnelly




## **Appendix 4 - SCIM Design Statement**

## SCIM Design Statement

### 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). 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</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>



those arriving in a distressed condition.



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 greenspace) 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.

1.4 Entry to the wards must allow security and arrival to be managed discretely and respecting the needs/wishes of individuals.

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.




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.

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.



There must be no hidden corners or dead ends where you might feel trapped or unsafe.

	<p>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</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</p>

wellbeing, respecting their privacy and belongings.

outside the window must provide privacy, peace and a positive view.

The doorway should form a threshold of control where other people need permission to enter (though not a barrier to staff access if needed).

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.



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.	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.



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.

2.5 Facilities management must be able to happen without impacting on the nature of patient areas, or staff rest areas.

Discrete servicing and bin stores/ meals  
Any needs on maintenance or linen etc


2.6 The layout and design of the facility must help staff come together to share learning.

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.

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.

Create a central hub area where all rooms are bookable spaces.  
Enable gender specific allocation to a room(s). All areas are dementia friendly.  
  
Future proof monitoring system to support new technologies including equipment.

### 3 Non Negotiables for Visitors

<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>
3.1 The layout must help those bringing in patients to do so easily and calmly.	<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>
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.	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. 



#### 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>          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 HSCP 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>

## 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	

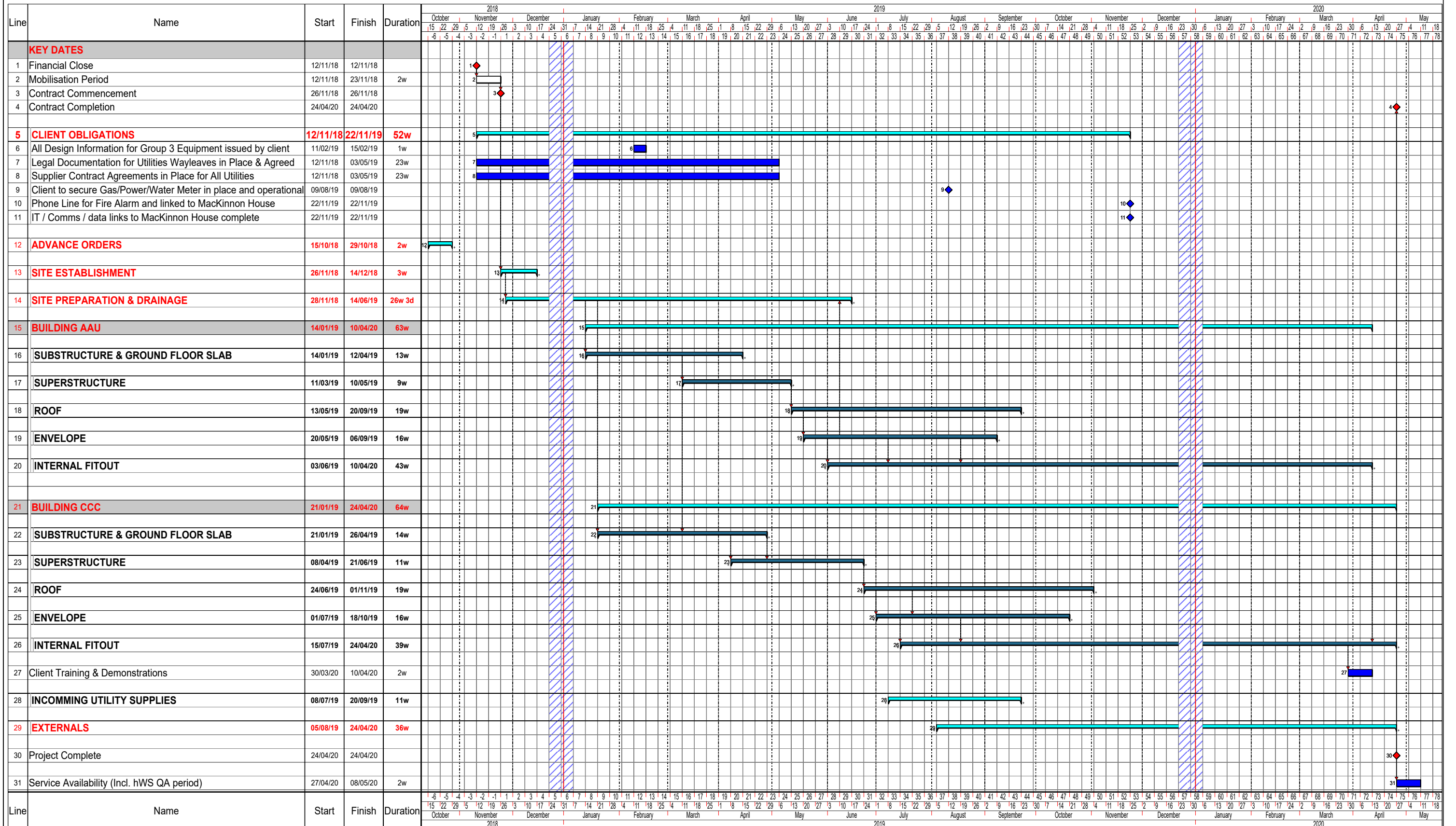
### **Stakeholders involved in preparation of the design statement**

David McCrae	- Head of Mental Health North East Sector
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
David Harley	- Planning and Performance Manager

## **Appendix 5 - Project Programme**



Hub West Scotland  
NHS Greater Glasgow & Clyde  
Stobhill Mental Health Estate



User  
█ Critical Path     Lead In / Mobilisation     Overall Summary     Client     Package Summary

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



T: 0131-244 2410 F: 0131-244 2162  
E: 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**



# **Appendix 7A - NHS Greater Glasgow & Clyde Clinical Output Specification**





## 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:

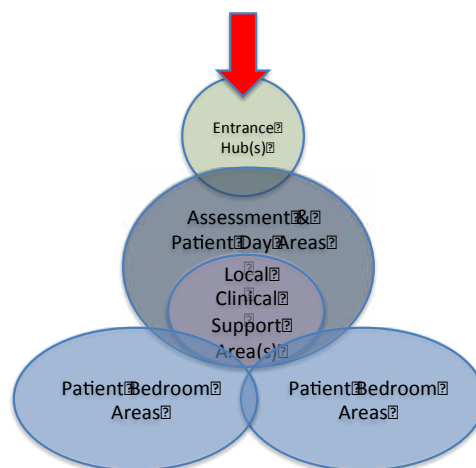
- A small entrance hub
- Patient day & activity areas
- Patient bedroom areas
- Local clinical support areas (Including interview rooms supporting the admission & assessment function)
- Staff and clinical support spaces shared with the adjacent Elderly development (as identified in the relevant separate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



## Stobhill AAU "Block" Relationships



## **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 timeous 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 NHSGG&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 NHSGG&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:

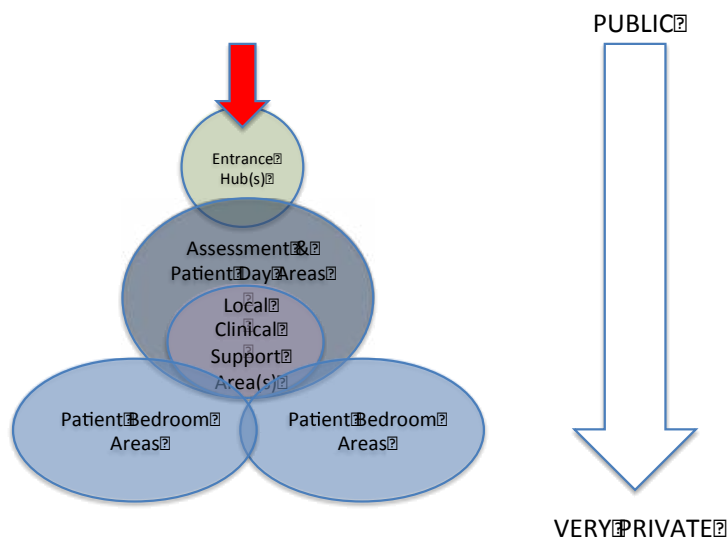
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial 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)



### Stobhill AAU “Block” Relationships



**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.

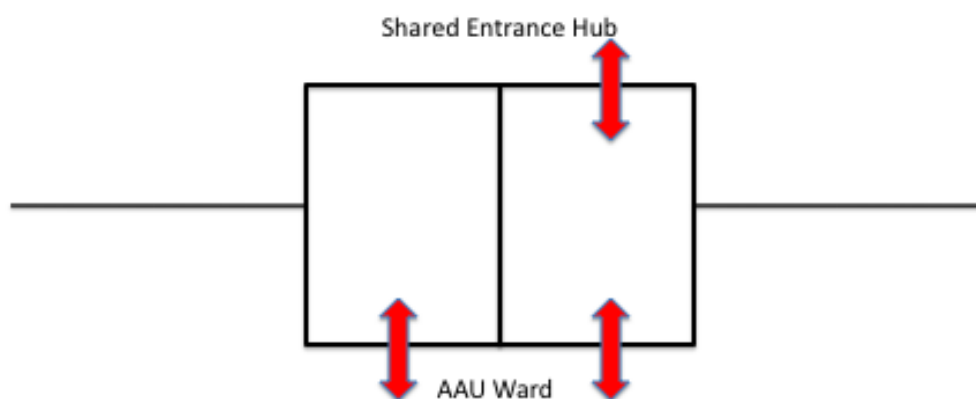
The entrance hub will be connected to the ward by a locked door with entry buzzer and video link that it will be possible to open remotely.

#### 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:

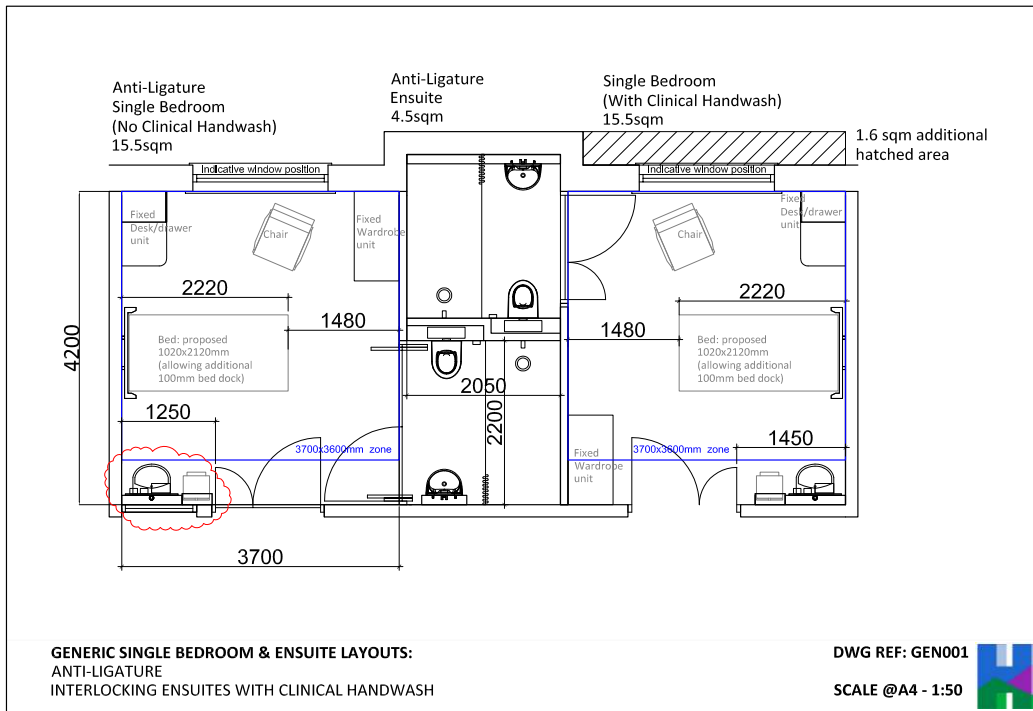
- Do not meet the minimum clear space around beds required to support any physical intervention
- Would therefore only ever be suitable for physically able patients groups
- Are incapable of supporting the preferred interlocking en-suite model utilising the HBN 00-02 model
- Are not therefore capable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

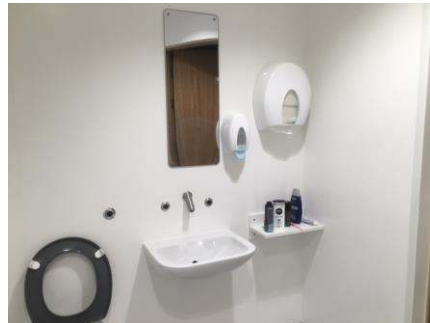
The preferred bedroom model for the balance of bedrooms is an in-board configuration – specifically EXACTLY as currently in use in the new build AAU at Leverdale. This is desirable to the Board as:

- 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 Leverdale AAU**



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

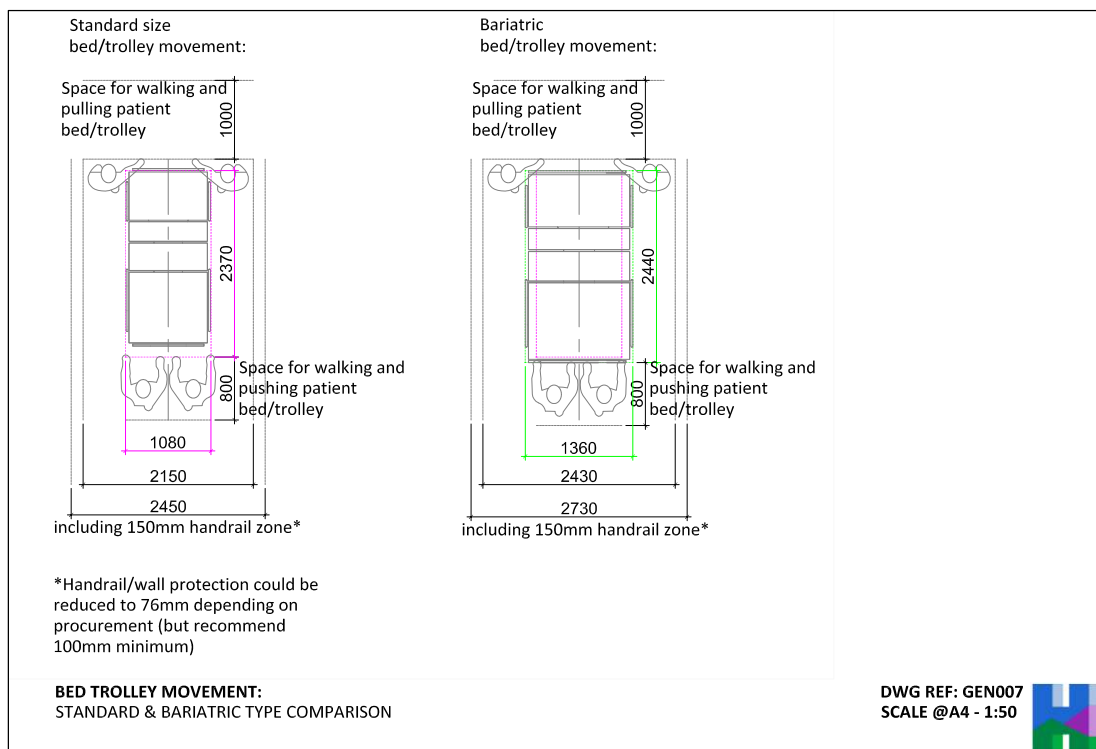
**In hours all patient and visitor access should be through a main entrance door that will be locked on the outside and only operable by staff with the appropriate access or remotely from inside the ward.**

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

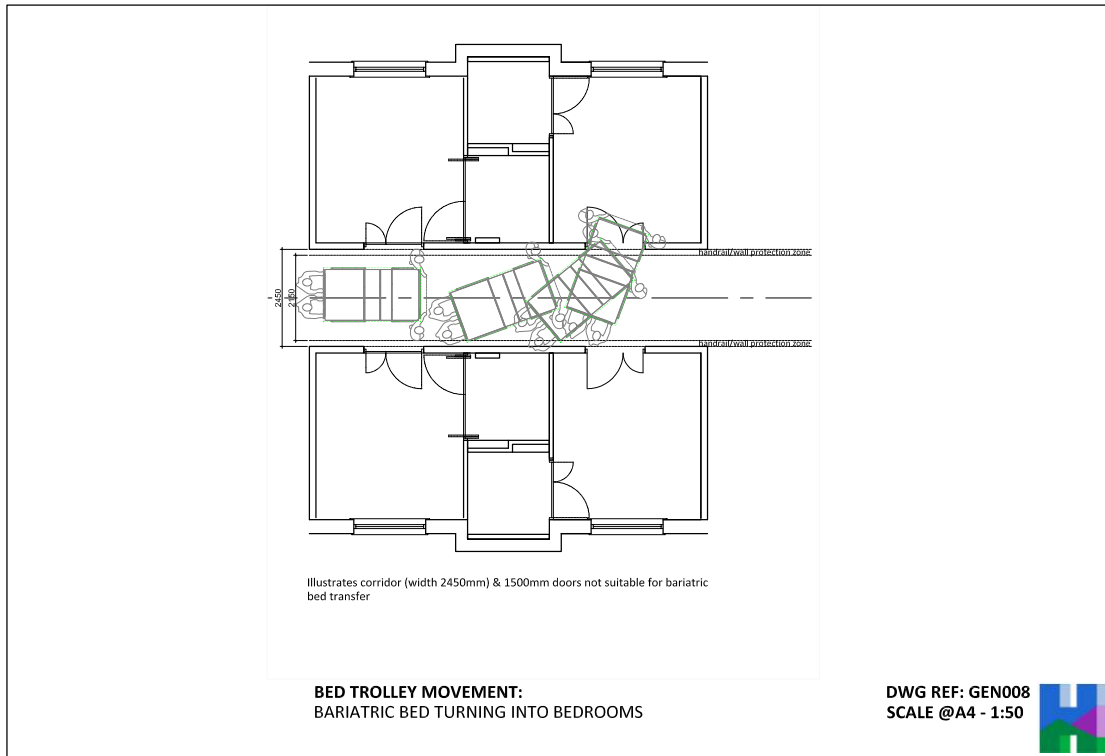
Regarding corridor sizes:

- 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

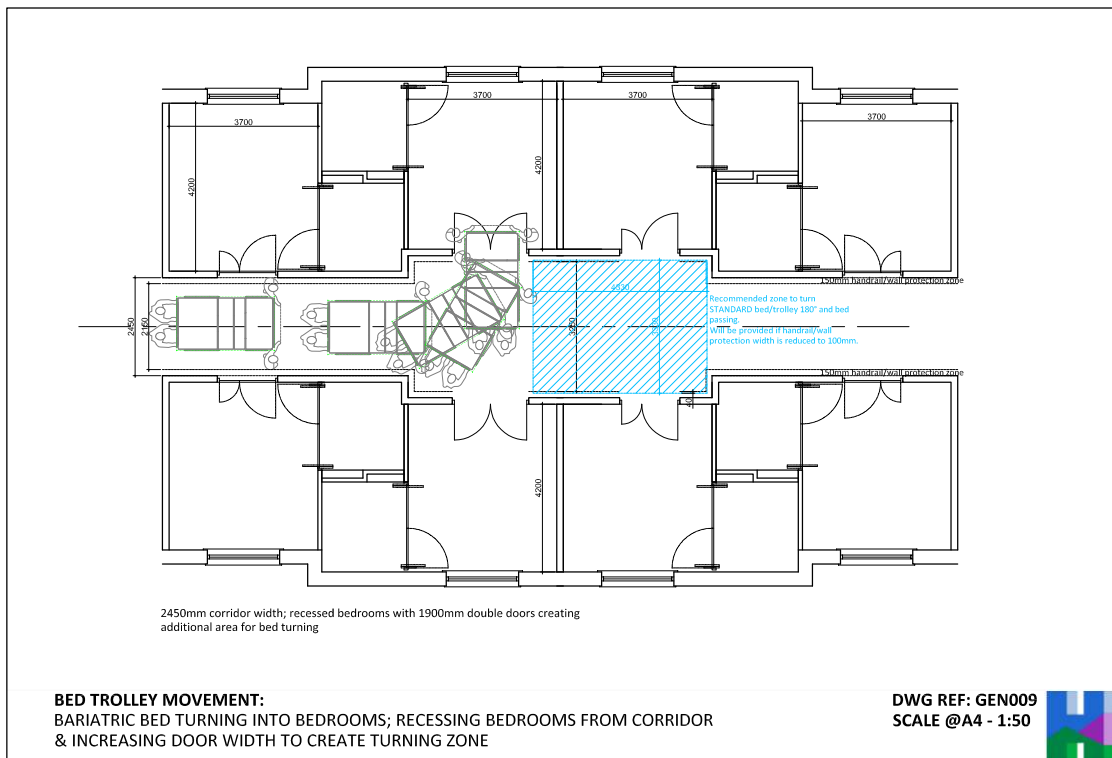
It is noted that the requirement for anti-barricade doors extends throughout the clinical areas. In addition, all doors will require to be lockable. If electronic systems are used (to minimise manual key requirements – which is desirable) these should be compatible with systems used on related facilities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

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

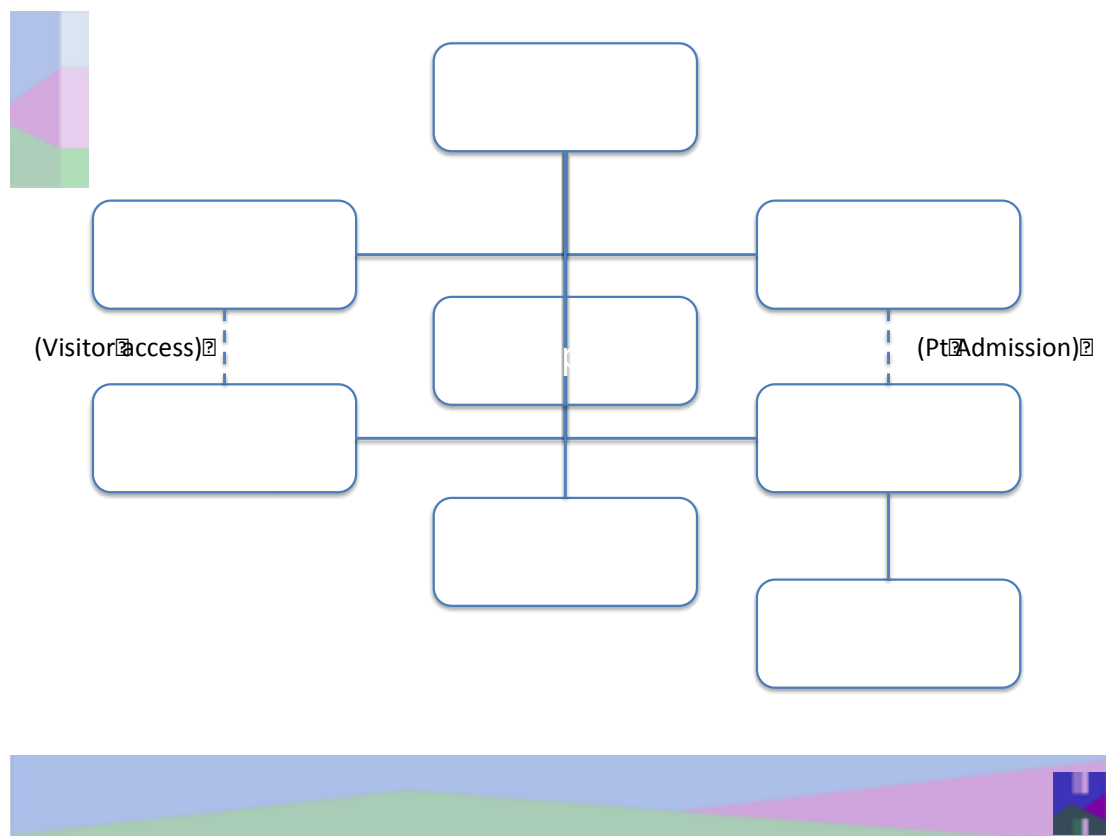
Throughout the planning process to date, the new development has been planned as an isolated facility on an identified site at Stobhill. Consequently only internal relationships and the impact of services not available locally have been considered.

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 vistamatic 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 7B - NHS Greater Glasgow & Clyde Clinical Output Specification**



## 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:

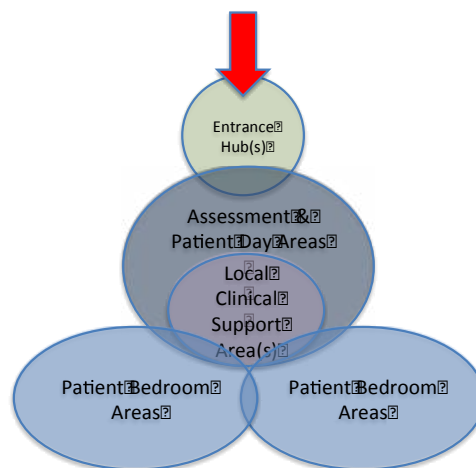
- A small entrance hub
- Patient day areas
- Patient bedroom areas
- Local clinical support areas
- Staff and clinical support spaces shared with the adjacent AAU development (as identified in the relevant separate COS document)

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)



## Stobhill Elderly Unit "Block" Relationships



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**

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:

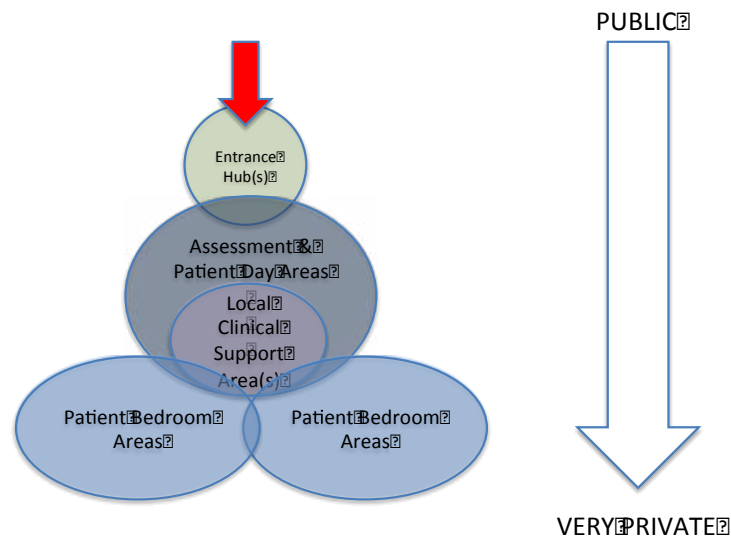
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Be capable of meeting dementia design standards;
- Create a feeling of well ventilated space, maximising the use of natural 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.

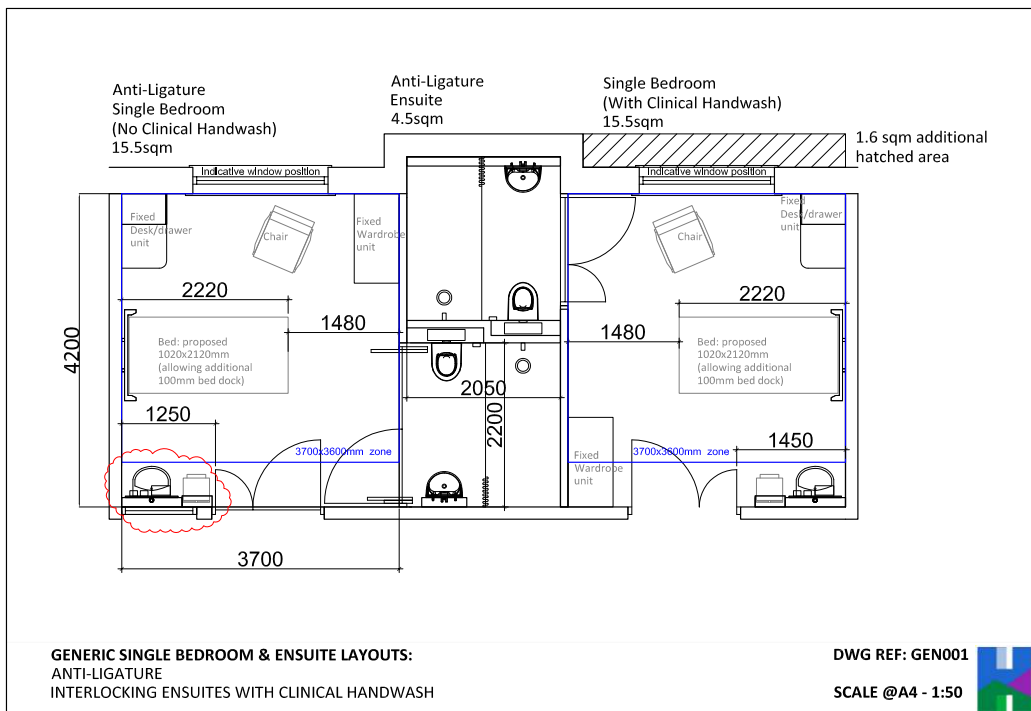
#### **4.2.3 Patient Bedroom Areas**

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.

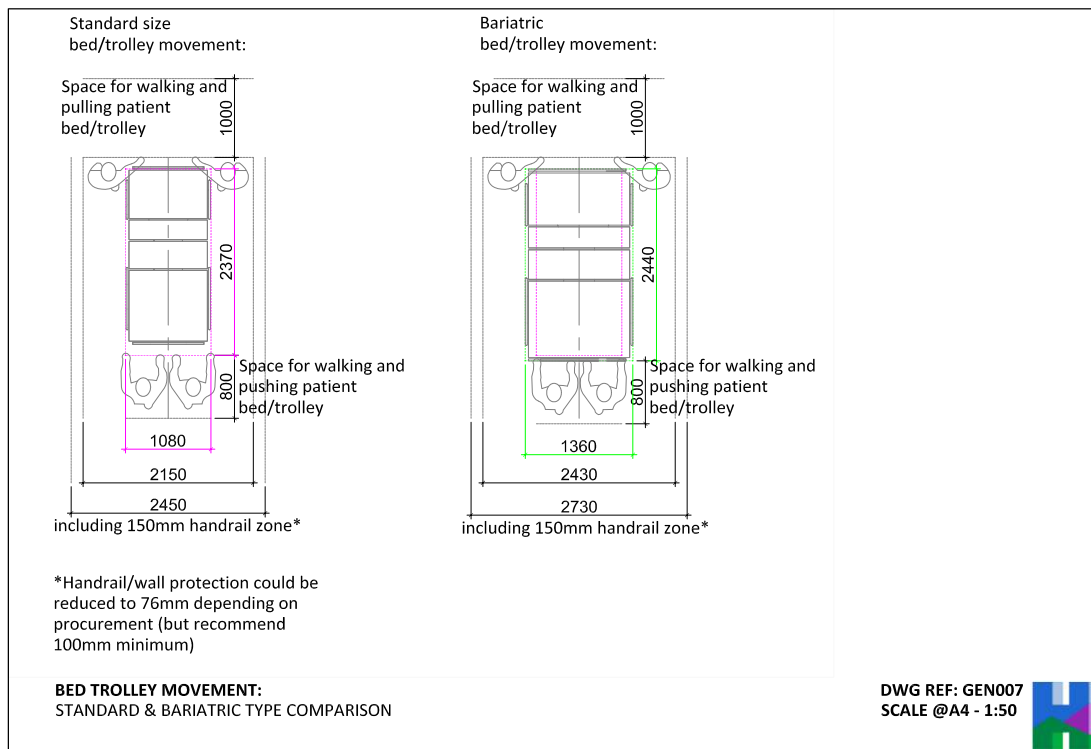
In hours all patient and visitor access should be through a main entrance door that will be locked on the outside and only operable by staff with the appropriate access or remotely from inside the ward.

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

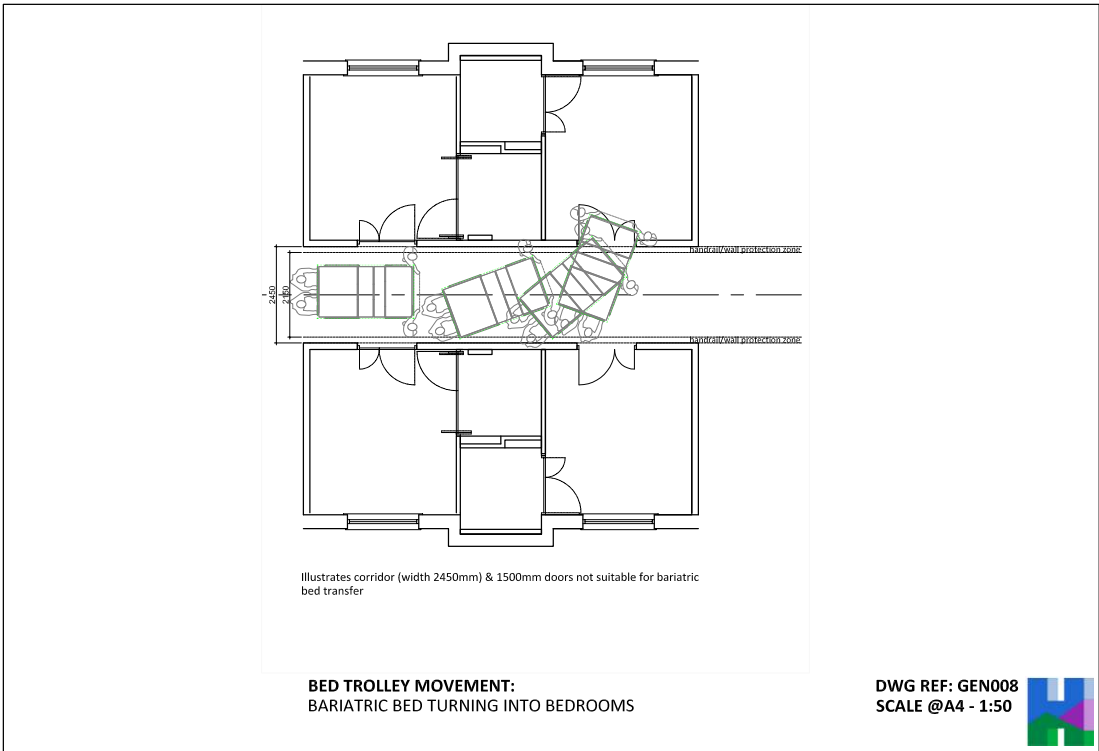
patient day/bedroom areas and access routes to/from that are required for bed supply/change



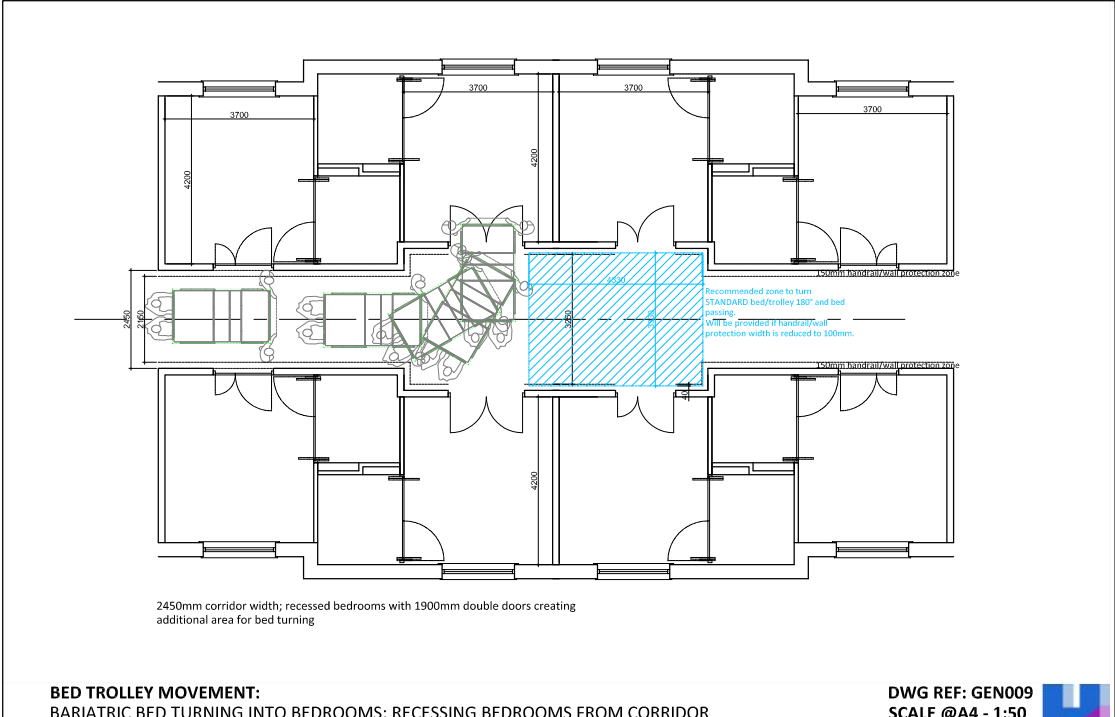
**Diag. 4. Standard & Bariatric Bed Dimensions For Comparison**

- 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

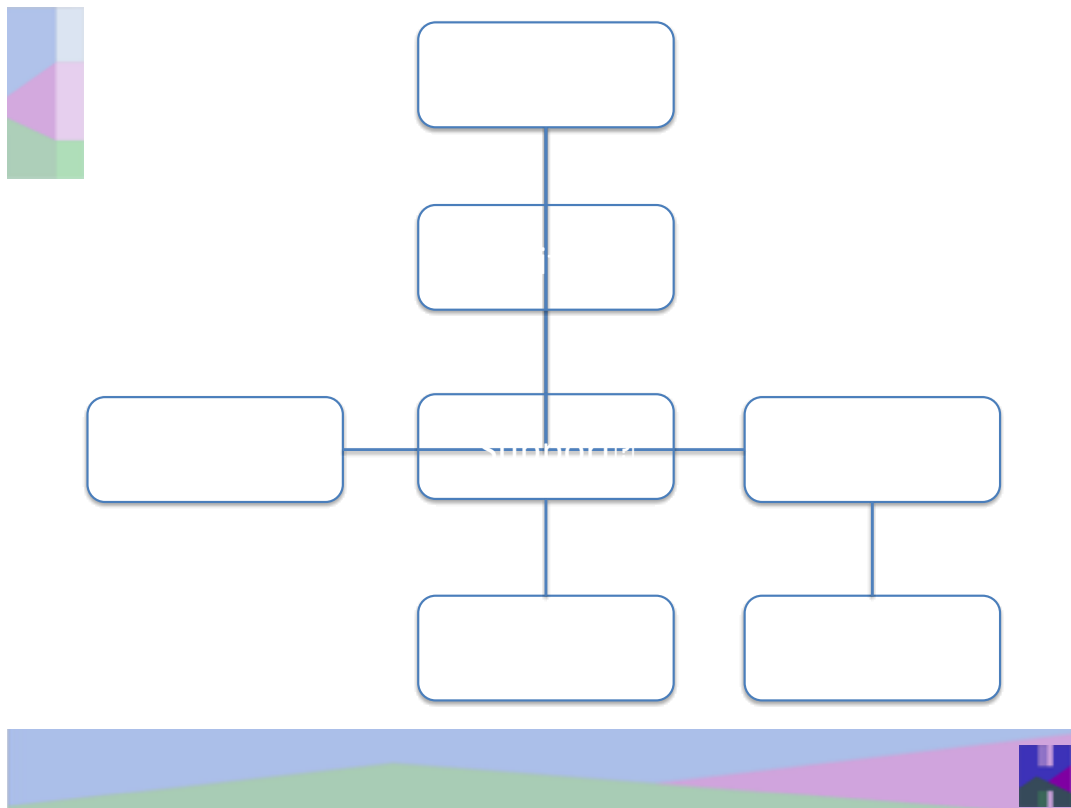
Throughout the planning process to date, the new development has been planned as an isolated facility on an identified site at Stobhill. Consequently only internal relationships and the impact of services not available locally have been considered.

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 - IA Schedule of Accommodation**

# IA Schedule of Accommodation

## Stobhill AAU & HBCCC Schedule of Accommodation

### STOBHILL OVERALL SUMMARY

Ref.	Activity Space		Net m2	Gross m2	Comments
<b>STOBHILL</b>					
	Stobhill HBCCC Unit		815.0	1159.0	
	Stobhill AAU		831.0	1181.3	
	<b>Sub-total</b>			<b>2340.2</b>	
<b>Total Net</b>					
	<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 No.	Area m2	Total m2	Comments
<b>ENTRANCE HUB</b>					
	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>	
<b>Total Net</b>					
	Planning allowance	5%		0.9	
	<b>Sub-total</b>			19.4	
	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	4.5m2/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>	
--------------------	--	--	---------------	--

**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 No.	Area m2	Total m2	Comments
------	----------------	------------	------------	-------------	----------

<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	
	Sub-total			804.8	
	Engineering Allowance	3%		24.1	
	Circulation	33%		265.6	
	<b>Total</b>			<b>1094.6</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	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>	
--------------------	--	--	---------------	--

**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 - FBC Schedule of Accommodation**

Room Schedule						
Department	Number	Name	Area	Briefed Area	Area difference	Comments
AAU	3	Disposal Hold	10.4 m <sup>2</sup>	10 m <sup>2</sup>	0.4 m <sup>2</sup>	
AAU	4	DSR	10.1 m <sup>2</sup>	10 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	5	Disposal/ Sluice/ Test room	12.1 m <sup>2</sup>	12 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	6	General store	16.1 m <sup>2</sup>	16 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	7	Patient belongings	7.6 m <sup>2</sup>	8 m <sup>2</sup>	-0.4 m <sup>2</sup>	
AAU	8	Change	9.8 m <sup>2</sup>	8 m <sup>2</sup>	1.8 m <sup>2</sup>	
AAU	10	Shower 2	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	11	Staff WC 1	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	14	Staff room	18.2 m <sup>2</sup>	18 m <sup>2</sup>	0.2 m <sup>2</sup>	
AAU	15	Staff corridor 1	25.2 m <sup>2</sup>			
AAU	16	Interview 01	11 m <sup>2</sup>	10 m <sup>2</sup>	1 m <sup>2</sup>	
AAU	17	Interview 02	11 m <sup>2</sup>	10 m <sup>2</sup>	1 m <sup>2</sup>	
AAU	18	Duty room	14.8 m <sup>2</sup>	14 m <sup>2</sup>	0.8 m <sup>2</sup>	
AAU	19	Draught lobby	5.2 m <sup>2</sup>	6 m <sup>2</sup>	-0.8 m <sup>2</sup>	
AAU	20	Treatment room	15.9 m <sup>2</sup>	16.5 m <sup>2</sup>	-0.6 m <sup>2</sup>	
AAU	21	Managers office	10.4 m <sup>2</sup>	10.5 m <sup>2</sup>	-0.1 m <sup>2</sup>	
AAU	23	Servery	15 m <sup>2</sup>	16 m <sup>2</sup>	-1 m <sup>2</sup>	
AAU	24	Staff corridor 2	13.9 m <sup>2</sup>			
AAU	25	MDT room	17.5 m <sup>2</sup>	18 m <sup>2</sup>	-0.5 m <sup>2</sup>	
AAU	26	Office	13.7 m <sup>2</sup>	10.5 m <sup>2</sup>	3.2 m <sup>2</sup>	
AAU	27	Activity room	21.1 m <sup>2</sup>	22 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	28	AR Store	3.7 m <sup>2</sup>	4 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	29	Quiet room	16.4 m <sup>2</sup>	18 m <sup>2</sup>	-1.6 m <sup>2</sup>	
AAU	31	Dining	36 m <sup>2</sup>	36 m <sup>2</sup>	0 m <sup>2</sup>	
AAU	33	Private corridor	120.6 m <sup>2</sup>			
AAU	35	Patient utility	10.5 m <sup>2</sup>	10 m <sup>2</sup>	0.5 m <sup>2</sup>	
AAU	36	Nurses station	9.4 m <sup>2</sup>	6 m <sup>2</sup>	3.4 m <sup>2</sup>	
AAU	37	Female day room	8.6 m <sup>2</sup>	10 m <sup>2</sup>	-1.4 m <sup>2</sup>	
AAU	38	Sitting room	33 m <sup>2</sup>	36 m <sup>2</sup>	-3 m <sup>2</sup>	
AAU	39	Patient pantry	11.7 m <sup>2</sup>	10 m <sup>2</sup>	1.7 m <sup>2</sup>	
AAU	40	Public corridor	35.3 m <sup>2</sup>			
AAU	41	Comms	6.9 m <sup>2</sup>	5 m <sup>2</sup>	1.9 m <sup>2</sup>	
AAU	42	Switch room	4 m <sup>2</sup>	2 m <sup>2</sup>	2 m <sup>2</sup>	
AAU	43	Shower 1	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	44	Staff WC 2	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
AAU	45	Roof access	6.2 m <sup>2</sup>			
AAU	47	Riser 2/Switch	8 m <sup>2</sup>			
AAU	49	AWC	5.3 m <sup>2</sup>	4.5 m <sup>2</sup>	0.8 m <sup>2</sup>	
AAU	50	IVS	4.1 m <sup>2</sup>			
AAU	51	IT	3.9 m <sup>2</sup>	5 m <sup>2</sup>	-1.1 m <sup>2</sup>	
AAU	52	Linen	5.8 m <sup>2</sup>	6 m <sup>2</sup>	-0.2 m <sup>2</sup>	
AAU	54	Foyer	6.2 m <sup>2</sup>	15 m <sup>2</sup>	-8.8 m <sup>2</sup>	
AAU	57	Touchdown space 01	1.7 m <sup>2</sup>	2 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	65	Switch Room	21.5 m <sup>2</sup>			
AAU	66	Touchdown space 02	1.7 m <sup>2</sup>	2 m <sup>2</sup>	-0.3 m <sup>2</sup>	
AAU	68	Private corridor	16 m <sup>2</sup>			
AAU	69	Escape Corridor	8.1 m <sup>2</sup>			
AAU	70	Private Corridor	95.4 m <sup>2</sup>			
AAU	B01	Bedroom 01 - Accessible	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B02	Bedroom 02 - Accessible	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
AAU	B03	Bedroom 03	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B04	Bedroom 04	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B05	Bedroom 05	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B06	Bedroom 06	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B07	Bedroom 07	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B08	Bedroom 08	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B09	Bedroom 09	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
AAU	B10	Bedroom 10	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B11	Bedroom 11	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B12	Bedroom 12	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
AAU	B13	Bedroom 13	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B14	Bedroom 14	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B15	Bedroom 15	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B16	Bedroom 16	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B17	Bedroom 17	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B18	Bedroom 18	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B19	Bedroom 19	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	B20	Bedroom 20	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
AAU	E01	Ensuite 01	4 m <sup>2</sup>	5 m <sup>2</sup>	-1 m <sup>2</sup>	
AAU	E02	Ensuite 02	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E03	Ensuite 03	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E04	Ensuite 04	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E05	Ensuite 05	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E06	Ensuite 06	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E07	Ensuite 07	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E08	Ensuite 08	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E09	Ensuite 09	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E10	Ensuite 10	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E11	Ensuite 11	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E12	Ensuite 12	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E13	Ensuite 13	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E14	Ensuite 14	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E15	Ensuite 15	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E16	Ensuite 16	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E17	Ensuite 17	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E18	Ensuite 18	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E19	Ensuite 19	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
AAU	E20	Ensuite 20	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
Grand total			1175.6 m <sup>2</sup>	816 m <sup>2</sup>	5.4 m <sup>2</sup>	

Rev	Description	Dr'n	Chk'd	Date
1	Hub Stage 2 Information	AD	TB	18/06/2018
0	Stage E Submission	AD	TB	23/04/2018



GLASGOW  
160 West Regent Street  
Glasgow  
G2 4RL  
Tel: 0141 204 0066  
www.keppiedesign.co.uk

Client  
**NHS GG&C/ HUB West Scotland**

Project  
**Stobhill Mental Health Estate**

Drawing  
**Room schedule**

Project No.  
**P16-101**

Drawing No.  
**KEP-AAU-XX-SH-A-0020-0101**

Status  
**For Information**

Created • AD  
Date • 08/08/17  
Checked • TB  
Scale •  
@ A2

**NOTE:** Does not include external courtyard areas or external undercroft plant areas. Includes enclosed undercroft Switch Room. Briefed areas do not include circulation. **Pink** denotes figures more than original briefed area **Blue** denotes less than original briefed area.

Room Schedule						
Department	Number	Name	Area	Briefed Area	Area Difference	Comments
CCC	3	Disposal Hold	10 m <sup>2</sup>	10 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	4	DSR	10 m <sup>2</sup>	10 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	5	Disposal/ Sluice/ Test room	12 m <sup>2</sup>	12 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	6	General store	9.9 m <sup>2</sup>	10 m <sup>2</sup>	-0.1 m <sup>2</sup>	
CCC	7	Patient belongings	9.9 m <sup>2</sup>	10 m <sup>2</sup>	-0.1 m <sup>2</sup>	
CCC	8	Change	9.9 m <sup>2</sup>	8 m <sup>2</sup>	1.9 m <sup>2</sup>	
CCC	10	Shower 2	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	11	Staff WC 1	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
CCC	14	Staff room	18.2 m <sup>2</sup>	18 m <sup>2</sup>	0.2 m <sup>2</sup>	
CCC	15	Staff corridor 1	33 m <sup>2</sup>			
CCC	16	Interview 01	9.5 m <sup>2</sup>	10 m <sup>2</sup>	-0.5 m <sup>2</sup>	
CCC	18	Duty room	14 m <sup>2</sup>	14 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	19	Draught lobby	5.9 m <sup>2</sup>	6 m <sup>2</sup>	-0.1 m <sup>2</sup>	
CCC	20	Managers office	10.3 m <sup>2</sup>	10.5 m <sup>2</sup>	-0.2 m <sup>2</sup>	
CCC	23	Servery	16.3 m <sup>2</sup>	16 m <sup>2</sup>	0.3 m <sup>2</sup>	
CCC	24	Private Corridor	15.1 m <sup>2</sup>			
CCC	26	Office	13.7 m <sup>2</sup>	13.5 m <sup>2</sup>	0.2 m <sup>2</sup>	
CCC	27	Activity room	21.4 m <sup>2</sup>	22 m <sup>2</sup>	-0.6 m <sup>2</sup>	
CCC	28	AR store	3.7 m <sup>2</sup>	4 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	29	Quiet room	19.7 m <sup>2</sup>	20 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	31	Dining	36.6 m <sup>2</sup>	40 m <sup>2</sup>	-3.4 m <sup>2</sup>	
CCC	33	Public corridor	30 m <sup>2</sup>			
CCC	40	Public corridor	52.6 m <sup>2</sup>			
CCC	42	Switch room	4.1 m <sup>2</sup>	2 m <sup>2</sup>	2.1 m <sup>2</sup>	
CCC	43	Shower 1	2.2 m <sup>2</sup>	2.5 m <sup>2</sup>	-0.3 m <sup>2</sup>	
CCC	44	Staff WC 2	2.1 m <sup>2</sup>	2 m <sup>2</sup>	0.1 m <sup>2</sup>	
CCC	45	Comms	6.9 m <sup>2</sup>	5 m <sup>2</sup>	1.9 m <sup>2</sup>	
CCC	49	Patient Utility	10.5 m <sup>2</sup>	4.5 m <sup>2</sup>	6 m <sup>2</sup>	
CCC	50	IVS	4.3 m <sup>2</sup>			
CCC	51	IT	3.1 m <sup>2</sup>	5 m <sup>2</sup>	-1.9 m <sup>2</sup>	
CCC	52	Roof access	6.2 m <sup>2</sup>			
CCC	53	Foyer	6.1 m <sup>2</sup>	8 m <sup>2</sup>	-1.9 m <sup>2</sup>	
CCC	57	Touchdown 02	4.9 m <sup>2</sup>			
CCC	74	Touchdown 01	2.7 m <sup>2</sup>			
CCC	75	Patient Pantry	11.3 m <sup>2</sup>			
CCC	92	Nurse Station	7.4 m <sup>2</sup>	6 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	93	AWC	5.2 m <sup>2</sup>	4.5 m <sup>2</sup>	0.7 m <sup>2</sup>	
CCC	95	Treatment Room	14.5 m <sup>2</sup>	16.5 m <sup>2</sup>	-2 m <sup>2</sup>	
CCC	96	Assisted bathroom	16 m <sup>2</sup>	16 m <sup>2</sup>	0 m <sup>2</sup>	
CCC	97	Sitting Room	42.9 m <sup>2</sup>	48 m <sup>2</sup>	-5.1 m <sup>2</sup>	
CCC	98	Office	14.9 m <sup>2</sup>	13.5 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	101	Corridor	15.9 m <sup>2</sup>			
CCC	103	Private Corridor	54.5 m <sup>2</sup>			
CCC	142	Private Corridor	123.4 m <sup>2</sup>			
CCC	B01	Bedroom 01 - Assisted	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
CCC	B02	Bedroom 02 - Assisted	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
CCC	B03	Bedroom 03 - Partially Assisted	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B04	Bedroom 04 - Partially Assisted	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B05	Bedroom 05	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B06	Bedroom 06	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B07	Bedroom 07	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	B08	Bedroom 08	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	B09	Bedroom 09	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B10	Bedroom 10	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	B11	Bedroom 11	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	B12	Bedroom 12	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B13	Bedroom 13	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	B14	Bedroom 14	17.2 m <sup>2</sup>	16 m <sup>2</sup>	1.2 m <sup>2</sup>	
CCC	B15	Bedroom 15	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	B16	Bedroom 16	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B17	Bedroom 17	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B18	Bedroom 18	17.3 m <sup>2</sup>	16 m <sup>2</sup>	1.3 m <sup>2</sup>	
CCC	B19	Bedroom 19	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	B20	Bedroom 20	17.4 m <sup>2</sup>	16 m <sup>2</sup>	1.4 m <sup>2</sup>	
CCC	E01	Ensuite 01	4.2 m <sup>2</sup>	5 m <sup>2</sup>	-0.8 m <sup>2</sup>	
CCC	E02	Ensuite 02	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E03	Ensuite 03	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E04	Ensuite 04	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E05	Ensuite 05	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E06	Ensuite 06	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E07	Ensuite 07	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E08	Ensuite 08	4 m <sup>2</sup>			
CCC	E09	Ensuite09	4.1 m <sup>2</sup>			
CCC	E10	Ensuite 10	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E11	Ensuite 11	4.1 m <sup>2</sup>			
CCC	E12	Ensuite 12	4.1 m <sup>2</sup>			
CCC	E13	Ensuite 13	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E14	Ensuite 14	4.1 m <sup>2</sup>			
CCC	E15	Ensuite 15	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E16	Ensuite 16	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
CCC	E17	Ensuite 17	4 m <sup>2</sup>	5 m <sup>2</sup>	-1 m <sup>2</sup>	
CCC	E18	Ensuite 18	4 m <sup>2</sup>	5 m <sup>2</sup>	-1 m <sup>2</sup>	
CCC	E19	Ensuite 19	4.1 m <sup>2</sup>			
CCC	E20	Ensuite 20	4.1 m <sup>2</sup>	5 m <sup>2</sup>	-0.9 m <sup>2</sup>	
Grand total			1152.8 m <sup>2</sup>	762 m <sup>2</sup>	12.5 m <sup>2</sup>	

**NOTE:** Does not include external courtyard areas or external undercroft plant.  
Briefed areas do not include circulation.  
**Pink** denotes figures more than original briefed area  
**Blue** denotes less than original briefed area.

1	Hub Stage 2 Information	AD	TB	18/06/2018
0	Stage E Report	AD	TB	23/04/2018
Rev	Description	D'r'n	Chk'd	Date

**keppie**  
architecture • interior design • planning • urban design

GLASGOW  
160 West Regent Street  
Glasgow  
G2 4RL  
Tel: 0141 204 0066  
www.keppiedesign.co.uk

Client  
**NHS GG&C/ HUB West Scotland**

Project  
**Stobhill Mental Health Estate**

Drawing  
**Room schedule**

Project No.  
**P16-101**

Drawing No.  
**KEP-CCC-XX-SH-A-0020-0101**

Status  
**Rev 1**

For Information

Created • AD  
Date • 08/08/17

Checked • TB  
Scale •  
@ A2

## Appendix 10 - Stobhill AEDET form

## Stobhill AEDET form

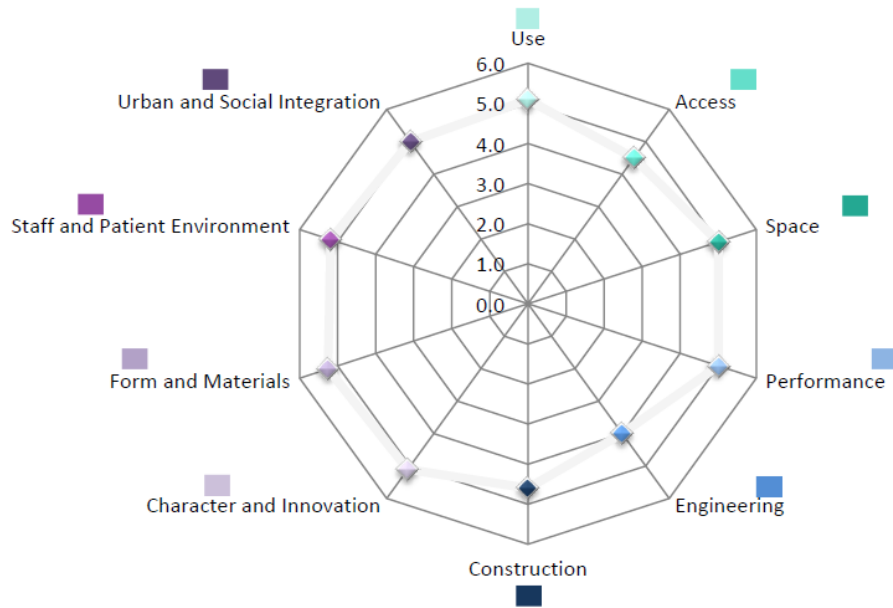
Throughout the planning process AEDET workshop have been carried out to create a baseline, at OBC development stage and a further meeting with key users for FBC stage on **4th June 2018**. The latest event involved local User and Carer Group input with the Mental Health Network. Thanks go to Donald Hosie, George Brown, John McNab, Pastor Mark Morris, Mark Wiseman, Michael McCann, Shona McCue and Stephen McGuire. The event also included Katrina Phillips, Head of Adult Services, Mary O'Donnell Inpatient Services Manager. The summary scores from this workshop can be viewed below:

**Diagram 01: Summary of FBC AEDET**

Target		Progress	
		Prev	Curr
5.0	Use	4.3	5.1
5.0	Access	4.3	4.5
5.0	Space	4.5	5.0
5.0	Performance	4.7	5.0
4.3	Engineering	3.7	4.0
5.0	Construction	4.2	4.6
5.0	Character and Innovation	4.2	5.1
5.0	Form and Materials	4.4	5.3
5.0	Staff and Patient Environment	4.8	5.2
5.0	Urban and Social Integration	4.9	5.0

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

AEDET Refresh FBC Summary



Scoring has been maintained or improved across all categories from the previous evaluation and it is anticipated that this would be the case post completion where it will be possible to provide a score establishing if the benchmarks set out in the design statement have been achieved.

## **Appendix 11 - Stakeholder Letter of Support**



## Stakeholder Letter of Support

Mr Paul Gray  
Director-General  
Health and Social  
Care and  
Chief Executive NHS  
Scotland  
ST Andrews House,  
Regent Road,  
Edinburgh,  
EH1 3DG

SAMPLE LETTER – once FBC approved formal letter to be attached

Dear Mr Gray

*[The letter should be provided by the appropriate individual(s) within the organisation – usually the Chief Executive Officer].*

Glasgow City Health and Social Care Partnership and NHS Greater Glasgow and Clyde have been actively involved in developing the Mental Health 2 Ward DBFM scheme through its various stages.

There is jointly confirmed acceptance of the strategic aims and investment objectives of the scheme, its functional content, size and services.

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.

In the unlikely event that the scheme's costs breach the agreed ceiling joint support will be re-validated.

The scheme is affordable via the DBFM route.

Yours sincerely

Chief Officer


## **Appendix 12 – HAI Scribe**

# SHFN 30: HAI-SCRIBE

## Questionsets and checklists

## Design and Planning Stage

### Project particulars and checklists for Development Stage 2

Development stage 2 : Design and planning HAI-SCRIBE Sign-off		
HAI-SCRIBE Name of Project	<b>Stobhill AAU and CCC Wards</b>	
Name of Establishment	<b>Stobhill AAU and CCC Wards</b>	National allocated number
HAI-SCRIBE Review Team	<b>Andrew Baillie Kirsty Ferguson Mary O'Donnell Stewart McKenzie Gail Brown</b>	
HAI – SCRIBE Sign Off		
Completed by (Print name) <b>Andrew Baillie (NHS GGC)</b>		Date <b>20/08/18</b>
Signature(s) 		Date <b>20/08/18</b>
<p>Stage 2</p> <p>The new wards comprise of 2 buildings with a combined floor area of 2543m2. These facilities are located on a self-contained site within the Stobhill Campus. This is an inpatient facility with overnight bed accommodation. The buildings are single story on a sloped site.</p> <p>There is DSR /Dirty Utility and Clinical Waste holds located within each building, these locations have been reviewed with Infection Control, Facilities and Hotel Services.</p> <p>The site was once the home to Victorian Mental Health Wards which were demolition but the board prior to this contract. This build procurement is by way of DBFM contract. Due to the nature of the site and the contract there is no GG&amp;C management responsibility until after building handover.</p> <p>In Advance of this Stage 2 HAI Scribe meeting, a series HAI-scribe Review meetings took place with the design team. These comments were captured and addressed.</p> <p>All sanitary fittings have been reviewed and approved during the design stage and any changed will be subject to review as part of the contracts' Reviewable Design Data' (RDD)..</p>		
Additional notes		
Construction /Refurbishment Activity – Type 4 Major demolition and construction projects.		

<b>Development Stage 2: Design and Planning</b> <b>Checklist to ensure all aspects have been addressed</b>		
2.a	Brief description of the work being undertaken.	<b>Construction of new AAU &amp; CCC wards on the site of former Victorian wards.</b>
2.b	Identify any potential hazards associated with this work.	<b>Ground Contamination – Ground Gas, and Asbestos.</b>
2.c	Identify any risk associated with the hazards identified above	<b>Safety of Staff and Patients after facility is completed</b>
2.d	Outline the control measures that require to be implemented to eliminate or mitigate the identified risks. Ensure these are entered on the project risk register.	<b>Gas Barrier within ground makeup. Damping down of ground during works to ensure no dust. Remediation Strategy has been developed.</b>
	Control Measures	
2.e	It has been recognised that control measures identified to address the project risk may have unintended consequences e.g. closure of windows can lead to increased temperatures in some areas. Such issues should be considered at this point, they should be noted and action to address these taken	
	Potential Problems	
	Control Measures	
2.f	Actions to be addressed	
By		Deadline

<b>Development Stage 2: Design and Planning</b> <b>General overview</b>		
2.1	<p>In order to minimise the risk of HAI contamination is there separation of dirty areas from clean areas?</p> <p>Have these issues and actions to be taken been noted in actions to be addressed section?</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p>		
2.2	<p>Are the food preparation areas (including ward kitchens) and distribution systems fit for purpose and complying with current food safety and hygiene standards?</p> <p>Have these issues and actions to be taken been noted in actions to be addressed section?</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p> <p>All areas have been designed to comply with current food safety and hygiene standards.</p>		
2.3	<p>Are waste management facilities and systems robust and fit for purpose and in compliance with the Waste (Scotland) Regulations?</p> <p>Consider: Local and central storage</p> <p>Systems for handling and compaction of waste Systems for segregation and security of waste (especially waste generated from healthcare requiring specialist treatment / disposal) to avoid mixing with other waste and recycles.</p> <p>Have these issues and actions to be taken been noted in actions to be addressed section?</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p> <p>All waste will be handled as part of a Stobhill site wide strategy.</p>		

<b>Development Stage 2: Design and Planning</b> <b>General overview (continued)</b>		
2.4	<p>Are there satisfactory arrangements for effective management of laundry facilities? Consider:</p> <p>Local and central storage</p> <p>Systems for movement of laundry to central storage</p> <p>Systems for handling laundry</p> <p>Have these issues and actions to be taken been noted in actions to be addressed section?</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p> <p>On site laundry in operation including Pick-Up and Delivery Systems.</p>		
2.5	<p>Are there sufficient facilities and space for the cleaning and storage of equipment used by hotel services staff?</p> <p>Have these issues and actions to be taken been noted in actions to be addressed section?</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p> <p>Location of DSR noted as being remote from main ward but this is acceptable as microfiber cleaning will be used.</p>		
2.6	<p>Are staff changing and showering facilities suitably sited and readily accessible for use, particularly in the event of contamination incidents?</p> <p>Have these issues and actions to be taken been noted in actions to be addressed section?</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p>		
2.7	<p>Is the space around beds for inpatients, day case and recovery spaces in accordance with current relevant NHSScotland guidance?</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p>
<p>Comments</p> <p>All bed spaces are within Single Room Accommodation.</p>		

<b>Development Stage 2: Design and Planning</b> <b>General overview (continued)</b>		
2.8	Are there sufficient single rooms to accommodate patients known to be an infection or potential infection risk?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments  All bed spaces are within Single Room Accommodation.		
2.9	Are all surfaces, fittings, fixtures and furnishings designed for easy cleaning?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.10	Are soft furnishings covered in an impervious material in all clinical and associated areas, and are curtains able to withstand washing at disinfection temperatures?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.11 P	Is the bathroom / shower / toilet accommodation sufficient and conveniently accessible, with toilet facilities no more than 12m from the bed area?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments  All bed spaces are within Single Room Accommodation with own En-Suite		
2.12 D	Are the bathroom/shower/toilet facilities easy to clean?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.13	Where required are there sufficient en-suite single rooms with negative/positive pressure ventilation to minimise risk of infection spread from patients who are a known or potential infection risk?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments  All bed spaces are within Single Room Accommodation with own En-Suite		



NB: In the above and following Table “D” refers to “Design” and “P” refers to “Planning”

<b>Development Stage 2: Design and Planning: Provision of hand-wash basins, liquid soap dispensers, paper towels and alcohol rub dispensers</b>		
2.14	Does each single room have clinical hand-wash basin, liquid soap dispenser, paper towels, and alcohol rub dispenser in addition to the hand-wash basin in the en-suite facility?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<b>Comments</b>  All bed spaces are within Single Room Accommodation with own En-Suite. Every En-Suit has a clinical hand-wash basin, liquid soap dispenser, paper towels, and alcohol rub dispenser. This approach is due to the patient group and the need to maintain patient safety and minimising risk. However there will be 2 rooms within each ward that have a separate clinical hand-wash basin within the bedroom itself.		
2.15	Do intensive care and high dependency units have sufficient clinical hand-wash basins, liquid soap dispensers, paper towels, and alcohol rub dispensers conveniently accessible to ensure the practice of good hand hygiene?  <i>An assessment should be made, however, to ensure that there is not an over-provision of hand-wash basins resulting in under-use.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
<b>Comments</b>		
2.16	Is there provision of clinical hand-wash basins, liquid soap dispensers, paper towels, and alcohol rub dispensers in lower dependency settings like mental health units, acute, elderly and long term care settings appropriate to the situation with a ratio of 1 basin/dispenser to 4–6 beds?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<b>Comments</b>  All bed spaces are within Single Room Accommodation with own En-Suite. Every En-Suit has a clinical hand-wash basin, liquid soap dispenser, paper towels, and alcohol rub dispenser.		
2.17	Do out-patient areas and primary care settings have a clinical hand-wash basin close to where clinical procedures are carried out?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
<b>Comments</b>		
2.18	Do all toilets have a hand-wash basin, liquid soap dispenser and paper towels?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<b>Comments</b>		

2.19	Are all clinical hand-wash basins exclusively for hand hygiene purposes?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>Comments</p> <p>The above question relates to the clinical hand wash basins in the ensuite where the facility will be used as a patient sink. If the sink is required by nursing staff, i.e. in the event of an outbreak, patient belongings can be removed and the ensuite door is designed in such a way that nursing staff can be provided with a clear thoroughfare.</p>		

<p><b>Development Stage 2:</b> <b>Design and Planning:</b> <b>Provision of hand-wash basins, liquid soap dispensers, paper towels and alcohol rub dispensers (continued)</b></p>		
2.20	Does each clinical hand-wash basin have wall mounted liquid soap dispenser, paper towel dispenser?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<p>Comments</p>		
2.21 D	Does each clinical hand-wash basin satisfy the requirement not to be fitted with a plug?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<p>Comments</p>		
2.22 D	Are elbow-operated or other non-touch mixer taps provided in clinical areas?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<p>Comments</p>		
2.23 D	Does each hand-wash basin have a waterproof splash back surface?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<p>Comments</p>		
2.24 D	Is each hand-wash basin provided with an appropriate waste bin for used hand towels?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<p>Comments</p>		

<b>Provision of facilities for Decontamination LDU</b>		
2.25 D	<p>Are separate, appropriately sized sinks provided locally, where required, for decontamination?</p> <p>(The sinks should be large enough to immerse the largest piece of equipment and there should be twin sinks, one for washing and one for rinsing. A clinical hand-wash basin should be provided close to the twin sinks).</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A <input type="checkbox"/></p>
<p>Comments</p> <p>Single stainless steel sink provided is sufficient for client group</p>		

<b>Development Stage 2: Design and Planning: Provision of facilities for Decontamination LDU (continued)</b>		
2.26 P	<p>Are appropriate decontamination facilities provided centrally for sterilisation of specialist equipment?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p> <p>There will be no local decontamination taking place within the ward.</p>		
2.27 P	<p>Is there adequate provision in terms of transport, storage, etc. to ensure separation of clean and used equipment and to prevent any risk of contamination of cleaned equipment?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p> <p>All equipment is single use within units.</p> <p>There will be no local decontamination taking place within the ward.</p>		
2.28 P	<p>Does the system in operation comply with the current guidance on decontamination facilities and procedures?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/></p>
<p>Comments</p>		

<b>Storage</b>		
2.29 P	Is there suitable and sufficient storage provided in each area of the healthcare facility for the following if required patients' clothes and possessions, domestic cleaning equipment and laundry, large pieces of equipment e.g. beds, mattresses, hoists, wheelchairs, trolleys, and other equipment including medical devices, wound care, and intravenous infusion equipment, consumables etc?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.30 P	Is there separate, suitable storage for contaminated material and clean material to prevent risk of contamination?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		

<b>Development Stage 2: Design and Planning: Engineering services (Ventilation)</b>		
2.31 P	Are heat emitters, including low surface temperature radiators, designed, installed and maintained in a manner that prevents build up of dust and contaminants and are they easy to clean?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.32 D	Is the ventilation system designed in accordance with the requirements of SHTM 03-01 'Ventilation in Healthcare Premises'?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.33 D	Is the ventilation system designed so that it does not contribute to the spread of infection within the healthcare facility? <i>(Ventilation should dilute airborne contamination by removing contaminated air from the room or immediate patient vicinity and replacing it with clean air from the outside or from low-risk areas within the healthcare facility.)</i>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		






2.34 D	Are ventilation system components e.g. air handling, ventilation ductwork, grilles and diffusers designed to allow them to be easily cleaned?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.35 P & D	Are ventilation discharges located a suitable distance from intakes to prevent risk of contamination?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.36 P	Does the design and operation of re-circulation of air systems take account of dilution of contaminants and the space to be served? <i>(NB: Recirculation would only arise in UCV theatres)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Comments		
<p><b>Development Stage 2:</b>  <b>Design and Planning:</b>  <b>Engineering services (Ventilation) (continued)</b></p>		
2.37	Is the ventilation of theatres and isolation rooms in accordance with current guidance?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Comments		
2.38	Do means of control of pathogens consider whether dilution or entrainment is the more appropriate for particular situations?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
<p>Comments</p> <p>Highly infectious patients would be relocated to another area.</p>		
2.39	Where ventilation systems are used for removal of pathogens, does their design and operation take account of infection risk associated with maintenance of the system?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Comments		
2.40	Are specialised ventilation systems such as fume cupboards installed and maintained in accordance with manufacturers' instructions?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Comments		

<b>Engineering services (Lighting)</b>		
2.41 D	Is the lighting designed so that lamps can be easily cleaned with minimal opportunity for dust to collect?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
<b>Engineering services (Water services)</b>		
2.42 D	Are water systems designed, installed and maintained in accordance with current guidance?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		

<b>Development Stage 2: Design and Planning: Engineering services (Water Services) (continued)</b>		
2.43	Are facilities available to enable special interventions for <i>Legionella</i> ?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.44	Is the drainage system design, especially within the healthcare facility building, fit for purpose with access points for maintenance carefully sited to minimise HAI risk?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
2.45	Are surface mounted services avoided and services concealed with sufficient access points appropriately sited to ease maintenance and cleaning? (These services would include water, drainage, heating, medical gas, wiring, alarm system, telecoms, equipment such as light fittings, bedhead services, heat emitters.)	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		

<b>Estates services (Pest control)</b>		
2.46	Is the concealed service ducting designed, installed and maintained to minimise risk of pest infestation?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
<b>Estates services (Maintenance access)</b>		
2.47	Does the design and build of the facility allow programmed maintenance of the fabric to ensure the integrity of the structure and particularly the prevention of water ingress and leaks and prevention of pigeon and other bird access?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Comments		
All addressed within DBFM Contract.		

<b>Development Stage 2: Design and Planning</b>
<p>Additional notes – Stage 2</p> <ul style="list-style-type: none"> <li>• All Planned Preventative Maintenance will be provided as part of the FM contract.</li> <li>• Both wards designed for various patient groups within mental health.</li> </ul>

Development stage 2: HAI-SCRIBE applied to the planning and design stage of the development.				
<b>Certification</b> that the following documents have been accessed and the contents discussed and addressed at the Infection Control and Patient Protection Meeting held on				
Venue	Stobhill Hospital	Date	13/08/18	
<b>'Healthcare Associated Infection System for Controlling Risk in the Built Environment'</b> (HAI-SCRIBE) Implementation Strategy Scottish Health Facilities Note (SHFN) 30: Part B).				
<b>Declaration:</b> We hereby certify that we have co-operated in the application of and where applicable to the aforesaid documentation.				
<b>Present</b>				
Print name	Signature	Company	Telephone Numbers	Email address
Andrew Baillie		Project Manager, NHS	07870915 923	Andrew.Baillie@ggc.scot.nhs.uk
Mary O'Donnell		In-Patient Services Manager, NHS	0141 531 3200	Mary.O'Donnell@ggc.scot.nhs.uk
Kirsty McDaid		Lead Nurse Infection Prevention and Control, NHS		Kirsty.McDaid@ggc.scot.nhs.uk
Gayle Brown		Deputy Site Facilities Manager, NHS	0141 201 3765	Gayle.Brown@ggc.scot.nhs.uk
Stewart McKenzie		Sector Facilities Manager, NHS	0141 211 3796	Stewart.McKenzie@ggc.scot.nhs.uk



## **Appendix 13 – Commissioning Requirement Brief**

# Commissioning Requirement Brief

## 1 Operational Commissioning Requirement Brief

2 There are two contractually separate commissioning roles required to bring the Stobhill 2 x Mental Health Wards into operational service.

3 **Building Commissioning**-These works are procured by way of DBFM contract, which includes the buildings Hard FM for a period of 25 years. Whilst, GG&C NHS may witness the building technical commissioning, they have no responsibility for this exercise.

4 **Operational Commissioning**- This operational commissioning requirement brief sets out the commissioning and handover requirements for the Stobhill 2 x Mental Health Wards. The brief will form an integral part of the Employer's Information Requirements (EIRs) and Asset Information Requirements (AIRs) required under BIM. The following sections will provide detail on the level of information and engagement required in order to successfully commission the project into service.

## 5 Project Overview

6 The Stobhill 2 x Mental Health Wards project is planned to provide improved mental health services in Glasgow and will replace beds from Birdston Care Home and former Parkhead Hospital bed temporarily located in decant accommodation at Stobhill.

## 7 Soft Landings and BIM Strategy

8 These works are procured by way of DBFM contract, which includes the contract requirement for DBFM Co to implement a soft landing and BIM strategy.

9

10 Specific details of Stobhill 2 x Mental Health Wards BIM strategy and implementation are detailed in the project BIM Execution Plan (BEP) and associated appendices which are updated in line with design progress.

## 11 Building Technical Commissioning and Aftercare

12 These works are procured by way of DBFM contract, which includes the buildings Hard FM for a period of 25 years. Whilst, GG&C NHS may witness the building technical commissioning, they have no responsibility for this exercise.

## 13 Defect Liability / Aftercare

14 Following successful handover of the project, DBFM Co will be responsible for the rectification of any defects during the concession period of 25 Years. This defect liability period is irrespective of any warranty provided by any manufacturer or supplier. DBFM Co will provide

suitable contact details within the O&M Manuals to allow the respective FM team to raise any defects for resolution.

15

## **16 Group 2 and 3 Equipping Strategy**

- 17 The Equipping Strategy remains the responsibility of the Project Director with support from the Operational Commissioning Manager. The Delivery Group however have agreed the Equipping Responsibility Matrix prior to the commencement of the equipping process. This matrix ensures that there is clear demarcation and ownership of equipment being provided by the Project and the Clinical Service. At a high level Group 1 equipment will be provided and fitted by DBFM Co, Group 2 equipment will be provided by NHS GGC Procurement and fitted by the PSCP, Group 3 equipment will be provided and fitted by the wider Operational Commissioning Team and Clinical Service post handover.

## **18 User Guides and Templates**

- 19 To enable successful handover and operation of the new facility there is a requirement to produce Standard Operating Procedures (SOP) for how the facility will be run. These should be purely for the facility and should remain separate from the SOPs used by the services for delivering the required level of care to patients. The responsibility for the production of the SOP remains with the Service Manager with support from the Delivery Group. A draft SOP checklist is provided in Figure 1, this will be agreed during the construction phase of the project prior to the start of the commissioning phase. The SOP should be used as basis for staff training and familiarisation of the new facility.

20

- 21 DBFM Co will ensure that, a video of the pre handover training sessions are captured on disk and passed onto the Building Management Team. This will allow training to be rolled out to the relevant personnel and can be retained for training of any new staff over the life of the building.

22

23

<b>Standard Operating Procedures Checklist</b>	
✓	<b>Services</b> – Confirmation of services to be provided by department
✓	<b>Hours of Operation</b> – opening hours, visiting hours, etc
✓	<b>Predicted Workload</b> – this should be taken from projections in the Full Business Case at the outlet, but should be modified by contracting targets
✓	<b>Staffing Requirements</b> – confirmation of number and grades of staff
✓	<b>Shift Arrangements</b> – confirmation of staff shift arrangements
✓	<b>Management Arrangements</b> – required for each staff group
✓	<b>Staff Training</b> – general staff induction, training arrangements in use of specialised equipment
✓	<b>Space Utilisation</b> – management of patient flows, how each room or activity space will be utilised
✓	<b>Quality Standards</b> – details of how these will be achieved
✓	<b>Logistics</b> – arrangements for delivery and collection of supplies, post, patient notes, materials management, transfer of deceased, etc.
✓	<b>Waste and Environmental Management Strategy</b> – How will waste be collected, disposed of, etc.
✓	<b>Interdepartmental Relationships</b> – how departments interact with the operation of the facility. How patients will be received, directed or transported to the services they require. Effects on other departments staffing levels and budgets
✓	<b>Data Collection</b> – how is data collected for patient records, clinical audit, financial systems, etc.
✓	<b>Health and Safety Legislation</b> – requirements relating to COSHH (Control of Substances Hazardous to Health) and other relevant legislation
✓	NHS Scotland – requirement relating to other NHS Scotland Body policies

25 Figure 1

## 26 Training and Site Visits Protocols

### 27 Pre Handover

28 Pre handover the site remains under the control of the DBFM Contractor who in turn is responsible for the Health and Safety (H&S) of all personnel on site. While staff visits are an essential part of the commissioning process they must not take place without the explicit agreement of the GG&C Project Manager and the DBFM Contractor.

29

30 As the project nears completion the GG&C Project Manager in conjunction with the HSCP should arrange site visits for staff training. Site familiarisation of staff will be undertaken post handover. 12 weeks prior to handover a schedule of visits should be agreed with DBFM Co/ DBFM Contractor to ensure that all visits do not conflict with the remaining works and the DBFM Contractors requirement to lock down completed areas to avoid mess or damage to finishes prior to handover.

31

32 DBFM Co remains responsible for providing training to the NHS GGC Team on any assets or systems installed as part of the project. This should be arranged alongside the testing programme discussed above.

### **33 Post Handover**

- 34 Post handover the operation of the facility will become the responsibility of NHS GGC Building Management Team. However, responsibility for the hard FM remains with DBFM Co by way of the FM provider. The Building Management Team will become responsible for controlling access to the building from handover. There may still be a requirement for the DBFM Contractor and their supply chain to visit the facility to undertake remedial works as required. Strict controls (control of access and permit to work) will be placed on the DBFM Contractor to ensure their work does not disrupt the service being delivered.

### **35 Handover and Snagging Protocols**

- 36 These works are procured by way of DBFM contract. An Independent Tester is appointed to assess if the contract conditions are being met during the contract. It is also their responsibility to assess when the works are complete and fit to be handed over to GG&C NHS.
- 37 Post handover the facility will be subject the NHS GGC policies and procedures. Arrangements for access and permit to work to carry out snagging works should be agreed between the DBFM Co and the Building Management Team and the Operational Commissioning Manager during the handover process. Weekly meetings should then be held to monitor the progress of the snagging works until all items have been successfully completed.

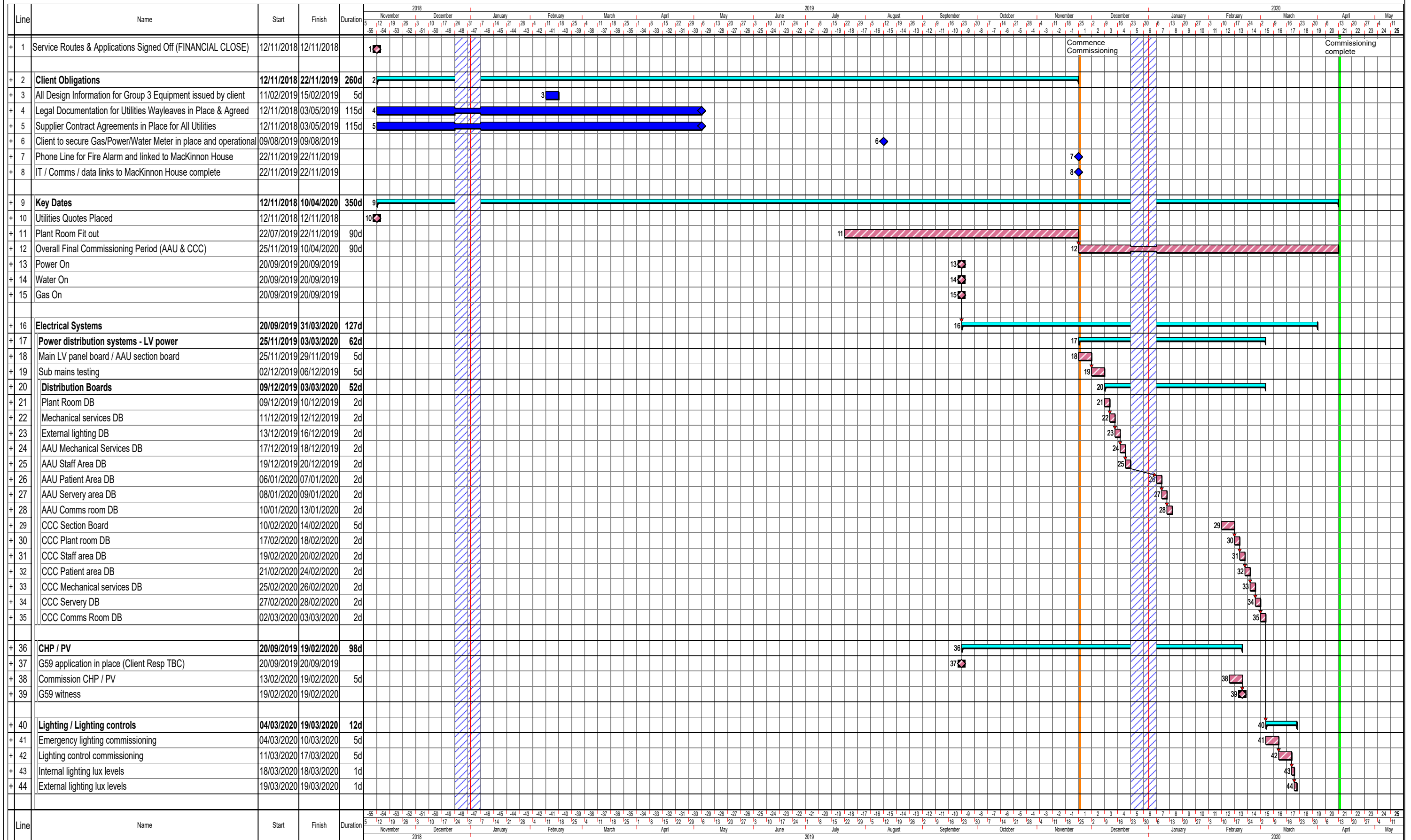
### **38 Equipping Responsibility Matrix**

- 39 The equipping responsibility matrix to be developed during the planning phase of this project.

## **Appendix 14 – Draft Commissioning Program**

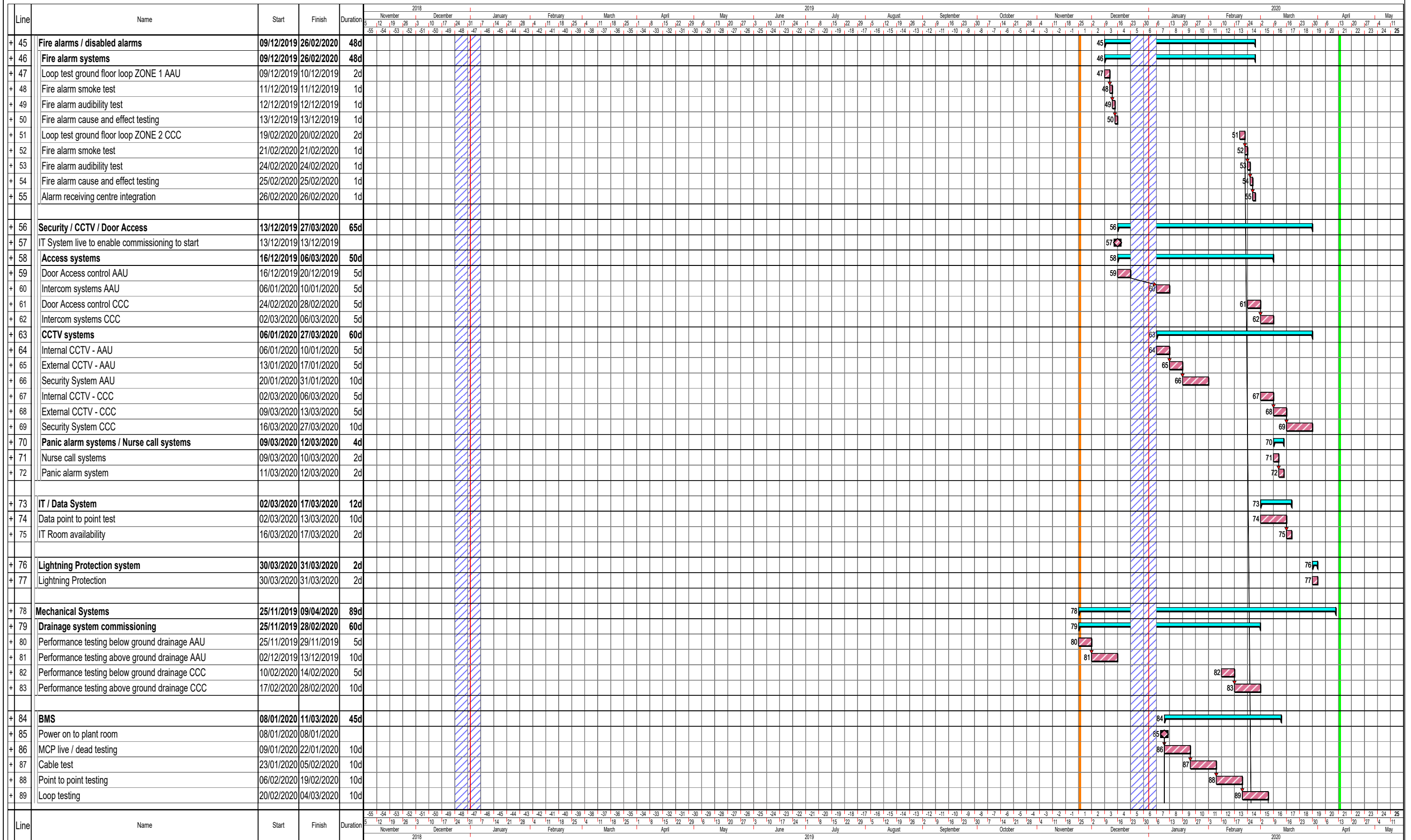


Hub West Scotland - NHSGGC  
Stobhill Mental Health Estate  
Outline Commissioning Programme





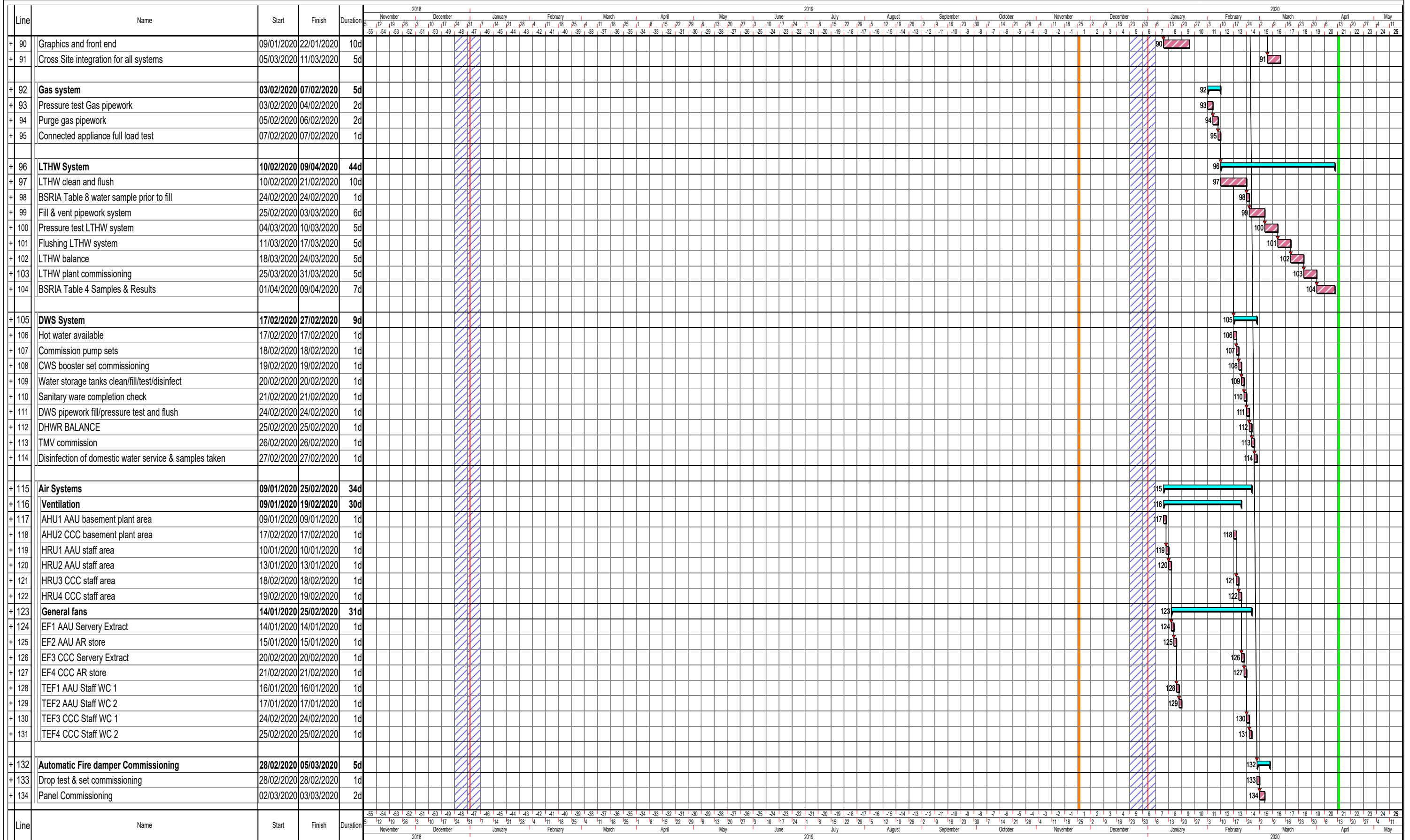
Hub West Scotland - NHSGGC  
Stobhill Mental Health Estate  
Outline Commissioning Programme







Hub West Scotland - NHSGGC  
Stobhill Mental Health Estate  
Outline Commissioning Programme





## **Appendix 15 – Project Monitoring Report**

<b>PROJECT TITLE</b>	<b>xx</b>	<b>PROJECT No.</b>	<b>xx</b>
Prepared By:	<b>xx</b>	Date:	<b>xx</b>

### Project Board and Governance

Senior Responsible Officer:	<b>xx</b>
Last Project Board was held on:	<b>xx</b>
Risk Register last updated on:	<b>xx</b>
Governance Status	<b>xx</b>

### Executive summary

<b>xx</b>
-----------

### Financial Summary

<b>Risk</b>		<b>Low</b>		
FC Contract Price	<b>xx</b>			
	Previous years	18/19	19/20	20/21
Spend to date	£	£	£	
Forecast Spend	£	£	£	
Comment:				
<b>xx</b>				

### Clients' Brief and Change Request Status

Brief Document Status:	<i>Update on progress. Identify any clarifications required and/or items still to be specified.</i>
Change Requests Status:	<i>List those under consideration/in progress/completed and the cost/programme implications associated with each project.</i>

### Programme and Progress

Programme Risk:	<b>Low</b>	<b>Med</b>	<b>High</b>
<i>Key dates including Works Start and Finish Dates and upcoming events</i>			

### Design & Technical Report

Programme Risk:	<b>Med</b>
<i>Update on design and technical progress</i>	

### Public Utilities

Programme Risk:	Low		
<i>Report any issues that arise</i>			

### Legal & Commercial

Programme Risk:	Low		
<i>Report any issues that arise</i>			

### Furniture, Fittings and Equipment

Programme Risk:	Low		
<i>Will be reviewed closer to handover in conjunction with commissioning plan</i>			

### Risk

#### **HUB Project Risk Register included within Appendix B.**

Risks <u>removed</u> since last month	Risk Score <u>reduced</u> from last month	Risk score <u>increased</u> from last month	New Risks <u>added</u> since last month

#### Red Risk Summary

Risk No	Risk Description	Mitigation	Score

#### **NHS Project Risk Register included within Appendix A.**

Risks <u>removed</u> since last month	Risk Score <u>reduced</u> from last month	Risk score <u>increased</u> from last month	New Risks <u>added</u> since last month

#### Red Risk Summary

Risk No	Risk Description	Mitigation	Score

### Health and Safety Update

<i>Comment on any reported Health &amp; Safety issues.</i>
--

### Construction Quality

<i>Comments from Site Monitor</i>
-----------------------------------

### Community Benefits

<i>Attach or include Hub's Community Benefits tracker</i>
---

## **Appendix 16 – Planning Consent**



Executive Director  
Richard Brown

Development and Regeneration  
Services  
Glasgow City Council  
231 George Street  
Glasgow G1 1RX  
Phone 0141 287 8555  
Fax 0141 287 8444

Keppie Planning  
Per Calum Glen  
160 West Regent Street  
GLASGOW  
G2 4RL

Our ref: DECISION  
GCC Application Ref: **18/00436/FUL**

19 July 2018

Dear Sir/Madam

**SITE: Stobhill General Hospital 133 Balornock Road Glasgow G21 3UW**

**PROPOSAL: Erection of two 20-bed care units with associated facilities.**

I am pleased to inform you that a decision to approve your application, **18/00436/FUL** has now been taken.

A copy of the decision notice is attached with any appropriate conditions/notes which should be read together with the decision.

**The decision notice is a legal document and should be retained for future reference.**

Should you require any additional information regarding the decision, please contact the case officer **Mr I Briggs** on direct phone **0141 287 6051**, or email [ian.briggs@drs.glasgow.gov.uk](mailto:ian.briggs@drs.glasgow.gov.uk), who will be happy to help you.

Yours faithfully

for Executive Director of Development and Regeneration Services

Encls.



# PLANNING DECISION NOTICE

## Full Planning Permission GRANTED SUBJECT TO CONDITION(S)

IN RESPECT OF APPLICATION 18/00436/FUL

**Erection of two 20-bed care units with associated facilities.**

AT

**Stobhill General Hospital 133 Balornock Road Glasgow G21 3UW**

AS SHOWN ON THE APPROVED PLAN(S)

This consent is granted subject to the following **condition(s)** and **reason(s)**:

01. Unless otherwise formally agreed in writing with the Planning Authority, external materials for the building shall be:

- Titan multi facing brick
- oak timber cladding to entrance recesses and bike store
- metal-clad projecting box windows
- PPC metal cope to parapets
- Standing seam aluminium roofing
- Aluminium framed curtain walling system to building entrances.

Samples and/or product literature of all proposed external materials shall be submitted to and approved by the Planning Authority in writing in respect of type, format, colour and texture. This written approval shall be obtained for all external materials before their use on site.

Reason: To enable the Planning Authority to consider this/these aspect(s) in detail.

Reason: In order to protect the appearance of both the property itself and the surrounding area

02. Before any work on the site is begun, a scheme of landscaping shall be submitted to and approved in writing by the planning authority. The scheme shall include hard and soft landscaping works, boundary treatment(s), tree pit specifications, and a programme for the implementation/phasing of the landscaping in relation to the construction of the development. All landscaping, including planting, seeding and hard landscaping, shall be completed in accordance with the approved scheme.



Reason: To ensure that the landscaping of the site contributes to the landscape quality and biodiversity of the area.

03. Before any work on the site is begun to implement the approved landscaping, a maintenance schedule for the landscaping scheme/open space, and details of maintenance arrangements, including the responsibilities of relevant parties, shall be submitted to and approved in writing by the planning authority.

Reason: To ensure the continued contribution of the landscaping scheme/open space to the landscape quality and biodiversity of the area.

04. Any trees or plants which die, are removed or become seriously damaged or diseased within a period of five years from the completion of the development shall be replaced in the next planting season with others of similar size and species.

Reason: To ensure the continued contribution of the landscaping scheme/open space to the landscape quality and biodiversity of the area.

05. Before works commence on site a detailed drainage strategy for the site including drawings and supporting calculations shall be submitted to and approved in writing by the Planning Authority. The approved measures shall thereafter be completed before any of the buildings are occupied. See also advisory note 02.

Reason: To minimise the risk of flooding and its adverse effects.

Reason: To enable the Planning Authority to consider this/these aspect(s) in detail.

06. Safe, secure and sheltered cycle parking facilities for staff and visitors shall be provided in line with the cycle parking requirements of policy guidance SG 11 'Sustainable Transport' of the City Development Plan (with a minimum standard of 1 space per 20 beds, and 1 space per 10 staff). Full details of this provision shall be submitted to and approved in writing by the Planning Authority, and the approved provision shall be in place prior to occupation of the approved development.

Reason: To ensure that cycle parking is available for the occupiers/users of the development, and in order to comply with the cycle parking requirements of policy guidance SG11: Sustainable Transport of the Glasgow City Plan.

07. In the event that any previously unidentified contamination is found at any time when carrying out the approved development, it shall be reported in writing to the planning authority within one week. A comprehensive contaminated land investigation, including risk assessment and remediation strategy, shall be carried out as required by the planning authority. The approved remediation works shall be carried out prior to the recommencement of development on the affected part of the site.

Reason: To ensure the ground is suitable for the proposed development.

08. Before development commences on site a Statement on Energy (SoE) shall be submitted to and approved in writing by the planning authority. The SoE shall analyse the energy and CO<sub>2</sub> savings that can be achieved in the development by utilising energy efficient design, practice and technologies. It shall demonstrate how the development will incorporate low and zero-carbon generating technologies to achieve at least a 15% cut in CO<sub>2</sub> emissions and the 'Silver Active' sustainability label, or better, as per the Building Standards Technical Handbook Section 7: Sustainability Standard. The development shall thereafter be constructed in compliance with the approved SoE. Formal confirmation of the constructed development's compliance with the SoE, carried out by a suitably qualified professional, shall be submitted to and approved in writing by the planning authority before the development/the relevant part of the development is occupied. See also advisory note 08.

Reason: To reduce energy consumption and greenhouse gas emissions by ensuring that the development is designed and constructed to be energy efficient, and utilises cleaner and more renewable sources of energy. To comply with City Development Plan policy CDP 5: Resource Management.

**Reason(s) for Granting this Application**

01. The proposal was considered to be in accordance with the Development Plan and there were no material considerations which outweighed the proposal's accordance with the Development Plan.

**Reason(s) for Granting this Application**

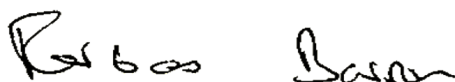
01. The proposal was considered to be in accordance with the Development Plan and there were no material considerations which outweighed the proposal's accordance with the Development Plan.

**Approved Drawings**

The development shall be implemented in accordance with the approved drawing(s)

1. KEP-AAU-XX-DR-A-0010-0009 Perforated Gate Sketch Proposal
2. L(90)01 REV E Landscape Masterplan
3. D(90)31 CCC Corner Detail
4. D(90)32 CCC Feature Planter Detail
5. KEP-XX-XX-DR-A-7030-0110 REV 0 Elevations
6. KEP--XX-XX-DR-A-7030-0201 REV 0 PLAN - Feature Bedroom Window
7. KEP-CCC-XX-DR-A-2530-0045 REV 1 PLAN - External Window Type A
8. IDV-4200 REV P6 Proposed Drainage Layout
9. KEP-XX-XX-DR-A-7060-0001 REV 1 Location Plan
10. KEP-XX-XX-DR-A-7060-0002 REV 1 Site Plan as Existing
11. KEP-XX-XX-DR-A-7060-0003 REV 2 Site Plan as Proposed
12. KEP-XX-XX-DR-A-7080-0001 REV 1 Site Sections
13. KEP-XX-XX-DR-A-7030-0001 REV 2 Site Elevations
14. KEP-AAU-00-DR-A-7060-0110 Rev 1 AAU - Ground Floor Plan
15. KEP-AAU-01-DR-A-7060-0111 Rev 1 AAU - Under Croft Plant
16. KEP-AAU-RF-DR-A-3010-0113 Rev 2 AAU - Roof Plan
17. KEP-AAU-XX-DR-A-7080-0110 Rev 1 AAU - Sections
18. KEP-CCC-00-DR-A-7060-0110 Rev 1 CCC - Ground Floor Plan
19. KEP-CCC-00-DR-A-7060-0111 Rev 1 CCC - Under Croft Plant
20. KEP-CCC-RF-DR-A-3010-0113 Rev 2 CCC - Roof Plan
21. KEP-CCC-XX-DR-A-7080-0110 Rev 1 CCC - Sections

As qualified by the above condition(s), or as otherwise agreed in writing with the Planning Authority



**Dated: 19 July 2018**

**Appointed Officer  
Development and Regeneration Services  
Glasgow City Council**

THIS DECISION NOTICE SHOULD BE READ WITH THE ATTACHED ADVICE NOTES

## IMPORTANT NOTES ABOUT THIS GRANT OF PLANNING PERMISSION

**IT IS YOUR RESPONSIBILITY TO SATISFY YOURSELF WITH REGARD TO THE MATTERS LISTED BELOW PRIOR TO IMPLEMENTATION OF THE WORKS WHICH ARE THE SUBJECT OF THIS CONSENT.**

### DURATION OF PLANNING PERMISSION

This permission lapses **3 years** from the date on this notice unless the development is begun before then and unless this notice specifies a longer or shorter period. Where there is such a specification, the permission lapses the specified number of years from the date on this notice unless the development is begun before then.

### CONDITIONS OF THIS NOTICE

By this notice, your proposal has been approved subject to conditions which are considered necessary to ensure the satisfactory implementation of the proposal. **It is important that these conditions are adhered to and these will be actively monitored to ensure this. Failure to comply with conditions may result in enforcement action being taken.**

### RIGHTS OF APPEAL

If you are not satisfied with the terms of this decision, including the conditions attached to the planning permission, you may request a review within **three months** of the date on this notice. Please note that the right of appeal is to the Planning Local Review Committee of the Council and **not** to Scottish Ministers.

**Before pursuing a review, you should consider contacting your case officer to discuss whether there are changes which could be made to the proposed development to make it acceptable. The case officer's contact details are on the letter accompanying this Decision Notice. Your case officer can also advise on how a fresh application could be submitted. Please note that if you do submit a fresh application within 12 months, you would be unlikely to have to pay a further planning fee.**

Before contacting the case officer, you would be well advised to view the report on the application. It is available for inspection at <https://publicaccess.glasgow.gov.uk/online-applications/> or electronically at Development and Regeneration Services, Development Management, 231 George Street, Glasgow G1 1RX, Monday to Thursday 9am to 5pm and Friday 9am to 4pm (excluding public holidays). The report explains how the decision was reached and should help you decide whether to proceed with further discussion or a review. If your application was granted subject to conditions, it may be clear from the terms of the report that any conditions which you might be concerned about are necessary.

A notice of review must be served on the Planning Local Review Committee on Form LR01 obtainable from:-

**Planning Local Review Committee  
Development & Regeneration Services  
231 George Street  
Glasgow  
G1 1RX  
Tel: 0141 287 6016, Fax: 0141 287 2037  
E-mail: [lrc@drs.glasgow.gov.uk](mailto:lrc@drs.glasgow.gov.uk)**

The notice of review must include a statement setting out your reasons for requiring the Planning Local Review Committee to review this case. You must state by what procedure (written representations, hearing session(s), inspection of application site) or combination of procedures you wish the review to be conducted. However, please note that the Planning Local Review Committee will decide on the review procedure to be followed.

You must also include with the notice of review a copy of this decision notice, the planning application form, the plans listed on the decision notice and any other documents forming part of the proposed development as determined. If you have a representative, you must give their name and address. Please state whether any notice or other correspondence should be sent to the representative instead of to you.

**THIS IS AN IMPORTANT LEGAL DOCUMENT AND SHOULD BE KEPT SECURE FOR FUTURE REFERENCE**

## NOTICES OF INITIATION AND COMPLETION

Under Section 27A of the Act, the person undertaking the development is required to give the planning authority written notification of the date on which it is intended to commence the development. Failure to comply with this statutory requirement would constitute a breach of planning control under Section 123(1) of the Act, which may result in enforcement action being taken. A pro-forma is attached to this decision which can be used for this purpose.

As soon as practicable after the development is complete, the person who completes the development is obliged by Section 27B of the Act to give the planning authority written notice of that position. A pro-forma is attached to this decision which can be used for this purpose.

## OWNERSHIP OF THE SITE

This consent only grants permission to develop on land of which you are the owner or have obtained the necessary consents from the owners of land or buildings.

If permission to develop land is granted subject to conditions, and the owner of the land claims that the land has become incapable of reasonably beneficial use in its existing state and cannot be rendered capable of reasonably beneficial use by the carrying out of any development which has been or would be permitted, he/she may serve on the planning authority a purchase notice requiring the purchase of his/her interest in the land in accordance with the provisions of Part V of the Town and Country Planning (Scotland) Act 1997.

## BUILDING WARRANT

This permission does not exempt you from obtaining a Building Warrant under the Building (Scotland) Acts. For further information, please contact Building Control within Development and Regeneration Services, 231 George Street, Glasgow, G1 1RX on 0141 287 5937.

## ROADS CONSTRUCTION CONSENT

This permission does not exempt you from obtaining a Roads Construction Consent under the Roads Scotland Act 1984. For further information please contact Roads and Transportation, within Land and Environmental Services, 20 Cadogan Street, Glasgow, G2 7AD on 0141 287 9000

## DISABLED ACCESS

You are reminded that in providing premises (including university and school buildings, offices, shops, railway premises, factories and toilets) which are open to the public, you should make provision, where reasonably and practicable, for the means of access and parking to be designed to meet the needs of disabled people. This should include appropriate signposting indicating the availability of these facilities. Your attention is specifically drawn to the BSI Code of Practice on Access for the Disabled to Buildings (BS 5810:1979) which explains the manner in which appropriate provision can be made for the needs of disabled people in the design of buildings. For further information please contact Building Control on 0141 287 5937.

## WORK INVOLVING GROUND EXCAVATION

The attention of any applicant proposing works involving ground excavation is drawn to the DIAL BEFORE YOU DIG website at [www.national-one-call.co.uk](http://www.national-one-call.co.uk). This provides access to information regarding the location of services to prevent damage to plant from uninformed ground excavation.

## SMALL FORMAT POSTERS

The City Council acknowledges the contribution that tourism, cultural, leisure and entertainment activities including film and theatre, music and dance, make to the economy and vitality of the City. Such activities tend to be advertised in small poster format (flyposting) which, if uncontrolled, can seriously detract from the appearance of the City. The City Council is working with the postering industry to prevent this, whilst accommodating the aspirations of the industry. It has approved a report stating that, where developments incorporate site screening panels prior to or during building operations, developers are encouraged to be receptive to approaches by the postering industry to accommodate an element of posting, in a controlled way, on the screen panels. It should be noted that any such posting will require separate Express Consent, usually sought by the advertiser, from the City Council to ensure that an acceptable standard of display is achieved. Developers are invited to assist the Council's initiative with the postering industry by making suitable sites available, as indicated above.

## COMMUNITY BENEFIT

Glasgow City Council (GCC) has developed a policy on Community Benefit to ensure that Glasgow secures the maximum economic and social benefit for residents and businesses from planned investment being made in the city.

The policy introduces measures to encourage:

- the targeted recruitment and training of those furthest from the job market, the long-term unemployed and individuals leaving education
- the advertising of sub-contracted business opportunities
- dedicated support for small to medium sized businesses (SMEs) and social enterprises (SEs) to build capacity.

These elements have been included in the development of the Commonwealth Arena, the Commonwealth Games Athletes' Village and the Hydro Arena at the SECC, among others, with significant success to date.

The Council is now working with Private Sector developers to maximise the impact of their investment in the City, for example Land Securities, developer of Buchanan Galleries. Significant assistance is available from various Public Sector agencies to achieve these outcomes and the support private contractors.

Should you wish to discuss these opportunities in more detail, please contact the Council's Community Benefit Programme Manager on 0141 287 6014.

Further background information on the Community Benefit model can be found at;

<http://www.scotland.gov.uk/Publications/2008/02/12145623/1>

## ADVISORY NOTES TO APPLICANT

01. The applicant is advised that the granting of planning permission does not remove him/her from the requirement to obtain the consent of adjacent landowners in respect of any access required to build or maintain this approved development. Such consent should be obtained prior to the commencement of works on site
02. The applicant should consult Scottish Water concerning this proposal in respect of legislation administered by that organisation which is likely to affect this development. In particular, sustainable drainage systems (SUDS) should be designed and constructed in accordance with the vestment standards contained in "Sewers for Scotland", 2nd edition 2007.

The applicant is advised that, where drainage systems including SUDS are not vested in Scottish Water, it is the applicant's/developer's responsibility to maintain those systems in perpetuity or to make legal arrangements for such maintenance.

03. The applicant is advised that, if the proposals hereby approved are altered in any way, for example as a result of obtaining any of the other statutory consents or for any other reason, they should so inform the planning authority and submit copies of the amended proposals in order that a view may be taken as to whether the alterations are material or not and whether a fresh application will be required.

04. Prior to implementation of this permission, the applicant should contact Development and Regeneration Services (Transport) at an early stage in respect of legislation administered by that Service which is likely to have implications for this development.

05. The applicant is advised that it is not permissible to allow water to drain from a private area onto the public road and to do so is an offence under Section 99(1) of the Roads (Scotland) Act 1984.

06. Construction and/or demolition work associated with this development should conform to the recommendations/standards laid down in BS5228 Part 1: 1997 "Noise and Vibration Control on Construction and Open Sites". Best Practicable Means as defined in Section 72 of the Control of Pollution Act 1974 should be employed at all times to ensure noise levels are kept to a minimum.

07. In order to protect local residents' amenity, noise associated with construction and demolition works in residential areas should not occur before 0800 or after 1900 Monday to Friday, and not before 0800 or after 1300 on Saturdays. Noise from construction or demolition works should be inaudible at the site's perimeter on Sundays and public holidays. The planning authority should be notified of necessary works likely to create noise outwith these hours.

08. It is recommended that the required Statement of Energy is submitted using the format set out in Annex A of City Development Plan supplementary guidance SG 5: Resource Management.

The development is required to meet a level of environmental sustainability set out in Building Standards Technical Handbook Section 7: Sustainability Standards. The developer will be reminded of this requirement on submission of subsequent Building Warrant(s) for the development. It is expected that the formal confirmation of compliance with the SoE which is required by this Decision Notice shall be satisfied by submission of the Certificate of Sustainability to the planning authority.

# TOWN AND COUNTRY PLANNING (SCOTLAND) ACT 1997

Notice under Section 27A Notification of Initiation of Development

## THE TOWN AND COUNTRY PLANNING (DEVELOPMENT MANAGEMENT PROCEDURE) (SCOTLAND) REGULATIONS 2008

Notice under Regulation 37 Notification of Initiation of Development

A person who intends to carry out development for which planning permission has been given, must, as soon as practicable after deciding on a date on which to initiate the development and in any event before commencing the development, give notice to Glasgow City Council by returning this completed Notice. It should be addressed to Glasgow City Council, Development and Regeneration Services, Development Management, 231 George Street, Glasgow G1 1RX

**FAILURE TO SUBMIT THIS NOTICE PRIOR TO COMMENCING WORK IS A BREACH OF PLANNING CONTROL UNDER SECTION 123(1) OF THE 1997 ACT AND ENFORCEMENT ACTION MAY BE TAKEN.**

<b>Application Reference:</b>	18/00436/FUL	IAB
<b>Application Address:</b>	Stobhill General Hospital 133 Balornock Road Glasgow G21 3UW	
<b>Proposal:</b>	Erection of two 20-bed care units with associated facilities.	
<b>Applicant:</b>	NHS Greater Glasgow & Clyde Per Andrew Bailie Admin Building Gartnavel Royal Hospital 1055 Great Western Road GLASGOW G12 0XH	
<b>Decision:</b>	Grant Subject to Condition(s)	
<b>Decision Date:</b>	19 July 2018	
<b>Full name and address of person(s), company or body carrying out the development (if different from applicant):</b>		
<b>Full name and address of all owner(s) of the land to be developed (if different from applicant):</b>		
<b>Full name, address and contact details of person(s), company or body appointed to oversee the carrying out of the development:</b>		
<b>START DATE:</b>		

Signed

Date

.....  
\*On

behalf

of

.....  
\*Delete where inappropriate

## TOWN AND COUNTRY PLANNING (SCOTLAND) ACT 1997

### Notice under Section 27B Notification of Completion of Development

A person who completes development for which planning permission has been given must, as soon as practicable after doing so, give notice of completion to Glasgow City Council by returning this completed Notice. It should be addressed to Glasgow City Council, Development and Regeneration Services, Development Management, 231 George Street, Glasgow G1 1RX

<b>Application Reference:</b>	18/00436/FUL	IAB
<b>Application Address:</b>	Stobhill General Hospital 133 Balornock Road Glasgow G21 3UW	
<b>Proposal:</b>	Erection of two 20-bed care units with associated facilities.	
<b>Applicant:</b>	NHS Greater Glasgow & Clyde Per Andrew Bailie Admin Building Gartnavel Royal Hospital 1055 Great Western Road GLASGOW G12 0XH	
<b>Decision:</b>	Grant Subject to Condition(s)	
<b>Decision Date:</b>	19 July 2018	
<b>COMPLETION DATE FOR DEVELOPMENT:</b>		

If the development is to be carried out in phases then, in accordance with the relevant condition of the planning permission, this Notice must, as soon as practicable after each phase is completed, be completed and returned to the address above.

<b>Phase 1 completed date:</b>	
<b>Phase 2 completed date:</b>	
<b>Phase 3 completed date:</b>	
<b>Phase 4 completed date:</b>	

Signed

Date

.....  
\*On

behalf

of

.....  
\*Delete where inappropriate





## Appendix 17 – Risk Register

Stobhill MH New-Build DBFM



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	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		Change to design may be necessary- impacting time and cost	Proactive engagement to purify during Stage 2.	hWS (KD)	NHS	15th March 2018; Allowance reinstated following feedback from the Project Team. 10th April 2018; Allowance to be maintained, NHS GG&C to advise regarding potential utilisation of allowance for design enhancements. 8th May 2018; Agreed to maintain allowance. Allowance to cover enhancements suggested by A&DS /HFS including lighting to perforated brick and external lighting to corner of CCC. 24th May 2018; Agreed to remove allowance to cover costs associated with AWV014.	Design Review held with A&DS / HFS on 15/08 and comments recorded. Agreed suitable time to reconvene will be once the thermal model has been developed further.	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	3rd August 2017; Stakeholder Engagement Schedule to be confirmed following confirming of Stage 2 development programme. 28th October 2017; Noted that S/H feedback being obtained as part of RL review and further engagement planned for review and approval of various design elements. 26th October 2017; Stakeholder Engagement Meetings with various parties ongoing. 27th November 2017; No update. 10th April 2018; Agreed risk now closed following I.C / Fire Office engagement throughout design development.	Project Team have scheduled various elements for S/H review at ongoing fortnightly meetings.	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	3rd August 2017; hWS currently preparing commercial document detailing impact of "stand-alone" status, await output from H&CC programme workshops. 28th October 2017; Stobhill programme revised to align with current H&CC FC date of 23/08/18. 26th October 2017; No further update. 27th November 2017; No update. 10th April 2018; Potential de-bundling still a risk and associated impact on development costs to be considered.	Programmes for bundle to be reviewed throughout Stage 2 to assess required alignment.	Closed
G5	19/10/2016	Additional Planning requirements including Masterplan	Change to design required		2	4	3	3	12		Additional cost and time implications	Early engagement with Planning Dept. to clarify requirements	hWS (KD)	NHS	8th May 2018; Agreed to maintain allowance until Planning determined. Potential to utilise allowance for cost increases associated with PV / Silver Active mandatory requirement if no further changes are stipulated. 24th May 2018; Agreed to remove allowance to cover costs associated with introduction of PV panels to satisfy mandatory planning requirement.	Planning Submission programmed for 06/10 but agreed to delay until Project Board decision confirmed in relation to under-croft plant space design solution.	Closed
G6	21/09/2016	Reduced-ligature requirements	Stage 2 design refinement results in increased cost		1,2	2	4	3	8			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	26th October 2017; To be reviewed following close-out of associated Stage 2 Change Control. 27th November 2017; To be reviewed following conclusion of S/H Engagement relating to reduced-ligature requirements. 18th December 2017; Allowance omitted following completion of Stakeholder Engagement exercise. 10th April 2018; "Likelihood" score reduced, only outstanding design issue currently reduced ligature curtain walling requirements to Activity / Quiet Room.	Await NHS GG&C confirmation in relation to Stage 2 Change Controls.	Closed
G9	01/08/2016	Building control approvals	Additional measures to achieve compliance requested		2	3	3	4	12		Change to design may be necessary	Early engagement with Building Control including Fire Consultant and Fire Control officer.	hWS (KD)	hWS	26th October 2017; No further update. 27th November 2017; No update. 19th December 2017; No further update. 24th January 2018; Allowance reduced to £25k. 10th April 2018; Noted that initial Stage 1 B.W response received. Main risk likely to relate to fire engineering requirements. Allowance to be maintained. 8th May 2018; Agreed to maintain allowance.	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	3rd August 2017; Noted that Schedule Part 5 issued by NHS GG&C and currently being reviewed by hWS / BAM. 26th October 2017; Noted that legal / commercial discussions ongoing between NHS GG&C and hWS in relation to the bundle. 27th November 2017; No further update. 10th April 2018; Noted NHS GG&C currently checking electrical substation status with feedback to follow.	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 Jan 2017; Site confirmed as being under complete ownership of NHS GG&C, cost allowance removed. 26th October 2017; No further update. 27th November 2017; No update. 10th April 2018; No issues anticipated.	hWS / NHS GG&C discussions ongoing regarding draft Schedule part 5	Closed
<b>SITE SPECIFIC RISKS</b>																
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	2	4	4	8	Significant potential programme/cost impact	Demolition/services diversion required scoping advised to NHS GGC. 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	27th November 2017; Demolition scope query responses received and being reviewed by the team. Agreed that material doesn't need to be classified as 6F2 for fill purposes below GF slabs. Demolition works on-programme with Phase 2 SI to commence following completion in early 2018. 10th April 2018; Agreed to reduce likelihood score. Demolition and service diversion works complete, risk still remains that works have not been completed as per requirements / scope.	Await NHS GG&C response in relation to condition of site at handover, confirmed demolition scope and programme status impacting on access date for Phase 2 Site Investigation.	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. 26th October 2017; No further update. 27th November 2017; No update. 10th April 2018; Design works ongoing to south-east corner of the CCC adjacent to existing retaining wall.	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	10th April 2018; Agreed to maintain allowance, gas and electrical applications submitted. Water application still to be submitted. 8th May 2018; Agreed to maintain allowance. Additional costs already encountered in relation to SP quote, further issues could be encountered as part of water / gas applications. 24th May 2018; Agreed to reduce allowance to £5k to cover risk associated with the outstanding gas connection quote.	Await NHS GG&C feedback in relation to site condition at handover and associated demolition scope. 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. 26th October 2017; No further update. 27th November 2017; Agreed to remove £20k allowance due to limited surface flows. 10th April 2018; Noted that existing pipework size issue identified through CCTV survey now by-passed. Await further drainage survey information to east of site.	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	28th October 2017; Phased S.I not possible due to ongoing demolition works. Await feedback from NHS GG&C in relation to confirmed access date for Phase 2 S.I. 26th October 2017; Demolition works completion delayed and Phase 2 S.I works now to be undertaken in early JAN 2018. 27th November 2017; No further update. 10th April 2018; Phase 2 Site Investigation complete and results anticipated on or before 17/04.	Await NHS GG&C confirmation in relation to demolition programme status and anticipated access date for Phase 2 S.I.	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	3	9	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	10th April 2018; Agreed to maintain allowance, enhancements may be required to address mandatory Planning / SBEM / BREEAM requirements. RSP to review and advise. Letter still awaited from Demolition Team. 8th May 2018; Agreed to maintain allowance to cover loss and potential further loss of credits required to achieve BREEAM "Excellent". 24th May 2018; Agreed to removal allowance to partially cover cost of PV required to satisfy mandatory BREEAM excellent credits.	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	3	9		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	27th November 2017; Agreed with project team to reduce allowance to £20k on basis of developed nature of design and ACR's. 19th December 2017; Agreed to maintain allowance until ACR's finalised. 24th January 2018; Allowance reduced as ACR's nearing finalisation. 10th April 2018; Agreed to maintain allowance until final revision / review of ACR's in case anything has been missed during the review / design process. 8th May 2018; Agreed to remove allowance on basis of ACR's nearing completion following numerous reviews and subsequent updates.	Final comments issued to NHS GG&C and update awaited.	Closed
SS18	22/03/2017	Solar shading requirements	Potential for additional requirements relating to solar shading		1,2	3	2	3	9	Design / Cost	Early Stage 2 design review and associated modelling to determine requirements	hWS	hWS	19th December 2017; Agreed to maintain allowance until outcomes of thermal model resolved. 10th April 2018; Agreed to maintain allowance until thermal modelling issues addressed, may be requirement for additional rooflights and/or mechanical ventilation. 8th May 2018; Agreed to remove allowance based on development of compliant model on 08/05 (TBC).	RSP/KD 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	4	12	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	26th October 2017; No further update. 27th November 2017; Agreed with the Project Team to omit £40k allowance on the basis of the developed design. 10th April 2018; No risk now anticipated, issue closed.	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	3	12	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	26th October 2017; No further update. 27th November 2017; No further update. 19th December 2017; Agreed allowance should be maintained. 10th April 2018; Agreed allowance to be maintained. 8th May 2018; Agreed to maintain allowance. 24th May 2018; Agreed to maintain allowance until BAM satisfied with CBR test results	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	4	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. 26th October 2017; Transportation Assessment / Travel Plan completed and distributed to the team for comment on 29/09. Review required regarding any additional requirements. 26th October 2017; No further update. 27th November 2017; No further update. 10th April 2018; No issues anticipated, no further risk anticipated.	Review of completed documents required to determine any additional requirements.	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	4	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. 26th October 2017; No further update. 27th November 2017; No further update. 10th April 2018; No further risk anticipated, issue closed.	Formalise access to area outwith Site red line boundary- Ancillary Rights?/ Schedule Part 5?	Closed

**SERVICE RISKS**

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	5		Carry out sensitivity testing or assumptions behind service demand projections to understand and	Katrina Philips	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.	Katrina Philips	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	Katrina Philips / David Harley	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	Katrina Philips	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	Katrina Philips / David Harley / Andrew Baillie	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	Katrina Philips / David Harley / Andrew Baillie	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	1		Set out a realistically achievable benefits realisation plan as part of the Initial Agreement. Further engagement with stakeholders during process	Katrina Philips	NHS	Benefits plan to be reconfirmed and updated as part of OBC process
S11	01/05/2018	Contamination within demolition material spread over the site.	Cost to clear up contamination could make the project unaffordable.	Programme / Cost	Construction & FC	4	4	5	20		Ensure Demolition team continue to monitor works on site to ensure any contamination found is contained.	Katrina Philips / Andrew Baillie	NHS	Contamination found in demolition material, scale of this being investigated.

## **Appendix 18 - OBC Letter Health & Social Care Directorates**

T: 0131-244 2790  
E: dghsc@gov.scot

Jane Grant  
Chief Executive  
NHS Greater Glasgow and Clyde  
J B Russell House  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow  
G12 0XH

31 August 2017

Dear Jane

### **Stobhill Mental Health DBFM – Outline Business Case**

The above Outline Business Case was considered by the Health Directorate's Capital Investment Group (CIG) at its meeting of 18 July 2017 and following satisfactory resolution of some outstanding issues, the CIG recommended approval. I am pleased to inform you that I have accepted that recommendation and now invite you to submit a Full 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. It is a compulsory requirement within SCIM, **for schemes in excess of £5 million**, that NHS Boards set up a section of their website dedicated specifically to such projects. The approved Business Cases / contracts should be placed there, together with as much relevant documentation and information as appropriate. Further information on this requirement can be found at <http://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm>

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

Yours sincerely



**Paul Gray**