Redevelopment of Dail Mhor Site, Strontian

Feasibility Study

FINAL REPORT

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Contents

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Ardgour Glensanda Trust

Sunart Community Benefit Fund

Note on Study Timing

This study was carried out in the context of an evolving healthcare situation with which Urram continues to engage. The information contained in this report is, to the best knowledge of the authors, an accurate representation of the situation as of October 2022.

RECOMMENDATIONS

1. **Dail Mhor Care Home**. It is technically feasible to develop a modern home on the site, but it is impractical from a financial point of view. Policy is moving away from care home provision to enhanced homecare provision with shorter periods of nursing care in a nursing home or a hospital at end of life. The rates being paid by NHS Highland for care home provision are insufficient to create a financial model for a small care home with a maximum of 10 beds. We cannot therefore recommend that Urram attempts to build and operate a small new care home facility at this time.

2. **Enhanced Care Provision**. The recommendation not to proceed with a new care home does not mean that the local population should simply accept poorer levels of health provision. Enhanced levels of care can be provided through:
   - **Exploring and developing new home care opportunities**. These arise from the move to Self-Directed Support and the willingness of NHS Highland to work with Urram to develop locally led solutions to local needs. There could be three elements to this:
     2..1. Using local knowledge, including existing staff knowledge to redesign the delivery of services to match needs and provide enhanced service delivery.
     2..2. Using local knowledge, community networks and community solidarity to enhance the recruitment, training, and retention of care workers (including those wishing to work only limited hours or support a specific client) to provide improved coverage and bespoke packages of service.
     2..3. The staff at Dail Mhor have an excellent reputation for the work that they do and redeployment of these staff to assist in providing enhanced care at home could be part of the solution. Some people who would formerly have received respite care in Dail Mhor could receive that care in their own homes if the necessary support is provided.
   - **Enhanced Medical Facilities in Strontian**. The existing facilities are clearly not fit for purpose. Urram should work with the NHS to design a new facility that fully meets community needs. This ought to include provision for co-location of the district nursing team, facilities for the provision of additional services such as physiotherapy and podiatry. Provision could also include space for Scottish Ambulance Service personnel.
   - **Preventive health activities**. Preventing people from becoming in need of care and maximising their years of healthy living is an area in which community groups such as Urram can play a significant role. Urram should explore with NHS Highland what physical and mental health promotion activities and services it could provide that meet local needs as part of the overall redesign of services.

3. **Enhanced Carer Provision**. Urram should work with NHS Highland to enhance support for unpaid local carers, in order to improve their quality of life and to enable them to continue caring for their loved ones. This could be a combination of provision of respite care at home services and funding of personal needs and services.

4. **Community Hall.** Consideration of the requirements of a new hall should be developed in the light of community health activities identified and planned to be delivered under 2.3.

5. **Dail Mhor Housing**. The site study has shown that 6 units of housing can be developed at the north end of the site regardless of whatever other building solutions are ultimately delivered elsewhere on the site. An allocation has already been made in the Strategic Housing Investment Plan for housing on this site. Therefore, detailed design should start at the earliest opportunity in order to enable the start of build in 2023-4.

6. **Other Housing Opportunities**. There are two elements to this. First, the provision of better-quality housing will enable more people to live healthier for longer and potentially require less care through living in better designed homes. Secondly, the crisis in health care recruitment is driven in part by the severe lack of affordable housing opportunities in the area. A reduced number of young families means fewer people in the workforce today and in the future. Therefore, everything possible should be done to address the housing shortage. Key actions could include:
   - Carrying out a full housing needs analysis of each local community.
   - Considering additional housing provision on the Dail Mhor site if there is no redevelopment of the residential care facility.
   - Redeveloping the site of the current district nurse facility for affordable housing once it is relocated to the redeveloped surgery on the Dail Mhor site.
   - Identifying, purchasing, and developing new sites in all communities as a priority to meet current and future local housing needs.

7. **Community provision of healthcare facilities**. Urram and/or another community group should investigate with the NHS the viability of the community constructing and leasing a healthcare facility if it would provide an enhanced facility where the NHS was unable to do so within a reasonable timeframe. The community should only do this if it has sufficient capacity to deliver such a project, the financial agreement allows for a reasonable return to the community and the facility provides improved healthcare outcomes.

SUMMARY REPORT

Urram was formed in May 2020 and has been working in consultation with NHS Highland and Highland Council (the site owners) to develop suitable plans for the redevelopment of the Dail Mhor care home site. In addition to the care home, it hosts a doctor's surgery, a village hall, and a former primary school. Urram developed a project concept to build a new care hub for delivering care services across the area, a new GP surgery, new village hall and six flexible housing units. The purpose of this study was to explore the potential for future site redevelopment and delivery of healthcare services.

Population and healthcare

The population of the area in 2011 was approximately 1921. Data from the census, local medical practice registers and latest population estimates demonstrate clearly show that the population of older age groups is much higher than for Scotland as a whole, while that of younger age groups is much lower. In 2011 fifty-six people were providing more than 50 hours of unpaid care per week within the area.

Consultations

Interviews with medical professionals showed that that there is support for improved surgery provision for visiting professionals, relocation of the district nursing service to the same site, provision for the ambulance service and retention of a care facility within the area. Interviewees also spoke highly of the quality of staff in Dail Mhor, but noted the difficulties in recruitment, with the lack of affordable housing cited as an important factor.

There was support for the provision of flexi homes although there were different views on how successful such projects had been. It was also noted that some tenants of flexi homes were those for whom the homes were not designed because more infirm people had declined to apply for tenancies.

A community drop-in event was held in the Sunart Centre on the 16th of May 2022 to explore the potential uses of the Dail Mhor site with the local community Approximately 35 people attended. Following the event Urram posted the questions online and a further 14 people responded with comments.

People were favourable towards demolition and rebuild of existing properties and were keen on a wide range of facilities and services to be provided on site including residential and respite care, supported accommodation, care tourism and day care.

Three options presented ranged from the straight replacement of the existing medical care and hall facilities (option 1), through to a larger 10 bed care facility with a much larger surgery/care hub facility (option 3). Option 2 included a modest increase in the size of the existing surgery provision and the care facility (with no increase in bed numbers). Of those who expressed a view most were in favour of option 3.

People were in favour of a new hall as being "The Heart of the Development" but some were concerned it might create overprovision in the community.

The community was supportive of a suggested phasing approach that would see the care home residents decanted temporarily to the flexi homes while the care building was demolished and rebuilt. Attendees were also generally supportive of the use of some of the neighbouring green space to provide additional parking if it was required for a larger development but were keen to

maintain green space around the development. There were a large number of comments both positive and negative regarding a technology driven approach to providing care.

Scottish Legal & Policy Framework

Attempts have been made to integrate care since the production of the Sutherland Report in 1999. The Community Health Partnerships (Scotland) Regulations 2004 and the Public Bodies (Joint Working) (Scotland) Act 2014 have attempted to further the integration agenda. The 2014 Act led to the creation of Integration Authorities with statutory responsibilities to coordinate local health and social care services. In the Highlands, Highland Council and NHS Highland have developed a different model whereby the council is Lead Agency for health and social care services for children, and NHS Highland is Lead Agency responsible for health and social care services in adults.

The Independent Review of Adult Social Care (IRASC) report was published in February 2021. It recommended a complete redesign of the system involving the creation of a National Care Service to ensure that a consistent level of care is made available across the country. The redesign would include:

- The setting of national standards, terms, and conditions
- An approach built on trusting relationships rather than competition
- Co-production of the system with the people whom it is designed to support

The *Social Care (Self-directed Support) (Scotland) Act 2013* gave the right to individuals to have as much involvement as they wish in the assessment of their own needs and in the provision of support or services for them. It provided for four options in terms of support to people with specific care needs and to carers. This legislation allows for much more bespoke provision than the traditional model of receiving it in an institutional setting. It therefore has significant implications for potential provision in remote communities.

The *Carers (Scotland) Act 2016* placed duties upon local authorities to prepare adult carer support plans with contents to include "whether support should be provided in the form of a short break from caring".

The *National Care Service (Scotland) Bill* was introduced into parliament on 20th June 2022. The Policy Memorandum to the bill states:

"…the Bill creates a framework for the National Care Service but leaves space for more decisions to be made at later stages through co-design with those who have lived experience of the social care system, and flexibility for the service to develop and evolve over time."

The movement of Government policy and legislation therefore is to enable the creation of new systems of care delivery that are responsive to people's needs, are flexible and adaptable. These are all characteristic of the approaches that community-led organisations take, whether in the health and social care or other sectors.

NHS Highland is going through a period of policy and culture change at the present time. It is currently developing "Together We Care", its new strategy for the period 2022-27. It is doing so in a co-production process with the people of Highland and its staff and has been consulting on its outline strategy through in-person and online events in June and July 2022.

The consultation document states that its first strategic objective is to:

Deliver the best possible health and care outcomes for our population

Its third strategic objective is:

Working through partnership to transform and integrate health and care

It seeks to deliver this through a further eight ambitions. Those that are of most relevance to Urram are: *Care Well; Treat Well; Age Well; End Well; Integrate Well.*

Regulation

Care services are defined under Schedule 12 of the *Public Services Reform (Scotland) Act 2010.*
In the context of the current study there are two types of services that are relevant. These are Care Home services and Support Services. Any person or organisation that wants to operate a care service in Scotland must, by law, register with the Care Inspectorate (CI). The CI monitors a range of data from the sector on a quarterly basis. The fall in registrations of homes run by the voluntary sector has been marked. These have declined from 103 to 76 over a 4 year period, a fall of 26.2%. There has also been a marginal fall in voluntary sector provision of Care at Home services, with a reduction from 501 to 494 services provided, a fall of 1.4%.

Opportunities & Challenges

Within the context of the legal, policy and regulatory framework a number of opportunities and challenges arise for Urram and the local community in terms of service provision and suitable buildings to provide those services.

The opportunities identified and explored in the study are: Increased openings for the voluntary sector; Promotion of Wellbeing; Providing Care at Home; Supporting Carers; Respite Care at Dail Mhor; Enhanced Medical Services; A Gathering Space; and Smart Sheltered Housing provision.

The challenges identified are: Viability of care home provision and Community Capacity.

Options Analysis

Two construction scenarios and three options were for different levels of provision were explored and analysed. The three options ranged in floor areas from 1083m^2 to 1613m^2 and estimated total project costs of £3.8m to £5.6m to provide a new surgery, care facility, hall and housing.

A variety of financial scenarios have been considered and modelled for the operation of Dail Mhòr as a care home, however it is clear that the staffing levels required from a regulatory perspective and resultant staffing costs pitched against the limitations on income levels to meet the operation costs of such as facility will mean that it is not possible for Urram as a community organisation to take on the direct operation of Dail Mhòr itself.

Alongside the health care services, there is scope for a gathering space to be developed which will not only provide a social focal point for the community but will also enable other activities to be undertaken that will help keep residents in the area both physically and mentally active for longer. This would work well in parallel with a health care hub so that the gathering space provides activities such as a ‘Men’s Shed’ type facility, and social groups and will deliver a modernised and more flexible approach to public health care.

Case Studies

Two case studies have been explored in detail. These are the Howard Doris Centre in Lochcarron and Tagsa Uibhist on the Isle of Uist. Both organisations have been faced with the challenge of operating built facilities designed for a particular set of services, which later became more challenging to deliver in financial and regulatory terms. The regulatory challenges included the need for multiple registrations for service delivery straddling two different areas of regulation. Tagsa Uibhist has made a successful transition to providing Care at Home services which could provide pointers to redesigned services in the peninsulas.

Care at Home

NHS Highland currently delivers the provision of non-residential Adult Social Care across the 5 Community Council Areas in West Lochaber to 21 recipients. There are no service users in West Ardnamurchan or Acharacle and the greatest number is in Ardgour (13).

Contracted Services to 7 individuals cost around £55,000 per annum. This equates to just over £9,000 per recipient. In-House Care at Home services are provided to 14 individuals. There are around 5,200 hours of Care at Home delivered per annum at a ballpark cost of around £250,000. This equates to approximately £18,000 per individual.

There is the potential for Urram to work with NHS Highland to explore how to deliver redesigned services to the local population, particularly if Dail Mhor were to close at some point in the future. Urram would need to be cautious about considering taking on a care at home service itself as the current cost of delivery is higher than rates offered to contractors.

Urram possesses a high degree of local knowledge. It can use this strength in collaboration with the NHS to identify what local needs really are and then to think about how these can be met in the context of the local setting.

Conclusions & Recommendations

- **Dail Mhor Care Home**. We cannot recommend that Urram attempts to build and operate a new small care home facility at this time due to the inability to develop a viable financial model.

- **Enhanced levels of care** can be provided through:
  - Exploring and developing new home care opportunities, including respite care at home.
  - Enhanced Medical Facilities in Strontian.
  - Preventive health activities.

- **Enhanced Carer Provision**. Urram should work with NHS Highland to enhance support for unpaid local carers.

- **Community Hall.** Consideration of the requirements of a new hall should be developed in the light of community health activities needs.

- **Dail Mhor Housing**. Detailed design on 6 units should start at the earliest opportunity in order to enable the start of build in 2023-4.

- **Other Housing Opportunities**. The provision of better-quality housing will enable more people to live healthier for longer. The crisis in health care recruitment is driven in part by the severe lack of affordable housing opportunities in the area. Therefore, everything possible should be done to address the housing shortage. Key actions could include:
  - Carrying out a full housing needs analysis.
  - Considering additional housing provision on the Dail Mhor site if there is no redevelopment of the residential care facility.
  - Redeveloping the site of the current district nurse facility for affordable housing once it is relocated to the redeveloped surgery on the Dail Mhor site.
  - Identifying, purchasing, and developing new sites

- **Community provision of healthcare facilities**. Urram and/or another community group should investigate with the NHS the viability of the community constructing and leasing a healthcare facility to the NHS.

1. INTRODUCTION

The Dail Mhor Care Home in Strontian has been operated for many years by Highland Council, and latterly by NHS Highland. Following concerns about its potential closure, the Dail Mhor Working Group was formed in 2018 to work with NHS Highland to re-open the home. Since that time, it has operated as a respite facility, and then during the Covid pandemic as a "step up/step down" facility. Urram was formed in May 2020 and has been working in consultation with NHS Highland and Highland Council (the site owners) since then to develop suitable plans for the redevelopment of the site.

In addition to the care home the site contains an empty primary school, a village hall and a doctor's surgery, all of which were built as part of the same complex and are also approaching the end of, or have surpassed, their useful life.

Urram developed the concept of a project incorporating:

- **A newly built care hub to provide a base for delivering care services across the area**
- **A new GP surgery for Strontian**
- **A large, bright new village hall**
- **Public spaces for meetings and/or events**
- **Approximately six flexible housing units (minimum)**
- **(optional) Opportunities for income generation/ additional services for the community**

Urram was also keen to identify whether there is scope to build a privately or community-run residential unit, offering long-term residential care and or respite care.

In order to further investigate this project concept Urram commissioned the current study with the following objectives:

a) Provide recommendations (cross referenced with relevant case studies) on an appropriate structure for a partnership with key stakeholders.

b) Consider capacity and constraints of the site.

c) Provide options and recommendations on how flexi-housing for the community might be delivered on site.

d) Provide options and recommendations on how a care hub, incorporating consulting room, treatment room, nursing, and ambulance base etc could be incorporated on site.

e) Consider the provision of residential care as part of the hub. This will not be provided by NHS Highland and as such, other options should be considered e.g., private providers, charities etc.

f) Provide recommendations on how a village hall/meeting/recreational space could be delivered as part of the development.

g) Consider the viability and costs of the redevelopment and make informed recommendations, with particular reference to whether a phased approach is achievable, or demolition/brownfield development is the pragmatic approach.

h) Take into account the views of local community stakeholders, key partners, and stakeholders (E.g., NHSH, HC, Communities Housing Trust, Lochaber Housing Association) as necessary.

2. POPULATION & HEALTH

There are challenges in delivering health service and care provision to communities spread across the diverse area of the peninsulas of Ardgour, Moidart, Sunart, Ardnamurchan and Morvern. This section considers the numbers of people living in the area, their demographic make-up, their health status, and the levels of unpaid care occurring.

POPULATION

In 2011 there were 1921 people in the census zones most closely matched to the area covered by the five peninsulas.

The local population is ageing and is considerably older than that of Scotland as a whole. Comparing the demographic spread locally to the demographic spread across Scotland as a whole there were 162 fewer people in the 16 to 29 age group than would be found in an 'average' Scottish community, but 145 more in the 60 to 74 age group (Table 1).

Table 1: Peninsulas Population 2011

	Age Range							
	0 to 15	**16 to 29**	**30 to 44**	**45 to 59**	**60 to 74**	**75 to 89**	**90+**	**Total**
Peninsulas	343	193	308	485	443	134	15	1921
Scotland Equivalent	332	355	384	405	298	136	12	1922[1]
Difference	+11	-162	-76	+80	+145	-2	+3	-1

These figures from 2011 demonstrate the double-edged nature of the demographic imbalance: large numbers of 'additional' people in older age groups who will increasingly need care to be provided for them by significantly fewer people in the younger age groups.

That demographic imbalance appears to be more pronounced today. A close look at the numbers registered with the local medical practices produces up to date data, although it does not include people who are registered with the Craig Nevis, Tweeddale, and Glenmore practices in Fort William[2]. However, the practice rolls cover 90.3% of the numbers recorded by the census in 2011. The largest number of people (537) are in the 65 to 74 age bracket. In the case of the Acharacle practice the figure of 468 is more than double the number in any other age group.

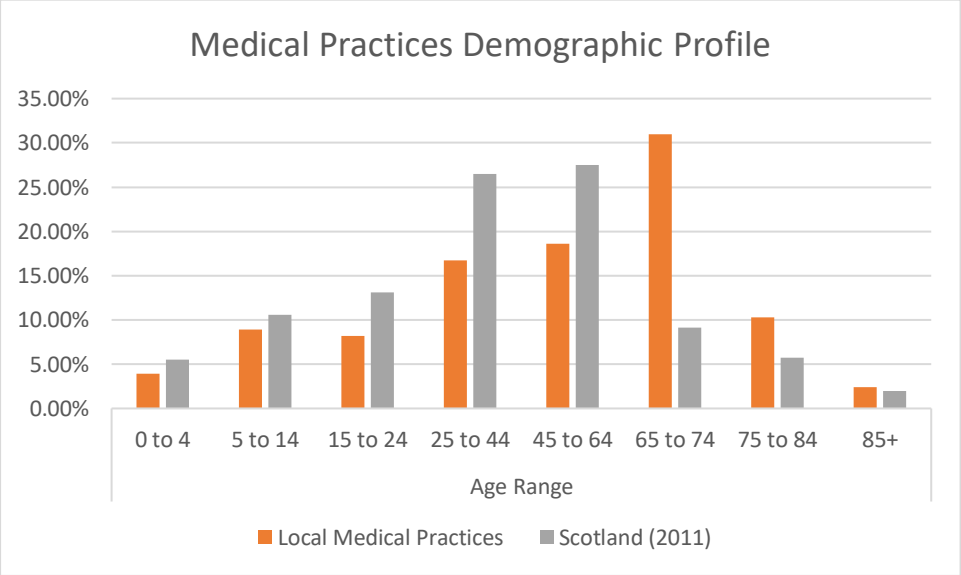
[1] Discrepancy due to rounding error.
[2] These largely correspond to the 2011 census output areas covering Drumsallie, Duisky, Blaich, Achaphubuil, Camusnagaul, Stronechreggan, Conaglen, Corran and Sallachan.

Table 2: Population Registered with a GP 2022

Medical Practice	Age Range								Total
	0 to 4	5 to 14	15 to 24	25 to 44	45 to 64	65 to 74	75 to 84	85+	
Acharacle	53	133	121	224	211	468	148	31	**1389**
Lochaline	14	22	22	65	112	69	30	11	**345**
Total	**67**	**155**	**143**	**289**	**323**	**537**	**178**	**42**	**1734**

Comparing the current practices profile with that of the 2011 census shows a marked contrast between the Scottish distribution (grey) and the peninsulas distribution (orange), with the 65 to 74 cohort in the peninsulas in 2022 being approximately three times the size of that in Scotland in 2011 (Figure 1).

Figure 1: Demographic Profiles



The deteriorating nature of the local demographic profile can also be illustrated by comparing the percentage of people under 45 against the percentage over 45 (Table 3)

Table 3: Comparison of percentage split of population age groups

Area	0-44 yrs (%)	45 yrs + (%)
Scotland 2011	55.8	44.3
Peninsulas 2011	43.9	56.1
Medical Practices 2022	37.7	62.3

HEALTH

The census data also includes information on the general health of the population, with people asked to classify their health as very good, good, fair, bad, or very bad. In 2011 there were 79 people who classified their health as bad or very bad (Table 4).

Table 4: Comparison of Health Status – Peninsulas & Scotland

General Health Status						
	Very Good	**Good**	**Fair**	**Bad**	**Very Bad**	**Total**
Peninsulas Number	**1067**	**566**	**209**	**65**	**14**	**1921**
Percentage	**55.5%**	**29.5%**	**10.9%**	**3.4%**	**0.7%**	**100.0%**
Scotland Percentage	**52.5%**	**29.7%**	**12.2%**	**4.3%**	**1.3%**	**100.0%**

The percentage of people reporting very good health locally is higher than for Scotland as whole, and lower for all other categories, with those reporting very bad health significantly lower at 0.7% compared to 1.3% for Scotland. This may seem counter-intuitive when the population living locally is significantly older than that of Scotland. However, the figures should be treated with caution. They may reflect the fact that there is no urban deprivation locally (which is associated with poorer health and life expectancy) or that some people leave the area to be closer to better services when their health starts to decline.

Unpaid Care

The census figures also reveal a significant unpaid care effort was being provided. There were 180 people or 9.4% of the population providing unpaid care. Of these 105 were providing 1-20 hrs/week while 56 were providing more than 50hrs/week, with smaller numbers providing between 20 and 49 hours of care (Table 5).

Table 5: Comparison of Unpaid Carer Provision

Provision of unpaid care/week						
	No Care	**1-19hrs**	**20-34hrs**	**35-49hrs**	**50hrs+**	
Peninsulas Number	**1741**	**105**	**11**	**8**	**56**	**1921**
Percentage	**90.6%**	**5.5%**	**0.6%**	**0.4%**	**2.9%**	**100.0%**
Scotland Percentage	**90.7%**	**5.2%**	**0.9%**	**0.8%**	**2.5%**	**100.1%**

This local distribution of care has a different pattern to that of Scotland as a whole, in that a larger percentage of people are giving care at the extremities of the care profile. A difference of 0.4% giving 50hrs+ plus care may appear modest but it is in fact 16% more people locally (seven individuals) than would be anticipated based on national rates. This may reflect the fact that there are fewer people in the younger age groups locally for the care burden to fall upon or be shared with.

The increased numbers of elderly people since 2011 means that it is likely that there is also an increased care requirement within the area. However, it is unlikely to be known until the 2022 census data is published whether the burden of care has fallen even more strongly on the unpaid or whether improved care package provision has gone at least some way to alleviating the need.

3. COMMUNITY & STAKEHOLDER CONSULTATIONS

A wide range of consultation has been carried out, both prior to and during the current study. This section summarises that consultation in order to:

- give an overview of the views of the different actors in the sector
- identify key issues affecting the potential redevelopment of the Dail Mhor site
- scope care needs and issues across the Urram area

PRIOR CONSULTATION

Urram carried out a community consultation process from November 2020 to February 2021 to identify the needs and aspirations of the local community with respect to the future shape of care within the 5 community council areas, with particular reference to redevelopment of the site in Strontian.

The survey showed that 91.5% of people were in favour of redevelopment of the Dail Mhor site. The executive summary identified that there was "a clear desire and requirement for":

- **A new GP surgery**
- **Respite care**
- **Palliative care**
- **Day care**
- **Residential care**
- **A flexible approach to bed provision (for respite, palliative or step up/step down)**
- **Flexible homes**
- **Integrated working from a single base**
- **Support services and clinics**
- **A base for home care and district nursing teams**
- **A redeveloped village hall**

There was strong support for the idea of a community health hub with all services located at one site. This was balanced with several comments on the need for transport provision to be considered for those in outlying villages and a concern that new provision should affect GP care in Morvern, where the GP was due to retire.

In response to a question on Flexi Homes, 19% said that they would be interested in living in one in future and 46% said "maybe". Comments reflected a range of views from "I would love to be allocated a flexi home" to open mindedness on what might be necessitated by future circumstances, to clear statements of wishing to stay in their own homes.

There was considerable support for a new hall arising from a belief that the Sunart Centre provision in the High School did not have a suitable space for ceilidhs, parties, weddings, and other large events.

Potential concerns about a development included noise, parking provision and the traffic associated with it, the difficulty of attracting staff, and how care jobs would be kept while the care facility was being redeveloped. Individuals also questioned whether a community group such as Urram would be capable of delivering such a project.

STAKEHOLDER CONSULTATIONS

Care Hub

Surgery

The surgery provision is run as part of the Acharacle medical practice. The facility needs upgraded with an entrance separate from other uses and dispensary provision to provide privacy (prescriptions are currently given out in lobby area). The service is currently delivered by one clinician visiting but this could increase to two (possibly a doctor and a nurse practitioner) if the population of Strontian were to increase. An additional room for a visiting physiotherapist, podiatrist or other healthcare workers would be beneficial and enable a multi-disciplinary team approach.

The practice has grown in size from 900 twenty years ago to 1400 today. A lot of new families have moved into the area in the last 12 months, rather than older people. There were suggestions from different people that the residents of Ardgour may benefit from being able to access services in Strontian rather than as has traditionally been the case, Fort William.

Community Nursing

There was strong support from a wide range of interviewees for the nursing team to be co-located with other services. There is currently a team of 5 nurses, one vacancy and a health care assistant. Their current base is not fit for purpose and if they could be relocated to a redeveloped Dail Mhor it would be much better. In an ideal situation they would require:

- **An office for general staff use with workstations.**
- **A separate office with a computer and space for small group meetings.**
- **A separate galley kitchen for daytime use and making meals when on call.**
- **On call room capable of taking a sofa bed. At peak season visiting staff cannot book elsewhere).**
- **Bathroom with shower.**
- **Storage room for a fridge and supplies e.g., wound care dressings, bandages, incontinence pads, spare mattresses.**
- **A separate entrance because of coming and going during the night.**
- **Dedicated parking for NHS cars. Charging points therefore required as they are switching to e- vehicles.**

Ambulance Service

The Scottish Ambulance Service would not be looking for a station but would be interested in a space for two personnel with access to facilities. The room would need to be private with space for a desk, filing cabinet and computer. This would allow staff to access the SAS intranet (which they cannot do from home) and carry out activities such as paperwork and online learning. It would also provide a suitable location for the Area Service Manger to meet with local staff.

Care Facility

The demand for respite care is huge at the Highland and national level. Prior to Covid Dail Mhor was providing a service to meet demand from across the Highlands. That demand has not gone away and there is significant unmet need. There is a need for respite provision to enable carers to cope with the burden of caring and there is also a need for a halfway house to support people who have been discharged from hospital. Several interviewees considered that discharges would be more successful if clients were able to get additional physiotherapy and occupational therapy support prior to going home. There could be additional demand if a service were to be offered that provided for families to

come on holiday with a loved one. It was noted that care home provision was lower in Lochaber than elsewhere in Highland.

It was noted that that there can be problems mixing respite and long-term care with anecdotal evidence of conflict occurring in homes where a respite patient inadvertently upsets a long-term resident for example. Respite patients may also have specialist requirements that may not be catered for well in a traditional long-term care setting. It was identified that a higher proportion of reportable incidents occur in a care home setting are related to respite provision. The two services do not necessarily sit comfortably together due to the unique needs of long-term residents which can be destabilised by the frequently changing patients occupying respite beds in the same location.

It was suggested that a workable future model could be developed with Urram taking on responsibility for basic care and being supported by NHS services. Others were not so sure, noting that care homes typically require 40 beds minimum to break even and that many are currently in danger of closing due to an unsustainable financial model and difficulties in recruiting staff. Although there was support for a care facility in the area, concern was expressed as to whether a community group, such as Urram, would be capable of operating a care facility and what accountability there would be.

Staffing & Housing

Respondents spoke highly of the quality of staffing in Dail Mhor and of the skills that they have. Comments by those who had used their services (social workers and relatives) were extremely positive.

It was noted that recruitment is very difficult at the current time. This was attributed to the general difficulties with recruitment that are being experienced everywhere, but also with the uncertainty surrounding the future of Dail Mhor. It was considered that this was putting off people from applying for long-term jobs if they could not be guaranteed that the job would in fact last. It could also take a long time between successful interview and appointment due to slow processing of necessary documentation.

A further complicating factor is the lack of suitable accommodation within the area. Examples were given of staff who have left because they were unable to secure a permanent place to live. It was suggested that communities will need to consider what effect Airbnb type operations are having on local housing supply and consider how they can create sufficient housing opportunities to enable people and services to remain within an area. It was suggested that if the district nursing team were to move into new accommodation on the Dail Mhor site, the existing building could be demolished, and the site redeveloped with a larger number of units providing accommodation for key workers.

Flexi Homes

There was support for the provision of flexi homes although there were different views on how successful such projects had been. Professionals spoke very favourably of their design and collaboration with communities elsewhere. Community representatives appreciated the flexible design aspects but in one case were disappointed that they had not been able to integrate care with the adjacent care home. It was also noted that some tenants of flexi homes were those for whom the homes were not designed because more infirm people had declined to apply for tenancies.

Hall

Views were expressed supporting the replacement of the hall and for its use to be connected to the care hub. It was noted that day care provision in homes had stopped and that this would not be started again. There could therefore be opportunities to provide services in a rebuilt hall. Linking the hall to the hub could also potentially enable a kitchen operation to provide meals for the care facility. However, care would need to be taken so that a change in rules would not make it ineligible to make such provision, as happened in the past.

Community Consultation Event

A community drop-in event was held in the Sunart Centre on the 16th of May 2022 to explore the potential uses of the Dail Mhor site with the local community. A number of boards with diagrams were presented and a range of questions was asked to help people explore the subject, although they were free to make any comments they wished. Approximately 35 people attended the event and virtually all took considerable time to study the material presented and to engage with the issues. Following the event Urram posted the questions online and a further 14 people responded with comments.

In responding to a question about how convenient Strontian is for the rest of the peninsula all those attending the meeting in Strontian thought it was a sensible location, as did most answering online. However, one online response suggested Acharacle, another Salen and another Fort William. There were several comments about the lack of frequency of buses from other locations (or none from Ardgour) to Strontian and a request for a:

"Better bus service as not everyone drives!"

Responses to a question regarding demolition and rebuilding of the facility responses included:

"Retrofit was not a viable option for school – better to demolish and build again"

"Demolish & rebuild YES. Phased? To provide continuation of care during build"

"Probably! Assuming this is the most cost-effective"

"As long as a community hall the same size is built. Highly insulated to minimize running costs. Heat pump?"

People were keen on a wide range of facilities and services to be provided:

"Local facilities to reduce long journeys to FW."

"Residential, Respite, Sheltered housing, GP Surgery etc. Day Care"

"Respite care is a very valuable resource"

"Care tourism is a big opportunity – many families have a member who needs care, without this families cannot holiday together.Care supported accommodation would allow such members to travel with their families (who would stay nearby in commercial accommodation). Also an opportunity for resident families to have vulnerable relatives visit them (and stay in suitable accommodation?)"

"Support for family members as carers – across the wider council areas"

"Probably best to avoid sheltered housing – Care at home means that people may be more able to stay in own homes"

"Long term residential care for natives of Ardnamurchan. In past few years local people born and bred in this area have had to leave their homes and sent to Oban, Inverness, Glencoe and Fort William as Dalmhor does not now have the facilities for those people. I know I'm wasting my breath on this, as I've said it so many times on so many occasions- but nobody interested!!"

The boards laid out three illustrative options which had been agreed in advance with the steering group. These options ranged from the straight replacement of the existing medical care and hall facilities (option 1), through to a larger 10 bed care facility with a much larger surgery/care hub facility (option 3). Option 2 included a modest increase in the size of the existing surgery provision and the care facility (with no increase in bed numbers). Of those who expressed a view most were in favour of option 3, one of option 2 and one who suggested:

"Move from Model 1 to at least Model 2 or 3"

In relation to site layout suggestions included:

"Surgery could be medical centre with nurse saving current nurse station"

"Residents need connection with outside world"

"Residents enjoy to look out on to the main street looking for their visitors. Also enjoy seeing children in play park"

"Views of activity important"

"Given that Strontian has a big hall in the High School, a hall in the Community Hub could be of moderate size."

"Omitting the sheltered housing would give more space for parking"

The architects proposed a new hall as being "The Heart of the Development" and asked what people thought of the idea. This brought a range of responses from very positive to questioning whether it might create overprovision in the community. There were also concerns about noise affecting the neighbouring uses, particularly a care facility.

"Yes we need a hall as a priority"

"The Hall Q is controversial <u>but</u> can the community sustain a hall, the Sunart centre + church/heritage centre?"

"Do not see the hall as essential. Care is priority! Communal spaces in care home more inclusive!"

"Noise issues? Central better for community?"

"The only comment I have is that the hall is charged realistically, if not be much cheaper than the Sunart Centre…."

The community was supportive of a suggested phasing approach that would see the care home residents decanted temporarily to the flexi homes while the care building was demolished and rebuilt:

"Correct approach"

"Closure must be dependent on need at the time and provision elsewhere"

"Surgery and Dail Mhor facilities should be available and not closed for faster build time"

Attendees were generally supportive of the use of some of the neighbouring green space to provide additional parking if it was required for a larger development:

"Yes – use some of the green space & relocate if necessary."

"We will have to use some greenspace so lets rebuild play park please"

"Access and parking essential with poor public transport links & disabled requirements for clients in and out."

"NEED TO MINIMISE CAR PARKING – PUBLIC/COMMUNITY/ACTIVE TRANSPORT THE FUTURE (ref the climate crisis). So parking provision needs to include bike parking/shelter, EV charge points, drop off areas etc. <u>All that said</u> if green space is needed for this from the Green it should be replaced by addition of green space elsewhere e.g on school road."

They were also supportive of maintaining green space around the development:

"Challenge with green spaces accepted as these are needed to. Some reduction large unused green play space acceptable."

"Need to think about gardens/ landscaping associated with new development – not least due to health benefits. <u>Lots</u> of studies show the benefits of this for mental and emotional health.; trees; flowers; wildlife – maybe food producing too? Obv. Needs be accessible (paths, raised beds etc.) trees for shade & shelter also outdoor wet weather shelter needed (verandahs, gazebos, huts/cabins)"

There were only two comments left with regard to whether the site was a good location for Smart Sheltered Housing, with these expressing different points of view:

"YES to smart homes with community space. Could they be sited further from other facilities? & even have some in other communities e.g. Lochaline, Ardgour, Acharacle etc"

"Not sure about the emphasis on sheltered housing."

There were however a larger number of comments regarding a technology driven approach to providing care:

"A sustainable approach makes sense"

"YES. Successive generations will be accustomed to technology."

"By putting the village hall at the centre of this development, we are designing to involve those in the sheltered housing within the community. technology shouldn't be used to limit 'human' access."

"Not sure about technology driven approach – question of isolation/loneliness for people"

"Think technology approach would isolate a lot of people – difficult at present but maybe in future everyone will be using it!!"

Respondents were asked to indicate their level of support for different activities the community could become involved in and whether they would be willing to support these by volunteering. There were 32 responses in total.

The largest level of support (97%) (Table 6) was for the option merely to be consulted on the design of new facilities. There was also very strong support for the construction of buildings to lease to NHS Highland and for the construction of a residential care home (78%).

Table 6: Community Support for Activities

Which of the following activities would you be happy for the community to be engaged in?		
	Number	**%**
Consultation on design of new facilities and services to be created at Dail Mhor	31	97
Construction and management of a new hall	22	69
Construction of buildings by the community to lease to NHS Highland	25	78
Construction of a residential care home	25	78
Operation of a residential care home	18	56
Community delivery of additional services	20	62

The lowest level of support was for the community operation of a care home at 56%. Community delivery of additional services received 62% support.

References to "a residential care home" were scored out by one person who inserted "community hub" instead and commented:

"I feel quite strongly that care delivery needs to be more flexible than just residential care. Yes, there is a need for residential, but respite/step up/step down, care at home 24/7 are equally important."

Some comments covered the community's ability and capacity to deliver:

"We are a fairly bolshy lot. We have built a high school & a primary school."

"….locals not qualified to run a care home unless professionals"

"Think overdependence on community – gets to the stage where too dependent on too few volunteers"

"Really not sure about the community capacity to deliver. Nice idea in theory…."

There were also concerns expressed about the previous experience of building and leasing the primary school:

"…we need to learn from the experience of leasing SPS to Highland Council."

Suggested additional services that the community could deliver were:

- **Care respite**
- **Care at home services**
- **Outreach to remote areas**
- **Transport to the hub**
- **Physiotherapy**
- **Mental health services**
- **A volunteering group for those who live alone**
- **A network for the isolated**

Not surprisingly there was a lower willingness to volunteer personally, although there were still reasonable numbers. People were most willing to volunteer to help with the community delivery of additional services (10) and construction and management of a new hall (8) (Table 7).

Table 7: Willingness to Volunteer

Which of the following would you be happy to support through volunteering?		
	Number	**%**
Construction and management of a new hall	8	25
Community delivery of additional services	10	31
Construction of buildings by the community to lease to NHS Highland	6	19
Construction of a residential care home	6	19
Operation of a residential care home	5	16

Fewer people were willing to volunteer to support construction of buildings (6) whether for lease to NHS Highland or for a community operated care home, with 5 being willing to volunteer to support the operation of a care home.

4. LEGAL FRAMEWORK & POLICY CONTEXT

SCOTTISH LEGAL & POLICY FRAMEWORK

Section 12 of the ***Social Work (Scotland) Act 1968*** places a duty on every local authority *"…to promote social welfare by making available advice, guidance and assistance on such a scale as may be appropriate for their area, and in that behalf to make arrangements and to provide or secure the provision of such facilities (including the provision or arranging for the provision of residential and other establishments) as they may consider suitable and adequate, and such assistance may **….** be given in kind or in cash to, or in respect of, any relevant person."*

Since the founding of the National Health Service in 1948 local health boards have been responsible for health services and local authorities have been responsible for social care support. However, the two sets of services have needed to work together in order to provide the best support for individuals. Where this provision is not as seamless as it is aspired to be there can be negative impacts on both the needs of the person being cared for and the ability to deliver services e.g., the inability to provide a suitable care package at home can lead to "bed blocking" in hospitals and care facilities.

Attempts have been made to integrate care since the production of the Sutherland Report in 1999. The **Community Health Partnerships (Scotland) Regulations 2004** and the **Public Bodies (Joint Working) (Scotland) Act 2014** have attempted to further the integration agenda. The 2014 Act led to the creation of Integration Authorities with statutory responsibilities to coordinate local health and social care services.

In most parts of Scotland, the local authorities and health boards have formed Integration Joint Boards to manage a range of services and budgets collectively. However, in the Highlands, Highland Council and NHS Highland have developed a different model whereby the council is Lead Agency for health and social care services for children, and NHS Highland is Lead Agency responsible for health and social care services in adults.

These developments have led to a greater integration of social care but there are still major pressures in the system. The **Independent Review of Adult Social Care (IRASC)** report was published in February 2021. It recommended a complete redesign of the system involving the creation of a National Care Service to ensure that a consistent level of care is made available across the country. The redesign would include:

- **The setting of national standards, terms and conditions**
- **An approach built on trusting relationships rather than competition**
- **Co-production of the system with the people whom it is designed to support**

In considering future models of care it recommended reducing the need for institutional/residential care, recognising that most people want to stay in their own homes as long as possible. It proposed earlier intervention, batter use of technology, greater people and family involvement in decision making and greater prevention and community support. The report said, *"The role communities play in supporting adults to remain active in their community simply cannot be overstated"*. It noted that community supports need infrastructure and funding *"often fairly modest to develop and flourish"*, and that transport is often essential to accessing suitable services.

The ***Social Care (Self-directed Support) (Scotland) Act 2013*** gave the right to individuals to have as much involvement as they wish in the assessment of their own needs and in the provision of support or services for them. It provided for four options in terms of support:

Option 1	The making of a direct payment by the local authority to the supported person for the provision of support.
Option 2	The selection of support by the supported person, the making of arrangements for the provision of it by the local authority on behalf of the supported person and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of that provision.
Option 3	The selection of support for the supported person by the local authority, the making of arrangements for the provision of it by the authority and, where it is provided by someone other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision.
Option 4	The selection by the supported person of Option 1, 2 or 3 for each type of support and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of the support.

These options apply to people with specific care needs and to carers. This legislation allows for much more bespoke provision than the traditional model of receiving it in an institutional setting. It therefore has significant implications for potential provision in remote communities. Despite this, the IRASC report noted that implementation of Self-Directed Support has not been as successful as it could have been, in part due to structural issues with the current system.

The ***Carers (Scotland) Act 2016*** placed duties upon local authorities to prepare adult carer support plans with contents to include "whether support should be provided in the form of a short break from caring".

Two key developments favour the development of locally driven priorities. These are the plans of the Scottish Government to develop a National Care Service and the desire of NHS Highland for a culture change that focusses on local communities.

The ***National Care Service (Scotland) Bill*** was introduced into parliament on 20th June 2022. The Policy Memorandum to the bill states:

"The purpose of the National Care Service (Scotland) Bill is to improve the quality and consistency of social services in Scotland."

It seeks to do this through several key mechanisms including:

- Giving the Scottish Ministers a duty to promote a comprehensive and integrated care service.
- Giving them the powers they need to achieve that, including making provision for the establishment of care boards to carry out Ministers' functions in relation to social care, social work and community health.
- Giving the Scottish Ministers powers to transfer relevant functions from local authorities or from health boards to the new care boards.
- Introducing a right to breaks from unpaid caring.
- Making changes to the powers of the Care Inspectorate and Health Improvement Scotland to improve the lives of people who access social care support and their carers.

Critically, the memorandum states:

"It is essential that reforms to social care support, social work and community health services must be developed with the people who access that support, including unpaid carers, and with those who provide it. The Scottish Government is committed to engaging with people with experience to co-design the detail of the new system, to finalise new structures and approaches to minimise the historic gap between legislative intent and delivery. For that reason the Bill creates a framework for the National Care Service, but leaves space for more decisions to be made at later stages through co-design with those who have lived experience of the social care system, and flexibility for the service to develop and evolve over time."

The movement of Government policy and legislation therefore is to enable the creation of new systems of care delivery that are flexible and adaptable, and responsive to people's needs. These are all characteristic of the approaches that community-led organisations take, whether in the health and social care or other sectors.

The Scottish Government's vision for the National Care Service is that it will:

• enable people of all ages to access timely, consistent, equitable and fair, high-quality health and social care support across Scotland

• provide services that are co-designed with people who access and deliver care and support, respecting, protecting and fulfilling their human rights

• provide support for unpaid carers, recognising the value of what they do and supporting them to look after their health and wellbeing so they can continue to care, if they so wish, and have a life beyond caring

• support and value the workforce

• ensure that health, social work and social care support are integrated with other services, prioritising dignity and respect, and taking account of individual circumstances to improve outcomes for individuals and communities

• ensure there is an emphasis on continuous improvement at the centre of everything

• provide opportunities for training and development, including the creation of a National Social Work Agency providing national leadership, oversight and support

• recognise the value of the investment in social care support, contribute to the wellbeing economy, make the best use of public funds, and remove unnecessary duplication.

This vision is laudable in that it seeks to put greater values on individuals needing care, the unpaid carers who support them and the workforce who deliver paid for care. The narrative to support the vision states:

"The NCS will aim to ensure everybody in Scotland can access a consistent social care support service, while noting the importance of local decision making and flexibility, and also that they can access early intervention and preventative support."

This can be taken to mean that the NCS will seek to deliver as good a service for people living in remote rural areas as those in urban areas, although the form in which it is delivered may be significantly different. That will not necessarily mean delivering the same type of care as has been historically provided. The emphasis on early intervention and preventative support implies an effort to keep people fitter for longer and managing support so as to slow down the rate at which individuals need progressively more intensive care provision.

Each care board will be required to have a strategic plan and within that plan they must have an ethical commissioning strategy. The policy memorandum gives the following definition of commissioning:

"Commissioning is the process of assessing and identifying the need for services, developing a vision, strategy, policy, and forward plan to meet these needs; and designing a service or system for delivery which includes monitoring and continually improving the effectiveness of how these needs are met in practice. Commissioning includes deciding whether a service should be delivered directly by the organisation or obtained from another provider, taking account of the market available and other relevant factors."

It also defines ethical commissioning:

"Ethical commissioning, in relation to social services, has a person-centred care first/human rights approach at its core, ensuring that strategies focus on high quality care. This includes Fair Work practices which encourage the development of a quality, sustainable, and appropriately valued work force; climate and circular economy considerations to support a just transition to net zero; financial transparency and commercial viability of any outsourced services; full involvement of people with living experiences throughout, putting the person at the centre of making the choice; and a shared accountability between all partners and stakeholders involved in delivery."

The policy memorandum further notes:

"Current procurement legislation provides a well-established framework to support an ethical approach to procurement in the NCS. The Public Contracts (Scotland) Regulations 2015 apply a Light Touch Regime (LTR) to social and other specific service contracts at certain threshold value, currently

£663,540. This regime specifically allows quality, continuity, accessibility, specific user needs and the involvement/ empowerment of users to be taken into account when awarding contracts. Below the LTR threshold value, no procurement procedural rules apply."

The Bill also proposes enabling the NCS to support Fair Work in the sector in order to support the improvement of pay and conditions and try to prevent the loss of skilled workers to other professions. It further proposes amending existing Public Contracts Regulations to give contracting authorities the option "….to reserve procurement processes to mutual organisations when contracting for social care provision."

This overall approach to delivery of care services has the potential to be very supportive of community delivery of services, providing local responses to need through a valued and supported workforce.

HIGHLAND POLICY FRAMEWORK

NHS Highland is going through a period of policy and culture change at the present time. It is currently developing "Together We Care"[3], its new strategy for the period 2022-27. It is doing so in a co-production process with the people of Highland and its staff and has been consulting on its outline strategy through in-person and online events in June and July 2022.

The consultation document states that its first strategic objective is to:

Deliver the best possible health and care outcomes for our population

It explains this further by stating:

"We will promote healthier lifestyles from the start to allow our population to thrive and stay well by actively addressing health inequalities. We will listen and respond to our population at all stages of their lives to ensure we are an active anchor in creating resilient communities."

There is a clear emphasis on nurturing good health through 4 ambitions to Start Well, Thrive Well, Stay Well & Anchor Well.

Its third strategic objective is:

Working through partnership to transform and integrate health and care

It explains this further by stating:

"We will continually improve and transform the quality of how we treat, respond and care for our population when they have physical or mental health needs to allow them to live well. We will work in partnership to create integrated services for all life stages. We will support our ageing population to live as long as possible with their independence and end well together"

It seeks to deliver this through a further eight ambitions. Those that are of most relevance to Urram are:

"Care Well - Put our population, families, and carers first to ensure that, in partnership with our local health and social care partners, care is delivered and experienced in an integrated way 'without boundaries."

[3] TWC Strategy.pdf (scot.nhs.uk)

“Treat well - Provide person centred, safe, compassionate and clinically excellent patient care in as timely manner as close to home as possible.”

“Age Well - Ensure older people are supported with personalised care and that we respect their choices, so they are truly able to take more control over their health and wellbeing.”

"End Well - “Support our population and families at the end of life with appropriate care at this time and beyond.”

“Integrate Well - Work towards, integrating and consolidating services across the providers, improving pathways and bringing together the organisations to work collectively to improve delivery and health outcomes for the Highland population.”

5. REGULATION

Care services are defined under Schedule 12 of the *Public Services Reform (Scotland) Act 2010*[4]. In the context of the current study there are two types of services that are relevant. These are Care Home services and Support Services. The act defines a care home service as:

"… a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need;…"

It defines a support service as:

"a service provided, by reason of a person's vulnerability or need (other than vulnerability or need arising by reason only of that person being of a young age), to that person or to someone who cares for that person by—

(a)a local authority;

(b)any person under arrangements made by a local authority;

(c)a health body; or

(d)any person if it includes personal care or personal support."

Any person or organisation that wants to operate a care service in Scotland must, by law, register with the Care Inspectorate. The inspectorate aims to process an application to provide a care service within 6 months[5] of providing a full and competent application, along with any additional information requested. As well as the information provided in the application the registration team will check

- **whether the provider is fit to provide the service**
- **whether the manager is fit to manage the service**
- **that the proposed premises are fit to be used for that purpose**
- **that the service will make all the proper provisions for the health, welfare, independence, choice, privacy, and dignity of everyone using the service.**

They may also check the financial viability of the service.

Registration fees are levied. These are currently £3,849 for a care home and £3,422 for a medium sized support service employing 4 to 15 full time equivalent persons. Annual continuation fees are £157 per registered place in a care home and £1,711 for a medium sized support service.

The CI monitors a range of data from the sector on a quarterly basis. The data shows that there has been a trend of declining registrations in Care Home registrations, falling from 842 in early 2018 to 799 in early 2022, a fall of 5.1% (Table 8). The fall in registrations of homes run by the voluntary sector has been more marked. These have declined from 103 to 76 over a 4-year period, a fall of 26.2%.

[4] Public Services Reform (Scotland) Act 2010 (legislation.gov.uk)

[5] Register care (careinspectorate.com).

Table 8: Registrations of services provided

Care Service	Quarter/Year	Health Board	Local Authority	Private	Voluntary	Total
Care Home (Older people)	Q4 2017-8	15	110	614	103	842
	Q4 2021-2	16	100	607	76	799
Change 2018-22		+1	-10	-7	-27	-43
Support Service (Care at Home)	Q4 2017-8	6	121	371	501	999
	Q4 2021-2	10	138	454	494	1096
Change 2018-22		+4	+17	+83	-7	+97

In contrast there has been an increase in Care at Home services over the same period. These have risen from 999 to 1096, an increase of 9.7%. Most of that increase has come from the private sector whose services have risen from 371 to 454. In contrast there has been a marginal fall in voluntary sector provision, with a reduction from 501 to 494 services provided, a fall of 1.4%.

6. OPPORTUNITIES & CHALLENGES

The previous sections have outlined the views of the community and stakeholders on a range of issues associated with healthcare in the peninsulas. They have also described the general environment for adult care and the direction of travel that legislation and policy is following. In that context a number of opportunities and challenges arise for Urram and the local community in terms of service provision and suitable buildings to provide those services.

OPPORTUNITIES

1. Increased openings for the voluntary sector.

Legislation, national government policies, and region health strategies recognise the role that voluntary sector organisations play in delivering quality healthcare. In seeking to put decision making on care in the hands of individuals there are increased opportunities for community organisations to support people in their decision making and to provide them with the kinds of services they require.

2. Promotion of wellbeing.

There is an increasing emphasis on prevention of lifestyle related diseases and on promoting good health, rather than simply treating poor health. This is exemplified by NHS Highlands objectives: Start Well, Thrive Well, and Stay Well. Even in a context where a necessary focus is upon care of the elderly and infirm, people will agree that it is best to prevent people from getting ill in the first place, and when they do, to maximise early intervention to minimise suffering and maximise beneficial outcomes. This applies to mental as well as physical health. Post-Covid lockdowns there is increasing recognition that caring for mental health and providing social opportunities are very important. Scotland has some of the highest obesity rates in the world and the data on health provided in Section 2 show that there is a significant opportunity to improve the health of some and maintain the health of many to prevent them declining into 'bad' and 'very bad' health status. NHS Highland personnel have indicated that NHSH could provide some financial support to activities that deliver positive health outcomes. Examples of these could include promoting and organising outdoor activities such as walking or cycling groups; growing and cooking healthy foods; promoting healthy diets etc. All of these activities can provide services for elderly people without necessarily targeting them or seeking to provide 'care'. It can be seen from the description of these activities that some can be delivered outdoors and that others would need to be delivered indoors. This could be via community hall facilities in Strontian (see below), Lochaline, Acharacle, and Kilchoan.

3. Providing Care at Home.

The increasing flexibility offered to people by Self Directed Support and the challenges in providing care at home with a smaller workforce to remote locations means that there is scope for a more flexible service to be developed and for community groups to use their agility to change the way care is delivered more quickly than public sector bodies. Urram has already has some initial discussions with Sunflower Care. This model offers the experience of an existing provider to work with a community to help establish a new service. Alternatively, Urram could develop its own independent service and seek to deliver it locally. Tagsa Uibhist provide such a service on the Isle of Uist, and its experience is covered as a case study in Section 9.

4. Supporting Carers.

Section 2 provided data on the demands on carers locally and Section 4 outlined how carers will now have a right to time off caring. There could be opportunities to provide support to them and support for their loved ones, such as through respite care at home.

5. Respite Care at Dail Mhor.

Respite care has already been provided in the institutional setting of Dail Mhor. The consultation found that staff expertise was highly valued, as was their provision of specialised respite care. This was because traditional care home settings can struggle to provide a quality service for this specialist group without conflict with long term care residents. The ability to continue providing this will depend upon the ability to finance the construction and operation of a new facility. This is considered in detail in Sections 7 & 8.

6. Enhanced medical services.

The Dail Mhor site offers the opportunity to provide an improved facility for the current GP services and accommodation for additional health professionals such as physiotherapists and podiatrists. This would allow local provision of these services and an improved service for residents of the care unit. It would also allow for the relocation of district nursing staff to the site. This is considered in more detail in Section 7.

7. A Gathering Space.

There is a desire and a sense of need to retain some form of community space such as the existing community hall. There is also the need for a space that can deliver health and wellbeing activities outlined at 2 above. The Sunart Centre provides good sports facilities but lacks intimate spaces for activities such as exercise classes small social groups. A suitable vision for a new hall would be for a Gathering Space that is an integral part of a new care hub that treats the ill and infirm and promotes community wellbeing. The care unit could capitalise on community activities taking place at the Gathering Space allowing respite care to extend outside the care unit itself. The surgery could direct patients to healthy activities associated with the gathering space being run by the community. The availability of a functional and welcoming space that will enable the community as a whole to participate in physical and social activities that can improve the general physical and mental wellbeing of the population on the peninsula could be of huge importance. The future delivery of respite care and general wellbeing services in a non-institutional setting would strongly contribute to maintaining a population in the community and at home for much longer, which will be beneficial to the health service in the longer term.

8. Smart Sheltered Housing provision.

The availability of land within Strontian offers the opportunity to deliver 6 flexi homes of 60m² each. As the consultation section noted, housing supply is a major problem in the area and the provision of homes suitable for the infirm will be particularly beneficial.

CHALLENGES

1. Viability of care home provision.

The challenges facing the care home sector are well documented. NHS staff have spoken of the precarious nature of the sector at the current time. Instead of only 1 or 2 homes being in difficulty as was historically the case, there are now many in difficulty. Problems are financial and staffing. Smaller homes in particular find it challenging to be financially viable, with 40 bed homes being commonly quoted as the minimum level for viability in the private sector.

The financial viability of this type of provision in Strontian is explored in Section 8. Homes can also become unviable through the inability to recruit and retain sufficient staff and need to be closed when operators are unable to provide a safe level of service.

2. Community Capacity.

The demographic profile of the community has been documented in Section 2. The community is already active in a range of areas. Although the consultation indicated a positive attitude to more community delivery of buildings and services it will be necessary to give careful consideration to how much additional responsibility the community can bear.

7. OPTIONS ANALYSIS

Development of potential design options occurred in discussion with the project steering group and following feedback from the community consultation event. The full detail of the design process is available in the accompanying design report[6].

The design options were developed in order to explore the feasibility of fitting all the elements identified in the brief (smart sheltered housing, care facility, new medical facility, and hall) onto the one site. The options developed are indicative and illustrative of how the site may be developed. In practice not all elements may be incorporated into a final development, but these options were developed to explore what is practically possible. The information gained was then used to develop financial models which are explored in Section 8. This section examines:

- Two scenarios for sequencing of demolition of existing elements and construction of new ones
- Three options for the size and location of the buildings on the site

CONSTRUCTION SCENARIOS

Two separate construction scenarios were developed during the design process. The first scenario envisions the construction of the Smart Sheltered Housing to the rear of the site and the surgery and care facility to the front of the site. A new hall would be developed at the front of the site. Dail Mhor residents would be temporarily relocated to the housing units while a new care home was built.

The different stages in the process would be:

- **Construction of smart sheltered housing**
- **Temporary occupation of housing as a care facility**
- **Demolition of former school and hall**
- **Construction of new care facility**
- **Occupation of new care facility**
- **Construction and occupation of surgery and hall**

[6] Rural Design: Dail Mhor Redevelopment, Design Progress Report, August 2022

The strengths of this scenario are:

- **The smart sheltered housing is located adjacent to existing housing stock and is accessed from a quiet residential area**
- **The care facility would not have to close during the construction process**

The weaknesses of this scenario are:

- **The residential care operation would have to move twice during the process**
- **Strong coordination of funding packages and construction timelines would be required between the housing and care elements**
- **The housing could not be used for its intended purpose for a period of time**

This scenario was well received at the community consultation, but concerns were expressed within the project steering group that there may be difficulties in receiving permission from the regulator to use the housing on a temporary basis and that two moves added extra complications to the process.

The architects therefore developed an alternative scenario which would enable the building of the new care facility first and for the direct transfer from the old to the new, before the old was demolished.

The sequence this time would be:

- **Demolition of old school and hall**
- **Construction of new surgery, care facility and housing**
- **Occupation of new facilities**
- **Demolition of old care facility**
- **Construction and occupation of new hall**

A variant on this scenario would be to construct the housing first of all prior to the completion of design and funding packages for the rest of the site. This would maximise the speed of delivery of the housing, which is already in the local Strategic Housing Investment Plan (SHIP).

The strengths of this approach are:

- **The housing could be constructed prior to the other elements**
- **The housing could be occupied for its intended purpose as soon as it is built**
- **There would only be one care facility relocation**

The weaknesses of this approach are:

- **The hall would be demolished at the beginning of this process and constructed at the end**

DEVELOPMENT SCALE AND COSTS

The total indicative floor areas of all elements range from 1083m² to 1613m² (Table 9)

Table 9: Floor Areas of Options

	Floor Areas (m²)		
	Option 1	**Option 2**	**Option 3**
Surgery	82	146	225
Care Facility	356	403	743
Hall	285	285	285
Housing	360	360	360
Total	**1083**	**1194**	**1613**

Building costs have risen rapidly in recent years and it is unclear what is likely to happen in the near future. Estimation of future capital costs is therefore difficult, so the figures presented below should be treated with caution. Costs are based on estimated sum of £3,500/m² for all building types. This is satisfactory for comparing costs between options and providing general guidance. However, costs will only become clear once the project has been fully developed.

Estimated capital costs for the entire project range from **£3.8m** to **£5.6m** (Table 10).

Table 10: Estimated Costs of Options

	Capital Cost (£)		
	Option 1	**Option 2**	**Option 3**
Surgery	287,000	511,000	787,500
Care Facility	1,246,000	1,410,500	2,600,500
Hall	997,500	997,500	997,500
Housing	1,260,000	1,260,000	1,260,000
Total	**3,790,500**	**4,179,000**	**5,645,500**

ASSESSMENT OF OPTIONS

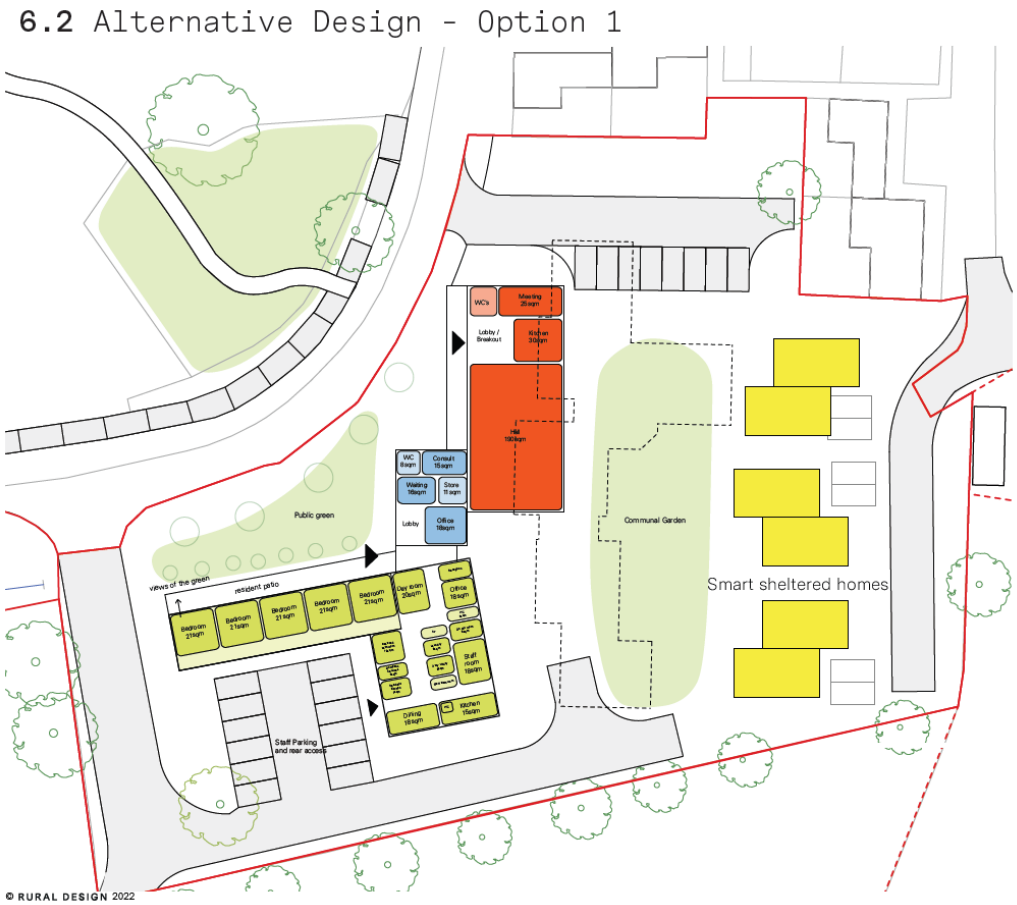
The design process has shown that the site is large enough and flexible enough to accommodate any of the 3 options agreed with Urram for consideration. Decision making on which option (if any) to pursue will then depend upon considerations such as the benefits delivered, available budgets, and value for money. **It should be noted that these options are very much illustrative**. Given that there are different actors that would be responsible for different elements a hybrid version may ultimately be favoured. However, a brief assessment of the practical benefits that may arise from each option is helpful at this stage.

Each of the options will enable the provision of 6 housing units and a new community hall facility with a floor area of 285m². Therefore, the focus of the assessment lies with the medical and care facilities that would be provided. There are slight differences in the drawings created for the 2 scenarios that were outlined above. Therefore, to avoid confusion the discussion below relates to the drawings for the second scenario on pages 20-22 of the design report, with the principles applying equally to the first scenario.

Option 1

For full design detail please refer to p20 of the Design Report.

This option essentially looks at a like for like replacement of existing facilities but constructed to modern building and energy standards.



The GP surgery would have a single consulting room and associated spaces. The consultation noted that the current facility struggles to provide the appropriate space with regards to privacy e.g., when dispensing prescriptions.

Small GP			
Rooms	Quantity	Area (sqm)	Total Area (sqm)
Waiting	1	16	16
Consult	1	15	15
WC	1	8	8
Resources/store	1	11	11
Office	1	18	18
Circulation	1	14	14
Total NIA			82

The care facility would provide for the modern needs of a 5-bed care unit so would be slightly larger than the existing building with better facilities.

Care Facility			
Rooms	Quantity	Area (sqm)	Total Area (sqm)
Entrance	1	5	5
Reception	1	5	5
Public WC	1	6	6
Dayroom	1	20	20
Dining Room	1	18	18
Resident Kitchen	1	7	7
Bedrooms	5	21	105
Assisted Bathroom	1	12	12
Laundry	1	8	8
Kitchen	1	15	15
Kitchen WC	1	2	2
Office	1	18	18
On call Room	1	8	8
Staff Room	1	18	18
Staff WC	1	8	8
Dirty Utility Room	1	8	8
Domestic Services	1	6	6
Store	1	5	5
Circulation	1	82	82
Total NIA			356

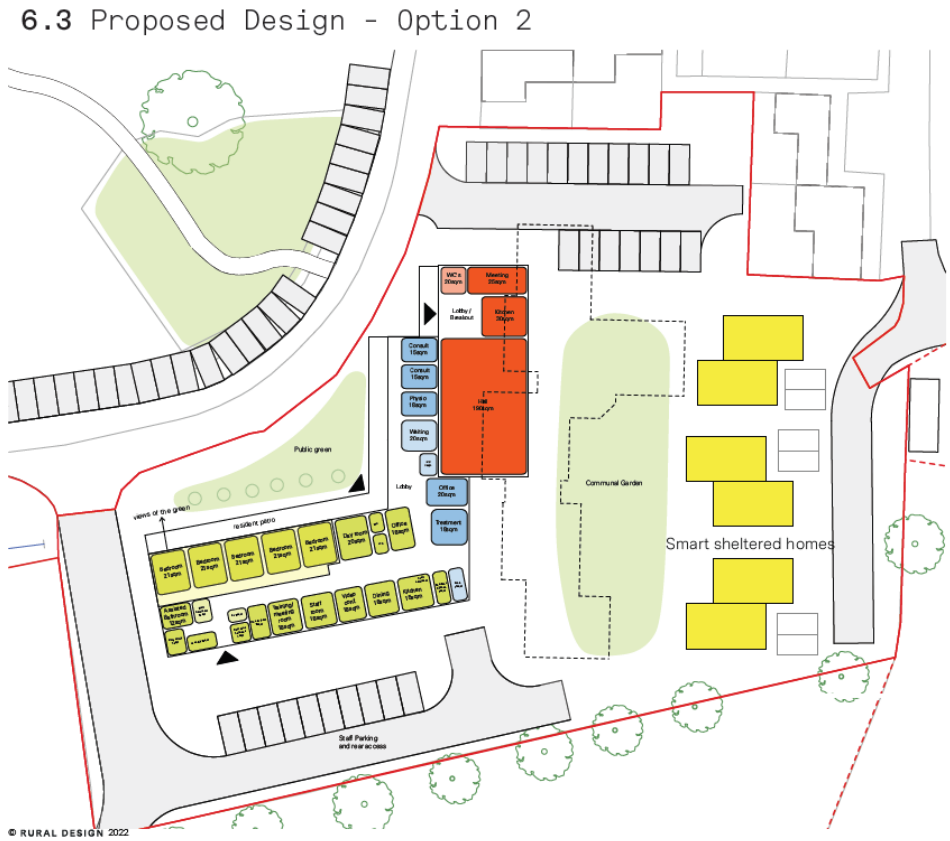
The demand for car parking would be provided on-site and using layby parking adjacent to the access road.

Overall, this would be the cheapest option to develop but would not provide for any additional health services either at present or to meet future needs. Nor would it provide accommodation for existing services (district nursing and paramedics) already present in Strontian. The overall benefit would therefore be modest. Value for money may be questionable.

Option2

For full design detail please refer to p21 of the Design Report.

This option would provide slightly larger spaces for both the surgery and the care facility.



The GP surgery would have an extra consulting room and the individual room sizes would be slightly larger.

Medium GP			
Rooms	Quantity	Area (sqm)	Total Area (sqm)
Waiting	1	20	20
WC	2	8	16
Consult	2	15	30
Treatment	1	18	18
Office	1	18	18
Resources/Store	1	20	20
Circulation	1	24	24
Total NIA			146

The care facility would be slightly larger than option 1 with the addition of extra rooms for meetings and training opportunities for staff.

Care Facility			
Rooms	Quantity	Area (sqm)	Total Area (sqm)
Entrance	1	5	5
Reception	1	5	5
Public WC	1	6	6
Dayroom	1	20	20
Dining Room	1	18	18
Resident Kitchen	1	7	7
Bedrooms	5	21	105
Assisted Bathroom	1	12	12
Laundry	1	8	8
Kitchen	1	15	15
Kitchen WC	1	2	2
Office	1	18	18
On call Room	1	8	8
Staff Room	1	18	18
Staff WC	1	8	8
Dirty Utility Room	1	8	8
Domestic Services	1	6	6
Store	1	5	5
Video Conference	1	18	18
Meeting Room	1	18	18
Circulation	1	93	93
Total NIA			403

The larger workspaces capable of accommodating more people in the surgery and care facility would require additional parking to be provided by using a perpendicular parking arrangement which would take some land from the neighbouring green space.

This option would provide better and more flexible workspaces for both the surgery and the care facility. It would also allow the surgery to provide greater privacy for patients than in Option 1.

Option 3

For full design detail please refer to p22 of the Design Report.

This option would allow for a significantly larger “surgery” to provide additional services and allow for the co-location of district nursing and ambulance personnel. The care facility would double its capacity, allowing 10 patients to be cared for.

6.4 Proposed Design - Option 3

Further rooms would be available to enhance the services offered in the surgery.

Large GP			
Rooms	Quantity	Area (sqm)	Total Area (sqm)
Waiting	1	25	25
WC	3	8	24
Consult	2	15	30
Treatment	2	18	36
Nurses	1	15	15
Physio	1	18	18
Office	1	18	18
Resources/Store	1	30	30
Circulation			29
Total NIA			225

Additional space would be available for nursing and ambulance staff. The care facility would be two storey with 10 bedrooms.

Care Facility			
Rooms	Quantity	Area (sqm)	Total Area (sqm)
Entrance	1	5	5
Reception	1	5	5
Public WC	1	6	6
Dayroom	1	35	35
Dining Room	1	30	30
Resident Kitchen	1	9	9
Bedrooms	10	21	210
Assisted Bathroom	1	12	12
Laundry	1	8	8
Kitchen	1	20	20
Kitchen WC	1	2	2
Office	1	20	20
On call Room	1	8	8
Staff Room	1	25	25
Staff WC	1	10	10
Dirty Utility Room	1	10	10
Domestic Services	1	8	8
Store	2	5	10
Video Conference	1	18	18
Meeting Room	1	18	18
Ambulance Room	1	20	20
Nurse Office	1	20	20
Resident Stair	1	25	25
Escape Stair	1	20	20
Resident Lift	1	10	10
Service Lift	1	8	8
Circulation	1	171	171
Total NIA			743

This option would enable all medical staff to be located on a single site, providing increased opportunities for integration of community health services. If this was combined with community health and well-being activities being directed from a renewed hall it could reasonably be considered to be an integrated community health and wellbeing hub.

Relocating the district nursing staff would offer the opportunity to redevelop their existing site, with the potential to use it to provide much-needed accommodation to assist with attracting and retaining healthcare personnel.

NHS Highland (in consultation with the local community) will be responsible for making a decision on the nature and size of its healthcare services. Urram and the community however will be responsible for deciding on whether to invest in and run a new Dail Mhor care facility. The viability of such an operation is therefore considered in Section 8.

8. Financial Analysis

In accordance with instructions given to us by Urram, we have prepared this financial feasibility report from the financial data provided from a variety of sources made available to us, in particular by NHS Highland. We have not audited or otherwise attempted to verify the accuracy or completeness of such information and accordingly express no opinion thereon but have no reason to doubt the validity of the data provided and we have been grateful for the collaborative and helpful approach by NHS Highland personnel. The figures are prepared for illustrative purpose and this report relates to future events and so the actual results may differ from the projections and these differences may be material. This report has been prepared solely for the use of Urram for the development of the Dail Mhòr feasibility study to inform the community's decision on whether they can take forward this project and is not to be relied upon by any third parties for any other purpose whatsoever.

This section explores:

- Four scenarios for the operation of a residential care facility offering respite care (each scenario modelled for 5-bed and 10-bed options)
- The capital and financing costs of the 3 design options explored in Section 7
- A financial model for the operation of a new community facility on the Dail Mhor site

Dail Mhor Existing operation

The data provided for Dail Mhòr shows that the overall annual running costs for the centre is almost £500,000 per annum with £400,000 attributed to staffing costs. Of the general running costs, the £46,000 related to energy costs with almost £30,000 attributed to the cost of oil. It may be possible to reduce the energy costs in a new building which may reduce to overhead costs from £100,000 to around £70,000. However, the figures we have been provided for Dail Mhòr exclude the cost of food provision, therefore it's likely that incorporating food costs will certainly eliminate the energy cost saving, and combined with inflation currently close to 10%, it is reasonable to assume that the operational running costs of Dail Mhòr will remain close to £500,000. It's likely that the operation of a future Centre will require at least this level of income to be financially viable.

Staffing costs are the most significant cost and this is not a cost that can be reduced as there are regulatory requirements to meet in terms of staffing ratios and particular levels of skill requirements that dictate the pay levels to be met when delivering care services in a residential setting.

Dail Mhor Financial analysis

Based on the existing financial data, some financial scenarios have been considered to better develop an understanding of the financial implications of operating Dail Mhòr.

Two Centre sizes have been considered for a 10-bed option and a 5-bed option. The 5-bed option allows for a slight lower staffing level, but as soon as the Centre rises above 5 beds, the staffing level required would be the same for the 6-10 bed option. It's assumed in the 5-bed option that the overhead costs would be less so these are assumed to be around 20% lower than for the 10-bed scenario.

Scenario 1 - Base case

Scenario 1 considers base case type scenario which takes into account the operating costs for Dail Mhòr and its potential income based on current levels of respite care weekly income rates that could be generated. Under both the 10-bed and 5-bed options there is a significant shortfall of £134,000 for the 10-bed model and £162,000 for the 5-bed model. This scenario is not a viable proposition for the community to take on as the requirement to fundraise that amount of a shortfall on an ongoing basis would be difficult for a small charity to sustain.

Respite Centre - Scenario 1				
Illustrating 1 bed for emergency respite and remainder for planned respite (80% occupancy)				
Standard charge of £940 per week plus £1,800 for emergency respite				
		10 beds		**5 beds**
Employment costs:				
Deputy/Manager		57,667		57,667
Band 4	3	242,243	2	161,495
Band 2 Nightshift	2	133,980	1	66,990
Band 2 Housekeeping		26,796		26,796
		460,686		312,948
General running costs (based on 2021 figures)		100,000		
Saving in energy costs cancelled by adding in food costs				
		100,000		80,000
Total running costs		**560,686**		**392,948**
Estimated income:				
Respite income - Assume 80% occupancy @ £940 per week		351,936		156,416
Emergency respite income - Assume 80% occupancy @ £1800 per week		74,880		74,880
Total income		**426,816**		**231,296**
Surplus/(Shortfall)		**(133,870)**		**(161,652)**

SUMMARY: This scenario confirms the NHS's view that a small 5 or 10 bed home is not financially viable at the current income rates paid by the public sector and will result in a significant annual deficit.

Scenario 2 – Variation on base case scenario 1

Scenario 2 is similar to scenario 1 but considering the position if Urram were able to secure a contract that paid the full income level assuming 100% capacity. This scenario might be possible if there was an agreement with NHS Highland to effectively pay for the full capacity to give them the ability to use those beds to fulfil their own respite requirements as and when required rather than paying for weekly bed spaces through a booking system.

This scenario also produces a shortfall but only £27,000 in the 10-bed option and £104,000 in the 5-bed option. If the agreement with NHS Highland allowed the contract to cover the full running costs including the £27,000 shortfall, then this scenario could be deliverable under the 10-bed model with an inbuilt annual uplift to take into account inflation.

Respite Centre - Scenario 2				
Illustrating 1 bed for emergency respite and remainder for planned respite (100% occupancy)				
Standard charge of £940 per week plus £1,800 for emergency respite				
		10 beds		**5 beds**
Employment costs:				
Deputy/Manager		57,667		57,667
Band 4	3	242,243	2	161,495
Band 2 Nightshift	2	133,980	1	66,990
Band 2 Housekeeping		26,796		26,796
		460,686		312,948
General running costs (based on 2021 figures)		100,000		
Saving in energy costs cancelled by adding in food costs				
		100,000		80,000
Total running costs		**560,686**		**392,948**
Estimated income:				
Respite income - Assume 100% occupancy @ £940 per week		439,920		195,520
Emergency respite income - Assume 100% occupancy @ £1800 per week		93,600		93,600
Total income		**533,520**		**289,120**
Surplus/(Shortfall)		**(27,166)**		**(103,828)**

SUMMARY: This scenario is not financially viable either at the current income rates paid by the public sector, even assuming payment for 100% occupancy and will require annual fundraising by Urram to cover the annual deficit.

Scenario 3 – Private model

In scenario 3 a model where respite care is being delivered at the high private/emergency rate of £1,800 per week with 100% occupancy is considered. This would be financially sustainable if this level of income could be secured, but that is a significant unknown, and realistically 100% occupancy would be extremely difficult to achieve, especially if this was to be marketed as a respite holiday centre as this would be to some extent seasonally driven.

However, a further variation on this scenario 3 would be if occupancy was at 80%. In this scenario, the 10-bed model would result in a surplus of £188,000 and the 5-bed model at deficit of £19,000. This would still be a high level of occupancy to achieve if the income was significantly driven by seasonal demand and in reality, there would need to be a mix of these high-rate beds with some regular weeks generating income at £940 as well from the NHS.

Respite Centre - Scenario 3				
Illustrating 1 bed for emergency respite and remainder for planned respite (100% occupancy)				
Standard charge of £1,800 per week				
		10 beds		**5 beds**
Employment costs:				
Deputy/Manager		57,667		57,667
Band 4	3	242,243	2	161,495
Band 2 Nightshift	2	133,980	1	66,990
Band 2 Housekeeping		26,796		26,796
		460,686		312,948
General running costs (based on 2021 figures)		100,000		
Saving in energy costs cancelled by adding in food costs				
		100,000		80,000
Total running costs		**560,686**		**392,948**
Estimated income:				
Respite income - Assume 100% occupancy @ £1800 per week		842,400		374,400
Emergency respite income - Assume 100% occupancy @ £1800 per week		93,600		93,600
Total income		**936,000**		**468,000**
Surplus/(Shortfall)		**375,315**		**75,052**

SUMMARY: This scenario could enable income to cover annual expenditure but would bear a considerable amount of risk beyond the limits of what would be reasonable for a community group to carry and is not a realistic option for Urram.

Scenario 4 – Break-even model

The 4th scenario considered looks at delivering at a break-even level.

The assumption is that occupancy would be at 80% and then looks at the pricing level required from the beds to enable the Centre to break-even. For the 10-bed model, its assumed that 1 emergency bed would be at £1,800 per week and remaining beds would need to be charged at £1,300 per week to enable the Centre to break-even. For the 5-bed model however, the emergency rate would need to £2,000 per week and the standard respite would be around £1,865 per week.

The 5-bed model seems like a significant increase in pricing, but the 10-bed model may be deliverable if the value of the service provided is recognised and there is the ability to pay this rate for it.

Respite Centre - Scenario 4 (approximate break even model)				
Illustrating 1 bed for emergency respite and remainder for planned respite (80% occupancy)				
Standard charge of £1,300 for 10 bed option and £1,865 per week for 5 bed, plus £1,800 for emergency respite (10 bed) and £1,900 for 5 bed		**10 beds**		**5 beds**
Employment costs:				
Deputy/Manager		57,667		57,667
Band 4	3	242,243	2	161,495
Band 2 Nightshift	2	133,980	1	66,990
Band 2 Housekeeping		26,796		26,796
		460,686		312,948
General running costs (based on 2021 figures)		100,000		
Saving in energy costs cancelled by adding in food costs				
		100,000		80,000
Total running costs		**560,686**		**392,948**
Estimated income:				
Respite income - Assume 80% occupancy @ £1,300 per week (10 bed) and £1,865 (5 bed)		486,720		310,336
Emergency respite income - Assume 80% occupancy @ £1,800 per week (10 bed) and £2,000 for 5 bed		74,880		83,200
Total income		**561,600**		**393,536**
Surplus/(Shortfall)		**915**		**588**

SUMMARY: This scenario does deliver a break-even financial position but would require a significant amount of work to deliver in the specialist health care sector of which Urram have limited experience. The risk of operating on the basis of this model is considered too risky for Urram to undertake and not a viable proposition.

SUMMARY OF DAIL MHOR SCENARIOS

The table below summarised the above scenarios for ease of reference.

Scenarios 1 & 2 produce deficits so are not particularly attractive to the community in terms of a future operating model. Scenarios 3 & 4 produces a surplus but it is unlikely that this level of price and occupancy can be achieved. Therefore at best, negotiating higher rates for the standard respite care might allow Dail Mhòr to break-even, but comes at significant risk to Urram. There would need to be close monitoring of costs with annual pricing increases applied as well, but it would not be advisable for Urram as a community group to take on such a financially challenging operation.

Respite Centre - Scenario Summary								
Scenario 1 - Base case	Illustrating 1 bed for emergency respite and remainder for planned respite (80% occupancy)							
	Standard charge of £940 per week plus £1,800 for emergency respite							
Scenario 2 - Maximum income from base case	Illustrating 1 bed for emergency respite and remainder for planned respite (100% occupancy)							
	Standard charge of £940 per week plus £1,800 for emergency respite							
Scenario 3 - Maximum income from private model	Illustrating 1 bed for emergency respite and remainder for planned respite (100% occupancy)							
	Standard charge of £1,800 per week							
Scenario 4 - Approx. break-even model	Illustrating 1 bed for emergency respite and remainder for planned respite (80% occupancy)							
	Standard charge of £1,300 for 10 bed option and £1,865 per week for 5 bed, plus £1,800 for emergency respite (10 bed) and £1,900 for 5 bed							
	1a	**2a**	**3a**	**4a**	**1b**	**2b**	**3b**	**4b**
No of beds	10	10	10	10	5	5	5	5
Standard charge	£940	£940	£1,800	£1,300	£940	£940	£1,800	£1,865
Emergency charge (1bed)	£1,800	£1,800	£1,800	£1,800	£1,800	£1,800	£1,800	£1,900
Occupancy	80%	100%	100%	80%	80%	100%	100%	80%
Estimated income	426,816	533,520	936,000	561,600	231,296	289,120	468,000	393,536
Estimated expenditure	560,686	560,686	560,686	560,686	392,948	392,948	392,948	392,948
Surplus/(Deficit)	**(133,870)**	**(27,166)**	**375,315**	**915**	**(161,652)**	**(103,828)**	**75,052**	**588**

FOLLOW UP: Would NHS Highland provide sufficient funding to Urram to cover the full operating costs of Dail Mhòr plus annual uplifts to cover the full additional inflationary costs?

Alternative Scenario

Capital costs in relation to the various options above are considered in the section below, as well as funding scenarios for the various options.

This is a relatively academic exercise however as it is evident that for a community organisation such as Urram, the financial position of operating Dail Mhòr is not viable. However, an alternative option that may be worth considering is that Urram construct a building that is then rented to the NHS for operation.

In such a scenario, Urram would be looking for a sizable rental income per annum for the delivery of such a building to cover the cost of loan financing and ensure sufficient funding for the future

maintenance of the fabric of the building. A suggested rate of return might be around 8% and would result in the following rental rates depending on the building size option selected.

This would utilise the strengths of the community in Strontian who have a track record of delivering innovative building solutions to house public sector services in the area and would be a significant improvement on the existing building provided at Dail Mhòr at the moment.

	Capital Cost (£)		
	Option 1	**Option 2**	**Option 3**
Surgery	287,000	511,000	787,500
Care Facility	1,246,000	1,410,500	2,600,500
Total	**1,533,000**	**1,921,500**	**3,388,000**
8% Return on investment	**122,640**	**153,720**	**271,040**
Cost per sq mtr	**280**	**280**	**280**

FOLLOW UP: Would NHS Highland rent a care facility/building from the community for the delivery of health services for a period of 20 years?

CAPITAL COSTS

The breakeven figures for scenarios 4a and 4b are based on meeting operational costs. If a new building is to be provided by the community, it will need to be financed. If borrowing is involved additional revenue will be required to cover repayment costs. There is also the potential for the community to construct a new building for NHS Highland and lease it to them. This section therefore explores the financial implications of these scenarios.

The capital cost for the project (excluding the housing aspect) is as follows:

	Capital Cost (£)		
	Option 1	**Option 2**	**Option 3**
Surgery	287,000	511,000	787,500
Care Facility	1,246,000	1,410,500	2,600,500
Hall	997,500	997,500	997,500
Total	**2,530,500**	**2,919,000**	**4,385,500**

Residential Care Home

The capital costs for the residential care home has been calculated as follows with an illustration of what fundraising/grant and loan might be required assuming that the majority of this will be funded by loan with some fundraising/grants obtained towards the facility.

The addition of these finance costs will require an increase in the respite care fees of an average of £304 per bed per week which will significantly increase the cost of delivering respite care for the community.

Care facility - residential	Option 1	Option 2	Option 3
Capital costs	**1,246,000**	**1,410,500**	**2,425,500**
Assume funded by:			
Loan	**1,000,000**	**1,000,000**	**2,000,000**
Fundraining/grant	**246,000**	**410,500**	**425,500**
Average loan interest	29,066	29,066	58,132
Average loan capital	50,000	50,000	100,000
	79,066	**79,066**	**158,132**
Additional cost per week per bed	£ 304	£ 304	£ 304

Other Health Care Rental spaces

Extracting the non-residential care elements provides approximately the following capital costs, and for illustrative purposes an approximate split has been show of how much might be generated from grants and fundraising and assuming that the rest is covered by loan:

Capital costs - other rented spaces	Option 1	Option 2	Option 3
Surgery	287,000	511,000	787,500
Care facility - other services			175,000
Total	**287,000**	**511,000**	**962,500**
Assume funded by:			
Loan (20 year, 5% interest)	**287,000**	**511,000**	**962,500**
Fundraining/grant	**0**	**0**	**0**

An illustration has been prepared of what rental income would be required to cover these loan repayments from the non-residential care spaces, each option for the rental of space for the surgery and also for other services such as a space for the Ambulance Service, Physio etc:

	Option 1	Option 2	Option 3
Rental income	Rate required to cover loan costs		
Surgery	24,600	43,800	67,500
Other services			15,000
Total	**24,600**	**43,800**	**82,500**
Loan interest	8,341	14,853	27,970
Loan capital	14,350	25,550	48,125
	22,691	**40,403**	**76,095**
Net cashflow/deficit	**1,909**	**3,397**	**6,405**

The rate per sq mtr is around £300 which will cover the annual loan repayments.

HALL/GATHERING SPACE

The Hall element of the project is expected to be community led and is a typical type of project that communities often undertake with various funding sources being available in terms of grants, donations and fundraising. It is assumed at this stage that the project will be 100% funded though these established funding sources.

A basic income illustration has been prepared to demonstrate how the hall would pay to cover its own operating costs. A newly built Gathering Space would be low cost to maintain and could be funded through reasonable levels of rental charges. Due to its location nearby the Care Hub though it will offer the potential to be so much more that simply a replacement community centre.

The proximity of the gathering space to the Care Hub itself allows the use of this space as an extended facility with activities such as seated exercises and chair yoga for example which could be accessible by residents of the care facility and the community in general.

The Gathering Space itself would not generate a significant level of income but with a modest charge would be expected to meet its own running costs.

Gathering Space							
Illustration of income							
	OCCURRENCE				**INCOME**	**INCOME**	**TOTAL**
Event	**Annually**	**Monthly**	**Weekly**		**CATEGORY**	**PER EVENT**	**CONTRIBUTION**
Total income							**15,960**
Weddings	5				Location fee	1200	6000
Ceilidhs, dances & parties		2			Rent	240	5760
Whist		1			Rent	10	120
Sports/ activities			3		Rent	20	3120
Historical society facility			1		Rent	20	240
Public meetings		2			Rent	20	480
Presentations		1			Rent	20	240

9. TWO CASE STUDIES

The study so far has charted the changing nature of healthcare provision, the opportunities and challenges that arise in terms of service provision, what can be delivered on the Dail Mhor site, and some of the financial implications of these. Change is challenging and therefore we use this section to explore how two other community organisations are responding to the challenges that they face.

CASE STUDY 1: THE HOWARD DORIS CENTRE

The Howard Doris Centre is a Scottish Registered charitable company limited by guarantee.
Charity Number: SC021024 Company Number: SC142359
Registered Office: Howard Doris Centre, Mill Brae, Lochcarron, IV54 8YQ

Website: www.strathcarronproject.org

The Howard Doris Centre provides a high level of nursing and social support, day care, supported accommodation, medical beds and community service - "a whole package of care" under one roof.

Background

'The custom-build Howard Doris Centre (the Centre) opened in August 1996 to enable the charity to provide care to older people in the Strathcarron electoral district; Highland Council and Albyn Housing Association jointly own the building.

The Howard Doris Centre is responsible for managing operations at the Centre and work is contracted by the NHS to deliver various services such as day-care, housing support and personal care at home. It also provides support for tenants of Albyn Housing Association who reside there.

Services for day-care clients, pre-Covid 19, included the provision of transport to and from the Centre, leisure activities for all clients (including tenants) and a lunchtime meal service with mid-morning and mid-afternoon drinks and snacks. The day-care service is funded in the main by NHS Highland although the contract conditions require that each client makes a contribution (over and above the meal charge).

There are a number of additional activities carried out by the charity:

- Short-term respite care (funded either privately, or by Social Work with a portion recharged by Social Work directly to the client)
- Two 'step up step down' beds (funded by NHS Highland)
- Warden services to adjacent sheltered housing (provided under a contract with Highland Council) – although this was suspended for the year ender review;
- Provision of free personal care to local residents (provided under a contract with NHS Highland); and
- Provision of free personal care to tenants (provided under a contract with NHS Highland).

Albyn pays a contribution towards upkeep of common areas: the charity is responsible for all the general maintenance, replacing furnishings, floor coverings. And other equipment (although not the fixtures) and ensuring the whole area is kept at the high standard both inside and out.

All care and support services are fully registered with the Care Inspectorate.'[7]

[7] The Howard Doris Centre Annual Report and Financial Statements for the Year Ended 31 March 2021, page 1, Trustees' Report

The Centre has always performed extremely well during Care Inspections with the comments from service users being highly appreciative and complementary about the service delivered.

The sheltered housing provides permanent accommodation for 8 people.

Challenges identified

Many challenges are faced by the care sector which has been made all the more difficult during the Covid pandemic, but recurring themes arise over the last few years in the Trustees' Annual Report including:

- **Budgetary Concerns**
- **Staff Recruitment/Retention**
- **Recruitment of Volunteers**

In addition, the following issue was highlighted in the 2019 report:

Diminishing attendance

'It is inevitable that, as years pass, our clientele will grow older, become less able and ultimately may leave the area to obtain greater levels of support than we can provide or, more commonly they pass away. We are aware that the numbers who regularly attend for Day-Care have been gradually reducing over the last few years.

We have consulted other similar organisations who confirm that this is a global phenomenon. We suspect that this is due to improved housing conditions and changing social mores. We are aware that, twenty years on, our local community may have become complacent with what is available at the Howard Doris Centre. However, the need for the care and support provided by our organisation remains. It is incumbent on us to maintain our service.

We have taken several steps to address this issue in the short, medium, and long term. During the summer of 2018 members of the Board, staff and users of the service made planned visits to the doctors' surgeries and communities of Applecross and Torridon to encourage attendance. Our chairman made several home visits to encourage individuals to attend for Day Care. We have explored expansion of the concept of 'Day-Care' by considering the construction of a multi-functioning new building adjacent to our dining room. This could function as an activity centre for various activities. Although at an early stage, initial response from our users and importantly from those who currently seldom attend, has been positive.' [8]

In response to some of these challenges, the Trustees outlined some changes to their potential future services:

Plans for the Future Periods

'We are at the early stages of investigating the provision of an extended range of care within the community. This may provide an additional revenue….

…Finally, we are considering the suggestion of developing a 'men's shed' type of facility and/or fitness centre.'[9]

[8] The Howard Doris Centre Financial Statements for the Year Ended 31 March 2019, page 2, Trustees' Report
[9] The Howard Doris Centre Annual report and Financial Statements for the Year Ended 31 March 2019, page 4, Trustees' Report

Following the Cover-19 pandemic, there are now increased challenges for the Centre which amplify some of the issues previously identified and require a more concerted plan to make some significant changes to the way the Centre operates in the future.

In the 2021 Trustees' Report, the following future plans have been outlined:

'The global pandemic has been a significant challenge for the organisation as it has for all Care Homes. It has led to a reassessment of risk and the sustainability of business models as we start the process of easing restrictions.

We have begun discussions with the NHS about the future shape and sustainability of the services offered at the Howard Doris Centre. These discussions are in the early stages but may lead to a change in the way the Charity works with the NHS. Any change will be the subject of consultation and it is, at this stage, impossible to forecast the outcome if the discussions.

The management committee has also considered a number of other options for the future including strengthening the existing management team and redesigning the provision of day care. The reason for this is that dealing with the pandemic has increased the bureaucracy around infection control as well as other areas of management increasing the pressure to the existing management team. These alternative options remain under consideration, pending the outcome of the NHS discussions. Additionally, there is evidence across the Highland region that existing models of day care have been overtaken by demographic and lifestyle changes in the older community. There is clearly still a need for support but the way in which this is delivered in future is likely to be blend of visits and activities rather than the fixed venue that has operated successfully for the past 25 years.

Opportunities to partner other organisations will also be considered and we will revisit plans for the development of a fitness suite and activities shed following consultation with relevant groups.'[10]

Day care has in the past been delivered to up to 30 people, 5 days per week, but this has significantly dwindled to around 12 people.

Financial Position

As a small charity, The Howard Doris Centre faces many challenges to be able to deliver good quality mix of services resulting in a complicated financial picture involving a number of contracts with the main funder being NHS Highland, but also some involvement from Highland Council, Albyn Housing Association, as well as contributions from some service users as well.

A summary of the financial accounts for the 4 years ended 31 March 2021 have been compiled below and shows that in every year the cost of delivering the charitable activities have exceeded the income related to those activities. The total deficit in those 4 years amounts to over £245,000 and demonstrates the significant financial challenge facing the organisation. The average annual expenditure is just over £598,000 per annum, but the income is only just over £537,000 per annum.

The Centre has covered this deficit through the receipt of donations and legacies, most notably a one-off donation in the year ended 31 March 2019 from a charitable trust of £151,000. Excluding this one of donation, the total other income is £209,000 which is still short of the operating deficit of £245,000. The need for donations and legacies to support the Centre brings its own challenges, particularly at a time when the UK is facing an economic recession with rising cost of living which will

[10] The Howard Doris Centre Annual Report and Financial Statements for the Year Ended 31 March 2021, page 4, Trustees' Report

not only increase the running costs of the Centre, but also make it more difficult to generate significant donation income from the general public.

The Howard Doris Centre					
Financial income and expenditure (extracted from Annual Financial Statements)					
		31/03/2021	**31/03/2020**	**31/03/2019**	**31/03/2018**
Charitable activities					
Day Care (NHS)		231,425	224,031	206,155	199,087
NHS Highland (step up step down beds)		75,551	75,551		
NHS Highland (medical beds)				75,549	73,699
Free personal care (tenants)		61,626	69,141	82,214	72,049
Housing support		48,422	56,337	54,902	66,019
Meals		48,422	34,560	24,713	32,285
Respite care		23,160	16,790	12,645	10,482
Service charge (tenants)		19,848	26,355	41,016	35,450
Weekly charges				13,410	11,814
free personal care (community)				746	4,720
Albyn maintenance contribution		6,854	6,854	7,104	6,854
Ancillary service charges		548	4,437	4,542	4,456
Department of Transport (grant)		706	393	2,094	2,508
Fundraising ventures		939	6,897	3,358	
Other income		14,196	782	1,072	1,491
Warden services			9,920	9,090	9,000
Sir Lewis Ritchie			16,500		
Total charitable activities income		**531,697**	**548,548**	**538,610**	**529,914**
Expenditure on:					
Charitable activities		**555,952**	**605,891**	**630,924**	**601,455**
Net surplus/(deficit) on charitable activities		**(24,255)**	**(57,343)**	**(92,314)**	**(71,541)**
Other income:					
Donations & legacies		34,303	57,056	216,262	13,705
Legacies		33,420			
Investments income		2,777	2,660	2,563	2,242
Gain/(Loss) on investments		(2,377)	(2,780)	1,044	(4,147)
Other income					3,605
		68,123	**56,936**	**219,869**	**15,405**
Net surplus/(deficit)		**43,868**	**(407)**	**127,555**	**(56,136)**
Charitable expenditure total cost above includes:					
Staff costs		428,804	451,867	464,239	450,842
Provisions		42,017	38,250	38,673	35,407
Light & heat		26,759	31,364	34,405	27,920
General unrestricted reserves		**355,333**	**308,421**	**304,533**	**72,652**

The Trustees of the Centre have very carefully managed the Centre and its finances and have been able to build up some reserves, but this does not reduce the ongoing financial pressures on the organisation to continually balance the financial position whilst also meeting the requirements of the various funders and Regulator. The mix of services being delivered adds its own complexity, particularly due to its classification as a care home.

Reflection on the Howard Doris Centre

Despite the regulatory challenges that all care services face, and more so when there are services being delivered with different service classifications, the Howard Doris Centre has been a highly effective service which provides an excellent model of delivery in a rural area over a 25-year period. There is a significant amount to be learnt from the success of this model.

The public sector funding for this service is not sufficient however to cover the costs at the present time but to maintain services in remote areas, it will be necessary to address this shortfall, particularly where the service is of such good quality, whilst at the same time also undertaking a redesign of delivering the more traditional Day Care services to meet the needs of the 21st century demographic being served by rural care services. Day Care services must be less orientated towards delivery from a fixed Centre and more community orientated and designed to keep the ageing population active and engaged in social and physical activities.

Of particular note is that after a 25-year period of sustained support from a core of committed Trustees, the organisation is struggling to find suitable Trustees to replace an ageing Board of Trustees. If new Trustees cannot be recruited that this will leave a void in the organisation that it will be necessary to address in the short term.

Factors impacting on the Howard Doris Centre's rural care services resulting in a required redesign:

- Improvements in housing, health and lifestyle demands of the older generation
- Changing rural demography
- Lack of staffing and affordable housing in rural areas
- Reduced number of available volunteers & Trustees
- Budgetary constraints on public sector funding
- Regulatory requirements

Learning points for Urram:

- Meet the demands and needs of potential service users through service design that will meet the requirements of the ageing population in the area, i.e., look at future need rather than past delivery so there is greater variety of activities that are more community based
- Work with other agencies to help alleviate staffing and housing shortages that could hinder the success of a future service
- Consider the governance structure of the organisation from the outset with a model that integrates representatives from other stakeholder organisations rather than only the Charity's own Trustees
- Ensure that the core funding required to run a rural centre is in place from the outset recognising that the financial cost will be greater than in a centre where greater economies of scale can be achieved but recognising how vital a rural care hub will be to the rural area whilst resulting in savings to medical services located elsewhere in the Highlands
- Consider the regulatory constraints, particularly where a mix of services involve different regulatory requirements, and consider ways to minimise the constraints placed on the services provided

CASE STUDY2: TAGSA UIBHIST (UIST SUPPORT)

Tagsa Uibhist (Uist Support) is a Scottish Registered charitable company limited by guarantee.
Charity Number: SC029417 Company Number: SC233410
Registered Office: East Camp, Balivanich, Isle of Benbecula HS7 5LA

Website: www.tagsaubihist.co.uk

In 2020, the charity adopted the simple mission statement Slàinte agus Sunnd, which means Health and Wellbeing. This gives a broad and inclusive remit, recognizing that achieving wellbeing means different things to different people. Tagsa is a practical organisation and our core services in care at home, elderly support and community transport reflect our commitment to respond to these important needs.

Background

'The principal objective of Tagsa Uibhist is to relieve the stress in carers and their families by enabling them to take regular breaks for their caring responsibilities and maintain their social role within the community.

In support of the principal objective of the board of trustees aims to provide high quality services for all those in need and their carers in our community. Services are provided for the disabled, individuals with dementia, the isolated, the elderly, those with serious acute illnesses and the vulnerable in Uist and Benbecula.

Referrals are received from all sources including individuals and their families, local health professionals, other care organisations and Comhairle nan Eilean Siar social work department. Services are funded by donations, grant support, direct funding for services from the local authority, and from individual fees.

The Board of Directors are always looking for new and innovative ways of delivering and increasing support to our client group and heir carers with the ultimate aim of enhancing the overall health and wellbeing of the individuals we support and the community as a whole.

Tagsa Uibhist has adopted as mission statement 'Promoting Health and Well-Being in our Community – Slàinte agus Sunnd' to encapsulate what we are trying to achieve. The charity recognises that support for carers and those in need of care best comes in a variety of different forms to meet the diverse needs of the individuals making up our community.

The charity provides an accessible transport service for those unable to use regular services. It is an important way of supporting our scattered rural community where isolation can have a severe impact on health and well-being.

The Community Garden project is the charity's other major initiative to support health and wellbeing in our community. We provide a safe supportive environment for vulnerable people and volunteers to participate together on growing local produce for both themselves and the community. As a result, the project supports and enriches the lives of not only those involved but also the wider community.'[11]

Within the Achievements and Performance section of the report it is noted that despite the challenges presented by Covid-19, that '… Tagsa Uibhist was able to extend the Care at Home

[11] Tagsa Uibhist (Uist Support) Report of the Trustees and Financial Statements for the year ended 31 March 2021, page 3 Trustees Report

service, taking on additional care packages and more respite care hours, mainly through increased commissioning from Comhairle nan Eilean Siar. 15,724 hours were delivered by our carers over the year (an average of 1,310 per month), continuing a significant year on year increase (2018: average of 760 hours per month, 2019: 987 hours).'[12]

The organisation's overall income was £776,319 in the year ended 31 March 2021 whilst its expenditure was £693,064 with a surplus of £83,255. Of its income, only £24,806 was generated from donations. The level of support from the local authority is significant and enables the organisation to operate in a financially sustainable way, and has been achieved by the organisation ensuring that its charges are sufficient to cover costs and ensure financial sustainability.

Interestingly, looking back at this particular organisation in the year ended 31 March 2017, it was a significantly different organisation and its Charitable activities are described as:

'Tagsa Uibhist – Home support

People who received care from Tagsa Uibhist in the year ender review were:

- Older people in need of support to remain in their own home or requiring respite,

- People under 65 with physical disabilities in need of support to remain in their own home, or requiring respite;

- People living with dementia in their own homes;

- Supporting carers in the community.

Service objectives

- To provide efficient and effective services which are value for money;

- To involve and consult service users and communities in the planning and delivery if services;

- To work in and sustain effective partnerships;

- To promote health and healthy lifestyles.

Service Improvement Priorities

- To shift the balance of care away from institutional care;

- To give greater emphasis to partnership working;

- To increase the involvement of communities and clients in the planning and delivery services;

- To improve the quality and effectiveness of services;

- To improve accessibility to services.

Total care hours

2017 – 376 people received care from Tagsa Uibhist during the year; (2016 – 282)

2017 – 1,416 Care Hours provided, Home Support and Respite for Carers; (2016 – 1,278)

[12] Tagsa Uibhist (Uist Support) Report of the Trustees and Financial Statements for the year ended 31 March 2021, page 4 Trustees Report

2017 – 1,806 hours of purchased care by family carers & people requesting extra support (2016 – 1,392 hours)

2017 – 3,882 hours of Local Authority spot purchase (2016 – 3,851)'[13]

Further on in the report, the charity's residential respite care is covered, and its suspension is outlined:

'Doigheag Respite Care Home Ltd

As noted in last year's report, demand for places in Doigheag has proved variable. Even with a contract for one of the beds with the local authority income was not reliably covering costs. The provision of respite care to clients in receipt of home care is acknowledged as an important part of the provision of a high-quality home care service. It has been established that regular access to respite care sustains clients in their own home for longer and reduces crises and hospital admissions. Despite the benefits, local demand for respite appears to have been met by in large by the beds available in local authority care homes.

A decision to suspend the delivery of residential respite care from Doigheag was reluctantly taken in April 2016. Provision of respite care ceased from the 30th April 2016.

It had become clear that there was insufficient demand for residential respite. Despite the funding contract the Comhairle were not fully utilising the one bed that had already been paid for. In addition, following advice about changes in employment practice it was clear that costs to provide respite care at Doigheag would be increasingly significant. The decision had to be taken without delay to avoid a potential significant debt. Fortunately, we have been able to redeploy staff to deliver home care in the community.

Since that date we have been exploring ways that this community resource could be used most effectively.' [14]

In the year ended 31 March 2017 the organisation has a total income of £209,224 and expenditure of £230,648 with an overall net expenditure for the year of £21,424.

In the Trustees' Report under Future Plans, it is noted that:

'We continue to look for a more stable arrangement with Comhairle nan Eilean Siar.

Health and social care in the Western Isles were integrated under the Integration Joint Board in April 2016. This has served to increase uncertainties for the charity as organisational change took place. During the year we were informed that the annual grant that we have been receiving since Tagsa Uibhist was formed would cease and be replaced by a new arrangement. We were left in the dark as to what the new arrangement might be. Eventually we were invited to reapply for the grant shortly before the end of the financial year, but not before a decision had been taken to reduce respite care provided through the grant revenue to protect both users and Tagsa Uibhist from the potential sudden change.

[13] Tagsa Uibhist (Uist Support) Report of the Trustees and Financial Statements for the year ended 31 March 2017, page 2 Trustees Report

[14] Tagsa Uibhist (Uist Support) Report of the Trustees and Financial Statements for the year ended 31 March 2017, page 3 Trustees Report

The board made the decision to significantly increase our charge to the Comhairle for spot purchase of home care at the end of the financial year. The decision was taken in the context of the uncertainty about the grant, a steady reduction in spot purchase requests and indications that the trend was likely to continue. At the same time, we proportionately increased charges to our fee paying clients to remain at 50% of the change to the local authority. This had a significant impact on several clients who relied heavily on the subsidised directly purchased service.

It remains a priority to negotiate a contract, or at least a Service Level Agreement, with Comhairle nan Eilean Siar dealing with spot purchase activity. Spot purchase is a substantial portion of the Charity's activity and the uncertainty associated with the current ad hoc arrangement presents a significant risk to the Charity, it inhibits forward planning and increase the hourly charge we need to set to protect our continuing viability. Tagsa Uibhist provides an important alternative choice for users of home care services and has the capacity and infrastructure to provide more care at significantly lower cost per hour.'[15]

The uncertainty of the changes identified above continued for a number of year until April 2021 as identified in the Financial Review section of the financial statements for the year ended 31 March 2021:

'The demand for our Home Care service, mainly commissioned by the local authority, rose from a total of 11,848 hours delivered in 2019/2020 to 15,724 this year 33%. The volume of our care at home work has increased steadily, which gives an indication of the trust with which Comhairle nan Eilean and, ultimately, our clients have for Tagsa Uibhist. The uncertainly stemming from lack of a contract with the Council has been resolved as a 3-year agreement, starting in April 2021, to deliver home care services has now been signed. This contract was achieved through competitive tendering through the Scotland Excel procurement framework. This agreement is based on Tagsa Uibhist delivering the historically high level of activity delivered in 2020/21.'[16]

Reflection on Tagsa Uibhist (Uist Support)

- Residential respite care was expensive to deliver due to the staffing requirements and the income generated was insufficient for the organisation to provide the service
- Regulatory challenges and requirements to maintain high staffing levels are difficult to sustain with a small number of beds
- Where residential respite beds can be provided elsewhere in care homes and hospitals if there is space available, this will take priority over the charity's provision of beds
- Uncertainty created by a lack of formal contractual agreements for the provision of services to the public sector can significantly undermine the ability of a charity to provide continuity of service
- Charges and contractual agreements must be sufficient to cover the running costs of the charity from the outset
- Continual redesign of the organisation is required to ensure that the charity evolves to reflect the changes required by the public sector both in terms of policy and budgetary requirements

[15] Tagsa Uibhist (Uist Support) Report of the Trustees and Financial Statements for the year ended 31 March 2017, page 5 Trustees Report

[16] Tagsa Uibhist (Uist Support) Report of the Trustees and Financial Statements for the year ended 31 March 2021, page 6 Trustees Report

Learning points for Urram:

- Care services are expensive to deliver in terms of regulatory and staffing requirements, therefore any decision to provide this service must be underpinned by an agreement securing public sector support to cover the core costs without the need for continually seeking donations and fundraising to support the service
- Ensure that demand for beds is going to be sufficient to use up capacity and not undermined by the availability of other beds that the public sector can access where the economies of scale result in lower costs
- Establish a financial agreement that provides medium to long term security for the service
- Ensure that the service is sufficiently flexible to evolve over a period of time and be open minded about the service being delivered to the community in a way that has not been in the past with respite services building up community resilience

10. CARE AT HOME

Section 8 highlighted the challenges of developing a viable financial model for a care facility, while Section 9 gave two practical examples of the difficulties faced by community organisations and how they have responded to them. The example of Tagsa Uibhist raises the question of whether a similar approach could be taken by Urram or whether Urram in partnership with NHS Highland could facilitate the creation of a new model of working that delivers improved level of care in the peninsulas. This section explores that with a focus on increased levels of care at home.

CURRENT PROVISION

NHS Highland currently delivers the provision of non-residential Adult Social Care across the 5 Community Council Areas in West Lochaber.

Key elements of that provision are:

- In total there are 21 service users across the 5 areas.
- There are no service users in West Ardnamurchan or Acharacle.
- The greatest number are in Ardgour (13)

NHS Highland has not been able to supply any data on unmet need, but it is notable that the majority of users are in the area closest to Fort William.

The contracted services received (per individual) are as follows:

- Direct Payment: 3
- Housing Support: 1
- Home-based Respite: 2
- Independent Sector Care at Home: 1

Contracted Services cost around £55,000 per annum. This equates to just over £9,000 per recipient.

In-House services received (per individual) are as follows:

- Care at Home: 14

There are around 5,200 hours of Care at Home delivered per annum at a ballpark[17] cost of around £250,000. This equates to approximately £18,000 per individual.

Analysis

The data provided by NHS Highland is very useful in outlining the scale of the needs being addressed and the different types of service provided to local residents. It is not sufficient to be able to develop alternative service and financial models but it can be usefully used to highlight areas for further consideration and exploration.

1. There are currently 21 service users in an area with a current population estimate over the age of 65 of 547. This equates to about 3.8% of the population over 65[18] and is a percentage similar to the 4.1% from the 2011 census who described their health as either “Bad” or “Very Bad”.

[17] The figures provided by NHS Highland are described as “ballpark” because it is difficult to separate out precise costs attributable to any individual service when overheads are shared between many areas of service delivery.

[18] The over 65s data in this section is a used as a proxy for those who may be in bad health and need of care due to the limited nature of the data available. It is fully recognised that younger age groups contain significant (but smaller) numbers of people with health and care needs.

2. One third of recipients are being helped through bespoke contracted services and two thirds through the Care at Home service.
3. It is notable that there are no service users in Ardnamurchan or Acharacle. Reasons for this could include: there is no current demand in these areas; there is a hidden unmet demand; there is a demand not currently being met; or people who are in need of care have moved away from the area, either to receive care at home elsewhere or to receive a care in a Care Home. The first of these reasons appears unlikely because there are an estimated 88 people over 65yrs old in Western Ardnamurchan and 145 in Acharacle. If 3.8% of these people were receiving care support at home, there could be an expected 5 or 6 service users.
4. In contrast 13 people in Ardgour are receiving care support at home. This equates to 13.3% of an estimated population of 98 over the age of 65. If the same level of care at home was provided across the peninsulas the total intervention required would be in the region of 73 packages. Reasons for the much higher level of intervention in Ardgour could include: the population are considerably more elderly and in need of care; it is easier to provide care packages in Ardgour because of the greater availability of workers from the Fort William area; people from elsewhere in the peninsulas are moving to Ardgour in order to receive such support; people with care needs in other areas are carrying on as best they can with normal life without support.
5. The cost of Contracted Services (£9000 per recipient) and NHS Care at Home Services (£18,000 per recipient) are considerably cheaper than the annualised cost of respite care in Dail Mhor (£70,000+ per bed). If NHS Highland were to close Dail Mhor there would be the potential to reallocate the highly skilled and highly valued staff resources to providing an enhanced level of Care at Home service (including at least some respite care services currently provided in Dail Mhor) for a lower overall cost.

Discussion

The above analysis highlights the uneven delivery of care services delivered to people in their homes across the area, whether by contracted or in-house services. The reasons for this are likely to be complex and may include unrecognised need, the inability to provide certain services in the remotest areas using current models, and people taking pre-emptive decisions to move closer to larger population centres in anticipation of increased future care needs.

There is the potential for Urram to work with NHS Highland to explore how to deliver redesigned services to the local population, particularly if Dail Mhor were to close at some point in the future. The potential for Urram to deliver health promoting activities has been discussed above, therefore the focus here is on providing care at home services. However, in reality there may be some potential to link these elements together to provide a more integrated service to maximise wellbeing whether living with or without homecare support.

Future homecare services could be delivered by NHS Highland, an external voluntary agency contracted to NHS Highland or by Urram itself. NHS Highland currently offers a contract rate of £26.75/hr in remote areas, compared to £21.67/hr in urban areas and £24.24/hr in rural areas. All PH43 4 postcodes are classed as remote. Despite the uplift for remote areas NHS Highland has found that the rate tends not to attract independent and private sector providers. The provision of 5200 hours of care for c. £250,000 by NHS Highland equates to an hourly rate of approximately £48. This scale of cost is likely to be due to a combination of factors including the additional costs of working in a remote area, higher overhead costs for an organisation with the structure of the NHS, and

generally better pay and conditions provided for staff than those in the private and voluntary sectors.

In the light of these figures Urram would need to be cautious about considering taking on a care at home service itself. Similarly, an external contractor such as Sunflower Home Care (with whom Urram has had initial contacts) may find that the available rate is insufficient to cover the costs in an area with a dispersed population.

However, any further discussion of delivery model at this stage would be to put the cart before the horse. A logical first stage is to identify where the current gaps are, what could be provided in the future and what form that service or services could take. Only then would it be necessary to consider what the best delivery model would be.

The issue of greatest relevance at this stage is that of Urram possessing a high degree of local knowledge. It can use this strength in collaboration with the NHS to identify what local needs really are and then to think about how these can be met in the context of the local setting. In considering local knowledge the current care team on the peninsula will also hold a great deal of knowledge and experience. Therefore, their input to the process would be invaluable. A further important element to take into account is that of the significant number of people using alternative options, courtesy of the possibilities opened up by SDS.

To summarise, the aim should be to identify ways of delivering an enhanced service to all those who need it across the area in ways that make use of community strengths and help to build community resilience. This could be ultimately delivered by whatever SDS options were the most appropriate and by the most appropriate structure to ensure success.

The next two sections of the report cover the practicalities of construction options for the different elements identified on the Dail Mhor site and governance issues for community delivered services. The reader who wishes to remain focussed on the consideration of healthcare provision may pass directly to Section 13 Conclusions & Recommendations.

11. Construction Delivery Mechanisms

The nature of the site, the diverse range of uses that can be delivered on (or from) it, the community's previous experience of delivering infrastructure for management or lease, and the different project partners involved mean that there are a range of mechanisms available for delivering the different infrastructure required.

The land is currently owned by Highland Council. Therefore, if any element is to be delivered by another party a transfer of land will need to take place.

HOUSING

There are 3 general options available for housing delivery:

1. Highland Council. The housing element is already in the SHIP and the council could have started building in the 2022-23 financial year if the project had been at a more advanced stage. However, the project will remain in the SHIP and delivery could start in the next financial year.
2. Community-led. Urram (or another community body) could seek to deliver a community-led project, with assistance from the Rural Housing Fund which can support the design and construction of community-owned properties with grants and loans. The advantages of this approach are that the community would control the project and would own built assets on completion of construction. The disadvantages are that delivery would likely take longer than with the council (due to the time required to apply for grants, transfer the land and raise a full funding package) and that the community would be responsible for long term property maintenance.
3. Housing Association/Communities Housing Trust. These voluntary sector bodies have significant experience in delivering a range of housing projects. The Communities Housing Trust has been able to deliver a range of innovative models of delivery and ownership in rural areas which have helped communities greatly.

In the Dail Mhor site context, there are other building elements (see below) and service delivery projects (as discussed above) to be delivered by the community. It would therefore be sensible for the community to focus on these when there are others capable of delivering this element of the project. Given that Highland Council own the site and are keen to see the housing units delivered it would be logical for the council to deliver the housing element. This ought to enable the speediest delivery of the housing provision and provide much-needed accommodation in the local area.

GATHERING SPACE/HALL

The original hall was built by Highland Council as part of the overall school/care home/hall/surgery development. As a general rule local authorities no longer provide buildings for communities although they may give discretionary grant support to help with their construction. In many cases the ownership of existing halls has been transferred to local groups that operate them, in order to allow them to apply for funding to renovate or replace them. This type of approach would be logical on the Dail Mhor site, although it would involve the transfer of the appropriate piece of land for a new hall rather than the site of the existing one.

The community will need to develop the plans for the hall and raise funding for it, either to be constructed as a standalone building or as part of the wider care hub project (see below). The estimated build cost of approximately £1m is challenging but not unachievable. Funders will look to

see that the proposed uses will serve the community well and be sustainable. A strong emphasis on activities promoting physical and mental health will be potentially attractive to funders.

SURGERY

It was noted in earlier sections that the surgery building is no longer fit for use, the building is at the end of its useful life and that more space is required if additional services are to be provided from it. It was also noted that the district nursing team require new premises and that the ambulance service would benefit from a small space for its staff to be able to use for administrative, meeting and rest purposes.

The responsibility for providing suitable accommodation for NHS Highland staff ultimately lies with NHS Highland. It could seek to deliver new accommodation in Strontian via:

1. Direct Build. NHSH would arrange for the design, construction, and management of new buildings itself. This process can take considerable time and is dependent upon capital availability.
2. Public Private Partnership. This model was developed to allow the public sector to access infrastructure in situations where it did not have the capital available to build it. Typically, the public body would specify the infrastructure it required and contract the private sector to build, then manage it for a predetermined period e.g 30 years before it would be handed over to the public sector. In return, the public sector body would make an agreed annual payment for use of the infrastructure. This model has been criticised for being a very expensive way of providing public infrastructure. It has also proved difficult to make the model work in rural situations. The Scottish Government has developed a non-profit distributing version of this model, but it states that the model "should only be pursued where it is likely to deliver better value for money than conventional procurement."[19]
3. Leasing from the Community. The Fort Augustus and Glen Moriston Community Company (FAGCC) pioneered this model with NHS Highland to deliver a new medical centre in Fort Augustus. The community constructed the building and leases it to NHSH. The agreement between the two bodies allows the community to bring in additional services e.g., opticians. The key advantage of this model is that it *may* result in a quicker delivery of a new facility than what could be provided under normal procurement processes. Other benefits include the role of the community in designing the building, the creation of a community-owned asset, and also in agreeing what services should be delivered from it. The disadvantages are the extra burden of responsibility on the community to deliver and maintain the building.

CARE FACILITY

The project brief was clear that NHS Highland would not build and run a new facility, and that if the community wished a new care facility it would need to build the facility itself. Therefore, the responsibility for the construction will lie with the community if it wishes to proceed with the project.

[19] Non-profit distributing public private partnerships - Scottish Public Finance Manual - gov.scot (www.gov.scot)

At an estimated cost of £1.25m - £2.6m the community would need to raise the funding through models such as public appeals, crowdfunding, commercial borrowing and community shares. For borrowing and share issues the community would need a comprehensive business plan that showed how revenue would be generated to repay the borrowing. In order to have a viable business plan and secure the borrowing it would need to have an agreement for a significant length of time with NHSH to pay a certain rate for a certain level of occupancy. Without such an agreement it is likely that funding will not be forthcoming.

12. GOVERNANCE

Presently, the redevelopment of Dail Mhòr is being explored by Urram, a Scottish Charitable Incorporated Organisation (SC050174). From a governance perspective, this is a suitable organisation to take forward the redevelopment of Dail Mhòr as the charitable regulations required to operate a charity place certain responsibilities upon the trustees that require good governance to be put in place.

The local community in Strontian have a strong track record of developing assets in order to safeguard services in the local area such as the primary school and the community facilities at the Sunart Centre and many of Urram's trustees have been involved with such projects in the past. This past experience results in Urram having a good mix of trustees who bring with them strong experience of being able to deliver capital projects and thereby safeguard services in the local area.

As a registered charity, Urram can potentially access and therefore contribute funding that will not necessarily be available to public sector organisations which can be a further benefit of Urram taking forward or contributing to the capital project development.

OPERATIONAL MANAGEMENT

There are, nevertheless, important management and governance issues that require consideration at an early stage so as to consider the future delivery of health care services from the Dail Mhòr site so that the operational management, and in particular the financial sustainability of the service is thought through and known in advance of commencing any capital project delivery.

Learning from the experience of the Howard Doris Centre, it would be important that in addition to having a Board of Trustees that the organisation would also have a management group. This would include other stakeholders in addition to the SCIO's Trustees including senior representation as a very minimum from NHS Highland and Highland Council, but also others who may have some involvement in the services being delivered from the Centre such as the Ambulance Service and local surgeries for example. This would be extremely important in the context of the new National Care Service that's currently being consulted on so that the organisation can ensure that it is best placed to ensure that the regulatory requirements are met and that future services are delivered in a manner that is fit for purpose.

In terms of the governance arrangements that will be put in place to oversee the management of Dail Mhòr, one of the key arguments in favour of community ownership is that it empowers communities to develop initiatives from the bottom-up, rather than having them imposed from the top-down by external agencies, however, the delivery of health care is complex, particularly in terms of ensuring regulatory compliance where more than one service is delivered from the one site. It is therefore essential that a careful balance is achieved in terms of community representation as well as professional guidance in relation to the regulatory environment to ensure that the governance arrangements for the management of Dail Mhòr include representation from the resident population of Strontian and the wider community on the peninsula as well as involving health care stakeholders as well. The exact arrangements for such structures remain to be decided but could, for example, involve the creation of an operational management group including a number of Urram's trustees, and key external stakeholders. This collaborative approach will be critical to ensuring that Urram can be properly supported in the delivery of future health care.

DELIVERY MODEL

In addition to creating a management group for the future operation of Dail Mhòr, Urram will need to consider the operating model as well.

Leasing

In the past, in the Strontian area there have been a number of assets developed and delivered by the community but then leased to the public sector to deliver the services, particularly in relation to the primary school and Sunart Centre and these have been hugely successful projects. This asset ownership and subsequent leasing option is attractive in terms of working in collaboration with the public sector to be able to access multiple funding sources for the delivery of capital assets which may not be accessible where only the community or the public sector are involved. The leasing option also reduces the operating risks to the community and the asset is effectively passed back to the public sector to operate, and as long as the rental charge is sufficient to cover at least the running costs of the building's care and maintenance, then the community do not bear any significant risk.

Whilst development of the building and leasing is an attractive option to the community, the significant operating costs of running care services from a small unit such as Dail Mhòr is clearly not a situation that NHS Highland is willing to continue to support, therefore not likely to be a viable option in the Dail Mhòr situation.

Direct Delivery

It seems likely that Urram would be required to not only be the asset owning body but would also need to operate and manage health care service deliver. Urram would have to directly employ staff and would be responsible for the management and operation of the Dail Mhòr, albeit with the employed manager taking on a significant amount of the day-to-day responsibility.

This bring significantly higher levels of risk to Urram in terms of being responsible for service delivery and exposure to the financial risks of operating the service. This can be mitigated through having a secure and significant service level agreement with NHS Highland for a reasonable length of time (e.g., 10 years) that is sufficient to cover realistic costs for the operation of Dail Mhòr.

The direct financial costs of this model will be high, however there could be many indirect cost savings through reducing the requirement for so much medical hospitalisation where there is not a medical requirement to do so and maintaining a healthier population at home and in their local communities for much longer resulting in cost savings to other parts of NHS Highland. In addition, the challenge of staff retention and recruitment would partly be improved if some security can be provided to staff that their jobs are guaranteed for at least the contractual period agreed. The Tagsa Uibhist model illustrates the importance of understanding the cost of delivery and working with the local authority to deliver a successful service delivery which is financially sustainable.

The key to the direct delivery model will be to have integrated operational management which ensures that NHS Highland and Highland Council and other stakeholders are involved in the operational management so that Dail Mhòr is delivered as a partnership arrangement to bring together the public sector and community in its delivery and operation to develop a new way of operating to secure a viable rural health care model.

13. CONCLUSIONS & RECOMMENDATIONS

This study has explored the challenges and opportunities offered by the Dail Mhor site as Urram seeks to find a way ahead for long term adult social care in the peninsulas. The following conclusions and recommendations are intended to help Urram and the local community more clearly define the most practicable options for developing appropriate adult social care in the current and likely context of available resources, legislation, NHS Highland strategy and community capabilities.

1. Dail Mhor Care Home. It is technically feasible to develop a modern home on the site, but it is impractical from a financial point of view. Policy is moving away from care home provision to enhanced homecare provision with shorter periods of nursing care in a nursing home or a hospital at end of life. The rates being paid by NHS Highland for care home provision are insufficient to create a financial model for a small care home with a maximum of 10 beds. We cannot therefore recommend that Urram attempts to build and operate a small new care home facility at this time.

2. Enhanced Care Provision. The recommendation not to proceed with a new care home does not mean that the local population should simply accept poorer levels of health provision. Enhanced levels of care can be provided through:
   - 2.1. Exploring and developing new home care opportunities. These arise from the move to Self-Directed Support and the willingness of NHS Highland to work with Urram to develop locally led solutions to local needs. There could be three elements to this:
     - 2.1.1. Using local knowledge, including existing staff knowledge to redesign the delivery of services to match needs and provide enhanced service delivery.
     - 2.1.2. Using local knowledge, community networks and community solidarity to enhance the recruitment, training, and retention of care workers (including those wishing to work only limited hours or support a specific client) to provide improved coverage and bespoke packages of service.
     - 2.1.3. The staff at Dail Mhor have an excellent reputation for the work that they do and redeployment of these staff to assist in providing enhanced care at home could be part of the solution. Some people who would formerly have received respite care in Dail Mhor could receive that care in their own homes if the necessary support is provided.
   - 2.2. Enhanced Medical Facilities in Strontian. The existing facilities are clearly not fit for purpose. Urram should work with the NHS to design a new facility that fully meets community needs. This ought to include provision for co-location of the district nursing team, facilities for the provision of additional services such as physiotherapy and podiatry. Provision could also include space for Scottish Ambulance Service personnel.
   - 2.3. Preventive health activities. Preventing people from becoming in need of care and maximising their years of healthy living is an area in which community groups such as Urram can play a significant role. Urram should explore with NHS Highland what physical and mental health promotion activities and services it could provide that meet local needs as part of the overall redesign of services.

3. Enhanced Carer Provision. Urram should work with NHS Highland to enhance support for unpaid local carers, in order to improve their quality of life and to enable them to continue caring for their loved ones. This could be a combination of provision of respite care at home services and funding of personal needs and services.

4. Community Hall. Consideration of the requirements of a new hall should be developed in the light of community health activities identified and planned to be delivered under 2.3.

5. Dail Mhor Housing. The site study has shown that 6 units of housing can be developed at the north end of the site regardless of whatever other building solutions are ultimately delivered elsewhere on the site. An allocation has already been made in the Strategic Housing Investment Plan for housing on this site. Therefore, detailed design should start at the earliest opportunity in order to enable the start of build in 2023-4.

6. Other Housing Opportunities. There are two elements to this. First, the provision of better-quality housing will enable more people to live healthier for longer and potentially require less care through living in better designed homes. Secondly, the crisis in health care recruitment is driven in part by the severe lack of affordable housing opportunities in the area. A reduced number of young families means fewer people in the workforce today and in the future. Therefore, everything possible should be done to address the housing shortage. Key actions could include:
    6.1. Carrying out a full housing needs analysis of each local community.
    6.2. Considering additional housing provision on the Dail Mhor site if there is no redevelopment of the residential care facility.
    6.3. Redeveloping the site of the current district nurse facility for affordable housing once it is relocated to the redeveloped surgery on the Dail Mhor site.
    6.4. Identifying, purchasing and developing new sites in all communities as a priority to meet current and future local housing needs.

7. Community provision of healthcare facilities. Urram and/or another community group should investigate with the NHS the viability of the community constructing and leasing a healthcare facility if it would provide an enhanced facility where the NHS was unable to do so within a reasonable timeframe. The community should only do this if it has sufficient capacity to deliver such a project, the financial agreement allows for a reasonable return to the community and the facility provides improved healthcare outcomes.

The key driver for the commissioning of this report was the fear of the community that it would lose the ability for its most vulnerable residents to receive care locally when they needed it. If the emphasis is moved from providing that care in a care home to providing enhanced services at home, the loss of the care home need not necessarily lead to poorer service provision. People will still be able to be cared for in their local community. Indeed, for many an enhanced home service would be considered an improvement (until such time as full-time nursing care was required) because they would much rather continue to live in their own homes than in a care facility. Therefore, the potential remains to provide a highly valued and appreciated level of care, albeit in a different setting.

The wider goal of a health and community hub is achievable, but its precise final form will require significant further work. NHS Highland has indicated a strong willingness to work with Urram to deliver redesigned local services. Therefore, there is a clear opportunity for the community to shape the future of local healthcare and local health and wellbeing services.