Monklands District General Hospital Replacement/ Refurbishment

Initial Agreement

September 2017

Table of Contents:

1 Overview

The main purpose of this Initial agreement (IA) is to confirm the need for investment in the proposal for the Monklands Replacement/ Refurbishment (MRR) to meet the requirements of the Healthcare Strategy "Achieving Excellence" and service re-configuration modelling in NHS Lanarkshire and to demonstrate that this is a good thing to do. It will do this by responding, as appropriate, to the following questions:

	Initial Agreement (IA)	
	Question	**Response**
Executive Summary	What is the proposal about?	Prepare Executive Summary of responses to the following questions.
Strategic Case	What is the strategic background to the proposal?	Outline: • Who is affected • Links to NHSScotland's strategic priorities • Links to other policies and strategies • Influence of external factors
	Why is this proposal a good thing to do?	Outline: • Current arrangements • Need for change • Investment objectives • Design quality objectives • Benefits realisation plan • Risk management strategy
Economic Case	What is the preferred strategic / service solution?	Confirm: • The Do Nothing option • Any major service change proposals • List of proposed solutions • Indicative costs • Preferred strategic / service solution
Commercial, Financial & Management Cases	Is the organisation ready to proceed with the proposal?	Confirm: • Procurement strategy & timetable • Affordability & financial consequences • Governance & project management arrangements
Conclusion	Is this proposal still important?	Confirm: • Strategic Assessment template

2 What is the proposal about?

	Question	Response
Executive Summary	What is the proposal about?	Prepare Executive Summary of responses to the main IA questions.

This Initial Agreement describes the proposals for a major investment in Lanarkshire's hospital estate, through either rebuilding or extensively refurbishing the hospital accommodation at Monklands District General Hospital (MDGH). The new hospital facility would provide between 400 and 500 beds and would be located either on the current hospital campus or nearby.

The benefits to be achieved through this investment centre on meeting the objectives set out in our healthcare strategy "Achieving Excellence" which was subject to public consultation between August and November 2016 and signed off by the Cabinet Secretary in April 2017. Achieving Excellence describes the changes to health and social care needed to meet the future needs of the population, and is the means by which Lanarkshire will implement the National Delivery Plan for Health and Social Care; National Clinical Strategy; and the 2020 Workforce Vision. The ambitions in Achieving Excellence are fully integrated with the strategic commissioning plans being prepared by North Lanarkshire Integration Joint Board and South Lanarkshire Joint Integration Board.

The current hospital accommodation is a product of 1960s design and 1970s construction techniques. The lack of provision of sufficient space, and of sufficient quality, to develop and expand clinical services prevents NHS Lanarkshire from meeting its strategic objectives.

The Initial Agreement describes the ambition to shift care away from inpatient treatment to day case, day treatment, outpatient and community care. The current accommodation is a barrier to this due to chronic lack of space, ongoing risks to business continuity and limitations on what can be achieved within the current footprint. The strategy also describes pan-Lanarkshire development of further centres of excellence for trauma, orthopaedics, cancer, general surgery and for training and research: again the limitations of infrastructure at Monklands prevent these.

The hospital has been the subject of significant investment of £35m over 7 years in an attempt to maintain the highest quality of the environment and to mitigate risk to business

continuity. However, there remain significant risks to the quality and effectiveness of services being provided in the current accommodation which cannot be mitigated entirely. The use of multi-bed rooms, lack of adequate toilet and shower facilities, the deterioration of the above-and below-ground drainage systems and the limitations on in-patient fire evacuation are all current risks which this project would seek to eliminate. The physical design key attributes (services based within space and configuration constrained twin towers) present a fundamental compromise to clinical functional suitability and patient safety, which is exacerbated by ageing fabric all of which hinder and present significant compromises to the need to embrace advancements in clinical practice. The entire building's construction methods included the extensive use of asbestos containing materials (as was normal at that time), and consequently every element of building maintenance and adaptations takes significantly longer to complete and demand disproportionate levels of service disruption. This adds time, cost and risk to every repair, reconfiguration and refurbishment project, adding disproportionate expense due to the extensive control measures which need to be applied to ensure that no contamination takes place.

The future service models for NHS Lanarkshire services (including the key planning assumptions) were endorsed by the public consultation process for "Achieving Excellence". The key assumptions on which this proposal is made (including the retention of three DGHs in Lanarkshire) were accepted by the Cabinet Secretary for Health and Sport in April 2017.

The measurable investment objectives which are set out in the initial agreement reflect the collaboration with key stakeholders and the engagement with design professionals. These focus on:

- Improving person-centred services
- Improving the safety of patient care
- Improving clinical effectiveness and enhancing patient experience and clinical outcomes
- Improving the quality of the physical environment
- Providing flexible and adaptable facilities across the healthcare system.

NHS Lanarkshire and partner agencies will continue to develop the detailed clinical and service models which will significantly influence the design of the new facility through 2018. This process will allow a clear assessment of the size of the specialties and support services which will be provided from each of the three DGHs and in the community at about 2025. The conclusions from this will allow the completion of a detailed accommodation

specification. However, there is sufficient information in the capacity/bed model at present for Lanarkshire to progress towards delivery options appraisal.

The National Design Assessment Process (NDAP) has allowed the preparation of a Design Statement which is included as Appendix 3 to this Initial Agreement.

The Initial Agreement sets out a shortlist of 4 delivery options to be considered at outline business case stage. These have been derived from a long-list of 7 options which were evaluated on their ability to be delivered and their match to our business objectives.

A - Do Minimum (which cannot deliver the service model, and is for comparison only)

B - Full refurbishment of current hospital (with two variants)

C - New-build on current hospital site (with two variants)

D - New-build on another site.

The four delivery options were included as specific areas for feedback as part of the formal consultation on Achieving Excellence, though no clear preferred option emerged from that process. Each of the four options are described in terms of their pros and cons which included programme duration and potential costs. Whilst no preferred option has been identified from the four, there are significant differences in cost and programme between the two new-build options (C&D) relative to the refurbishment option (B). A further options appraisal process will take place in 2018 to determine which of the shortlisted options should be taken through to the outline business case.

The dependencies and risks associated with this project have been identified in the Initial Agreement, and these will be carried into the outline business case, alongside mitigation strategies for the project risks.

Based on advice from Scottish Government, the procurement strategy will be based on a traditionally funded capital allocation. The form of contract will be further considered in the outline business case.

3 What is the strategic background to the proposal?

	Question	Response
Strategic Context	What is the strategic background to the proposal?	Outline: • Who is affected • Links to NHSScotland's strategic priorities • Links to other policies and strategies • Influence of external factors

The main purpose of this section is to set out the strategic background to the proposal by identifying those strategic, policy, and external drivers that have led to a need for change. It will also demonstrate stakeholder support for the proposal. It will do this by responding in detail to the following questions:

- Who is affected by this proposal?
- How does the proposal respond to NHSScotland's strategic investment priorities?
- What strategies does this proposal directly respond to, and how?
- What external factors are influencing this proposal?

These questions are further described in the following sections:

3.1 Who is affected by this proposal?

In detailing the requirement for the new facilities, consideration has been given as to who is affected by the proposal and work undertaken to engage their views at an early stage. Consideration as to how NHS Lanarkshire's objectives align with and help to deliver the local and national strategic NHS priorities, has also been taken along with the key external factors which influence or are influenced by the proposal.

Table 01: Stakeholder Engagement

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Organisation:	*NHS Lanarkshire are fully supportive of this proposal, with Colin Sloey, Deputy Chief Executive taking the lead role in its development.* *The proposals for Monklands DGH within this IA form an integral part of the wider NHS Lanarkshire draft healthcare strategy "Achieving Excellence" which was developed by the NHS Board and Lanarkshire HSCPs during 2015/16 and was published in August 2016 and consulted on, in accordance with CEL4 (2010), through August to November 2016.* *The proposals described in Achieving Excellence were accepted by the Cabinet Secretary for Health and Sport on 28th April 2017.* *The specific benefits which would be gained from this proposal and the evolving options have been considered on a number of occasions in 2015-17 by the NHS Board's Planning, Performance & Resources committee.* *This proposal is also incorporated into the Board's Local Delivery Plan (LDP), and Property and Asset Management Strategy (PAMS), both of which have received NHS Lanarkshire Board approval*	*This Initial Agreement was approved by the NHS Lanarkshire Board on 27th September 2017.*

	The West Regional Planning Group (RPG) reviewed the draft IA at their meeting of 25th August. It was agreed that the draft is consistent with the ambitions of the West Region Delivery Plan whilst acknowledging: ▪ *The regional planning and delivery work looking at a strategic appraisal and new clinical models for the West* ▪ *The outcome of this work will inform the next steps of the developing Monklands case*	*The RPG agreed that the draft IA should be submitted as per letter in Appendix 5 on 25th August 2017.*
Service or Department	*This project has engaged the input of the appropriate service leads in the Lanarkshire Acute Division, and the North and South Lanarkshire HSCPs, who are integral members of the MRR Project Board described in 6.3*	*This Initial Agreement was approved by the MRR Project Board on 15th September 2017.*

Staff / Resources	*Staff representatives and representative bodies (including the Area Partnerships Forum and Area Clinical Forum) have been involved in the development of this proposal through the "Achieving Excellence" planning cycle and subsequent consultation.* *Individual members of staff and staff representatives within HSCP localities and acute services have been engaged in consultation meetings and workshops during the Achieving Excellence consultation, specifically including the emerging options for the MRR Project.* *These proposals will have a significant impact on a wider range of resource areas including: community and primary care clinical services, estates, hotel services, transport, eHealth, human resources and finance. These functions have been included in both the wider healthcare strategy, and the specific proposals developed for Monklands DGH.* *The full extent of the consultation and engagement is described in Appendix 1.*	*Staff and other stakeholders were consulted in the options described in this IA through a formal 3 month process between 2nd August 2016 and 1st November 2016.* *A MRR Core Team was established at Monklands site:* *Andrea Fyfe Site Director* *Dr Rory MacKenzie Chief of Medical Services* *Ruth Thompson Chief of Nursing Services* *Dr Jim Ruddy Clinical Lead* *A Clinical Advisory Group and supporting structure has been set up with representation from all clinical stakeholders. The detail of this is included in section 5.2 and Appendix 4.*

Scottish Health Council (SHC)	*Scottish Health Council have been involved in ongoing discussions through 2016 on the impact of any proposed service change on patient care.* *The SHC provided guidance on the Achieving Excellence consultation process, including the questions asked during consultation on the MRR Project.*	*Scottish Health Council has confirmed as part of the quality assurance report on the Achieving Excellence consultation that they are content with the kind and level of engagement carried out to date, and that it is in line with guidance.*
Patients / service users	*Patients and service users affected by this proposal include future users of hospital services. Their involvement in its development includes stakeholder workshops during the period May 2016-June 2017.* *The impact that this has had on the proposals development includes the development of the options and benefits criteria, and as partners in the NDAP process.*	*The stakeholder workshops held between May and November 2016 agreed the objectives and benefits to be obtained by the Project, the design statement and the shortlisted options contained in the IA which were the subject of the formal consultation process under Achieving Excellence.* *Over 500 responses were received to the consultation questions, and a summary of these responses is shown in Appendix 1. There was no clear consensus on the preferred option from that exercise, and so further engagement with patients and service users will take place during a formal option appraisal process in 2017.*
General public	*The proposals in this IA will have a significant impact on the quality of clinical care being provided in Lanarkshire. This is one component of the implementation of the plans for service improvement described in Achieving Excellence.*	*Outcomes from the public consultation events have influenced this proposal. This is demonstrated in the proposal by their response to the MRR element of the formal consultation process. The level of support from the general public for this proposal is high,*

	This has thus required a range of public consultation event, of which these proposals formed part.	*with a clear consensus that the status-quo is not a beneficial outcome, for more see Appendix 1*
Other key stakeholders	*Other key stakeholders identified for this proposal includes: North and South Lanarkshire Councils, MPs, MSPs and elected representatives, Scottish Ambulance Service, West of Scotland NHS Boards (through RPG). Their involvement in the development of this proposal includes specific briefing/workshop sessions, inclusion in the formal consultation process, and inclusion in standing planning agendas.*	*All key stakeholders have been engaged through the formal consultation process and/or the stakeholder workshop development process. As described above, there is very little support for the status quo, and high levels of support for the benefits which form the objectives of this project.*

3.2 How does the proposal respond to NHSScotland's strategic priorities?

NHSScotland's Strategic Investment Priorities are:

- Person centred.
- Safe.
- Effective quality of care.
- Health of population.
- Value and sustainability.

These are derived from the Delivery Plan for Health and Social Care. This proposal responds to these strategic priorities in the following way:

Table 02: How Proposal Responds to Strategic Investment Priorities

NHSScotland Strategic Investment Priority:	How the proposal responds to this priority	As measured by:
Person Centred	*It supports people in looking after and improving their own health and wellbeing as part of the integrated Healthcare Strategy "Achieving Excellence"*	National Health and Wellbeing Outcome Indicators
	It will increase the proportion of people with intensive needs being cared for at home by enabling the shift in the balance of care, and proportion of investment, towards integrated community support systems.	National Health and Wellbeing Outcome Indicators
	It improves the physical condition of the healthcare estate by replacement of a large proportion of the NHSL estate at Monklands which is below required standards. *The clinical environment will allow greater privacy and more user-friendly spaces for patients, carers and visitors.*	NHS Lanarkshire PAMS KPIs Patient Opinion Responses

Safe Care and Environment	*Risks to patients, visitors and staff - which are inherent within buildings of this age - including fire protection/evacuation, asbestos and control of infection - will be reduced or eliminated completely.* *Ongoing impact to business continuity brought about by infrastructure failure (including drainage, windows, temperature control) will be reduced or eliminated completely. Supports the delivery of "Centres of Excellence" ethos set out in NCS which is underpinned by substantial evidence that this model provides improved clinical outcomes for patients.*	NHS Lanarkshire PAMS KPIs
Effective Quality of Care	*It will ensure timely discharge from hospital by enabling a reduction in lengths of stay, improving access to services, and enabling modern communications systems.*	National Health and Wellbeing Outcome Indicators
Health of Population	*The service changes which will be enabled by this project will improve clinical outcomes within acute services and support community and primary care services in promoting preventative models of care and self-care.*	NHSL LDP HSCP Commissioning Outcomes. 'Evidence' set out in the NHS Scotland Companion Document to the NCS "Creating a World Class NHS"
Value & Sustainability	*It will significantly reduce backlog maintenance currently running at an average £5m per annum for Monklands.(which will never be*	NHSL PAMS and LDP KPIs

	able to provide a clinical environment sufficient to meet the strategic objectives of NHS Lanarkshire). *The operational costs will be better managed through improved energy efficiency and reduced maintenance liabilities. This will significantly improve the environmental sustainability of the hospital estate in Lanarkshire.*	

3.3 What strategies does this proposal directly respond to, and how?

In April 2017 the Cabinet Secretary for Health and Sport endorsed the NHS Lanarkshire Healthcare Strategy 'Achieving Excellence':

> I note that "Achieving Excellence" has been developed using detailed analysis of the current and expected needs of the local population and……. I am pleased to note that your local plans have been fully informed by national policies and guidelines, including the national Clinical Strategy and the Delivery Plan for Health and Social Care.

Letter from Cabinet Secretary for Health and Sport to Chair, NHS Lanarkshire 28th April 2017

The full text of "Achieving Excellence", the letter from the Cabinet secretary and the Joint strategic Commissioning plans are available at:

http://www.nhslanarkshire.org.uk/involved/consultation/healthcare-strategy/Pages/default.aspx

http://www.sharedservices.scot.nhs.uk/media/1421/hsc-delivery-plan-2016.pdf

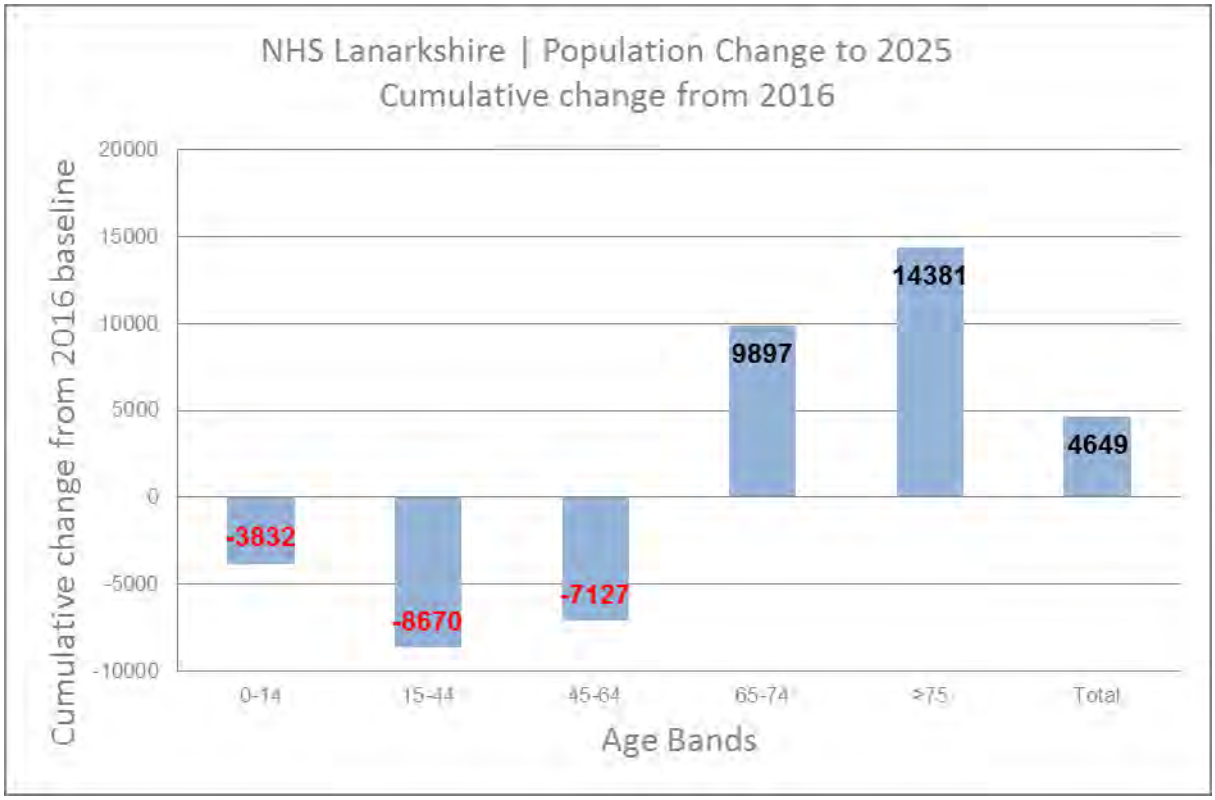
3.3.1 Achieving the Strategic Ambitions of the Health and Social Care Delivery Plan

In accord with the Health and Social Care Delivery Plan for Scotland, and the Lanarkshire Healthcare Strategy "Achieving Excellence", both North and South Lanarkshire Health and Social Care Partnerships (HSCPs) have a clearly articulated intention to shift care away from inpatient treatment to day case, day treatment, outpatient and community care. This ambition is principally described in the respective Strategic Commissioning Plans and thereafter in the detailed action plans which seek to reduce the length of time people spend in hospital through a range of actions. These actions aim to deliver a reduced requirement of 50,000 unscheduled care bed days per annum across NHS Lanarkshire by 31 March 2019. This would see a reduction of demand for hospital services of over 6% relative to a 2015/16 baseline. Work is continuing across the HSCPs and the acute sector to continue this reduction in demand to achieve a 20-25% target by the mid-2020s, as set out in "Achieving Excellence". However, the population needs assessment for the people of Lanarkshire anticipates a corresponding increase in demand for service relative to 2015/16 of a similar order of magnitude. Therefore, the action plans of the HSCPs and reduction in demand will be offset by the increasing needs of the population across that time period.

- In 2016 Lanarkshire residents used the equivalent of 1,750 acute hospital beds; mostly in Lanarkshire, but also in the Glasgow and Lothian acute hospitals
- If we do not change our models of care, the population needs assessment shows that this will rise to over 2,200 by 2025: nearly a 30% increase which would require over 500 more hospital beds, the equivalent to another District General Hospital
- To stand still, admissions and/or hospital lengths of stay must reduce by 25% in the next 10 years.
- The service redesign work both in hospitals and in the community over the last 10 years has already delivered a 29% reduction in lengths of stay in hospital.

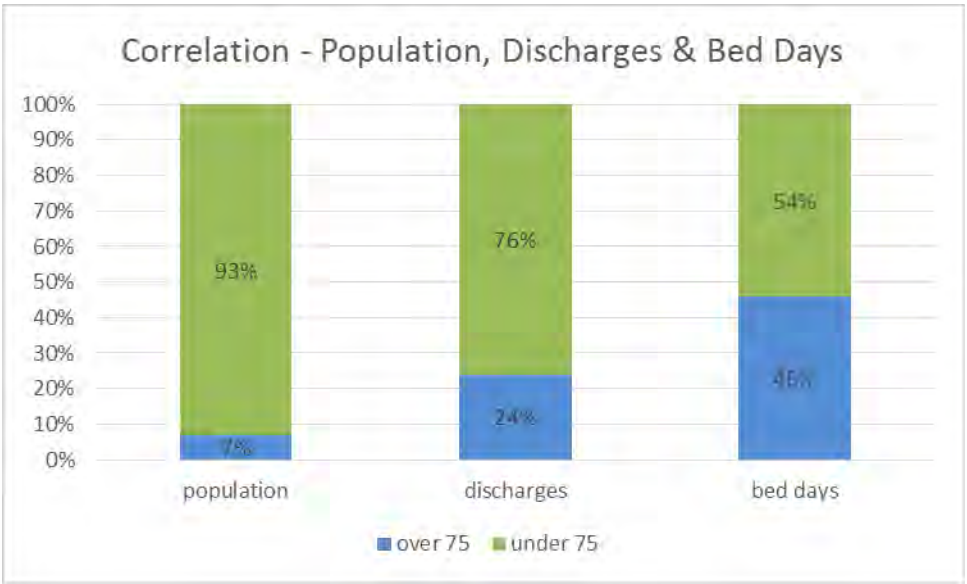
Achieving Excellence, page 50

Figure 01: Population Change to 2025



Between the censuses in 2001 and 2011 the size of the very elderly population in Lanarkshire increased by nearly 22%, the fastest growth in any NHS Board area. Whilst people aged over 75 make up only 7% of the population of Lanarkshire, 24% of people discharged from our acute hospitals are in that age group. And, when combined with longer average lengths of stay (due to frailty), people aged over 75 use nearly 50% of hospital bed days. That is why the increase in the number of older people, as described in graph below, will have a major impact on the future scope of our hospital services.

Figure 02: Population, Discharges and Bed Days



Both Partnerships have also been heavily involved in the development of "Achieving Excellence", which fully aligns with the vision set out within the respective Commissioning Plans of the Partnerships.

The implementation infrastructure for "Achieving Excellence" has been jointly agreed across the whole system, including key personnel from the Health and Social Care Partnerships either leading or contributing to each group. The Chief Officers of the H&SCPs together with the two Medical Directors also chair a number of the implementation groups of Achieving Excellence – namely the groups taking forward action plans for Community Capacity Building (Chief Officers), Frailty (Medical Director South) and Mental Health (Medical Director North).

Significant developments have also taken place around joint planning, including the commencement of the Delayed Discharge/Unscheduled Care Board, which is co-chaired by the two Chief Officers and the Director of Acute services, and the development of a whole-system planning group for Lanarkshire.

Through the joint planning processes, synergies have been realised between "Achieving Excellence" and the respective Strategic Commissioning Plans in North and South, which aim to deliver the 9 national health and wellbeing outcomes – as outlined below.

Table 03: National Health and Wellbeing Outcomes

1.	People are able to look after and improve their own health and wellbeing and live in good health for longer
2.	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonable practicable, independently and at home or in a homely setting in their community
3.	People who use health and social care services have positive experiences of those services, and have their dignity respected
4.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
7.	People who use health and social care services are safe from harm.
8.	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9.	Resources are used effectively and efficiently in the provision of health and social care services.

3.3.2 South Lanarkshire Health and Social Care Partnership

3.3.2.1 South Lanarkshire Health and Social Care Partnership Vision

The South Lanarkshire Integration Joint Board has agreed a vision which commits the Partnership to "working together to improve health and wellbeing in the community – with the community".

This Partnership vision underpins the challenge set out nationally by the Scottish Government to local Partnerships that they work to demonstrate how strategic commissioning will deliver the integration principles which are intended to re-shape how services should be provided in the future.

3.3.2.2 Progress to Date

In the last two years, there has been investment in community services to support significant change to service delivery such that the H&SCP is able to provide extended services in the community. This has reduced reliance on hospitals such that there has been a subsequent reduction of numbers of beds as well as better utilisation of those which remain in the system. For example, across Lockhart Hospital in Lanark; Ward 18 Hairmyres; and Avon Ward Udston there are approximately 90 fewer beds in use. Additionally, plans are in place to improve safe and effective community-based treatment and care options which will further lessen dependence on acute in-patient care.

Add to this, average length of stay in care of the elderly beds has reduced by circa 20% in the last 2 years.

To allow such bed reductions and associated increased care in the community, the Partnership has invested in Integrated Community Support Teams which see a combination of nurses, OTs. Physios and home care staff provide a 24/7 service to assist in sustain people in their own homes.

This is now augmented by Hospital at Home Services which also seek to provide an alternative to hospital admission by undertaking a range of diagnostic tests, traditionally undertaken in a hospital setting, whilst the patient remains in their own home. Thereafter, if at all possible the treatment plan is based around the patient staying in their own home and being supported through their respective care journey.

The Partnerships have also undertaken a leading role in the introduction of tele-health approaches to the management of a range of long term conditions in a concerted plan to increase the numbers of patients able to manage their own care and thereby reduce reliance on traditional face to face consultation, such as the use of OPD appointments.

The recently completed redesign of Urgent Care Out of Hours services in primary care has seen a reduced reliance on A&E services as well as increased numbers of practitioners able to provide direct patient support in a community setting. Specifically, by introducing nurse practitioners to manage paediatrics, this has reduced the number of children presenting to A&E in Wishaw hospital prior to paediatric inpatient admission. Moreover, for those children who do need admitted, they are now able to go directly to the ward and have had preparatory procedures undertaken in the out of hours area.

There have been similar advances in managing mental health patients out of hours where the introduction of nurse practitioners has improved service provision for patients and directly reduced the requirement for patients to attend A&E by over 1,000 per annum.

3.3.2.3 Future Plans

- The Partnership is embarking on a process of Building Community Capacity in a way which will maximise resources available at a community level thereby building community capacity and resilience and being less reliant on traditional statutory sector care provision. In turn, this will see a targeted approach to reduce inequalities and the associated health burden which results. This will be locality based and will complement the work which is also progressing in maximising integrated approaches to ongoing health and care delivery.

- By moving to integrate health and care delivery at a Locality level, it is intended that as much care delivery as possible will be available at Locality level. This will also see traditionally hospital based care provision being re-located to communities with as much self- care as possible being promoted positively.

- Ultimately, this will result in an integrated team which is familiar with the needs of individuals being able to manage as much of the patients care journey as possible in the community with access to a hospital being by exception.

- To support the approach being developed in expanding care provision at, or as

close to home as possible, so the Partnership is looking to review the use of residential care beds and look to maximise linkages between these, flexible housing options and greater opportunity for intermediate care outwith a hospital setting.

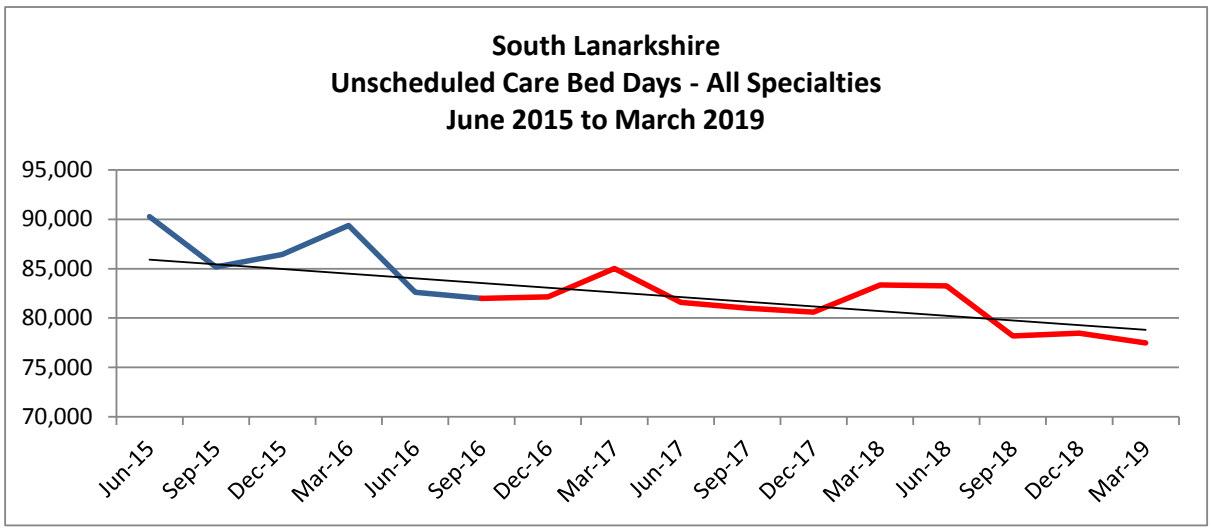
- A significant tranche of work is being undertaken in 'transforming primary and mental health care' which will see an increased range of services available in a community setting as well as supporting the sustainability of GMS.

- Work is in hand to implement new care pathways for COPD patients and also IV therapies in a community setting.

- Work is in hand to re-define care pathways which will see increased emphasis on intermediate care and rehabilitation both during the inpatient and community aspects of the care journey.

- The Partnerships are heavily involved in the improvement schemes associated with the 6 unscheduled care measures and, in turn, ensuring there is synergy between these and community based work to ensure consistent pathways. The primary measure within the dataset is to reduce the unscheduled bed days in hospital care by 10%, which in a South Lanarkshire context is 24,000 bed days, by March 2019. Through the Unscheduled Care/Delayed Discharge Board, a Lanarkshire-wide partnership group covering both acute and community health and social care services, action plans have been developed to support delivery of the following trajectory (which is based on the 2015 population profile):

Figure 03: Unscheduled Care Bed Days South Lanarkshire



3.3.3 Health and Social Care North Lanarkshire

3.3.3.1 Health and Social Care North Lanarkshire Vision

Health and Social Care North Lanarkshire has an agreed vision that the people of North Lanarkshire will achieve their full potential through living safe, healthy and independent lives in their communities, through receiving the right information, support and care they need at the right time in the right place. North Lanarkshire has a longstanding partnership history that predates integration, with a strong focus on shifting the balance of care towards community provision.

3.3.3.2 Progress to Date

North Lanarkshire has a longstanding partnership history that predates integration, with a strong focus on shifting the balance of care towards community provision. Through the Reshaping Care for Older People programme and subsequently the Integrated Care Fund programmes, the partnership was able to reduce the demands on hospital provision significantly, supporting the removal of 56 community hospital beds and allowing a reinvestment in community services to the value of £1.79m. Further evidence of the positive changes made in Lanarkshire is the reduction in the average length of stay in care of the elderly beds by around 20%.

There has been a significant investment in community services over this period, including:

- Roll out of Hospital at Home service across North Lanarkshire, preventing admission and supporting acutely unwell older people to remain in the community

- Development of Reablement teams in all six Localities, supporting individuals to maximise their independence and remain in the community setting

- Roll out of overnight Home Support services across all six Localities

- Roll out of the Intensive Home Support service, which works on an integrated basis with District Nursing to support end of life care within the community

- Provision of Social Work Intermediate Care beds, supporting step up, step down and respite provision for all communities in North Lanarkshire

- Expansion of the District Nursing Out of Hours service, delivered alongside Social Work's Out of Hours provision

- Development of the Scottish Ambulance Service Falls Pathway, which links Paramedics with Locality services to reduce the conveyance of non-serious falls to hospital

- Long-standing Locality Planning Groups formed in all Localities, to coordinate the care for the most complex cases in the area on a multi-agency and multi-disciplinary basis

- Roll out of the Locality Response, which aims to reduce GP initiated hospital admissions by providing an urgent response across all Locality services for unscheduled cases

- Developments around Telehealth and telecare approaches to support people to better manage their long term conditions, reducing the requirement for outpatient appointments and reducing the risk of unscheduled admissions.

3.3.3.3 Future Plans

Building on this direction of travel, the partnership has set out a number of developments within its Strategic Commissioning Plan that aim to support the development of an integrated health and social care system focused on prevention, anticipation and supported self-management. Doing so will support patient to stay healthy at home, or in a community setting, as long as possible, with hospital admission only occurring where appropriate. This includes:

- Development of integrated locality teams, with a single point of contact and the ability to respond rapidly assess crisis, prevent admission and support early discharge.

- Creation of a new model of rehabilitation that will see a shift in delivery from hospital towards the community. This will also support a much greater rehabilitation and reablement focus in community hospitals, supporting a greater number of individuals to return to the community, reduce length of stay and ultimately create off-site capacity for the acute system.

- Further development of North Lanarkshire's long-standing Community Capacity Building and Carer Support workstreams, supporting people to access information, community assets and low level supports which prevent or delay the need to use more resource intensive services, including acute hospital ED attendance.

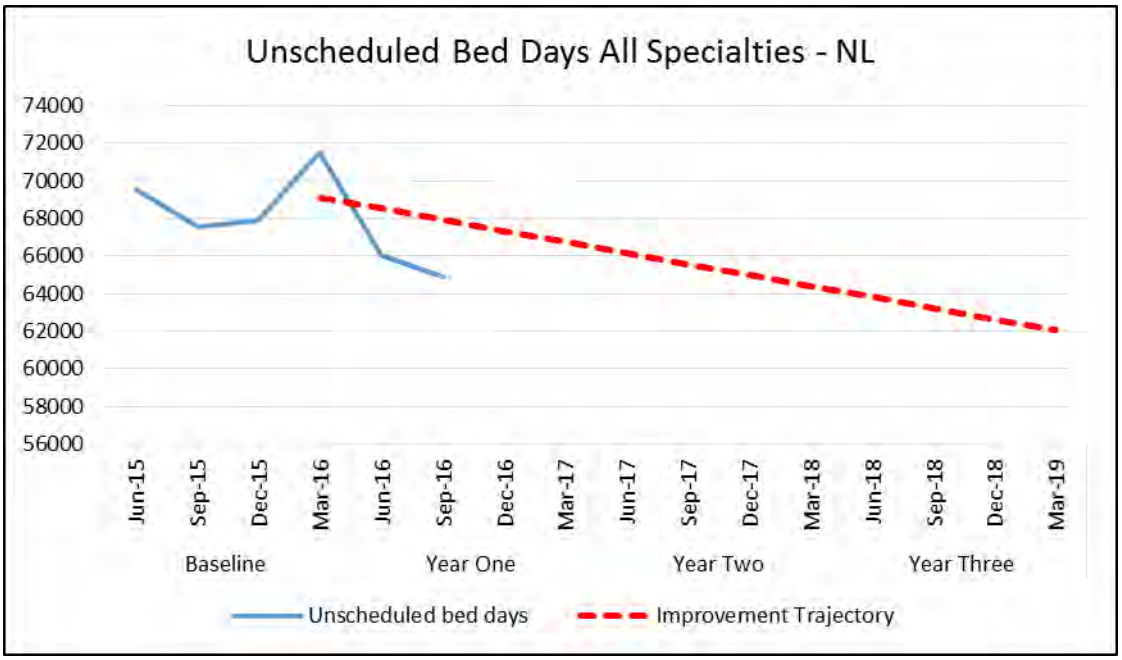
- Roll out of a range of initiatives under the Primary Care Transformation programme that will see an increased range of services available within the community

- Developments around supporting those individuals who frequently attend ED services to access more appropriate Locality services. In addition, developments within the Locality Planning Groups aim to identify those individuals who require the greatest level of support to ensure they are assisted to better manage their condition or where required, supported via a care management approach.

Health and Social Care North Lanarkshire is also undertaking a range of improvement schemes in line with the Health and Social Care Delivery Plan's associated six unscheduled care measures. The rationale for the development is to seek more integrated working across the wider health and social care pathways, recognising that this progress will require joint working across acute, community health and care services.

The principle measure within this is to reduce the unscheduled bed days in hospital care by 10%, which in a North Lanarkshire context is 26,000 bed days, by March 2019. Through the Unscheduled Care/Delayed Discharge Board, a Lanarkshire-wide partnership group covering both acute and community health and social care services, action plans have been developed to support delivery of the following trajectory (which, again, is based in the 2015 population profile and does not anticipate the ageing population into the future):

Figure 04: Unscheduled Care Bed Days North Lanarkshire



3.3.4 Linkage to Other Strategies

NHS Scotland Quality Strategy

The ability of NHS Lanarkshire to provide safer, more person-centred and more effective care is significantly compromised within the current Monklands Hospital environment (as described in section 4.1). This same environment is also becoming increasingly more difficult and costly to maintain and keep clean, as the building continues to age and drift further away from contemporary healthcare facilities' statute and standards.

http://www.gov.scot/Resource/Doc/311667/0098354.pdf

NHS Scotland Clinical Strategy 2016 – Centres of Excellence

http://www.gov.scot/Resource/0049/00494144.pdf

The national clinical strategy sets out how the safety and effectiveness of clinical care can be improved for the population through the continued development of "centres of excellence". This will improve outcomes, reduce waste and variation and provide better value in the provision of hospital services. The centres of excellence model is also shown to improve workforce training, aid recruitment, and enhance research and development of services.

NHS Lanarkshire currently has some 16 centres of excellence, and this project will enable further progress towards improved outcomes by providing (as part of a three-hospital strategy) additional centres of excellence in the areas of gastro/upper gastro surgery, cancer care, orthopaedics and mental health services. These are articulated in our healthcare strategy Achieving Excellence.

Chief Medical Officer's Annual Report "Realistic Medicine" 2014/15

http://www.gov.scot/Resource/0049/00492520.pdf

The Chief Medical Officer's Annual Report for 2014-15 on Realistic Medicine gives food for thought and signals many areas for review. It challenges our thinking about how we share decision making with our patients and whether many of the treatments that we offer are not treatments that we would wish for ourselves and that we have become too focussed on delivering evidence based medicine guidance that was developed to manage single system disease, while the patients that we treat often no longer fit into that category.

As part of Achieving Excellence, this project will provide facilities which will enable the provision of services based on these principles, specifically through integrated team working across health and social care, efficient access to diagnostics and specialist advice, and clearer criteria for access to –and discharge from – acute services.

Everyone Matters: 2020 Workforce Vision, 2013

http://www.gov.scot/resource/0042/00424225.pdf

NHS Lanarkshire's workforce, and the workforce of partner agencies, will be instrumental in the successful delivery of the Healthcare Strategy through making best use of the skills and capabilities of staff. The principles set out in Everyone Matters are intrinsic to the future improvement in services, and in achieving the objectives and benefits set out in this proposal.

This project will create a modern working environment which will meet current facilities' construction standards and improve the efficient delivery of care and support services. Access to appropriate training facilities will be improved, which will improve the standard of care. All of these factors will assist in meeting the overall objectives of this project.

3.3.5 Workforce Planning Strategy

NHS Lanarkshire's workforce will be instrumental in the successful delivery of Monklands Replacement / Refurbishment Project through making best use if the skills and capabilities of its staff. The workforce, in all professions and at all levels, will have a part to play and staff will be supported and developed to ensure they can fully engage and commit to the revised service delivery model. The future workforce will be based on teams of staff rather than individual practitioners to develop effective multi-disciplinary teams working with the appropriate knowledge and skills. It will integrate more closely the work of hospital based specialties alongside community based teams, with a clear understanding and value of each other's roles and a culture which supports people with long term conditions and their carers to be the lead partners in decisions about their health and wellbeing.

3.3.5.1 Workforce Availability

Medical Staffing

Currently, there are ongoing issues with availability of medical staffing within acute and primary care services in Lanarkshire and across Scotland. This is particularly acute in general practice and acute medical specialities. With an increasing older population and subsequent increase in healthcare needs, the continuation of clinical services delivery based on the current workforce model, with the same level of reliance on medical staffing, is unsustainable. The Monklands Replacement / Refurbishment Project plans to adopt a workforce model whereby there is higher reliance on a range of Advance Practitioner roles. These roles will develop from several professional backgrounds (nursing, allied health professionals, pharmacy and physician associates), will be trained to take on traditional medical roles/tasks and will become an ever increasing proportion of the future Monklands workforce.

Ageing Population

The ageing population will not only change the service demands, it will also be reflected in the availability of the NHS Lanarkshire workforce. In effect, we will have an older workforce in 2025 and a higher volume of retirements year on year. With this, NHS Lanarkshire is considering approaches to support older staff to remain in employment (e.g. less physically demanding roles, reduced hours, etc.) while recognising and succession planning for potential loss of skills and knowledge. A Working Longer in NHS Lanarkshire webpage was launched in spring 2017.

Service Delivery

To provide safe, effective and person-centred care, the workforce should match the workload demands in the care context, location and hours of service. In Monklands, the number of beds is unlikely to change but the patients will be in single rooms and have higher acuity requiring a change in clinical and staffing model. Further scoping is required to determine if this will require an increase in resource. This will be conducted taking into account recommendations from the Safe Staffing initiative.

Recruitment & Retention

NHSL recognises the importance of being an Employer of choice which attracts and retains staff, supported by, recruitment, selections, induction, performance management, strong leadership and staff development processes.

To maximise workforce availability and reduce agency/locum spend, NHSL should promote Lanarkshire as a place to work and where possible review workforce strategies and policies to reflect and support this both for substantive and bank staff.

3.3.5.2 Workforce Adaptability

Commissioning New Roles

NHS Lanarkshire will undertake detailed multi-professional workload and workforce planning to support the Monklands Replacement / Refurbishment Project. Effective use of existing resources will be essential as will gaining an understanding of current utilisation of the workforce and the likely implications for retention of the existing workforce, many of whom will remain part of the workforce for the next 5-10 years. This will provide essential baseline data for future remodelling work. The identification of skills and competency gaps will be equally important in ensuring appropriate training and development is ongoing to ensure the workforce is appropriately prepared and supported for the future: it can take at least 18-24 months to train an experienced qualified healthcare professional to advanced practice level..

A similar approach will be required to define the generic support worker role. It may not be

possible to determine the exact numbers of each role required and so an initial estimate of need should be agreed and used for the purposes of development. To do this, it is essential that professions are able to define their unique professional contribution and identify tasks which can be delegated and carried out effectively by support workers, thus building safe and effective capacity.

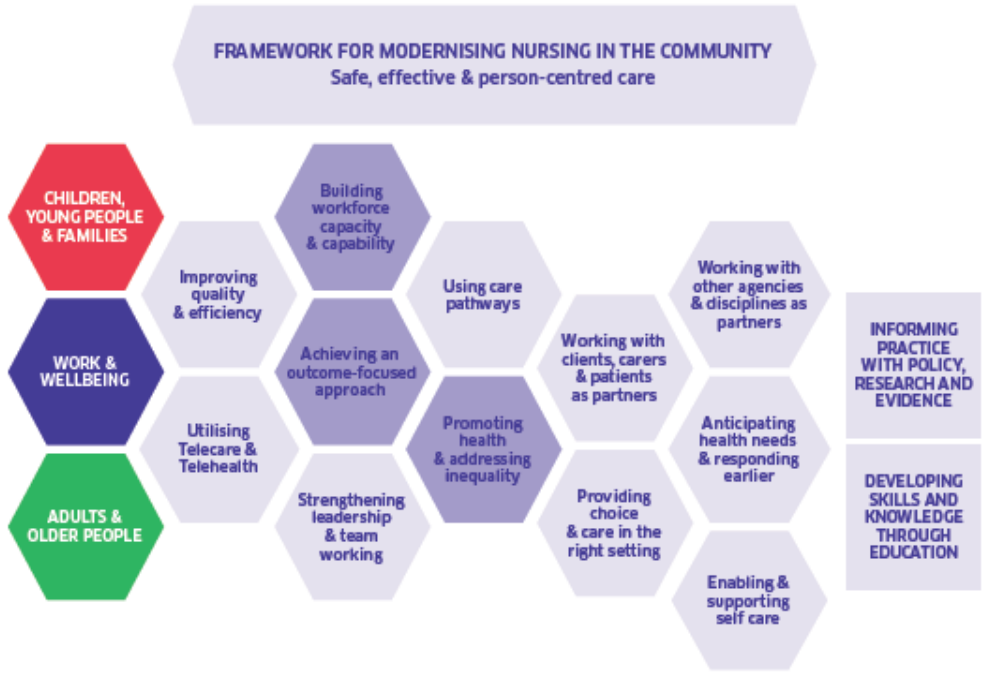
Influencing Undergraduate Programmes

Ongoing work is required with Regulators, Scottish Government and Higher Educational Institutions (HEIs) to ensure that the development of undergraduate programmes is designed in line with the future healthcare need, with sufficient focus on community care.

Development of existing staff skills

It is envisaged that advanced practice roles will be an integral part of building capacity and capability within the Monklands Replacement / Refurbishment Project. The developments for extended roles, such as intravenous therapy, advanced practice, non- medical prescribing and extension of health care support worker roles to support the future community care will require engagement with HEIs in conjunction with NHS Lanarkshire's Practice Development Team and GP practices. NHS Lanarkshire is fully engaged in the national agenda to develop the roles of community practitioners with a view to ensuring it meets the needs of people using our services. The framework below has been developed by NHS Education for Scotland for community nursing and outlines the elements required for safe, effective and person centred care and support in the community. While it focuses on nursing in the community, it reflects the direction of travel in our approach across all professions.

Figure 05: Framework for Modernising Nursing in the Community



3.3.5.3 Workforce Affordability

Improve efficiency

To maximise the efficiency of service delivery, several workforce redesign factors are being considered:

- **Avoid duplication** – opportunities to integrate and streamline patient pathways will be considered and where possible generic support workers introduced both across health and health / social care (AHP, nursing, social care). This also has the added benefit of providing a greater career structure for the staff involved.

- **Work to "top of licence"** (registered and support staff) – roles require to be reviewed with staff supported and developed to work to the "top of their licence". This offers the potential to increase staff numbers and redistribute the workload to lower banded but appropriately trained staff, thus avoiding an increase in cost.

- **Extended scope** – to streamline the patient journey and minimise "hand-offs", certain roles will require to extend their scope to provide some additional aspects of care and avoid referring on to a different healthcare provider or into acute services e.g. community nurses developing Intravenous (IV) therapy skills to allow patients to be

cared for in the community; extending psychological care approaches, growing the resilience of people using services to effectively self-care and supporting concordance with agreed personalised treatment plans reducing demands on unscheduled care.

- **Roles appropriate to skill** – to ensure efficiency, appropriately skilled staff should undertake roles e.g. admin staff undertaking admin roles, not clinicians. Staff developed to conduct proactive engagement with patients, their families and carers about what matters to them and how they feel better supported to access services and to self- care when they are able; staff empowered to promote healthy lifestyles and provide support to patients and carers to meet social challenges such as financial security and employment.

In addition, there are other opportunities for efficiency which would support the workforce:

- Improvements in technology such as electronic patient records, mobile technology (tablet computers), etc. would support greater workforce productivity and efficiency.

- Innovative practice using existing technology based platforms (e.g. NHS Inform MATS) and developing other web-based access to services for early advice and self- management, influencing a culture of self-efficacy which deflects demand away from healthcare services and into upstream services e.g. leisure, voluntary and third sector services.

- NHS Lanarkshire, North and South Lanarkshire Health and Social Care Partnerships will continue to work with third sector colleagues to focus on supporting and testing out new approaches for the delivery of community-based support for people with complex and multiple conditions. This will include delivering an integrated approach that complements mainstream services by other agencies, is fully linked into locality planning arrangements, continuing to focus on building community capacity and local infrastructure to support the delivery of local services and further develops the commitment to carer support through a structured programme of assessment and support.

- Integrate more closely all contractor disciplines such as community pharmacists, dentists, optometrists and care providers to enable patients to better access appropriate care and advice

- Introduce pharmacists in GP practices with advanced clinical assessment skills to support the care of patients with long term conditions and better manage their medications

The workforce to support the Monklands Replacement / Refurbishment Project will not be "more of the same". The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will work to the maximum of their trained potential with work aligned to their skills. The workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care.

It is difficult at this stage to indicate the exact numbers and development requirements for each role until more detailed workload and planning has been undertaken.

3.4 What external factors are influencing this proposal?

Enabling Change

This project has the principal aim of enabling the delivery of the improved clinical services described in NHS Lanarkshire Healthcare strategy “Achieving Excellence” by 2025.

The case for major investment in the replacement/refurbishment of Monklands DGH is set out in the context of the changing healthcare needs of the people of Lanarkshire, and the benefits that this development would bring in terms of improved models for the delivery of integrated health and social care. A key aspect of this is to ensure a better experience for patients who require to attend the hospital.

The opportunities for using this project to further the strategic objectives of the Healthcare Strategy will be to the fore in the business case, closely aligned to the delivery of the National Health and Wellbeing Outcomes.

There are infrastructural and environmental factors affecting Monklands DGH which both block the achievement of these aims. Also, the project opens up opportunities for the future configuration of services as envisaged in Achieving Excellence.

The clinical areas in Monklands DGH remain much as they were designed in the late 1960s. The lifecycle replacement costs are high and the current buildings are functionally unsuitable to meet modern standards:

- Poor configuration of “front door” services (such as emergency department, receiving unit) which limits the clinical efficiency and which cannot be completely solved despite ongoing investment;
- Inpatient wards have a low proportion of single rooms and poor storage space which reduces efficiency and increases infection risk which cannot be improved due to the limited floor areas of the two ward towers;
- Compromised environment for fire protection and evacuation;
- Diagnostic facilities, particularly imaging, operate in a constrained environment with poor patient flows;
- Surgical capacity (particularly day surgery) is constrained and this limits the ability to shift care away from admission;
- Outpatient clinic space has not been able to expand fast enough to meet current demand and cannot expand further to meet future demand;

- Provision for the reduction of risk from fire presents continuing challenges and ever increasingly onerous maintenance obligations, elements of which can be mitigated but not wholly eliminated.

The overall infrastructure of the hospital (such as mechanical/ engineering services, structural features and drainage) have reached the end of (and in many cases gone beyond) their life-cycle and require upgrading. This has, in part, been tackled at a cost of over £35m in specific high-risk areas over the past 7 years, with work being targeted at ensuring business continuity only, and not significant enhancements. However, conducting this long-term series of building and engineering works necessary to maintain safe, continuous operation of the hospital, in itself causes significant disruption to clinical services, and is a serious risk to business continuity. There is no readily available significant decant space available for the majority of work required for most work needed.

The current building, even if full back log investment is made, will still not address the issues of poor patient flow, overcrowding and functional suitability across a large number of departments. Leaving aside key engineering infrastructure, the visible fabric of the building overall is visibly tired and increasingly difficult and resource intensive to maintain, clean and present in condition which is conducive to positive patient outcomes and feeling of wellbeing and detracts from the patient experience.

Figure 06: Same Day Admissions Unit (SDAU): Case Study

Clinical Model:

All elective patients to be admitted to one area and cascaded to other clinical areas after their procedure to reduce the number of in-patient episodes and promote 'same day admission and day surgery procedures' and to improve flexibility of space by having 'Medical Programmed Investigations' at same area - improving patient journey, general efficiencies and skills concentration.

Issues preventing Clinical Model

- Only 4 chairs to review patients
- No privacy
- No trolleys
- Poor flow

Solution

New SDAU, but with new building regulations the available space for 3 bays and 2 rooms despite expansion.

The service is currently limited by the confines of the fabric of the building thus limiting further improvement (despite investment) in both the patient journey and the ability to deliver excellence.

Operational and infection control issues are created by the insufficient number of single bedrooms to isolate patients and there is an increased cross-contamination risk due to short bed spacing. This can result in four-bed bays being reduced to two beds when contamination risks occur.

Each four bed bay shares only one toilet/shower facility and not all single rooms are en-suite. Infection control risks arise from these limitations, the small size of rooms, and inadequate ventilation.

Another infection control risk relates to flooding to ground floor accommodation caused by capacity and design issues to the underground drainage. This occurs a couple of times a month. NHS Lanarkshire has commissioned improvement works which have improved, if not necessarily eliminated, this issue.

Key Planning Assumptions

The key planning assumptions which underpin this proposal are set out in Achieving Excellence and endorsed by the Cabinet Secretary:

- Lanarkshire will have 3 district general hospitals
- Each of these hospitals will have:
    - an emergency department supported by
    - Acute Medical and surgical services
    - Critical care
    - Diagnostics, outpatients and other support services

As at present, the acute specialty bed configuration will vary between the three sites with core service provision plus Centres of Excellence.

The strategic aim will be for the number of acute beds to be maintained at current levels into the future. On the face of it this is a conservative approach but in fact this sets a major challenge for the health and social care systems in Lanarkshire because:

- In 2016 Lanarkshire residents used 1,750 acute beds in Lanarkshire, Glasgow and Lothian acute hospitals;
- Based on current admission rates and length of stay this would rise to 2,259 in 2025; 29% growth; over 500 beds; equivalent to another general hospital;

- This is neither desirable nor affordable;
- To stand still admissions/ lengths of stay must reduce by 25% in 10 years. This means reducing average length of stay from 4 to 3 days;
- Our service models need to change to facilitate this in hospital, in primary care and in the community;
- At the same time our workforce configurations need to modernise to meet this challenge (in primary, community and acute sectors).

It is an assumption within this proposal that the emergency medicine catchment areas for this part of Scotland will not be distorted by any new hospital development. At present for emergency medicine Monklands serves a local catchment population of 240,000 people in North Lanarkshire.

This area is bounded

- to the west by Stobhill Hospital (which has a minor injuries unit) and Glasgow Royal Infirmary (an emergency department),
- to the south by Wishaw General Hospital (an emergency department) and
- to the east by Forth Valley Royal Hospital (an emergency department) and St John's Hospital (an emergency department).

This planning assumption will dictate (through analysis of travel times) where any new-site-new-build developments could take place.

The specific changes from the implementation of NHS Lanarkshire's Healthcare Strategy "Achieving Excellence" are described in section 5.2

Wishaw and Hairmyres Hospitals

The facilities at Wishaw and Hairmyres Hospitals, which were commissioned in 2001 and are provided under separate Private Finance Initiatives (PFIs), are regarded as modern in terms of design and condition. The initial periods of these agreements will run until 2028 and 2031 respectively. Provision exists within each agreement to continue the operation of the facility beyond these original dates and a range of options are available. It is anticipated that formal negotiations with the respective PFI providers will take place from 2025 with a view to agreeing arrangements which will be effective from 2028 and 2031 respectively.

The current bed modelling assumes that both facilities will continue to operate beyond this

point for some considerable number of years and continue to provide facilities consistent with current arrangements.

However in order to ensure that NHS Lanarkshire is able to consider all future service delivery options it will be a prerequisite that all options considered for refurbishing or replacing Monklands Hospital have sufficient development potential opportunity to accommodate additional clinical capacity.

4 Why is this proposal a good thing to do?

	Question	Response
Strategic Context	Why is this proposal a good thing to do?	Outline: • Current arrangements • Need for change • Investment objectives • Design quality objectives • Benefits realisation plan • Risk management strategy

This section should investigate whether the benefits to be gained from this investment proposal are sufficiently worthwhile to proceed.

The Strategic Assessment has already made statements on a number of the benefits to be gained from this proposal; therefore, this section focuses on expanding on these benefits and providing the evidence base behind those statements. It will thus follow a similar question set as the Strategic Assessment, i.e.:

- What are the current arrangements related to this proposal?
- What is the need for change?
- What is the organisation seeking to achieve from this proposal?
- What measureable benefits will be gained from addressing these needs?
- What risks could undermine these benefits?

4.1 What are the current arrangements related to this proposal?

The following information outlines how clinical services are configured both within Monklands District General Hospital and outwith, throughout the wider NHS Lanarkshire estate.

4.1.1 Current Service Provision:

There are three acute hospitals within NHS Lanarkshire, sited at Wishaw, East Kilbride and Airdrie. Monklands District General Hospital is currently located in Airdrie, North Lanarkshire. Each hospital delivers the following core services:

- An emergency department (ED),
- Acute medical and surgical services
- Diagnostics and imaging
- Operating theatres and critical care
- Outpatient services

Clinical services on each hospital site are relevant to each hospital's bed configurations and service models are arranged around 16 Lanarkshire 'Centres of Excellence' where individual specialty services deliver care for the whole of the Lanarkshire population with consistently high levels of clinical quality and patient satisfaction. These are arranged as follows:

Table 04: Centres of Excellence

Monklands DGH	Hairmyres Hospital	Wishaw Hospital
▪ ENT surgery ▪ Urology surgery ▪ Infectious disease medicine ▪ Renal medicine ▪ Histopathology ▪ Radiotherapy ▪ Haematology ▪ OMFS ▪ Dermatology	▪ Vascular surgery ▪ Ophthalmology surgery ▪ Optimal cardiac reperfusion ▪ Interventional radiology	▪ Paediatric services ▪ Maternity & neonatal ▪ Intensive Psychiatric Care ▪ Bariatric surgery ▪ Specialist Lab services ▪ Womens Health

NHS Lanarkshire will make a decision in late 2017 on the location of its elective orthopaedic surgery centre. This will be either at Hairmyres or Monklands. This would add a further Centre of Excellence to the table above for the respective hospital. For Monklands, this would allow a schedule of accommodation for elective orthopaedics to be included in the consideration of the Outline Business Case in 2019.

Monklands DGH provides emergency medical and surgical services for a catchment area covering North Lanarkshire north of Bellshill, an area with a population of 240,000 people, and sees 65,000 patients in the Emergency Department each year.

Table 05 below provides the current bed complement within Monklands Hospital.

Table 05: Monklands Bed Complement as at 15/08/2017

Specialty	Beds
General Medicine inc HDU	128
General Surgery	58
Cardiology and Coronary Care	18
Geriatric Assessment	44
Geriatric Rehabilitation	36
Geriatric Orthopaedic Rehabilitation	12
Haematology*	16
Emergency Medicine	6
Intensive Care inc HDU	10
Urology*	30
Communicable Diseases*	17
Renal Medicine*	17
ENT*	26
Acute Adult Psychiatry	24
Maxillofacial	4
Total	**446**

*services for the whole Lanarkshire population

There are 7 theatres and 2 day surgery theatres; however these are not ideally configured as they currently work as separate stand-alone units within the hospital due to their location. This means the realisation of efficiencies within workforce and resources is limited due to disparate clinical adjacencies.

The outpatient department sees 60,000 new and 125,000 return outpatients each year.
The Lanarkshire Beatson unit has two linear accelerators which provide radiotherapy for the whole Lanarkshire population.

In general, Wards within Monklands Hospital have a racetrack design, surgical wards are located in the west tower (above theatres) and medical beds in the east.

Wards have 4 bedded rooms and a limited number of single rooms. There is generally one shower room and toilet available for each 4 bedded room. Six wards do have single rooms but

these do not have ensuite facilities. These areas all require significant upgrading and have been highlighted as a cause of patient and public concern with regards to the facilities general inadequacy and condition.

The reduced ward space, the size of rooms and the facilities provided within means patients are restricted to ward areas with no social or therapy space for rehabilitation and re- ablement post periods of sickness. Wards have very limited storage, so waste and laundry receptacles are in public corridors with lifting aids and other ward equipment stored within the ward corridors. This causes many potential risks in terms of slips, trips and falls for patients and staff and provides an additional fire risk with boxes of ward supplies also stored in these corridors. This is also highly inefficient in terms of managing stock and is disruptive to the cleaning of these areas.

It is also noted that there are 24,000 inpatient admissions of Lanarkshire residents to Glasgow hospitals annually. The Regional Delivery Plan process will determine whether this has any significant bearing of the shape of future NHS Lanarkshire hospital provision.

4.1.2 Service Arrangements, Care Pathways and Patterns of Working

Care across NHSL is delivered using a pathway approach that delivers services co- designed between patients, carers and families. These pathways are integrated to deliver a high quality of care and to ensure access to services and treatment crossing traditional boundaries including primary, community, hospital and social care.

Monklands Hospital is a key site in delivering 24/7 clinical care within an acute setting. This is delivered by staff who work both rostered and flexible arrangements, and by a wide range of healthcare professionals depending on the clinical need.

The current clinical models being developed are based on a 10 session medical week (5 day service with 2 sessions per day). This model will produce improvements in quality of care and efficiencies as laid out in 'Achieving Excellence'.

Cognisance should be paid to a possible greater benefit if *all* workforces – e.g. medical, pharmacy and other Allied Health Professionals move to 7 day working and/ or 3 session days. This would come at a further financial cost above the capital costs for the project and as such will have to undergo a benefits analysis exercise along with complying with employment legislation and directives.

Each service is measured against the outcomes it delivers to patients and performance is reviewed within the existing General Management / Site Triumvirate arrangements. This is a senior manager/ senior clinician structure that reports to NHSL Board. Monklands Hospital is a part of the concept of 'one hospital over 3 sites' in Lanarkshire.

Services across NHSL are continually challenged by demand and the capacity to deliver within treatment time guarantees. The age and condition of Monklands Hospital and inability to expand services due to building restrictions means that there is currently not enough space or facilities to deliver any additionality to deal with increased demand. The service provision and requirement to grow services is therefore constrained and staff need to work across the Acute Division in more than one hospital. This leads to inefficiencies and presents challenges both in terms of medical and nursing skills and also recruitment and retention of staff.

The current demand and capacity pressures lead to service numbers increasing. This in turn applies pressure to accommodate growing inpatient and outpatient capacity. Monklands Hospital's specific age/ design related issues mean there are seasonal pressures associated with wind and rain that cause impact to the delivery of services for inpatients and

outpatients. The building has significant routine issues with drainage and limited pipes and experiences water ingress (from above and below) exacerbated during heavy rainfall, with associated disruptions to service impacting upon patient care.

Further impact includes unplanned closure of resuscitation areas due to drainage backflow, closure of inpatient areas and closure of theatres due to leaks and damage to clinical areas. This leads to significant clinical care interruption and also disruption for patients in the form of cancellations and transfers out with specialty beds. There is also general distress for staff who have to manage within this environment.

There remains a growing list of infrastructure issues which affect the whole of the main hospital building, despite the past 6 years of investment, which has optimised the continuity of services to the highest level of expectations possible in this environment. However, the level of disruption to clinical service necessary to remove the remaining risks (including drainage, fire, asbestos and storage) would be very considerable and is not achievable without closure of major parts of the acute services with corresponding impact across the whole of Lanarkshire. Even if technically achievable, such ongoing construction work, would result in further potential risk to patient safety and service continuity, and further detract from the (already compromised) patient experience, through further noise and disruption associated with construction sites being largely unavoidable for a protracted timescale.

4.1.3 Condition and Performance

Monklands DGH is an ageing and tired facility which requires a significant ongoing and increasing level of investment to make safe and improve its infrastructure (building envelope and services) including heating, water pressure, electrical and mechanical functions. Continued recurring failures of the hospital's assets not only have financial implications but have a direct impact on the delivery of clinical services. In addition, the building contains asbestos, increasing the timescale and disruptive nature of any maintenance required to return an asset to an acceptable condition. Most of the mechanical and electrical infrastructure (for example the electrical systems and building management control system) date back to 1974 and have greatly exceeded their life expectancy and are in need of further upgrading.

A focussed risk led programme is in place aimed at addressing the highest risks arising from basic building attributes which threaten business continuity; such as roof replacements, theatres refurbishments, improved fire compartmentation which fall well below current standards. This business continuity programme is currently funded to £5.6m in 17/18 and has been ongoing since 2009. As the programme is risk led and subject to finite funding availability, in the main it does not and cannot extend to addressing the replacement of the original 1970s fabric and defining aspects of the building, such as insufficient space allocations and inappropriate adjacencies for clinical activity, substandard fire escapes & stairs, ventilation, historic sanitaryware and other HAI related issues.

The table below notes the status of the infrastructure based on an assessment through the estate asset management system for Monklands:

Figure 07: Extract:

Property & Asset Management Strategy 2013 – 2017 Annual Update Statement for Period 2015/2016

Site Code	Name	GIA (m^2)	GIA % Total Area	Area Designation	Physical Condition	Functional Suitability	Quality	Space Utilisation	Total Backlog Cost (£)
	Acute Hospitals								
L106H	Monklands DG Hospital	55,462	19	Clinical	C	D	C	O	£30,513,916

28th April 2016 Source: Estate Management System

The table below notes the status of the infrastructure based on an assessment through the EAMS for Monklands:

Table 06: EAMS extract

Facets	Condition	Descriptor
Physical Condition	C	not satisfactory with significant change needed
Statutory Standards	D	unacceptable in its present condition, major change needed
Environment	G	unacceptable in its present condition, major change needed
Functional suitability	D	unacceptable in its present condition, major change needed
Quality	C	not satisfactory with significant change needed
DDA	C	not satisfactory with significant change needed
Space utilization	O	overcrowded, overloaded and facilities generally stretched

The Energy Rating for the main Hospital and Endoscopy Unit are both G – which is classed as very poor and whilst there has been some work carried out on improving lighting the EPC is still in the Very Poor range. An energy audit of the site identified a number of issues including:

- A major upgrade of lighting is required. Some installation of LED fittings has been carried out in public areas; however the remainder of the hospital still has a mixture of older, inefficient lamps that require replacement
- The current zoning arrangement of the heating and DHW system at the hospital is outdated and not flexible and large parts of the building are heated when not in use.
- The current heating and DHW system is poorly insulated and old control valves and varying flows result in large losses.
- The roof of the 2 tower blocks are poorly insulated.
- The glazing throughout the hospital is inefficient and in poor condition.

The newly proposed climate change targets mean that Public Bodies will have to substantially reduce their carbon footprint. Without a major overhaul of every part of the building and structure it is extremely difficult to reduce the carbon footprint of the existing building.

Fire Safety

Whilst considerable investment has gone into improving fire compartmentation and detection across the site, of particular note is the fact that much of the site (especially the two tower blocks) are significantly non-compliant with current Fire Code and building standards. The most noteworthy issue is the lack of provision for progressive horizontal evacuation with appropriate fire compartment sizes, combined with lower than expected adequacy of ability to escape from fire (by today's standards). This is due to the fundamental constraint on the ability to descend narrow stairs.

Whilst major fire events have low probability but high impact, the physical constraints of the narrow access stair network compromises the ability to provide safe patient care. This is especially the case when considering the restricted mobility of patients (who in many cases would need to evacuate on mattresses), would face considerable restriction from the narrow fixed walls of the access stairs, as per the original design. Any reconfiguration of fire escapes to the width and flow expected by current standards would be a major undertaking if assessed as physically possible as part of the refurbishment option.

Infection Control Issues

The main concerns of the Infection Prevention and Control Team are the constraint on isolating patients on the ward, limitations and poor design of ward shower facilities, and flooding to ground level departments due to failures of the drainage system.

The design limitations of a typical ward are outlined in other parts of this document. The operational and infection control issues this creates includes insufficient single bedrooms to isolate patients and increased cross-contamination risks due to short bed spacing. NHS Lanarkshire is monitoring the number of beds lost due to limiting four bed bays to two beds when contamination risks occur.

Each four bed bay shares only one toilet/ shower facility and not all single rooms are en-suite. IPC risks arise from these limitations, small size of rooms, and inadequate ventilation.

The third main infection control risk relates to flooding to ground floor accommodation caused by capacity and design issues to the underground drainage. This occurs a couple of times a month. Documentary evidence of reported incidences is available to support this, including a SBAR Incident report in 2016 of major flooding across A&E, Radiology, Theatres, etc. Some improvement works have been carried out to improve under MKBC, but this remains an intractable risk.

4.1.4 Public and Service User Expectations

The information below provides a summary of patient feedback which allows an understanding of where they consider improvements must be made. The key areas for improvement in any option for future development include the following:

- Waiting Areas– The majority of inpatient areas have no defined waiting areas or privacy rooms for carers and families due to the inherent space constraints in the current buildings. This is a significant issue when dealing with dying or very unwell patients and means bereft families are forced to use very public areas. This is routinely raised, both formally and informally, as a point of real distress to the public. The hospital is currently unable to offer private facilities for relatives/ carers who may be staying overnight in the hospital to be with a loved one, and single side-rooms are unable to accommodate a second bed resulting in relatives resting in an armchair. This lack of facilities for relatives and visitors creates challenges for open visiting and the sites ability to support John's Campaign for patients with cognitive impairment. It is also important to know that several wards do not have day rooms as these were converted to office accommodation. This has resulted in patients having little opportunity to be outwith the 4 bedded rooms.
- Toilets and showers – Generally, these are in a very tired state and do not offer an adequate level of protection against bacterial growth and are limited in number within inpatient areas. There are fundamental inadequate ventilation issues which give rise to infection control concerns associated with this. The space available within the bathrooms is not in line with current room standards and not conducive with space for activities such as undressing/dressing, wheelchair, manual handling aids access etc. This has resulted in patients being unable to be showered during their hospital stay. The limited single room availability means patients with known or potential infectious illnesses are nursed in multi-patient areas. There were 9 room closures between March and May 2017 which has been a significant pressure on the system to manage in terms of maintaining patient flow. The Infection Protection Control Team worked closely with the teams during each outbreak to ensure appropriate management of the patients was undertaken. This process breaks with good practice; provides privacy/dignity issues and can cause excessive financial spend in cases of outbreak of infection. There are no realisable plans which would alleviate this as an issue in the current buildings.
- Temperature – The wards have old metal windows which have secondary glazing. These are unsightly; they leak and are draughty and cold in the winter and will ultimately require full replacement in the short to medium term. This has been raised in several patient complaints/ feedback

- In terms of ventilation the wards are over warm in the summer and cold in the winter. The main hospital corridor includes a glass tunnel covered walkway which is draughty, unheated and leaks during very heavy rainfall and is excessively warm in the summer. This is an inherent failure in the current building's construction, and a replacement project would cause major disruption to current services, being the main link between key buildings.
- Car Parking – Highlighted as a key area of concern due distance from services and lack of accessibility for disabled patients. Overall the numbers of parking spaces are insufficient for the demand on site. The last 6 years has seen an expansion in parking, but this remains insufficient. All available land has been used, and the construction of additional decks and/or multi-storey parking would in itself cause major disruption to the hospital site and it is doubtful if planning permission could be obtained.
- Accessibility in general is poor as the hospital has very narrow stairwells and the inpatient areas are spread over many parts of the hospital. These areas have been bolstered with 'add-ons' to services and departments but not always provided clinically adjacent which means walking to another area and signposting for public and patients is frequently raised as an issue. Much of the original building footprint has been added to with modular or "temporary" structures, and no more land is available to develop services (particularly day surgery, clinics and diagnostics). The lifts servicing both towers are coming towards the end of their lifespan and increasingly are out of commission for prolonged periods. Replacement parts are now difficult to source and are now being made as bespoke parts which incur increased costs

These areas noted for improvement are not exhaustive and during public and patient consultations facilities and comfort within the physical environment are frequently raised.

The anticipation of patients is for the provision of a Hospital that is accessible to the Lanarkshire population and responds to their expectation, with facilities to support them during inpatient and outpatient visits and a space that is inviting, modern and fit for technical and clinical service delivery.

4.2 What is the need for change?

There are various reasons why a need for change can be driving forward an investment proposal; including overcoming a problem with the existing arrangements, responding to a driver for change, or presenting an opportunity to improve outcomes when compared to existing arrangements.

A full list of the main issues causing the need for change is provided below, much of which is a direct response to problems with the existing arrangements described earlier. The table also describes the effect it is having (or likely to have) if nothing is done about it, and an explanation of why action needs to be taken now and through this proposal.

Table 07: Need for Change

Cause of the need for change:	Effect of the cause on the organisation:	Why action now:
The future clinical model is based on building high quality centres of excellence, which requires a remodelling of acute services in line with the healthcare strategy.	*Existing facilities are functionally ineffective and unable to support the proposed service model. Lack of capacity at Monklands is preventing the reconfiguration of services across Lanarkshire.*	*The lack of capacity for outpatient, diagnostic, day case and day treatment activity is a serious block to the NHS Board and HSCPs achieving their strategic goals (as described in section 3.2 and 3.3).* *Future configuration of general surgery, orthopaedics and cancer care are predicated on the ability of NHSL to reconfigure services between the three DGHs.*

The population of Lanarkshire is ageing, which will place additional demands on all clinical services.	*More patients than need be are being admitted to hospital rather than treated in a home/ community setting.*	*The development of specialist secondary care facilities will allow better whole-system integrated working, using modern technology with the necessary highly specialist diagnostic and interventional facilities to support hospital Centres of Excellence and primary and community care teams.* *This will reduce admission rates and shorten lengths of stay*
Given the right clinical facilities, assessment and treatment which would otherwise require inpatient care could now be provided through clinics, day-care interventions and day case surgery	*Patients are staying in hospital for longer than necessary. Patients who could be treated as outpatients or day cases are waiting for longer periods or are being admitted to hospital.*	*The new/ refurbished facility (along with the two other Lanarkshire DGHs) will provide sufficient specialist outpatient, diagnostic, day-case and day care facilities to meet current and future service needs.*
A larger proportion of health and social care should be provided in a community and primary care setting.	*Requirement to build pathway, capacity and capability between acute and community care teams*	*The future shape of the patient pathways in Lanarkshire are being planned in a whole system integrated process. This recognises the impact of prevention, primary care, secondary care and continuing care facilities on achieving our strategic objectives. The changes to acute provision this project offers are essential in this whole systems approach specifically the (shift away from inpatient episodes towards community, outpatient and day case interventions).*

The current hospital environment is over 40 years old, and presents an ongoing risk to business continuity	*The current infrastructure is failing on a regular basis. The lack of space in all areas prevents the provision of good quality care, and the opportunity to develop services in line with the healthcare strategy.*	*The functional issues of the current estate will be resolved (described in section 4.1) with reference to functional suitability, backlog maintenance, patient safety, clinical effectiveness and amenity.*

4.3 What is the organisation seeking to achieve from this proposal?

This section of the IA identifies the investment objectives of the proposal by considering what the organisation is seeking to achieve. It is not, at this stage, aimed at identifying the potential solution. The table below provides a response to the effects of the cause on the organisation as highlighted in the Strategic Assessment and in doing so defines the investment objectives for the project:

Table 08: Investment Objectives

Effect of the cause on the organisation:	What needs to be achieved to overcome this need? (Investment Objectives)
More patients than necessary are admitted to hospital rather than treated in a home/ community setting. Therefore the proportion of resources must shift more towards building community capacity.	Provision of the necessary clinical environment (diagnostics, clinics and outpatients) and support functions (eHealth, transport) to deliver the necessary shift in the balance of care to achieve the strategic objectives set out in "Achieving Excellence" Successful conclusion to negotiations with Wishaw and Hairmyres PFI providers for long term service provision or provision of additional clinical capacity at new Monklands
Patients are staying in hospital for longer than necessary	The new facility will be designed to match the new models of service described in "Achieving Excellence". This will ensure we provide facilities which enable a lower proportion of inpatient admissions and higher proportion of community, outpatient and day case/treatment facilities. We will develop centres of excellence to provide more effective and efficient services. This will reduce lengths of stay.
Requirement to build pathway, capacity and capability between acute and community care teams	The new facilities will be an integral element in redesigning those patient pathways where acute admission is absolutely required.

Existing facilities are functionally ineffective and unable to support the proposed service model	Application of modern technical and environmental standards to the accommodation being used will provide clinical and non-clinical services with functional suitability and improved efficiency.
Poor environment for clinical care and risks to business continuity	The risks which the current facility place on safe and efficient clinical activity will be removed by the shift to a new facility.

4.4 What measurable benefits will be gained from addressing these needs?

The principal benefits from this proposal centre on the ability this gives NHS Lanarkshire to reshape clinical services to meet the future healthcare needs of the population. This is achieved through removing the physical/infrastructure risks which exist at present and also providing opportunities for services to be redesigned to meet changing models of care and healthcare pathways.

Stakeholder workshops have been used to develop the benefits to be described as below:

- Person centeredness – service change reduces the inequalities gap, facilitates realistic medical decisions, allows patients to understand care pathways, and provides improved personal outcomes. Additionally, it allows for best models of care and support to allow seamless transitions through care pathways, recognising equality and diversity.

- Improved safety of patient care – reduced risk to business continuity, through robust infrastructure designed to the most modern standards. Reduced risk of healthcare acquired infection through better use of space. Reduced risk to patients through improved fire protection. Provision of care in buildings where no asbestos is present.

- Improved clinical effectiveness – to “stream” from community to acute services provision as appropriate and reduce pressure on whole system working. Lowering stress levels for patients, staff, and relatives with easier journeys and care in the right place at the right time. Providing the opportunity to created centres of excellence with better clinical outcomes.

- Improving the quality of the physical environment – any facilities being built are a tool for clinical excellence, easy to orientate, to use, and maintain, that are energy efficient and environmentally friendly, and a pleasant environment internally and externally that is conducive to calm, healing, and recovery. Theatres and bed spaces, especially in high dependency areas, designed to accommodate the advancing technology and equipment required to deliver the safest care and best possible clinical outcomes for patients.

- Flexible / adaptable facilities across the health system – future proofed with generic spaces that can accommodate bariatrics, dementia, care of the elderly and other arising demographic trends. Cost effective in services and facilities as well as

increasing staff retention and optimising performance. Lower running costs with telehealth and telecare options to be adopted as far as is possible and overall best value.

This proposal recognises that NHS Lanarkshire will seek agreement with the PFI providers at Wishaw and Hairmyres Hospitals to continue service provision beyond the initial contract terms, 2028 and 2031 respectively. However in order to ensure that NHS Lanarkshire is able to consider all future choices for service delivery options it will be a prerequisite that all options considered for refurbishing or replacing Monklands Hospital have sufficient development potential opportunity to accommodate additional clinical capacity.

At this Initial Agreement stage, the Benefits Register below has been developed to record the main benefits expected to flow from addressing the need for change. This has also considered opportunities for wider social, environmental and employment benefits for the local community that the project might influence.

Table 09: Benefits Register

Benefits Register				
Identification				**Prioritisation**
Ref. No	*Benefit*	*Assessment*	*As measured by:*	*Relative Importance*
1	*Person centeredness*	*Improved access to health and social care.* *Higher engagement of patients in clinical decisions.* *Reduction in delays in transitions between episodes of assessment and care.*	*National key outcome measures.* *Patient satisfaction measures.* *Activity & performance measures*	*2*

2	*Improved safety of patient care*	*Improved clinical outcomes.* *Higher patient/carer satisfaction with assessment/ treatment.* *Reduction in disruption to clinical activity caused by accommodation and /or environmental factors.*	*Patient safety indicators.* *Morbidity and mortality indicators.* *Patient satisfaction measures.* *Activity & performance measures*	*1*
3	*Improved clinical effectiveness*	*Reduced number and length of stays in hospital.* *Improved clinical outcomes. More treatments delivered on a day case basis.*	*Activity & performance measures.* *Morbidity and mortality indicators.*	*3*
4	*Quality physical environment*	*Improved functional suitability.* *Improved space utilisation.*	*PAMS & EAMS assessments.* *Patient satisfaction measures.* *Reduction in backlog maintenance.*	*5*

5	*Flexible / adaptable facilities across the health system*	*Adherence to current accommodation standards.* *Ability to shift the use of space from inpatient to outpatient/day care usage.* *Reduction in running costs.*	*PAMS & EAMS assessment.* *Revenue cost indicators.*	*4*

4.5 What risks could undermine these benefits?

The Board views effective risk management as a positive method of achieving the wider aims of a project.

The Board therefore recognises the value of putting an effective risk management framework in place to systematically identify, actively manage and mitigate the impact by:

- Identifying potential risks before they materialise and putting mechanisms in place to mitigate any adverse effect
- Instigating a process to monitor and report on the progress of mitigating actions
- Implementing controls to address consequences of materialised risks
- Ensuring a clear and effective framework of risk analysis and evaluation is in place

The project specific risk register has been included in this IA within Appendix 2 but the following highlights the High Risks identified at this stage. Assessed at June 2017, it is noted that the 'likelihood' scoring will be reduced through the mitigation measures advised. The risk register will also be reviewed again by the Project Board in October 2017, at which point the categorisation of risk will be amended in line with the revised NHS Lanarkshire risk categorisation system (which was issued in July 2017).

Table 10: High Risks Identified in Register

Risk Description	Probability (Likelihood)	Impact	PI Score	Risk Level	Risk Effect	Mitigation
Failure to secure an appropriate funding stream	4	5	20	High	Programme Delay Unable to commence construction	Define and cost scope of works. Acceptance of IA. Regular engagement with SGHSCD. Robust OBC/FBC.
Potential environmental issues	4	5	20	High	Delay to programme Increased Costs	Appropriate Site Surveys and Historical Survey Reviews on the selected sites.
Interruptions to business continuity during construction (refurb)	4	5	20	High	Delay to programme Increased Costs Reputational Damage	Business Continuity Plan Appropriate Engagement with Site Teams Early Planning and Ongoing Dialogue
Management of ongoing MKBC risks	5	4	20	High	Increased cost Reputational risk	Ongoing MKBC programme/Strategic Risk Register approach to maintaining business continuity
Impact on design due to unknown defects (refurbishment option)	4	4	16	High	Impact on programme and cost	Full access to identified areas to allow intrusive surveys to be carried out
Failure to comply with HAI guidance (refurb)	4	4	16	High	Delay to programme	Continual monitoring of HAI scribe process
Interruptions to business continuity during construction (new build, same site)	4	4	16	High	Delay to programme Increased Costs Reputational Damage	Business Continuity Plan Appropriate Engagement with Site Teams Early Planning and Ongoing Dialogue
Regional/elective discussions may impact on prog	4	4	16	High	Programme delay	Early engagement and agreement on regional matters via Regional Planning Group

These risks will continue to be managed as the project moves into the Outline Business Case process through discussion at the fortnightly Project Team meetings. The project will make use of the NHS Healthcare Improvement Scotland (HIS) assessment matrices. This allows for four categories of risk, identified as follows:

Table 11: HIS Rating

Rating = Severity x Likelihood	
High	16 - 25
Significant	11 - 15
Moderate	7 - 10
Low	1 - 6

The risks will then be categorised under Impact and Likelihood as follows:

Table 12: Impact/ Likelihood

Likelihood	Impact/ Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely					
Possible					
Unlikely					
Rare					

4.6 Are there any constraints or dependencies?

Constraints are limitations on the investment proposal, which can include constraints on available resources. Dependencies are where actions from others are needed to ensure the success of the proposal. The following represents initial discussions held around the Constraints and Dependencies identified for this proposal:

Table 13: Constraints

Constraint	Explanation
Options must be compatible with existing service and estates strategies	Options must fit with any current service and estates strategies that the Board has previously approved.
Options should provide sufficient flexibility for future service requirements	Options must provide the flexibility to respond to future changes in service expansions or contractions.
Service continuity must be maintained during construction/ refurbishment	Services must be maintained during the process of any redevelopment.
Maintaining a link with the Lanarkshire Beatson and Maggie's	The Lanarkshire Beatson and Maggie's services must be co- located on site with the Hospital which may necessitate their re-provision.
No adverse impact on Partners e.g. Local Authority Partners such as Social Services.	In developing the options, due consideration must be given to the impact of any service changes on key partners and agencies to ensure there is no adverse impact as a result of changes to the model of care or service specification.
CEL 48 (2009) guidance regarding the provision of single inpatient rooms.	Options should be able to deliver the proportion of single inpatient rooms as follows: New build – up to 100% Refurbished facilities – 50% single rooms minimum This may increase staffing costs.

To provide safe, effective and person-centred care, the workforce should match the workload demands in the care context, location and hours of service. In Monklands, the number of beds is unlikely to change but the patients will be in single rooms and have higher acuity requiring a change in clinical and staffing model. Further scoping is required to determine if this will require an increase in resource. This will be conducted taking into account recommendations from the Safe Staffing initiative."	
Impact significantly on the emergency medicine catchment areas for neighbouring hospitals	The new facility will serve the same emergency medicine catchment population (240,000 people). Should the preferred option be to move the location then this will be constrained in terms of viable locations which meet this criteria.

Dependencies

- The Board, together with North and South Lanarkshire Health and Social Care Partnership's, ability to manage change and the associated changes in working practices and shift in the balance of care sufficient to deliver the redesigned service models
- Availability of site, appropriately sized and viable to be adequately serviced by utilities and transport.
- The ability of the new facility to complement the clinical strategy and service model for the other Lanarkshire DGHs (referred to as "one hospital, three sites" in Achieving Excellence)
- Recognition that NHS Lanarkshire will seek agreement with the PFI providers at Wishaw and Hairmyres Hospitals to continue service provision beyond the initial contract terms, 2028 and 2031 respectively. However in order to ensure that NHS Lanarkshire is able to consider all future choices for service delivery options it will be a prerequisite that all options considered for refurbishing or replacing Monklands Hospital have sufficient development potential opportunity to

accommodate additional clinical capacity.

- The West of Scotland has significant infrastructure challenges and a new clinical model must be considered and evaluated which may conclude that the population will need to access services in a different way, based on evidence, outcomes and sustainability. The work requires to be carried out with some urgency to understand the transformation opportunities that may exist to support future need. The significance of this work will be apparent when the West of Scotland Regional Delivery Plan is published in March 2018.

- The availability of both capital and revenue funding acceptable to all stakeholders

5 What is the preferred strategic / service solution?

	Question	Response
Economic Case	What is the preferred strategic / service solution?	Confirm: • The Do Nothing option • Service change proposals • List of proposed solutions • Indicative costs • Preferred strategic / service solution

The purpose of the Economic Case stage at Initial Agreement stage is to identify the preferred strategic or service solutions(s) which are suitable for further assessment at Outline Business Case stage. It will do this by comparing a range of proposed solutions against existing arrangements to identify which one(s) best meet the requisite investment objectives.

5.1 The Do Nothing option

An assessment of the Do Nothing option has been carried out under Section 4.1 of this IA when describing the current arrangements related to this proposal. A summary description of this is presented in the following table:

Table 14: Do Nothing

Strategic Scope of Option:	Do Nothing
Service provision:	Reduced ward space, size of rooms and facilities provided within current towers means patients are restricted to ward areas with no social or therapy space for rehabilitation and re-ablement post periods of sickness. Wards have very limited storage, waste and laundry receptacles are in public corridors and manual handling aids and other ward equipment are stored within corridors causing risks in terms of slips, trips and falls for patients and staff and providing a significant fire risk with boxes of ward supplies also stored in these corridors. This is also highly inefficient in terms of managing stock and cleaning of these areas. All the preceding will mean an absolute inability to deliver on the Clinical Models being developed to improve patient care, reduce harm and waste as detailed in National and Local Strategies.
Service arrangements:	Services across NHSL are continually challenged by demand and the capacity to deliver within treatment time guarantees. Monklands Hospital's age and inability to expand services (clinics, day surgery, day treatment and diagnostics) due to building restrictions means that there is currently not enough space or facilities to deliver any additionality to deal with increased demand. The service provision and requirement to grow services is therefore constrained and staff need to work across the Division in more than one hospital. This leads to inefficiencies and presents challenges both in terms of medical and nursing skills and also recruitment and retention of staff.
Service provider and workforce arrangements:	The current demand and capacity pressures lead to service numbers increasing. This in turn applies pressure to accommodate growing inpatient and outpatient

	capacity. Monklands Hospital's age/ specific design related issues mean there are seasonal pressures associated with wind and rain that cause impact to the delivery of services for inpatients and outpatients. The building has significant issues with deteriorating drainage pipework leading to frequently blocked pipes, and with water ingress during heavy rainfall there is a potential for significant spend as areas require to be refurbished. Further impact includes closure of resuscitation areas due to drainage backflow, closure of inpatient areas and closure of theatres due to leaks and damage to clinical areas. This leads to significant clinical care interruption and also disruption for patients in the form of cancellations and transfers out with speciality beds. There is also general distress for staff who have to manage within this environment.
Supporting assets:	A significant ongoing level of investment is required to improve building, heating, water pressure and electrical and mechanical functions in the current hospital. The facility does not have sufficient space to enable services to provide the full range of services necessary. This will severely impact NHSL ability to deliver the Healthcare Strategy.
Public & service user expectations:	The key areas for improvement include the following: ▪ Bedrooms ▪ Waiting – Inpatient areas have no defined waiting areas or privacy rooms for carers and families. ▪ Toilets – Facilities are considered poor and limited within inpatient areas. ▪ Temperature – The wards have old metal windows which leak, are draughty and cold in the winter. The wards are over warm in the summer and cold in the winter. The main hospital corridor glass tunnel is unheated, leaks as a result of rainfall and is over warm in the summer. ▪ Car Parking – Concern due to non- proximity to services and lack of accessibility for disabled

	patients. Overall the numbers of parking spaces are insufficient for the demand on site. ▪ Accessibility in general is poor as the hospital has very narrow stairwells and the inpatient areas are spread over many parts of the hospital.

In terms of a 'Do Nothing' solution there is a very limited amount that can be achieved within the confines of the current infrastructure. While ongoing reactive maintenance enables the functionality of daily hospital operations to be maintained this does not provide anything more than a series of short term fixes to the issues described in the above table from a clinical service or a public expectation perspective. This is not a sustainable solution over the medium/ long term and is included for comparative purposes only.

Independent assessment of the facility fully supports this position. Health Facilities Scotland in their recent review, July 2017, commented:

"The overarching conclusion observed of Monklands Hospital is that it consists of many compromises and challenges in being able to deliver modern expectations of quality healthcare services. The main causes appear to be an outmoded hospital design, an ageing building (commissioned in 1974/5), and limited flexibility to be able to resolve some of its underlying issues"

5.2 Service Change Proposals

The level of support achieved for this proposal to date and the public and stakeholder engagement carried out are detailed within the table in Section 3.1 of this Initial Agreement.

The following describes the overarching healthcare strategy for NHS Lanarkshire which drives the service change underpinning this proposal:

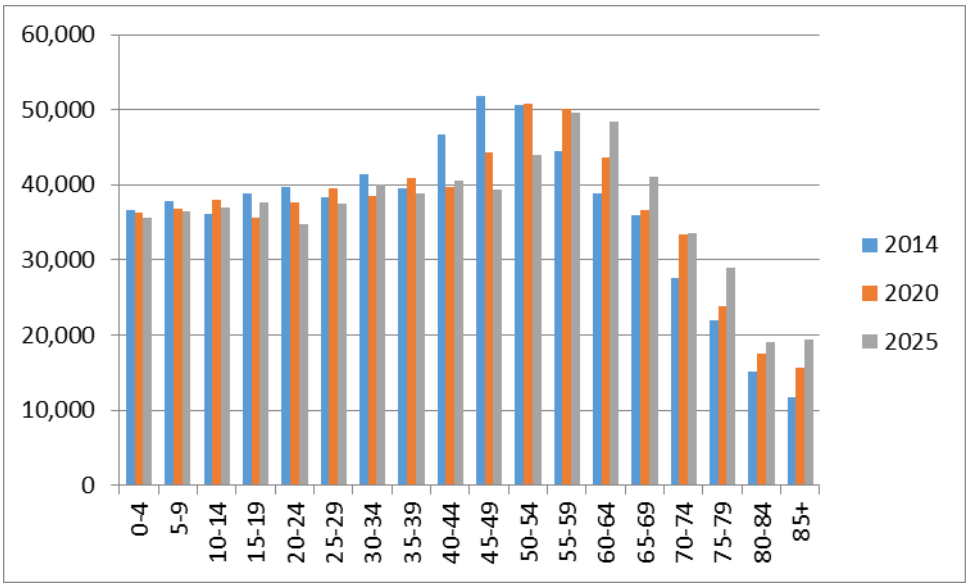
NHS Lanarkshire Clinical Strategy "Achieving Excellence"

NHSL has stated in "Achieving Excellence" that there will continue to be three DGHs in Lanarkshire, each providing a core of clinical services which specifically includes:

- An emergency department (serving the same catchment populations as at present)
- A range of acute medical and surgical services
- Diagnostics and imaging
- Operating theatres and critical care
- A range of outpatient services

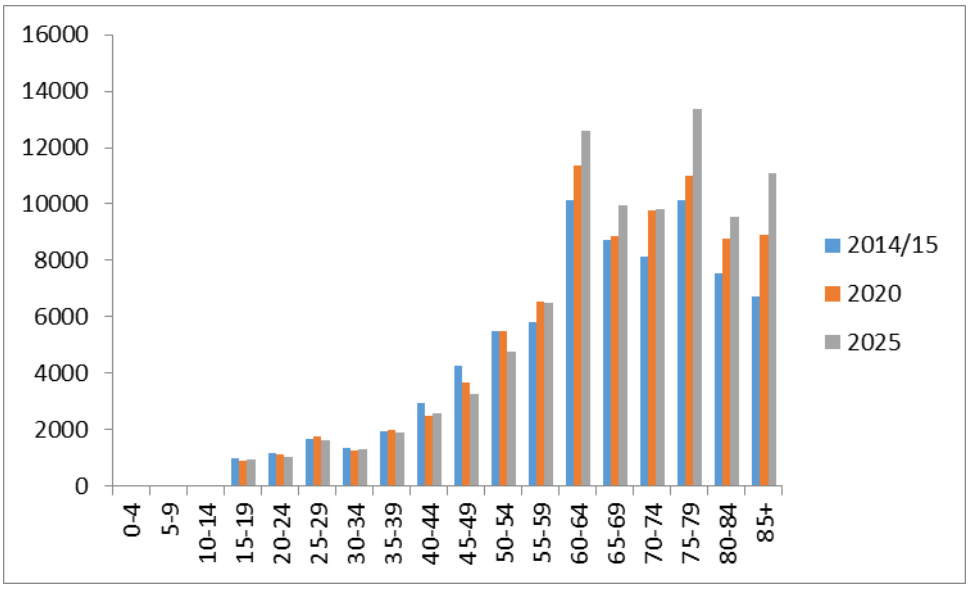
Detailed bed modelling work which sets out the demographic challenges has been completed and this process has enabled future activity projections to be validated and finalised. This work has identified two factors which are key in the future determination of service requirements and service solutions. In particular the acute bed modelling for the future needs of the Lanarkshire population is predicated on a number of changes to the health and social care system which will deliver a 25% reduction in activity through reduced admissions and length of stay by 2025. Conversely, the same modelling data predicts a significant increase in the demand for some acute specialties driven by the welcome increase in the number of people living beyond 75 years in the same time period. The graphs below illustrate the extent of change in age profile by 2020 and 2025 and the consequential projection of additional activity (bed days) which derives from this change in size of the older proportion of the Lanarkshire population.

Figure 08: Change in Age Profile



The graph above clearly illustrates the increase in the proportion of the population in the age bands 55-60 and above in 2020 and 2025 respectively. This is accompanied by increases in all of the subsequent age bands reflecting the expectation of continuing demographic growth over this period.

Figure 09: Increase in projected bed days by age



Following an analysis of the projected increase in age of the population a further projection of anticipated bed days resulting from this shift in age profile has been undertaken. This illustrates an increase in bed day activity being driven by the age profile change. This is particularly significant at age 75-79 and 85+.

The net result of this modelling predicts that the size of the DGHs, and therefore the total number of acute beds within Lanarkshire will not change significantly, but recognises that there will be variations in the disposition of acute specialties. This is illustrated in the table below which sets out the required beds at 2025, taking cognisance of the increased age profile of the population, and projects how these vary as Average Length of Stay (ALOS) improves.

Average Length of Stay Projected improvement		NHSL Acute Inpatient Bed Numbers – Planning Scenarios (Nov 2015)		
		Acute Beds Required		Change in Bed Numbers
%	IN DAYS	2016/17	2025	2025
Current ALOS		1,691	2,132	441
15%	-0.60	1,691	1,812	121
20%	-0.80	1,691	1,705	14
25%	-1.00	1,691	1,460	-92

Table 15: Required beds: 2025

Scenario B using population and ALOS as at Nov 2015

A number of workstreams which will assist in defining the detailed requirements for clinical and support services for the new Monklands DGH (and the other two DGHs) **and** which will have a material effect on the accommodation schedule to be included in the OBC include:

- The size and location of Lanarkshire's elective orthopaedic service (impacting on inpatient bed numbers, in patient theatre numbers, day case theatre numbers, and diagnostics)
- Lanarkshire service model for gastroenterology and GI bleeding (inpatient bed numbers, endoscopy capacity)
- The size and location of systemic anti-cancer therapy and other cancer treatments (capacity and size of day treatment areas, pharmacy aseptic rooms)
- Estimated future growth in robot-assisted surgery (size and structural elements of operating rooms)
- Future disposition of acute mental health inpatient facilities (beds and support accommodation)

- Estimated future growth in demand for interventional radiology (diagnostic capacity)
- Future demand/capacity modelling for the other specialties which will continue to be provided at Monklands beyond 2025: general medicine, elderly care, cardiology, communicable diseases, renal medicine, haematology, general surgery, urology, radiotherapy and ENT (outpatient capacity, diagnostics, inpatient beds, day case/treatment capacity, support services)
- Size and location of NHSL's training and education facilities (classrooms, lecture rooms, simulation infrastructure)
- Size and location of NHSL's research and development facilities (clinics and support services)
- Future strategic partnerships with academic departments and institutions and life sciences companies (available land for development for "bioquarter")
- Estimated future use of public and private transport (car parking provision)
- The proportion of single- and multi-bed accommodation in general ward areas.
- Assessment of the volumetric impact of new diagnostic/treatment centres at St John's Hospital and the Golden Jubilee National Hospital.

The necessary planning processes and governance arrangements have now been implemented and a process is underway which will ensure that the detail of the elements described above is defined in sufficient time and depth to fully enable the completion of the OBC. In particular this includes:

Establishment of Clinical Advisory Group and Clinical Support Group structure which is responsible for developing and designing the new clinical models which will underpin the delivery of Achieving Excellence (Structure shown in Appendix 4). Formal work programmes have been established and a process of progress monitoring is now in place.

Appointment of Healthcare Planner – Healthcare Planner tender evaluation and selection process is now complete. Formal appointment process will be completed by early September 2017.

Formal process to review impact of implementation of first phase of change for orthopaedic services, move to two combined trauma and elective units, is now underway. The change in service configuration in November 2016 was undertaken on the grounds of clinical safety

and service sustainability. The long term strategic objective is to move to the creation of a designated major trauma unit at Wishaw General Hospital and the development of an elective centre which will be located at either Monklands or Hairmyres hospitals. While the decision on the location of the elective centre will impact on required beds, anticipated at 48 based on current projections; it will be theatre requirements which will have the most impact on planning for Monklands OBC as the current assessment indicates that provision for three laminar flow theatres would be required to support this service. This reflects the high level of day surgery already in place within this specialty and recognises the requirement to continue to develop this as a preferred model of care. This process will also include assessment of the impact of the planned diagnostic/treatment centres at St John's and GJNH.

Publication of the Shared Services report on Aseptic Pharmacy provision (June 2017) – Chief Executives have accepted the strategic objectives set out within the report including the development of a central aseptic unit at a new/redeveloped Monklands Hospital providing aseptic services for Lanarkshire and Forth Valley.

5.3 Developing a short list of proposed solutions

This analysis was prepared by Currie & Brown (interim lead advisors) in association with Reiach and Hall (architects), and takes into consideration research undertaken over the last few years to examine development options for Monklands Hospital.

Criteria for the consideration of options are:

- The options will be able to deliver the NHS Lanarkshire healthcare strategy "Achieving Excellence" and the project benefits as described in section 4.4
- The completed clinical model will drive the functions and capacities rather than the status quo.
- Continuity of service should be maintained throughout all phases of construction operations in terms of both facilities and bed numbers.
- All buildings and facilities eventually provided should comply with current technical and quality standards.

The main underlying problems for refurbishment options on the Monklands site are identified as:

- The issues listed below combine to impact significant constraints on the delivery of clinical services that cannot readily be addressed in the current buildings. The current facility is sub optimal and could not support delivery of the proposed new clinical strategy.
- The original building was constructed in the 1970s and much of the existing fabric now requires major refurbishment of envelope, finishes and services; some of this has been undertaken under the backlog maintenance programme.
- Effects of HAI-Scribe and control of infection issues generally during construction will have a significant mandatory influence on how building activities can be undertaken.
- In their present configuration the existing ward towers are unsuitable to accommodate patients in accordance with current standards, and are not designed to achieve progressive horizontal evacuation.
- As the hospital plan has had to evolve on an ad-hoc basis within these physical

constraints some critical departments within the existing layout are not in the most appropriate co-location.

It should be noted that the issues outlined above are directed towards physical aspects of the fabric of the building that make best clinical delivery challenging and will have to be addressed to meet the necessary clinical requirements which are part of the developing strategy.

Seven potential development options were initially considered, ranging from ‘do-nothing’ to full redevelopment, of which two ‘do-nothing’ and ‘refurbish existing buildings with current bed numbers’ were discounted as not fulfilling the criteria outlined above in terms of maintaining continuity of service, developing an environment fit for 21st Century healthcare, and compliance with current standards.

This left four options to be considered in more detail. Three of these involve construction of a substantial new building on the Monklands site to provide decant space allowing refurbishment to a varying extent of the existing buildings, while the fourth is to develop a new hospital on a new site.

Over the years considerable work on backlog maintenance generally had been carried out at Monklands Hospital through risk prioritised programmes of works to mitigate clinical service risks related to the physical environment.

These investment programmes have been essential to maintain the building fabric and also to both keep the buildings functioning safely and to meet increasing demands. A key element of this is the new ITU and refurbishment of the seven existing theatres currently underway.

5.3.1 Description of Options

Option A: Do Minimum:

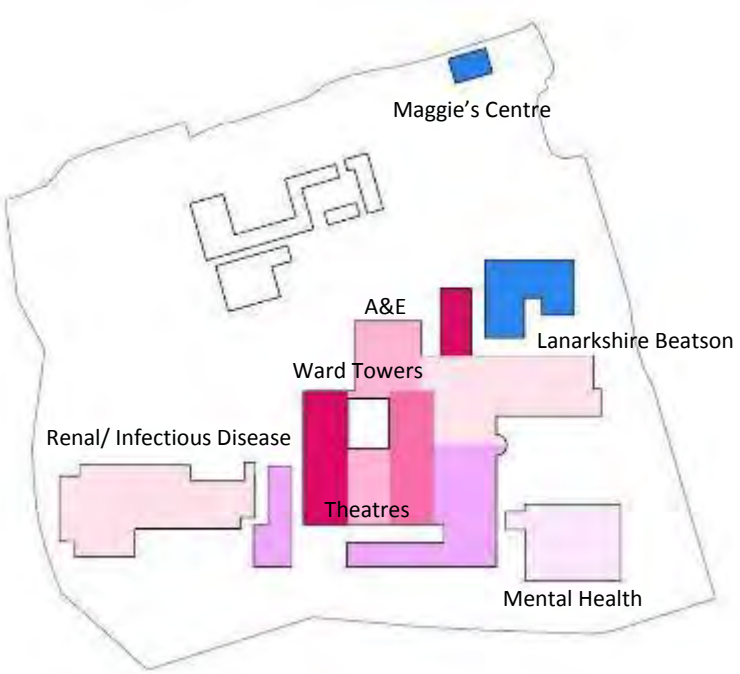
This is to continue with the current programme of backlog maintenance and renewal (the on-going MKBC Programme) through to their end point. This will impact NHS Lanarkshire's ability to deliver the Healthcare Strategy which may preclude it as a viable option.

It is retained however as a base-line option for comparison purposes only.

Figure 10: Existing Monklands Site Layout

The diagram below simply indicates the current site layout, and that phasing across the highlighted buildings will be required:

Figure 11: Existing Monklands Site Layout Phases



Option B: Refurbishment at Monklands:

This involves construction of a new building at Monklands sufficient to provide new facilities with decant capacity to enable the remaining existing buildings on site to be progressively refurbished and upgraded while maintaining business continuity. There are two sub-variants which affect the balance of accommodation between the new building and refurbished accommodation:

- (i) All new in-patient ward accommodation is provided to current standard within the new building, making the existing ward towers available for alternative use.
- (ii) To facilitate the new building the existing Renal, Infectious Diseases, and Endoscopy, will first have to be relocated elsewhere either on or off site permanently or temporarily. The building sequence is shown in the phasing diagrams below.
- Patient ward accommodation as far as possible is provided to current standard within the existing ward towers, with the balance in the new building; numbers are determined by the need to maintain continuity of service and bed numbers during construction.

Figure 12: Relocation of Renal and Infectious Diseases

Figure 13: Construction of New Wards

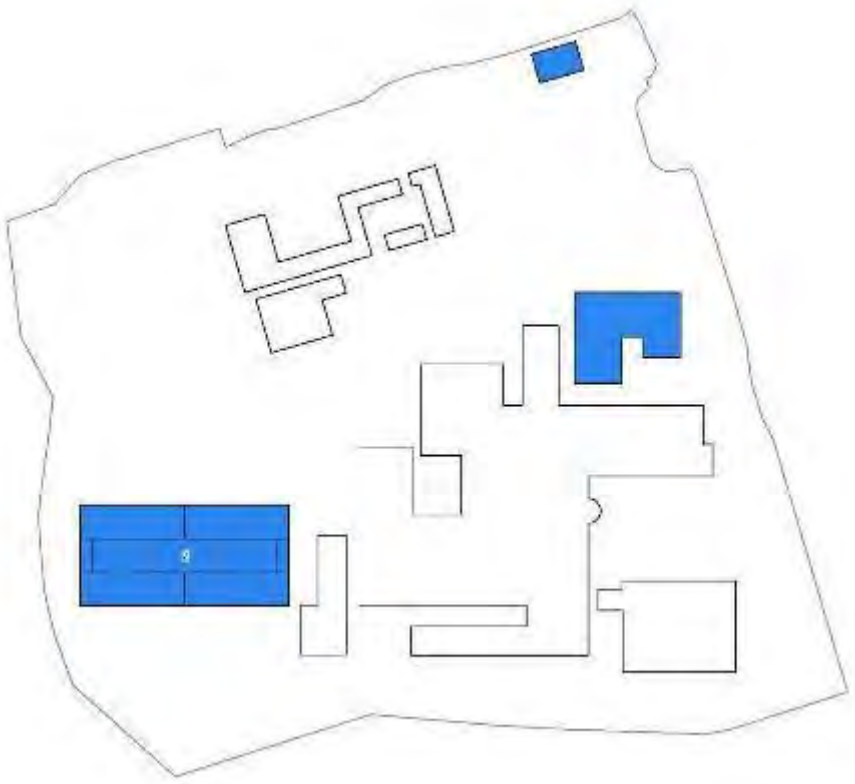
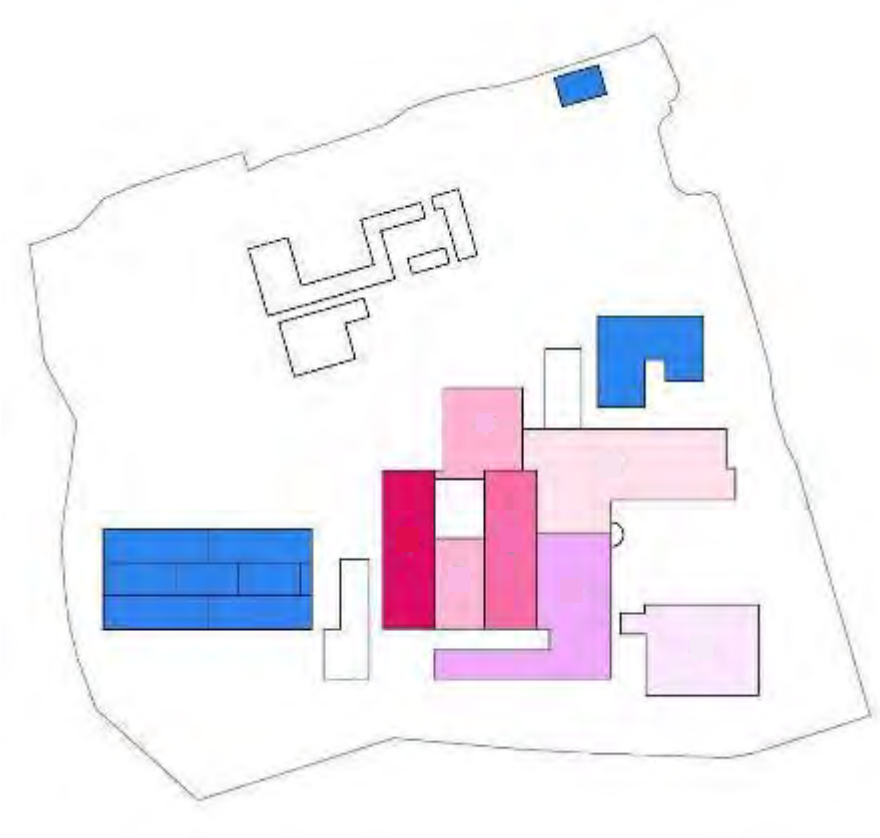


Figure 14: Renovate Site over a series of Phases



The phases required could include as follows:

- Surgical Tower
- Area between Towers
- Medical Tower
- OPD North of Hospital Street
- Rehab etc South of Hospital Street
- Mental Health

Option C: New-build at Monklands:

This involves construction of a larger new building at Monklands containing all hospital departments to replace all facilities required under the clinical strategy; on completion the existing buildings would be demolished, and their site will give capacity for future expansion development. There are two sub-variants on where the new building would be located:

- (i) New building located on the site of existing Renal, Infectious Diseases and Endoscopy, which will have to be relocated elsewhere before construction can start. This could either be a permanent relocation to another site or a temporary relocation to another or the Monklands site for each of or a combination of these departments.

- (ii) New building located on the site of the previous residential accommodation, avoiding any need to decant existing clinical facilities as in (i). This option may present planning issues as it involves locating a significant new building on the crest of the hill overshadowing adjoining private residential accommodation.

The building sequences are shown in the phasing diagrams below:

VARIATION 1

Figure 15: Relocate Renal and Infectious Diseases

Figure 16: Build New Multi Storey Hospital and Demolish Redundant Buildings

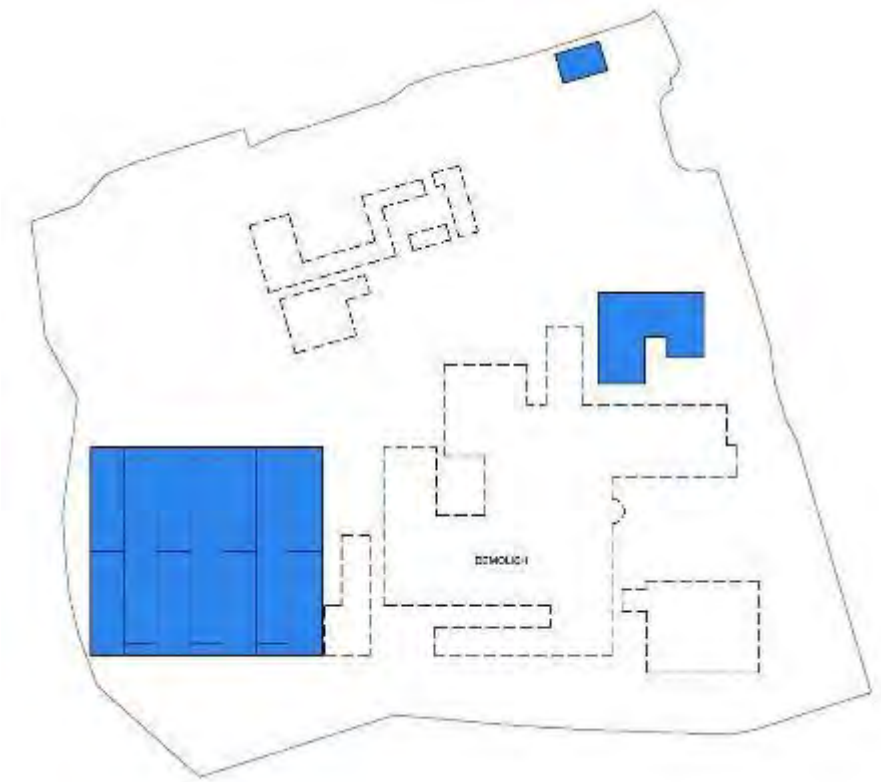
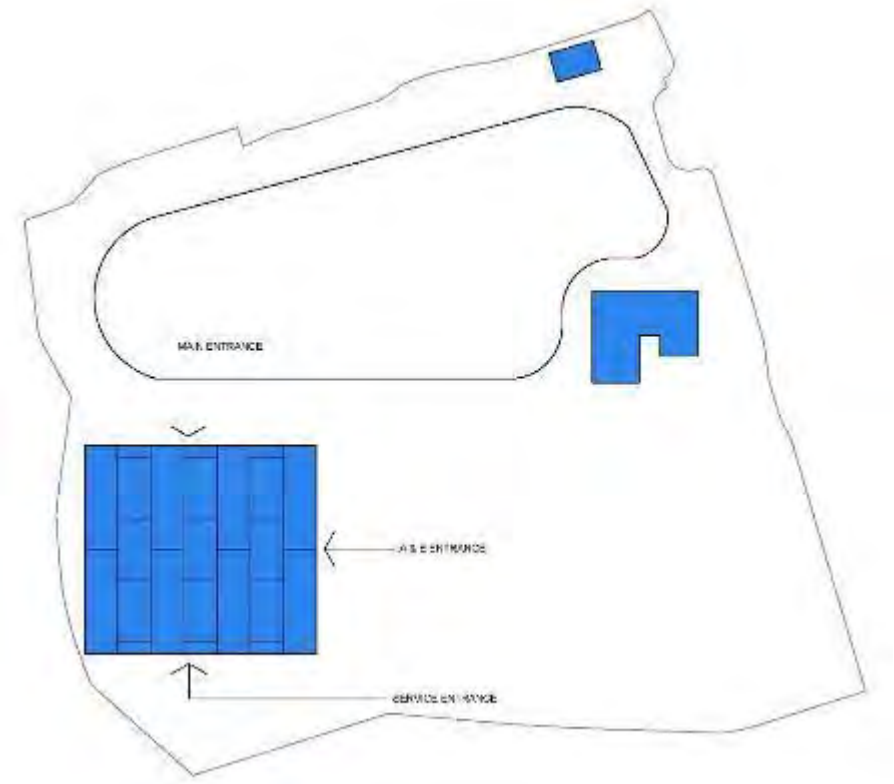


Figure 17: Form New Roads, Parking and Grounds



VARIATION 2:

Figure 18: Demolish David Matthews

Figure 19: Construct New Hospital

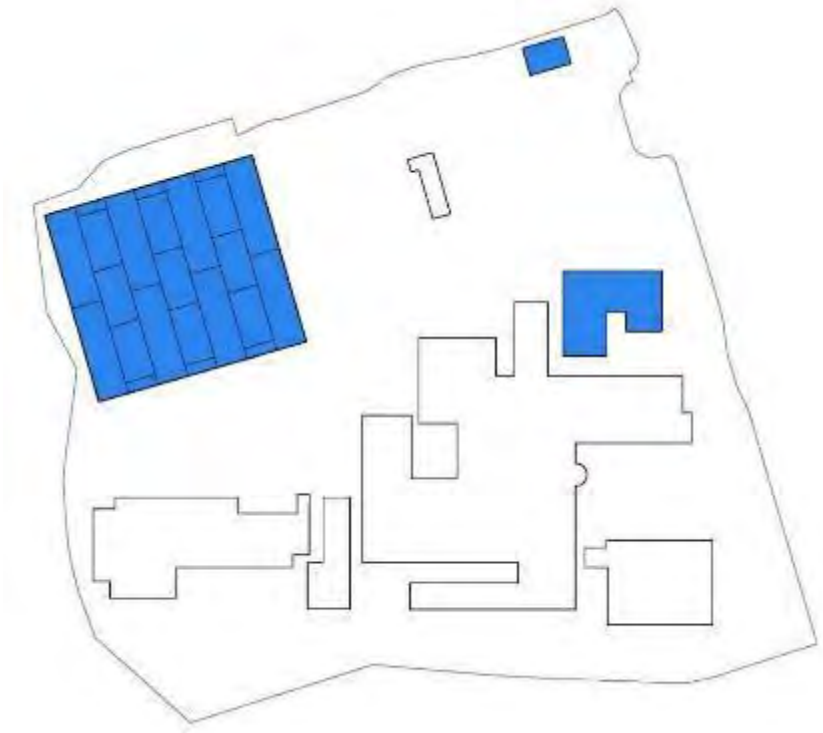


Figure 20: Demolish Existing Buildings

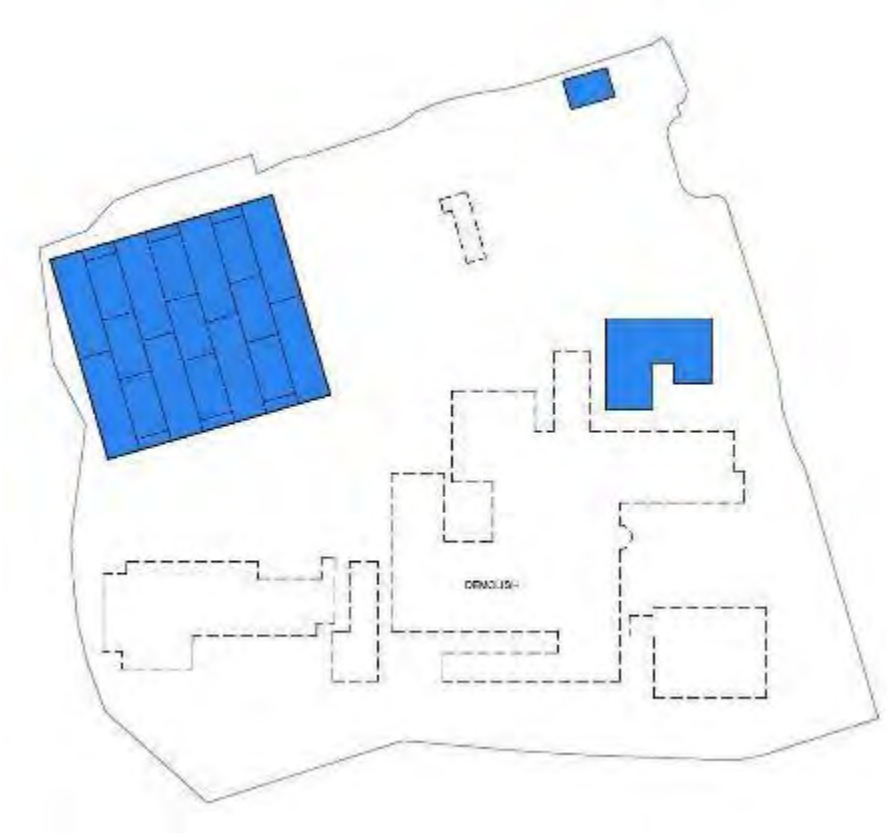
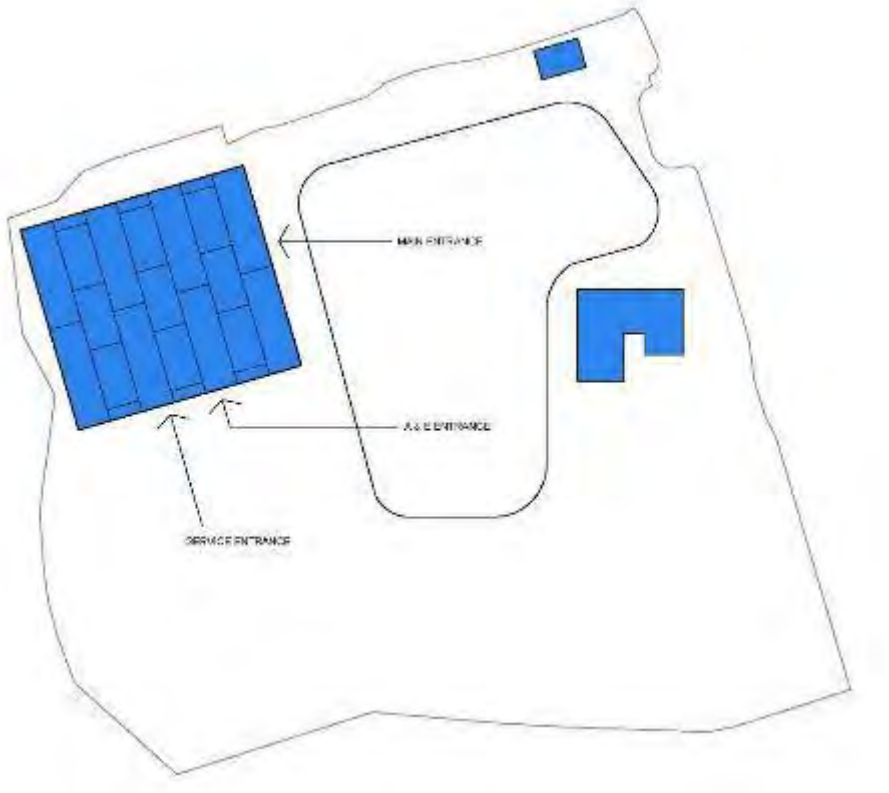


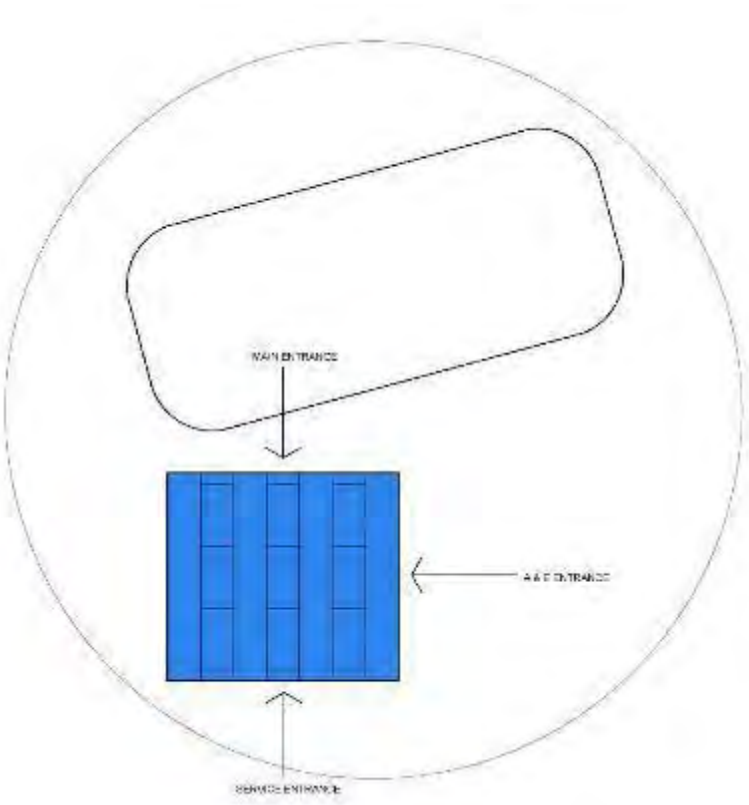
Figure 21: Form New Roads, Parking and Grounds



Option D: New-build on new site:

This involves construction of a new hospital containing all departments on a new site. The physical design of this building will depend on the availability of land on the new site and may not necessarily be a multi- storey construction. On completion all required functions of Monklands hospital under the clinical strategy will move to the new building, and the existing site would be disposed of.

Figure 22: Construction on New Site



Options B(i), B(ii) and C(i) each involve construction of a substantial new building on the Monklands site as a first step to provide decant space for subsequent refurbishment or demolition phases of the existing buildings. This is inevitably problematic in an active hospital where the level parts of the site are currently almost completely occupied by buildings or surface car parking.

However there are single-storey buildings on the western part of the site accommodating Infectious Diseases, Renal and Endoscopy which are less efficient in terms of building density than other parts of the site buildings, and the proposal is to move these functions elsewhere to provide the site for the new multi-storey building. In this scenario Infectious Diseases, Renal and Endoscopy would either move permanently to another hospital within

NHS Lanarkshire, or would be decanted elsewhere on the Monklands site to allow ultimate re-provision within new or refurbished facilities.

Option C (ii) is to construct the new building on the site of the previous staff residential accommodation (now a surface car park) in the north-west corner of the Monklands site. While this will have a significant impact on parking numbers (which may give rise to a requirement for other parking solutions in order to maintain numbers), it avoids the need to decant clinical departments as above. However this option may present planning issues because it involves locating a significant new building on the crest of the hill overshadowing adjoining private residential accommodation, to which there may be valid objection.

In comparison, Option D is to develop a new hospital on a new site. This will have none of the phasing and decant issues associated with the other options, but will be dependent on obtaining a suitable site within an appropriate timescale.

5.3.2 Programming

Option A: Do minimum:
Time scale for this option is dependent on funding, but is likely to involve a continuous stream of ongoing general refurbishment work over the remaining life of the hospital.

Option B: Refurbishment at Monklands:
While specific scenarios for decanting and refurbishing of the existing buildings have been considered and assessed, the detail depends on the final clinical model. Variant (ii) is more complicated than Variant (i) because of the need to interlink the two existing ward towers to achieve progressive horizontal evacuation if they are to be retained in use as in-patient ward accommodation. For the purposes of the current assessment it is anticipated that there will not be significant programme variations between the two.

Programme timescales have been assessed from FBC approval to migration [including any restoration of ground and road access]. For relocation of Renal, ID and Endoscopy the programme could be four years with a further four years for construction of the new building. The timescale for refurbishment in say 6 major phases could be 2-4 years each. The total timescale would therefore be in the order of **20-32** years. Refurbishment of the existing building can only start after provision of the new building following re-location of Renal, ID and Endoscopy. We anticipate that the existing building would be refurbished in five or six major stages in a phased sequence, each comprising a block from lowest floor to roof, which would be taken back to the frame to be refurbished with new external envelope, staircases and vertical circulation, internal finishes and services.

The phasing blocks over the 18 years average period could be described as:

- Surgical Tower
- Area between Towers
- Medical Tower
- OPD North of Hospital Street
- Rehab etc. South of Hospital Street
- Mental Health

Each phase will be a multi-million pound construction site in the centre of an occupied and operating hospital with all issues of noise, vibration, dust, site access etc., which will limit speed of construction.

Option C: New- build at Monklands:
Variation 1: New building on site of existing Renal, Infectious Diseases and Endoscopy:

Programme timescales have been assessed from FBC approval to migration [including any restoration of ground and road access]. The timescale for relocation of Renal, ID and Endoscopy could be four years with the timescale for construction of new building taking another four to five years. Demolition of the existing building could take a period of a year or so and final access roads and car parking say one or two years after occupation of the new building. The total timescale would therefore be in the order of **10-12** years.

The main criteria affecting programme are the time it will take to make the site available for construction of the new hospital, followed by the time required for construction and commissioning of the new building itself. It is assumed that the existing Renal, ID and Endoscopy facilities can be provided in a new building either on the Monklands site or elsewhere and that briefing and pre-contract work would be carried out in parallel with the Renal, ID and Endoscopy relocation. It should be noted that demolition of the existing building will take place after it is vacated and, because of its proximity to the occupied hospital and because of potentially deleterious materials, could take a period of a year or so. Therefore final infrastructure in terms of access roads and car parking may not be finally in place until say two years after occupation of the new building.

Variation 2: New building on site of the previous residential accommodation:

Again the programme timescales have been assessed from FBC approval to migration [including any restoration of ground and road access]. The timescale for appointment, briefing, pre-contract could be in the order of four years and the timescale for construction of new building another four to five years. Demolition of the existing building could take a period of a year or so and final access roads and car parking say one or two years after occupation of the new building. The total timescale could therefore be in the order of **10-12** years.

The main criteria affecting programme are the time it will take to appoint a design team, and then to carry out design and construction work. Alternative car parking measures could be put in hand during the pre-construction period. Demolition of the existing building will take place after it is vacated and could take a year or so, but its effect would be less because it

is not so close to the occupied hospital. However final infrastructure in terms of access roads and car parking may not be finally in place until say two years after occupation of the new building.

Option D: New-build on New Site:

The timescale to acquire site is likely to be in the order of two years with another two years for planning permission and infrastructure, Timescale for construction of new building could then be four to five years, giving a total timescale of around **8-9** years.

The main criteria affecting programme are the time it will take to obtain/ purchase a suitable site, obtaining planning permission for the site use and detailed planning permission for the proposed development, the degree to which new roads and infrastructure are required, and the time required for construction and commissioning of the new building. It is assumed that briefing and pre-contract work would be carried out in parallel with planning permission and infrastructure work.

5.3.3 Initial Assessment of Identified Options

A summary of the pros and cons associated with each delivery Option is provided below:

Option A: Do Minimum:

Pros:

- Hospital use has already been established for the site
- Maggie's and Lanarkshire Beatson are retained on site
- Renal, ID, Endoscopy not decanted

Cons:

- There are no clinical benefits to this option
- No benefits in functionality
- Sub- optimal patient journey
- Chaotic mixing of both scheduled and unscheduled flows
- Risk of failure of some Regional Services to be able to continue deliver these services
- Inability to remodel given modular nature of buildings
- Cannot deliver "Achieving Excellence" clinical strategy
- All existing sub-standard site and infrastructure issues will remain, as will the majority of cost liabilities associated with backlog maintenance.
- Clinical efficiencies will not be achieved
- Sustainability and energy efficiencies will not be achieved
- No ability to significantly increase clinical capacity in future.

Option B: Refurbishment at Monklands:

Pros:

- Refurbished hospital makes use of existing building fabric
- Hospital use has already established for the site
- Maggie's and Lanarkshire Beatson are retained on site

Cons:

- Renal, ID and Endoscopy will have to be relocated prior to site start, with potential double- decant
- Functionality of the refurbished elements could be limited by fabric considerations
- Construction work and demolition work will be carried out very close to a live occupied hospital resulting in significant ICP risks over a prolonged period.
- Significant disruption in terms of noise, dust, traffic and asbestos risk
- Refurbishment phases will involve major construction work within a live occupied hospital for an extended period. This presents risks to safe patient care and would cause diminution of the quality of patient experience over a long timescale (e.g. noise, dust etc).
- All existing site and infrastructure issues will remain, as will a large proportion of cost liabilities associated with backlog maintenance.
- Demolition and final roads disposition and parking will not be complete until two years after occupation with associated loss of parking
- Regional services e.g. Renal and I.D. not able to develop aspirational clinical models as limited by site.
- Space for Construction Village limited
- Limited ability to significantly increase clinical capacity in future
- Current very high levels of energy inefficiency are unlikely to be improved

Option C: New-build at Monklands:

Pros:

- New hospital should be fully functional
- New hospital should be capable of meeting appropriate sustainability targets
- Hospital use has already been established for the site
- Maggie's and Lanarkshire Beatson are retained on site
- Would significantly reduce or eliminate backlog maintenance cost liabilities at the time of opening
- Ability to significantly increase clinical capacity in future

Cons

- Renal, ID and Endoscopy will have to be relocated prior to site start, with potential double-decant
- Construction work and demolition work will be carried out very close to a live occupied hospital in terms of traffic disruption, noise and dust. This presents risks to safe patient care and would cause diminution of the quality of patient experience over a long timescale.
- There will be a significant reduction in parking numbers during construction, which will require development of alternative parking arrangements
- Existing site and infrastructure issues will remain
- Demolition and final roads disposition and parking will not be complete until two years after occupation
- Clinical Models may be affected by compromises in build design due to site boundaries affecting clinical adjacencies
- Limitation of horizontal space therefore only able to develop vertically which limits clinical functionality
- Life Science Faculty for excellence in training and teaching for staff may be compromised given site size limitations/ boundaries
- Space for Construction Village limited

Option D: New-build on New Site:

Pros:

- Best possible patient- centred care models can be developed and implemented without compromise.
- Mix of open and enclosed spaces to promote patient recovery
- Full development of Life Sciences Faculty to promote on site teaching, training, Quality Improvement and research centres together with Patient Safety hub to improve recruitment and retention of all staff
- New hospital should be fully functional
- No phasing/ decant issues; Renal, ID and Endoscopy can be accommodated in new building in single decant on completion
- No disruption to existing hospital buildings during construction period
- New hospital should be capable of meeting appropriate sustainability targets
- Would eliminate backlog maintenance cost liabilities (from the current Monklands Hospital (at the time of opening), and create a better and cheaper to operate facility (in terms of future maintenance liabilities).
- There will be no reduction in parking numbers or diminution in the Monklands patient environment during construction and indeed improvements in car parking and accessibility would be a key objective.
- Ability to significantly increase clinical capacity in future

Cons:

- Site not yet identified nor obtained, so access, infrastructure and planning risks not yet determined; assessment of a number of alternative sites currently being undertaken
- Need to write-down costs of areas of recent investment (theatres, radiotherapy and Maggie's Centre)

5.3.4 Conclusions

Option A: Do Minimum:

- This option is to continue with the current strategy on backlog maintenance.
- This option will not enable the delivery of the healthcare strategy and cannot achieve compliance with current buildings standards.
- This option has been retained as a base-line option for comparison with other options.

Option B: Refurbishment at Monklands:

- This option involves construction of a new building at Monklands to create the decant space to enable the existing fabric to be refurbished while maintaining continuity of service.
- Existing Renal, Infectious Diseases and Endoscopy would have to be decanted to create the site for the new building.
- There are two sub-variants arising from whether the existing ward towers are retained for in-patient ward accommodation or not. This issue would affect the complexity and phasing of the refurbishment operation
- Overall timescale is likely to be eight years for completion of the new building, followed by an average of 18 years for phased refurbishment in six major phases, a total of approximately of 25 years overall.
- The effect of major construction work being carried out over a long period in the heart of an operational hospital will place limitations of the programme and increase costs.

Option C: New-build at Monklands:

- This option involves construction of a new building at Monklands that will accommodate the whole hospital; on completion the existing buildings will be demolished to provide space for future development.
- There are two sub-variants: in C (i) the existing Renal, Infectious Diseases and Endoscopy would have to be decanted to create the site for the new building. In C (ii) the new building would be constructed on the former site of residential accommodation (currently a surface car park) which avoids the initial decant, but may not be a way forward because of planning permission issues.
- Overall time scale is likely to be eight years for completion and occupation of the new building for Option C (i), and seven years for C (ii). A further two years would be required for demolition of the existing buildings and installation of new parking and road infrastructure, a total of around 10 years of construction on the Monklands site.

Option D: New-build on New Site

- This option involves construction of a new building on a new site within the local area; on completion all hospital functions will move to the new building, and the existing site will be disposed of.
- While consideration is currently being given to potential sites, no specific site has so far been identified.
- There are no phasing or decant issues associated with this option, together with no disruption caused by construction operations.
- Overall time scale is likely to be 8 or 9 years to: finalise site acquisition; planning permission; site infrastructure; construction and commission.

5.4 Indicative costs

Capital costs have been developed for each option to include Works Costs, Design Fees other NHS Direct Costs, Risk, Optimism Bias, Inflation and VAT.

Table 16: Capital Costs Ranges (£m)

Cost in £m	Option A – Do Minimum	Option B - Refurbishment	Option C – New Build at Monklands	Option D New Build at New Site
Works	£125 - £128	£272 - £269	£234 - £240	£239 - £245
Design Fees	£19 - £19	£35 - £35	£30 - £31	£31 - £32
NHS Direct Costs	£6 - £6	£41 - £46	£35 - £36	£41 - £42
Risk	£48 - £49	£84 - £98	£60 - £62	£56 - £57
Inflation	£73 - £75	£161 - £181	£54 - £56	£55 - £56
VAT	£54 - £56	£119 - £126	£83 - £85	£84 - £86
Total	**£325 - £333**	**£712 - £755**	**£496 - £510**	**£506 - £518**

The Capital Costs for Option A, the Do Nothing Option, were prepared on the basis that the only costs incurred are those required to continue to address risks and ensure Business Continuity is maintained. The costs assume that the hospital will continue to function for 20 years but will not necessarily address all intractable risks. It should be noted that Option A (Do Nothing), on clinical grounds and on the basis of the recent Health Facilities Scotland report on the current infrastructure challenges cannot be considered as a viable option and is only included here as a baseline comparator.

Therefore, only options B, C and D are viable options that will be taken forward to the Outline Business Case for appraisal.

For Option B, Refurbishment at Monklands, the Capital Costs allow for the construction of a new building sufficient to provide new facilities with decant capacity to support a phased refurbishment of the buildings whilst maintaining business continuity. This option would require 6 phases and these phases would take in excess of 20 years to deliver completely. This option assumes that the hospital will function for 50 years.

In principle this option requires to be delivered without disruption to business continuity. In reality there would be considerable disruption to services over a prolonged period with each phase involved representing a major construction project, which would in turn present great

risk to business continuity. There will be significant costs to address car parking and site access issues as well as decant and enabling costs for each phase. There will also be demolition costs in respect of Renal, ID and Endoscopy. The length of time required to deliver this option and the requirement to maintain business continuity over the delivery period has resulted in a significant allowance in respect of risk and inflation. A range of capital costs are included to recognise the costs associated with this option as described in section 5.3.1.Option B: Refurbishment at Monklands. A range of capital costs are included to recognise the costs associated with the 2 variants of this option.

For Option C, New build at Monklands, Capital Costs allow for the construction of a new build on the current site with 2 possible variants under consideration:

- New build on site of existing Renal, ID and Endoscopy
- New build on the area of the site of the previous residential accommodation, now part of the site car parking

There are significant costs attached to ensuring that business continuity is maintained and ensuring car parking and traffic flows are safe and adequate during the period of the delivery of the works. Demolition of vacated buildings has been included in the costs of this option. The upper range cost for this facility includes provision of up to 100% single bed ward accommodation.

This option assumes the hospital will have a 50 year life and a range of capital costs are included to recognise the costs associated with this option as described in section 5.3.1.Option C : New-build at Monklands

For Option D New Build on new site, Capital Costs allow for the full costs of acquiring a new site and full construction costs to provide a new build facility. This includes the cost of re-providing a new West of Scotland Satellite Radiotherapy Treatment Centre and Maggie's Centre to replace the facilities currently located on the Monklands Site. The upper range costs for this facility includes the provision of up to 100% single bed ward accommodation.

This option assumes the hospital will have a 50 year life and a range of capital costs are included to recognise the costs associated with this option as described in section 5.3.1.Option D : New-build on New Site.

For Option D New Build on new site, Capital Costs allow for the full costs of acquiring a new site and full construction costs to provide a new build facility. This includes the cost of re-

providing a new West of Scotland Satellite Radiotherapy Treatment Centre and Maggie's Centre to replace the facilities currently located on the Monklands Site.

The upper range costs for this facility includes the provision of 100% single bed ward accommodation.

Life cycle costs for each option have been calculated by the board's cost advisors Currie & Brown and these are reflected in table 17 below.

Table 17: Lifecycle Costing

Costs in £millions	Do Nothing: As existing arrangements	Proposed option B - Refurbishment	Proposed option C – New build at Monklands	Proposed option D – New build at New site
Whole of life cycle costs	£34 - £38	£108 -£124	£98 - £110	£98 - £110

Clinical service costs for the new build have been calculated to allow for the increased nursing costs required to manage up to 100% single bed ward accommodation. This has been estimated at 10% of ward based nursing staff in line with increased costs experienced by NHS Greater Glasgow and Clyde in respect of the new Queen Elizabeth University Hospital. This would equate to an increase in nurse staffing costs of £1.9m. Work on developing a more detailed appraisal of these costs is currently being progressed with Workforce Planning, Monklands senior nursing and Finance staff.

Non- clinical operating costs will increase as a result of the increase in clinical accommodation and the extended working week and the requirement to have up to 100% single bed provision. This is estimated at £0.25m for the purposes of the IA.

Work on producing a more detailed appraisal of these costs is currently being progressed with Property and Support Services and Finance staff. This estimate is primarily to cover increased domestic services costs to provide the additional cleaning requirements resulting from a move to 100% single bed ensuite accommodation and an increase in the use of the building.

Building running costs are also anticipated to increase. This is estimated at £0.75m and covers potential cost increases in Local Authority rates, utilities, facilities and the requirement to move towards up to 100% single bed provision. Work on producing a more detailed appraisal of these costs is currently being progressed with Property and Support Services and Finance staff.

These costs are assumed as being effective from the opening of new facilities under Option C and D but are phased as the new ward facilities are developed and brought into use under Option B.

For Option D it has been assumed that any surplus land will be sold and this will be reflected in the Financial Appraisal of the appropriate Options. Option C costs are not likely to be offset by any resulting land sale.

Under this option the full Monklands site will be available for sale. An initial valuation of this has been assessed by the board's property advisor and this will be revised as the project progresses. The capital, life cycle, associated revenue costs and land sales were used to carry out an economic appraisal of the options, using discounted cash flow techniques as outlined in the Scottish Capital Investment Manual. In line with this guidance a discount rate of 3.5% has been used in the appraisal and the results are as shown in table 18. This shows the net present value (NPV) equivalent annual costs (EAC) for each of the options and is presented in ranges using the lower and upper bound figures.

Table 18: Economic Appraisal of Proposed Solutions

Cost in £m	Option A – Do Minimum	Option B - Refurbishment	Option C – New Build at Monklands	Option D New Build at New Site
Net Present Value	£131 - £136	£329 - £345	£347 - £356	£353 - £364
Equivalent Annual Cost	£8 - £9	£13 - £13	£13 - £13	£13 - £14

The Economic Appraisal calculation takes account of:

- Capital development costs including fees
- Life Cycle Costs
- In-House Fees and Costs, including Equipment to support the delivery of the project
- Land acquisition and enabling works
- Additional recurring annual revenue costs and Non-recurring revenue costs in respect of double running, relocation and other enabling costs

Cash flows were calculated using capital and revenue costs referred to above net of VAT, inflation and capital charges. In discounting it has been assumed that:

- New builds would have a life of 50 years including Option B the full Refurbishment and Rebuild on the Monklands Site
- Refurbishment for the do minimum options would have a life of 20 years
- New build capital costs and land purchase will be incurred in years 3 -6
- Backlog maintenance costs in respect of the do minimum options would be spread over the life of the building
- Land disposal proceeds are reflected for the full site under Option D on the assumption that disposal of the site would be achieved within three years of the site being vacated

Although the "do minimum" option has significantly less capital cost compared to the refurbishment and the 2 "new build" options within the shortlist, it is included in this assessment as a baseline to allow it to be compared to the other options.

This project will require capital impairments in respect of the write down of existing buildings earmarked for demolition. This will require to be funded by Scottish Government Health Department as Annually Managed Expenditure (AME) and will require to be included within the Board's future returns.

Indicative costs for the proposed options can be summarised in the following table:

Table 19: Indicative Costs

Costs in £millions	Do Nothing: As existing arrangements	Proposed option B - Refurbishment	Proposed option C – New build at Monklands	Proposed option D – New build at New site
Capital cost (or equivalent value)	£325 - £333	£712 - £755	£496 - £510	£506 - £518
Whole of life cycle costs	£34 - £38	£108 -£124	£98 - £110	£98 - £110
Whole of life operating costs (Clinical & Building Costs)	£0	£83 - £88	£130 - £140	£130 - £140
Estimated Net Present Value	£131 - £136	£329 - £345	£347 -£356	£353 -£364

5.5 Initial Assessment of Proposed Solutions

An extensive explanation of the Strengths/ Weaknesses of each of the proposed solutions has been provided throughout the discussion in Section 5.3. The table below therefore summarises the proposed solutions viability against the Investment Objectives and Indicative Costs detailed earlier in this Initial Agreement:

Table 20: Initial Assessment of Proposed Solutions

	Option A: Do Minimum	Option B: Refurbishment at Monklands	Option C: New build at Monklands	Option D: New build on New Site
Investment Objective	**Does it meet the Investment Objectives (Fully, Partially, No, N/A):**			
Provision of the necessary clinical environment (diagnostics, clinics and outpatients) and support functions (eHealth, transport) will deliver the necessary shift in the balance of care to achieve the strategic objectives set out in "Achieving Excellence" Provision of services at both Wishaw and Hairmyres beyond their original PFI contract periods or opportunity for provision of additional clinical capacity at new Monklands	N	P	F	F
The new facility will be designed to match the new models of service described in "Achieving Excellence". This will ensure we provide facilities which enable a lower proportion of inpatient admissions and higher proportion of community, outpatient and day case/treatment facilities. We will develop centres of excellence to provide more effective and efficient services. This will reduce length of stay.	N	P	F	F
The new facilities will be an integral element in redesigning those patient pathways where acute admission is absolutely required.	N	P	F	F
Application of modern technical and environmental standards to the accommodation being used will provide clinical and non-clinical services with functional suitability and improved efficiency.	N	P	F	F
The risks which the current facility place on safe and efficient clinical activity will be removed by the shift to a new facility.	N	P	F	F
	Are the indicative costs likely to represent value for money and be affordable? (Yes, Maybe / Unknown, No)			
VfM & Affordability	N / M	N / N	Y / Y	Y / Y
Preferred / Possible / Rejected	**Rejected**	**Possible**	**Preferred**	**Preferred**

It can be noted that whilst Option A and B are possible and therefore will be brought forward to the Outline Business Case for appraisal, Options C and D provide the most positive solution for the project.

A single preferred solution cannot be identified at this point in the process with further work to be undertaken on the clinical strategy and site search. All the solutions identified above will therefore be subject to the formal Benefits Appraisal process as part of the Outline Business Case.

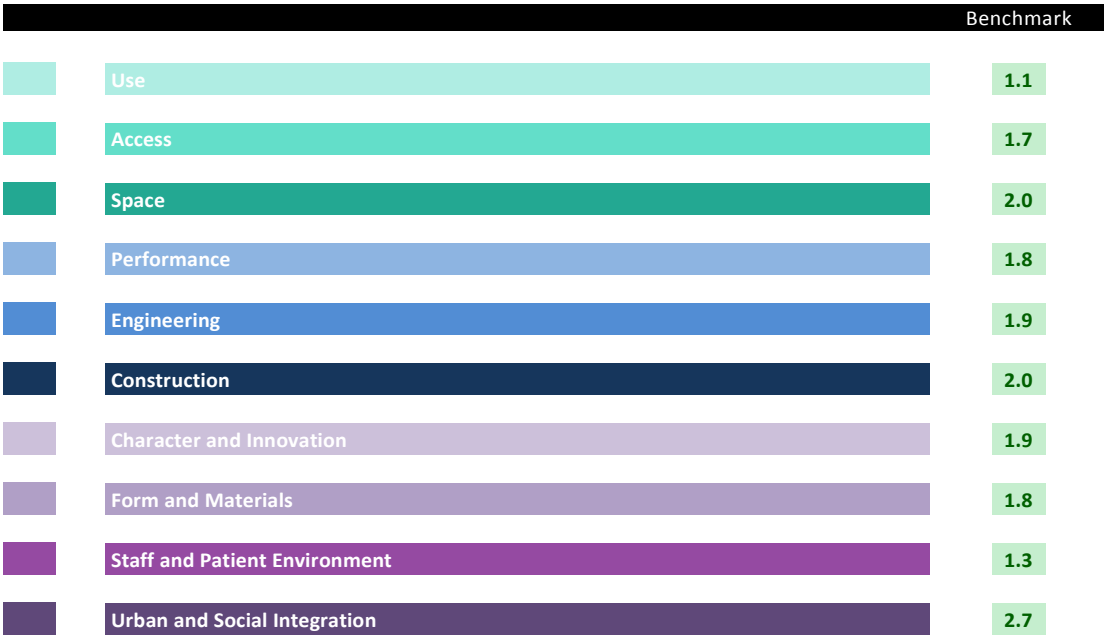
5.6 Design Quality Objectives

The Project Team has had early engagement with Health Facilities Scotland (HFS) and Architecture & Design Scotland (A+DS) with regards to using the NHS Scotland Design Assessment Process (NDAP).

The Achieving Excellence Design Evaluation Toolkit (AEDET) process is underway as detailed below and a Design Statement has been prepared (included as Appendix 3). This has been submitted to HFS to allow their IA stage report to be prepared for SGHSCD CIG.

A multi- stakeholder workshop was carried out on 16th May 2016 to establish the AEDET score for the current arrangements at Monklands. The results of this workshop are shown below:

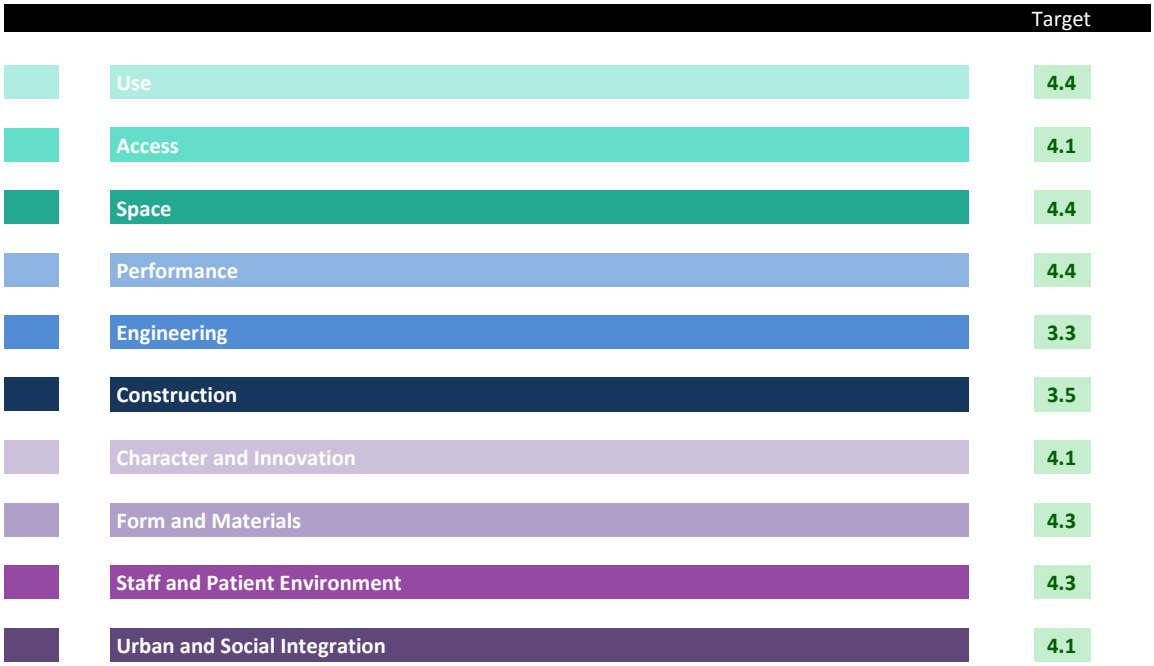
Table 21: Monklands Existing Arrangements: AEDET scores



The HFS AEDET Refresh guidance would suggest that a score of at least 3 is achieved as a target in each category, so it is clear that across all ten categories there is significant room for improvement on the current Benchmark scoring, with the majority of scores noted as below 2.

A Target score has been developed with key stakeholders for the project through a further Workshop held on 16th November 2016 as follows:

Table 22: Monklands Target Scoring: AEDET scores



This Target significantly raises the scoring for each category against the Benchmarked value and progress against this will be measured at each stage of the Business Case development and post Construction in order to achieve a high design quality in accordance with the Board's Design Action Plan and guidance available from A+DS.

It is understood that a Building Research Establishment Environmental Assessment Method (BREEAM) rating of 'Excellent' will be targeted for the proposal and appropriate engagement with HFS will be undertaken in order to achieve this.

A number of Design Statement Workshops have been undertaken at this early stage facilitated by A+DS, and the subsequent document (the Design Statement) will provide a constant benchmark for agreed design principles throughout the lifetime of the project. There has been a significant level of engagement in this process with a range of patient representatives, staff and staff representatives.

The Design Statement is included as Appendix 3.

6 Is the organisation ready to proceed with the proposal?

	Question	Response
Commercial, Financial & Management Cases	Is the organisation ready to proceed with the proposal?	Confirm: • Procurement strategy & timetable • Affordability & financial consequences • Governance & project management arrangements

6.1 The Commercial Case

This section will provide a statement of the proposed procurement route likely for the preferred solution(s), along with a timetable covering the key business case stages, design development milestones, main procurement steps and likely construction / implementation period.

6.1.1 Statement on Proposed Procurement Route

Prior to 2015 the MRR Project would have been procured using the Non-Profit Distributing (NPD) privately financed, revenue funded model. Currently no projects are being progressed under the NPD model and following discussion with the Scottish Government it is anticipated that this project will be traditionally funded capital procurement.

In order to identify at an early stage the preferred procurement route to be adopted, a procurement strategy workshop was held on 9th December 2016. This was facilitated by Currie & Brown and included technical, finance, and clinical representatives from NHSL. The attendees also included individuals involved in the Queen Elizabeth University Hospital and Royal Hospital for Children project for NHS Greater Glasgow & Clyde who were able to advise on experience form this and other major healthcare procurements.

The workshop related both to the procurement of external consultant technical advisors that NHSL has established are required to support the internal NHSL team and to the constructing partner.

6.1.2 Procurement Workshop – Construction Partner

Prior to commencing the shortlisting process the group reviewed and agreed the selection criteria included in the pre workshop procurement paper and the first part of the process was to shortlist suitable potential procurement routes form the eight possible routes identified in the pre workshop paper.

Through the discussions the group arrived at the following procurement shortlist that would meet the required criteria:

- Traditional
- Design & Build
- Design, Develop & Construct

The other options were reviewed and discounted as follows:

Table 23: Procurement Options

Procurement Options	Reasons for Discounting
Early Integrated Team	Early integrated team is a pure partnership form where the designers and constructor would be involved before there is a clear brief. This is not suitable for the MRRP.
FS2/3	FS2/3 is intended for smaller health projects up to a value of the order of £20 million and is not appropriate for use on projects of this scale and complexity.
hub	hub was ruled out for similar reasons to FS2/3 being appropriate in taking forward community projects up to a value in the order of £20m in value where multiple stakeholders\organisations are joining together e.g. Health Board and Local Authority.
Construction Management	Construction Management places a significant separate contracts structure on the client and does not give time or cost certainty at contract award and only when the final works package is let.
Management Contracting	Management Contracting does not give time or cost certainty at contract award and only when the final works package is let.
Revenue Financed	Revenue funding (NPD) is no longer available.

Discussion then took place around the scoring of the three viable options and this was scored on the basis of the criteria and weightings identified in the guidance paper and subsequently agreed at the workshop. The scores are shown in the following table:

Table 24: Viable Options

		Procurement strategies					
		Traditional		Design and build		Design, develop and construct	
Characteristic	Weighting	Score	Weighted score	Score	Weighted score	Score	Weighted score
Client control over design and specification	25	10	25	6	15	8	20
Innovative design	10	4	4	6	6	8	8
Impact & control of change	10	7	7	5	5	6	6
Single point design and construction responsibility	20	2	4	10	20	10	20
Cost and time certainty after contract execution	25	7	17.5	9	22.5	9	22.5
Speed of development	10	4	4	6	2.4	7	4.2
	100						
Total weighted score / Ranking			61.5		70.9		80.7

As can be seen the shortlist of three procurement option and weighted scores were:

- Design, Develop & Construct 80.70
- Design & Build 70.90
- Traditional 61.50

Design Develop and Construct is the clear preferred procurement option.

A sensitivity analysis was carried out on the scoring and found to have no effect on the score ranking.

The group noted that discussions would be required during the development of the OBC on the particular form of contract to be adopted.

6.1.3 Procurement Workshop – Technical Advisors

The workshop group discussed the options for engaging the required technical advisors (TA) based on the support required by the internal NHSL team and the Design Develop and Construct procurement route.

The TA team will have to be capable of taking the design to around RIBA Stage 2. This initial stage will also need input from a healthcare planner to assist NHSL finalise the clinical strategy / clinical output specifications that require to be reflected in design proposals. The TA team members will need to demonstrate:

- Major health project experience
- Procurement expertise
- Experience of capital funded procurement
- Healthcare planning experience
- Relevant design experience
- Programming/planning expertise
- Commercial expertise

OJEU/FS2/Hub Strategic Advice options were all considered.

Hub Strategic Advice - It was noted that NHSL have had some discussions with South West Hub on strategic support services for TA support however it was advised that the Hub option would not cover the scope of service required to procure the works contractor.

FS2 - There had also been discussion with HFS who considered that FS2 would be an option, with appointments being made for Lead Advisor (LA), CDMC and Healthcare Planning.

However the group concluded firstly that the LA framework providers may not all be appropriate, secondly that managing three separate appointments would not be best, and thirdly the exclusion of others not on the framework would be open to challenge

OJEU - The OJEU process would allow the greatest flexibility in procurement to appoint the most appropriate TA without risk of challenge and the restricted and open procedures can be assessed for the most appropriate and optimum programme advantages.

The OJEU route is therefore to be progressed under either the open or the restricted procedure.

The workshop report and pre workshop paper is included in Appendix 2.

6.1.4 Timetable of Key Business Stages

Table 25: Timetable of Key Stages

Activity	Period
SGHSCD Initial Agreement Approval	3rd QTR '17
Outline Business Case Approval	3rd QTR '17 – 2rd QTR '19
Technical Advisor Procurement	3rd QTR '17 – 1st QTR '18
Contractor Procurement	4th QTR '18 – 1st QTR '20
Full Business Case	2nd QTR '20 – 2nd QTR '21
Construction/Demolition	3rd QTR '21 – 3rd QTR '25
Commissioning	3rd QTR '25 – 1st QTR '26
Migration	1st QTR '26 – 1st QTR '26

The construction/ demolition phase is based on options C New build on Monklands and D New build on a new site i.e. a 4-5 year construction period from approval of the FBC. For option B Refurbishment at Monklands this would be 20+ years.

6.2 The Financial Case

NHS Lanarkshire consistently meets its financial targets and is predicting a financial out-turn which will ensure that the board meets the 2017/18 Revenue & Capital Resource Limits. The re-provision of a District General Hospital to replace the current facility at Monklands is seen as a catalyst to support delivery of the NHS Lanarkshire Healthcare Strategy 'Achieving Excellence'. The board recognises that this represents a significant challenge not only in the delivery of the strategy but also ensuring that this is achieved within the Revenue Resources made available to the board.

While NHS Lanarkshire recognise that the replacement of the current Monklands Hospital, either by way of major refurbishment or rebuild on the current site or a new build on another site, is a significant undertaking it is a key requirement to support the delivery of the board's Healthcare strategy 'Achieving Excellence'. Between now and the development of the OBC there will be several key issues which will need to be considered to allow the successful delivery of this project and to ensure that the project remains affordable within the revenue resources available to the board. These will include:

- Ability to deliver the clinical model
- Ability to reduce length of stay
- Bed numbers required within the new hospital
- Overall NHS Lanarkshire bed numbers
- Single Room requirements
- Link to national initiatives
- Development of NHS Lanarkshire centres of excellence
- Impact of potential regional centres of excellence
- Development of Health & Social Care Partnerships

At this stage the Board do not anticipate any specific financial contributions from external partners. The development of the new facility and the contribution this will make to the delivery of the Board's Healthcare strategy will be strongly influenced by the way in which the integration of Health & Social Care develops within Lanarkshire and the budgets aligned to supporting this will be key to the overall delivery of an affordable financial plan for NHS Lanarkshire. Resourcing of the project is key to successful delivery and the PID has identified key support across a range of disciplines to support the process. Full provision for the funding of this resource is contained within the board's financial plan.

The individuals involved in this project have previous background experience in delivering Capital Developments across a range of size, complexity and procurement routes.

The current assumption in this IA is that the funding for this project is by way of a Capital Allocation to support a traditionally funded capital build. The main elements of this funding will be required during the Construction Phase in financial years 2019/20 – 2022/23 however funding will be required to fund the development of the design during the OBC/ FBC phases of the project.

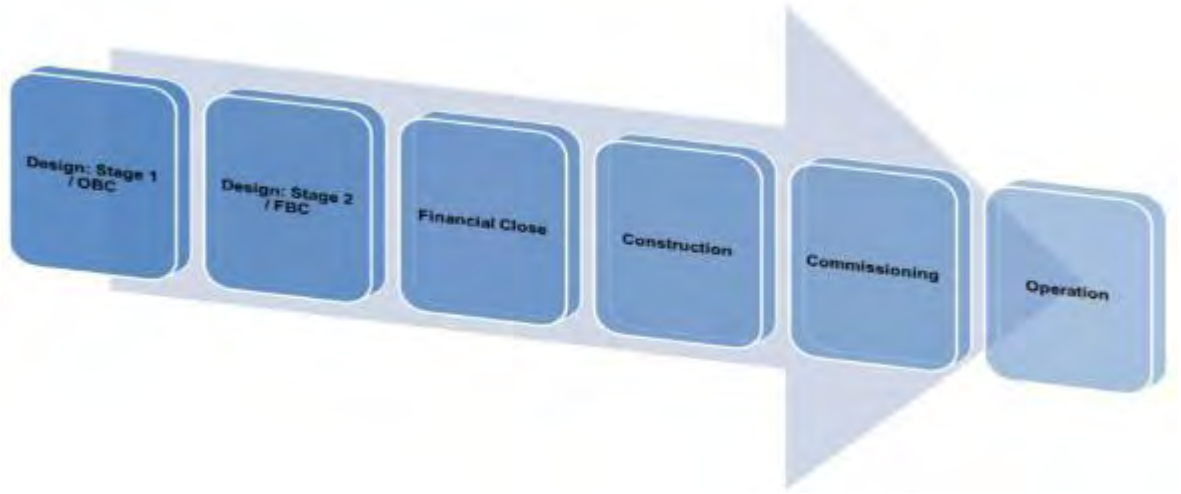
6.3 The Management Case

A benefits register (Section 4.4) and a synopsis of strategic risks (Section 4.5) have been prepared as part of this Initial Agreement. To successfully manage and deliver this project clearly defined project management arrangements have been established and experienced personnel identified to implement them.

The project management approach is underpinned by the high level principles as outlined in SCIM's 'Programme and Project Organisation Guide' in identifying Project Roles and Responsibilities.

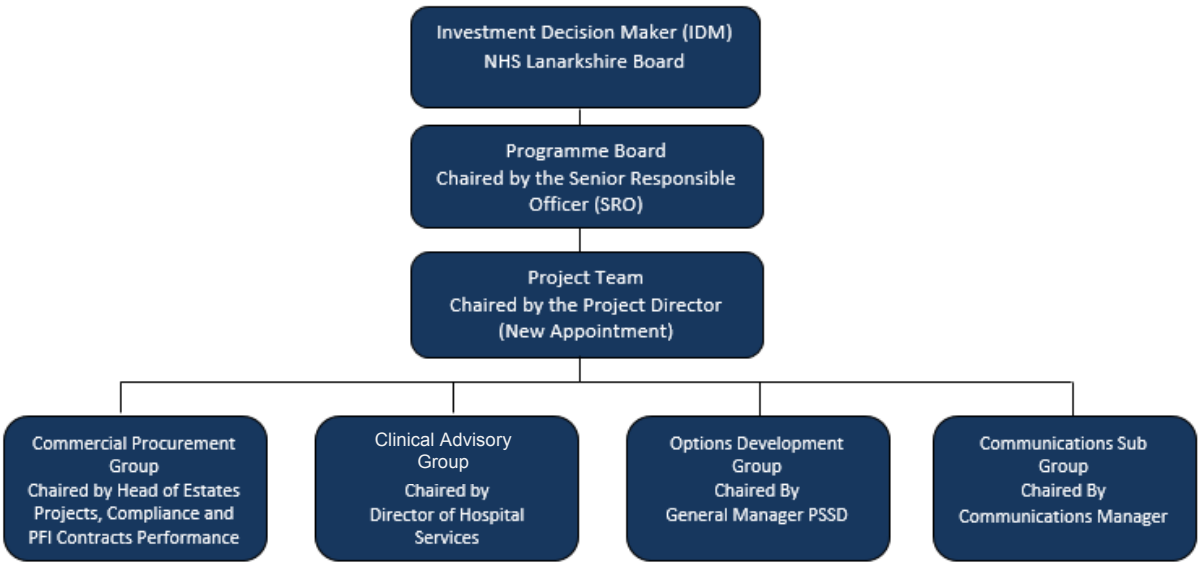
The approach required is of a phased nature due to the scale and complexity of this project and this is set out below:

Figure 23: Project Phasing



The organisational diagram below demonstrates the governance arrangements which have been developed to take forward the proposal at this stage:

Figure 24: Project Governance



Each phase of the project will require a distinct operational structure, with the various groups within that structure performing specific roles and responsibilities during each phase.

6.3.1 Project Board

The NHSL Deputy Chief Executive is the Senior Responsible Officer (SRO) and will provide overall direction and leadership to the project.

The Project Board is a strategic group responsible for ensuring that a dedicated, qualified and sufficiently resourced Project Team is in place to lead the delivery of the project and that a project governance structure has been established that clearly links to the governance arrangements of the NHSL Board and to the wider healthcare strategy “Achieving Excellence”. The Director of Acute Services, Director of Finance, leads from the Lanarkshire Health and Social Care Partnerships and advisors from Health Facilities Scotland have places on the Project Board.

The NHSL Board has considerable experience in the delivery of capital projects and has successfully delivered two district general hospitals, a community hospital and an extensive Primary Care Investment Programme in the recent past. The level of experience within the NHS Board is significant particularly within planning, finance and property services, and we believe that this is an area of specific relevant experience that will add value to the delivery of this project.

The Project Board meets quarterly.

6.3.2 Project Team

The Project Team is responsible for controlling and managing all matters relating to the day to day development of the project. The Project Team is led by the Project Director, a new appointment to NHS Lanarkshire. The Project Director provides expert project management skills to successfully deliver the Board's MRRP across project procurement, construction, commissioning and post project evaluation phases.

The Project Director will support the Senior Responsible Officer (SRO) specifically in the day-to-day project management of the MRRP and for ensuring that the MRRP meets its objectives and delivers its projected benefits. He/she ensures that on a day-to-day basis that the frameworks put into place for accountability and governance are actively implemented and that defined project management components covering business case development, project organisation, plans, controls, risk management, project quality, configuration management and change control covering all of the activities of the multi-disciplinary project team members are actively managed. The post holder will also ensure that all relevant stakeholders are fully engaged in the project through the delivery of an agreed strategy for communication across the Board and wider health economy.

Critically during the procurement of the development partner, the post holder will provide the necessary day to day project management of a multi-disciplinary project team and the competitive tendering exercise for selection and appointment of the development partner including negotiation, tender analysis and reporting, authorisation and formal appointment of the successful tenderer.

This includes responsibility for:

- Clinical modelling
- User engagement and consultation
- Design and technical development
- Commercial Procurement
- Programme management
- Communications
- Key Project Issues
- Risk management

The Project Team incorporates the necessary mix of skills and experience required to deliver the project, incorporating clinical advisors, leads in key operational areas, planners and communications leads. The Project Team meets fortnightly.

6.3.2.1 Clinical Advisory Group

The Clinical Advisory Group is responsible for developing and determining the detail of the clinical models which will underpin service delivery. This is supported by a Clinical Support Group structure which is responsible for the detailed work across individual clinical specialties. This structure is shown below (and in Appendix 4). Formal work programmes have been established and a process of progress monitoring is now in place.

Figure 25: Clinical Advisory Group

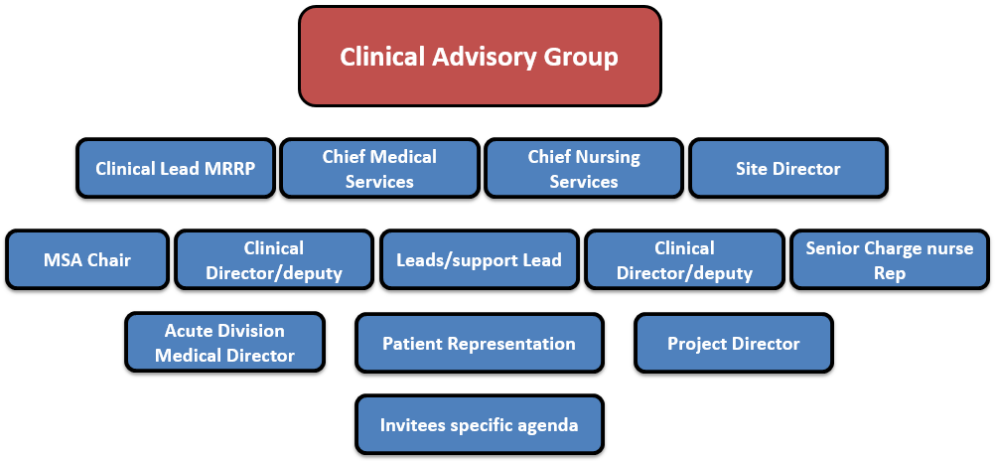
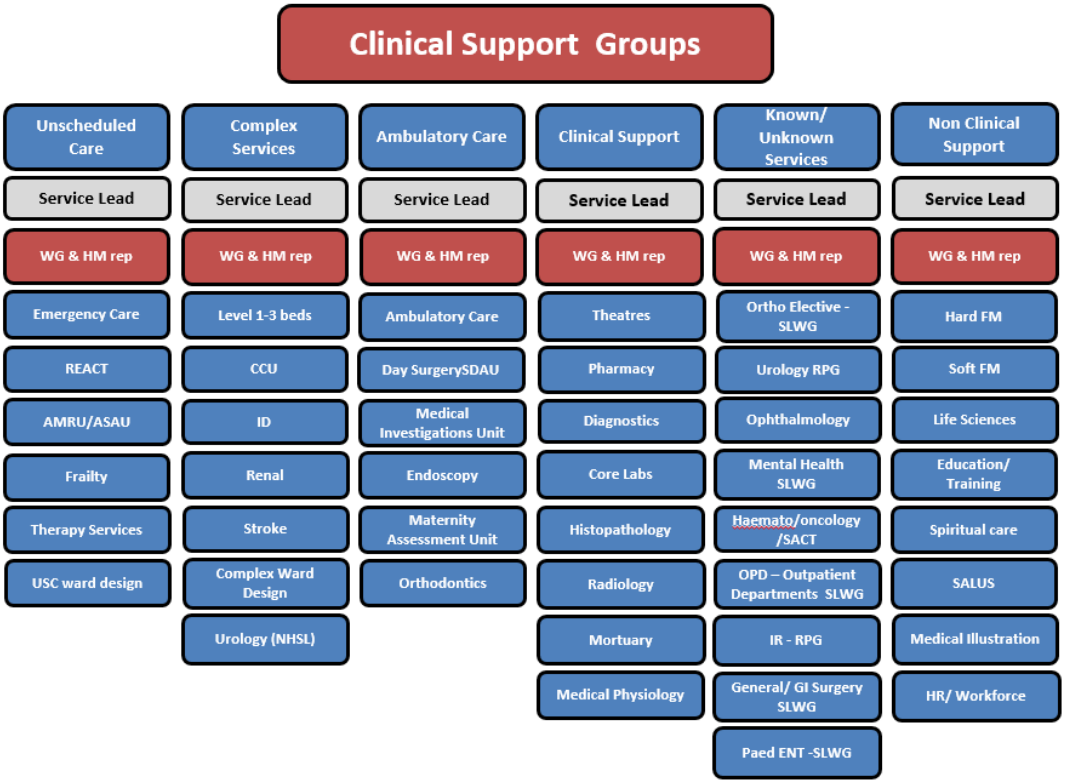


Figure 26: Clinical Support Group



6.3.3 Use of Specialist External Advisors

The Board will engage all appropriate specialist technical advisors as the project develops. This process will develop as the project progresses and is based upon the lead advisor approach with appointments facilitated via HFS Frameworks 2 arrangements. The Board is familiar with managing appointments of this type via Frameworks 2 and has significant experience of this mechanism. These resources will be managed via the Project Team and associated task groups.

Additionally the support available from National Organisations such as Health Facilities Scotland (HFS) and Architecture & Design Scotland (A+DS) will continue to be accessed as this is recognised as a key resource to be deployed in successfully delivery large complex projects.

6.4 Readiness to proceed

The following checklist has been drafted to provide comfort that NHSL is ready to submit the Initial Agreement for approval and is subsequently ready to proceed to the Outline Business Case stage:

Action	√ / X
Is the reason made clear why this proposal needs to be done now?	**Section 4**
Is there a good strategic fit between this proposal, NHSScotland's Strategic Priorities, national policies and the organisation's own strategies?	**Section 3**
Have the main stakeholders been identified and are they supportive of the proposal?	**3.1** **Appendix 4**
Is it made clear what constitutes a successful outcome?	**4.3**
Are realistic plans available for achieving and evaluating the desired outcomes and expected benefits to be gained, including how they are to be monitored?	**4.4**
Have the main project risks been identified, including appropriate actions taken for mitigating against them?	**4.5** **Appendix 2**
Does the project delivery team have the right skills, leadership and capability to achieve success?	**6.3.2**
Are appropriate management controls explained?	**Section 6**
Has provision for the financial and other resources required been explained?	**6.2**

7 Is this proposal still a priority?

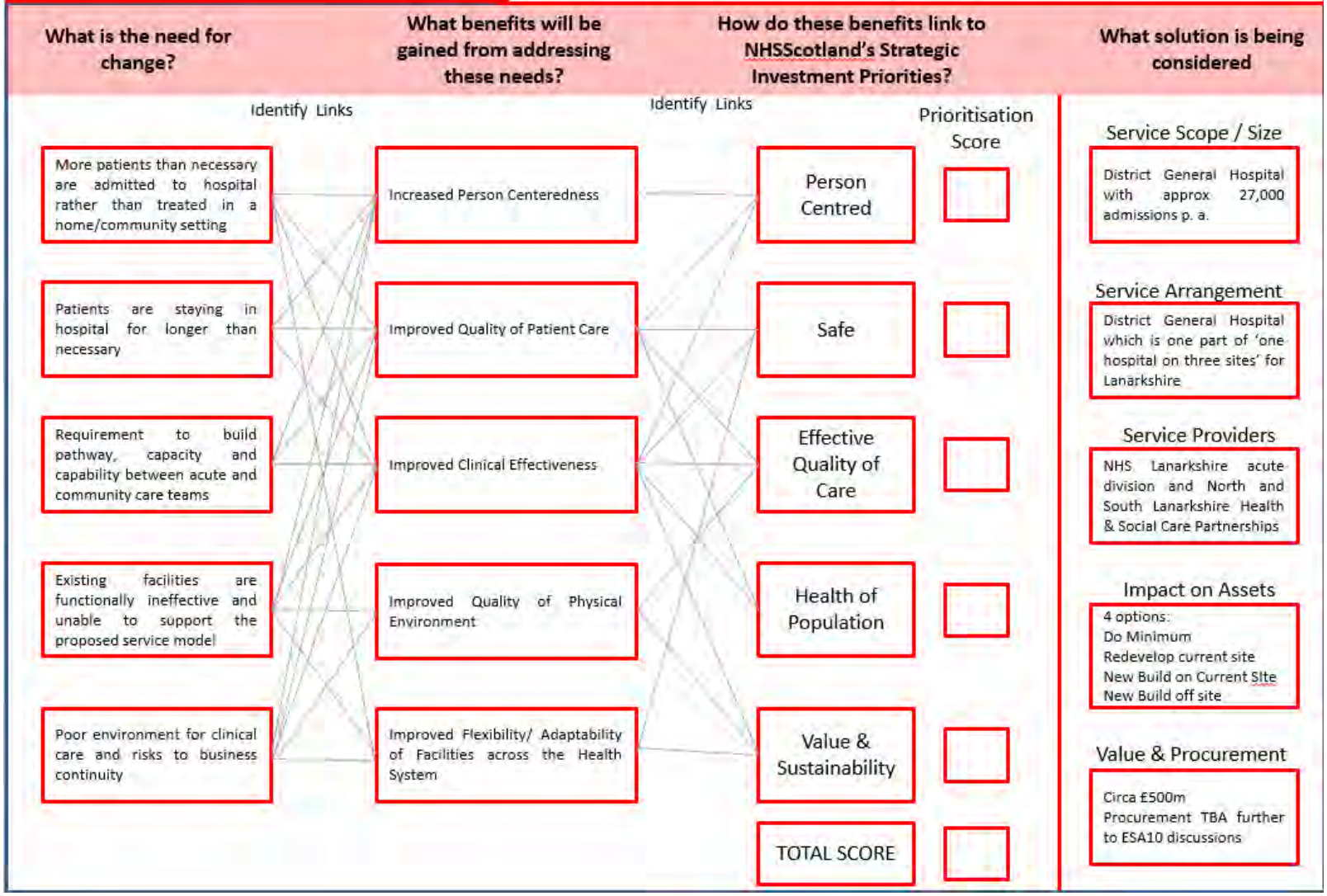
	Question	Response
Conclusion	Is this proposal still important?	Confirm: • Strategic Assessment template

There has been no change to the Strategic Assessment as submitted to SGHSCD in 2016. This has been provided as per the submission, below:

PROJECT:

What are the Current Arrangements:

Lanarkshire residents receive secondary and tertiary care in three local DGHs and in NHS Greater Glasgow and Clyde. This is part of an integrated health and social care system. Monklands hospital provides local emergency care for a defined catchment, plus some specialist medical and surgical services for the whole of Lanarkshire.



Glossary of Terms:

A+DS	Architecture + Design Scotland
AEDET	Achieving Excellence Design Evaluation Toolkit
AME	Annually Managed Expenditure
BREEAM	Building Research Establishment Environmental Assessment Method
CEL	Chief Executive Letter
CIG	Capital Investment Group
DGHs	District General Hospital
EAC	Equivalent Annual Costs
EAMS	Estates Asset Management Strategy
ED	Emergency Department
ENT	Ear, Nose and Throat
FBC	Full Business Case
GI	Gastro Intestinal
HAI	Hospital Acquired Infection
HDU	High Dependency Unit
HFS	Health Facilities Scotland
HIS	Healthcare Improvement Scotland
HSCP	Health and Social Care Partnership
IA	Initial Agreement
ITU	Intensive Trauma Unit
KPIs	Key Performance Indicators
LDP	Local Delivery Plan
MDGH	Monklands District General Hospital
MKBC	Monklands Business Continuity
MRR	Monklands Replacement/ Refurbishment
NCS	National Clinical Strategy
NDAP	National Design Assessment Process
NHSL	NHS Lanarkshire
NPD	Non- Profit Distributing
NPV	Net Present Value
OBC	Outline Business Case
PAMS	Property an Asset Management Strategy
PID	Project Initiation Document
RPA	Risk Potential Assessment
RPG	Regional Planning Group
SCIM	Scottish Capital Investment Manual
SGHSCD	Scottish Government Health and Social Care Department
SHC	Scottish Health Council
SRO	Senior Responsible Officer
VAT	Value Added Tax
VfM	Value for Money

Appendix 1

Consultation and Engagement Summary

NHS Lanarkshire recognises that the voice of the patient is an essential element in designing new facilities and significant work has been undertaken to ensure that our processes of engagement and consultation fully reflect this.

Issues such as layout of the various departments, creating a patient friendly environment, access to the site and many other important facets of the design will be established quite early in the process. It is therefore important that we have been able to enlist the support of individuals who have the interest and enthusiasm to make a significant contribution.

Initially in March 2016 a press release and social media posts announced NHS Lanarkshire's intention to prepare a major new development to replace the existing Monklands Hospital. A public website has also been developed to ensure that up to date accurate information is freely available.

This announcement was immediately followed by the establishment of a working group to take forward the initial planning work for this new development. This included a series of workshops from May to October 2016 which included representation from a range of patient representatives in addition to clinicians and staff representatives.

Much of this early work has been to develop our Design Statement which is a key document setting out our high level aspirations and design objectives. We have embraced the NHSScotland Design Assessment Process (NDAP) and a number of workshops have been completed to facilitate this process. Further workshops in June 2017 allowed this process to be concluded.

NDAP was introduced as a means of facilitating a process to assist public bodies such as NHS Boards describe a clear path between the business objectives for a project and the necessary qualities of the building development. These meetings have been attended by a number of patient representatives. Clinical staff and staff representatives were also in attendance. This comprehensive audience is vital to ensure the design of the hospital meets the requirements of the hospital community.
In parallel further work has been taken forward within the overarching NHS Lanarkshire healthcare strategy "Achieving Excellence".

As part of this process a formal consultation exercise was held between August and November 2016 to engage, consult and seek the views of members of the public.

The four options consulted on in relation to the redevelopment of Monklands Hospital were:

a) Continue to maintain the existing hospital buildings
b) Partial redevelopment on the existing site – this would include redeveloping some of the existing hospital in addition to adding new buildings to replace some wards and other departments
c) Complete redevelopment on the existing site – build a new hospital on the
   - Monklands site to replace most of the existing buildings

d) Complete new build elsewhere in North Lanarkshire – build a new hospital
   - within the Monklands catchment area. (If this is selected as the preferred option, the final location would then be determined as part of the planning process).

Stakeholders were encouraged to share their views by a variety of methods including:

- Online through a SurveyMonkey questionnaire
- By email to a dedicated out-of-hours review email address
- By letter or paper copy of the questionnaire using a freepost address
- Public meetings
- Consultation roadshows.

The consultation aims were to:

- Consult widely with the people in Lanarkshire to ensure stakeholders have an opportunity to have a say on the future of services and the proposed Monklands Hospital development
- Carry out the consultation process in line with CEL 4
- Select methods that support effective and meaningful consultation
- Clearly articulate the benefits of the proposals to stakeholders
- Clearly set out what stakeholders have the ability to influence through their participation in the consultation process
- Involve stakeholders in the planning and delivery of the consultation process
- Work with Scottish Health Council to inform the verification process

In summary

The survey results have been provided a mixed response:

a) Maintain 11.2%
b) Partial redevelopment 30.4%
c) Complete redevelopment on same site 32.6%
d) Complete redevelopment on new site 25.8%

Reasons:

- Level of disruption
- Cost
- Transport

During the consultation process:

- Five public meetings were held attended by 270 people
- 10 locality stakeholder events were held attended by around 800 people
- 27 additional meetings attended by around 500 people featured the consultation. NHS Lanarkshire has been responsive to requests for additional engagement with community groups. This included attending a meeting of the Airdrie Local Area Partnership with the sole item on the agenda being the new Monklands development. A formal presentation was given followed by a questions and answers session. 46 people attended the meeting.
- 435 Survey Monkey questionnaires were completed online
- A dedicated email address hcsviews@lanarkshire.scot.nhs.uk was available for consultation enquiries and responses. Three consultation responses were also received by post.
- 21 newspaper articles on the consultation with a combined circulation of more than 108,000. In addition, advertisements for the public meetings appeared 13 times in local newspapers.
- There were 7,737 page views (6,758 unique visitors) of the Achieving Excellence consultation webpages on NHS Lanarkshire website.
- Staff and public engagement sessions took place at the main entrance and in the restaurant of Monklands Hospital.

- A dedicated Monklands Hospital Facebook page has been created - https://www.facebook.com/Monklands-Hospital-1185708261488427/

Approval of "Achieving Excellence"

The Scottish Health Council prepared a report on the outcomes from the consultation. "Achieving Excellence" was reviewed and amended in light of the responses to the 2016 public consultation and the SHC report, including the proposals for the development of Monklands DGH. The final version of the Healthcare Strategy was approved by the Cabinet Secretary for Health and Sport in April 2017. Her letter dated 28th April 2017 to the Chair of Lanarkshire NHS Board is shown below.

Cabinet Secretary for Health and Sport
Shona Robison MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@gov.scot

CHIEF EXECUTIVE/CHAIRMAN OFFICE
3 - MAY 2017
Original Copy to:

		By
For Action	✓	
For Information		
Draft Reply		
Comment		
Return		
File		

Ms Neena Mahal
Chair
NHS Lanarkshire
Kirklands
Fallside Road
Bothwell
G71 8BB

28 April 2017

Dear Neena,

Thank you for your letter of 29 March which presented NHS Lanarkshire's clinical healthcare strategy, entitled 'Achieving Excellence', for my approval. The strategy has been prepared in partnership with the two Health and Social Care Partnerships in Lanarkshire, and was approved by the Health Board at its meeting on 1 March.

I note that 'Achieving Excellence' has been developed using detailed analysis of the current and expected needs of the local population and seeks to describe, at a high level, how the Board and its planning partners will best meet these needs over the next ten years. In doing so, I am pleased to note that your local plans have been fully informed by national policies and guidelines, including the National Clinical Strategy and Delivery Plan for Health and Social Care.

In line with national guidance on effective engagement with local stakeholders, your plans have been informed by three months of formal consultation, and a report on this has been prepared by the independent Scottish Health Council (SHC). I am pleased to note your assurance that the Board has fully accepted the recommendations in the SHC report, and that you will fully adhere to these as your plans are taken forward. In particular, I have noted from the SHC report that, whilst local people are generally supportive of NHS Lanarkshire's 'centres of excellence' approach, there remain concerns that any planned service changes resulting from the strategy must fully consider issues of transportation and access. I am therefore pleased to note your further, specific assurance that the Board will continue to work with its planning partners, including Strathclyde Partnership for Transport and the Scottish Ambulance Service, to evaluate and address such concerns.

I note the Board's intention to continue to meaningfully engage with local stakeholders in preparing specific plans for improving local services under the 'Achieving Excellence' strategy. You will appreciate that this work must be informed by your continued adherence to the well-established national guidance on engaging local people in service change (CEL (4) 2010), in close liaison with, and as informed by the views of, the SHC.

In terms of specific service developments, I note the Board's intention to conduct an options appraisal exercise later in 2017/18 to identify whether the local elective orthopaedic centre of excellence should be best located at Hairmyres Hospital or Monklands Hospital. I welcome your assurance that this process will be fully evaluated by the SHC.

I also welcome the Board's intention to prepare a business case for either the redevelopment or replacement of Monklands Hospital, pending the approval of the Initial Agreement by the Government's Capital Investment Group.

In conclusion, and having considered your submission, I am content to approve the Board's 'Achieving Excellence' strategy. I am grateful to NHS Lanarkshire for the considerable efforts that have been made to date in bringing this work forward. The Board has made a compelling case for change which is consistent with national policy and supported by the majority of local stakeholders, including clinical staff, planning partners, local people and their representatives.

I am also pleased to note that the view of the SHC, as the independent arbiters of how consistent Health Boards' activity is with national guidance on effective engagement and consultation, that NHS Lanarkshire has conducted the process to date in a meaningful and inclusive way, providing local people with numerous and reasonable opportunities to express their views. I know the Board will appreciate the need to ensure that all local stakeholders continue to be kept fully informed and engaged in the on-going development and delivery of local services under the 'Achieving Excellence' strategy.

SHONA ROBISON

Next Steps

Engagement and communication with the stakeholders in this project will continue into the development of the outline business case in 2018. This process will have be implemented and monitored by the Project Team. Stakeholders' input will be an important element in the options appraisal process which (alongside the consideration of other criteria) will inform the preferred option for consideration as part of the OBC.

Appendix 2

Project Risk Register

			Pre - Mitigation							Post Mitigation			
Risk No.	Risk Category	Risk Description	Probability (Likelihood)	Impact	PI Score	Risk Level	Risk Effect	Risk Owner	Mitigation	Probability (Likelihood)	Impact	PI Score	Risk Level
1	Business	Potential environmental issues	4	5	20	High	Delay to programme Increased Costs	NHSL	Appropriate Site Surveys and Historical Survey Reviews on the selected sites.	2	5	10	Moderate
2	Business	Changes to operational policies	3	3	9	Moderate	Redesign Increased Costs	NHSL	A project Framework is in place which will manage and control any changes to policies through the development of The Clinical Model.	2	2	4	Low
3	Business	Legislative change	3	4	12	Significant	Redesign Increased Costs	NHSL	Monitoring of Legislative changes.	2	3	6	Low
4	Business	Changes in Government Policy	2	3	6	Low	Delay to programme Increased Costs	NHSL	Maintain dialogue with SGHSCD	2	2	4	Low
5	Business	Risks associated with plans for national elective treatment centres including Orthopaedics	3	4	12	Significant	Delay to programme Increased Costs	NHSL	Maintain dialogue with SGHSCD and our Regional Colleagues.	3	4	12	Significant
6	Business	Retention of Key Project Team members	3	2	6	Low	Delay to programme	NHSL	Maintain key personnel positions Ensure effective handover to new personnel	2	2	4	Low
7	Business	Organisational Changes	3	2	6	Low	Delay to programme Increased Costs	NHSL	Clinical Speciality Groups are now underway with an aim to build a Clinical Model which will the determine any Organisational changes.	2	2	4	Low
8	Business	Failure to delver adequate stakeholder engagement	3	4	12	Significant	Delay to programme	NHSL	Develop and Agree consultation programme with appropriate stakeholders Execute consultation programme	1	4	4	Low
9	Business	Failure to manage/react to changes within the overall programme	3	4	12	Significant	Inability to meet demand	PSC	A rigorous review and monitoring process is on-going	2	4	8	Moderate
10	Business	Failure to secure an appropriate funding stream	4	5	20	High	Programme Delay Unable to commence construction	NHSL	Define and cost scope of works. Acceptance of IA. Regular engagement with SGHSCD. Robust OBC/FBC.	4	5	20	High
11	Business	NHSL Board Advisors - capacity and capability	3	3	9	Moderate	Programme/ Cost Impact Benefits not realised	NHSL	Early procurement of Technical Advisors/Resource clearly established at interview Continuous monitoring and review throughout the project	1	3	3	Low
12	Business	Contractor - capacity and capability	3	3	9	Moderate	Programme/ Cost Impact Benefits not realised	NHSL	Resource clearly established at interview Continuous monitoring and review throughout the project	2	2	4	Low
13	Business	Scope of works changing – expansion/ reduction of proposed works	4	3	12	Significant	Redesign Delay to programme	NHSL	Appropriate 1:200/ 1:50 engagement Change control process	2	3	6	Low
14	Business	Contradictory aspirations of different stakeholders	2	2	4	Low	Redesign Delay to programme Increased Costs	NHSL	A clear escalation plan is in place to highlight and ensure control of issues as appropriate	1	2	2	Low
15	Business	Clinical Service Change through duration of project	4	3	12	Significant	Redesign Delay to programme Increased Costs	NHSL	A clear escalation plan is in place to highlight and ensure control of issues as appropriate	3	3	9	Moderate

16	Business	Failure to pass a Gateway Review	3	3	9	Moderate	Redesign Delay to programme Increased Costs	NHSL	Ongoing discussion with SGHSCD and Gateway teams throughout project to ensure each step is properly managed and controlled.	2	2	4	Low
17	Business	Delay in Statutory Approvals	3	4	12	Significant	Redesign Delay to programme Increased Costs	NHSL	Early consultation with all relevant bodies required	2	4	8	Moderate
18	Business	Impact on design due to unknown defects (refurbishment option)	4	4	16	High	Impact on programme and cost	NHSL	Full access to identified areas to allow intrusive surveys to be carried out	2	3	6	Low
19	Business	Condition of the Development Option sites	3	4	12	Significant	Delay to programme Increased Costs	NHSL	Appropriate surveys and other works undertaken as part of Option Appraisal process	2	4	8	Moderate
20	Design	Failure to develop an appropriate clinical model	3	4	12	Significant	Delay to programme Increased Costs	NHSL	A Project Framework, including Clinical Speciality Groups, is now in place to build a Clinical Model. Involve Clinical teams in wider discussion	2	4	8	Moderate
21	Design	Failure to meet technical guidance (refurb)	3	3	9	Moderate	Non Compliant Installation	Contractor	Derogation List established early Early engagement with HFS	2	2	4	Low
22	Service	Failure to comply with HAI guidance (refurb)	4	4	16	High	Delay to programme	NHSL	Continual monitoring of HAI scribe process	3	4	12	Significant
23	Service	Failure to comply with HAI guidance (new build, new site)	1	1	1	Low	Delay to programme	NHSL	Continual monitoring of HAI scribe process	1	1	1	Low
24	Service	Failure to comply with HAI guidance (new build, same site)	3	3	9	Moderate	Delay to programme	NHSL	Continual monitoring of HAI scribe process	2	3	6	Low
25	Service	Interruptions to business continuity during construction (refurb)	4	5	20	High	Delay to programme Increased Costs Reputational Damage	NHSL	Business Continuity Plan Appropriate Engagement with Site Teams Early Planning and Ongoing Dialogue	3	5	15	Significant
26	Service	Interruptions to business continuity during construction (new build, new site)	1	1	1	Low	Delay to programme Increased Costs Reputational Damage	NHSL	Tight controls in place to monitor commissioning process and the migration plan	1	1	1	Low
27	Service	Interruptions to business continuity during construction (new build, same site)	4	4	16	High	Delay to programme Increased Costs Reputational Damage	NHSL	Business Continuity Plan Appropriate Engagement with Site Teams Early Planning and Ongoing Dialogue	3	4	12	Significant
28	Service	Management of ongoing MKBC risks	5	4	20	High	Increased cost Reputational risk	NHSL	Ongoing MKBC programme/Strategic Risk Register approach to maintaining business continuity	4	4	16	High
29	Service	Failure to identify and deliver appropriate staffing associated with new clinical models and new ways of working	2	4	8	Moderate	Reduced service	NHSL	Project Framework process will identify required staffing levels/configurations using Workforce Modelling Tools and engagement with HR	1	1	1	Low
30	Service	Continuity and Provision of Estates/ Facilities Services for Technical Support	2	4	8	Moderate	Delays and Disruption to Patient Services	NHSL	Engagement with Facilities Senior Team	2	4	8	Moderate
31	Business	Regional/elective discussions may impact on prog	4	4	16	High	Programme delay	NHSL	Early engagement and agreement on regional matters via Regional Planning Group	3	4	12	Significant

Appendix 3

Design Statement

Monklands Refurbisment/Replacement: Design Statement

(IA version, post workshops held on 20th May 2016, 2nd November 2016 and 22nd June 2017)

This Design Statement has been compiled to support the refurbishment/replacement of Monklands Hospital and will act as a key briefing document for the Project Technical Team. It will be used to enhance the design process to ensure that the objectives of the project are achieved. The business objectives for the facility are:

- Improving person-centred services
- Improving the safety of patient care
- Improving clinical effectiveness and enhancing patient experience and clinical outcomes
- Improving the quality of the physical environment
- Providing flexible and adaptable facilities across the healthcare system.

The key design principles underpinning the project are:

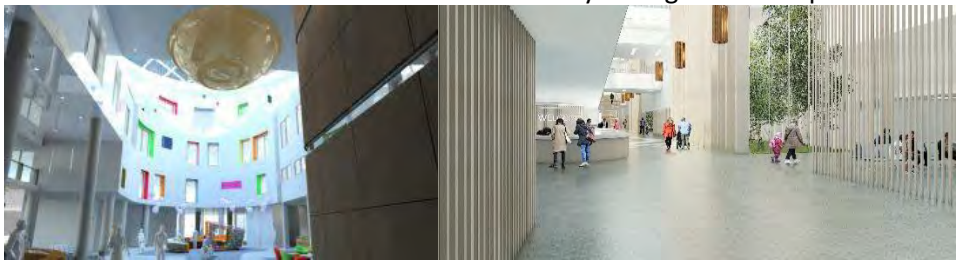
- Provide services that will be easily and safely accessible
- Improve clinical effectiveness through the development of new service models
- Provide an environment that supports the service models, clinical effectiveness and integrated service provision
- Provide a clinical environment which promotes the health and wellbeing of the building users
- Ensure that the new facilities reflects local needs
- To provide facilities that are efficient, sustainable and flexible to support service provision in the future
- Provide a facility which patienst and staff can be proud of

Therefore, in order to meet these, the facility/s in which services are provided must possess the attributes listed on the following pages. These may be achieved through refurbishment, re-use, reconfiguration, and/or new-build; the preferred route for this will be developed and tested through the business case process.

1 Non Negotiables for Patients

Non-Negotiable Performance Objectives *What the design of the facility must enable*	Benchmarks *The physical characteristics expected and/or some views of what success might look like*
1.1 The facility must be easy to find and get to, particularly considering more limited travel options of dispersed and rural communities, and affordability of travel.	• The site must be a physical or cultural landmark in the community • Within 100m of public transport serving local communities • Within 20 minutes' drive for 85% of primary catchment population • Clear signposting from A roads and Motorway network.     Campus

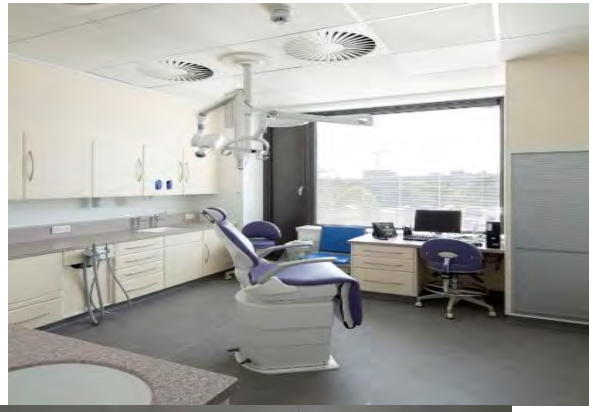
1.2 The experience of arriving (planned arrivals such as outpatients, admissions) must reduce stress and give reassurance in the service. The initial impression must be of a place that is safe, welcoming, professional, calming and attractive with a strong emphasis on being easily accessible. It must say something of "who *we* are", both the people of Lanarkshire and the service (inspiring staff, see 2.1 below), sitting well in the landscape and community it serves, not a work of ego or a blot on the landscape.	• Though not part of the physical environment, the first step in this is the quality and accessibility of information provided in advance, this should include information on how to get to the appointment, including travel/parking options. • Parking must be easy to navigate, easy to use and prioritised by need. • The walking route(s) from the street/public transport/parking to the entrance must be easy to navigate with the entrance visible from a distance, with shelter from wind. Max walking distance from site entrance and car park will be no greater than 100m. • The public entrance to be clearly visible from the street, public transport and the route to the parking, with the view from main walking routes not obscured by parking. • All spaces must be well lit and not add to light pollution for neighhbours • There must be a discrete route in and out for people feeling vulnerable (such as patient transfer etc.)  

1.3 Arrival on an unplanned visit (emergency/minor injuries/out of hours GP service etc.) must give clear and direct access to the right services.	• This entrance must be distinct (separate and looks different) from the main hospital entrance, but obviously visible from arrival routes, with clear signage to reassure and reinforce this. The entrance however shouldn't dominate the view of arriving at the site as this would undermine 1.2 above and increase chance of people with planned attendance coming in through the wrong entrance. • Emergency admissions must be within 100m direct walking route of the main entrance space to allow quick diversion of any people who chose the wrong entrance.  
1.4 The initial arrival space must be welcoming, calm, not frenetic or crowded, with a community feel, and communicate a sense of a 'health promoting' facility. It should feel soft and not clinical, a place where you can relax but where you feel you are in the right place to deal with your health concerns. The next step on your journey (check-in, route to appointments) must be clear from the point of entry with the differing needs of all patients addressed. This space must also serve the needs of those	• A welcoming space that is bright and airy with daylight and views, and a social feel with places to sit and access to food/refreshments/cash dispenser, and a range of health promoting amenities. However it should not be so comfortable and entertaining that you might want to stay all day. The design, in its form, materials and fixtures/art must not be alienating, but respond positively to the culture of Lanarkshire. Assistance with wayfinding should be provided. 

leaving unaided, allowing people to wait for transport (pick-up/bus) in shelter or gather their thoughts in an appropriate area.	• Check-in facilities (electronic and a person who can help you and direct you) to be visible from the point of arriving in the entrance space.   • Easy to maintain with a clean appearance, access to information to support health promotion. • Reliable information on transport options, including timetables and a place to sit where you can see bus stops and drop off/pick-up area.  

1.5 The layout of the development must mean patients go no further into the building than is needed. It must be easy to find where you need to go. There must be a discrete route to wards for those being transferred.	• Typically no more than 100 metres or 5 minutes' walk from building entrance to clinics/outpatient departments • Typically no more than 100 metres or 5 minutes' walk from building entrance to day admissions/ward admissions • Patient circulation spaces to be bright and airy with easy to follow wayfinding and clear visibility of destinations.     

1.6 While systems should minimise the need for waiting, where waiting is likely (due to transport, between appointment/diagnostics etc.), people must be able to have some personal choice in environment. There must be clear methods/systems in place for people on how to find out any delays and how/when they will be called, and the option to wait in comfort at your destination if preferred.	• Waiting areas to have daylight, external views and sources of positive distractions (such as public art, health promotion information and access to Wi-Fi. Seating should be in groups to allow choice of environment (more social or quieter in feel). The design of these areas should be age appropriate, recognising the wide age range of patients and must convey a sense of safety. • There should be good IT service for patients, allowing entertainment and access to information, and a range of check-in options.  

1.7 Consulting and treatment rooms must be calming and professional.	• Rooms situated so that occupants can have privacy (visual and audio) and daylight, where appropriate, at the same time.    

1.8 Green spaces throughout the building and site to be designed to provide easy access to therapy and respite that compliments the internal facilities, and to discourage misuse.	• Positioned so that they are easy to get to (direct access off/within typically 50m of waiting/social/physical therapy spaces) and observable from staff areas. • Shelter to extend use due to weather and by those required to avoid UV exposure.    

1.9 Ward environments must be welcoming, and support patients to feel comfortable, connected to others and relieve boredom. The layout must facilitate rehabilitation.	• Staff member (friendly face) visible when you enter the ward so you're confident staff know you're there and can assist direct you where to go. • Bedrooms have windows you can see out of (to interesting view) when lying down, and good visual connection to see staff & life in the ward. Access to an appropriate mechanism, e.g. blinds, to allow patient to control privacy and glare. • The ward layout should have spaces (not necessarily rooms) to encourage patients out of their room for both social interaction and mobility, so to minimise reliance on staff and aid independence. • There should be facilities to enable staff to easily serve healthy food and refreshements in a range of locations – bed, bedside chair, more social setting, depending on patients needs  

1.10 There must be means of supporting those who are leaving in a more vulnerable physical or emotional state than they arrived in to do so with privacy and dignity.	Discrete discharge area (comfortable to meet waiting standard above) with direct access to sheltered collection point visually screened/separate from main arrival routes. 

2 Non Negotiables for Staff

The majority of working areas are patient areas listed above. The sections below cover the additional aspects needed to support staff in their role and own wellbeing.

Non-Negotiable Performance Objectives *What the design of the facility must enable*	Benchmarks *The physical characteristics expected and/or some views of what success might look like*
2.1 The layout of the site/parking must provide reliable and quick access in/out for peripatetic staff. Staff access and parking for routine/regular access must support the green travel plan for the site.	• Parking within 5 minutes' walk of entrances. • Drop-off space with access to secure store for large/heavy equipment/materials • Walking routes for staff from street/bus/parking to be typically a maximum of 100m and of equal quality (nature/safety etc.) to those described for patients above. 

	  
2.2 The layout of the building must provide flexibility in use to cope with uncommon but critical events.	• There must be a means of isolating one access point and routes from that for consulting treatment areas, and keeping the rest of the building in operation.
2.3 Normal use of working environments must bring staff from different disciplines or departments together to increase recognition and share/grow learning. Environment must promote learning.	• Rest/social areas positioned so accessible by all, within 5 minutes' walk of working areas, and designed to encourage use (see below for nature of rest spaces) • Staff walking routes not separated by department, and circulation designed to allow impromptu discussions at natural meeting points. • Office/meeting/ learning areas not separated by department, but shared and designed to be used

	
2.4 staff environments must support their wellbeing and communicate the value placed on them. These must not be basic.	• Changing facilities provided directly en-route from arrival to working areas. • 'Modern' approach to working environments, allowing choice in the nature of space to do work. • Any staff areas occupied continuously to have views of life/sky and ground. • Staff rest areas to support both social gatherings and time apart (solo or small groups) for respite. There must be access to refreshments and food (catering and or storage/prep). • Access to green space and opportunity to support health/wellbeing through exercise and use of designated walking routes of varying lengths. City of Glasgow College, City Campus

	  
2.5 The building must enable service change both now and into the future.	• Services co-located such that there is continuity for patients being treated by the same clinical team irrespective of their route of referral • Equipment and materials to be stored local to their point of use to increase effectiveness • Consulting areas and receptions designed flexibly to facilitate changes in the number of consulting rooms accessed from any one department or the use of rooms over time. • Flexible design to allow service change to be accommodated

2.6 Management of supplies and waste must be accommodated out with view of primary public areas to ensure that image of a professional and clean facility is readily maintained.	• Service yard for refuse, clinical waste and supplies - separate from, and not impacting upon, patient pedestrian and vehicle movement.

3 Non Negotiables for Visitors

Non-Negotiable Performance Objectives *What the design of the facility must enable*	Benchmarks *The physical characteristics expected and/or some views of what success might look like*
3.1 There must be places which are quiet and comfortable, are outwith the clinical area, where you can wait for prolonged periods with easy and direct access to information on how patient is.(Patient in A&E or during operations)	• Waiting environment similar to benchmarks in 1.6 above, but with direct access to refreshments/toilets (within 50m) without loosing contact to staff. • Access to external areas for fresh air to sit quietly or to allow accompanying children to run-off some steam, within 200m of A&E waiting and surgical waiting 
Carers accompanying patients must be able to find information and additional support to assist them in caring for a friend/family member.	• Information and signposting points – This can be done through information points within atrium, • Option for providing drop-in carer support services in a Multi functioning/purpose atrium space • Space for mutual support groups – Multipurpose atrium / options for seating configuration

4 Alignment of Investment with Policy

Non-Negotiable Performance Objectives *What the design of the facility must enable*	Benchmarks *The physical characteristics expected and/or some views of what success might look like*
4.1 The development, through its location and design, must be a positive part of the community and regeneration of the area	• Good regeneration development practices provide a healthy, self-perpetuating cycle, these will include: early, wide and continuous Community Engagement; incorporation of Health Promoting Health Service (HPHS) principles, enabling healthy decisions, e.g. stair visibility, food outlet standards or usable gardens/ courtyards, non-car dependant transport network. Build on wider Green Infrastructure locally, to encourage physical activity and biodiversity, e.g. cycle/ walking travel routes; positive tree use to reduce energy + CO^2, add to well being; plus enable ongoing community engagement and benefits, e.g. growing spaces, walking groups, art. • Creating a building with suitable civic presence that is welcoming and modern with potential for providing a catalyst for wider urban regeneration. • Sites selected should be provided with appropriate parking and access from public transport to ensure convenient ease of access for both patients and staff. • Buildings will be designed with appropriate privacy in terms of overlooking and closeness. • Sites should enable appropriate massing of the buildings to achieve a coherent and economic use of space. • The area will be located to allow access to the landscape which promotes greater us eof outdoors for physical activity and contact with nature 

4.2 The facility must be designed to allow future adaptation and service expansion or reconfiguration for growing/aging/changing population	• The Site is to be large enough for up to 20% in total expansion; but to an agreed list of percentages per service/ dept; NOT blanket wide. • The Building design and construction will enable adaptation & flexibility, e.g. 'repeatable rooms & standard components'; 'loose fit'; modular grid; 'soft spaces'; climate change; all electric energy source. • Safety, Accessibility & Equality will be at the foundation of our design and operations. • Collaborative workshops & independent reviews at key stages to evidence progress e.g. HAI Scribe, Inclusive design (SDEF), Dementia (DSDC). • Where parts of the facility are provided for the sole use of one service they must be located and designed such that they may be realigned to meet changes in service. • Non-clinical rooms such as storage areas to be designed such that they can, if required, be adapted to clinical uses or use by other (incoming) services. • The design adopted will maximise the ease of maintainance and alteration and minimise disruption to clinical services for PPM
4.3 Sustainability. Promotes health, social, environment and economic sustainability by delivering whole life value form investment	• Collaborative workshops using current BREEAM, BRUKL, BIM and DSM (dynamic simulation model) are required at key stages, evidencing a holistic approach to delivering safe, sustainable long term investment. For example, new build target: BREEAM 2014 NC 'Excellent'. Options pre-assessments and early NDAP reviews will allow HFS to set a bespoke/ pragmatic % target BREEAM score. • Minimum criteria will include: Man03: Considerate construction; Man04: Building user guide; Man05: 2yrs seasonal commissioning; Ene01: 5credits; Ene02: sub-meter; Wat01: 1credit; Wat02 + Mat03: Criteria1 only; HEA04: 3credits. • Operational energy consumption target: ≤320kWhr/m^2; plus thermal safety & comfort (TM52: all 3 criteria); evidenced by realistic DSM using future local weather data. • Continuous improvement, i.e. annual operational energy report (DEC or equivalent) min. 3yrs /FM contract period. • Social, economic and technical sustainability to be considered as part of the design process • The design should minimise energy consumption in use and during construction/demolition phases • The building should be well insulated and designed to make maximum use of passive solar energy while avoiding overheating • Designed to include as much natural daylight as possible to reduce the need for artificial lighting and improve the wellbeing of the occupants. • Provide zoning of heating and cooling to allow different thermal requirements to be compartmentalised • Natural Ventilation - designing clear and robustly controlled air flows through buildings for cooling.

4.4 Wider community benefits – Good corporate citizenship	• Collaborative workshops for Equality & Diversity Impact Assessment (EDIA) at key stages, to set and evidence positive steps to reduce local health inequality; e.g. public WiFi, Changing Places toilet, electric scooter bay, bariatric access.

This statement was developed through the engagement and participation of the following key stakeholders/groups:

Patient representatives:

Donald Masterton, North PPF	Pat O'Reilly, North PPF	Jack Ferguson, South PPF
Wilson Paton, South PPF	Joyce McPherson, North Access Panel	Alan McPherson, North Access Panel

NHS Lanarkshire

Andrew Carton, Head & Neck Surgeon	Ann Chapman, Infectious Diseases Consultant	Sanjiv Chohan, Consulatant Anaesthetist
Marion Devers, Endocrinology Consultant	Andrea Fyfe, Director of Hospital Services	David Litherland, Consultant in Emergency Medicine
Rory Mackenzie, Chief of Medical Services	Graeme McGibbon, Surgical Services Manager	Brian McWatt, Head of Finance
John Murphy, Consultant Heamatologist	John Paterson, Director of PSSD	Colin Lauder, Deputy Director of Strategic Planning
Graham Johnston, Head of Planning	George Reid, Deputy Director of PSSD	Nicola Ruddy, Senior Nurse
Praveen Sharma, Consultant Surgeon	Donald Spence, Staff side representative	Nicola Summers, Medical Services Manager
Ana Talbot, Care of Elderly Consultant	Robert Peat, Head of Podiatry	Ruth Thomson, Chief of Nursing Services
Jim Ruddy, Consultant Anaesthetist & Project Clinical Lead		

Facilitators:

Tom Bostock, Reiach & Hall	Jim Hackett, Currie & Brown	Fiona McDade, Currie & Brown

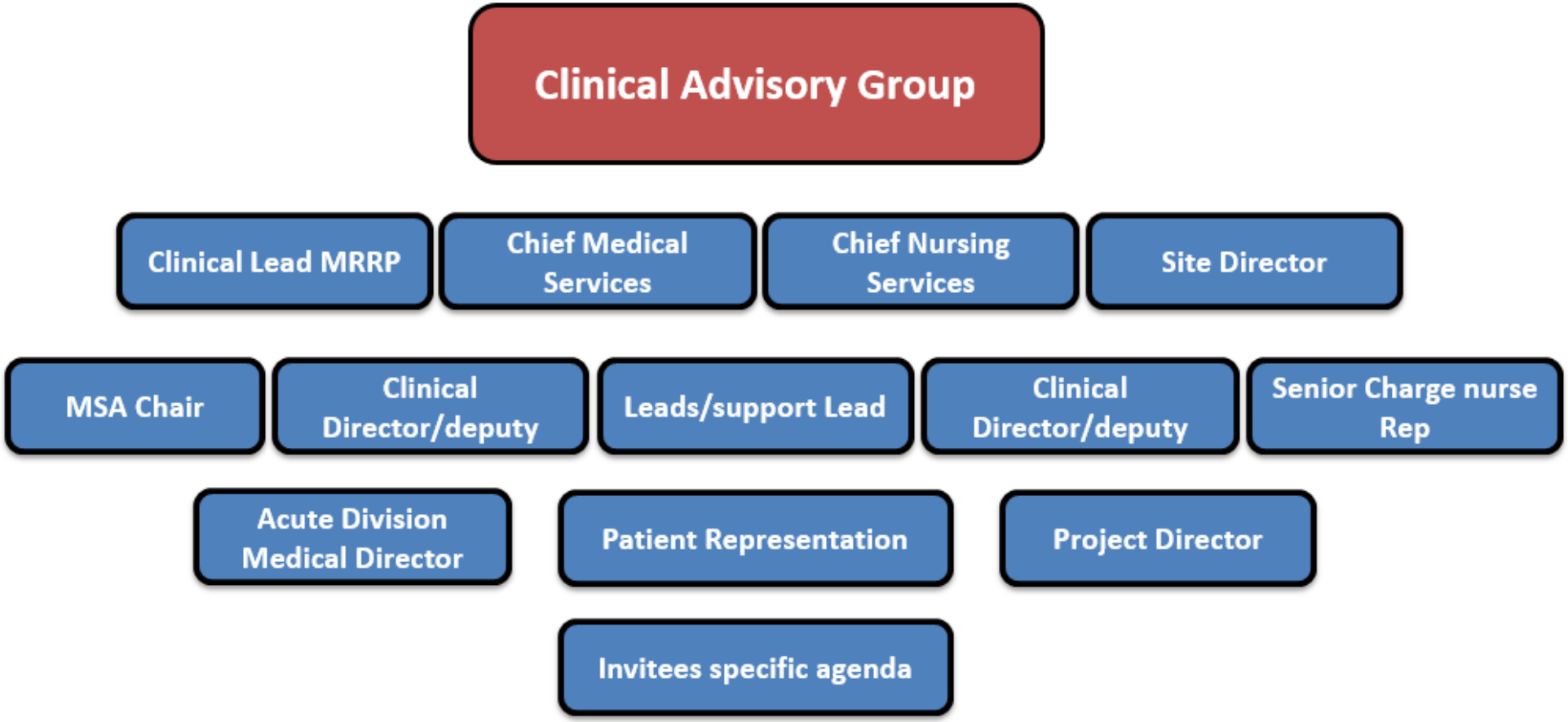
5 Self-Assessment Process

Decision Point	Authority of decision	Additional skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information required to allow evaluation
Site selection	Decision by Corporate Management Team with advice from Project Board	Comment to be sought from NDAP to inform a Corporate Management Team decision	Risk/benefit analysis considering the capability of sites to deliver a development which meets the above stated criteria	Site feasibility (including sketch design to RIBA stage B) for alternative sites. Cost estimates (construction and operating costs) based upon feasibility.
Completion of brief	Decision of Project Board with advice for Project Manager & Project Team	Peer review across stakeholders	The above design statement will be included within the brief	Completed brief
Selection of Delivery/Design Team	Decision of Project Board with advice for Project Manager & Project Team	Design Advisor external to Project Team	Quality cost ratio to comply with guidance for complex projects as per annex A, para A.3.5 of Scottish Government Construction Procurement Manual. Must also comply with NHS Lanarkshire SFI's	Design team proposals and costs
Selection of early design concept from options developed	Decision of Project Board with advice from Project Manager & Project Team	Comment to be sought from NDAP	Assessment of options, utilising AEDET or other methodology, to assess the likelihood of options delivering a facility which demonstrates compliance with the above criteria	Sketch proposals developed to RIBA stage C with colour used to distinguish main use types – circulation, outpatient areas, ward areas, theatres, ICU, offices, staff facilities, etc.
Approval of design proposals to be submitted for planning authority approval	Decision of Project Board with advice from Project Manager & Project Team	Public /stakeholder engagement process incorporated	Formal option appraisal to assess the likelihood of options delivering a facility which demonstrates compliance with the above criteria	Formal process to approve Stage D agreed with Project Board
Approval of detailed design proposals to allow construction	Decision of Project Board with advice from Project Manager & Project Team	Design Advisor/Health care Planner external to Project Team	Review with reference to agreed clinical model and Design Statement objectives	Full design information

Post Occupancy evaluations	Formal Post Project Evaluation in accordance with SCIM	Design Advisor/Health care Planner external to Project Team	Assessment of completed development by stakeholder group representatives and staff involved in establishing the criteria set out in the original Design Statement	Completed SCIM pro-forma documentation

Appendix 4:

Clinical Advisory Group/ Clinical Support Groups

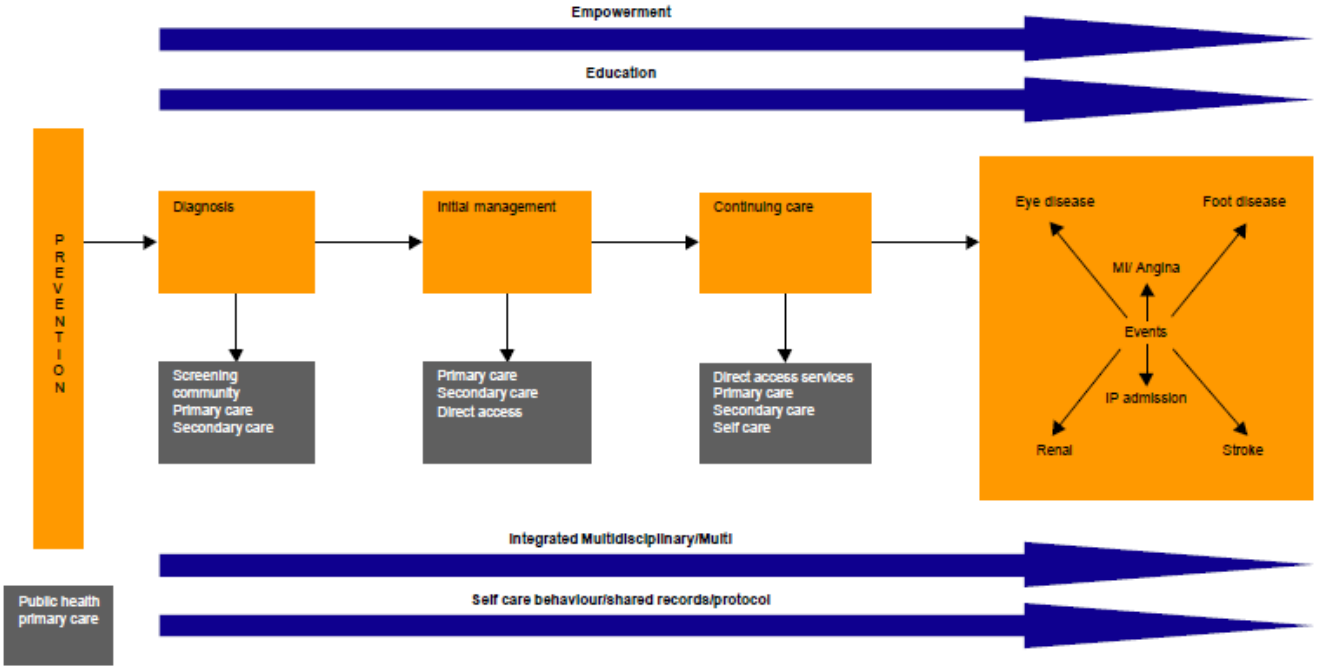

Clinical Advisory Group
Clinical Lead MRRP
Chief Medical Services
Chief Nursing Services
Site Director
MSA Chair
Clinical Director/deputy
Leads/support Lead
Clinical Director/deputy
Senior Charge nurse Rep
Acute Division Medical Director
Patient Representation
Project Director
Invitees specific agenda

Clinical Support Groups

Unscheduled Care	Complex Services	Ambulatory Care	Clinical Support	Known/ Unknown Services	Non Clinical Support
Service Lead	Service Lead	Service Lead	Service Lead	Service Lead	Service Lead
WG & HM rep	WG & HM rep	WG & HM rep	WG & HM rep	WG & HM rep	WG & HM rep
Emergency Care	Level 1-3 beds	Ambulatory Care	Theatres	Ortho Elective - SLWG	Hard FM
REACT	CCU	Day SurgerySDAU	Pharmacy	Urology RPG	Soft FM
AMRU/ASAU	ID	Medical Investigations Unit	Diagnostics	Ophthalmology	Life Sciences
Frailty	Renal	Endoscopy	Core Labs	Mental Health SLWG	Education/ Training
Therapy Services	Stroke	Maternity Assessment Unit	Histopathology	Haemato/oncology /SACT	Spiritual care
USC ward design	Complex Ward Design	Orthodontics	Radiology	OPD – Outpatient Departments SLWG	SALUS
	Urology (NHSL)		Mortuary	IR - RPG	Medical Illustration
			Medical Physiology	General/ GI Surgery SLWG	HR/ Workforce
				Paed ENT -SLWG	

Example of a clinical pathway that the groups are producing:

Diabetes pathway with emphasis on Health & Social Care Partnership working in the community and 'diabetic events' only being managed on the Acute Site.



Appendix 5

Regional Planning Letter of Agreement

West of Scotland Regional Planning

Chief Executive's Office
Eglinton House
Ailsa Hospital
Dalmellington Road
AYR
KA6 6AB

Christine McLaughlin
Director of Finance

By email to:
Christine.McLaughlin@scotland.gsi.gov.uk

Date	4 September 2017
Your Ref	
Our Ref	JGB/lp
Enquiries to	Laura Parker
Extension	13628
Direct line	01292 513628
E-mail	l.parker4@nhs.net

Dear Christine

Regional Delivery of Major Capital Projects – Monklands Replacement/Refurbishment Project

I am writing in my capacity as the Regional Implementation Lead for the West of Scotland. I have been asked to consider how the West Region can review the Monklands Initial Agreement in the context of a Regional Delivery Plan that addresses;

- the population health need;
- evidence based clinical models;
- pathways that will deliver high quality care that is sustainable.

I acknowledge that NHS Lanarkshire has a Cabinet Secretary approved Clinical Strategy and have been working on the proposal for Monklands for some time and have been supported to take forward an Initial Agreement. Scottish Government are supportive of NHS Lanarkshire's plans to develop a business case. In order to better understand the position of NHS Lanarkshire I have met and discussed the matter with Calum Campbell, and recognise that he has wider considerations across his hospital estate in respect of the two PFI hospitals that will require renegotiation in the future and the risks that this may have for NHS Lanarkshire and therefore NHS Scotland. I also understand that the Board has an ambition to rationalise its hospital estate in the future. Against this strategic background, NHS Lanarkshire sees the replacement of Monklands as a key step in the future shape of services within the Board.

I have discussed with Calum the intention to undertake a piece of work across the West of Scotland that will look at what future models of clinical services should be to meet the needs of the population in a sustainable way. Calum recognises the importance of this work and has asked that I consider how he can continue to progress the Monklands work and inform and influence this through the regional modelling work. Given the position that we find ourselves with I am of the opinion that we need to have a pragmatic response that supports colleagues in NHS Lanarkshire whilst we seek to do work at pace across the West that will inform the future case for change across the West Region.

It is clear that the West of Scotland has significant infrastructure challenges and a new clinical model must be considered and evaluated which may conclude that our population will need to access services in a different way, based on evidence, outcomes and sustainability. This work requires to be done with some urgency if we are to begin to understand the transformation opportunities that may exist to support future need, but will not be completed by the end of September for the draft plan. To this end I have had an initial discussion with Alan Morrison, Carmel Sheriff and Colin Proctor of the Scottish Futures Trust. The requirement to prepare a draft plan by the end of September requires a rapid assessment of the West Region and in discussion with Scottish Futures Trust I have agreed to an initial commission for expert health planner resource (Carnall Farrar) to carry out a strategic appraisal. In addition the West Region is looking at different models of care that would support a sustainable health care system in the West in line with meeting extant policy aims for elective, and urgent/ emergency care. It will also be important to bring Health and Social Care Partnerships into these discussions given their role in commissioning urgent and unscheduled care services. As they have not previously been involved in Regional Planning we have work to do to align Strategic Plans into a coherent regional model.

The above brings me to conclude that we would not have wished to start from this position so I offer the following as a pragmatic way forward that does not introduce unnecessary challenge that would divert from the work that we need to carry out.

NHS Lanarkshire should continue the work underway to submit the Initial Agreement by end September as requested. I have agreed with Calum that this submission will acknowledge

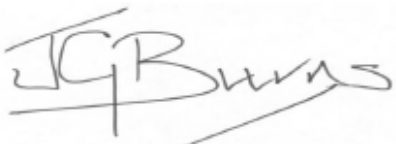
- the regional planning and delivery work looking at a strategic appraisal and new clinical models for the West
- the outcome of this work will inform the next steps of developing the Monklands case.

This wider work should help to evidence that all potential solutions are being explored whilst recognising the service improvement, risks and need for change that are specific to Monklands and Lanarkshire, within the context of regional clinical models and the strategic intent within the regional delivery plan

I hope this is helpful and as always happy to discuss.

Kind regards

Yours sincerely



Mr John G Burns
Regional Implementation Lead (West)

Appendix 6

HFS Infrastructure Report

Review of

Monklands District General Hospital

1. Background

1.1. Remit of the review

This review has considered the documented and observational evidence relating to the current and ongoing risks associated with the operational safety, functional suitability, and building & engineering infrastructure at Monklands District General Hospital, which supports the case for change for NHS Lanarkshire as described in the draft Initial Agreement.

The review has followed the principles of the Gateway Review process to provide a peer review on the extent and depth of the work carried out by NHS Lanarkshire within this context. It is intended to provide an additional perspective on these issues and an external challenge to the robustness of the plans and processes in place.

1.2. Current understanding of the condition of the estate and the provision of clinical services at Monklands Hospital

This review has considered the documented and observed evidence supporting the following description of the hospital estate and clinical services.

The Initial Agreement for a potential replacement / refurbished facility describes the hospital as a product of 1960's design and 1970's construction techniques – this includes the extensive use of asbestos containing materials. The hospital has been subject of significant investment of £35m over 6 years in an attempt to maintain the highest possible quality of the environment and to mitigate risk to business continuity.

The current lack of quality space to develop and expand clinical services is described as preventing NHS Lanarkshire from meeting its strategic objectives.

Current accommodation challenges and risks are described as the use of multi-bed rooms, lack of adequate toilet and shower facilities, the deterioration of the above and below ground drainage systems, and the limitations on in-patient fire evacuation. Further examples of functionality issues affecting the efficiency

and effectiveness of clinical service delivery described in their IA includes poor configuration of 'front door' (A&E) services, sub-optimal clinical adjacencies, the low proportion of single rooms, a general lack of storage, poor patient flows within diagnostic facilities, constrained surgical capacity (particularly day surgery), and outpatient clinic space struggling to meet current or future demand.

1.3. Review Team members

The Review Team consisted of John Connolly, Paul Mortimer, and Stephen Gallacher:

- John Connolly is an associate director at Health Facilities Scotland and is a qualified surveyor with over 30 years of experience in the construction industry.

- Paul Mortimer is the asset management policy advisor at Health Facilities Scotland and is a qualified surveyor with previous estate management consultancy experience in the public sector across the UK.

- Stephen Gallacher is Consultant Physician & Endocrinologist at Queen Elizabeth University Hospital who was involved in the healthcare service planning associated with this major new hospital.

1.4. Appropriateness of documented evidence

The Review Team were provided with documentary evidence (listed in Appendix A) and referenced within the Initial Agreement for Monklands Hospital. A summary list of these documents can be found in Appendix A of this report. This evidence was reviewed by holding a range of interviews with senior hospital staff (see Appendix B for schedule of interviews), and visiting several clinical and non-clinical departments.

Throughout the review exercise there was a consistency of support from those interviewed regarding the validity and credibility of this information, which provided a high degree of assurance to the Review Team. Additional

reassurances were gained from observations gained during a tour of the hospital.

2. Review Conclusions

The overarching conclusion observed of Monklands Hospital is that it consists of many compromises and challenges in being able to deliver modern expectations of quality healthcare services. The main causes appear to be an outmoded hospital design, an aging building (commissioned in 1974/5), and limited flexibility to be able to resolve some of its underlying issues.

The following three sections provide examples of such constraints as gained from the review:

2.1. Consideration of operational safety issues

The three main themes raised by NHS Lanarkshire relating to operational safety issues were fire safety, infection control, and the adequacy of the current infectious diseases department. Each is discussed below:

2.1.1. Fire Safety Issues

Fire safety was raised as one of NHS Lanarkshire's biggest concerns, which was explained in detail by its Fire Officer (supported by a summary internal report). This included key concerns over the adequacy of fire compartmentalisation and vertical circulation within its two ward blocks. Current investigations of the structure have involved sample checks of fire stopping / gaps between walls and floors supported by extended simulation work (carried out in 2015). A full extrusive survey would close wards and potentially expose asbestos materials. Narrow (900mm wide) staircases add further concerns and challenges to the ability to effectively evacuate bedded patients in the event of a fire.

The Review Team were informed that a solution has been agreed with the fire service which is regarded by both parties as a mid-term compromise until decisions on a new facility are confirmed. The agreed solution followed the

recommendation of an appraisal report in 2016 jointly prepared by NHS Lanarkshire, Graham Construction, Oberlanders and Atelier Ten. The solution involved creating a single fire barrier wall across each ward to create two compartments for better horizontal evacuation, and the introduction of a managed process whereby each patient is RAG assessed by ward staff on a daily basis for their mobility support needs during an emergency evacuation.

Documentary and observational evidence provided reassurance to the Review Team of the validity of the conclusions reached by the Board.

2.1.2. Infection Control Issues

The main concerns raised by NHS Lanarkshire's Infection Control officer were the constraint on isolating patients on the ward, limitations and poor design of ward shower facilities, and flooding to ground level departments due to failures of the drainage system.

The design limitations of a typical ward are outlined in the 'considerations of building and engineering infrastructure issues' section. The operational and infection control issues this creates includes insufficient single bedrooms to isolate patients and increased cross-contamination risks due to short bed spacing. NHS Lanarkshire is understood to be monitoring the number of beds lost due to limiting four bed bays to two beds when contamination risks occur.

It was observed that each four bed bay shares only one toilet/shower facility and not all single rooms are en-suite. Infection control risks arise from these limitations, the small size of rooms, and inadequate ventilation.

The third main infection control risk relates to flooding to ground floor accommodation caused by capacity and design issues to the underground drainage. It was reported that the frequency of occurrence was a couple of times a month. Documentary evidence of reported incidences supported this, including a SBAR Incident report in 2016 of major flooding across A&E, Radiology, Theatres, etc. NHS Monklands commissioned an investigation and report in 2017, following which some improvement works have been carried out to improve, if not necessarily eliminate, this issue.

The Board's Head of Infection Prevention and Control reported her view that the current buildings present risks which can only be resolved by either comprehensive redevelopment or replacement of the hospital facility.

2.1.3. Adequacy of current infectious diseases department

A visit to the Infectious Diseases department confirmed conversational reports of inadequacies related to the design and location of this department. Admissions can arrive at front-of-house services such as main entrance and A&E. Both of these locations are some distance from the infectious diseases department and pass by several clinical departments. Poor functional layout and inadequately small rooms were reported to affect both operational effectiveness and increase safety concerns.

2.2. Consideration of functional suitability issues

Observations relating to the functional suitability issues at Monklands Hospital were mainly evidenced through discussions with senior clinical staff at the hospital and as observed during visits to several clinical departments.

A repeated theme of functional compromise was raised and mainly attributed to the outmoded design and layout of accommodation and clinical adjacencies. The Initial Agreement suggests that *"The current lack of quality space to develop and expand clinical services is preventing NHS Lanarkshire from meeting its strategic objectives"*.

The following example observations (which are not intended to be a full catalogue of issues) would seem to support this argument:

- Development of the hospital campus over the years has created long distances between critical departments e.g. critical care and the emergency department; CT to Radiology; day surgery to theatres & critical care.

- Limited spare land across the estate has created further compromises to recent developments, such as:

- Theatres - number of theatres limited to space available, disconnect between theatres and its pre-surgery admissions area, location of theatres above kitchen area is not ideal for fire safety reasons.
- New ICU - space limitations meant that not all medical HDU beds could be located there.
- A&E upgrade – current improvements will not resolve limited space issues.

- The demand for emergency and unscheduled care is creating pressures on the functional capacity of the A&E department; for example, average attendances are 200 per day which would normally require circa 30 bays, however, only 19 are available.

- Design limitations at ward level means that bed capacity for the hospital is probably at its limit, and would reduce significantly if modern bed design recommendations were implemented.

- Several departments appeared to be below floor area standards compared with modern expectations of space requirements, for example:

  - All inpatient accommodation, including bed / bed bay sizes, and limited storage space causing obstructions in clinical areas and corridors.
  - A&E department (as described above).
  - Infectious Diseases department.
  - Limited teacher / training areas.
  - Radiology – lack of space for further CT scanners.
  - Outpatient clinics – it was difficult to observe previously reported floor space / capacity deficiencies within the outpatient clinics during the time of the review.

The Review Team were impressed that clinical staff were not over-emphasising the restrictions and deficiencies of the accommodation and were working within these constraints to deliver and improve; where possible, patient pathways and treatment experiences.

2.3. Consideration of building and engineering infrastructure issues

Monklands Hospital is over 40 years old, which is a time when any building of this age would need significant investment to replace original building and engineering elements. Additionally, standards and expectations of quality accommodation and layout have changed since the original design of this hospital. The inflexibility caused by limited spare land, lack of available investment, and the need to maintain operational healthcare services at the hospital has resulted in many of the compromises already discussed in this report.

The following provides some examples provided to the Review Team of how noted limitations to the size and layout of the hospital accommodation impacts on effective healthcare service delivery (in addition to those described earlier):

- NHS Lanarkshire commissioned an independent report in 2009 by Reiach and Hall Architects which provided the following conclusion on bed space limitations at each ward:
  'the current theoretical 72 beds per floor would be reduced to 36-40 beds per floor to comply with current space standards as per HBN 04-01 2008. It would be almost impossible to achieve 100% single-bed rooms, and difficult to achieve even 50% single-bed rooms. The area of the wards will almost double if the present bed numbers are to be maintained at current space standards, which means that at least some new ward accommodation will have to be built."
  The Review Team also observed such limitations when it visited several wards. It also noted a general lack of support accommodation such as storage space, staff briefing areas, relative & patient rooms, clean/dirty segregation areas, space for confidential conversations, etc.

- A lack of standardised ward layouts due to many alterations over the years was also noted to potentially cause staff inefficiencies and patient safety issues.

- Travel routes for patients and the public can involve mixed public / patient areas, which causes concern over cross-contamination & privacy / dignity issues e.g. infectious disease patients going to x-ray.

- Some service improvement investments have been necessary to overcome immediate issues e.g. theatres / ICU project and Accident & Emergency / Rapid Emergency Assessment upgrade, however, site constraints have caused sub-optimal solutions and further clinical adjacency problems.

In addition to the above, several building and engineering infrastructure issues were reported and observed, which add to the general compromise that staff face in order to continue to deliver high quality healthcare services. These include:

- Flooding leaks (as noted in the Infection Control Issues section) causing service disruption and infection control issues. Some improvement works have taken place to hopefully reduce the occurrence of such events; however, residual problems remain due to its age and lack of gradient to pipes running under the existing hospital.

- Whilst there is no evidence of issues with the structural frame of the building, the flat roof over the ground floor accommodation between the two ward blocks isn't structurally load bearing which restricts any vertical extension opportunities or maintenance works between the two blocks.

- NHS Lanarkshire reported that they had a comprehensive asbestos register covering this hospital which highlights the prevalence of asbestos containing materials (ACM's) within the building fabric; including ceiling tiles and infill panels between external windows. Whilst this is appropriately controlled and managed, it does create several operational challenges in terms of day-to-day maintenance and any disruptive improvement works.

- Much of the engineering infrastructure (boilers, pipework, electrical wiring, generators, etc.) seem well maintained; however, significant investment is likely to be needed over the medium term simply due to the current age of this infrastructure.

- Whilst medical gases are available at each ward level, outlets are not provided to each bed thus causing operational issues when needing to manage the needs of different patients.

- Outlets for wired IT infrastructure are also limited throughout the hospital, mainly due to installation challenges caused by ACM containing building fabric.

3. Overall findings and recommendations

The Review Team recognises that Monklands Hospital is probably one of the oldest major acute hospitals in Scotland; which is in need of ongoing and most likely substantial investment to resolve both the aging aspects of the building infrastructure and also the growing pressures to provide modern healthcare to an aging population.

Approximately £35m has been spent since 2009 on what NHS Lanarkshire describe as 'business continuity' building and engineering improvements i.e. essential improvements to maintain short to medium term operational delivery. Residual issues remain and will continue whilst improvements are restricted to these essential needs; such as vertical fire evacuation difficulties, space constraints, drainage issues, poor patient flows, clinical adjacency challenges, and other functional suitability issues as highlighted in this report.

The key enabler to any major improvements on this site would appear to be the need to develop a new ward block to create flexible decant facilities and modern inpatient accommodation. A steeply sloped area to the rear of the site appears to be the only spare land on the site but its location away from the heart of the hospital would create further compromises to clinical adjacencies, etc.

This review concludes that the documented and observed evidence relating to the current and ongoing risks associated with the operational safety, functional suitability, and building & engineering infrastructure at Monklands District

General Hospital is sufficiently robust and comprehensive to support NHS Lanarkshire's case for change - as set out in the draft Initial Agreement – and that significant investment in the facility will be required..

Finally, an overriding observation by the Review Team from speaking to clinical directors and visiting several clinical departments was the can-do attitude of staff who on a daily basis have to accept the operational compromises caused by limitations of the building design, age and footprint. Following interviews with a range of staff; including some impromptu discussions with staff during the tour of the hospital, the Review Team were concerned that the lack of decision on a future way forward could risk frustrating this good will.

4. Appendices

4.1. Appendix A: List of documents

The following table provides a list of documentary evidence provided to the Review Team prior to commencement of the review:

Item	Description
1	Detail of all work undertaken under the MKBC Programme - 2009 - present
2	Gateway 1 Report on MRRP
3	Current Estatecode Evaluation MDGH
4	Evidence of the hospitals level of energy efficiency
5	Future significant works
6	Detailed log of service failures/disruption
7	Details of complaints from patients/relatives relating to the building
8	Summary of functional suitability/space constraints
9	Current status of fire prevention, detection, containment and evacuation
10	Site health & safety risks - labs, nitrogen, vehicle movement
11	Condition of drainage systems - internal and external
12	Condition of tower window system
13	Asbestos register and summary of MDGH asbestos containment issues
14	A case study with respect to the operational impact of flooding
15	Infection prevention and control site issues
16	Condition of inpatient shower and toilet areas (IDP report + McCulloch Report)
17	Condition of tower roofs GRAHAM Report
18	Security of hospital site

19	Condition report on existing lifts

4.2. Appendix B: Review team interview schedule

The following is a list of scheduled interviews held as part of the review:

Day 1 Tuesday 13th June

Time	**Schedule**	**Details**
09:30-10:30	Interview - Colin Lauder	Deputy Director of Strategic Planning & Performance, Interim Project Director
10:30-11:30	Interview - Colin Sloey	Director of Strategic Planning & Performance, Project SRO
11:30-12:30	Interview - Dr Rory MacKenzie	Chief of Medical Services, MDGH
12.30–13.30	Lunch – delivered to MRRP Office	
13:30-14:30	Interview - Alex Gordon	Senior Fire Officer, NHSL
14:30-15:30	Interview - Gordon Gray	Head of Health & Safety, NHSL
16:00-16:30	Feedback day 1	Colin lauder, John Connolly, Paul Mortimer and Dr Stephen Gallagher

Day 2 Wednesday 14th June

Time	**Schedule**	**Details**
09:30-11:30	Visit to Clinical Areas Guided by Ruth Thompson/Dr Jim Ruddy	1. Ward 14 (General Medicine) 2. Ward 7/Ward 8 3. Renal 4. Ward 2 – Infectious Diseases 5. Emergency Dept – Ward 5 6. Radiology/X-Ray
11:30-12:30	Interview - Ruth Thompson	Chief of Nursing Services, MDGH
12.30–13.30	Lunch – delivered to MRRP Office	
13:30-14:30	Interview - Emer Shepherd	Head of Infection Prevention & Control, NHSL
14:30-15:30	Interview - Dr Jim Ruddy	Clinical Director MRR Project
16:00-16:30	Feedback day 2	Colin lauder, John Connolly, Paul Mortimer and Dr Stephen Gallagher

Day 3 Thursday 15th June

Time	Schedule	Details
09:30-10:30	Interview - George Reid	Head of Estates Capital, NHSL
10:30-12:30	Visit Non-Clinical areas	Guided by George Reid
12.30 – 13.30	Lunch – delivered to MRRP Office	
13:30-14:30	HFS preparation time	John Connolly and Paul Mortimer
14:30-15:30	Final day feedback	Colin Sloey, John Connolly and Paul Mortimer