# Monklands District General Hospital Replacement/ Refurbishment

Initial Agreement

**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:<br>• Who is affected<br>• Links to NHSScotland's strategic priorities<br>• Links to other policies and strategies<br>• Influence of external factors |
| Strategic Case | Why is this proposal a good thing to do? | Outline:<br>• Current arrangements<br>• Need for change<br>• Investment objectives<br>• Design quality objectives<br>• Benefits realisation plan<br>• Risk management strategy |
| Economic Case | What is the preferred strategic / service solution? | Confirm:<br>• The Do Nothing option<br>• Any major service change proposals<br>• List of proposed solutions<br>• Indicative costs<br>• Preferred strategic / service solution |
| Commercial, Financial & Management Cases | Is the organisation ready to proceed with the proposal? | Confirm:<br>• Procurement strategy & timetable<br>• Affordability & financial consequences<br>• Governance & project management arrangements |
| Conclusion | Is this proposal still important? | Confirm:<br>• 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. 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 2020 Vision 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 6 years in an attempt to maintain the highest possible 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 entire building's construction methods included the extensive use of asbestos containing materials (as was normal at that time), and so many building maintenance and adaptations take longer to complete. This adds time, cost and risk to any repairs, reconfigurations and refurbishment projects, which adds disproportionate expense due to the extensive control measures which need to be applied to ensure 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 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 2017. This process will allow a clear assessment of the specialties and support services which will be provided from each of the three DGHs and in the community at about 2023. 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 2017 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:<br>• Who is affected<br>• Links to NHSScotland's strategic priorities<br>• Links to other policies and strategies<br>• 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, Director of Strategic Planning & Performance taking the lead role in its development.*<br><br>*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.*<br><br>*The specific benefits which would be gained from this proposal and the evolving options have been considered on a number of occasions in 2015 & 16 by the NHS Board's Planning, Performance & Resources committee.*<br><br>*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 25th January 2017.* |
| Service or Department | *This project has engaged the input of the appropriate service leads in the Lanarkshire Acute Division* | *This Initial Agreement was approved by the MRR Project Board on17th January 2017.* |

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| | *and the North and South Lanarkshire HSCPs, who are integral members of the NMK Project Board. The composition of the Project Board is described in section 6.3* | |
| 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.*<br><br>*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.*<br><br>*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.*<br><br>*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.*<br><br>*A MRR Core Team was established at Monklands site:*<br><br>*Andrea Fyfe Site Director*<br><br>*Dr Rory MacKenzie Chief of Medical Services*<br><br>*Ruth Thompson Chief of Nursing Services*<br><br>*Dr Jim Ruddy Clinical Lead*<br><br>*A Clinical Advisory Group has being set up with representation from all clinical stakeholders.* |

| | | |
|---|---|---|
| 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.*<br><br>*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-November 2016.*<br><br>*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.<br><br>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, |

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| | This has thus required a range of public consultation event, of which these proposals formed part. | with a clear consensus that he status-quo is not 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 currently listed as:

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

These are derived from NHSScotland's Quality Strategy & 2020 Vision 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.*<br>*The clinical environment will allow greater privacy and more user-friendly spaces for patients, carers and visitors.* | NHS Lanarkshire PAMS KPIs<br>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.*<br><br>*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<br><br>HSCP Commissioning Outcomes.<br><br>'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, but which will never be* | NHSL PAMS and LDP KPIs |

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|---|---|---|
| | *able to provide a clinical environment sufficient to meet the strategic objectives of NHS Lanarkshire.*<br><br>*The operational costs will be better managed through improved energy efficiency. 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?

This proposal directly responds to the strategic vision, and service development proposals set out in the NHS Lanarkshire Healthcare Strategy "Achieving Excellence" www.nhslanarkshire.org/Involved/consultation/healthcare-strategy

The healthcare strategy is built upon national, regional and local strategic priorities as described below:

**2020 Vision for Health and Social Care, Reshaping care for Older People 2011-21,** the **Health and Social Care North Lanarkshire strategic plan 2016-26,** and the **South Lanarkshire Health and Social Care Partnership strategic commissioning plan 2016-19.**

**http://www.gov.scot/Resource/0042/00423188.pdf**

**www.gov.scot/Resource/0039/00398295.pdf**

**http://www.nhslanarkshire.org.uk/About/HSCP/Documents/Strategic%20Commissioning%20Plans/HSCNL-Strategic-Plan.pdf**

**http://www.nhslanarkshire.org.uk/About/HSCP/Documents/Strategic%20Commissioning%20Plans/SLHSCP-Commission-Plan-16-19.pdf**

These national and local strategies are integral to the further development of clinical and social care for the people of Lanarkshire. The main element of the actions resulting from these strategies is to continue to avoid the need for hospital attendance and/or admission, to reduce the lengths of stay in secondary care, and enable a higher proportion of resources to be released from acute services to provide care in, or closer to, patients' homes. This will enable development of improved care pathways between primary, secondary, social and community care.

This project anticipates the successful implementation of the plans arising from this strategic vision, in that there will be a continuing shift away from hospital care into community care. This will represent a reduction in admission and/or reduced lengths of hospital stay of the order 25% in the period leading up to the opening of any new hospital facility, to be delivered through the HSCP commissioning strategies. The project also anticipates a doubling in the number of people living longer lives and requiring the associated level of treatment and care (including hospital care), over the same period.

These factors are included in NHSL healthcare strategy Achieving Excellence, and will influence the final function and size of any new or refurbished hospital facility.

**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.

## 3.4 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, 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 6 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 tired and increasingly difficult to maintain, clean and present in condition which is conducive to positive patient outcomes and feeling of wellbeing and detracts from the patient experience.

**Key Planning Assumptions**

The key planning assumptions which underpin this proposal are set out in Achieving Excellence:

- 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

# 4 Why is this proposal a good thing to do?

| | Question | Response |
|---|---|---|
| Strategic Context | Why is this proposal a good thing to do? | Outline:<br>• Current arrangements<br>• Need for change<br>• Investment objectives<br>• Design quality objectives<br>• Benefits realisation plan<br>• 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 03: Centres of Excellence**

| Monklands DGH | Hairmyres Hospital | Wishaw Hospital |
|---|---|---|
| ▪ ENT surgery<br>▪ Urology surgery<br>▪ Infectious disease medicine<br>▪ Renal medicine<br>▪ Histopathology<br>▪ Radiotherapy<br>▪ Haematology | ▪ Vascular surgery<br>▪ Ophthalmology surgery<br>▪ Optimal cardiac reperfusion<br>▪ Interventional radiology | ▪ Paediatric services<br>▪ Maternity & neonatal<br>▪ Intensive Psychiatric Care<br>▪ Bariatric surgery<br>▪ Specialist Lab services |

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 04 below provides the current bed complement within Monklands Hospital.

**Table 04: Monklands Bed Complement as at 15/11/2016**

| 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 | 14 |
| Urology* | 30 |
| Communicable Diseases* | 17 |
| Renal Medicine* | 17 |
| ENT* | 25 |
| Acute Adult Psychiatry | 24 |
| Transitional Care | 16 |
| Maxillofacial | 5 |
| **Total** | **466** |

*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 standalone 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.

### 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.

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 issues with drainage and blocked pipes and with water ingress during heavy rainfall.

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 remain 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 level of investment to make safe & improve building, heating, water pressure and electrical and mechanical functions. 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 circa £5M in 16/17 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;

**Diagram 01: 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 | 53,926 | 19 | Clinical | C | D | C | O | £23,775,934 |

*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 05: 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 |

In terms of the investment now required to return the estate to condition B i.e. satisfactory condition with evidence of only minor deterioration, the current backlog figure stands circa £23.8M.

The investment required to replace items or return them to condition B (when the item reaches the end of its useful life) over period of property i.e. life cycle costs in the short- to medium-term are circa £103.2M using a 2015 baseline. These high levels of backlog maintenance costs are a present and future liability, which could be eliminated through the options being proposed.

**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 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.

### 4.1.4 Public and Service User Expectations

The illustration below provides information gained via patient feedback which allows an understanding of what patients consider works well in Monklands Hospital and also areas where improvements must be made. The key areas for improvement in any option for future development include the following:

- Waiting – 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 and 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
- Toilets and showers – Facilities are poor and limited in number within inpatient areas. There are fundamental inadequate ventilation issues which give rise to infection control concerns associated with this. The limited single room availability means patients are nursed in multi-patient areas. On many occasions this 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.
- 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

and leaks as a result of rainfall and is over warm in the summer. This is an inherent failure in the current building's construction, and a replacement projectwould cause major disruption to current services, being the main link between key buildings.

- Car Parking – Highlighted as a key area of 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. 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).

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 06: Need for Change**

| Cause of the need for change: | Effect of the cause on the organisation: | Why action now: |
|---|---|---|
| *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.*<br>*This will reduce admission rates and shorten lengths of stay in hospital.* |
| *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 (redesigned) service needs.* |
| *A larger proportion of* | *Requirement to build* | *The future shape of the* |

| | | |
|---|---|---|
| *health and social care should be provided in a community and primary care setting.* | *pathway, capacity and capability between acute and community care teams* | *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 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).*<br><br>*Future configuration of general surgery, orthopaedics and cancer care are predicated on the ability of NHSL to reconfigure services between the three DGHs.* |
| *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 07: 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) will deliver the necessary shift in the balance of care to achieve the strategic objectives set out in "Achieving Excellence" |
| *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.

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 08: 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.*<br><br>*Higher engagement of patients in clinical decisions.*<br><br>*Reduction in delays in transitions between episodes of assessment and care.* | *National key outcome measures.*<br><br>*Patient satisfaction measures.*<br><br>*Activity & performance measures* | *2* |
| *2* | *Improved safety of patient care* | *Improved clinical outcomes.*<br><br>*Higher patient/carer satisfaction with assessment/ treatment.*<br><br>*Reduction in disruption to clinical activity caused by accommodation and /or environmental factors.* | *Patient safety indicators.*<br><br>*Morbidity and mortality indicators.*<br><br>*Patient satisfaction measures.*<br><br>*Activity & performance measures* | *1* |

| | | | | |
|---|---|---|---|---|
| *3* | *Improved clinical effectiveness* | *Reduced number and length of stays in hospital.*<br><br>*Improved clinical outcomes. More treatments delivered on a day case basis.* | *Activity & performance measures.*<br><br>*Morbidity and mortality indicators.* | *3* |
| *4* | *Quality physical environment* | *Improved functional suitability.*<br><br>*Improved space utilisation.* | *PAMS & EAMS assessments.*<br><br>*Patient satisfaction measures.*<br><br>*Reduction in backlog maintenance.* | *5* |
| *5* | *Flexible / adaptable facilities across the health system* | *Adherence to current accommodation standards.*<br><br>*Ability to shift the use of space from inpatient to outpatient/day care usage.*<br><br>*Reduction in running costs.* | *PAMS & EAMS assessment.*<br><br>*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 corollary being that inadequate risk management can lead to a reduction in identified benefits being achieved.

The Board therefore recognises the value of putting an effective risk management framework in place to systematically identify, actively manage and mitigate the impact of risk. This will be achieved 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

A number of high level risks have been identified at this IA stage. These cross reference the submission of the Risk Potential Assessment (RPA) made in October 2016 which initiated the Gateway 1 Review, separated into Strategic and Project risks. At this time, these risks sit with the Project Board and Team to mitigate.

**Table 09: Strategic Risks**

| | RPA reference | Strategic/ Project Risk | Owner |
|---|---|---|---|
| NHS and other policies may change during design and construction which impact on cost and/ or programme. | C1.1 | Strategic | Project Board |
| The Healthcare Strategy planning process may be delayed or incomplete, and so impact on overall functional suitability, cost and/ or programme. | C1.1 | Strategic | Project Board |
| Legislative change during design and construction may impact on cost and/ or programme | C1.1 | Strategic | Project Board |
| Scottish Government policy may change during business case development leading to no approval to proceed | C1.1 | Strategic | Project Board |
| The preferred design solution may not meet current technical and operational standards | C1.1 | Project | Project Team |
| The clinical and service models for the new facility may have an adverse impact on other hospital services in neighbouring catchment areas (i.e. emergency flows) | C1.6 | Strategic | Project Board |

| | | | |
|---|---|---|---|
| The clinical and service models for neighbouring facilities may have an adverse effect on the new facility's ability to deliver emergency and planned care (e.g. diagnostic treatment centres) | C1.6 | Strategic | Project Board |
| Lack of capacity and capability within the project team may lead to impact on cost and/ or programme and/ or benefits realisation | C2.1 | Project | Project Team |
| Lack of capacity and capability within the NHS Board's advisors may lead to impact on cost and/ or programme and/ or benefits realisation | C2.1 | Project | Project Team |
| Lack of capacity and capability within the PSCP may lead to impact on cost and/ or programme and/ or benefits realisation | C2.1 | Project | Project Team |
| The business case development and design process may not adequately involve key stakeholders which impacts on programme and benefits realisation | C2.2 | Strategic | Project Board |
| Organisational change with NHS Lanarkshire and/ or NHS Scotland may lead to impact on deliverability, cost and/ or programme | C2.4 | Strategic | Project Board |
| During the design and construction period the current facility may suffer significant loss of business continuity. | C3.1 | Project | Project Team |
| Delivery of the chosen solution (if redevelopment on current site) may increase the risk to business continuity of clinical services. | C3.1 | Project | Project Team |
| Failure to identify the funding mechanism may lead to increased cost and/ or programme delay | C3.2 | Strategic | Project Board |
| The preferred solution may not be affordable | C3.2 | Strategic | Project Board |
| The clinical benefits of the new facility may not be achieved. | C3.3 | Project | Project Team |
| Non-clinical (e.g. patient amenity, financial) benefits may not be achieved. | C3.3 | Project | Project Team |
| HAI Scribe may identify risks which impact on cost and/ or programme | X | Project | Project Team |
| The site chosen for development of the new facility may have significant environmental issues which impact on cost and/ or programme (e.g. mine workings, contamination, drainage services) | X | Project | Project Team |

A project specific risk register has also been developed which will manage the identified risks through the lifetime of the project. This has been included in this IA within Appendix 2

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 10: 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 11: 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 12: 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:<br><br>New build - 100%<br><br>Refurbished facilities – 50% single rooms minimum<br><br>This may increase staffing costs. |

| | |
|---|---|
| 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)

☐ 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:<br>• The Do Nothing option<br>• Service change proposals<br>• List of proposed solutions<br>• Indicative costs<br>• 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 13: 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 lifting 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. |
| 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 drainage and 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:<br>▪ Bedrooms<br>▪ Waiting – Inpatient areas have no defined waiting areas or privacy rooms for carers and families.<br>▪ Toilets – Facilities are considered poor and limited within inpatient areas.<br>▪ 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 leaks as a result of rainfall and is over warm in the summer.<br>▪ 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.<br>▪ 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 minimal amount that can be achieved within the confines of the current infrastructure. Ongoing reactive maintenance enables the functionality of daily hospital operations to be maintained but this does not provide anything more than a short term fix to the issues described in the above table from either a service or a public expectation perspective. This is not a sustainable solution over the medium/ long term.

## 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 will guide the service change for 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)
- Acute medical and surgical services
- Diagnostics and imaging
- Operating theatres and critical care
- Outpatient services

This is based on an acute bed model for the future needs of the Lanarkshire population which is predicated on changes to the health and social care system delivering a 25% reduction in admissions and/or length of stay by 2025. However, the same model predicts an 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 net result of current models predicts that the size of the DGHs in Lanarkshire will not change significantly, but that there will be variations in the disposition of acute specialties.

Specific areas of work which will assist in defining the requirement for clinical and support services for the new Monklands DGH **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 process and governance will be put in place from November 2016 to ensure that the unknown elements described above are defined in sufficient time and detail to enable the completion of the OBC.

## 5.3 Developing a short list of proposed solutions

This analysis has been prepared by Currie & Brown (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:

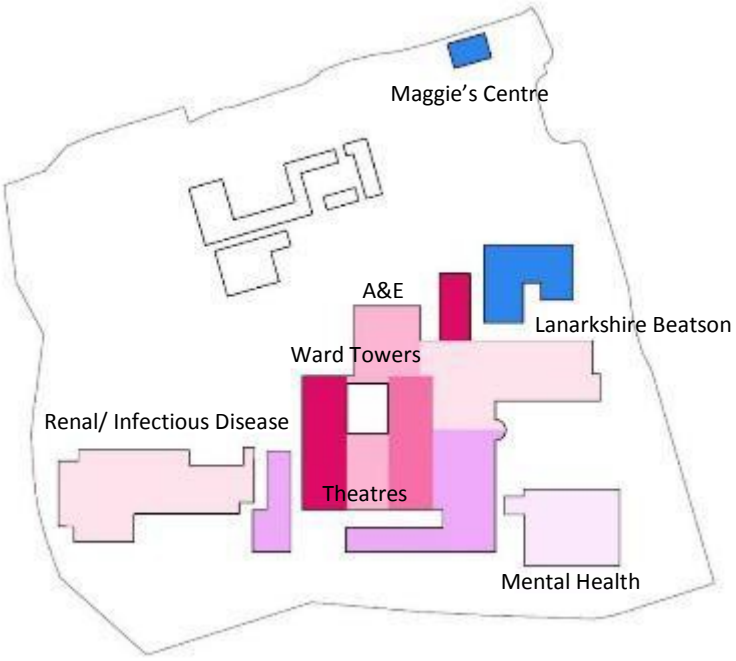
This is to continue with the current programme of backlog maintenance and renewal (the on-going MKBC Programme) through to their end point. This will impact NHS Lanarkshire's ability to deliver the Healthcare Strategy which may preclude it as a viable option.

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

**Diagram 02: Existing Monklands Site Layout**


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

**Diagram 03: 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.

**Diagram 04: Relocation of Renal and Infectious Diseases**

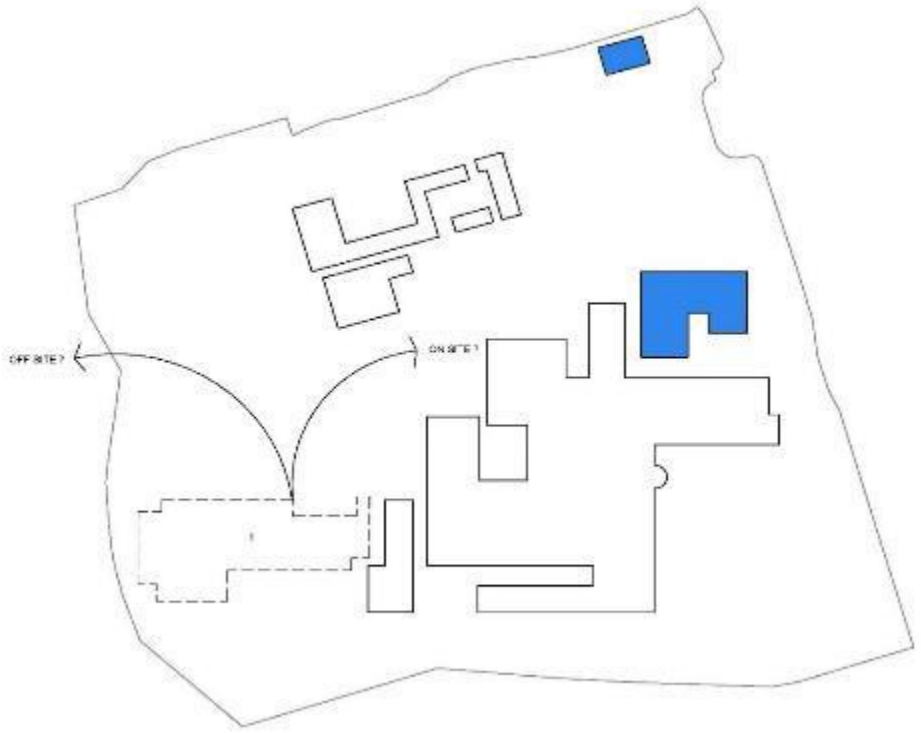


**Diagram 05: Construction of New Wards**

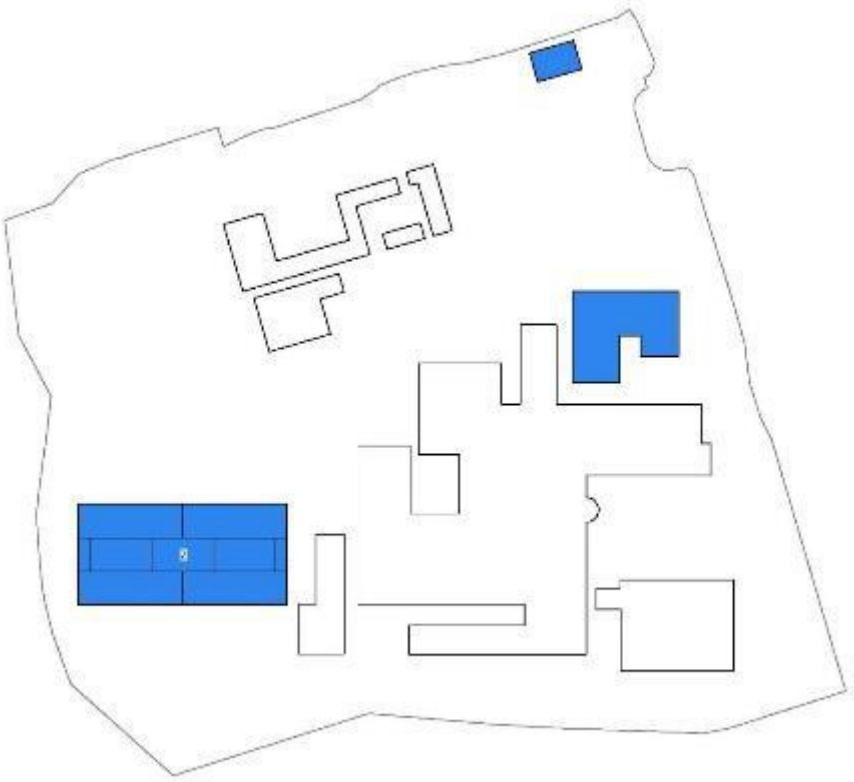
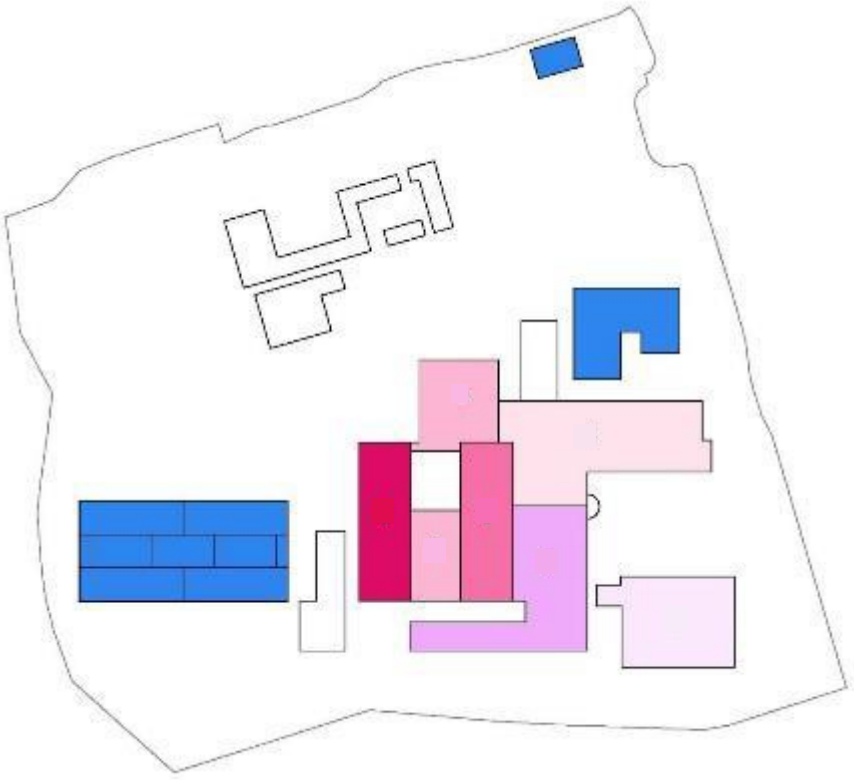


**Diagram 06: Renovate Site over a series of Phases**



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**

**Diagram 07: Relocate Renal and Infectious Diseases**

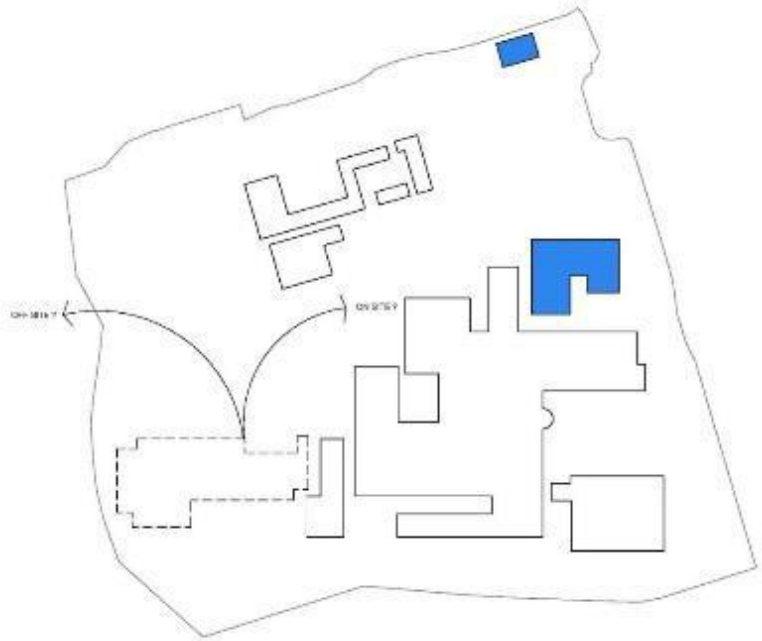


**Diagram 08: Build New Multi Storey Hospital and Demolish Redundant Buildings**

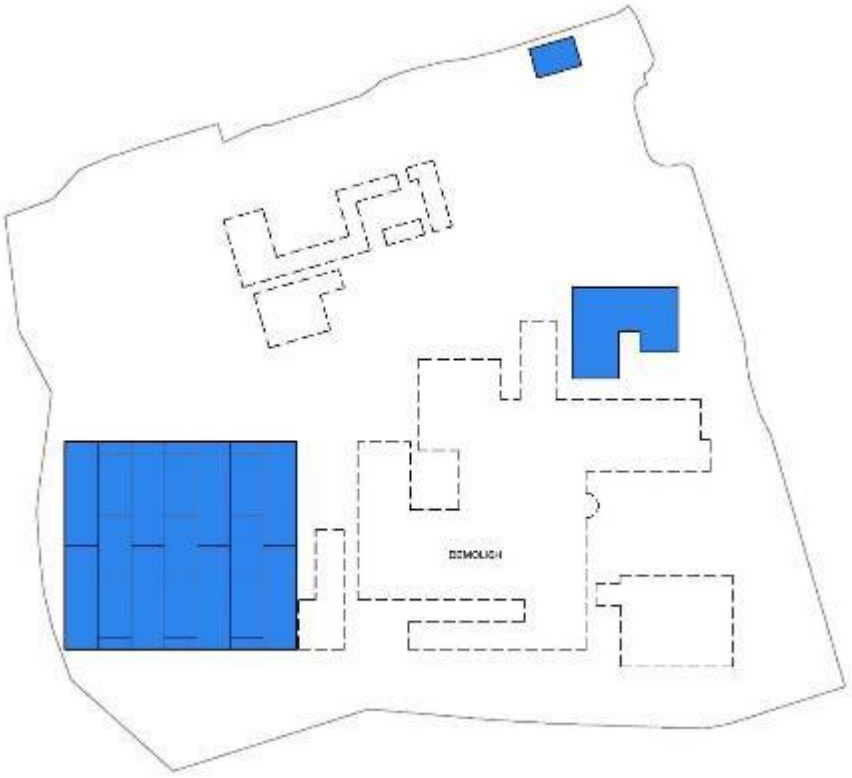
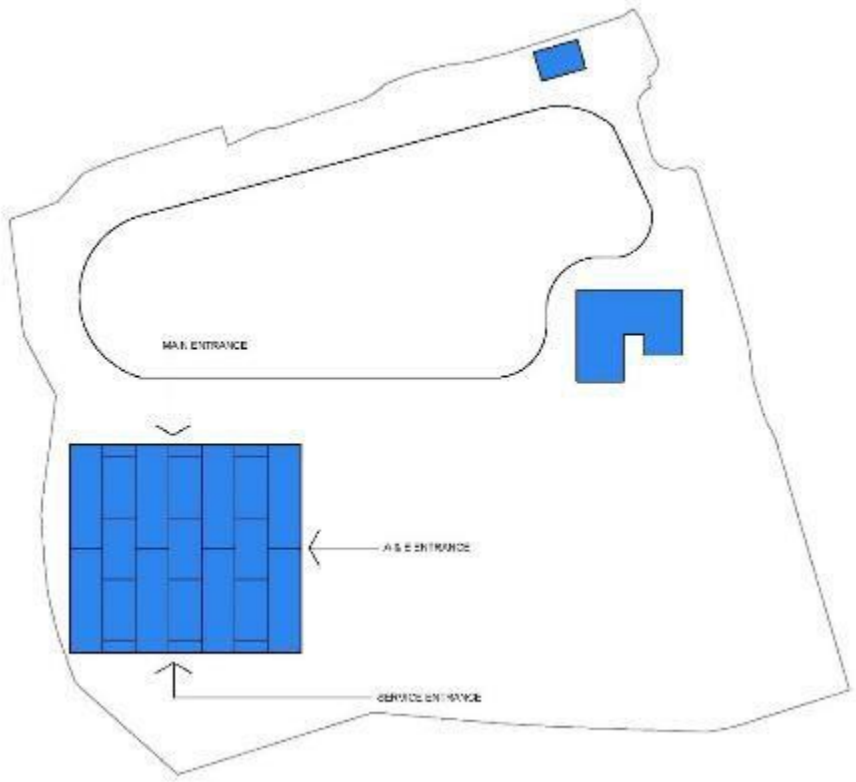



**Diagram 09: Form New Roads, Parking and Grounds**



## VARIATION 2:

**Diagram 10: Demolish David Matthews**

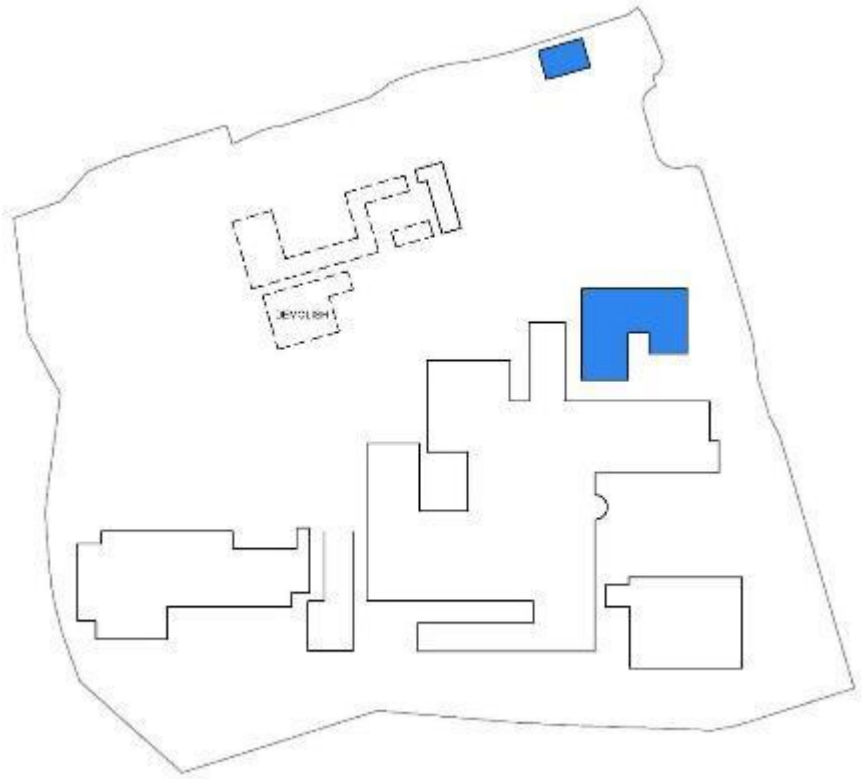


**Diagram 11: Construct New Hospital**

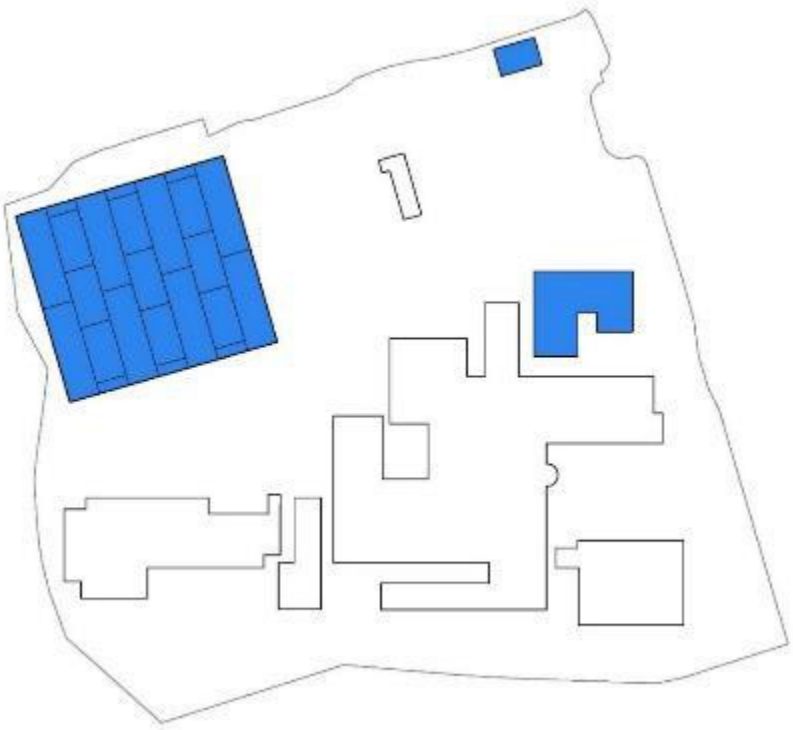


**Diagram 12: Demolish Existing Buildings**

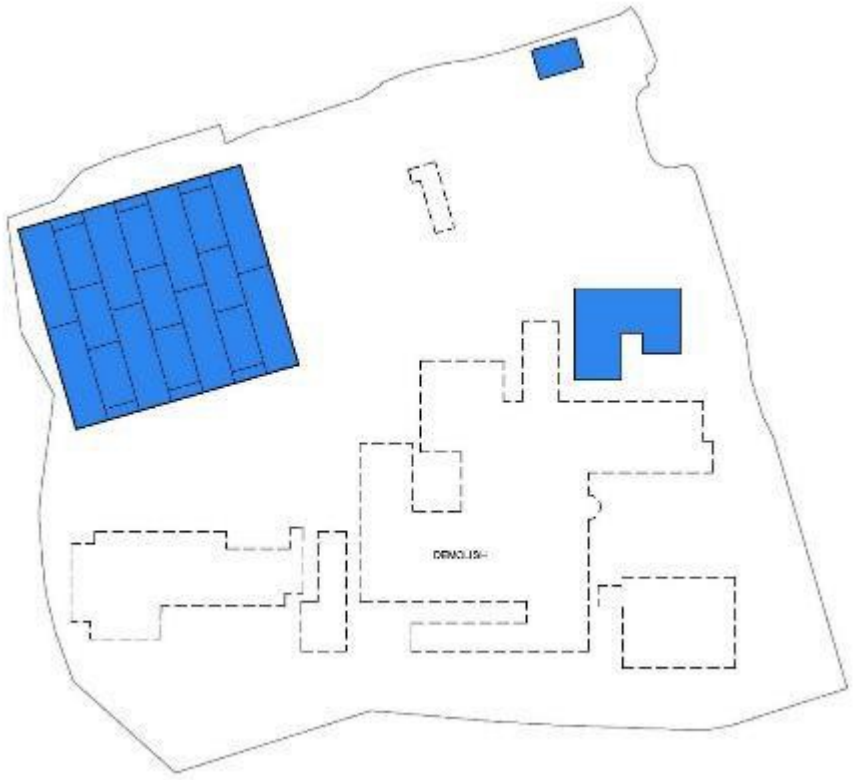
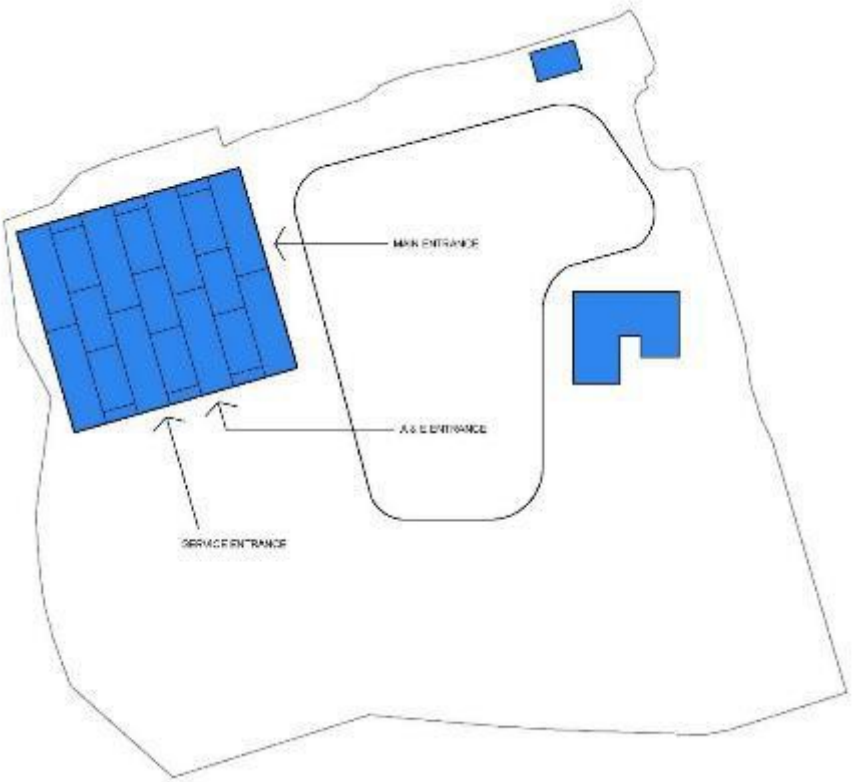


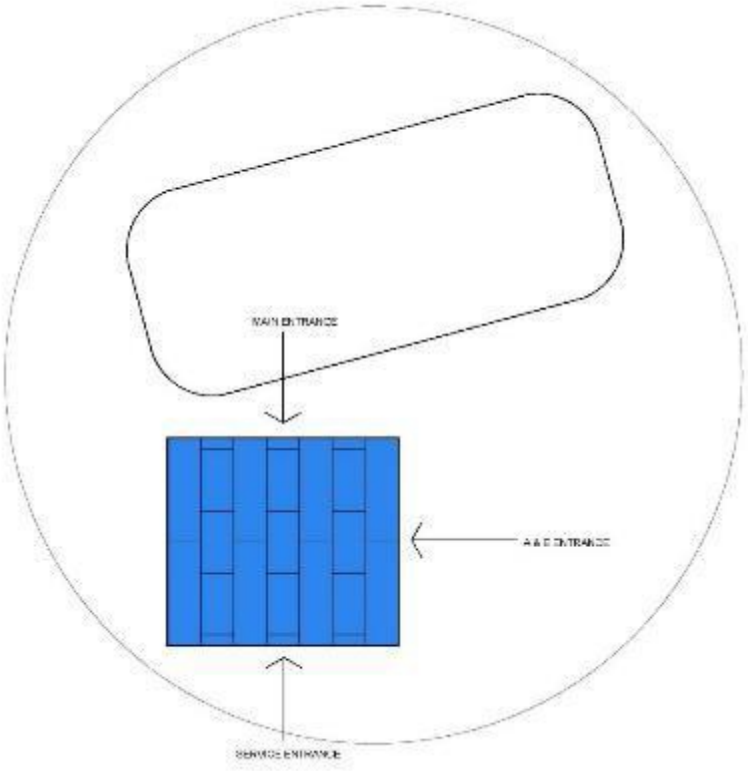

**Diagram 13: Form New Roads, Parking and Grounds**



**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.

**Diagram 14: 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:

- Refurbished hospital makes use of existing building fabric
- Hospital use has already been established for the site
- Maggie's and Lanarkshire Beatson are retained on site
- Renal, ID and Endoscopy not affected

Cons:

- Will not deliver "Achieving Excellence"
- 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

**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 in terms of traffic disruption, noise and dust

- 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).

- 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

**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

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 reduction in parking numbers during construction, which could give rise to a requirement for 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

**Option D: New-build on New Site:**

Pros:

- 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.

Cons:

- Site not yet identified nor obtained, so access, infrastructure and planning risks not yet determined; assessment of alternative sites currently being carried out
- Costs should include the write-down 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 7 or 8 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 14: 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 - £249 | £228 - £234 | £239 - £245 |
| **Design Fees** | £19 - £19 | £32 - £35 | £30 - £30 | £31 - £32 |
| **NHS Direct Costs** | £6 - £6 | £41 - £42 | £34 - £35 | £39 - £40 |
| **Risk** | £36 - £37 | £84 - £91 | £59 - £60 | £49 - £51 |
| **Inflation** | £63 - £64 | £145 - £182 | £18 - £18 | £18 - £19 |
| **VAT** | £50 - £51 | £116 - £120 | £74 - £76 | £75 - £77 |
| **Total** | **£299 - £305** | **£693 - £716** | **£443 - £453** | **£451 - £464** |

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. It is recognised that these costs will continue and increase over the period that the hospital continues to be used to provide clinical services and that this option would not allow safe delivery of the "Achieving Excellence" strategy.

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.

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. 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

Both of these variants have 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 100% single bed ward accommodation.

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 14 below.

**Table 15: 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 | £30 - £34 | £145 -£169 | £88 - £101 | £88 - £101 |

Clinical service costs for the new build have been calculated to allow for the increased nursing costs required to manage 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 100% single

bed provision. This is estimated at £0.25m.

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 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 have 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. As there is no fundamental change to the building, other that improving the fabric of the Wards and other areas. No increase in operating costs has been assumed.

For Option C & 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. In the case of Option C this will be in respect of the areas of the site that do not require to be retained following the completion of the works and to provide car parking and access to the new facility. Option C costs are therefore not likely to be offset by the option resulting in available land to sell.

This return will be different depending on which area of the site was used to provide the new building. Under Option D this will be disposal of the full Monklands site. A valuation of this has been is currently being assessed by the board's property advisor. 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 15. 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 16: 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 | £324 - £334 | £338 - £349 |
| **Equivalent Annual Cost** | £8 - £9 | £13 - £13 | £12 - £13 | £13 - £13 |

The Economic Appraisal calculation takes account of:

- Capital development costs including fees
- Life Cycle Costs
- In-House Fees and Costs to support 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 17: 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) | £299 - £305 | £693m - £716m | £443m - £453m | £451m - £464m |
| Whole of life cycle costs | £30 - £34 | £145 -£169 | £88 - £101 | £88 - £101 |
| Whole of life operating costs (Clinical & Building Costs) | £0 | £88 | £105 | £105 |
| Estimated Net Present Value | £131 - £136 | £329 - £345 | £324 -£334 | £338 -£349 |

## 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 18: 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 | 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 lengths 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** | Possible | 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.

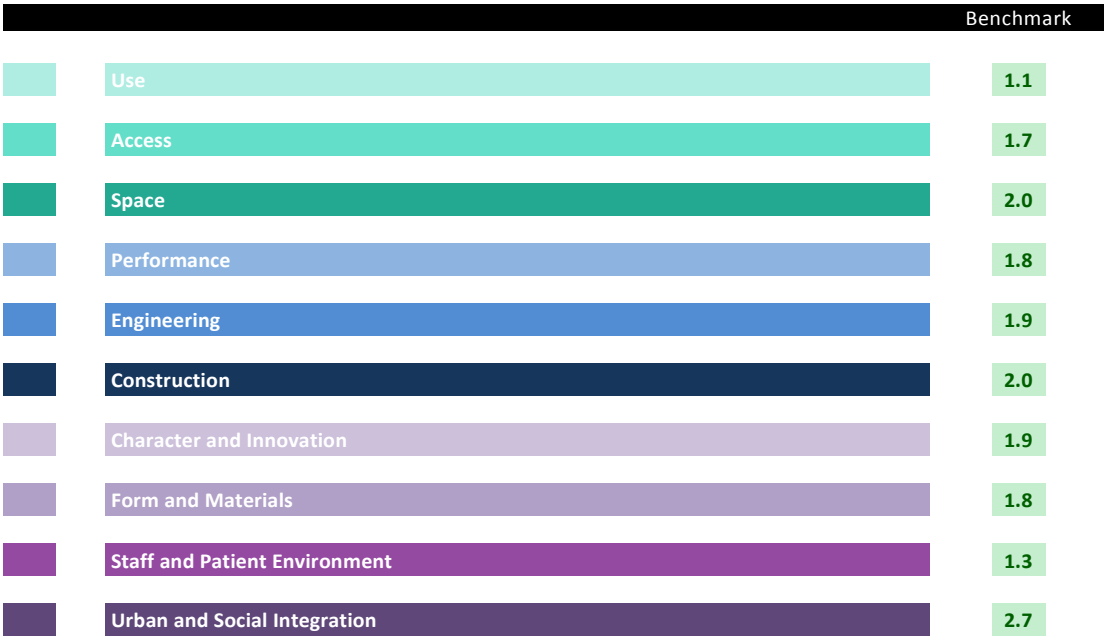
## 5.6 Design Quality Objectives

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 XX). This will be 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:

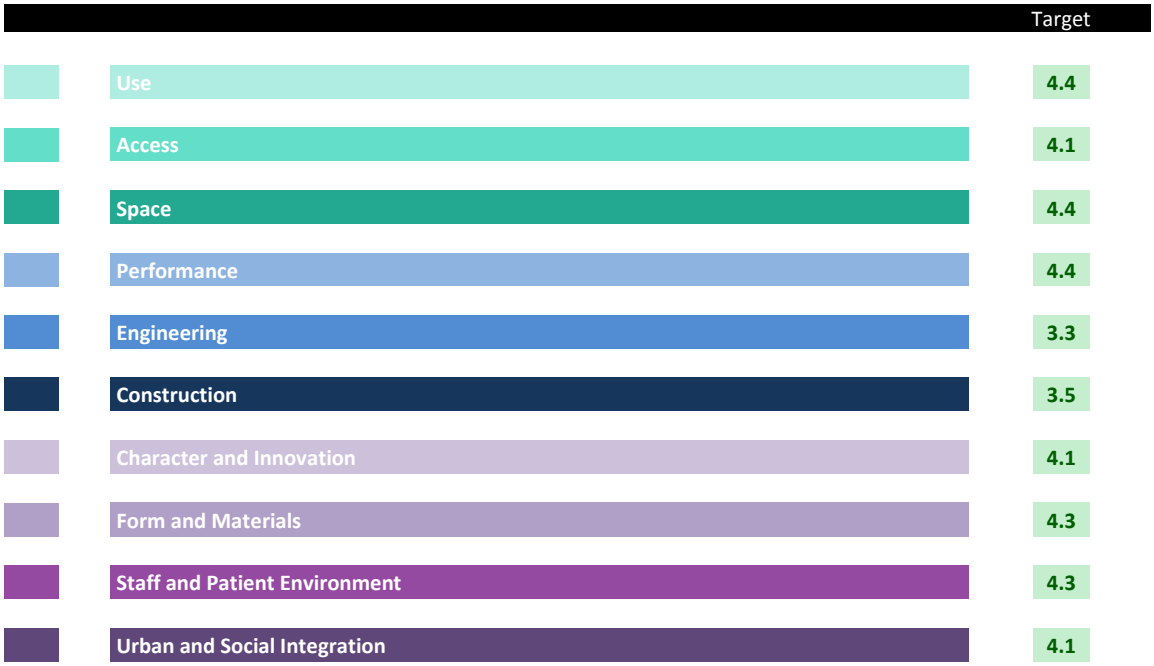
**Table 19: Monklands Existing Arrangements: AEDET scores**




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 20: 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.

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.

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:<br>• Procurement strategy & timetable<br>• Affordability & financial consequences<br>• 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 – Constructing 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 21: 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 22: 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. The group also noted that the projectcannot afford to wait until the new Framework Scotland is procured in July 2017.

**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 23: Timetable of Key Stages**

| Activity | Period |
|---|---|
| SGHSCD Initial Agreement Approval | 2nd QTR '17 |
| Outline Business Case Approval | 3rd QTR '17 – 3rd QTR '18 |
| Technical Advisor Procurement | 1st QTR '17 – 2nd QTR '17 |
| Contractor Procurement | 2nd QTR '18 – 2nd QTR '19 |
| Full Business Case | 1st QTR '19 – 1st QTR '20 |
| Construction/Demolition | 2nd QTR '20 – 1st QTR '25 |
| Commissioning | 2nd QTR '24 – 3rd QTR '24 |
| Migration | 4th QTR '24 – 1st QTR '25 |

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 2016/17 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 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.

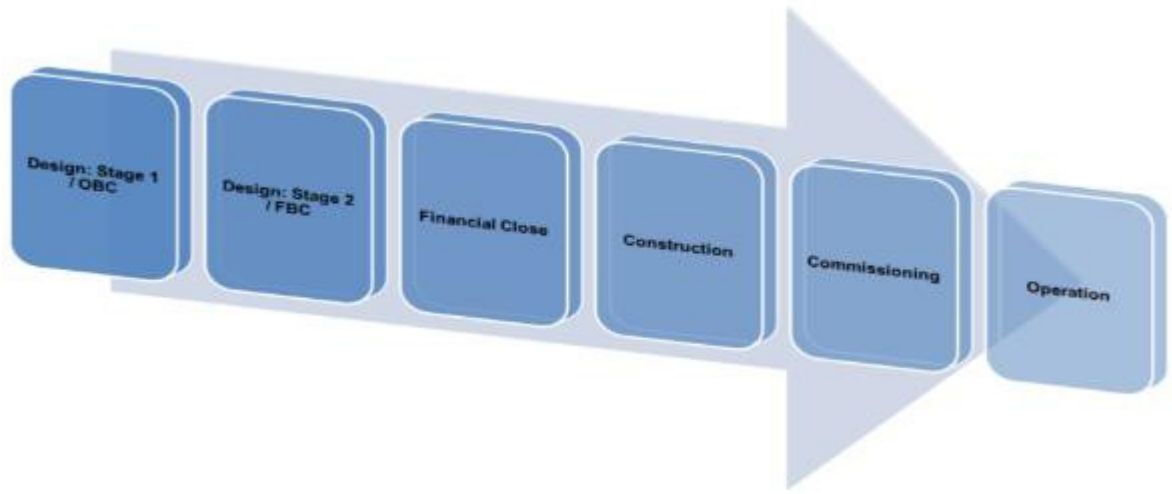
## 6.3 The Management Case

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.

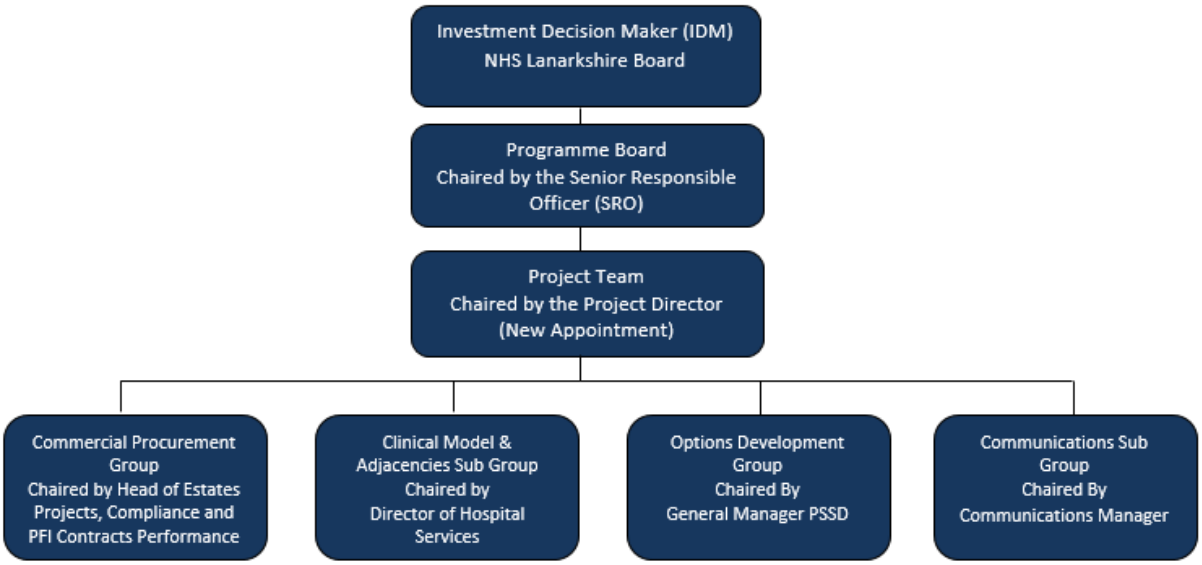
The approach required is of a phased nature due to the scale and complexity of this project and this is set out below:

**Diagram 15: Project Phasing**




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

**Diagram 16: 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 monthly during design stage 1.

### 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.

### 6.3.3 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

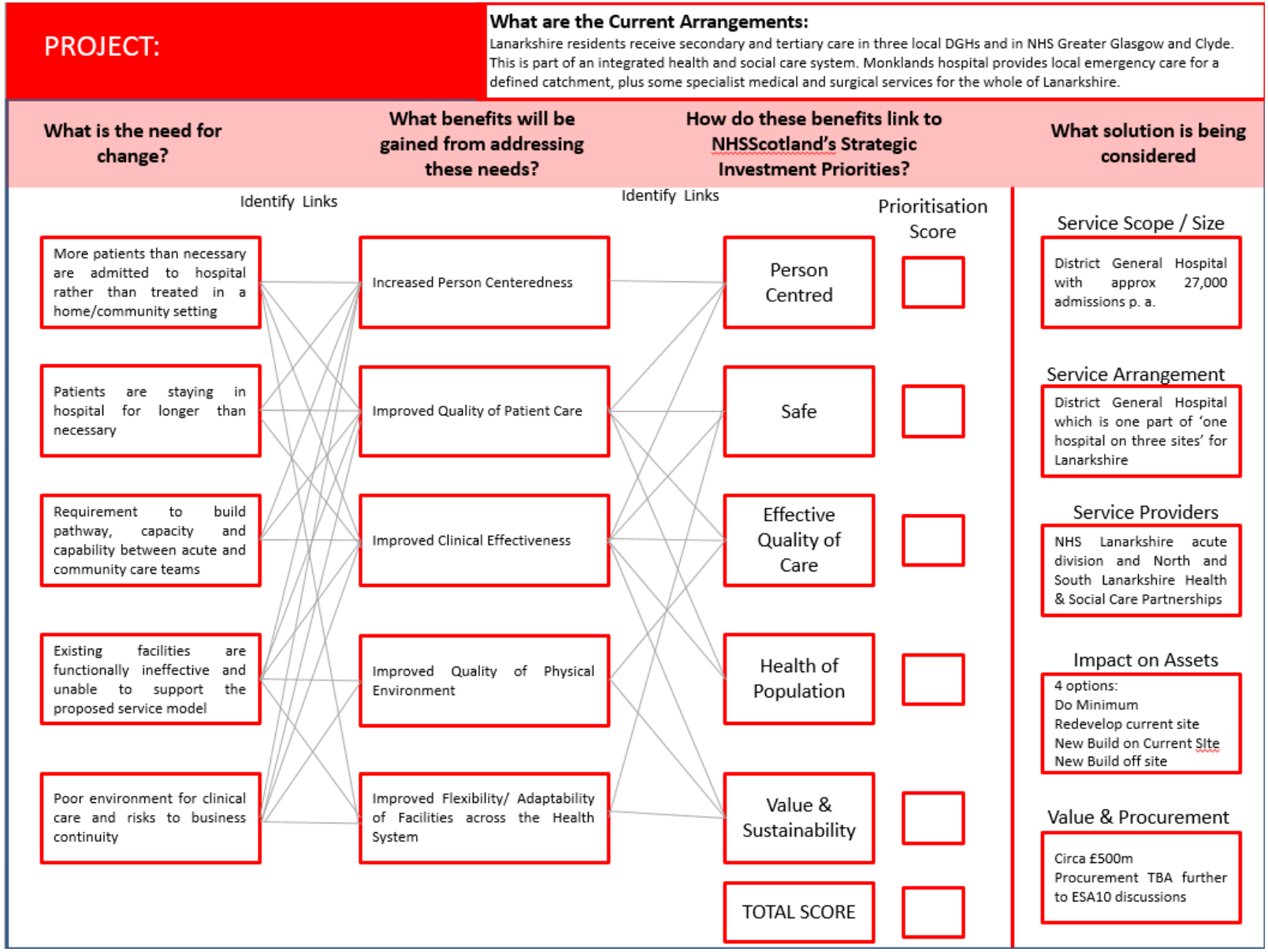
The following checklist has been drafted to provide comfort that NHSL is ready to submit the Initial Agreement for approval and is subsequently ready to proceed to the Outline Business Case stage:

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

# 7 Is this proposal still a priority?

| | Question | Response |
|---|---|---|
| Conclusion | Is this proposal still important? | Confirm:<br>• 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.
What is the need for change?
What benefits will be gained from addressing these needs?
How do these benefits link to NHSScotland's Strategic Investment Priorities?
What solution is being considered
Identify Links
Identify Links
Prioritisation Score
More patients than necessary are admitted to hospital rather than treated in a home/community setting
Patients are staying in hospital for longer than necessary
Requirement to build pathway, capacity and capability between acute and community care teams
Existing facilities are functionally ineffective and unable to support the proposed service model
Poor environment for clinical care and risks to business continuity
Increased Person Centeredness
Improved Quality of Patient Care
Improved Clinical Effectiveness
Improved Quality of Physical Environment
Improved Flexibility/ Adaptability of Facilities across the Health System
Person Centred
Safe
Effective Quality of Care
Health of Population
Value & Sustainability
TOTAL SCORE
Service Scope / Size
District General Hospital with approx 27,000 admissions p. a.
Service Arrangement
District General Hospital which is one part of 'one hospital on three sites' for Lanarkshire
Service Providers
NHS Lanarkshire acute division and North and South Lanarkshire Health & Social Care Partnerships
Impact on Assets
4 options:
Do Minimum
Redevelop current site
New Build on Current SIte
New Build off site
Value & Procurement
Circa £500m
Procurement TBA further to ESA10 discussions

**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. A final workshop on 2 November 2016 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.

**In addition**

- A dedicated Monklands Hospital Facebook page has been created - https://www.facebook.com/Monklands-Hospital-1185708261488427/
- Double page spread in The Pulse (September/October 2016) about the proposed new Monklands Hospital development and how staff can give their views.

**Next Steps**

Engagement and communication with the stakeholders in this project will continue into the development of the outline business case in 2017. 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<br>Increased Costs | NHSL | Appropriate Site Surveys<br>Historical Survey Review | 2 | 5 | 10 | Moderate |
| 2 | Business | Changes to operational policies | 3 | 3 | 9 | Moderate | Redesign<br>Increased Costs | NHSL | Ongoing dialogue with NHSL to anticipate proposed future change | 2 | 2 | 4 | Low |
| 3 | Business | Legislative change | 3 | 4 | 12 | Significant | Redesign<br>Increased Costs | NHSL | Monitoring of Legislative announcements<br>Awareness of proposed future changes | 2 | 3 | 6 | Low |
| 4 | Business | Changes in Government Policy | 2 | 3 | 6 | Low | Delay to programme<br>Increased Costs | NHSL | Maintain dialogue with SGHSCD | 2 | 2 | 4 | Low |
| 5 | Business | Risks associated with plans for national treatment centres | 3 | 3 | 9 | Moderate | Delay to programme<br>Increased Costs | NHSL | Maintain dialogue | 3 | 3 | 9 | Moderate |
| 6 | Business | Organisational change | 3 | 2 | 6 | Low | Delay to programme<br>Increased Costs | NHSL | Maintain key personnel positions<br>Ensure effective handover to new personnel | 2 | 2 | 4 | Low |
| 7 | Business | Failure to deliver adequate engagement | 3 | 4 | 12 | Significant | Delay to programme | NHSL | Develop and Agree consultation programme with appropriate body<br>Execute consultation programme | 1 | 4 | 4 | Low |
| 8 | Business | Failure to adequately determine the overall programme | 3 | 4 | 12 | Significant | Inability to meet demand | PSC | Engagement/ Ongoing review/ Benchmarking | 2 | 4 | 8 | Moderate |
| 9 | Business | Secure appropriate funding stream | 4 | 5 | 20 | High | Programme Delay<br>Unable to commence construction | NHSL | Define and cost scope of works.<br>Acceptance of IA | 3 | 5 | 15 | Significant |
| 10 | Business | Affordability of Project | 4 | 5 | 20 | High | Unable to commence construction<br>Programme Delay | NHSL | Clearly define scope of works<br>Project capital/ revenue costs<br>Acceptance of IA | 3 | 5 | 15 | Significant |
| 11 | Business | NHSL Board Advisors – capacity and capability | 3 | 3 | 9 | Moderate | Programme/ Cost Impact<br>Benefits not realised | NHSL | Early procurement of Technical Advisors/Resource clearly established at interview | 2 | 2 | 4 | Low |
| 12 | Business | Contractor – capacity and capability | 3 | 3 | 9 | Moderate | Programme/ Cost Impact<br>Benefits not realised | NHSL | Resource clearly established at interview<br>Contiuous dialogue throughout project | 2 | 2 | 4 | Low |
| 13 | Business | Scope of works changing – expansion/ reduction of proposed works | 4 | 3 | 12 | Significant | Redesign<br>Delay to programme | NHSL | Appropriate 1:200/ 1:50 engagement<br>Design Freeze<br>Change control process | 2 | 3 | 6 | Low |
| 14 | Business | Contradictory aspirations of different directorates | 2 | 2 | 4 | Low | Redesign<br>Delay to programme<br>Increased Costs | NHSL | Project Board meeting discussion | 1 | 2 | 2 | Low |
| 15 | Business | Clinical Service Change through duration of project | 4 | 3 | 12 | Significant | Redesign<br>Delay to programme<br>Increased Costs | NHSL | Project Board as part of service discussion | 3 | 3 | 9 | Moderate |

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| **15** | Business | Clinical Service Change through duration of project | 4 | 3 | 12 | Significant | Redesign<br>Delay to programme<br>Increased Costs | NHSL | Project Board as part of service discussion | 3 | 3 | 9 | Moderate |
| **16** | Business | Failure to pass Gateway Review | 3 | 3 | 9 | Moderate | Redesign<br>Delay to programme<br>Increased Costs | NHSL | Ongoing discussion with SGHSCD and Gateway teams throughout project | 2 | 2 | 4 | Low |
| **17** | Business | Delay in Statutory Approvals | 3 | 4 | 12 | Significant | Redesign<br>Delay to programme<br>Increased Costs | NHSL | Early consultation with Planning Department | 2 | 4 | 8 | Moderate |
| **18** | Business | Stakeholders have contradictory aspirations | 3 | 4 | 12 | Significant | Unclear brief leading to programme pressure | NHSL | Feedback and Communication (Clarity in IA)/Deddicated NHSL PM | 2 | 1 | 2 | Low |
| **19** | Business | Failure to control scope creep - client change | 4 | 4 | 16 | High | Increased cost and programme issues | NHSL | Governance and Change Control | 2 | 3 | 6 | Low |
| **20** | Business | Failure to control budget creep | 4 | 4 | 16 | High | Increased cost and programme issues | NHSL | Governance and Change Control | 2 | 3 | 6 | Low |
| **21** | Business | Failure to adequately resource OBC | 2 | 4 | 8 | Moderate | Delay to FBC | NHSL | Performance Management of Process/Early procurement of technical advisor/Internal Project Team | 1 | 2 | 2 | Low |
| **22** | Business | Failure to secure available capital funding | 3 | 5 | 15 | Significant | Major project scope review | NHSL | Early and ongoing dialogue with SGHD | 2 | 4 | 8 | Moderate |
| **23** | Business | Failure to secure appropriate revenue funding level | 3 | 4 | 12 | Significant | Major project scope review | NHSL | Early and ongoing dialogue with NHSL Health Board | 2 | 2 | 4 | Low |
| **24** | Business | Affordability requires altered design causing programme delays | 4 | 4 | 16 | High | Design review and delay | NHSL | Governance and Change Control | 3 | 3 | 9 | Moderate |
| **25** | Business | Impact on design due to unknown structural defects (refurb 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 |
| **26** | Business | Condition of Development Option site | 3 | 4 | 12 | Significant | Delay to programme<br>Increased Costs | NHSL | Appropriate survey works undertaken ahead of site purchase | 2 | 4 | 8 | Moderate |
| **27** | Business | Locating a development option site | 1 | 4 | 4 | Low | Delay to programme<br>Increased Costs | NHSL | Enagegment with consultants to identify most appropriate solution | 1 | 3 | 3 | Low |
| **28** | Design | Failure to develop the clinical model | 3 | 4 | 12 | Significant | Delay to programme<br>Increased Costs | NHSL | Early engagement with Clinical teams<br>Involve Clinical teams in wider discussion | 2 | 4 | 8 | Moderate |
| **29** | Design | Failure to properly identify the clinical requirements | 3 | 4 | 12 | Significant | Delay to programme<br>Increased Costs | NHSL | Early engagement with Clinical teams<br>Involve Clinical teams in wider discussion | 2 | 4 | 8 | Moderate |
| **30** | Design | Failure to meet technical guidance (refurb) | 3 | 3 | 9 | Moderate | Non Compliant Installation | Contractor | Derogation List established early<br>Early engagement with HFS | 2 | 2 | 4 | Low |

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| **30** | Design | Failure to meet technical guidance (refurb) | 3 | 3 | 9 | Moderate | Non Compliant Installation | Contractor | Derogation List established early<br>Early engagement with HFS | 2 | 2 | 4 | Low |
| **31** | Design | Failure to meet technical guidance (new build) | 2 | 3 | 6 | Low | Non Compliant Installation | Contractor | Derogation List established early<br>Early engagement with HFS | 1 | 3 | 3 | Low |
| **32** | Design | Design delay due to key information not being provided | 4 | 3 | 12 | Significant | Project progress affected | Contractor | Early engagement and communication | 3 | 2 | 6 | Low |
| **33** | Design | Design isn't complete at the point of agreeing price | 3 | 2 | 6 | Low | Further detailed design will be required following agreement of Price | Contractor | Progress design as far as possible prior to agreement of price | 2 | 2 | 4 | Low |
| **34** | Service | Risk of Patient Infection due to operational environment (refurb) | 4 | 4 | 16 | High | Delay to programme | NHSL | Early and ongoing engagment with Infection Control teams | 3 | 3 | 9 | Moderate |
| **35** | Service | Risk of Patient Infection due to operational environment (new build, new site) | 1 | 1 | 1 | Low | Delay to programme | NHSL | Early and ongoing engagment with Infection Control teams | 1 | 1 | 1 | Low |
| **36** | Service | Risk of Patient Infection due to operational environment (new build, same site) | 3 | 3 | 9 | Moderate | Delay to programme | NHSL | Early and ongoing engagment with Infection Control teams | 2 | 3 | 6 | Low |
| **37** | Service | Interruptions to business continuity during construction (refurb) | 4 | 4 | 16 | High | Delay to programme<br>Increased Costs<br>Reputational Damage | NHSL | Business Continuity Plan<br>Appropriate Engagement with Site Teams | 2 | 5 | 10 | Moderate |
| **38** | Service | Interruptions to business continuity during construction (new build, new site) | 1 | 2 | 2 | Low | Delay to programme<br>Increased Costs<br>Reputational Damage | NHSL | Business Continuity Plan<br>Appropriate Engagement with Site Teams | 1 | 2 | 2 | Low |
| **39** | Service | Interruptions to business continuity during construction (new build, same site) | 1 | 2 | 2 | Low | Delay to programme<br>Increased Costs<br>Reputational Damage | NHSL | Business Continuity Plan<br>Appropriate Engagement with Site Teams | 1 | 2 | 2 | Low |
| **40** | Service | Ongoing MKBC risks | 5 | 4 | 20 | High | Increased cost<br>Reputational risk | NHSL | Ongoing MKBC programme/Strategic Risk Register approach to maintaining business ccontinuity | 4 | 4 | 16 | High |
| **41** | Service | Knock on effect to other sites (Hairmyres and Wishaw) | 2 | 4 | 8 | Moderate | Increase cost/delay to programme | NHSL | Maintain dialoge with other sites | 2 | 4 | 8 | Moderate |
| **42** | Service | NHSL resources - capacity and capability | 3 | 4 | 12 | Significant | Unable to staff facility adequately<br>Reputational Damage | NHSL | Early engagement with manpower resourcing teams<br>Develop manpower plan/Dedicated | 2 | 4 | 8 | Moderate |
| **43** | Service | Maintaining a safe site environment throughout the works | 3 | 5 | 15 | Significant | Delay to programme<br>Reputational Damage | Contractor | Pre Construction H&S Plan<br>Site Incident Group (SIG)<br>Site Progress Meetings | 2 | 5 | 10 | Moderate |
| **44** | Service | Lack of available decant space to maintain all services | 3 | 5 | 15 | Significant | Delay to programme<br>Increased Costs | NHSL | Early space planning investigation<br>Early involvement of service in design | 2 | 4 | 8 | Moderate |
| **45** | Service | Failure to identify appropriate staffing | 2 | 4 | 8 | Moderate | Reduced service | NHSL | Workforce Modelling Tools | 1 | 1 | 1 | Low |

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| **40** | Service | Ongoing MKBC risks | 5 | 4 | 20 | High | Increased cost<br>Reputational risk | NHSL | Ongoing MKBC programme/Strategic Risk Register approach to maintaining business coontinuity | 4 | 4 | 16 | High |
| **41** | Service | Knock on effect to other sites (Hairmyres and Wishaw) | 2 | 4 | 8 | Moderate | Increase cost/delay to programme | NHSL | Maintain dialoge with other sites | 2 | 4 | 8 | Moderate |
| **42** | Service | NHSL resources - capacity and capability | 3 | 4 | 12 | Significant | Unable to staff facility adequately<br>Reputational Damage | NHSL | Early engagement with manpower resourcing teams<br>Develop manpower plan/Dedicated | 2 | 4 | 8 | Moderate |
| **43** | Service | Maintaining a safe site environment throughout the works | 3 | 5 | 15 | Significant | Delay to programme<br>Reputational Damage | Contractor | Pre Construction H&S Plan<br>Site Incident Group (SIG)<br>Site Progress Meetings | 2 | 5 | 10 | Moderate |
| **44** | Service | Lack of available decant space to maintain all services | 3 | 5 | 15 | Significant | Delay to programme<br>Increased Costs | NHSL | Early space planning investigation<br>Early involvement of service in design | 2 | 4 | 8 | Moderate |
| **45** | Service | Failure to identify appropriate staffing | 2 | 4 | 8 | Moderate | Reduced service | NHSL | Workforce Modelling Tools | 1 | 1 | 1 | Low |
| **46** | Service | Failure to achieve BREEAM Excellent (Pragmatic) rating | 3 | 3 | 9 | Moderate | Achievement of Very Good rating | NHSL | Discussion with HFS to approve Very Good rating | 2 | 2 | 4 | Low |
| **47** | Service | Disturbance to adjacent buildings and users | 3 | 3 | 9 | Moderate | Cost and Delay - loss of service | Contractor | Pre Planning and Communication | 3 | 3 | 9 | Moderate |
| **48** | Service | Failure to achieve AEDET aspirations | 2 | 2 | 4 | Low | Design review/Delay to NDAP approval | Contractor | Early engagement and communication | 1 | 2 | 2 | Low |
| **49** | Service | Over/ under provision of facilities due to a disconnect between Services | 2 | 4 | 8 | Moderate | Cost and redesign | NHSL | Cross Board Communication within Project Board | 1 | 2 | 2 | Low |
| **50** | Service | Lack of as built information (refurb) | 5 | 4 | 20 | High | Programme delay and cost increase | NHSL | Early Liaison with PSSD/ carry out investigative surveys | 1 | 2 | 2 | Low |
| **51** | Service | Failure to involve and consult specialist support services adequately in design process e.g. Infection Control | 2 | 4 | 8 | Moderate | Design Change and cost increase | NHSL | Early engagement and communication | 1 | 2 | 2 | Low |
| **52** | 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 |

**APPENDIX 3 – Design Statement**

## Monklands Re-fresh: Design Statement (IA version, post workshops held on 20th May 2016 and 2nd November 2016)

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 patients 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**<br>*What the design of the facility must enable* | **Benchmarks**<br>*The physical characteristics expected and/or some views of what success might look like* |
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| 1.1 The facility must be at least as easy to find and get to as the current Monklands, particularly considering more limited travel options of disadvantaged communities, and affordability of travel. | • The site must be a physical or cultural landmark in the community<br>• Within 200m of public transport serving local communities<br>• Within 20 minutes' drive for 85% of primary catchment population<br>• Clear signposting from A roads and Motorway network.<br>   |
| 1.2 The experience of arriving (planned arrivals such as outpatients, admissions) must reduce stress and give reassurance in the service.<br><br>The initial impression must be one of welcoming and safety, with a strong emphasis on being easily accessible. | • 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.<br>• Parking must be easy to navigate and prioritised by need.<br>• 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.<br>• All spaces must be will lit |

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| |  <br>• There must be a discrete route in and out for people feeling vulnerable (such as patient transfer etc.)<br>  |
| 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 reinforce this and reassure. The entrance however shouldn't dominate the view of arriving at the site (this would undermine 1.2 |

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| | above and increase chance of people with planned attendance coming in through the wrong entrance).<br>• 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.<br><br>This space must also serve the needs of those leaving unaided, allowing people to wait for transport (pick-up/bus) in shelter or gather their thoughts in an appropriate area. | Bright and airy with daylight and views, and a social feel with places to sit and access to food/refreshments, and other 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.<br><br>   <br><br>Easy to maintain with a clean appearance, with access to information to support health promotion. |

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| |   <br>Reliable Information on transport options 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 not be confusing to find where you need to go.<br>There must be a discrete route to wards for those being transferred. | Typically no more than 250 metres or 5 minutes' walk from (site/building) entrance to clinics/outpatient departments<br>Typically no more than 250 metres or 5 minutes' walk from (site/building) entrance to day admissions/ward admissions<br>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. |

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| 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 100m of waiting/social/physical therapy spaces) and observable from staff areas.<br>Shelter is to extend to use due to weather and by those required to avoid UV exposure.<br>Some views of what success might look like for the range of external environments<br>   |

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| 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 where to go.<br>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.<br>   <br>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. |
| 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**<br>*What the design of the facility must enable* | **Benchmarks**<br>*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.<br>Staff access and parking for routine/regular access must support the green travel plan for the site. | • Parking within 5 minutes' walk of entrances.<br>• Drop-off space with access to secure store for large/heavy equipment/materials<br>• Walking routes for staff from street/bus/parking to be typically a maximum 250m and of equal quality (nature/safety etc.) to those described for patients above.<br>  |

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| 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)<br>• Staff walking routes not separated by department, and circulation designed to allow impromptu discussions at natural meeting points.<br>• Office/meeting/ learning areas not separated by department, but shared and designed to be used<br>   |
| 2.4 staff environments must support their wellbeing and communicate the value placed on them. | • Changing facilities provided en-route from arrival to working areas.<br>• 'Modern' approach to working environments, allowing choice in the nature of space to do work.<br>• Any staff areas occupied continuously to have views of life/sky and ground.<br><br>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). |

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| |   <br><br>Access to green space and opportunity to support health/wellbeing through exercise and use of designated walking routes. |
| 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<br>• 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. |
| 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**<br>*What the design of the facility must enable* | **Benchmarks**<br>*The physical characteristics expected and/or some views of what success might look like* |
|---|---|
| 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,<br>• Option for providing drop-in carer support services in a Multi functioning/purpose atrium space<br>• Space for mutual support groups – Multipurpose atrium / options for seating configuration |

**4 Alignment of Investment with Policy**

| **Non-Negotiable Performance Objectives**<br>*What the design of the facility must enable* | **Benchmarks**<br>*The physical characteristics expected and/or some views of what success might look like* |
|---|---|
| 4.1 Implementation of NHS Lanarkshire's Achieving Excellence strategy | ☐ Improving person-centred services<br>☐ Improving the safety of patient care<br>☐ Improving clinical effectiveness and enhancing patient experience and clinical outcomes<br>☐ Improving the quality of the physical environment<br>☐ Providing flexible and adaptable facilities across the healthcare system. |
| 4.2 Sustainability – the facility must be designed to be sustainable in construction , use and decommissioning/demolition | BREEAM excellent/very good<br>Social, economic and technical sustainability to be considered in the design |

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| 4.3 The facility must be designed to allow future adaptation and service expansion or reconfiguration | Where facilities 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.<br>Non-clinical rooms such as storage areas to be designed such that they can be adapted to clinical uses or use by other (incoming) services.<br>The form of construction adopted will maximise the ease of alteration |
| 4.4 The site position, massing and visual appearance of the facility must provide a positive addition to the landscape as a demonstration of the value placed on the community – aiding local perception/pride - and establishing a good precedent. | Creating a building with suitable civic presence that is welcoming and modern with potential for providing a catalyst for wider urban regeneration.<br>Sites selected should be provided with appropriate parking and access from public transport to ensure convenient ease of access for both patients and staff.<br>Sites should enable the buildings to be designed with appropriate privacy in terms of overlooking and closeness.<br>Sites should enable appropriate massing of the buildings to achieve a coherent and economic use of space.<br>  |

The above statement was drafted through the engagement and participation of the following key stakeholders/groups:

Clinical leads within Acute and Primary Care

Patient representatives – Patient Partnership Forum, Disability Access Group

Architecture and Design Scotland

Staff side representatives

Hospital management team

NHSL Lead Advisors

**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 |
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| Site selection | Decision by NHS Board with advice from Project Board | Comment to be sought from NDAP to inform NHS Board 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 |

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| 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 |