

Borders NHS Board**INPATIENT SPECIALIST PALLIATIVE CARE UNIT (WITH REFURBISHMENT OF STROKE UNIT) BUSINESS CASE****Aim**

The aim of this paper is to present the Full Business Case for the development of a Palliative Care Specialist Inpatient Unit along with the plans to refurbish the Stroke Unit and seek Board approval for the award of the construction contract.

Background

In 2008, it was recognised that the existing model of inpatient specialist Palliative Care posed significant challenges in respect of patient mix, continuity of care, clinical risk and the ability to deliver the patient-centred care as described in the Audit Scotland (2008) recommendations. At the Board's request, a project was initiated to consider and recommend options to improve the environment and model of care provided for Palliative Care patients. The feasibility of progressing a suitable option was enhanced with the emergence of legacy funding from the Margaret Kerr Charitable Trust in 2010 and at this time the Strategy & Performance Committee requested that options be appraised to identify the most suitable option to progress. Ward 11 is a co-located ward with both Palliative Care and Stroke beds and it was agreed that improving the environment for Stroke patients would also form part of the project to be progressed.

An Architect worked with the Palliative Care and Stroke teams to develop a draft plan which included an extension from Ward 11 to form the Palliative Care Specialist Unit. In June 2011, NHS Borders approved that the outlined Business Case which recommended the development of a Palliative Care Specialist Inpatient Unit with part of Ward 11 refurbished for Stroke patients. Given the capital costs associated with the project, it was agreed that the project should be progressed using the Frameworks Scotland approach and in May 2011, BAM Construction was appointed as Principle Supply Chain Partner (PSCP).

Since June 2011, the architect plans have been further refined with input from the Palliative Care and Stroke Clinical teams and the level of information required to develop detailed build and inventory costs has been collated. The PSCP's team have worked with NHS Borders to produce the guaranteed maximum price (GMP) for the scheme which is outlined in the Full Business Case, found at appendix 1. The GMP has been confirmed as £3.90 million which is below the high level costs detailed in the outline Business Case of £4.1 million. Along with other associated support costs, this brings total gross costs to £4.22 million for the project (estimated at £4.5 million in the outline Business Case).

All capital costs associated with this project are to be delivered through charitable donations and fundraising. Work has been progressing which has secured pledges from a range of charitable trusts and funding partners and to date, just over £3.46 million has

been pledged for the project. This includes the use of appropriate endowment funds as approved by the Endowment Committee in June 2011. The Endowment Committee also approved a public appeal launch to raise the final million and a successful launch event was held in September 2011. There has been a high level of interest from the public in the appeal and many fundraising events have been registered with the Fundraising Manager. The reduction in gross project costs to £4.22m results in an outstanding balance of funding required of £762,000, this leaves a comfortable balance to raise based on progress to date.

The PSCP was requested to provide a GMP based on the construction phase commencing in April 2012 and a second price based on a start date of October 2012. Due to the challenging financial environment, the PSCP is unable to provide a GMP based on an October start date. In the event of a shortfall on the date of award of contract between the assured funds and the contract price the Endowment Board of Trustees will be asked to underwrite this shortfall up to the level of £643,000 from the General Endowment fund and the Investment income fund. In addition the Endowment Fund Investment Advisor has noted a further estimated investment income of £60,000 is likely to be received to unrestricted funds in the next 12 month period. Therefore total Endowment Fund monies available (including the investment income projection) as an underwrite to the award of contract for the procurement of the Margaret Kerr Unit are £703,000. A plan has been developed to ensure that further pledged funds of £59,000 are in place by April 2012 so that the shortfall does not exceed £703,000.

Summary

This Business Case outlines the work that has been carried out to identify the most suitable solution to improve the environment for Palliative Care and Stroke patients and the significant developments in fundraising have created the potential to create an exciting and inspiring facility for Borders General Hospital and to reduce the current inequity experienced by Borders patients.

Recommendation

The Board is asked to:

- **Approve** the Full Business Case for the development of the Palliative Care Specialist Inpatient Unit (with refurbishment of Stroke Unit) which will be funded fully from Charitable Funds.
- **Note** the work progressed in securing firm pledges for the capital costs of the scheme and launch of the public fundraising appeal
- **Note** that in the event of a shortfall between the assured funds and the contract price the Board of Trustees have agreed to underwrite the shortfall up to the level £703k utilising funds from the General Endowment, Investment Income and including a projection on the anticipated Investment income.
- **Approve** the award of tender to BAM Construction who are the Principal Supply Chain Partner with a construction start date of April 2012.

Policy/Strategy Implications	This is consistent with Borders Living & Dying Well Action Plan which was approved by the Board in 2009
Consultation	The Palliative Care MCN, BGH HMT, P&CS SMT and the Strategy Group have been consulted about this work
Consultation with Professional Committees	Not applicable
Risk Assessment	The redevelopment of Ward 11 will reduce the clinical risks associated with the current patient mix and will enable the 2011/12 Stroke HEAT target to be delivered
Compliance with Board Policy requirements on Equality and Diversity	Fully compliant
Resource/Staffing Implications	Resourcing and staffing implications have been highlighted within the Business Case

Approved by

Name	Designation	Name	Designation
Ross Cameron	Medical Director		

Author(s)

Name	Designation	Name	Designation
Susan Yates	Planning & Performance Officer		



**INPATIENT
SPECIALIST
PALLIATIVE CARE
UNIT
FULL
BUSINESS CASE**
*With Refurbishment of
Stroke Unit*

January 2012

Planning &
Performance

Document History

Version	Date	Author	Comments
1.0	7 th Nov 2011	Susan Yates	First version of document
1.1	5 th Dec 2011	Susan Swan & Clare Oliver	Updated Finance & Fundraising Sections added
2.0	13 th Dec 2011	Susan Yates	Updated following feedback from Project Board
2.1	9 th Jan 2012	Susan Yates	Some figures updated with feedback from Susan Swan
2.2	13 th Jan 2012	Susan Yates	Further revision of figures following feedback from Susan Swan
2.3	18 th Jan 2012	Susan Swan	Final revision of Finance section

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1. Executive Summary

Background

In 2008 a national review of Palliative Care services undertaken by Audit Scotland highlighted the inequity of service provision with the Borders being one of two areas not to have a Specialist Inpatient Unit for Palliative Care. At this time, the NHS Borders Board acknowledged that there were clinical risks associated with the existing Palliative Care Inpatient Service due to the co-location of services in Ward 11 and that this compromised the ability to deliver patient centred care. The inappropriate environment and the lack of family space available was deemed unfit for purpose.

In June 2011, the NHS Borders Board gave approval for the development of a Specialist Palliative Care Inpatient Unit within Borders General Hospital, which would be a new build facility attached to Ward 11. Given the position of the new unit in relation to Ward 11, the proposed development would provide opportunities to improve the Stroke area and it was agreed in June that this would be included within the project. This approval was based on high level costs and the Board requested that a Full Business Case be developed to include detailed build costs and other support costs.

Work has continued since June to confirm the detailed costs for this project. The project is being progressed using the Frameworks Scotland approach. BAM Construction has been appointed as Principal Supply Chain Partner (PSCP) and they have worked up the Guaranteed Maximum Price (GMP) for this project. This detailed cost is lower than the high level costs presented in June. Additional costs have also been further reviewed and confirmed and this information is now presented for consideration and final approval.

Methodology

This work to progress this project was initially led by the Palliative Care Managed Clinical Network (MCN). The MCN undertook a review of Palliative Care facilities across Scotland and assessed the Inpatient Service against the Scottish Government's Living & Dying Well Action Plan (2008) to identify gaps in services and the potential requirements of a Specialist Inpatient Unit. A number of options were identified based on a schedule of accommodation to improve facilities however it was recognised that due to the challenging financial situation, capital costs would need to be met through fundraising, and due to the downturn in the economy it was unclear whether major fundraising would be feasible.

In 2010, a major lead legacy from the Margaret Kerr Charitable Trust emerged which would contribute a significant percentage of the capital costs and enable this work to be progressed. The options identified earlier in the project were then evaluated through a non financial option appraisal. Throughout 2011, discussions have taken place with other potential donors and charitable organisations and a significant level of the capital required for this scheme has been secured. In September, a public fundraising campaign was launched to raise the remaining costs required (circa £1 million).

Estates have worked with an Architect and the Palliative Care and Stroke teams to create a plan for the Specialist Palliative Care Unit along with the refurbishment of the Stroke Unit. The initial plan was included in the presentation to the Board in June 2011 and since then specifications have been defined for all rooms and other areas with input from key staff including Ward 11 Nursing Staff, Infection Control, Risk Health & Safety and Prevention of Aggression & Violence. The detailed design schedules have been utilised by the PSCP to develop the GMP. The overall plan has been updated and refined with the final version being signed off by relevant Leads.

2. Strategic Context

Introduction

The World Health Organisation defines Palliative Care as “the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of Palliative Care is achievement of the best quality of life for patients and their families. Many aspects of Palliative Care are also applicable earlier in the course of the illness in conjunction with other treatments”¹.

Within NHS Borders, Primary Care Teams manage the long term needs of Palliative Care patients with GPs and District Nurses delivering care in patients’ homes, Community Hospitals or in other locations such as Care Homes. There is a high level of skill within the Primary Care Teams. Some of these patients may enter a challenging phase of their illness particularly when they are nearing the end of their life which requires specialist input from the Inpatient Palliative Care Service which is located within Borders General Hospital. It has been acknowledged for some time that whilst the Specialist Inpatient Service can meet the clinical needs of Palliative Care patients in Borders, there are constraints due to the location of beds in delivering a full range of holistic services required by this patient cohort and their families. This project was initiated to explore ways of improving the Specialist Inpatient Palliative Care Service. This Business Case recommends the development of a Specialist Inpatient Palliative Care Unit for NHS Borders in order to improve the quality of patient care, including the environment, and reduce the clinical issues which currently exist. The Business Case proposes a new build extension which would be attached to Ward 11 and this would provide an opportunity to redevelop the adjoining Stroke Unit to also improve the environment for this cohort of patients.

Outline of the Current Inpatient Service

The Specialist Palliative Care Inpatient Service cares for patients who require specialist input in the Inpatient setting. The service has 8 beds which are located in Ward 11 on the ground floor of the BGH. The service is Consultant led and the multi disciplinary team includes a Nurse Consultant, Specialist Nurses as well as Staff Nurses and there is also Allied Health Professional (AHP) input. In addition to providing a Specialist Service, this team also provides support and out reach to patients in the community, visiting patients in their own home or in the Community Hospitals as well as providing support to GPs, Primary Care Teams and Community Hospital staff.

An integrated approach to delivering the service is taken supported by the Palliative Care MCN which is led by the Palliative Care Consultant and the membership includes staff from the acute setting, community, local authority and voluntary services. The MCN has strived to raise the standard of Palliative Care provided in the Borders and has led the way in Scotland with innovations such as the Out of Hours Handover Sheet, a document which summarises the circumstances of Palliative Care patients. Patients and Carers can give this to healthcare staff when problems arise in the out of hours period. This has been recognised as exemplary practice in Scotland.

The Inpatient beds have been co-located in Ward 11 since 2008. Ward 11 is a mixed Ward with Stroke and Palliative Care beds and up until June 2011 included GP beds, however following redesign work, these beds have been removed. Due to the co-location of the service, there are difficulties in providing spiritual and psychological support for patients and their families who are experiencing a difficult time in their lives. The limited consultation and quiet space available in

¹ National Cancer Control Programmes – Policies & Guidelines – World Health Organisation (2002)

Ward 11 is not fit for purpose in terms of meeting with patients and their families to discuss treatment plans, issues and the way forward. Furthermore there are some clinical risks associated in respect of patient mix and the ability to deliver patient centred care. This is inconsistent with NHS Borders Corporate Objectives where the aim is to ensure that high quality services are delivered and where patient safety is a key priority.

Comparing Service Provision in Borders with the National Picture

In 2008, with the aim of redesigning the service provided within Borders, the Palliative Care MCN reviewed models of care being delivered across Scotland. Questionnaires were sent out to Specialist Units to examine staffing levels, funding arrangements and facilities provided. Visits were also undertaken to 5 units with a similar demographic to identify practices and models which could be implemented in the Borders.

In August 2008, Audit Scotland² produced a report following a review of Palliative Care services across Scotland. This highlighted the wide variation of Palliative Care services and that there was considerable inequity in access with NHS Borders and NHS Shetland being the only areas who did not have a dedicated Specialist Palliative Care Inpatient Unit. Better Health Better Care³ (2007) made a commitment to improving equity of access and the delivery of high quality Palliative Care to everyone in Scotland. The national action plan for Palliative Care "Living & Dying Well"⁴ was also launched in November 2008 by the Scottish Government which was a basis for implementation of the Scottish Partnership for Palliative Care's report: Palliative and End of Life care in Scotland: a Cohesive Approach⁵ (2007).

Improving Specialist Inpatient Care in NHS Borders

The MCN communicated the key messages from both the Audit Scotland report and the Living & Dying Well action plan at the October 2008 NHS Borders Strategy & Performance Committee. The Committee requested that the MCN consider ways to reduce the significant challenges in respect of patient mix, continuity of care and clinical risk within the current inpatient environment and the ability to deliver the patient-centred care described in the Audit Scotland recommendations. This was to include a range of suggestions for improving Specialist Inpatient Palliative Care which would be revenue neutral with the MCN exploring the potential for fundraising to provide any capital investment which may be required.

In July 2009, a paper was taken back to the Board to update members on progress regarding developing improvements in Palliative Care and also to provide an update on the Living & Dying Well action plan. At this time it was acknowledged that due to the challenging financial climate which was emerging that progressing the solutions identified which were based on fundraising to cover the capital costs would prove extremely difficult. Some initial scoping of staff costs and outline build costs for a dedicated unit were progressed by the MCN and contact was made with Fundraising Consultancy Companies regarding the potential to raise the capital costs, however the group were not confident that the project would progress to the implementation phase.

² A Review of Palliative Care Services Across Scotland – Audit Scotland (2008)

³ Better Health, Better Care – Scottish Government (2007)

⁴ Living & Dying Well – An Action Plan – Scottish Government (2008)

⁵ Palliative and End of Life Care in Scotland: a Cohesive Approach – Scottish Partnership for Palliative Care (2007)

In the Summer of 2010 a legacy emerged from the Margaret Kerr Charitable Trust to be utilised in the area of Palliative Care, within the BGH, which would be a major lead gift and would allow the work to create a dedicated facility to be recommenced. A project initiation document was developed which was agreed by the MCN and the solutions identified in the previous work were revisited to be taken forward to option appraisal which is described in section 3. At this time, it was also proposed that this legacy could be built on through securing funding from charitable organisations and that along with this a public fundraising campaign could be launched which would have the potential to provide the necessary capitals funds to deliver this ambitious facility. Detail on fundraising activities to date is found in section 5.

Fit With Local Policies

The delivery of this project (both phases 1 & 2) will enable NHS Borders to achieve its Corporate Objectives by removing the clinical risk associated with the co-location of specialties in Ward 11. There would also be the potential through increasing the range of facilities to be provided and improving the environment that Palliative Care patients and their families would benefit from a holistic service which is person centred. This would improve the quality of the service provided, a key priority identified within the Corporate Objectives and reconfiguration of the Stroke facilities would also have the potential to raise the quality of this service.

The creation of a Specialist Inpatient unit within Borders would also improve equity of access for patients who are currently under the care of a Specialist team as the current configuration does not provide the full range of holistic services required within the last stages of life such as spiritual and practical support within an appropriate environment. Access to this type of support for families is equally important when facing difficult circumstances. This would enable NHS Borders to come into line with all other parts of Scotland.

Should the recommendation to move to the construction phase for the development of a Specialist Unit not be approved, although there have been some improvements within Ward 11 due to the bed reductions, patients would continue to receive care in a busy acute environment which would continue to prove distressing for patients and their families. Depending on the phase of their illness, length of stay for Palliative Care patients can be high. So far, in 2011/12, the average length of stay has ranged from 5.1 days in May to 11.3 days in June, a considerable period of time in a busy environment. It is likely that national audits or reviews of Palliative Care will be conducted in the future and if a dedicated facility is not progressed then concerns may be raised at a national level and this may have an impact on the reputation of NHS Borders within the local community. This would also be the case if the legacy funds that have been made available to NHS Borders are not used. Development of the unit will allow NHS Borders to fully implement the recommendations within the Living & Dying Well Action Plan.

3. The Non Financial Option Appraisal Process

Introduction

Following the request by the Board to test the feasibility of improving Specialist Palliative Care including developing a Specialist Unit, a number of options were identified in 2008. Following the emergence of the legacy funding, the options were reviewed and it was felt that these were still valid ways to improve Palliative Care. An initial review was carried out on each option to pull out the constraints and benefits and it was agreed by the Palliative Care MCN that these should be formally appraised. The criteria against which the options were appraised were also set by the MCN.

Appraisal of Options

The list of options which were appraised were as follows:

- Option 1 – Minimum change – improve the existing environment within Ward 11
- Option 2 – Refurbish the existing area including an extension
- Option 3 – Build a unit in the grounds of the BGH
- Option 4 – Build a unit outwith the grounds of the BGH
- Option 5 – Refurbish an existing ward in a Community Hospital.

The Option Appraisal took place on the 24th of September 2010. There was representatives from GPs, Specialist Palliative Care Medical Staff, Specialist Palliative Care Nursing Staff, AHP Services, Scottish Borders Council Social Work, Board Executive Team, Finance, BGH Senior Management Team, Marie Curie, Public Reference Group, the Heart Failure Nursing Team and Fund Raising. The appraisal was observed by members of a local charity who provide support for people with lymphoma, leukaemia and myeloma. The trustees of the legacy were also in attendance. Attendees were split into 2 groups and during the appraisal a consensus view was sought, but if this was not possible, the majority view was accepted if required. Any assumptions, or concerns, made during this process, were noted.

The results of the option appraisal are detailed below.

Table 1 – Results of Non Financial Option Appraisal

Option	Score	Rank
Option 1 – Minimum change – improve the existing environment within Ward 11	897.5	5
Option 2 - Refurbish the existing area including an extension	1360	1
Option 3 - Build a unit in the grounds of the BGH	1182.5	2
Option 4 - Build a unit outwith the grounds of the BGH	1062.5	4
Option 5 - Refurbish an existing ward in a Community Hospital	1106.25	3

4. The Preferred Option

Introduction

Following the non financial option appraisal the option identified to be progressed was option 2: refurbish the existing area including an extension. It was felt that this was also the most feasible option by the project group to be progressed.

Description of the Preferred Option

The floorplan of Ward 11 will be extended out from the end of Ward 11 into the existing garden and Consultant car park area. Schedules of accommodation were initially defined by the Palliative Care and Stroke teams, based on current best practice and the initial work to gather information about other units in Scotland.

NHS Borders Estates department worked with an Architect and the Palliative Care and Stroke teams to draw up plans for the Specialist Palliative Care Unit and Stroke Redevelopment. The floor plan which is found at appendix 1 has been approved by the Project Board who have agreed that this scheme provides an opportunity to enhance the facilities and environment for Palliative Care patients. The build costs for this scheme are consistent with the funding which has been secured to date and also with the income planned from the public fundraising campaign.

Patients and their families will also be able to access the services of the Tryst for spiritual support.

During the build phase, alternative accommodation will be secured for all patients using Ward 11, this is likely to be within Ward 14.

An analysis of the benefits and constraints associated with this option has been carried out and the findings are listed below.

Table 2 – Benefits & Constraints of Preferred Option

Benefits	Constraints
<ul style="list-style-type: none">• Option allows creation of Specialist Unit which with no additional impact on other services eg catering, general services• Cross cover of medical and nursing staff will continue• Present arrangements for out of hours cover would continue• Extension would allow for full range of additional facilities to be provided within the unit which would improve the therapeutic environment• Palliative care patients would have full and ease of access to other medical services such as Diagnostics• At peak times of demand a flexible approach could be taken between Palliative Care and Stroke beds	<ul style="list-style-type: none">• Patients will need to be relocated when building work is ongoing and this will need careful planning• this scheme would require some reinvestment in revenue expenditure

<ul style="list-style-type: none">• Contributes to the achievement of NHS Borders Corporate Objectives – quality services and patient safety• Allows NHS Borders to fully achieve the actions contained within the Living & Dying Well Action Plan• Additional beds will allow for predicted increase in future demand• This option is feasible and is within the boundaries of the legacy funding• The unit would have its own front door which would provide easy access for patients and visitors.	
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5. Financial Appraisal

Introduction

It is recognised that all of the capital requirements for the project must be secured from charitable sources. In addition to the provisional gross capital costs outlined below there will be fundraising costs and project support costs, which will be factored into the gross target. This will bring gross costs to £4.222 million.

Procurement

The project to progress the development of a Specialist Palliative Care Unit and Stroke Refurbishment is mandated for NHS Scotland through the Frameworks Scotland procurement route. NHS Borders appointed to a Frameworks contract the Principle Supply Chain Partner to complete the project to the stage of design and target price. More information on the Frameworks approach is found in section 8.

Charitable Fundraising & Ownership

NHS Borders Endowment Fund Board of Trustees approved a charitable fundraising appeal to support the procurement of a Specialist Palliative Care Unit and Stroke Refurbishment. The Specialist Palliative Care Unit will be registered as an asset donated by the Trustees to NHS Borders Board.

Financial Analysis of Cost

The appointed Frameworks Scotland PSCP has under contract completed the required design stage and issued a guaranteed maximum price for the project totalling £3.898m. Full analysis of the build costs of the scheme are detailed in the table below.

Table 3a – PSCP Cost Analysis December 2011

			<u>Total Cost Plan</u>
			<u>£000s</u>
Construction Cost Plan			2824
Design Fees	12.11%		258
PSCP Mark Up	6.60%	included in cost plan	0
			<hr/>
			3082
Cost Advisor/CDM Fees & Planning			76
Other Construction (incl Ward 14 enabling)			10
Equipment			101
VAT @ 20%			527
Optimism Bias			76
Art Strategy/Recommendations			25
Total Framework Contract			<hr/> 3898 <hr/>

There are some additional costs associated with fundraising, project support and clinical release which are outlined below

Table 3b – Fundraising & Project Support (Non Recurring) Costs

	£000s
<u>Year 1</u>	
Professional Services - Estates	70
Project Management and Support	20
Clinical Release	5
Fundraising Function & Appeal Costs	42
<u>Year 2</u>	
Professional Services - Estates	70
Project Management and Support	39
Clinical Release	10
Fundraising Function & Appeal Costs	69
Total Fundraising & Project Support Costs	<u>325</u>

Table 4 – Total Gross Project Costs

	£000s
Total Frameworks Contract	3898
Total Fundraising and Project Costs	325
Total Gross Project Costs	<u>4222</u>

Main points to note from the financial analysis are:

- 1 Guaranteed Maximum Price Construction Start Date – this has been issued with an anticipated award of contract date in early February 2012. The full construction timeline from award of contract to commissioning and opening of the unit would be 40 weeks. An estimated increase in cost of £86k has been provided by the Cost Advisor should the award of tender be in October 2012. This increase is strongly caveated and any revised target price would require additional tender exercises to be completed with the supply chain.
- 2 Discussions on the Guaranteed Maximum Price - the Cost Advisor and NHS Borders Estates Officers continue to work with the PSCP to further drive down the costs of the project.
- 3 VAT recovery – the Board’s contracted VAT Advisors are currently reviewing the build schedule of works to assess the project in terms of overall VAT recovery. At the time of issue of the Business Case recovery of VAT has been indicated at circa 8%. VAT

recovery will be possible on any items of specialist equipment purchased from the charitable funds.

- 4 Artwork Strategy – the commissioned Art Co-ordinator for the project has proposed that a provision for the purchase of artwork be held in line with the total costs for construction. Within the total costs presented, a provisional sum of £25k has been included which will be secured through fundraising.

Recurring Costs of Specialist Palliative Care and Stroke Services

At the June 2011 meeting, NHS Borders agreed to the level of recurring resource required for the Unit which is detailed overleaf. This funding has been set aside in the NHS Borders Financial Plan.

Table 5 – Total Revenue Investment

Total Revenue Investment Required		
	Wte	£
Nursing	5.19	186,271
Domestic	2.26	46,000
Property Costs, including rates & utilities	-	40,000
Total	7.34	272,271

Developments in Fundraising and Assurance Statement

The charitable fundraising appeal to support the Specialist Palliative Care and Stroke Refurbishment project has committed pledges from 4 major funders, The Margaret Kerr Charitable Trust, The Robertson Trust and Macmillan Cancer Support and an anonymous donation. Together these major funders have pledged funds totalling £2.35 million. Currently the appeal has only verbal assurance for the significant donation pledged by Macmillan Cancer Support as a small number of legal technicalities remain outstanding in relation to the formal buildings agreement which will secure the donation. Macmillan have scheduled the request for formal approval of the buildings agreement by their Finance and Legal Committee on 19th March 2012.

The Endowment Fund Board of Trustees approved a public appeal launch for the final £1 million for the Specialist Palliative Care Unit which together with utilising existing Endowment Funds, approaches to Charitable Trust and grant making organisations and pledges from fundraising partners is aimed to cover the full costs required for the project. The full range of partners is outlined in the table overleaf which has been compiled to give further information on the level of assurance on the charitable funding pledges from partners of the Margaret Kerr Unit project.

Table 6 – Review of Funders Schedule – Level of Assurance

	Total Sum £'s	Assured £'s	At Risk £'s
Fund 407 Transfers	446998	446998	0
Margaret Kerr Charitable Trust	700000	700000	0
Anonymous Donor	550000	550000	0
Macmillan	750000	750000	0
The Robertson Trust	350000	350000	0
Mainhouse Charitable Trust	5000	5000	0
The Glenpark Foundation	10000	10000	0
The Hugh Fraser Foundation	40000	40000	0
RS Hayward Trust	20000	20000	0
Binks Charitable	50000	50000	0
Miss M B Reekie Trust	50000	50000	0
WRVS	250000	250000	0
Rotary	30000		30000
Borders Change Foundation	30000	30000	0
Friends of the BGH	70000	70000	0
Lavendar Touch	20000	10000	10000
Callums Trust	40000	25000	15000
Other donations	102356	102356	0
Other funds committed	6030		6030
INCOME - sub total	3550384	3459354	91030
Target Price	4222000	4222000	0
Fundraising still to raise	671616	762646	-91030

In summary, as at 13th January 2012, by modelling the level of assured funds as detailed in the above table, a total of £3.459m can be set against the gross project cost of £4.222m resulting in a balance of funding required of £762k.

The Endowment Board of Trustees have been asked to agree to utilise the NHS Borders General Endowment Fund and the Investment Income Fund which currently has a total balance available of £643k to support the fundraising appeal. In addition the Endowment Fund Investment Advisor has noted a further estimated investment income of £60k is likely to be received to unrestricted funds in the next 12 month period, this view has been based on current and projected market conditions. Therefore total Endowment Fund monies available (including the investment income projection) as an underwrite to the award of contract for the procurement of the Margaret Kerr Unit are £703k. The Fundraising Manager is currently working towards ensuring that the assured sums and the contract price is equal to or less than the value of general endowment fund and the investment income fund at the point when the construction contract is likely to be awarded (early February). Currently a difference of £59k (£762k less £703k) is being reported.

Fundraising Progress

The gross project costs of £4.222m including capital costs and non recurring costs must all be met by charitable funds. The early feasibility project costs have been subject to significant review during the course of the project., Now that the guaranteed maximum price has been confirmed the

fundraising strategy required to deliver the total funds required within the timescale identified to end March 2013 has been confirmed.

Table 7 Fundraising Progress Up to Approval of Outline Business Case

Date	Meeting	Amount secured	Details
March 31 st 2011	Strategy & performance meeting	£2.5m	Firm pledges of support
June 30 th 2011	NHS Borders Board	£3.172m	Pre-launch total including pledges and donations banked

Since the status was reported in the outline Business Case continued fundraising activities including successful funding applications since June have increased the level of assured funds to £3.459m as outlined in table 6.

On September 1st 2011 the public fundraising appeal to raise the 'final million' for the Palliative Care aspect of the project was launched. It is hoped that a second phase of targeted approaches to charitable trusts and other grant giving organisations will contribute to this target.

The various income streams targeted to achieve this remaining balance are listed below. Each stream has its own target figure which is constantly monitored and adjusted as appropriate. The income streams are detailed overleaf.

Table 8 Fundraising Income Streams

Income stream
Scottish / UK Trusts and grant making organisations ⁶
Local Trusts
Rotary
Dinners and events (organised by the appeal team)
Local organisations
Corporate
Major donors
Local charities
Schools
Community fundraisers / other

The initial phase of the fundraising campaign concentrated on only a small number of targeted approaches to charitable trust and grant making organisations, there remains the clear potential for significant income still to be realised from other charitable trusts to which applications are being submitted during the current phase of the appeal. A target of £400,000 has been set for these approaches and this is considered to be achievable. Twelve applications are currently under consideration by trusts. Of these, four are capable of six figure awards, while a further four are considering requests for £10,000+. The results of these applications will be known from March onwards and, in the meantime, a further tranche of applications to medium level bodies is being prepared for submission during February. In summary, work in this area of the appeal remains extremely active, with the potential to enhance the income from the community fundraising activity to a significant level.

The public fundraising appeal is now in the early implementation stage, with the primary objective of raising awareness and securing fundraising commitments. The communications strategy is currently focussed on media, and the appeal is benefiting from a planned series of articles in the Southern Reporter, agreed as part of their official endorsement as media sponsor of the project. Public relations activity talks and presentations to local community groups is also underway. Targeted approaches are also being made to local businesses, schools, clubs, societies and individuals. Community fundraising will become increasingly active during the course of 2012, with large numbers of fundraising events being registered to take place during the year.

Donations received during the first 3 months since launch (£50,097) have exceeded expectations for such an early stage of the appeal, and strongly indicate that money will flow steadily in to the fund. As anticipated, the appeal has captured the hearts of the people of the Borders and would appear to be fully viable, with the outstanding balance a very achievable target indeed, provided that the structured approach which has been adopted over the past year continues within the appropriate timeframe.

The gross project cost of £4.222m results in an outstanding balance of funding required of £762k as at 13th January 2012. This leaves a comfortable balance to raise based on progress to date.

⁶ This second phase of applications to Trusts will consist of high, medium and low level approaches, depending on the funding capabilities of each individual trust. Applications are tailored according to the specifications of the trust.

6. Summary of Developments Following Approval of Outline Business Case

Introduction

Following approval of the outline Business Case in June 2011, a focused Project Core Group was established whose main focus has been to manage operational issues and to facilitate the development of the GMP. The Core Group reports directly to the Project Board. A summary of completed tasks and actions is outlined below.

Key Developments

The following is a high level of summary of deliverables progressed through the Project Core Group since June 2011:

- review of PSCP project development programme
- co-ordination, confirmation and sign off of room data sheets with input from Ward 11 Nursing staff, Estates, Risk Health & Safety, Infection Control, Prevention of Management & Aggression and Dementia Team
- development of ward equipment inventory to identify new equipment which will be required with full costing of new equipment
- Creation of dedicated endowment fund
- transfer of project costs from Margaret Kerr Trust
- Completion of HAISCRIBE levels 1 & 2 which aims to minimise the occurrence of healthcare acquired infection related to construction projects
- Art Strategy Group established with membership including carers, nursing staff and hospital art group – supported by Art Co-ordinator
- update paper developed for Endowment Committee
- costs for decant to Ward 14 developed
- confirmation of signage to be used throughout new build and refurbished area which has been informed by best practice guidelines for patients with Dementia (due to age group of patients).

The Project Core Group will remain in place following approval of full Business Case and during the construction phase.

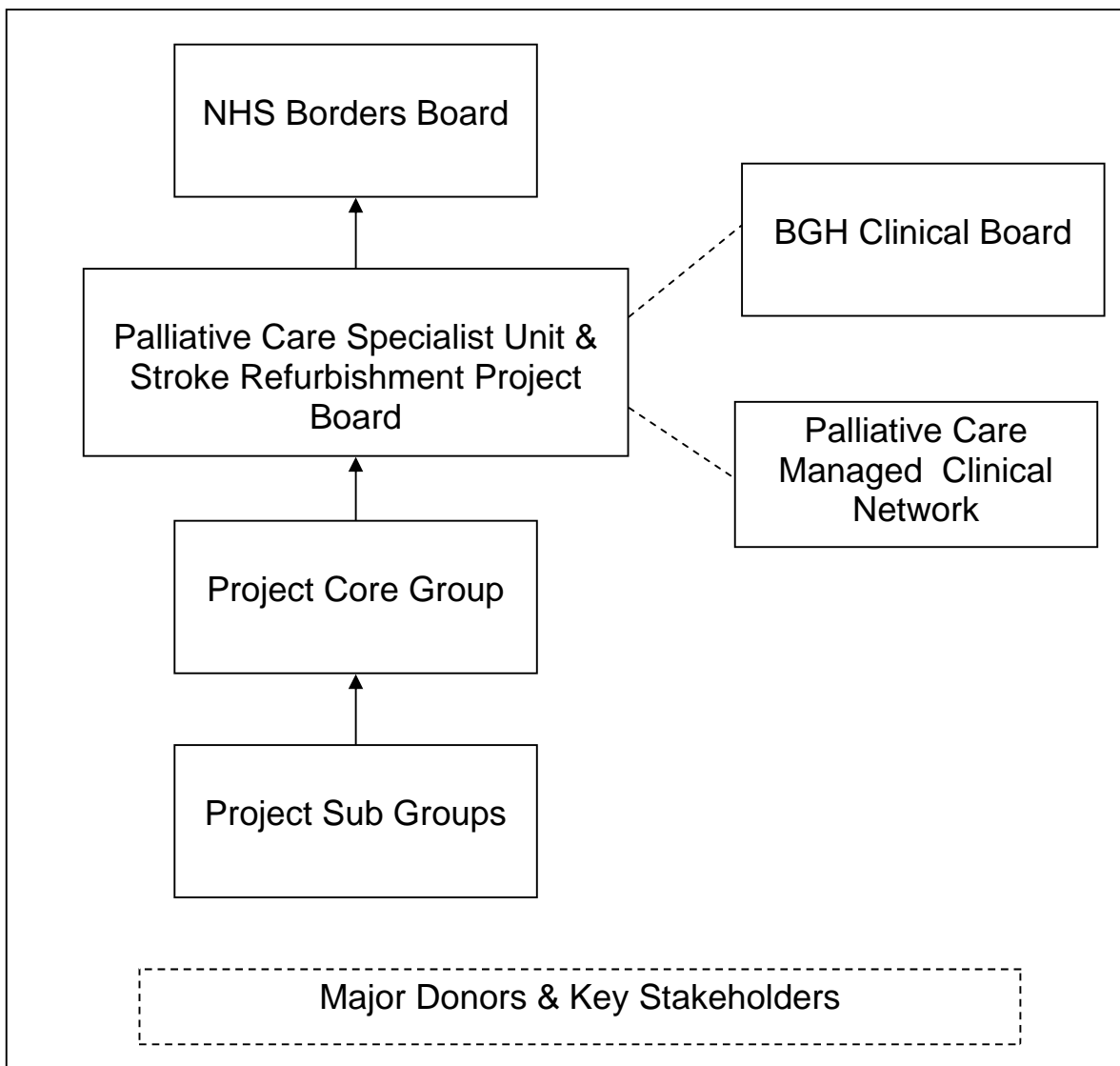
7. Project Governance & Management

Introduction

The initial work to develop solutions to improve the Specialist Palliative Care Inpatient Service was led by the Palliative Care MCN and a PID was developed in July 2010. A combined approach for the Ward 11 Reconfiguration Project and the Specialist Palliative Care Inpatient Unit as described earlier in this Report has been implemented to oversee the creation of the Specialist Palliative Care Unit and the redevelopment of the Stroke Unit.

Project Governance Arrangements

The project and governance structure is outlined below.



The Project Board is the forum where representatives come together to make decisions on the project and to provide overall direction, guidance and advice to a project. This means that they:

- Are accountable for the success of the project
- Have responsibility and authority for the project within the remit that they have been given
- Are responsible for dissemination of information about the project
- Lead, motivate and gain commitment from the organisation around the project and its outcomes
- Are responsible for making sure that the project remains on course to deliver its final outcome

Project Board Membership

Individual	Role	Team
Ross Cameron	Project Owner	Executive Team
Susan Yates	Project Manager	Planning & Performance
David McLuckie	Project Support, Construction Project Director	Estates & Facilities
Diane Devenney	Project Support	Ward 11 (Palliative Care & Stroke)
Cameron Fergus	Project Support	Palliative Care
Dot Partington	Project Support	Palliative Care
Jamie Thomson	Project Support	Stroke
Clare Oliver	Project Support	Fundraising
Catherine Duthie	Project Support	Non Executive Team
George Anderson	Project Support	Patient Representative
Judith Smith	Project Support	Palliative Care
Susan Swan	Project Support	Finance
Adam Wood	Project Support	Infection Control
Matt Hall	Project Support, Construction Project Manager	Estates & Facilities
Stephanie Errington	Project Support	Planning & Performance
Sandi Haines	Project Support	Stroke Specialist Nurse
Lindsay Dun	Project Support	Occupational Therapy
TBC	Project Support	Physiotherapy

Reporting Arrangements

Reporting mechanisms include the following:

- Highlight reports will be generated by the Project Manager for the Project Board for all Project Board meetings. This will detail progress against:
 - The agreed project plan, including milestones
 - Finance
 - Risk Management and Mitigation strategies in place.
 - Stakeholder communication
 - Fundraising.
- The Project Manager will also report on a monthly basis to a Project Managers Group, if the project is part of a Programme, if not, to the Efficiency Board.
- Proposed changes to the project plan will be submitted to the Board for agreement
- A Project Close Out report following the end of the project.

The Project Manager will maintain a risk, issues and communication log.

A smaller focused Project Core Group has been established to manage operational issues. The group meets either on a weekly or fortnightly basis depending on the project milestones to be delivered. Issues which cannot be resolved by this group will be escalated to the Project Board.

A range of sub groups (made up of clinical and support services) will be established to undertake pieces of work on behalf of the Project Board to deliver the project on an as require basis. This will be negotiated with the services at the outset, with further work being commissioned, as appropriate, during the life of the project. A short life Art Strategy working group is currently undertaking the development of the Art Strategy for the project. This Strategy will make recommendations regarding the art to be displayed within the unit and will also inform design aspects such as colour schemes. This work is being undertaken with the support of an Art Co-ordinator who is part of the design team and includes input from carers and Nursing Staff.

A Project Administrator is now in post to provide support to the Project Manager and the Fundraising Manager and will also support all project groups as required.

Stakeholder Involvement

The Project Board will be required to liaise with identified stakeholders on an ongoing basis as the development of the specialist unit progresses. A list of key stakeholders is shown below:

Key Stakeholders	
Legacy/Fundraising Stakeholders	Ward staff (as appropriate)
OPC Project Team	GPs
CE Strategy Group	Current patients, relatives & carers
BGH Clinical Board	Partnership
Primary & Community Services	Patient & public involvement

Overarching Project Timetable

Milestone	Timescale
Communications	
Communication plan developed	February 2011
Communication plan further refined	July 2011
Engagement with appropriate stakeholders	Ongoing throughout project
Initial Scoping	
Initial Fundraising Contact	December 2010/March 2011
Feasibility Report developed	February 2011
Feasibility Report discussed by BGH Clinical Board	March 2011
Feasibility Report discussed by P&CS Clinical Board	March 2011
Feasibility Report discussed by Strategy Group	March 2011
Feasibility Report discussed by Strategy & Performance Committee	March 2011

Milestone	Timescale
Architect plans drawn up	March/April 2011
Schedule of accommodation & costs worked up	March/April 2011
Staffing levels agreed and fully costed	April 2011
Feasibility Report discussed by Endowment Committee	April 2011
Development of business case	May/June 2011
Development & sign off of room data sheets	September/October 2011
GMP process completed	Late November 2011
Full Business Case considered by Endowment Committee	24 th January 2012
Full Business Case included on agenda of BGH Clinical Board	25 th January 2012
Full Business Case presented to Board	26 th January 2012
Fundraising	
Planning for Public Fundraising Appeal	June/July/August 2011
Launch of Public Fundraising Appeal	September 2011
Construction	
Commissioning of Principal Supply Chain Partner	May 2011
Commissioning of Professional Services Contractor, Joint Cost Advisor	June 2011
Commissioning of Construction Design and Management Co-ordinator (CDM-C)	June 2011
Enabling Works in Ward 14 (to be utilised b BGH for general HEI improvements works)	Early 2012
Decant Ward 11 to Ward 14	Spring 2012
Construction begins	Spring 2012
Construction complete	December 2012
Specialist Palliative Care Unit & redeveloped Stroke Unit Opens	January 2013

7. Construction of Scheme

Due to the complexities of the project and the estimates of capital costs, the Director of Estates and Facilities recommended that the scheme be delivered using the Frameworks Scotland principles. Frameworks Scotland is a strategic and flexible partnership approach to the procurement of publicly funded construction work. It provides Boards with the ability to readily appoint accredited Principal Supply Chain Partners (PSCPs) and Professional Services Contractors (PSCs) facilitated through a pre-agreed commercial arrangement, utilised by the NHS in Scotland on most medium to large scale projects.

These frameworks have been established to achieve the following key benefits:

- earlier and faster delivery of projects
- certainty of time, cost and quality
- value for money
- well designed buildings procured within a positive collaborative working environment.

The PSCPs are very different to traditional contractors as their supply chains contain a wealth of expertise from construction professionals through to specialist members of the supply chain. This provides Boards with the unique opportunity of engaging the PSCP to undertake a wide variety of duties from brief and design development through to completion and handover.

Frameworks Scotland is based upon a framework agreement (4 years with provision for a 2 year extension) between National Services Scotland (NSS) and a number of framework partners and is operational across Scotland. Using the Selection Procedure, Boards can select any one of the PSCPs based on their performance and track record established during the Frameworks tendering process. Five Principal Supply Chain Partners (PSCPs) operate within 4 year Framework Agreement co-ordinated through a Frameworks Scotland Board by Health Facilities Scotland with participation from Scottish Government Health Department.

Following interviews with 3 of the PSCPs, BAM Construction was commissioned as PSCP for the Palliative Care Specialist Unit. The PSCP has worked closely with the Project Team to undertake detailed costing of the approval plans incorporating the standards set out in Specialist Palliative Care (2004)⁷ and Improving Supportive and Palliative Care for Adults with Cancer (2004)⁸ during the planning phase.

In addition, following interviews with 4 Cost Advisors (PSCs), Thomson Gray Construction Consultants were commissioned to work closely with both NHS Borders and the PSCP in the provision of joint Cost Advisor services (Quantity Surveying), in the development and monitoring of costs throughout the life of the contract.

⁷ Specialist Palliative Care – National Overview – NHS Quality Improvement Scotland 2004

⁸ Improving Supportive and Palliative Care for Adults with Cancer – NICE 2004

8. Recommendation

NHS Borders Board is asked to:

- **Approve** the Full Business Case to progress the development of the Palliative Care Specialist Inpatient Unit which will be fully funded from Charitable Funds.
- **Note** the work progressed in securing firm pledges for the capital costs of the scheme and launch of the public fundraising appeal
- **Note the Endowment Fund Board of Trustees agreement that, in the event of a shortfall between the assured funds and the contract price, funds up to £703k will be made available from the General Endowment fund, Investment income fund and future investment income to support the award of contract.**
- **Approve** the award of tender to BAM Construction who are the Principal Supply Chain Partner with a construction start date of April 2012.

Appendix 1 – Plan of Margaret Kerr Unit & Stroke Refurbishment

