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 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 that this project moves to the implementation phase.

Background

In late 2008, following the publication of the Audit Scotland Review of Palliative Care Services in Scotland, the Board acknowledged 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 recommendations. The Board requested the Palliative Care MCN to consider and recommend options to improve the environment and model of care provided for this cohort of patients.

A number of issues impacted on this work, perhaps most significantly the challenging financial situation which was emerging just as this work commenced which led to this being postponed. In 2010, the emergence of legacy funding from the Margaret Kerr Charitable Trust enabled this work to be recommenced.

In March 2011, a Feasiblity Report was presented to the Strategy & Performance Committee which outlined the work that had taken place to that point to identify options to improve Palliative Care. The Report outlined that the Palliative Care Unit Project had been joined with the Ward 11 Reconfiguration Project which was looking at realigning beds within Ward 11 and would also aim to improve the environment for Stroke patients with 2 distinct phases:

- Phase 1 – reconfiguration of beds with reduction from 30 to 20 beds
- Phase 2 - Development of Business Case for Palliative Care Specialist Inpatient Unit with part of Ward 11 refurbished for Stroke patients.

An Architect had 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. At the meeting in March 2011, the Strategy & Performance Committee approved the move to a Business Case with further work to be carried out on the Architect plans and refining of revenue costs. The Committee also approved that the new unit should be named the Margaret Kerr Unit, a request which was made by the initial legacy funders. In May 2011, the Endowment Committee also approved the development of a Business Case.

The brief has been that all capital costs should be delivered through charitable donations and fundraising. Indications have estimated that the build cost will be in the region of £4.5 million. Since March 2011, further discussions have taken place with charitable trusts, voluntary organisations and significant donors and to date, firm pledges of £2.6 million have been secured. A breakdown of secured funding is found within the Business Case. Approval has also been given from the Endowment Committee to use existing endowment funds totalling £426,982 and a public fundraising campaign is being planned to raise the remaining capital required. Confidence is high that this is entirely feasible and achievable.

The initial Architect plans have been further refined since March. As the proposal is to extend the existing footprint of Ward 11 to develop the Palliative Care unit, there will be additional revenue costs associated with this relating to nursing, domestic and utility and rates costs. These costs have been reviewed by the relevant Services and assurance and scrutiny has been sought that these include only minimal costs and that no contingencies have been included. These costs have also been scrutinised by the Directors of Nursing and Finance in order to identify further economies. A breakdown of the revenue costs is found in the Business Case.

The Stroke refurbishment and Palliative Care Unit will be developed using the Frameworks Scotland approach and in May 2011, the Principal Supply Chain Partner was selected with BAM Construction being appointed.

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:

- **Note** the work progressed in developing this Business Case
- **Note** the work progressed in securing firm pledges for the capital costs of the scheme
- **Approve** the plans described in the Business Case to be progressed with the development of the Specialist Inpatient Palliative Care Unit and refurbishment of the Stroke Unit.
- **Approve** the launch of the public fundraising campaign for the 1st of September 2011

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**
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NHS Borders

INPATIENT SPECIALIST PALLIATIVE CARE UNIT BUSINESS CASE

With Refurbishment of Stroke Unit

June 2011

Planning &
Performance

Document History

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0.1	30th May 2011	Susan Yates	First version of document
0.2	1st June 2011	Susan Yates	Fundraising section updated by Clare Oliver
0.3	7th June 2011	Susan Yates	Updated with comments from Project Board
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0.5	21st June 2011	Susan Yates	Capital & Project Management Costs Updated
0.6	22nd June 2011	Stephanie Errington	Updated document

Contents

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 and Shetland being the only 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 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. This Business Case summarises the work that has taken place to identify the most suitable option to improve the Specialist Palliative Care Inpatient service within Borders General Hospital. This also includes detail on the improvements to the Stroke facility which is also located within Ward 11.

Methodology

This work has been led by the Palliative Care Managed Clinical Network (MCN) in the first instance with a smaller focussed project team. The MCN undertook a review of Palliative Care facilities across Scotland and made an assessment of 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 for improved facilities and the options were assessed through a non financial option appraisal. 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. Discussions have taken place with other potential donors and charitable organisations to identify sources for the bulk of capital required for this scheme with a public fundraising campaign to be launched to support this. In March 2011, the Board reviewed the Feasibility Report which outlined the work to date and approved that a Business Case be developed with further detail.

Estates have worked with an Architect and the Palliative Care and Stroke teams to draw up a plan for the Specialist Palliative Care Unit along with the refurbishment of the Stroke Unit. An initial plan was developed which was very ambitious and proved to be unaffordable in terms of additional revenue costs. This plan was subsequently refined and the approved version is found at appendix 1. Due to the increased footprint there will be additional revenue costs associated with this new unit in terms of nursing costs, domestic costs and rates and utilities. These costs have been revisited and scrutinised to ensure these are minimised. It has been agreed that this project will be run using the Frameworks Scotland approach and the Principal Supply Chain Partner has now been appointed to commence the initial scoping work which will inform the design schedules and detailed costings.

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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, the Primary Care Teams are skilled in managing the long term needs of the Palliative Care patients with GPs and District Nurses delivering care in patients' homes, Community Hospitals or in other locations such as Care Homes. 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. In addition there is the opportunity to redevelop the adjoining Stroke Unit to improve the environment for this cohort of patients.

Outline of the Current Service

The Specialist Palliative Care Inpatient Service cares for patients who require specialist input in the Inpatient setting. The service has 6 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 with the support of the Palliative Care Managed Clinical Network (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.

For a number of years, it has been acknowledged that the Specialist Inpatient Service could be improved. The Inpatient beds are currently accommodated within Ward 11 which is a mixed ward with Stroke and GP beds. The service has been co-located since 2008 and it has been

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

recognised that the care provided for Palliative patients may not be delivered in the most appropriate environment and that there are difficulties in providing spiritual and psychological support for patients and their families which is often very important for people who are experiencing a difficult time in their lives due to the mixed ward environment. 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 began to explore 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 Scotland[2] 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 Care[3] (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 Approach[5] (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.

[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 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.

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.

Ward 11 Reconfiguration Project

In October 2010, a project commenced to examine the issues around the co-location of beds within Ward 11 which was also an issue for Stroke Patients. Ward 11 has been a mixed ward accommodating 15 Stroke beds, 9 GP beds and 6 Palliative Care beds. It was acknowledged that this busy acute ward was an inappropriate environment for GP patients and better use could be made of the Community Hospitals across NHS Borders. Furthermore analysis of the data showed that usage of the beds by GP patients was very low and the beds were regularly used by other specialities within the hospital. The project recommended a reduction of 10 beds overall including Stroke beds to be reduced to 12 which would be enabled through a decreasing length of stay in line with agreed performance targets. LEAN improvement work saw a reduction in LoS from 19.8 days for 2009/10 to 15 days at the end of the LEAN work in October 2010. Reducing beds would have the additional benefit of allowing more space between beds thus improving the environment for Stroke patients. This project recommended that the number of Palliative Care beds be increased from 6 to 8 which would allow continued access for GP Palliative Care patients. Given that the Borders is facing an increase in the number of older people within the total population, this will provide ongoing capacity for Palliative Care patients. It is likely that demands for Palliative Care will increase in the future as the population ages with the more common causes of death being chronic disease such as organ failure, cancer and dementia/frailty[6].

Due to the significant interdependencies, it became essential that these projects were joined up and delivered as one scheme in 2 phases:

- Phase 1 – completion of Ward 11 Reconfiguration Project – implementation of reduced bed numbers and reduction in staffing levels with this being completed in June 2011

- Phase 2 – Development of Business Case for Palliative Care Specialist Inpatient Unit with refurbishment of Ward 11 for Stroke patients

[6] Living & Dying Well, Scottish Government, 2007

The public fundraising campaign would focus on the development of the Specialist Palliative Care unit however provision could be made within the fundraising campaign for additional funds to be raised for refurbishment of the Stroke area. In addition, agreement to utilise endowment funds towards the costs of the redevelopment of the Stroke Unit has been sought from NHS Borders Endowment Board Trustees.

A review of the nurse staffing for the 20 beds has been carried out in line with best practice guidelines for both Stroke and Palliative Care and this has recommended a wte of 23.73. A reduction of the 10 beds within Ward 11 is now complete with a revised complement being 8 Palliative Care beds and 12 Stroke beds. This will deliver a disinvestment of £263,311 on the existing staffing budget. The table below provides more detail on the proposed staffing expenditure.

Fit With Local Policies

The delivery 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 currently access the care of a Specialist team as they are unable to access a facility which would 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 development of a Specialist Unit not be approved, although there will be 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. In 2009/10, the average length of stay for Palliative Care patients in Ward 11 was 10.3 days[7] (2010) which is a considerable period of time in this type of 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.

[7] Ward 11 Reconfiguration Project Data Pack, Planning & Performance, 2010

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 were as follows:

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 garden and Consultant car park area. Schedules of accommodation have been defined by the Palliative Care and Stroke teams which is based on current best practice and the initial work to gather information about other units in Scotland and this has been further refined to include consideration of the following facilities:

- Day Facilities
- Treatment Space
- Isolation Rooms
- Consultation Room
- Relatives' overnight rooms/family room/Quiet Room
- Therapy Space
- Lounge/Waiting Area/Reception
- Staff facilities including office space
- Resource/Information Suite
- Stock Room
- Locked Drug Prep Room.

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

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

Benefits	Constraints
• 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 could continue • Present arrangements for out of hours cover would continue • Extension would allow for full range of 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	• Patients will need to be relocated when building work is ongoing and this will need careful planning

services such as Diagnostics • At peak times of demand a flexible approach could be taken between Palliative Care and Stroke beds • 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 • In implementing the recommendations of the Ward 11 Reconfiguration Project and the overall bed reductions within the footprint of Ward 11, there may be opportunities to improve environment for Stroke patients • The unit would have its own front door which would provide easy access for patients and visitors.	

NHS Borders Estates department worked with an Architect and the Palliative Care and Stroke teams to draw up initial 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.

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

5. Preliminary Costs & Developments in Fundraising

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, which will be factored into the gross target for the public fundraising aspect of the appeal. This will bring gross costs to £4.5 million.

Preliminary Capital Costs

Outline capital costs for this project are outlined in the table below:

Specialist Palliative Care Unit
PSCP Cost Analysis June 2011

		Stroke Refurbishment £000s	Palliative Care New Build £000s	Total Cost Plan £000s
Construction Cost Plan		910	1840	2750
Design Fees	12.11%	110	223	333
PSCP Mark up	7.10%	72	146	219
		1093	2209	3302
Cost Advisor/CDM Fees & Planning				78
Other Construction (incl Ward 14 enabling)				48
Equipment				275
VAT @ 20%				725
Optimism Bias				80
			Total Outline Business Case	**4,508**

It is important to note that these are outline costs at this stage and are subject to further refinement and review. Work will progress by the Principal Supply Chain Partner to finalise these costs. There is potential for a reduction in VAT due to possible reclaim, however a specialist advisor will assess this and therefore this has not been reflected in the table above.

Revenue Costs

Recurring Costs

This Business Case cannot be assessed using standard business case techniques as there is only one option to be considered and costed. Therefore the cost associated with running the facility has been considered against national standards for cleaning specifications and workforce and benchmarking information for nursing establishments.

While there is no formal financial option appraisal it is vital the costs are appropriate to the type of area concerned and are minimised where possible whilst ensuring patient safety.

The following table outlines the Nursing costs for ward 11. This is broken down to highlight both phase 1 and 2 of the project:

Ward 11 Reconfiguration

Phase 1			
Nursing Review 30 Beds		Nursing Review 20 Beds	
Wte	£	Wte	£
1.00	50700	1.00	50096
1.00	42351	1.00	41847
15.73	548888	11.34	391063
14.47	368328	10.39	263952
32.20	1010268	23.73	746957
Total Disinvestment Phase 1			263311

Phase 2					
Stroke 12 Beds		Palliative Care 8 Beds		Total 20 Beds	
Wte	£	Wte	£	Wte	£
1.00	50791	0.00	0	1.00	50791
1.00	42428	1.00	41585	2.00	84013
8.63	301745	6.79	232728	15.42	534472
5.19	131976	5.19	131976	10.39	263952
15.83	526939	12.99	406289	28.81	933228
Total Investment Phase 2					186271

The above table demonstrates the additional nursing component required to run the 20 bedded facility across both the ward area and the extended floor area of 12 stroke beds and 8 palliative care beds.

Other revenue costs will also be incurred including Domestic, Rates and Utilities. The table below outlines these costs and highlights the total additional revenue investment required for the new facility:

Total Additional Revenue Investment Required		
	Wte	**£**
Nursing	5.08	186,271
Domestic	2.26	46,000
Property Costs, including rates & utilities	-	40,000
Total	**7.34**	**272,271**

The above costs demonstrate the investment required by NHS Borders in this scheme of £272,270.

1 Year Non Recurring Costs

There will be associated project management costs as outlined in the table below. These costs will be further refined and will be charged against the appeal. Project management costs for year 2 have yet to be determined.

Description	**Cost**
Associated project management costs including associated costs linked to the fundraising campaign	£155,000

The benefits of this project are as demonstrated earlier in this paper and are in line with NHS Borders vision, values and Corporate Objectives and also in line with national standards.

Summary of Developments in Fundraising

At the December 2010 Strategy and Performance Committee meeting it was reported that a figure in excess of £500,000 was available from the Margaret Kerr legacy (now held in the Margaret Kerr Charitable Trust). An undertaking was given to the Board that a further £1 million of firm pledges would be secured by the time that this feasibility report was presented to the Board, thus ensuring an initial sum of £1.5 million secured in advance of a public appeal for the balance. At that time the plan was that the launch of the public appeal would be timed to follow the approval of the business case by the Board. The public launch date was, therefore, projected as September 2011.

The work on securing pledges began immediately after the December meeting. The increase in the capital requirement to include the refurbishment of Ward 11 had a considerable bearing upon this and activity was intensified, resulting in the position at 31st March 2011 Strategy and Performance meeting of £2.5m secured from firm pledges of support.

Position at May 31st 2011

Following the approval at the March 2011 Strategy and Performance meeting to proceed to business case, work has continued to maximise firm pledges of support for the project, in tandem with the preparation work for the public appeal.

The following firm pledges of support have now been secured:

Funder	**Amount**
Margaret Kerr Charitable Trust (including legacy and other ingathering of funds)	£700,000
Robertson Trust	£350,000
Binks Charitable Trust	£50,000
Miss M B Reekie Charitable Trust	£50,000
WRVS	£100,000
Friends of BGH	£50,000
Macmillan Cancer Support	£750,000
Bona fide anonymous donors	£550,000
Total Committed Pledges at 31st May 2011	**£2,600,000**
Utilisation of existing endowment funds	£420,000
Pre Launch Total	**£3,020,000**

In addition to this, cash donations totalling £28,000 have been received and banked, and further pledges of smaller amounts totalling £124,000 have been received.

Public Appeal

The precise financial target for the public appeal is still to be determined, depending on the detailed finalised costings. The Fundraising Development Manager is currently working on a detailed public appeal plan which will be subject to full discussion at the next Fundraising Committee meeting which will be held in the week commencing 15th August 2011. A number of individuals, groups and organisations have already indicated their interest and commitment to support.

Communication

Key to the success of the overall project and, in particular, the public appeal will be clear communication and co-ordination among the partner organisations. The Fundraising Development Manager will have an essential role in this. A full communications plan will be implemented.

Recognition of Funders

Following the approval at the March 2011 Strategy and Performance meeting to name the new unit '*The Margaret Kerr Unit*' in recognition of Miss Kerr's legacy as the initial lead gift, and the continuing interest and involvement of the Trustees, the public fundraising appeal, when launched will be named 'The Margaret Kerr Unit Appeal'.

Requests have also been received from other committed funders, including the Robertson Trust which celebrates its 50th anniversary in 2011. At their meeting to consider in full the funding application submitted, the Trustees of the Robertson Trust increased their gift by £100,000 resulting in a financial commitment to the project of £350,000. The Robertson sisters lived in Berwickshire and the Trustees have asked that some appropriate recognition be considered. Similarly, Macmillan, the Friends of BGH and the WRVS have indicated that they would like to have their support recognised. Proposals for ways in which these requests, and others, can be met in an appropriate and creative manner will be put forward by the Fundraising Committee in due course.

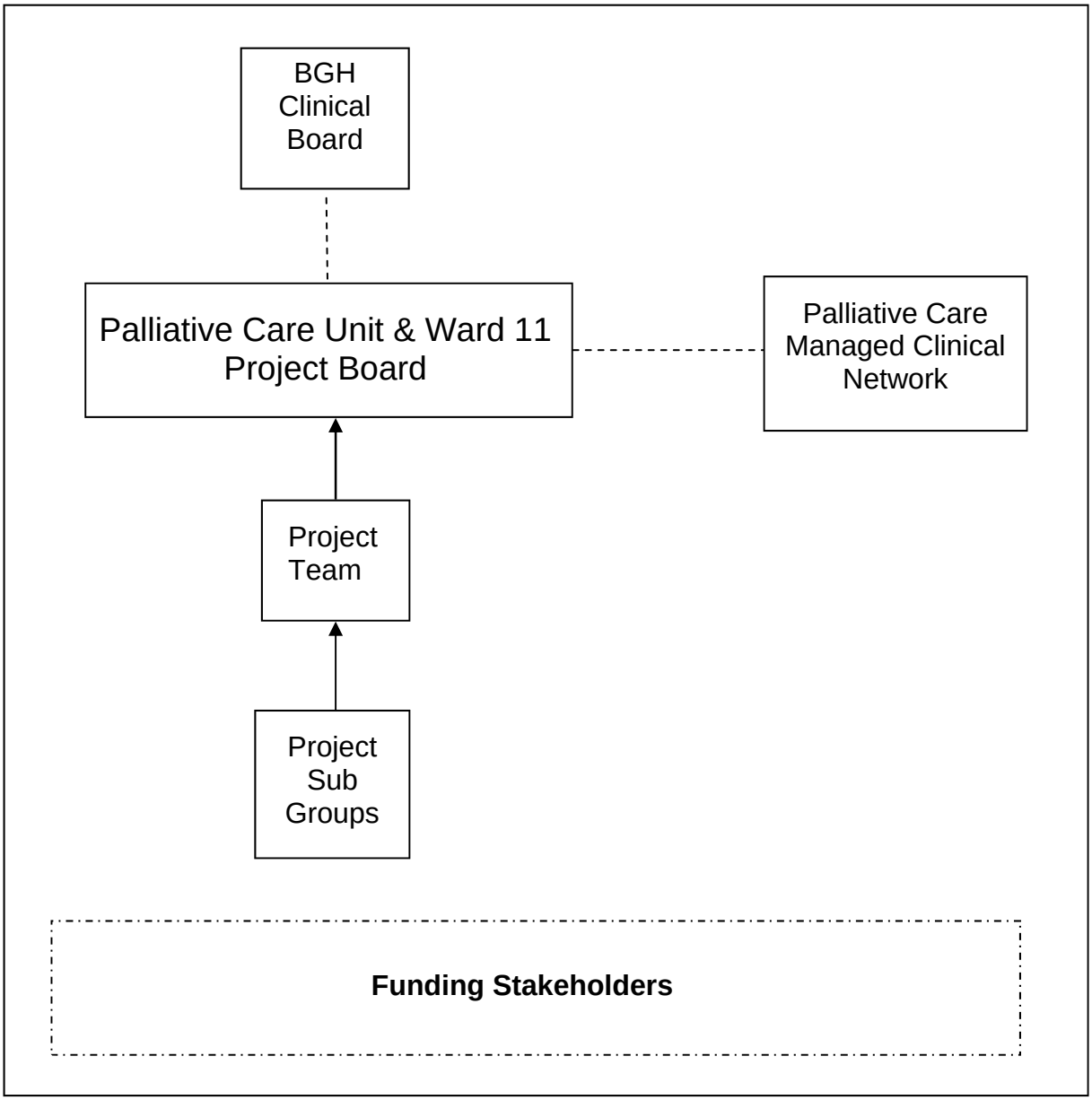
6. Project Management

Introduction

The initial work to develop solutions to improve the Specialist Palliative Care Inpatient Service has been 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 Management Arrangements

A proposed 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
Stephanie Errington	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
Susan Yates	Project Support	Planning & Performance
Sandi Haines	Project Support	Stroke Specialist Nurse
TBC	Project Support	AHP Representative

A range of sub groups (made up of clinical and support services) will be required to undertake pieces of work on behalf of the Project Board to deliver the project. This will be negotiated with the services at the outset, with further work being commissioned, as appropriate, during the life of the project.

A Project Team or Core Group will be established to manage operational issues.

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
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

Milestone	Timescale
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)	July 2011
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* * provisional timescale

7. Construction of Scheme

Due to the complexities of the project and the estimates of capital costs, the Director of Estates and Facilities has recommended that the scheme is 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 has been commissioned as PSCP for the Palliative Care Specialist Unit. The PSCP will work closely with the Project Team to undertake detailed costing of the approval plans incorporating the standards set out in Specialist Palliative Care (2004)[8] and Improving Supportive and Palliative Care for Adults with Cancer (2004)[9] during the planning phase.

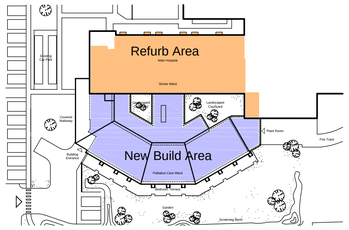
In addition, following interviews with 4 Cost Advisors (PSCs), Thomson Gray Construction Consultants have been commissioned to work closely with both NHS Borders and the PSCP in the provision of joint Cost Advisor services (Quantity Surveying), in the development and monitoring of costs throughout the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

[8] Specialist Palliative Care – National Overview – NHS Quality Improvement Scotland 2004
[9] Improving Supportive and Palliative Care for Adults with Cancer – NICE 2004

8. Recommendation

NHS Borders Board is asked to:

- **Note** the work progressed in developing this Business Case
- **Note** the work progressed in securing firm pledges for the capital costs of the scheme
- **Approve** the plans described in the Business Case to be progressed with the development of the Specialist Inpatient Palliative Care Unit and refurbishment of the Stroke Unit.
- **Approve** the launch of the public fundraising campaign for the 1st of September 2011



Area of Enabling Works (Partial Refurb.) - 64m²

Area of Refurbishment Works - 575m²

Area of New Build - 632m²

A 03.06.2011 AMENDMENTS FOLLOWING CLIENT DISCUSSION

Revisions

project

NHS Borders

Proposed Palliative Care/Stroke Unit
Borders General Hospital
Melrose

title

Plan as Proposed

date May 2011

drawing no. AT1791-L-01-A

scale 1:100

drawn

Aitken Turnbull
architects
survey
plan
create

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t: 01450 372297 f: 01450 378106

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Duddingston House Milton Road West
Edinburgh EH15 1RB t: 0131 652 4082

E-01 North Elevation 1:100

E-02 West Elevation 1:100

Revisions

project

NHS Borders

Proposed Palliative Care/Stroke Unit
Borders General Hospital
Melrose

title

Elevations as Proposed

date May 2011

drawing no. AT1791

scale 1:100

drawn

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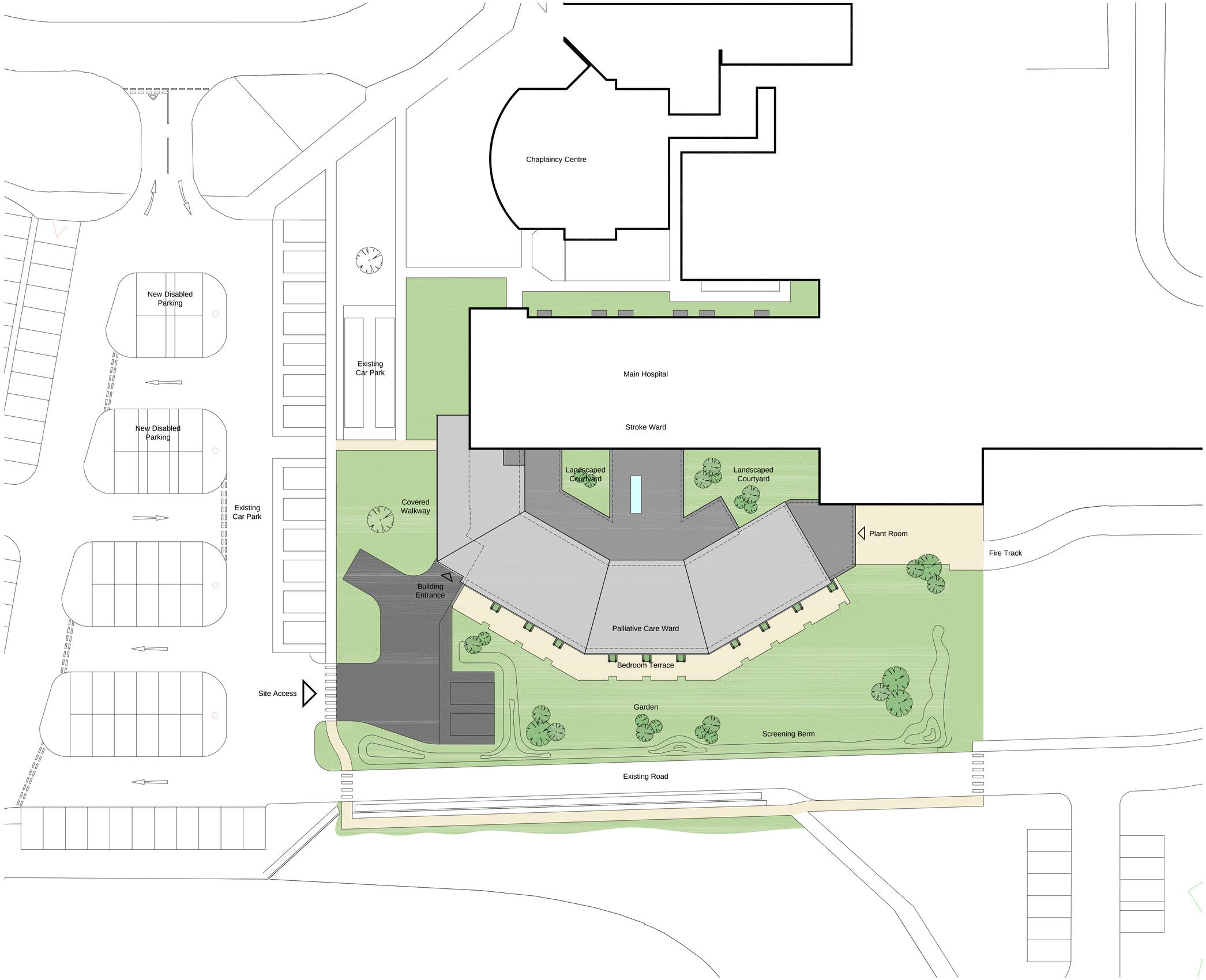

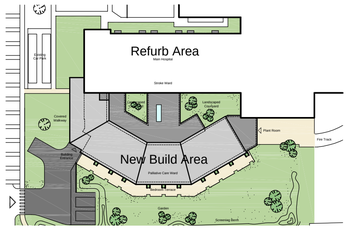

Area of Soft/Hard landscaping

Area of Vehicular Surfacing

Area of Paving

A 03.06.2011 AMENDMENTS FOLLOWING CLIENT DISCUSSION

Revisions

project

NHS Borders

Proposed Palliative Care/Stroke Unit
Borders General Hospital
Melrose

title

Site Plan as Proposed

date May 2011

drawing no. AT1791-L-03-A

scale 1:200

drawn

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