**CAPITAL INVESTMENT GROUP MEETING MINUTE**
**NHS Lanarkshire Monklands Replacement Project (MRP) Outline Business Case**
**22 FEBRUARY 2023**
**0930 -1200**

## Attendees

### CIG members

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|---|---|
| Alan Morrison | Chair, CIG (AM) |
| [redacted s.38(1)(b)] | Head of NHS Strategic Capital Investment – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Capital Accountant – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Health Sponsorship Team – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Head of Capacity Building and Recruitment ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Professional Advisor – Mental Health and Social Care Directorate ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Policy Team Leaders – Digital Division ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Analytical Unit Head - Analytical Services Division ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Economic Advisor – Analytical Services Division ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Trainee Accountant – Health Finance ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Economist – Health and Social Care ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Head of Strategy & Policy – Digital Division ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | SFT – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | HFS/Assure – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Health Improvement Scotland Engagement Team – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Capital Project Advisor – ([redacted s.38(1)(b)]) |

### NHS Lanarkshire

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|---|---|
| Jann Gardner | NHS Lanarkshire, Chief Executive (JG) |
| Martin Hill | NHS Lanarkshire, Chair (MH) |
| Colin Lauder | Project SRO and Director of Planning, Property and Performance (CL) |
| Laura Ace | Director of Finance (LA) |
| Ross McGuffie | Chief Office, North Lanarkshire HSCP (RM) |
| Dr Chris Deighan | Executive Medical Director (CD) |
| [redacted s.38(1)(b)] | Project Director ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | MRP Clinical Lead for Nursing ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | MRP Clinical Lead for Medicine ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Chief of Medicine for University Hospital Monklands ([redacted s.38(1)(b)]) |

### Apologies

| | |
|---|---|
| [redacted s.38(1)(b)] | Head of Financial Reporting |
| [redacted s.38(1)(b)] | Head of NHS Facilities and Environmental Sustainability |
| [redacted s.38(1)(b)] | Unit Head Cancer Policy |
| [redacted s.38(1)(b)] | Financial Reporting Manager |
| [redacted s.38(1)(b)] | Economist |

Lesley Thomson NHS Lanarkshire, Vice Chair

**NHS Lanarkshire Monklands Replacement Project (MRP) Outline Business Case**
AM welcomed CIG members and all attendees from NHS Lanarkshire to this CIG meeting and thanked the Lanarkshire team for their submission and recognised the milestone of reaching the OBC submission.

**NHS Lanarkshire presentation**

- Opening statement from MH, stating the strategic importance for the people of Lanarkshire and Scotland, the importance of the climate emergency and addressing areas of multiple deprivation. The project will address a number of business continuity issues in the existing facility, the proposal will provide resilience and provide a fit for purpose and future proofed facility.

- JG noted that the pandemic had a significant effect on NHS Lanarkshire, but the resilience of staff has been significant and the MRP is crucial to investing for the future resilience of workforce. The MRP will be a pathfinder project and that MRP has been supported by the Chief Executives and the West of Scotland Programme Board. It was also noted that if the opportunity arose the programme could potentially be brought forward a little.

- [redacted s.38(1)(b)] noted that the major development from the approved IA and ongoing investment of £55 million there are still significant ongoing issues with the existing hospital building and business continuity is affected by flooding on a weekly basis. Windows have reached the end of their life and the overall condition is illustrated in the EAMS data. There are significant issues with Fire - £10 million has been spent on improving compartmentalisation, but this has not removed all risk though it has mitigated the extent of the risk.

- Due to constraints on the existing Monklands site, redevelopment of the existing location was disregarded. Site selection had originally concluded that Gartcosh was the preferred site, but following local political action and a debate in parliament, Ministers instructed the University of Glasgow to undertake a review of the site selection process. A subsequent site selection process was undertaken and Wester Moffat was identified as the preferred site.

- [redacted s.38(1)(b)] presented geographical information illustrating the nearby railway station and the East Airdrie link road and he confirmed the intention to have a place-based approach that integrated the development into the local community.

- [redacted s.38(1)(b)] described the proposed clinical model, which has been driven by the clinicians and operating team. The existing facility has a lack of coordination and multiple area in which patients are received, whereas the new facility will have an assessment village and wards adjacent to the Radiology and Emergency departments.

- The new model will incorporate the ‘peri-op’ rooms.

- NZC: the existing building is a carbon intensive installation, while the new building will utilise Air Source Heat pumps and will be an all-electric hospital. NZC will be about the construction and operational energy and it is a focus of the team to make sure that all Construction partners ensure that both elements are thought through and that this is a focussed process.

- Digital Hospital: [redacted s.38(1)(b)] described the Digital strategy as having two strands: Clinical and Operational/Digital Twin. MRP is seen as a key enabler for service delivery and it should give the whole system a better visualisation of patients in all acute hospitals. There is an intention to embrace the Digital Twin concept which entails asset tagging all appropriate assets and elements.

- [redacted s.38(1)(b)]requested a separate meeting to discuss the Digital strategy. [redacted s.38(1)(b)] had to leave the CIG Meeting at this point. The request was received with thanks and [redacted s.38(1)(b)] confirmed that a separate session would be arranged.

- Community Benefits: the MRP have been working with North Lanarkshire Council and the local community to shape the benefits. A 'Future Fridays' initiative will bring school children into the Hospital and let them learn about opportunities in healthcare and construction.

- Workforce development planning has started, which will embrace the new environment and the digital innovations that will be built into the new facility.

- Costs – [redacted s.38(1)(b)] stated that benchmarking has been undertaken and appropriate indices have been applied. Cost Control will be scrutinised by a cost review group within NHSL. The MRP Team have a high degree of confidence in the costs being the same at the FBC stage – this confidence is due to the degree of development of designs and material prices have been appropriately assessed. Value for money – it was noted that the MRP is seen as value for money because of the Clinical models productivity and integration with the HSCP to appropriately receive patients and the peri-op room model having the ability to deliver efficiencies.

- Area – there has been extensive engagement with the Healthcare Planner and Clinical team to ensure that the correct accommodation is included. The NZC design has resulted in a larger FM space requirement than has traditionally been the case, but this has been sense checked with Construction partners and NHS Scotland Assure to ensure provision is appropriate.

- Key Stage Assurance Review (KSAR) ongoing reviews are planned into the whole development of the MRP. The OBC KSAR has received a supported status and an action plan is in place to address the observations.

  NHSScotland Design Assessment Process (NDAP) has also provided a supported status to the project for this OBC stage.

  Supported Gateway status was also received in November 2022 at the OBC stage.

**CIG then discussed the business case with NHS Lanarkshire**

- AM noted that the site selection and timeline (2031 delivery) have been through full consultation with the Scottish Government.

**Strategic Case:**

- [redacted s.38(1)(b)] noted that the cost of the OBC is £1.3 billion which is around £10k/m2 which actually appears to be a low cost/m2 compared to other recent submissions and asked how robust the cost will actually be.

  [redacted s.38(1)(b)] responded that as [redacted s.38(1)(b)] had reflected that this is the cost of doing business these days. [redacted s.38(1)(b)] stated that 70-80 per cent of the rooms will be repeatable rooms in MRP. Construction partners have undertaken significant Healthcare projects in England and that experience is providing a degree of confidence in the understanding of cost certainty. [redacted s.38(1)(b)] also noted that some of the NZC requirements are relatively cheap building types (to house the plant) and this is reflected in the slightly lower cost/m2.

- [redacted s.38(1)(b)] noted that NHS Lanarkshire have two other Hospitals of very similar size to Monklands how do these fit into the acute strategy.

[redacted s.38(1)(b)] responded that NHSL are developing a programme called 'Operation Flow', to optimise, sustain and reform as a strategy for NHSL which will be instigated well before MRP is delivered. NHS Tayside have been consulted as to their clinical model improved patient throughput.

[redacted s.38(1)(b)] and [redacted s.38(1)(b)] noted that the Clinical pathways model has been key to reducing the length of stay and to ensure that patients who do not need to be in hospital, can be cared for in the correct location. The design has been developed by the Architects as a response to what the MRP team has advocated in that model.

- Have costs for demolition of the existing hospital been included?

  [redacted s.38(1)(b)] stated that demolition is not carbon neutral and they are not assuming that they will demolish the existing structure as the structural frame is still in good condition and they do not currently have a plan for the existing site.

- [redacted s.38(1)(b)] asked how the whole system approach and analysis has affected the current delivery or will the MRP be the pivot point.

  [redacted s.38(1)(b)] noted the extent of Whole System Planning which has been undertaken to date – and the optimum service models have driven the design. There have been several funding streams that have allowed community-based assessment and planning capacity has been allowed to develop with the aim to take activity out of the Acute Hospital environment.

- [redacted s.38(1)(b)] asked about place-based approach opportunities and what might happen with the existing site.

  [redacted s.38(1)(b)] noted that the East Airdire Link Road is part of a City deal, but the hospital's location next to the road with the adjacent land provides many opportunities for development. There are potential opportunities with the existing site.

- [redacted s.38(1)(b)] asked how does the NTC Lanarkshire affect the MRP?

  [redacted s.38(1)(b)] noted that the NTC Lanarkshire will be in Cumbernauld and was a manifesto commitment. There will be a collaborative approach with NHS Forth Valley, but with the NTC being several years away, there is a consideration that dermatology may be better suited in the NTC rather than in the MRP acute site.

**Economic Case:**

- [redacted s.38(1)(b)] – GEM model has been received and initially looks in good order and may feedback in due course.
  Cost per Benefit scoring – could more site-specific information be inserted into the other site options.

  [redacted s.38(1)(b)] and [redacted s.38(1)(b)] noted that the level of ground condition survey/feasibility work would be significant to match the Wester Moffat option and moving to that level of detail was discounted.

- [redacted s.38(1)(b)] noted that Optimism Bias was listed as £20 million in the IA and was clearly inadequate in containing the cost rises that have been seen and it was suggested that maybe a larger optimism bias allowance would be more appropriate.

JG noted that there has been a great deal of consideration to provide as realistic a cost as possible. [redacted s.38(1)(b)] note that the events of the last couple of years have been unprecedented, but there are indications that inflation is easing.

[redacted s.38(1)(b)] asked if the design has been novated to the Contractor?
[redacted s.38(1)(b)] responded that the procurement is a 2 stage process and that NHSL 'own' the design much longer than might be the case, but the MRP team want to get the Contractors expertise.
[redacted s.38(1)(b)] responded that there is still a chance for the design to change. [redacted s.38(1)(b)] acknowledged that this is the case, but the scope is reduced.

- There were a number of questions noted in the MS Teams Chat function from [redacted s.38(1)(b)] which were asked if [redacted s.38(1)(b)] could copy and respond to outwith this meeting.

**Procurement:**

- [redacted s.38(1)(b)] asked is the procurement strategy still fit for purpose and what contractual mechanisms will be included to protect NHSL?

  [redacted s.38(1)(b)] noted that early in 2022, a second PIN was issued and workshops were undertaken with various potential partners. Legal Advisors were also consulted to ensure that the procurement route is still appropriate and the MRP team will continue to review the procurement strategy.

- [redacted s.38(1)(b)] noted that the existing Design Team will be novated but that Currie and Brown are being retained as Lead Advisor. Which other consultants will be required and retained?

  [redacted s.38(1)(b)] noted that Currie and Brown will be retained as the Lead Technical Advisor and that expertise will be expanded appropriately to provide the correct level of Project Management. Site supervision will also include a high level of digitisation and it is the intention to have a full 'shadow design team' once the current design team is novated.

- [redacted s.38(1)(b)] asked how will the MRP Team ensure that NDAP is embedded in the development and be provided enough time.

  [redacted s.38(1)(b)] noted that NDAP engagement will be programmed into the overall design development. [redacted s.38(1)(b)] noted that he had a recent meeting with the NHS Assure Director specifically around NDAP interaction.

**Workforce:**

- [redacted s.38(1)(b)] would be keen to see a robust training and recruitment plan in due course. She offered to include MRP in the Workforce Group which has proved very useful for NTC projects to see what other projects are doing with their plans.

  [redacted s.38(1)(b)] noted the highest risk on the risk register is workforce availability. [redacted s.38(1)(b)] noted that there is a lot of additional information on workforce availability and separate discussions would be welcomed. One point to note was that the larger GIFA is the reason for the increased domestic workforce.

**Finance:**

- AM considered the cost increase which has happened since the last publicised statement on the cost of the MRP and that will need careful handling. JG noted that the impact of not proceeding with MRP would have a significant effect on the rest of NHSL, but also the neighbouring NHS

Boards. MH recognised the importance of engaging with Chief Executives to reiterate the importance of the MRP.

- AM noted that further discussion would be made specifically on Finance out with this CIG meeting to expedite the progress of this CIG meeting.

JG and MH expressed their thanks for CIG members time in considering the OBC.

**NHS Lanarkshire left the meeting**

- [redacted s.38(1)(b)] noted a concern that there are a number of Mental Health issues that are not mentioned at all. They are small scale and are really better suited out with an Acute setting but there is a need to know that they are being considered.

- [redacted s.38(1)(b)] noted that there are a number of items of cost uncertainty and that there is no plan for the existing site. There is still an uncertainty around the number of Linacs to be provided.

- It was noted that there is no actual alternative proposal on the table currently and if the £1.3 billion is not affordable, a strategy for creating resilience for less cost across the ageing estate will be required. It was agreed that the case for the building failing and requiring significant investment or replacement is clearly made and if funding was available this would be an approvable OBC.

Normally the CIG would make a recommendation direct to DG Health and Social Care as to whether a business case should be approved, but given the scale of investment - £1.3 billion – and therefore the significant wider implications, it was recognised that HSCMB should be given the opportunity to comment on the proposal. Based on the portfolio's current capital budget, this project is not affordable over the next three years which considerably complicates the approval process.

The Permanent Secretary has decided that the Executive Team in Investment Mode, will also consider the proposal and a session has been arranged for 11 April. This is the first health capital investment project that has been subject to a review by the Executive Team, so the governance and decision making has not gone through this route before. However, given the considerable level of interest in this project, we would expect the Permanent Secretary and Director General Health and Social Care to discuss options with Ministers, before any formal decision is announced.

**Conclusions from the CIG's review are:**

- NHS Lanarkshire have produced a good quality, approvable business case, albeit there remain areas which require further development over the next phase.
- Due to modern standards of design and compliance, the costs are well over £1 billion and we should expect similar costs for other average sized acute projects (which could become relatively common given the age of the NHS Scotland estate).
- There remains a risk that costs for this project could rise further, as the market for a new hospital has not been tested in recent years. [redacted s.30(b)]

**Recommendations from CIG**

- Unless capital funding is made available for the entirety of the project and there are some assurances in this regard, then the business case should not be approved on the grounds of affordability.
- If funding was to be made available, then we should consider approving the OBC and moving to Full Business Case.

**AOB**

- There was no AOB.

**Meeting ends**

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**CAPITAL INVESTMENT GROUP MEETING MINUTE**
**NHS Greater Glasgow & Clyde Radionuclide Dispensary (RND) Outline Business Case**
**22 March 2023**
**0930 -1200**

**Attendees**

**CIG members**

| | |
|---|---|
| Alan Morrison | Interim Deputy Director Health Infrastructure and Sustainability, Chair CIG (AM) |
| [redacted s.38(1)(b)] | Head of NHS Strategic Capital Investment – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Economic Adviser, H&SC Directorate Analytical Team ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Health Sponsorship Team – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | CNO Directorate – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Financial Reporting Manager ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | HFS/Assure – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | SFT – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Health Improvement Scotland Engagement Team – ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | Capital Project Advisor – ([redacted s.38(1)(b)]) |

**NHS GG&C**

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| [redacted s.38(1)(b)] | NHS GG&C, Programme Director – Major Projects |
| [redacted s.38(1)(b)] | NHS GG&C, Depute Programme Director – Major Projects |
| [redacted s.38(1)(b)] | NHS GG&C, Head of Finance for Capital Expenditure |
| [redacted s.38(1)(b)] | NHS GG&C, Head of Radionuclide Dispensary |
| [redacted s.38(1)(b)] | NHS GG&C, General Manager Clinical Physics and Medical Illustration |
| [redacted s.38(1)(b)] | NHS GG&C, Director of Diagnostics |

**Apologies**

| | |
|---|---|
| [redacted s.38(1)(b)] | Head of NHS Facilities and Environmental Sustainability ([redacted s.38(1)(b)]) |
| [redacted s.38(1)(b)] | HFS/Assure |
| [redacted s.38(1)(b)] | Head of GMS Contract Team |
| Alison Strath | Chief Pharmaceutical Officer |

**NHS Greater Glasgow & Clyde Radionuclide Dispensary (RND) Outline Business Case**
AM noted that although this project was although not included in the SG Infrastructure Investment Plan is a project that needs to be taken forward given the risks to service that are already understood. It was also noted that Alison Strath (who is unable to make todays meeting and has offered apologies) of the Chief Medical Officers Office has provided a letter of support of this project (appendix 2 of these meeting minutes).

**The NHS GG&C Project Team presented slides:**

The presentation begins with some photos of the existing facility which is 30 years old and sits on the old Western Infirmary Glasgow Site in the west end of Glasgow. This is now an isolated facility which is bounded by a University access road on one side and what is now Glasgow University campus and a building site.

This is the largest Radio Pharmacy in the UK provides products to 5 Health boards in the west of Scotland (around 35,000 patient doses annually under MHRA manufacturing licence) and without it patients would not get their tests for Diagnostics, Therapeutic, diagnosis of cancer pathways. There are no patients accessing this facility but the doses are taken to the patients across the WoS.

Drivers for change:

- MHRA Inspection in 2021 revealed that MHRA would no longer support the facility as it is no longer compliant - various minor adaptations have been made in the short term but MHRA have made it clear that they need to see continued progress on the development of replacement facility.

- Access for the last 4-5 years is in effect through the Glasgow University building site and some very basic facilities management services have been difficult to arrange (deliveries, grass cutting, gritting).

- Air Handling Plant is aging and has only one fan which is a single point of failure. The type of cabinets that the facility uses means that a failure of a fan means that manufacture will have to stop. More modern air handling plant and cabinets have far greater resilience and would eliminate that single point of failure. There is currently not regional or national resilience for the scale of service which this facility provides.

- The layout of the building is not flexible and the floor space is limited for adaptation.

- Electrical installations have been described as a ‘bowl of spaghetti’ and ‘well past their sell by date’.

- A Gallium service would never be able to be supported from this site due to the weight of the isolator required.

Objectives

MHRA inspection: in 2018 was the first indication that the facility was non-compliant and the fact that the Business Case process for a replacement facility was initiated it was deemed that the minor adaptations would be sufficient to allow the facility to continue operating and reports are having to be submitted every couple of months.

- Clinical adjacencies are noted as an important factor – the site is now no where near any clinical support teams to provide the required support to nuclear medicine and receive the necessary support from health physics.
- A site under long term NHS control was noted as necessary to allow resilience, adaption and be flexible as required.

- The centralised model has been endorsed by all the facilities users who are all in agreement that this model should continue.

Site Selection

- It was noted that a preferred location would be a site already owned by NHS GG&C
- Clinical adjacencies and support on site are deemed important as it aids response to incidents, increases education opportunities and minimises movement of radioactive materials.
- Good transport links are important as products are delivered all over Scotland and as far as Carlisle.
- A clear site was noted was a preferable to ensure as few obstacles to the deliverability as possible.

A Long list of 22 options was reduced to 4.

- Do Minimum
- 1 - Refurbishment of existing level within laboratory block RAH
- 2 - New-build at Gartnavel General Hospital
- 3 - New-build at Stobhill Hospital

It was described that the existing site as a Do Minimum option was not ideal as there are now no clinical adjacencies.

Option 1 - was noted as having some of the desired adjacencies but these are limited and geographically it was not ideally placed to the west of Glasgow to optimise transport links.

Option 2 – Gartnavel has good adjacencies, with the Beatson Cancer Centre and a clear site along with public transport options. The road transport links from Gartnavel are considered as well placed to support the distribution network.

Option 3 – Stobhill would be a clear site but clinical adjacencies are limited. Transport links for public transport deemed to be inferior to the Gartnavel option.

Costs

It was noted that costs have increased from £12.2m at IA to £20.9m which is attributed to an increase in the gross internal floor area to accommodate Net Zero Carbon requirements (from 938m2 to 1257m2) and compliance with guidance. Inflation has also had an impact on costs.

Programme: It was noted that if approval of the OBC was forthcoming an FBC submission was targeted for February 2024 with a site start of March 2024, construction being complete in May 2025 and once MHRA inspections were complete service would commence in July 2025.

Project Risks

- The main Risk is noted as the failure of the existing facility there are multiple business continuity plans and mitigations in place to ensure the service is maintained.
- Supply Chain delays and labour shortages are a concern for delivery of the project

- Cost estimates - volatility of the current construction market is a concern
- Delay to building commissioning, any delay in the construction of the building will knock on to the commissioning of the building.
- Some of the Equipment procurement is on a very long lead in time and there will be a need to plan purchase very carefully to ensure delivery is available when required.
- Statutory approvals related to a radionuclide facility have the potential to be complicated and could potentially take longer than expected.

Benefits

A number of service, patient and Board related benefits were illustrated:

- Meets future demand for the treatment of cancer in the West of Scotland
- Potential opportunity to co-locate with similar services to enable flexible use of staff
- Improved safety for staff and handling of hazardous materials
- New facility will reduce the risk of loss of service for diagnosis and treatment for cancer pathway patients
- PET Generation to support the early detection of cancer and treatment
- Reduction in risk of microbiological contamination of products
- Potential for improved space utilisation, reduced carbon and optimised running costs
- A modern facility on an NHS owned site which fully complies with MHRA Standards
- Improve the quality / physical condition of the healthcare estate

**CIG members then discussed the business case with the NHS GG&C Team**

- AM asked about the project teams interactions with the MHRA in the risks in the existing estate and involvement in the replacement facility.

  Since the MHRA inspection in 2018 are very focussed on the current RND service. The MHRA was very supportive of the plan for a new facility but an inspection highlighted that the current facility falls well short of expectations. It is noted that the main mitigating factor which allows the MHRA to allow the existing facility to remain operational is that there is a replacement facility under development along with the Team taking a positive attitude to implementing any recommendations to maintain an acceptable standard in the existing facility. The Project team noted that the MHRA have been in very regular communication and two monthly updates have been requested to illustrate continued progress with the new facility.

  The project team has also enlisted the services of an ex-MHRA inspector as a consultant on the project to ensure that the concerns and issues identified by the MHRA are understood and dealt with appropriately in terms of the current adaptations and interpretation of the requirements for the new facility.

- AM noted the increased costs at £16.5k/m2 and asked for comment from the project Team.

  [redacted s.38(1)(b)] noted that the Project Team has scrutinised the Cost Advisors cost plan since it was submitted in late November. The Cost Advisors firmly stated that the costs are reflecting their experience of the current market costs.
  The total cost was increased with the increase in overall area of the building since IA. In terms of specification it was noted that inclusion of ground source heat pumps which has added around £1m to the overall project cost. Thirdly it was noted that the general market inflation has contributed to the cost per m2.

The project is utilising the Frameworks Scotland 3 procurement route.

It was noted that the optimism bias figure is 7% and it is not expected that there will be any significant changes to the project. The design solution is described as a robust and future proofed solution.

- [redacted s.38(1)(b)] noted that the existing building is only circa 30 years old and it is disappointing that a building of this age is failing. There is no indication of service improvement in the OBC, is there any opportunity for improving service for GG&C and the wider stakeholders?

  The MHRA standards for sterile medicines manufacture have been changed significantly over the past 30 years which could not have been foreseen 30 years ago. The gallium service which is to be provided in the new facility was also not foreseeable 30 years ago.

  The project team described real improvements in the RND and Pharmacy collaboration and flexibility of workforce which will be available on the preferred Gartnavel site.

  Some of the future proofing provision (i.e. space in the plant room to allow installation of a replacement AHU) along with allowing expansion space around the proposed building are intended to ensure that the proposed building is designed for a 60 year life.

  The existing building does not have the expansion space available to expand to meet current requirements and the way that the plant room is designed does not allow the AHU to be replaced without a significant period of service shutdown and the weight of the new gallium service equipment cannot be accommodated in the existing facility.

- [redacted s.38(1)(b)] noted his appreciation for the presentation and responses to the comments submitted.

- [redacted s.38(1)(b)] commented that some of the existing Gartnavel Royal and Gartnavel General Hospital buildings are now a significant age and asked for some reassurance that the site is indeed secure for the lifecycle of the proposed RND facility.

  A extract from the Gartnavel masterplan has been shared with the CIG as part of the Project Teams response to CIG written comments and notes the there are numerous facilities which are long term commitments and illustrates that the proposed site is on the periphery of the Gartnavel site away from areas that may be more suited to patient facing expansion in the future.

- [redacted s.38(1)(b)] asked if the current electrical infrastructure on the Gartnavel Site was sufficient to accommodate the proposed RND facility.

  [redacted s.38(1)(b)] confirmed that analysis undertaken confirms that the existing electrical utilities supply capacity is sufficient to accommodate the proposed RND including its ground-source heat pump heating solution.

- [redacted s.38(1)(b)] asked if an EQIA has been undertaken for this proposal.

  The project team noted that an EQIA has not yet been undertaken on this project. It had not been considered necessary as the service is not directly patient facing. The project team will get in touch with [redacted s.38(1)(b)] regarding development of an EQIA during the further development of the business case..

- [redacted s.38(1)(b)] noted that a Soft Landings Champion has been identified for the project but asked what information requirements are identified with regards to Building Information Management (BIM).

  [redacted s.38(1)(b)] confirmed that this project will be a BIM level 2 compliant project and the wider team are developing GG&Cs requirements.

**NHS GG&C left the meeting and CIG members discussed the OBC**

- [redacted s.38(1)(b)] noted that this building is not a particularly complex building however the cost at £16k/m2 will be the most expensive project in terms of a unit rate. There was discussion about how the costs are coming in so high. It was noted that the RND project team have considered a change to the HUB procurement route but it is acknowledged that this would probably have a programme implication.

- It was also commented that the by [redacted s.38(1)(b)] that the equipment cost appears to be very low. [redacted s.38(1)(b)] noted that the equipment is part of a cyclical replacement and is therefore not identified as a significant cost in the OBC.

**Recommendations from CIG**

- The CIG is content to approve the OBC.

**AOB**

- Minutes of previous CIG meeting of the Monklands Replacement Project (MRP) on the 22nd Feb 2023 were approved.
- AM updated that the Executive Team in SG are due to meet in two weeks time on the 11th April 2023 to undertake a further review of the MRP OBC and noted that by then a new First Minister will be in post. There is still no confirmed .
- It was noted that there will not be a CIG meeting next month and the earliest next CIG will be May 2023 tbc.

**Meeting ends**

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**CAPITAL INVESTMENT GROUP MEETING MINUTE**
**25 JANUARY 2023**
**0930 -1200**

## Attendees

### CIG members

Alan Morrison – Chair, CIG
[redacted s.38(1)(b)]– Head of Local Care Infrastructure - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]– Head of NHS Strategic Capital Investment - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]– Capital Accountant - [redacted s.38(1)(b)]

[redacted s.38(1)(b)]– Health Improvement Scotland Engagement Team – [redacted s.38(1)(b)]
[redacted s.38(1)(b)]– Capital Project Advisor - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]– SFT - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]– Health Sponsorship Team - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]- Financial Reporting Manager - [redacted s.38(1)(b)]
[redacted s.38(1)(b)] - Ministerial Support Team
[redacted s.38(1)(b)]– Economic Adviser - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]- Head of GP Contract Operations - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]- Professional Advisor: Mental Health and Social Care Directorate - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]– NHS Assure

**NHS Western Isles and CnES**

Gordon Jamieson – CEO NHS WI – GJ
Malcolm Burr – CEO CnES
[redacted s.38(1)(b)]– Director for Investment Activity CnES - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]- Project Director Hub North - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]– Director of Finance and Procurement – NHS WI
[redacted s.38(1)(b)]- Project Director NHS WI - [redacted s.38(1)(b)]
[redacted s.38(1)(b)]- Technical Director Hub North
[redacted s.38(1)(b)]- Cost Consultant - [redacted s.38(1)(b)]
Gillian McCannon – Chair of NHS WI

**Barra and Vatersay Community Campus OBC**

**NHS Western Isles presentation**

GJ gave a presentation about the business case – it covered strategic context, problems with current St Brendan's hospital and care home and overview of proposed new facility.

**A discussion followed the presentation**

The Chair said that this was a good ‘place-based’ project with benefits for the island, he would explain the funding position later in the meeting.

[redacted s.38(1)(b)] said that he knew the project quite well but had three questions. First, why has the decision been taken to replace a 30 year old building rather than refurbish it?

[redacted s.38(1)(b)] said the greatest challenge with the existing building was its functional suitability which compromised quality of care. Staff couldn’t move patients in beds easily around the building because doorways and corridors were too small. GJ said they have been doing all the maintenance that could be done. He pointed out that the residential care home will be replaced with individual homes with extra care, which is a benefit that can't be realised in the current building. [redacted s.38(1)(b)] mentioned that the new building will have lifespan of at least 60 years and would be subject to a lifecycle maintenance programme.

[redacted s.38(1)(b)] said Barra would get a bigger building but with same number of staff. He asked what a new facility would do for patients in terms of outcomes and benefits that couldn't be done at the moment. [redacted s.38(1)(b)] said new building would improve quality of care staff can give due to better functional suitability. A refurbishment wouldn't deal with issue of functional suitability.
GJ said new facility would improve joint-working and integration of teams which would improve care.

[redacted s.38(1)(b)] said SG advocating whole-system planning approach - how does the proposed facility fit in with whole system plan across NHS WI? GJ said NHS WI developed a clinical strategy which determined that WI needed three health and social care hubs - this campus is one of the hubs. A hub has already been created on Harris in Tarbert - the other two main hubs were to be in Uist and Barra (which is now expanded into this campus) - so this project is part of wider clinical strategy developed around 2010.

[redacted s.38(1)(b)] asked the project team for examples of the existing building's lack of functional suitability. [redacted s.38(1)(b)] said rooms and corridors couldn't fit modern hospital beds. Moving patients around hospital was undignified for patients. GJ said that the ScotSTAR (Scottish Specialist Transport and Retrieval) service didn't have enough space to operate in current building. There was a lack of space in inpatient and resuscitation rooms. There were not enough rooms for visiting services. Lack of rooms meant hospital couldn't be used during covid and they couldn't fly people off the island because ScotSTAR said there was a lack of space to operate in.

[redacted s.38(1)(b)] said there were no family rooms for end of life conversations and a general lack of privacy. She said there was one corridor in the hospital, which was full of equipment and was effectively an obstacle course. New hospital will provide more space to store equipment. In the new hospital integrated GP rooms will be open to hospital staff which is important - GP and hospitals will be as one for all staff.

[redacted s.38(1)(b)] said we shouldn't forget about the functional suitability of the current educational offering. Education, learning and sport facilities is a council priority. The education facilities are no longer suitable to facilitate modern approaches to teaching and learning - size and adjacency of spaces in school is an issue – the problems with functional suitability of the school will be addressed in this project.

[redacted s.38(1)(b)] asked if the GP practice was currently a '2C' practice. GJ said yes and they didn't anticipate returning to GMS arrangements, it will remain run by the health board. This addresses a concern that a GP practice shared by hospital staff might be unattractive to a GP contractor.

[redacted s.38(1)(b)] said it was important for everyone to remember the education aspect of this campus. He said there has been good joint working with the local council – the presence of the council's chief executive at CIG meeting is testament to that. He said this was a good project and wanted to know more about the housing partnership, cost envelope, and delivery management in remote location.

[redacted s.38(1)(b)] said that health board and council have been collaborating on Goathill care campus which had a 52 unit conventional care home and 50 units of houses with extra

care - handover 27 February. The buildings were owned by the Hebridean Housing Partnership (HHP) but services provided by HSCPs - that model will be replicated on Barra.

[redacted s.38(1)(b)] said major challenge had been cost and affordability - there has never been more difficult circumstances in which to build. Inflation and remoteness having an impact on cost. [redacted s.38(1)(b)] said SG LEIP (Learning Estates Improvement Programme) contribution would be significantly higher than expected which reduced the affordability gap. [redacted s.38(1)(b)] said they are within touching distance of making this affordable. He said council would continue to work on project cost, seek additional sources of funding and continue to revisit scope of project

[redacted s.38(1)(b)] said it was important to have a grip on costs and risk management. [redacted s.38(1)(b)] acknowledged that and explained they were using standard Hub procurement model. Team were engaged with principal contractor Robertsons regarding delivery of project on Barra. The team had done a lot of engagement with supply chain and were developing detailed cost plan with Robertsons. [redacted s.38(1)(b)] said they were far on with detailed designs to allow good engagement with supply chain. Team have gone beyond main contractor and engaged with supply chain to make sure they can do the project. So delivery risk is being mitigated.

[redacted s.38(1)(b)] said there was a cost premium for working on Barra but they had worked to ensure delivery certainty from cost and programme perspective. [redacted s.38(1)(b)] mentioned that a lot of ground investigation had been done and consideration had been given to site abnormalities. Also working with utility providers to determine what utility requirements and costs. A lot of work has been done to de-risk programme so risk levels are lower than what you would usually see. AM said they were currently at RIBA design stage 2.

[redacted s.38(1)(b)] noted that SMART objectives included in appendix, she asked how the objectives would be measured/demonstrated? AM said they have a benefits realisation plan – they have engaged with community to understand what benefits will have most impact – they will ensure that plan is robust. [redacted s.38(1)(b)] said they would follow SFT guidelines on project evaluation - post occupancy evaluations and post project reviews will be carried out to demonstrate what has been achieved.

[redacted s.38(1)(b)] asked whether the engagement section of the business case had been revisited and whether EQIA had been carried out? [redacted s.38(1)(b)] said they had done unprecedented amount of engagement with the community. He said community were initially not sure about housing with extra care model and the layout of the building. In response to that they did a reassessment exercise which came up with current layout. The new layout provides a degree of physical separation in line with the community's views. Concerns about housing with extra care were resolved by taking community representatives to Goathill care campus to show them the type of facilities proposed for Barra. They have made difference to level of community support for project through their work. Community councils and other local representative bodies are supportive of this campus. [redacted s.38(1)(b)] added that there would be a drop-in centre during construction to allow locals to get up-to-date information on construction. [redacted s.38(1)(b)] said he would like to see some of that work so that he can provide some advice and support regarding that engagement

The Chair turned to the funding situation. He noted that from the table on page 21 of the OBC the health funding requirement was £39.5m and that there was a £21m shortfall for the whole

project. He noted there was about six different funding sources for that shortfall. He asked about the realistic prospect of securing funding.

[redacted s.38(1)(b)] said the business case dates from December 2022. In the last few weeks the increase in the LEIP contribution had changed the financial picture. Also hope to get another £1.5m from council's next capital programme. Gaelic language fund is going to be enhanced to £2.5m. The 'Levelling Up' fund for £3.9m was unsuccessful in recent round but they will resubmit application in third round. LEIP sum has increased to £23.5m, which is an extra £10.5m from SG Education. Council will need extra £5m to match LEIP contribution. Council looking at more prudential borrowing. That all brings funding gap down to £4.5m which includes construction inflation costs which is levelling off. [redacted s.38(1)(b)] said they could shave £2-3m off that if they revalue construction costs. Funding gap has been closed considerably but based to an extent on assumptions.

The Chair said project team would need confirmation that funding was secure and equals total cost. He said inflation was still high so six months delay could add millions. He asked how team characterised risk re non health funding. [redacted s.38(1)(b)] said level of risk reduced considerably since confirmation of LEIP increase in funding. [redacted s.38(1)(b)] said he wanted to move forward with stage 2 and do detailed design in parallel with obtaining funding. He said the shortfall is much lower now than portrayed in OBC and said if stage 2 designed delayed then financial close will be delayed and that would lead to increased costs. [redacted s.38(1)(b)] said he feels that risk has gone from very high to medium, rather than very high to high. [redacted s.38(1)(b)] said there was local political commitment, the project was a high priority and funding would be found for it.

The Chair said there was Scottish Government political commitment to this project but there was no budget commitment. He said this project was mentioned in SG infrastructure plan, there was a need to mitigate delay, so he would pursue a quick decision from Ministers. [redacted s.38(1)(b)] to send update to Chair re costs.

[redacted s.38(1)(b)] said this project needs a design assessment report as it was unusual to approve project without design assessment report. NDAP report would help understand net-zero implications of project. He acknowledged KSAR report not required for this stage. [redacted s.38(1)(b)] said they were going through NDAP process. They were in touch with NHS Assure and providing necessary info.

AM said there was no gas supply on Barra so building power would be electric with air source heat pumps mainly. Future capability to connect to wind source being considered. Resilience would be provided by a backup diesel generator because no other reliable alternative back-up.

The Chair said he would be in touch with NHS WI and would progress this as a priority.

**BVCC project team left the meeting and CIG moved to discussion in private.**

The Chair asked the group whether this project represented value for money. He said that while the plans were laudable he was worried that the required funding would increase.

[redacted s.38(1)(b)] said OBC did not demonstrate value for money. There was no 'do minimum' option so there was no way to evaluate this project and its cost against a 'do minimum' option.

[redacted s.38(1)(b)] said Barra had a reducing and ageing population. Mental healthcare was not viable because of lack of workforce caused mainly by a lack of housing. This business case has not resolved that issue, it did not have a convincing strategy to deal with workforce difficulties
He said the case for adjacent services was based primarily on poor quality of existing buildings – he wasn't sure that the adjacencies were necessary or of benefit. [redacted s.38(1)(b)] was also interested in the comments from CEO about the initial opposition to the design proposals and wondered if this contributed to the proposed design of separate buildings. It wasn't clear what impact that change in design might have on build/maintenance cost and efficiency.

[redacted s.38(1)(b)] said there was a clinical convenience having GP beside hospital because GP does treatment in hospital. [redacted s.38(1)(b)] said the proposed accommodation was not that big - it was the minimum to be viable but it costs a lot. It's very expensive for what it was. [redacted s.38(1)(b)] said there was a need for a 'do minimum'. The existing building was not the worst, might need a couple of more rooms, which this business case adds. [redacted s.38(1)(b)] said NDAP process had not been used and that represented a design risk and might undermine net zero objectives.

[redacted s.38(1)(b)] said he had reservations about having the GP practice on site in the hospital if they were looking to find another GMS contractor because he didn't think most GPs would welcome providing open access to services outside their practice. He didn't think that's a factor here because he suspected they would struggle anyway to find new contractors for Barra. However, if they have a functional GP premises already, he'd have doubts about spending more to bring the GP practice on site.

[redacted s.38(1)(b)] wondered how significant the demand from non-residents on medical services was (fishing accidents and tourists). He wondered whether it effectively double the relevant population. [redacted s.38(1)(b)] said current and projected activity data in the business case would be helpful.

[redacted s.38(1)(b)] said he had not had much engagement with NHS WI. The health board had not responded to HIS queries about community engagement and had not appeared to complete a EQIA. He said he couldn't say the health board was meeting statutory duties because HIS hasn't had information to determine that. DB said he would contact MA.

The Chair said extra LEIP funding was encouraging. [redacted s.38(1)(b)] mentioned that he wasn't aware of the increase in funding, and he has been involved on the education side of this project. [redacted s.38(1)(b)] said he hadn't seen a project with this much collaboration but better engagement with SG required. [redacted s.38(1)(b)] acknowledged the value for money issue but said a whole government view about investment on such an island is perhaps needed. [redacted s.38(1)(b)] said this is the most remote island we'll ever build on, it's a once in a generation investment and is of value to local people. [redacted s.38(1)(b)] said we need to know whether project is fundable now, not in 12 months' time. The Chair agreed and said a funding decision needed now.

[redacted s.38(1)(b)] mentioned that the impact of separating the NHS building from the rest of the campus and putting it on the other side of the road makes it more likely that we will need to pay 20% VAT on SG contribution.

[redacted s.38(1)(b)] said he'd like to see a 'Do Minimum' option considering the integration of H&SC for older people being achieved by a redeveloped/new care home/supported accommodation with resident or in reach health team. And separation of the GP/MIU and perhaps admission function. The key for [redacted s.38(1)(b)] was understanding the current and projected activity information. He was not sure what added value there was for education/police being on site.

[redacted s.38(1)(b)] [redacted s.30(b)]

[redacted s.38(1)(b)] said the business case didn't properly explain the increased revenue and staffing costs. Those costs are not clear and it's not clear how they would be funded.

The Chair said this project was unaffordable at the moment. Ministers need to make a decision about this investment. Either this project represented value for money but is inevitably expensive or it simply does not represent value for money on any level.

[redacted s.38(1)(b)] said that in terms of value for money this is not a strong business case.

[redacted s.38(1)(b)] said the business case was driven by buildings and not by service model, which would have allowed the group to asses a do minimum option.

[redacted s.38(1)(b)] acknowledged [redacted s.38(1)(b)]'s point and said we needed more confidence that NHS WI was thinking innovatively about future service model.

[redacted s.38(1)(b)] was not convinced the project represented value for money.

[redacted s.38(1)(b)] said there was no activity modelling and therefore no idea if new hospital could cope with demand in summer in tourist season. He said there was no optimism bias in the business case at the moment either.

[redacted s.38(1)(b)] said there was a need for some kind of investment (and because of the circumstances, this will always be expensive on a per capita basis) but it was not clear that this was the correct option.

The Chair said this would be a decision for Ministers and he would advise them on the basis of the group's views. A funding decision was required quickly.

**AOB**

Minutes were agreed and mention made of next meeting. No other AOB.

**Meeting ends**

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**CAPITAL INVESTMENT GROUP MEETING MINUTE**

**NHS Tayside, National Treatment Centre Tayside (NTC-T) Outline Business Case**
**25 OCTOBER 2023**
**0930 -1200**

**Attendees**

**CIG members**

Alan Morrison Chair, CIG (AM)
[redacted s.38(1)(b)] Head of NHS Strategic Capital Investment – ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Professional Advisor – Mental Health and SC Directorate ([redacted s.38(1)(b)]) (until 11.30)
[redacted s.38(1)(b)] Economist – Health and Social Care ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] SFT – ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NHSScotland Assure – ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Economic Advisor ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Financial Planning Manager ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Head of GMS Contract Team Primary Care ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Trainee Accountant ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Head of Sponsorship ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Trainee Accountant ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] HIS Engagement Team – ([redacted s.38(1)(b)]) (joined after presentation section)
[redacted s.38(1)(b)] Chief Nursing Officer ([redacted s.38(1)(b)]) (joined after presentation section)
[redacted s.38(1)(b)] Capital Project Advisor – ([redacted s.38(1)(b)])

**NHS Tayside**

[redacted s.38(1)(b)] NTC-T SRO/Chief Officer Acute Services ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Project Director ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Clinical Director ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Associate Director of Clinical and Regional Programmes ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Technical Lead ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Project Manager ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Technical Lead – PRI Electrical Infrastructure Project ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Project Manager – PRI Electrical Infrastructure Project ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Revenue Finance Manager ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] NTC-T Capital Financial Accountant ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Admin Support Officer ([redacted s.38(1)(b)])

**Apologies**
[redacted s.38(1)(b)] Head of Strategy & Policy – Digital Division ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Analytical Unit Head ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Health Sponsorship Team – ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Unit Head - Sponsorship and Infrastructure ([redacted s.38(1)(b)])
[redacted s.38(1)(b)] Head of Capacity Building and Recruitment ([redacted s.38(1)(b)])

**NHS Tayside, National Treatment Centre Tayside (NTC-T) Outline Business Case**
AM welcomed CIG members and all attendees from NHS Tayside to this CIG meeting and thanked the Tayside team for their submission and recognised the milestone of reaching the OBC submission. It was noted that there had bee a 'dry-run' of review of an earlier draft of this OBC.

**NHS Tayside presentation**

- Opening statement from [redacted s.38(1)(b)], stating the context of this Business case as a response to the request to SG to develop an NTC. It was that this CIG approved the IA in 2018. There have been a number of developments in terms of economy, Major Service Change, pandemic and sustainability requirements since that IA approval.

- It was noted that the OBC has supported status from NDAP, SDaC and KSAR.

- Strategy – Acute Services strategy – helped inform the clinical model and how the building solution would evolve and has shaped the PRI Acute Services. A Major service change for Acute Services was approved by Cabinet Secretary. The Clinical model was developed in line with this strategy.

    - Ninewells will deliver Complex surgery and emergency and urgent cancer cases care

    - PRI Intermediate and low risk planned surgery and include the expansion plan for NTC.

    - Stracathro a regional treatment centre to provide a role for Tayside and Grampian for low risk procedures, incorporating learning from the NTC programme.

- Case for change: [redacted s.38(1)(b)] – the case for change is that patients should not spend so long on waiting lists. Clinically lead modelling established demand with 11 specialties producing a detailed output for each specialty.

- Target operating Model – all patients arrive at NTC directly. There is one pathway for enhanced treatment rooms where patients in for dermatology appointments will be in and out in under 30mins. Surgical Theatre patients – straight to a peri-operative room, which will be their room for their entire stay, they will be 'prep'd' here and changed here, they will go to the nearby theatres and then return to the same room. The close adjacency to theatres means that clinicians can see their next patient between procedures. The peri-op room model reduces handover points of patients between different teams. 80% of these 'day case' patients will be discharged. There is also the option of some patients who will need an overnight stay or for 2 to 3 nights.

- The floor plan was described to illustrate the adjacency to the existing PRI theatres and how close ot the new theatres are to the peri-op rooms. On the floor above the in-patient beds are situated and again the links to the rest of the existing PRI were illustrated.

- Ophthalmology and Orthopaedics will form the bulk of the additional procedures to be delivered.

- The NTC will comprise of 5 existing theatres and 5 new theatres and 2 enhanced treatment rooms. This will deliver 21,000 cases per year 16,00 additional cases.

- [redacted s.38(1)(b)] talked through how the proposed option for the NTC would fit into the PRI overall site plan. There are 6 existing buildings which require demolition to provide the site for the proposed NTC – these buildings until recently had numerous services which have now been relocated into much more appropriate facilities. Urology services are one major service who have now been relocated into the heart of the Outpatients Dept, which is where they are best placed. These buildings will be vacant and ready for demolition once completely vacated by the end of this year. Once demolished there are savings in revenue expenditure which can be made.

- It was noted that the proposal incorporates the retention of a band of mature trees.

- The project is required to be Net Zero Carbon when it opens. The solution to this is to make the NTC and all electric building and to do this a significant upgrade to the PRIs electrical infrastructure is required. RW described the route of and limitations of the existing power supply. The PRI Electrical Infrastructure Project Initial Agreement forms part of this submission as a dependant project to the NTC.

- The PRI site has experienced power outages which happen across the city centre of Perth. The proposal for the PRI Electrical Infrastructure works are proposed in 2 phases. Phase 1 would provide a new electrical supply to the PRI site this will be in the form of a new dual primary supply to improve resilience and provide the required capacity for the NTC-T along with full compliance with technical standards and construction of a new Energy Centre. Phase 1b comprises a new high voltage ring main around the PRI site and replacement of the transformers.

- [redacted s.38(1)(b)] described the Investment requirements: NTC-T estimated as £136.7m compared to IA of £35.4m, the increase is attributed to NZC requirements and global economic factors. Revenue costs for the NTC-T will be expected to be £34.6m once the centre is working at full capacity. The Electrical infrastructure project cost is £26.7m.

**CIG then discussed the business case with NHS Tayside**

- AM noted the target operating model and the focus on putting the patient at the centre and the complexity of the project to get to the final stage.

- [redacted s.38(1)(b)] noted the learning which has been taken from the KSAR process in terms of the timing of gaining approvals/supported status.

- AM requested comment on Decontamination capacity in relation to the additional Theatres in this NTC proposal: NHS Tayside have formally responded to an NHSScotland Assure query about NHS Decontamination confirming that NHS Tayside has sufficient capacity to support the new NTC.

- [redacted s.38(1)(b)] commented that the OBC represents a good solid project and complimented the patient pathway.

- The NTC throughput in the year that the proposed NTC would become active (2027/28) was questioned as a significant uplift in activity and asking for confirmation that the transferred procedures from Ninewells start to appear in the NTC and what decision making was undertaken on the level of affordability of staffing to achieve the figures in the OBC. [redacted s.38(1)(b)]stated that the additional activity could not be achieved without the NTC, this is activity that is currently not being achieved at Ninewells and that the figures noted for 2026/27 are all growing until the NTC opening date.

- It was noted that 2014 population projections were used as the baseline. [redacted s.38(1)(b)] asked if this baseline should be updated. [redacted s.38(1)(b)] noted that the 2014 baseline has been reviewed through the development of the project.

- [redacted s.38(1)(b)] asked if the Demolition costs could be more definite as it appeared to be an undefined cost at this stage. [redacted s.38(1)(b)] confirmed that the Demolition costs are actually fully understood and there is a contingency amount allowed in the costings to account for any unknown ground conditions.

- [redacted s.38(1)(b)] asked what stage of development the design has progressed to. [redacted s.38(1)(b)] confirmed that in fact where an OBC would usually expect a RIBA Stage 2 design maturity however in this instance due to some of the queries that the KSAR process have been probing the Project has in fact been developed to RIBA Stage 3.

- [redacted s.38(1)(b)] asked whether the level of activity is in line with the benchmarking available from other NTCs in terms of the value of the investment against number of procedures. It was noted that comparisons may be difficult given that this an NZC building and that the resilience and upgrade of the Electrical infrastructure contribute to the overall cost of this project.

- [redacted s.38(1)(b)] asked on behalf of [redacted s.38(1)(b)]if the workforce plan which was approved in January still current and valid. [redacted s.38(1)(b)] confirmed that this was the case and will be reviewed along with [redacted s.38(1)(b)] and [redacted s.38(1)(b)] as the project progress'.

- [redacted s.38(1)(b)] reiterated that confirming the population growth and the state of the health of that population should be reconfirmed.

- [redacted s.38(1)(b)] noted that the OBC is a solid document and business case. [redacted s.38(1)(b)] did note that there has been movement in the population projections and these should be reassessed.

- [redacted s.38(1)(b)] stated that the facility has been designed to be generic to be flexible and with the specialities that lend themselves to access to other boards – this NTC will provide something slightly different to the other NTCs which are designed for low risk patients, with the backup of the rest of the facilities at the PRI. The location of PRI is accessible to the North and the rest of Scotland.

- [redacted s.38(1)(b)] confirmed that the NDAP and KSAR are supported and therefore no further comment on these process' at this stage.

- [redacted s.38(1)(b)] asked about the PSCP appointment; do the Project Team see any risk in the re-appointment of the PSCP. [redacted s.38(1)(b)] confirmed that the PSCP who worked with the Team up to OBC stage has stopped. It was decided to re-tender the project which produced 3 bids and it was noted that these offers seem to be superior to the previous appointment, this includes the previous PSCP but in this tender they are offering a different tender. The tender process is underway and the result will be concluded soon. [redacted s.38(1)(b)] asked if there was any risk in a potential change to PSCP – [redacted s.38(1)(b)] reiterated that he did not consider any risk in a potential change, the same external design teams are still involved in the bids and along with an overall higher quality of offering the Project Team are comfortable with the re-tender decision.

- [redacted s.38(1)(b)] asked about costs, the inflation figure listed in the OBC is £30m and the equipment list is £7m (which had previously been stated as 25% of the IA cost and that his was higher than the norm) and also the £19m listed against sustainability. [redacted s.38(1)(b)] noted that all costs and specifically the equipping costs are much more solid than at IA. [redacted s.38(1)(b)] noted that the site has changed since IA from Ninewells to PRI and the previously flat site is now a sloping site at PRI, along with the PRI infrastructure differences compared to the IA site. The NZC solution has a significant change to the building fabric and the site connections.

- [redacted s.38(1)(b)] confirmed that HIS have very positive feedback from their team and stakeholders with regard to the NTC. [redacted s.38(1)(b)] noted that the next stage of engagement would focus on access and digital connectivity and EQIA will be developed. There

has been no further communication locally and the next communication will be coordinated through the NTC programme. There have been 70 or so workshops with stakeholders to engage with the local population and the feedback from public partners has been very positive in terms of the accessibility and engagement of the workshops.

- [redacted s.38(1)(b)] and [redacted s.38(1)(b)] confirmed that they had no significant queries regarding the Primary Care or Mental Health perspective.

**NHS Tayside left the meeting and the CIG discussed the OBC.**

- The narrative on capacity is not completely clear in the business case although the OBC is solid and a good document however the uncertainty over the capacity means that this business case is potentially different to other NTCs. The capacity being transferred from Ninewells is not clearly articulated in its impact of overall waiting times and activity at Ninewells. There is also some uncertainty over the cross boundary 'National' element of capacity from the business case and therefore the overall scale of the facility. The impact on revenue funding is more significant than expected. The question is whether this project is resolving existing issues at Ninewells beyond the remit of the NTC programme.

- [redacted s.38(1)(b)] noted that from a Scotland point of view and the extent of additionality is not clearly articulated. A reconfirmation of what are they building and who in Scotland is it going to benefit is probably required.

- [redacted s.38(1)(b)] noted the surprising cost of the Electrical Infrastructure works and is this correcting historic infrastructure of Perth. The CIG were reminded that the NTC-T team noted that there have been two power outages within the last year. [redacted s.38(1)(b)] raised the point of what are the Electrical Infrastructure implications for the rest of the PRI site. It was noted that separate to the NTC the electrical resilience of the PRI site was already known issue, the length of the connecting cable across Perth is a significant part of the cost.

- The Capital and revenue funding and workforce challenges are significant and will be required to have further development before this business case could be approved.

- Clarity of what the do nothing impact on NHS Tayside. It was noted that NHS Tayside generally are performing quite well.

**Recommendations from CIG**

- This would be an approval business case if the items discussed above could be developed and resolved satisfactorily however due to the existing finance position the expense of undertaking this further work is not recommended until Capital Funding is available.

**AOB**

- There was no AOB.

**Meeting ends**