

WESTERN HEALTH & SOCIAL CARE TRUST

**FULL BUSINESS CASE FOR THE NEW
ACUTE HOSPITAL FOR THE SOUTHWEST**

FINAL VERSION

6TH AUGUST 2009

COMMERCIAL IN CONFIDENCE

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EXECUTIVE SUMMARY

This Full Business Case (FBC) presents the case for the Western Health and Social Care Trust (the 'Trust') to progress to Financial Close with the Preferred Bidder; Northern Ireland Health Group (NIHG).

This Full Business Case (FBC) was updated following its submission in February 2009 and subsequent approval by the Department of Health, Social Service and Public Safety received on 18th May 2009 (Appendix 1.01; DHSSPS FBC Approval Letter). This FBC now includes the Unitary Charge at the point of closure of the Procurement Phase of the project at Financial Close which took place on 20th May 2009. This update is provided throughout the document under the title, 'Position at Financial Close'.

The contract with Northern Ireland Health Group, is a 30 year PFI contract to design, build, operate, maintain and finance the New Acute Hospital for the South West on a green field site within the development limit to the north of Enniskillen. The receipt of Full Planning Approval, was received on 23rd December 2008. Allowing for statutory period of 3 months for a potential judicial review, the Trust will be in a position of achieving Financial Close the week commencing 23rd March 09.

This FBC fully outlines the future costs, in relation to both PFI and Non PFI costs. In relation to revenue costs it takes account of the Comprehensive Spending Review, RPA (Review of Public Administration) savings, and the TCH (Tyrone County Hospital) investment plan. It analyses the changes since Acute Phase 2 OBC in the base case budget and how this is reflected in future pay and non pay costs.

As a PFI, the project incorporates Hard Facilities Management Services of Estates and Maintenance. However, the project does not include Soft Facilities Management services which include catering, cleaning, portering and laundry among other services. Full details of the scope of the contract are contained in Chapter 1 of this FBC.

Background

The New Acute Hospital Project has evolved from the 'Developing Better Services' model for the reform and modernisation of health and social services. This model has been developed to re-design acute services and answer the challenge to provide faster diagnostics and treatment and incorporate new ways of working and a joined-up approach to delivering health and social care services based on clinical networks. The policy background includes;

- Fit for the Future: DHSSPS 1999
- Acute Hospital Review (AHRG), 2001 (The Hayes Report)
- Developing Better Services (DBS) – Modernising Hospitals and Reforming Structures June 2002

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- Planning for Change: WHSSB 2004
- A Healthier Future – A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025
- Investment Strategy for Northern Ireland (2008- 18)

The New Acute Hospital project is re-designing hospital services to offer advanced methods of practice, using the latest technologies, delivered in attractive and well-designed buildings that meet the needs of staff, patients and visitors. This new facilities will be located at Wolf Lough, off the main A32 Irvinestown Road to the north of Enniskillen. The expected completion date is the Summer of 2012. The new hospital will deliver a wide range of services including acute medicine, accident and emergency services, day and elective surgery, paediatrics and older people care services, critical care, imaging and diagnostics and consultant-led maternity services.

Objectives

The Primary Objectives to this FBC are listed below and are linked to the key benefits in Section 8.7 (Benefits Realisation- approach to evaluation process.) within Chapter 8.:

1. Ensuring that services are delivered in a clinically effective and safe manner;
2. Developing and retaining a workforce that enables the delivery of the level of patient activity forecast for the future to the appropriate professional standard and within the agreed affordability ceiling;
3. Delivery of accessible services based on the principles set out in DHSSPS policy and strategies;
4. Provision of sustainable hospital services, reflecting the level of need and complementing other service providers;
5. Establishing a coherent set of services demonstrating value for money, which are financially sustainable and are within agreed levels of affordability; Overarching objectives or guidelines; and
6. Ensuring continuity of care and patient services throughout the development stages of the new service model and minimisation of disruption during the period of development.

Document Structure

This Full Business Case document has been structured as follows:

- Chapter 1 introduces the Project and establishes the Strategic Context. The future cost of both the PFI Project and other costs that the Trust will incur in the delivery of the Project i.e. Non PFI costs are outlined.
- Chapter 2 outlines the Value for Money (VFM) test applied during the procurement process, while Chapter 3 demonstrates affordability and outlines the accounting treatment.

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- Chapter 4 illustrates the range of specifications that have been developed which outline the Trust's Project requirements.
- Chapter 5 highlights the risks which transfer to the Private Sector PFI Provider, and those which remain with the Public Sector and the Trust.
- Chapter 6 outlines the Commercial Structure and contractual arrangements for the Project that are detailed in the Project Agreement.
- Chapter 7 provides a detailed overview of the Competitive Dialogue tendering procedure, which began in 2006 and culminated in Financial Close achieved in May 2009.
- Chapter 8 deals with the Post Project Evaluation Process and outlines how the intended benefits of the investment will be realised.
- Chapter 9 provides an overview of the Management Considerations associated with each phase of the Project through Procurement, Construction, Commissioning, Operation and Contract End.
- Chapter 10 indicates how the FBC meets the requirements of the Department of Finance and Personnel (DFP)
- Chapter 11 provides a succinct conclusion and recommends the full implementation of the Project.

Following approval of this FBC and Financial Close achieved in May 2009, the FBC document was updated to reflect the position at Financial Close. This resulted in the addition of a new Section 1.9.5 (PFI Revenue Costs) of Chapter 1, an updated Chapter 3 (Affordability and Accounting Treatment) and new section 7.6.4 (Activity to Financial Close) within Chapter 7. These updates are highlighted under the subheading 'Position at Financial Close'.

Business Case Approvals

The request to progress to Financial Close is the culmination of a PFI procurement process that commenced with an advertisement in the European Journal in July 2006 and progressed through to the Appointment of the Preferred Bidder; NIHG in August 2008

This FBC builds upon the previous Business Case Approvals:

- 1) The Acute Phase 1A Outline Business Case (OBC);
- 2) The Acute Phase 2A Outline Business Case (OBC); and
- 3) The Appointment Business Case (ABC).

Phase 1A report was submitted in February 2005 and Phase 2A report submitted in March 2006. Following assessment by Department of Health, Social Services and Public Safety (DHSSPS) approval was given to the Trust to commence the procurement in July 2006 and formal approval was granted in September 2006. (Refer to appendices 1.07 & 1.08 for Phase 2 OBC Approvals Letters). An ABC requesting permission to appoint a Preferred Bidder was submitted to the DHSSPS in May 2008 and subsequently approved

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in August 2008. The successful tender, NIHG was appointed as Preferred Bidder for the project.

Acute Phase 1A OBC

The purpose of the previous Acute Phase 1A OBC was three-fold. It presented the strategic context and case for change to obtain Department of Health Social Services and Public Safety (DHSSPS) approval and release of funding by the Department of Finance and Personnel (DFP) to:

1. Secure the option to acquire a site North of Enniskillen for a new acute hospital in the South West;
2. Appoint an Exemplar Design Team (EDT) to take forward the overall sizing, design and development of a new acute hospital facility in order to secure planning permission and a robust build specification for the procurement; and
3. To proceed with the overall development of the full OBC for two new hospitals in the South West in line with DBS.

Acute Phase 2A OBC

The Acute Phase 2A OBC presented the case for the new acute hospital in more detail. It included the strategic context, established the need, the case for change, the project objectives and constraints, the preferred option and site and capital cost detail which was provided by Health Estates. In addition, the Phase 2A OBC more fully considered the value for money and suitability for PFI procurement of the new acute hospital as well as the affordability, project strategy, project and contract management arrangements.

The Phase 2A OBC also facilitated:

- Exercising the option to purchase the hospital site (subject to planning approval);
- Gaining approval to move ahead with enabling site works; and
- Commence the procurement of the new acute hospital and related services under a PFI contract.

Appointment Business Case

The purpose of the ABC was to provide an overview of the procurement process, the results of the final bid evaluation and to recommend a Preferred Bidder that the Trust will then partner with to deliver the New Acute Hospital for the South West. The ABC also provided an update on the key changes since Phase 2A OBC; the most noteworthy elements being the exclusion of Soft FM, the landslip¹ at the site of the new acute hospital and the move to 100% single rooms.

¹ A landslip occurred on 13 September 07 which affected a portion of low-lying land towards the front of the site and is detailed in Section 1.5.1 of this FBC.

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To keep on programme with the Stage 4 timetable the Trust are seeking approval of the FBC in March 2009.

The following sections of this Executive Summary summarise the chapters within this FBC and any changes that have been carried out moving from ABC to FBC. New or revised text has been highlighted in light grey shading throughout each chapter. It is also worth noting that each chapter has been updated to take into consideration responses to DHSSPS / DFP queries that were received on the ABC.

CHAPTER 1: INTRODUCTION / STRATEGIC CONTEXT

This chapter has been updated to reflect the updated affordability position following developments since Phase 2 OBC. A detailed analysis and bottom-up approach to Non PFI costings and full review of budgets was completed for this Full Business Case. The need is confirmed with the presentation of updated population projections.

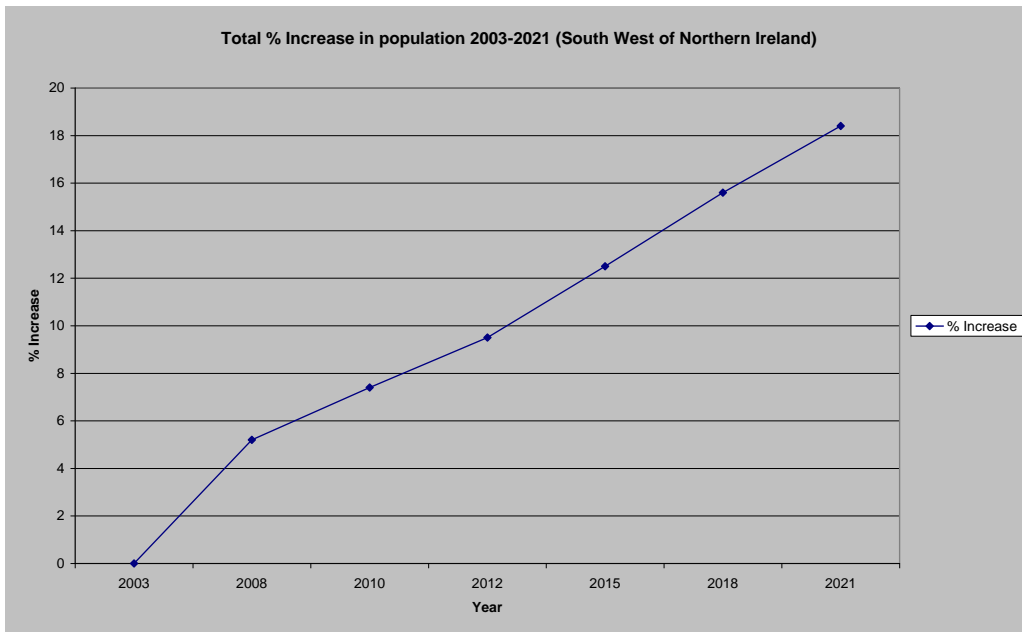
The Introduction / Strategic Context draws on and brings together information from the Outline Business Cases that outline the need for the New Acute Hospital to serve primarily the population of the southwest of Northern Ireland.

This chapter within the FBC deals with the strategic context, confirms the need for the hospital demonstrated in the Acute Phase 2 OBC, illustrates the new Service Model and the underpinning activity assumptions, outlines the key recommendations arising from Acute Phase 2 OBC, and provides an update to incorporate changes that have occurred in the Trust since Acute Phase 2 OBC and ABC that impact on this project. It outlines the opening position required at 2012 in line with activity assumptions, the position at 2015 and finally at 2018 when all 312 beds are projected to be fully utilised.

Population Projections

This chapter now reflects the updated NISRA population projections (2008 published data) to 2021 based on 2006 base population projections as illustrated in the graph overleaf. This reflects an overall increase in the general population by 18.4% from 2003 to 2021. As Graph 1.1 in Chapter 1 of this FBC illustrates, this increase impacts most significantly on older age groups (60 +), who have increasing medical needs. By 2015 there is an increase of this age group by 35.8%, with this trend continuing in line with general population growth as demonstrated in the graph overleaf. There will be a proportionately greater increase in the number of older people in the Southern sector of the Trust by comparison with the Northern sector.

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Source: NISRA Local Government District Home Population 2006–2021 (Published 2008)

2003 Baseline data: NISRA Mid Year Population Estimates (1991 – 2007).

NISRA Population Projections to 2021 apply 2006 based projections.

Efficiency Assumptions

Efficiency assumptions have been updated in line with NISRA population projections (2008 published data) and performance assumptions have been benchmarked against upper quartile performing Trusts in GB (England and Wales). The need for the DBS profile of services for the New Acute Hospital for the South West has been confirmed. The analysis presented in Chapter 1.2.3 of this Full Business Case demonstrates that the new facilities provide the capacity to accommodate the predicted future population growth.

Non PFI Capital Costs

In respect to non PFI capital costs the Trust is identifying funding requirements of approximately £4.7 million for Group 2 and Group 3 non medical equipment. These categories have been explained in Chapter 1 of this FBC.

An ICT Business Case is currently being reviewed by the new Western Health and Social Care Trust in the light of developing a Trust wide ICT Strategy. The Trust will resubmit this ICT OBC in a phased manner with Phase 1 to be submitted in July 2009. This Phase 1 ICT OBC will seek funding for the ICT infrastructure elements that are fundamental to the operation of the new hospital. The estimated capital costs requested for these items is in the region of £1.4 million. This has been fully detailed in Chapter 1 of this FBC.

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Additional Capital costs are outlined in this Chapter 1 in relation to commissioning the new building and decommissioning the Erne site, this is detailed in the subsequent paragraphs.

The Commissioning stage is crucial and guides the project into operation following the construction completion and handover. Detailed plans for the Commissioning Phase will be developed during the construction phase in close liaison with operational and technical staff that form a core part of the Commissioning Team structures. Key outputs for this phase include the Commissioning Master plan, Commissioning Programme, Occupational Procedures, Transition plan including staff training and occupation programmes and Staff and Patient Transfers.

Non-recurring costs associated with the Commissioning Phase of the project are £1.892 million.

Decommissioning issues are also dealt with and a timetable for the disposal of the Erne Hospital Site are based on the following:

Completion of the New Hospital	March 2012
Decommissioning of Erne	March – June 2012
Demolition of Erne	June 2012 – June 2013
Disposal of Erne	2013 / 2014

The estimated costs associated with the decommissioning of the Erne Hospital is £2.6 million against a potential sale cost of £6 million.

Non-PFI Revenue Cost Overview

Based on the updated bed modelling undertaken as part of this FBC, the Trust now outlines a new Acute Hospital opening with 269 beds in 2012, 292 beds in 2015 and 312 beds in 2018. The Non-PFI Revenue costs have been costed accordingly.

A summary of the affordability requirements for all these scenarios can be seen in the subsequent tables:

	Affordability Requirement £000
1.27A – 269 beds reflecting 2012 position	£2,711
1.27B – 292 beds reflecting 2015 position	£3,784
1.27C – 312 beds reflecting 2018 position	£4,485

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Table 1.27A

DBS Revenue Costs	269 Beds			PHASE 2 OBC		
	FULL BUSINESS CASE			PHASE 2 OBC		
	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
£'000	£'000	£'000	£'000	£'000	£'000	
Pay Costs						
Medical	11,676	0	11,676	9,168	(41)	9,127
Clinical Services Manager	0	0	0	88	0	88
Nursing	14,952	805	15,757	14,609	(873)	13,736
AHPS	1,986	247	2,233	3,431	214	3,645
Imaging Department	662	22	684	520	41	561
Scientific & Technical	1,281	(206)	1,075	1,472	(207)	1,265
Admin & Clerical	2,011	0	2,011	1,861	165	2,026
Pharmacy	599	89	688	603	26	629
Agenda for change probable funding	0	0	0	0	0	0
Total pay costs	33,167	957	34,124	31,752	(675)	31,077
Non pay costs						
Facility Management	3,277	255	3,532	5,215	(760)	4,455
Goods & Services	6,407	0	6,407	4,752	278	5,030
Heat, Light & Power	463	910	1,373	327	351	678
Rates & Rent	360	469	829	328	245	573
Contract Management Costs	0	120	120	0	0	0
Total non pay costs	10,507	1,754	12,261	10,622	114	10,736
Total DBS Costs	43,674	2,711	46,385	42,374	(561)	41,813

Table 1.27B

DBS Revenue Costs	292 Beds			PHASE 2 OBC		
	FULL BUSINESS CASE			PHASE 2 OBC		
	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
£'000	£'000	£'000	£'000	£'000	£'000	
Pay Costs						
Medical	11,676	0	11,676	9,168	(41)	9,127
Clinical Services Manager	0	0	0	88	0	88
Nursing	14,952	1,785	16,737	14,609	(873)	13,736
AHPS	1,986	247	2,233	3,431	214	3,645
Imaging Department	662	22	684	520	41	561
Scientific & Technical	1,281	(206)	1,075	1,472	(207)	1,265
Admin & Clerical	2,011	0	2,011	1,861	165	2,026
Pharmacy	599	89	688	603	26	629
Agenda for change probable funding	0	0	0	0	0	0
Total pay costs	33,167	1,937	35,104	31,752	(675)	31,077
Non pay costs						
Facility Management	3,277	348	3,625	5,215	(760)	4,455
Goods & Services	6,407	0	6,407	4,752	278	5,030
Heat, Light & Power	463	910	1,373	327	351	678
Rates & Rent	360	469	829	328	245	573
Contract Management Costs	0	120	120	0	0	0
Total non pay costs	10,507	1,847	12,354	10,622	114	10,736
Total DBS Costs	43,674	3,784	47,458	42,374	(561)	41,813

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Explanation for Cost Increase of Affordability from 269 beds to 292 beds.

The increase in affordability from 269 beds to 292 beds is £1,073K (£3,784K - Table 1.27B and £2,711K - Table 1.27A).

This reflects an increase in nursing costs of £980K, associated with an additional 23 beds and 30 nurses, and an additional £93K associated with Facilities Management for these 23 beds.

Table 1.27C

DBS Revenue Costs	Adjusted 312 Beds FULL BUSINESS CASE			PHASE 2 OBC		
	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
	£'000	£'000	£'000	£'000	£'000	£'000
Pay Costs						
Medical	11,676	0	11,676	9,168	(41)	9,127
Clinical Services Manager	0	0	0	88	0	88
Nursing	14,952	2,458	17,410	14,609	(873)	13,736
AHPS	1,986	247	2,233	3,431	214	3,645
Imaging Department	662	22	684	520	41	561
Scientific & Technical	1,281	(206)	1,075	1,472	(207)	1,265
Admin & Clerical	2,011	0	2,011	1,861	165	2,026
Pharmacy	599	89	688	603	26	629
Agenda for change probable funding	0	0	0	0	0	0
Total pay costs	33,167	2,610	35,777	31,752	(675)	31,077
Non pay costs						
Facility Management	3,277	376	3,653	5,215	(760)	4,455
Goods & Services	6,407	0	6,407	4,752	278	5,030
Heat, Light & Power	463	910	1,373	327	351	678
Rates & Rent	360	469	829	328	245	573
Contract Management Costs	0	120	120	0		0
Total non pay costs	10,507	1,875	12,382	10,622	114	10,736
Total DBS Costs	43,674	4,485	48,158	42,374	(561)	41,813

Explanation for Cost Increase of Affordability from 292 beds to 312 beds

The increase in affordability from 292 beds to 312 beds is £701K (£4,485K - Table 1.27C and £3,784K - Table 1.27B).

This reflects an increase in nursing costs of £673K, associated with an additional 20 beds and 20 nurses and an additional £28K associated with Facilities Management for these 20 beds.

These tables also include the affordability requirements at Phase 2 OBC, which showed a saving of (£561K).

For each of these scenarios a thorough re-examination of workforce plans was undertaken with Assistant Directors and Managers.

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A detailed budget allocation exercise has been undertaken for all Southern Sector budgets to inform this exercise.

As Table 1.27A illustrates, the affordability requirements on opening the Hospital in 2012 with 269 beds is £2,711K, of which £957K relates to pay costs over current budgets and £1,754K which relates to non-pay costs over current budgets.

The key elements of the movements for the opening position at 2012 are as outlined in the Table below:

Non-PFI Revenue: Affordability Acute Phase 2 OBC to FBC

	£000
Net Annual Acute Phase 2 OBC Revenue Savings	(561)
Affordability gap increases:	
Nursing	1,678
Facilities Management	1,015
Heat, Light and Power	559
Rent and Rates	224
Contract Management	120
Affordability gap reductions:	
Admin and Clerical	(165)
Goods and Services	(278)
Other	119
FBC Affordability Gap: Opening Position	2,711

This £2,711K affordability gap over current budgets compares with an affordability gap at Phase 2 OBC stage of (£561K).

Overall affordability has moved from (£561K) to £2,711K, an increase of £3,272K.

The key drivers for the cost movements for the opening position at 2012 are as outlined in the Table below:

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Non PFI Cost Movements: Acute Phase 2 OBC to FBC

	£000	£000
Non Pay Cost increases:		
Facilities Management	1,015	
Heat, Light and Power	559	
Rent and Rates	224	
Contract Management	120	
Non Pay Costs decreases:		
Goods and Services Savings	(278)	
Net increase in Non-Pay costs		1,640
Pay Costs increases:		
CSR Cash Releasing (since Acute Phase 2 OBC)	3,213	
Nett nursing budgets transferred from Acute Hospital since Acute Phase 2 OBC	322	
Pay Costs decreases:		
Nursing Costs of 43 beds not opened (312 beds at OBC –269 beds at FBC opening)	(1,653)	
Contribution from TCH Transition Plan to Affordability	(182)	
Other	(68)	1,632
Total		3,272

Acute Phase 2 OBC Affordability Assumptions

The Acute Phase 2 OBC net savings were heavily reliant on Facilities Management Savings (based on an integrated hard and soft FM service delivery model) and Nursing Savings. The original saving estimates are not now considered possible.

The Acute Phase 2 OBC assumed significant savings in nursing costs by applying enhanced working efficiencies and the development of new roles. These savings have now been included as part of Trust's Comprehensive Spending Review (CSR) initiatives and attendant budgets are not now available, as a saving contribution to the FBC.

FBC Affordability Drivers

Pay Costs

Pay costs affordability gaps from Acute Phase 2 OBC have increased by £1,632K, which is the difference between (£675K) affordability saving at Acute Phase 2 OBC and an FBC affordability gap of £957K.

The principle cost drivers are:

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	Description	£000
1	The impact of releasing budgets, originally available at OBC, towards Comprehensive Spending Review proposals.	3,213
2	Nursing savings, from not opening full compliment of beds at opening. 312 beds at OBC less 269 at FBC equals 43 beds, which equates to 50 nurses at an average nursing cost of £33K per annum.	(1,653)
3	Other cost increases.	72
	Total	1,632

Non-Pay Costs

Non-Pay costs affordability gap from Acute Phase 2 OBC has increased by £1,640K, which is the difference between £114K affordability gap at Acute Phase 2 OBC and an FBC affordability gap of £1,754K.

The principle cost drivers are:

	Description	£000	£000
1.	<p>Energy</p> <p>This cost is based on a revised method of calculation developed by the Trusts professional advisers in conjunction with Health Estates Agency (HEA) for the evaluation of Final Tenders in 2008. The cost is based on the exemplar design for the New Acute Hospital and represents the target to be achieved by the Preferred Bidder.</p> <p>Cost Shifts have resulted for three core factors:</p> <ul style="list-style-type: none"> • Application of an updated method of calculation reflecting the energy requirements for a modern Acute Hospital, following advice from HEA; • Increased energy costs; and • Increase in the metres squared to applied areas requiring energy from 55,855m² – 58,788m², following advice from HEA. 		559
2.	<p>Rates</p> <p>These costs have increased from Phase 2 OBC stage due to an increase in cost per m² by £1.45 per m² to £11.70 per m².</p> <p>The application of a higher metres squared figure at FBC (55,855m² to 70,800m²). This reflects the change from nett floor area to gross floor area following advice from Land and Property Services (LPS).</p>		224

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	Description	£000	£000
3.	Contract Management The creation of a PFI Contract Management Team of £120K, following National Audit Office (NAO) and Northern Ireland Audit Office (NIAO) advice regarding same.		120
4.	Facilities Management		
	Diseconomies of Scale/Enhanced Requirements <ul style="list-style-type: none"> • Removal of economies of scale from Acute Phase 2 OBC associated with: • Separation of Hard/Soft FM; and • Loss of economies from cross site / multi skilling; Enhanced requirements including: <ul style="list-style-type: none"> • Cleaning associated with a Ministerial decision regarding 100% single room occupancy; • Cleaning associated with infection control requirements; • Onsite laundry on direction from Regional Advisor; • Enhanced Catering via increased ward level satellite kitchens. 	1,018	
	Facilities Management Budget variance - Acute Phase 2 OBC to FBC <ul style="list-style-type: none"> • A number of budgets included at Acute Phase 2 OBC could not be reconciled back to 05/06 budgets. • A number of budgets included in Acute Phase 2 OBC were subsequently not available at FBC, since these related specifically to community services. 	122 271	
	Transport and Logistics A reduction in investment in transport and logistics, which was assumed at Acute Phase 2 OBC.	(396)	1,015
5.	Goods and Services A reduction in planned Goods and Services expenditure since Acute Phase 2 OBC to reflect efficiency drives of CSR.		(278)
	Grand Total		1,640

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Non Recurring Revenue Costs & Other Funding Considerations

The Trust has identified non recurrent non-PFI costs associated with the impact of and a shuttle bus service from Enniskillen bus depot to the new hospital (£56 k per annum for 2 years).

Finally, consideration is given to other requirements from the Commissioner i.e. service developments.

Summary of Non PFI Costs

	£K	Comments	Notes
Non-PFI Costs			
Capital Costs			
Commissioning Costs	1,892	Based on current estimates	Costs required to transfer services from existing facilities and bring the New Acute Hospital into full operation. This included commissioning team costs, staff training, and logistics.
Decommissioning costs (nett of disposal proceeds)	(3,400)	Based on current estimates	The cost associated with the sale and disposal of existing Erne Hospital site.
Non-Medical Equipment	4,794	At 08/09 prices	Group 2 and 3 equipment including fixtures and fittings required to bring the new hospital into use.
Total Capital	3,286		
Recurring Revenue Costs			
Non-PFI Revenue Costs	2,711	Opening position 269 beds at 08/09 prices	Revenue consequences that remain with the Trust and are outside the PFI contract. This includes Pay Costs and Non-Pay Costs of Goods and Services, Soft Facilities Management, Energy, Rates and Contract Management.
Non Recurring Revenue Costs			
Shuttle bus service	56	For 2 years at 08/09 prices	Extension of current Enniskillen Town bus service to transfer staff, patients and visitors from the Enniskillen Bus Depot to the site of the New Acute Hospital.

PFI Revenue Costs

Pre-Financial Close Position

The indicative Unitary Payment of £13,385k reflects the bidders inclusion of a club of four banks to optimise the delivery of funding. This figure reflects their specific funding terms and current market conditions. This Unitary Payment figure shall remain indicative up the point of Financial Close. The terms are subject to market conditions at the point of closure and to final credit committee approval anticipated in early March 2009. This Unitary Charge also reflects the benefit of including the European Investment Bank's (EIB) contribution to funding. This is a result of the inclusion of the Mandatory

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Variant, European Investment Banks (EIB) funding contribution, submitted at final tender.

Mandatory Variant – EIB

The EIB has confirmed that it is committed to providing 50% of the senior debt funding. This variant presents a much more competitive rate than commercial lenders, who are pricing at levels significantly higher than seen in recent years, due to the current difficulties in the international infrastructure financial markets.

The club of banks and the EIB are finalising any outstanding requirements in order to have a full integrated funding package well in advance of the projected financial close date.

EIB terms remain more competitive than the commercial lenders, as would be expected, though they have also worsened since the submission of the final bids and the selection of the preferred bidder.

In running the most recent version of the Unitary Payment model, the effects of the inclusion of the EIB have been separately identified. These effects include the margins and debt tail indicated in the section above, but also includes the additional legal costs associated with their inclusion. The impact is summarised in the table below, with additional detail provided in Chapter 7 of this FBC.

Impact of EIB on the Unitary Payment

	£'000
Indicative Unitary Payment (real terms) excl the EIB	13,813
Impact of all EIB changes	(428)
Revised Unitary Payment	13,385

The indicative figures shows that it is clearly beneficial in terms of reduction of the Unitary Payment to include the EIB, and that this delivers much better Value for Money for the Trust. This figure also takes account of any savings in the first three years of operation based on the profiled bed numbers.

Position at Financial Close

Unitary Payment at Financial Close	£'000
Unitary Payment	13,831

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The unitary charge achieved at Financial Close was £13,831k. This was based on the funding terms outlined in Chapter 7 of this FBC which were subject to independent verification. The terms were based on a funding package based on a contribution from the European Investment Bank approaching 50%, with NordLB, Bank of Ireland (Corporate Banking) and Barclays Bank combining to provide the remaining 50%. The impact of including EIB was to reduce the Unitary charge by approximately £600k.

CHAPTER 2 - PFI VALUE FOR MONEY TEST

There have been some minor changes to the content of Chapter 2.

The aim of this assessment (equivalent to the Stage 3 assessment in the HMT Guidance), which runs continuously from the issue of the OJEU notice to contract award, is to ensure that both procuring authorities and sponsoring departments are fully appraised of market conditions and can identify any market problems early on in the procurement process, in order to effectively evaluate whether there is any erosion of Value for Money (VfM).

Areas considered throughout Stage 3 were:

- **Quality of Competition;**
The quality of the competition was good with four Bidders being taken to Competitive Dialogue, with one de-selected at Stage 2A. These 3 Bidders were retained to submission of final bids following which a preferred bidder was selected.
- **Risk Sharing;**
The risk transfer included in the Project Agreement is the NI version of the standard form agreement and transfers all the usual risks.
- **Stability of Costs;**
Costs have been reviewed during the procurement process as a result of the following decisions:
 - Removal of soft FM from the Core Bid;
 - Reductions in the size of key worker accommodation;
 - A landslip occurring during the enabling works programme which resulted in the remedial works being included in the scope of the PFI project;
 - Adjustments to MIPS and risk as more information became available;
 - An updated assessment of the revenue consequences of running the new facility, which took into account the CSR efficiency programme currently underway in the Trust.

A full explanation of these adjustments is included in Chapter 1, and a rerun of the Treasury's quantitative VfM test at ABC confirmed that the project continued to demonstrate value for money.

- **Financial Flexibility;**
The preferred Bidder's funding package is a debt funding structure with a "club" of banks providing half of the funding requirement, with EIB providing the required funding for the other half. This is a change from the funding solution initially proposed and is in response to the current volatility in the global financial

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infrastructure markets. It is not anticipated that there will be any significant changes prior to financial close.

- **Financial Structures;**

There are three specific areas where the financial structures of the project could have an impact on flexibility: Contract Variations; Refinancing; and Authority Voluntary Termination. Each of these areas are covered in the Project Agreement.

- **Contractor Distress.**

All Bidders were assessed at PQQ stage in terms of their financial robustness. There have been no changes to the consortia throughout the procurement process with the exception of the removal of soft FM providers.

The Trust considers that Value for Money has been maintained throughout the procurement process up to the date of this Full Business Case. This will mitigate some of the inherent difficulty (that could arise due to possible future changes in the funding markets) in generating and maintaining Value for Money in the selected funding package.

The Trust will ensure that there is no weakening of the position achieved to date regarding VFM as they move towards financial close.

CHAPTER 3 - AFFORDABILITY AND ACCOUNTING TREATMENT

This entire content of this chapter has been updated in line with the PFI and Non PFI Revenue Costs in Chapter 1 of this FBC.

Furthermore, following the approval of this FBC on the 18th May 2009, this chapter was updated to reflect the final Unitary Charge achieved at Financial Close. This analysis is therefore based on the information obtained from the Financial Model for the new Acute Hospital produced at Financial Close.

An Accounting View for the project has been prepared by the Trust's Full Business Case Advisors, Deloitte. This concludes that under FRS5 Note F as interpreted by TTF TN1, the Western HSC Trust should account for the underlying assets of the Acute Hospital at Enniskillen on balance sheet. Details are shown in Chapter 3, Section 3.1.

The Trust has sought the Accounting View of the Northern Ireland Audit Office (NIAO) and its external auditors on the accounting treatment. NIAO has concluded that as guided by SSAP21, FRS5 (particularly Application Note F), Treasury Taskforce Technical Note 1 and other Treasury and DFP guidance the assets should be accounted for as on balance sheet.

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The Trust shall prepare its 2009/10 accounts applying International Financial Reporting Standards (IFRS). At this point the balance sheet treatment of this PFI scheme will be revisited. This process shall be implemented with the full engagement of the Trust's external auditors.

An analysis of the capital and revenue consequences of the PFI contract is included in Table 3.2 and the resultant affordability gap in Table 3.6. The remodelled Unitary Charge at £13.8 million is still within the target Unitary Charge of £15.2 million set in 2007.

As a result of the On-Balance Sheet accounting treatment, there will be a net increase in capital charges of approximately £7.1m per annum in 2012/13 and 2013/14, reducing to £4.9m in 2014/15 when existing capital charges from the Erne Hospital become available for set off. In addition, capital DEL of £223.9m is required in May 2012, together with a one off cash payment of £100.4m.

Near cash costs (finance lease interest, lifecycle costs, hard FM and SPV running costs) show a net increase of £14.3m in 2013/14 (first full year of the project), together with additional non-PFI running costs of £3.1m. Additional costs for commissioning, decommissioning, non medical equipment and the cost of providing a shuttle bus are also outlined.

An analysis of the impact on the income and expenditure account and balance sheet of the Trust is included in Chapter 3, Tables 3.7 and 3.8.

CHAPTER 4 - DETAILED OUTPUT SPECIFICATIONS

Moving this chapter from ABC to FBC there have been no changes to the content of this chapter. However, there have been minor changes to appendix 4.00 (PEL list has been updated) and the Clinical Output Specifications (Minor changes & revised Schedules of Accommodation (SOA's) have been inserted).

Clinical, Facilities Management and Construction specifications were developed by Trust staff, Health Estates and Trust Advisors. They were developed against best practice guidance, Health Technical Memorandums, Health Building Notes, Royal College Guidance, Infection control advice and National Patient Safety guidance.

The specification defined the scope and objectives of the service to be provided and the standards that the Trust required from the Consortia.

Chapter 4 provides further details on these specifications.

CHAPTER 5 - RISK ALLOCATION

Moving this chapter from ABC to FBC there have been minor grammar changes. The overall content remains the same.

A summary of how risks have been allocated between the public and private sector through the Project Agreement is included in Chapter 5. This considers risk allocation in the following areas:

- Design;
- Construction and development;
- Performance;
- Operating costs;
- Variability of revenue;
- Termination
- Technology and obsolescence
- Control
- Residual value
- Other project risks

A more detailed and accurate breakdown of the risks and how these are apportioned is contained in Chapter 5.

CHAPTER 6 - COMMERCIAL STRUCTURE

Moving this chapter from ABC to FBC there have been minor grammar changes and rearrangement of sections. Referencing to sections within this document has also been revised. The overall content of this chapter remains the same.

Chapter 6 provides a summary of the commercial structure of the deal. The South West Acute Hospital Draft Project Agreement and forty schedules are based on the form of agreement proposed by the Strategic Investment Board (SIB) for use in health projects in Northern Ireland. The SIB in effect are keepers of the Project Agreement having published it on behalf of DHSSPS. The Trust's PFI Legal advisors L'Estrange & Brett have been in constant contact with the SIB's Lawyer and agreed the very few derogations from the standard form necessary to ensure that Project-specific issues are adequately addressed.

A summary of the key terms and conditions is provided in Chapter 6 covering the following matters:

- The Planning and Development Phase

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- Contract Change and Contract Completion
- Relief and Delay
- Provision of Services
- Payment, Insurance and Other Financial Matters
- Other Sundry Matters

During the course of the dialogue, one of the bidders raised a concern regarding the vires of the trust to construct a new hospital on a new site. This matter was discussed with amongst others, the SIB and the Departmental Solicitor's Office (DSO). Although it has never been raised by the other two bidders (including the PB), it was agreed that as the legislation was in the process of being amended following the Review of Public Administration (RPA), this matter could be dealt with at the same time. The SIB has been liaising with DSO in this regard and has confirmed that the legislation will shortly be in place that will address any perceived concern.

An amendment has been forwarded by the Department of Health, Social Services and Public Safety relating to Article 3 (2)(a) of the Western Health and Social Services Trust (Establishment) Order (Northern Ireland) 2006. This amendment will ensure that there is no legal reason why the Department cannot issue a Vires Certificate under the Health and Personal Social Services (Private Finance) (Northern Ireland) Order 1997 for the Trust to provide new hospital accommodation and services from a new site. This will bring the legislation into line with the equivalent legislation in GB. As this is a regional issue, the Strategic Investment Board has been liaising with the Departmental Legal advisers relating to this. A recent update suggests that this amendment should become law by the end of 2008.

CHAPTER 7 - OVERVIEW OF THE TENDERING PROCESS

Moving this Chapter from ABC to FBC a new section 'Stage 4 finalisation' has been inserted. There have also been minor changes to the overall content of this chapter to take into consideration responses to DHSSPS / DFP queries.

The New Acute Hospital for the South West is being procured in accordance with HM Treasury guidance under the Private Finance Initiative (PFI) and utilising the Competitive Dialogue procurement procedure. Competitive Dialogue was introduced into England, Wales and Northern Ireland by the Public Contracts Regulations 2006 and has been mandatory from 31 January 2006 for major complex projects of this nature and where discussion of the requirement is needed to develop final specifications. This is a procedure whereby the contracting authority conducts dialogue with bidders, with the aim of developing one or more suitable alternatives capable of meeting its requirements.

A key aspect of Competitive Dialogue is that all key issues are addressed during the dialogue as the regulations do not permit the re-opening of issues after the Closure of Dialogue. This is the core difference between Competitive Dialogue and its predecessor,

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the Negotiated Procedure. Therefore it was essential that the project progressed to a level of detail where commercial certainty would be reached on all key aspects prior to Closure of Dialogue.

There are four key stages as outlined in the diagram overleaf, which is accompanied by the procurement timeline.

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Procurement Stages & Key dates

Stage	Activity	Date
Stage 1 Pre- Qualification	OJEU Notice	Jul 06
	Pre-Qualification Questionnaire/ Selection	Aug 06
Stage 2 Competitive Dialogue	2A: Strategic Approach	Oct 06
	Invitation to Participate in Dialogue (IPID) issued	Nov 06
	2B: Design Concept Proposals	Nov 06
	2C: Firm Design Proposals	Feb 07
	2D: Total Package Proposals	Apr 07
	Closure of Dialogue	Feb 08
Stage 3 Bid Evaluation	Invitation to Submit Final Bid (IFB) issued	Feb 08
	Final Tenders	Feb 08
	Select Preferred Bidder	May 08
Stage 4 Finalisation	Appoint Preferred Bidder	Sept 08
	Full Planning Approval required	Dec 08
	Submit Full Business Case	Dec 08
	End of Judicial Review Period (Planning)	Mar 09
	Financial Close	Mar 09

Details on Stages 1 to 3 of the procurement process are described in detail within Chapter 7 of this FBC.

Stage 4: Finalisation

Stage 4 of the procurement process involves four key steps, the first of which is the appointment of the Preferred Bidder. The Preferred Bidder appointment followed receipt of DHSSPS approval of the recommendations outlined in the Appointment Business Case and the signing of the Preferred Bidder letter by the selected tenderer. The Preferred Bidder letter outlines the requirements that the Trust wishes to impose on the Preferred Bidder as a result of the tender evaluation process.

The second element of finalisation is receipt of Full Planning Approval, which was received on 23rd December 2008 . Three months have been factored into the finalisation timetable to allow for the statutory judicial review period.

Part three of Finalisation is the development and approval of this Full Business Case. Following WHSSB and Trust Board approval, the Full Business Case shall then be submitted to the Department of Health, Social Services and Public Safety for approval.

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The final part of the Finalisation process is Financial Close, which is the signing of the contract documentation.

Impact of Global Market Conditions

The programme and processes of achieving Financial Close was impacted by the Global Market Conditions, in evidence at the time, as explained in the subsequent paragraphs.

As a result of the changing global Market conditions which has resulted in banks significantly reducing their lending to each other because they were uncertain about how much liquidity they had and how much exposure other financial institutions had to low quality loans. The impact on the project was threefold, the bidders original funder (HSBC) announced that they would be unable to underwrite the whole the required funding. Secondly, they were unable to provide the funding rates quoted in their final tender and finally banks were not prepared to hold their offered terms for longer than a matter of weeks.

Subsequently HSBC's announced that they would be unable to act as structuring bank or to participate in the funding club.

The Trust, Health Estates, Project Advisers and SIB have been working with NIHG and its advisers through this period, between their appointment and financial close, in order to provide a funding package which delivers the maximum possible benefit to the Trust, whilst remaining achievable in the current volatile market. NIHG have now presented the Trust with a solution, demonstrating that this will be best achieved through the creation of a club or panel of banks to provide the funding, each providing a portion of the debt on an equal basis, alongside a 50% funding commitment from the EIB.

The process for creating the club is designed to optimise the deliverability of the funding in an ever contracting market whilst at the same time managing the value for money of the funding in light of the current market.

The Trust, the SIB and the Trust's advisers are monitoring, and will continue to monitor up to financial close, the terms resulting from the formation of the club of banks, particularly in light of the terms currently being offered across the PFI market in the United Kingdom as a whole, whether in health or in other sectors.

Position at Financial Close

Financial Close was achieved on 20th May 2009 with a Unitary Payment of £13,831k reflecting the market rates at the point of closure as agreed, checked and verified by a process of independent verification. Through this process, the Trust, supported by the SIB and professional advisers, continually monitored the terms resulting from the formation of the club of banks up to Financial Close

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The Unitary Payment reflected a funding package for the New Acute Hospital for the South West based on a contribution from the European Investment Bank approaching 50%, with corporate banks of NordLB, Bank of Ireland (Corporate Banking) and Barclays Bank combining to provide the remaining 50%.

Following a detailed verification and authorisation process, the Project Agreement contractual documentation was signed at Financial Close.

CHAPTER 8 - POST PROJECT EVALUATION & BENEFITS REALISATION

This chapter has been updated to append a section on the Post Project Evaluation (PPE). The Benefits Realisation section has been updated to highlight that the Benefits Realisation Plan (BRP) that will form part of the Trusts Performance Management and will be endorsed by the Assistant Director of Performance Management, Directorate Business Managers and New Acute Hospital for South West's project team.

Appendix 8.09B has been updated, by adding three socio-economic benefits and updating benefits to reflect best practice guides which are over and above Trust standards.

Both the PPE and the BRP will continue throughout the life of the project, collecting lessons learnt on each stage to determine whether the project has achieved its objectives, as well as ensuring accurate measurements are captured for all project Benefits.

Post Project Evaluation

Post-project evaluation is a mandatory requirement on all Trusts who are undertaking a projects of this scope and scale.

The Trust is committed to ensuring that a thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from other local recent Healthcare projects e.g. Altnagelvin Labs & pharmacies PFI.

Key stages identified as applicable to this project are:

- Evaluation of the project procurement stage
- Evaluation of the various processes put in place during implementation
- Evaluation of the project in use shortly after the new unit is opened
- Evaluation of the project once the new unit is well established

The detailed plans for evaluation at each of these 4 stages will be drawn up by the Trust in consultation with its key stakeholders. Chapter 9 will also set out how these arrangements will be managed, how information will be disseminated and in what timescale.

Benefits Realisation

Following the completion of the hospital, it will be essential to assess the effectiveness of the project by carrying out a Project Benefit Evaluation. The main objective of this evaluation will be to assess the benefits that are being, or have been, derived from the project, compared with those that were envisaged.

Benefit Realisation Management is an ongoing process that will continue throughout the life of the project.

The BRM process has four main stages:

- identifying and modelling the benefits;
- planning the benefits;
- executing the Benefits Realisation Plan; and
- evaluating the benefits achieved.

A draft benefits Realisation Plan has been included in Chapter 8 of this FBC, with associated benefit map and profiles at Appendix 8.09B respectively. The Benefits Realisation Plan is a live document that will be reviewed and updated throughout the life of the project.

CHAPTER 9 - MANAGEMENT CONSIDERATIONS

This following sections within this chapter have been inserted / updated in response to DHSSPS / DFP queries & concerns:

- | | |
|------------------------|--|
| <i>- Section 9.2:</i> | <i>Updated to outline the steps and structures to manage the Stage 4 – Finalisation.</i> |
| <i>- Section 9.3:</i> | <i>Role of the independent tester has been updated.</i> |
| <i>- Section 9.4:</i> | <i>Commissioning section inserted.</i> |
| <i>- Section 9.5:</i> | <i>Decommissioning section inserted.</i> |
| <i>- Section 9.8:</i> | <i>Section has been updated and independent tester summary inserted.</i> |
| <i>- Section 9.10:</i> | <i>Project timetable has been updated to reflect the Stage 4 Programme.</i> |
| <i>- Section 9.11:</i> | <i>Vires update inserted.</i> |
| <i>- Section 9.12:</i> | <i>EQIA update inserted</i> |
| <i>- Section 9.13:</i> | <i>Programme for Managed Equipment Service OBC inserted.</i> |

There are 4 key phases in PFI; Procurement, Construction, Operation and Contract End. Each of these phases requires different management considerations and activities to be undertaken, and a description of the principle activities that have been and will be undertaken during each phase is presented in Chapter 9 of this FBC.

This Chapter details the plans that the Western Health & Social Care Trust has developed to take forward the commissioning & decommissioning phases of the project.

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Commissioning is the crucial phase that guides the project into operation and follows the construction completion and handover. This is fully detailed within this Chapter of the FBC and the associated Commissioning Costs have been detailed in Chapter 1 of this FBC.

In terms of decommissioning the opening of the New Acute Hospital for the South West will see the transfer of Trust services from the existing Erne Hospital site. The vast majority of services will transfer to the site of the New Hospital, with some retained estates and community services to be delivered from existing satellite locations in the area. Following handover and occupation, the Erne Hospital site will be decommissioned. The site will be vacated and prepared for disposal working to a target date of 31st May 2013. This has been discussed in more detail in this Chapter and the costs associated with the decommissioning of the Erne Hospital Site have been detailed in Chapter 1 of this FBC.

For this FBC a summary has been inserted in relation to the Independent Tester. The Independent Tester shall be a joint appointment between the Trust and Project Co.

For this FBC, an Equality Impact Assessment update has been provided on the Equality Screening exercise of the proposed FM Service Delivery Model that was carried out in 2007, and which will be updated during Stage 4 of the procurement process to Financial Close. The removal of Soft FM services from the scope of the procurement has lessened the impact of the project on staff.

The statutory process is also outlined with reference to the Establishment Order for the new WHSCT. The Establishment Order provides detail on the Review of Public Administration (RPA), Establishment and Nature, Functions and Externally Financed Direct Agreements (EFDA).

There are currently a number of other initiatives that will impact the New Acute Hospital. These include the following:

- ***The Omagh Hospital Complex (£190 million)*** - The delivery of the service model is dependent on the Omagh Hospital Project being operational as soon as possible after the new Acute Hospital to prevent diseconomies of scale in running costs, staff transfer, complexities and clinical risks;
- ***Development of ICT (£1.4 million)*** - The ICT approval of the capital expenditure is vital to the commissioning and operation of the new facility; and
- ***The Outline Business Case for Managed Equipment Services (MES) (with a Unitary Charge of £4.8 million (combined total for Acute and Omagh) and a capital value of £33.8m for acute and £11.7m for Omagh over a 15 year contract))*** – The approval of this Business Case is key for service delivery and function of the new facility.

Chapter 9 covers these dependencies in further detail.

CHAPTER 10 - CHECK LIST AGAINST DFP FBC REQUIREMENTS

There have been no changes to this chapter moving from ABC to FBC.

Chapter 10 provides a reference against the FBC requirements as per Annex 1 of DAO DFP 02/07.

CHAPTER 11 - CONCLUSIONS AND RECOMMENDATIONS

This chapter has been updated to recommend that the project is brought to Financial Close and a thirty year contract is signed with Preferred Bidder Northern Ireland Health Group.

The DHSSPS approval of this Full Business Case, received on 18th May 2009 and the signing of the contract at Financial Close on 20th May 2009 will result in the construction of the new facilities as per agreed specifications and latest accommodation standards for healthcare facilities with the facilities planned to open in 2012. The contract establishes the unitary charge for the operation of the new hospital at £13,831k (1/04/07 prices), which is within the affordability target. This unitary charge figure reflects the inclusion of the EIB variant which has been demonstrated as Value for Money for the Trust in Chapter 3 of this Full Business Case.

1. INTRODUCTION / STRATEGIC CONTEXT

1.1. INTRODUCTION

This FBC has been prepared by the WHSCT and presents the case for the Trust to progress to Financial Close with the Preferred Bidder; NIHG. The approval by the DHSSPS to appoint NIHG as Preferred Bidder was granted by the ABC in August 2008. The FBC also builds on the former Stage 1 and 2 Outline Business Cases (OBC's) for provision of acute hospital services in the South West of Northern Ireland previously submitted to the DHSSPS which have been agreed with Commissioners and DHSSPS.

This chapter deals with the strategic context, confirms the need for the hospital demonstrated in the Acute Phase 2 OBC, illustrates the new Service Model and the underpinning activity assumptions, outlines the key recommendations arising from Acute Phase 2 OBC, and provides an update to incorporate changes that have occurred in the Trust since Acute Phase 2 OBC and ABC that impact on this project.

This document fully outlines the future revenue costs with a bottom up approach taken to project future pay and non pay costs. It takes account of Base Budget movements, Comprehensive Spending Review (CSR), RPA administration savings, and TCH investment plan. It analyses the changes since Acute Phase 2 OBC in the base case budgets and how this is reflected in future costs.

This chapter outlines the revenue costs associated with an opening position in June 2012 of 269 beds moving in 2015 to 292 beds and 2018 to the full bed compliment of 312 beds.

Additional capital costs are outlined in relation to commissioning the new building and decommissioning the Erne site. Non Medical equipment costs have been updated.

Consideration is given to other funding considerations and to non recurring revenue costs in relation to transport and other requirements from the Commissioner i.e. service developments.

A glossary of terms can be referenced in appendix 1.01A.

1.1.1. Changes to Trust Structure (April 2007)

The Review of Public Administration (RPA) commissioned by the Office of First Minister and Deputy First Minister in 2001, proposed a number of changes to the structure of the public sector in Northern Ireland. Recommendation arising from this review were approved by the Minister in 2007, implementation of which saw the 19 existing Health and Social Services Trusts reducing to 6, with the establishment of 5 new

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integrated Health and Social Care Trusts. The Northern Ireland Ambulance Service Trust remained as is.

As part of this, the Sperrin Lakeland Health and Social Care Trust (SLT), became part of the larger Western Health and Social Care Trust (WHSCT), that also incorporated the former Altnagelvin Area and Foyle Community Trusts. The new Trust was established on 1 August 2006 pursuant to The Western Health and Social Care Trust (Establishment) Order (Northern Ireland) 2006² and became operational on 1 April 2007³. The Order makes provision for the functions of the Trust both before and after its operational date.

It will be the WHSCT, which enters into the Project Agreement with the Preferred Bidder (Project Co).

The structure of the new Trust is shown in Figure 1.1 below:

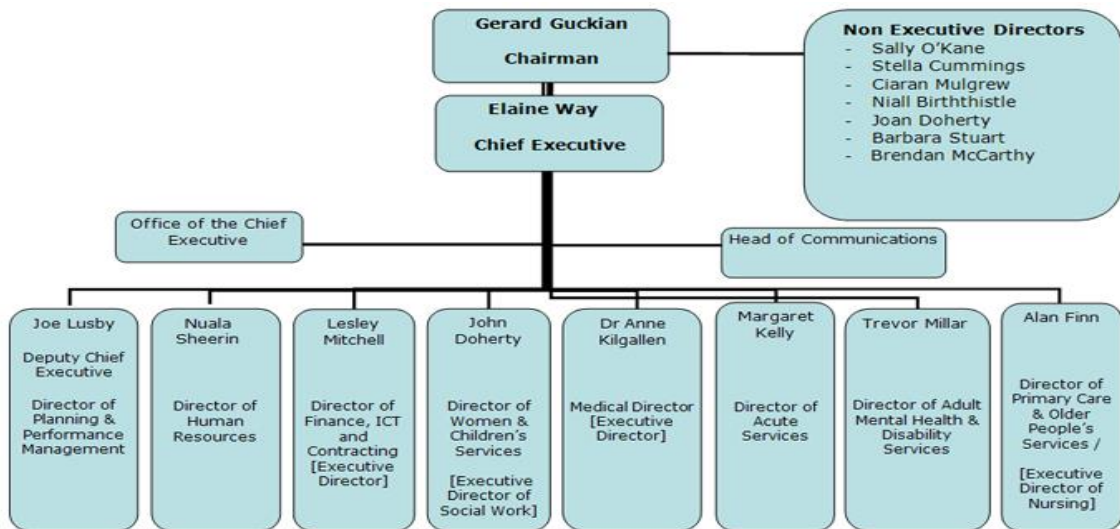


Figure 1.1 Structure of the Western Health & Social Care Trust (October 2008)

Responsibilities for the project to provide the New Acute Hospital for the South West (NI) fall within the Planning and Performance Management Directorate, with the Trust's Deputy Chief Executive, Mr Joe Lusby, the project's Senior Responsible Owner.

² Statutory Rule 2006 No. 296

³ Article 6

1.2. ASSESSMENT OF NEED AT ACUTE PHASE 2 OBC

1.2.1. Overview

In the Acute Phase 2 OBC the Strategic Context and the drivers for change were acknowledged and account provided to regional policy for the future delivery of health and social care services in NI and more specifically in the South West. A summary of this policy context is included in Table 1.1 overleaf.

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Table 1.1 Summary of the Policy Context from Acute Phase 2 OBC

Strategic / Policy Context	Implications
<p><i>A Healthier Future – A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025</i></p> <p><i>Fit for the Future – Proposals for the Future of the HPSS in NI, 1999</i></p>	<ul style="list-style-type: none"> • As well as setting out the rationale for reductions in the number of acute hospitals in Northern Ireland, these policies highlighted a number of key issues and themes of great relevance to especially smaller sized acute hospitals such as the New Acute Hospital for the South West, including: <ul style="list-style-type: none"> - The move towards clinical networks based on partnerships and a team approach, and co-ordination of the delivery of services at various levels from the home to regional hospitals; - The pressures in the area of medical manpower and retaining training accreditation, and the effect that this will have of perhaps concentrating training opportunities in larger hospitals with a knock-on effect on service delivery. The move to increased specialisation is also highlighted; - The important future role of specialist nurses, although there are recognised pressures in relation to accessing key nursing skills. Skill-mix changes may involve a variety of developments including enhancement of skills among a particular group of staff, substitution between different groups, delegation and innovation in roles. Such changes may be driven by a variety of motives including service innovation, shortages of staff in particular disciplines, quality improvement and a desire to improve the cost- effectiveness of service delivery; and - The expected impacts of technology, in particular telemedicine, to allow smaller hospitals to be supported by regional centres.
<p><i>Acute Hospitals Review Group Report (AHRG), 2001 (The Hayes Report)</i></p>	<ul style="list-style-type: none"> • The AHRG proposed that the Erne and Tyrone County hospitals should be replaced with a single, new acute hospital for the South West on a ‘green-field’ site, located north of Enniskillen. The report indicated that this site would maximise accessibility for the South West’s dispersed population and ensure that it attracted a critical mass of activity and staff to sustain the safe delivery of acute health services. The AHRG also anticipated that work could begin on developing a modern local hospital facility in Omagh. • “We strongly believe, therefore, that a new hospital on a single site, linked with others as part of a larger Southern Health and Social Care System, represents the best way forward for sustaining the safe delivery of the necessary range of high quality services for the population of the South West.” (The Hayes Report, 2001)
<p><i>Developing Better Services (DBS) - Modernising Hospitals and Reforming</i></p>	<ul style="list-style-type: none"> • DBS built on the principles set out in the national strategy “Keeping the NHS Local”. This strategy emanated from the NHS Plan and the vision of a service designed around the patient and sets a clear direction of travel for the NHS, especially when considering service expansion and redesign. Both documents emphasised the need to ensure hospital sites were in the best

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Strategic / Policy Context	Implications
Structures, June 2002;	<p>locations locally to maximise patient access and also to form part of an effectively managed clinical network to ensure availability of appropriate acute clinical skills and expertise.</p> <ul style="list-style-type: none"> • DBS confirmed the need for an acute site in the South West and analysed the location that would ensure the greatest access for all residents in the South West. • The DBS recommendation to locate an acute hospital to the north of Enniskillen was based on work to ensure that the new facility met the acute service needs of the population, which included a detailed analysis of travel times. • Travel times were a central component of the discussions and analysis undertaken in assessing journey times within Fermanagh and Tyrone. It was recommended that no patient should be expected to travel more than one hour to access emergency care and consultant led maternity services (in line with AHRG recommendation). • The DBS report documented that the appropriate location of acute services in the South West, supported by effective pathways, adoption of innovative clinical practice and 'state of the art' purpose built facilities would ensure that, for the first time, all residents in this region and beyond would have access to high quality, modern, acute services. The DBS report was formally issued for consultation in June 2002 through to October 2002. • Subsequent to the consultation process in February 2003, Des Browne (the Minister for Health) made an announcement on DBS and confirmed the site for the new Acute Hospital for the South West as being North of Enniskillen.
<i>Planning for Change, a strategic context to support the implementation of DBS (WHSSB), 2004</i>	<ul style="list-style-type: none"> • Initially in 2002, the WHSSB, in partnership with its main provider organisations in the Western Area, produced Planning for Change, its strategic response to supporting the implementation of DBS in the Western Board area. This strategic plan, was updated in 2004 and responds to AHRG and more specifically DBS and presented the drivers for the future vision of health and social services in the Western Area. • The vision is underscored by the following key elements: <ul style="list-style-type: none"> - <i>Focus on needs of service users;</i> - <i>Improved/integration of services (primary, community, secondary care);</i> - <i>Co-ordinate and manage all services through managed networks of care;</i> - <i>Enhance and extend range of services provided in primary and community care;</i> - <i>More work to be done as a day case; and</i> - <i>Changing workforce roles.</i>

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Strategic / Policy Context	Implications
	<ul style="list-style-type: none"> The WHSSB's response to DBS documented that a new acute South West hospital would be required to be part of an interdependent network of services and have a link to a local hospital, an area hospital and regional services. Acute hospital services must also be networked with primary and community care services in line with the wider reform and modernisation plan.
Department of Health's (DoH's) NHS Plan, which is the Government's ten year programme of investment and reform for healthcare	<ul style="list-style-type: none"> The NHS Plan aims to deliver services designed around the needs of patients and improved health outcomes particularly for the poorest in society. The subsequent NHS Plan Implementation Programme encompasses targets to: <ul style="list-style-type: none"> <i>Reduce waiting times for hospital treatment;</i> <i>Allow patients to receive treatment at a time that suits them in accordance with their clinical need;</i> <i>Improve clinical quality across primary, secondary and tertiary care;</i> <i>Give patients' views greater prominence in shaping NHS services;</i> <i>Improve diagnosis, treatment and clinical outcomes in cancer, coronary heart disease and adult mental health services in line with the National Service Frameworks (NSFs);</i> <i>Develop information systems to support clinicians in the delivery of care;</i> <i>Improve services for older people;</i> <i>Improve standards of accommodation, cleanliness and food;</i> <i>Help narrow the gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country; and</i> <i>Fast-track mental health developments.</i>
Keeping the NHS Local – A New Direction of Travel” DoH, 2003.	<ul style="list-style-type: none"> The NHS operates in a highly complex environment. Everyone, staff, patients and the wider public needs to understand that patient safety must come first and this may limit the range of possible options for change. For example, some specialised services are only viable across a particular population size. Equally, even with the current expansion in staffing and resources, some possible models may not be viable. There then needs to be understanding about the place of hospitals within the whole system. The models emerging are of smaller general hospitals focusing on common conditions, routine procedures and immediate access. These would vary considerably in different locations, so it is impossible to describe a typical hospital. Although some of these hospitals would be geographically remote, none would be isolated, as they would operate in partnership with surrounding primary care teams and with neighbouring hospitals.
The Review of Public	<ul style="list-style-type: none"> The service model developed by legacy Trust, Sperrin Lakeland Trust was always within the context of working in a network of

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Strategic / Policy Context	Implications
Administration (RPA)	primary, community, secondary and tertiary care. The RPA arrangements, which became effective as of April 2007 consolidated, formalised and in essence supported this concept, and Sperrin Lakeland Trust was formally linked and integrated with Foyle and Altnagelvin Trusts as a new Western Health and Social Care Trust..
SIB investment strategy (2008 – 2018)	<ul style="list-style-type: none"> • SIB’s investment strategy contains plans for investment in hospitals, primary and community care, schools, roads, water reform, waste management and government accommodation. In terms of specifically health, details of the investment programme identified, indicates up to £2.9billion will be allocated to health in Northern Ireland over the next 10 years. The new Acute Hospital for the South West is identified as contributing to this investment, as well as a new maternity hospital in Belfast, local hospitals in Omagh, Downpatrick, Mid-Ulster and Whiteabbey. Significant improvements are also proposed for Altnagelvin, Craigavon, Antrim, the Royal Victoria and Ulster hospitals.
<p>NHS CGST Phase 1 Report: Validation of the Trust’s Risk Assessment into Anaesthetics and Critical Care Services, May 2005;</p> <p>Royal College Of Surgeons Review Report, September 2005;</p> <p>Invited Service Review, Royal College of Physicians, November 2005; and</p> <p>NHS CGST Risk and Governance Review of Medical Services, December 2005.</p>	<p>These reports/reviews highlight the non-sustainability of the current service model at Erne and Tyrone County Hospitals and re-emphasise the aforementioned drivers for change.</p> <ul style="list-style-type: none"> • In particular, the recommendations from these reviews have highlighted the need to change the profile of elements of existing service provision in advance of the new facilities and for interim arrangements to be in place. The recommendations have included: <ul style="list-style-type: none"> - <i>A move to a single properly resourced 24/7 Accident and Emergency Unit sited at the Erne Hospital with a linked 24 hour, doctor led Urgent Care and Treatment Centre at the Tyrone County site;</i> - <i>Full critical care services can no longer be safely continued on two separate sites. Arrangements were introduced in 2006 to ensure that those patients requiring or likely to require Level III critical care support be managed at the Erne Hospital or Altnagelvin Area Hospital;</i> - <i>Realignment of acute surgical services took place in 2006, such that emergency surgery and more complex elective surgery will be provided at the Erne Hospital or other appropriate hospitals outside the Trust;</i> - <i>Recommendations on General Internal Medicine highlight the difficulties of smaller units and conclude that with reduced surgical and level III critical care provision, patients with life threatening conditions should no longer be managed at the Tyrone County hospital; and</i> - <i>All the reports emphasise the further development of robust clinical networks with neighbouring larger district general</i>

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Strategic / Policy Context	Implications
	<p style="text-align: center;"><i>hospitals such as Altnagelvin and Craigavon.</i></p> <p>All of the above re-arrangements took place in 2006 and are being kept under review. A service reconfiguration group chaired by the Director of Acute Services oversees the required service changes necessary for the development of the future models.</p>
December 2007 DHSSPS 100% Single In-Patient Room Policy	<ul style="list-style-type: none"> - All new hospitals in Northern Ireland to be planned on the basis of 100% single rooms to enhance the Privacy and Dignity of Patients. - In line with this policy, the New Acute Hospital for the South West (NI) was redesigned from the basis of 50% single rooms to 100% single rooms as detailed in Section 1.7.4 of this Full Business Case.
The Recommendations for the Review of Pathology Services in Northern Ireland, December 2007	The report examined the current provision of pathology services and made 24 recommendations for the future provision of these services. The report highlighted the sweeping changes under way in the provision of health services across N Ireland and stressed the need for pathology services to change too, to ensure that they retain sustainable and deliver high quality, cost effective services.
The Assessment of Services at the TCH May 2007	<p>The terms of reference for this report were:</p> <ul style="list-style-type: none"> • An assessment of the existing arrangements for meeting the needs of patients either presenting to or being admitted to the TCH. This will include arrangements within the Urgent Care and Treatment Centre (UC&TC), the Clinical Decision Unit (CDU)and the Medical High Dependency Unit (MDHU). • The identification of any necessary service re-design and associated timescales, investment plans and implementation issues necessary to sustain those services during the transition towards full implementation of Developing Better Services (DBS). • The identification of further opportunities for TCH to provide appropriate services, in the context of a collaborative/networked approach to delivering quality patient care across the new Western Trust. • The reports proposals for the transition period to the DBS model were: An Urgent Care Centre (UCC) will be established at the TCH, networked much more strongly with the A&E services in Altnagelvin and the Erne, the ambulance service, intermediate care and GPs. The UCC would include a nurse led Minor Injuries Service and a Clinical Decision Service. The proposed Clinical Decision Service would be staffed by both doctors and nurses. Central to the model is the leadership of Advanced Nurse Practitioners (ANP) who are skilled in medical assessment. Supervision would be provided by consultant physicians with day-to-day medical cover being delivered by Staff Grades. The ANPs would also be supported by a consultant nurse in emergency/first contact care. <p>The report also identified further opportunities for TCH to provide appropriate services, in the context of a collaborative network.</p>

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Strategic / Policy Context	Implications
	Key further opportunities identified include a) Elective Day Case Surgery, b) Diagnostics, c) Rehabilitation and d) Ambulatory Care.
The Assessment of Services at the TCH May 2008	This was an updated version of the 2007 report as detailed above.
Royal College of Physicians Invited Service Review, November 2007.	<p>This paper recommended:</p> <ol style="list-style-type: none"> 1. Acutely ill medical patients should not be admitted to hospitals which do not have critical care and appropriate diagnostic services. No further such services should be created. 2. Hospitals which do not have critical care and diagnostic services should be reconfigured to provide intermediate or step-down care. Patients should be transferred to these hospitals only when a definite diagnosis has been confirmed, the patient's condition has been stabilised and a plan for further management has been formulated. <p>It is not appropriate for a consultant physician to have responsibility for emergency admissions or acutely ill patients on two separate sites. Job plans for new or replacement posts should not require the postholder to take on this dual responsibility and hospital trusts should work towards phasing out this requirement for existing postholders.</p> <ol style="list-style-type: none"> 3. Further research is needed to establish the potential role of telemedicine in the provision of acute medical services. 4. Proposed solutions for reconfiguring acute hospital services should be tested in trials before they are introduced.

The Trust has reviewed the Strategic Context Policy outlined above and confirmed the following:

- The policies continue to be relevant and highlight the overwhelming need to consolidate Acute Hospital services for the South West on a site north of Enniskillen.
- There are no further policy documents issued in the intervening period between OBC and FBC that would impact on the proposed service model detailed below.
- The Trust continues to work to introduce elements of the new service model in advance of the new facilities being available.

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1.2.1.1. Population increase and future projected demand

In developing the Acute Phase 2 OBC, prior to projecting future demand for services, consideration was given to population projections based on Northern Ireland Statistics and Research Agency (NISRA). Table 1.2 below represents the total population increase predicted at the Acute Phase 2 OBC and presents the updated NISRA projections applied within this Full Business Case . (Graph 1.1 details the uplift in population by age bands.)

Table 1.2 Updated NISRA statistics: Population Projections for South West of Northern Ireland.

2003 Population Projections		2008 Population Projections	
4%	2010	7.4%	2010
7%	2015	12.5%	2015
13%	2020*	18.4%	2021

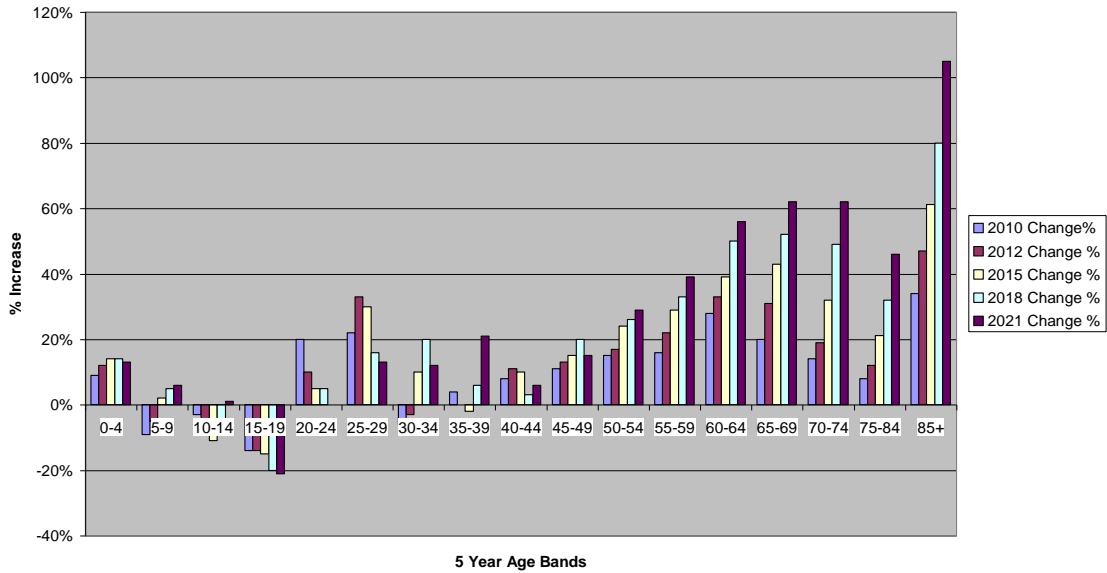
- *For the Acute Phase 2 OBC CHKS estimated a projection of 13% by 2020 based on trends in the absence of NISRA figures.*
- *South West Population defined as: Fermanagh District Council, Omagh District Council, 1/3 Strabane District Council.*

The Table (1.2) above reflects 2008 NISRA published data. which shows the overall population in the South West of Northern Ireland increasing by 7.4% in 2010, 12.5% by 2015, 18.4% by 2021. This is higher than previously anticipated. Table 1.3 overleaf presents revised NISRA projections to 2021, and illustrates how population increases impact most significantly on the older age groups and particularly those over 65 years. Understanding these population projections has been key to planning the future service model.

In developing the capacity planning model it has been important for the Trust to consider the population uplift by 5 year age bands. Graph 1.1 outlines this impact in terms of population growth from 2003 at key years, 2010 to 2021 based on recent NISRA data, February 2008.

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**% Increase Population by 5 Year Age bands
South West (NI) (2008 NISRA data)**



Graph 1.1: % increase in population by 5 year age bands

Source Data: NISRA Local Government District Home Population 2006–2021 (Published 2008). NISRA Population Projections to 2021 apply 2006 based projections.

2003 Baseline data: NISRA Mid Year Population Estimates (1991 – 2007).

There will be substantial growth both in real and percentage terms in the older population, especially the very old population. It will be important to ensure that appropriate health care provision is in place so as to facilitate this age group due to the increased need for acute services associated with aging. This supports the need for the profiled New Acute Hospital as presented in this Full Business Case and further discussed in the Capacity Planning Section 1.2.4.

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Table 1.3 NISRA 2008 Population Projections to 2021: Southwest of Northern Ireland
SOUTH WEST OF NORTHERN IRELAND

Age	NUMBER OF PEOPLE						
	2003	2006	2010	2012	2015	2018	2021
Age Group: 0-19							
Total	36786	35401	35043	35230	35533	35869	36404
% Increase against 2003 benchmark		-3.76	-4.74	-4.23	-3.41	-2.49	-1.04
Age Group: 20-59							
Total	63617	67087	70377	71439	72660	73519	73913
% Increase against 2003 benchmark		5.45	10.63	12.29	14.21	15.57	16.18
Age Group: 60-64							
Total	5260	5886	6737	6972	7325	7873	8225
% Increase against 2003 benchmark		11.89	28.07	32.53	39.24	49.67	56.35
Age Group: 65-69							
Total	4482	4790	5390	5870	6429	6800	7250
% Increase against 2003 benchmark		6.88	20.26	30.98	43.45	51.73	61.78
Age Group: 70+							
TOTAL	10975	11480	12525	13107	14370	15918	17636
% Increase against 2003 benchmark		4.60	14.13	19.43	30.93	45.04	60.69
Age Group: ALL							
TOTAL	121,120	124,644	130,072	132,618	136,317	139,979	143,428
% Increase against 2003 benchmark		2.91	7.39	9.49	12.55	15.57	18.42

Source: NISRA Local Government District Home Population 2006–2021 (Published 2008). NISRA Population Projections to 2021 apply 2006 based projections.

2003 Baseline data: NISRA Mid Year Population Estimates (1991 – 2007).

1.2.2. Proposed Service Model

Since the creation of the new Western Health and Social Care Trust in April 2007 the new service model developed by the former Sperrin Lakeland Trust in conjunction with the WHSSB and shown below in Figure 1.2 has been fully adopted. The Trust aims to have this service model in place to derive the benefits of the new acute facility and a service reconfiguration group has been set up, chaired by the Director of Acute Services.

At the core of WHSCT's future service model is reform and modernisation via a New Acute Hospital and Local Hospital provision in the South West. The Trust considers that this offers significant opportunities to deliver on the health and social care modernisation agenda in its broadest sense. The model supports the provision of safe, accessible, sustainable, equitable, affordable and high quality services. At the core of the Trust's new

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model is a focus on improving the patient's experience, as summarised in Figure 1.2 and which in turn will also contribute to:

- Increasing the quality of acute care;
- Managing admissions and reducing length of stay;
- Improving bed usage;
- Managing chronic care;
- Providing rapid access to senior opinion;
- Providing one stop services; and
- Alternatives to acute hospital care.

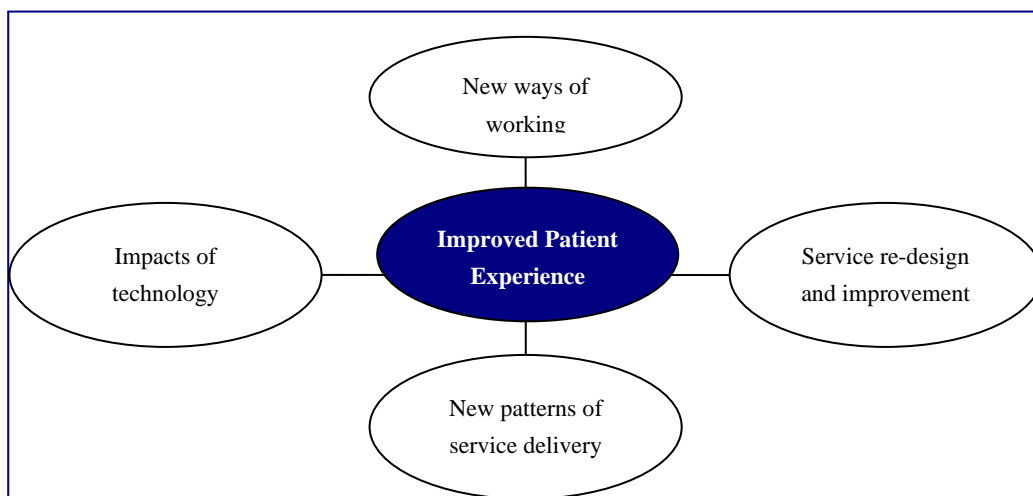


Figure 1.2 WHSCT service model – improved patient experience

WHSCT's service model promotes a focus on:

- Primary prevention;
- Acute care;
- Inpatient care;
- Regional networks;
- Rapid diagnostics;
- Early discharge planning;
- Ambulatory care;
- Linked community care; and
- Secondary prevention.

Acute hospital provision under this model should not be seen in isolation, it will also be networked and integral to the final shape of several other service settings particularly self-care, primary and community care, health and care centres as well as those services provided at Omagh and Altnagelvin hospital and other tertiary services (Figure 1.3).

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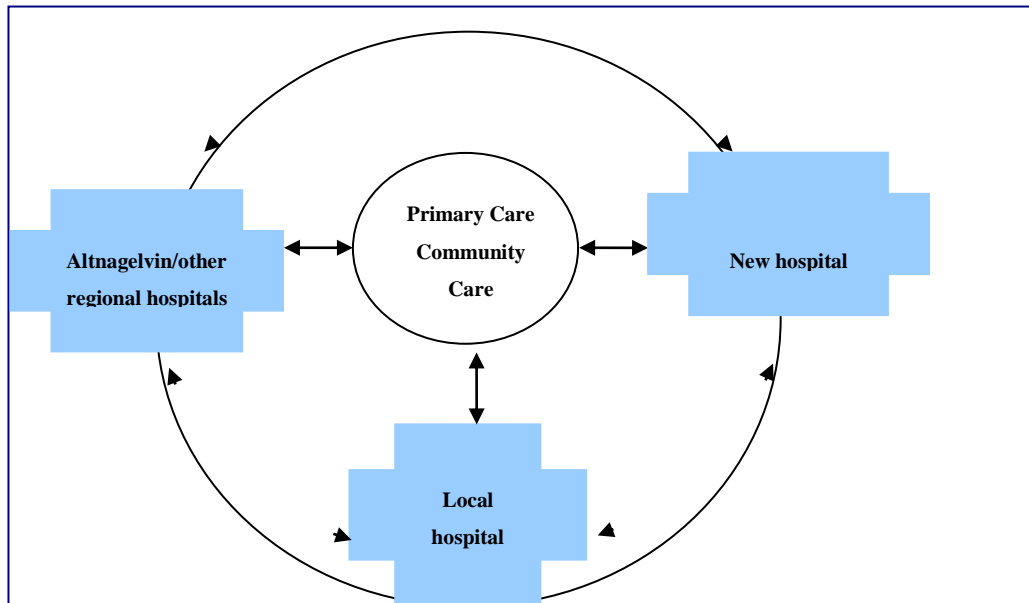


Figure 1.3: Networks of care

It is the Trust's view that the implementation of such a hospital model will benefit the 'whole system' and provide the ability to:

- Develop patient centred services and meet patient expectations;
- Deliver highest quality care with improved clinical outcomes;
- Scale to sustain and increase service accessibility;
- Use, implement and support new technology;
- Exceed regional efficiency expectations;
- Strengthen relationships with other provides; and
- Maintain and develop a strong skilled workforce.

1.2.3. Future projected demand for acute services in the South West and the associated bed capacity required

When the former Sperrin Lakeland Trust presented the new Clinical Model and this was agreed with the WHSSB, the WHSSB appointed CHKS to perform a capacity planning exercise for the new Acute Hospital. This planning exercise took place in 2004 and took account of:

- The future NISRA population predictions (2002 published data based on 2000 census) to the time horizon of 2017;
- The activity and efficiency performance assumptions set out by the Regional DBS Steering Group (2004) (with peer comparison with English District General Hospital (DGH) upper quartile performance);
- Cross Boundary and Intra Board flow (Ref Section 1.2.3.3); and
- Implementing an Evercare or similar type model (designed to prevent unnecessary acute hospital admissions).

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The outcome of this planning exercise resulted in the following bed model (Table 1.4A):

Table 1.4A Acute Phase 2 OBC Bed Model

SPECIALTY	Phase 2 OBC (2006) - CHKS 2005			TOTAL BEDS
	INPATIENT BEDS	DC BEDS	OTHER	
GENERAL SURGERY	42	6		48
ORAL SURGERY		1		1
ENT	5	1		6
ANEASTHETICS		1		1
Combined Assessment Unit	24			24
GENERAL MEDICINE	53	3		56
ACUTE STROKE UNIT	16			16
Cardiology & Coronary Care	29			29
PAEDIATRICS	15			15
Neonates	7			7
CARE OF THE OLDER PERSON	49			49
OBSTETRICS	16			16
GYNAECOLOGY	7	2		9
Critical care	6			6
Labour Ward	5			5
Day Case from Altnagelvin		4		4
Paliative Care	3			3
Total Acute Beds	277	18		295
Intermediate Care			20	20
Total Beds				315
Evercare 10% has been applied to medical beds in this table.				

Notes to Table 1.4A above:

- *The Combined Assessment Unit was made up of General Medical, Surgery and Care of the Older Person Beds.*
- *Evercare 10% has been applied.*

1.2.3.1. Efficiency Assumptions

In 2004, the Regional DHSSPS DBS Steering Group provided all Trust's with the key assumptions to be used in Business Cases in relation to improved efficiencies regarding patient activity, projected activity levels to 2015 based on NISRA projections for population change, the reconfiguration of hospital services that resulted from DBS and resultant interboard flow assumptions:

- Occupancy rates to be included in bed modelling are 83% for all specialties except Paediatrics 65%, Critical Care 75%, Obstetrics 75% and Geriatric Assessment & Rehabilitation 95%.

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- Day Case Rates: Procedure specific day case rates at the 90th percentile rate of the NHS in England. There should be an improvement in day case rates and in the shift from day case/inpatient to outpatient procedures.
- Length of Stay targets: Consideration of achieving an average length of stay in line with the 75th percentile of the NHS in England by hospital type i.e. District General Hospital (DGH). (The Trust applied a 30 day length of stay trim to all specialities except stroke and elderly care where a 50 day length of stay trim was applied.)
- Waiting Lists: These reflect latest inpatient/day case demand.
- Outpatients: assume more procedures performed at outpatients rather than as a day case or inpatient.
- Endoscopy: assume that endoscopy would be performed in appropriately staffed endoscopy suites.
- Theatre usage: assume optimum use of theatres through implementation of the recommendations of the 2003 NI Audit Office report.
- Delayed Discharges: assume no bed days arising from delayed discharges.

All these assumptions underpin the bed capacity modelling exercise in Table 1.4A.

1.2.3.2. Updated Capacity Planning

In 2008 as part of the FBC preparation CHKS was commissioned to update the previous capacity planning exercise. The purpose of the exercise was to:

- Assess the validity of the bed modelling used as the basis for the outline business case which was based on activity in 2003/04;
- Apply the activity data for 2007/08;
- Apply new NISRA 2008 published for the population projections to 2021;
- Apply increased performance targets by benchmarking against the upper quartile performers in GB (England and Wales); and
- Look in more depth at the future bed requirement from the opening position in 2012 until 2018 in 3 year bands.

From this exercise the Trust required information on the capacity that would be required in 2012 for the opening of the hospital and when the hospital would be potentially using its full inpatient bed complement. The Trust also wanted to acknowledge the impact of the new population information produced by NISRA (Refer to Section 1.2.1.1).

The updated CHKS report 2008 was based on:

- a) New NISRA Population Projections to 2021 based on 2008 NISRA published data (Appendix 1.01B);
- b) A comparison with upper quartile performers of NHS hospitals in Great Britain (across CHKS database) using speciality specific peers;

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- c) The regional efficiency assumptions as indicated by the Directorate of Secondary Care in 2004 in relation to occupancy level. This can be referenced in Section 1.2.3.1;
- d) The Trusts 07/08 activity performance data;
- e) Assuming an acute setting of a 30 day trim across all acute specialities apart from Stroke Medicine and Care of the Older Persons where a 50 day trim is applied; and
- f) The Trust will retain the 90th percentile of English performance for day case procedures.

The CHKS 2008 report can be referenced in Appendix 1.01C.

1.2.3.3. Evercare or similar type model

In addition, in December 2004, all Boards and Trusts preparing Outline Business Cases for Developing Better Services projects were requested to quantify the potential impact of the application of an Evercare model. The Evercare model of care aims to prevent emergency admissions to hospital, whilst providing person-centred and individually tailored health care.

Following discussions between the DHSSPS, the WHSSB and the Trust and in order to best fit with the current Modernisation and Reform agenda, the application of a 10% Evercare or similar type model was the preferred option with regard to acute hospital provision under the new proposed service model. The 2008 analysis equates to 6 medical beds less for 10% Evercare in 2012.

1.2.4. Result of Bed Capacity Planning & Activity Analysis

The updated CHKS analysis validates the bed profile for the New Acute Hospital, it indicates that less inpatient beds will be required in 2015 than was originally predicted when performance is benchmarked against the higher performing Trusts in GB. The CHKS analysis confirms that by 2018 the full bed complements of 312 beds will be required.

The analysis of 2021 shows a continual rise in activity across surgery, general medicine, cardiology and care of the older persons.

1.2.4.1. Methodology Applied by CHKS

CHKS has undertaken the assessment of bed requirements by modelling activity, performance and other factors in order to identify bed needs for a range of given criteria in Section 1.2.3.2. The purpose of the bed modelling is to measure the extent to which changes in clinical performance may impact on the need for acute hospital beds for each bed-holding acute specialty, based on changes in aspects of performance and the level and mix of patient activity.

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The analysis done by CHKS is:

- Adjusted for age in 5 year age bands;
- Adjusted by male and female; and
- Case mix adjusted by Healthcare Resource Groups (HRG's).

The following Table 1.4B illustrates the inpatient and day case activity that informed the bed modelling and shows the percentage increase in the volume of activity generated by changes in the population statistics as applied to each specialty.

Table 1.4B Inpatient & Day Case Activity for Southwest Hospital

Activity Summary 2007-2008 to 2012, 2015, 2018							
Specialty	2007-2008	2012	Percent	2015	Percent	2018	Percent
	Total	Total	Change	Total	Change	Total	Change
General Surgery	7707	8479	10.0	8854	14.9	9297	20.6
Oral Surgery	543	550	1.3	570	5.0	592	9.0
Anaesthetics	349	386	10.6	400	14.6	426	22.1
General Medicine	5641	6371	12.9	6715	19.0	7233	28.2
Rehabilitation	238	278	16.8	293	23.1	330	38.7
Cardiology	1797	2047	13.9	2163	20.4	2344	30.4
Paediatrics	2060	2234	8.4	2138	3.8	2310	12.1
Neonatology	72	81	12.5	74	2.8	83	15.3
Care of Older Persons	839	989	17.9	1045	24.6	1187	41.5
Obstetrics	1920	2059	7.2	2074	8.0	2090	8.9
Gynaecology	1659	1784	7.5	1824	9.9	1861	12.2
Total	22825	25258	10.7	26150	14.6	27753	21.6

Specialties associated with elderly care have the greatest increase in volumes of activity. In summary other areas of increase are summarised in Table 1.4C below:

Table 1.4C Rise in activity in Key Specialities

Speciality	2007-2008	2012	2015	2018
General Medicine	5641 FCE's	6371 FCE's (12.9%)	6715 FCE's (19%)	7233 FCE's (28.2%)
General Surgery	7707 FCE's	8479 FCE's (10%)	8854 FCE's (14.9%)	9297 FCE's (20.6%)
Rehabilitation	238 FCE's	278 FCE's (16%)	293 FCE's (23.1%)	330 FCE's (38.7%)
Care of Older Persons	839 FCE's	989 FCE's (17.9%)	1045 FCE's (24.6%)	1187 FCE's (41.5%)
Cardiology	1797 FCE's	2047 FCE's (13.9%)	2163 (20.4%)	2344 (30.4%)

1.2.4.2. Methodology for Bed Capacity Planning

Based on the above activity analysis, CHKS produced a number of bed capacity scenarios relating to 2012, 2015 and 2018. These bed capacity scenarios can be referenced in Appendix 1.01D. Firstly, there is a scenario based on the current level (2007/08) of met demand from its population. The purpose of this scenario is to examine the extent to

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which the current bed base can cope with current demands. Subsequent scenarios are based on the likely impact of demographic change to 2012, 2015 and 2018 with performance applied.

CHKS examined bed utilisation at specialty level for specified age groups in order to estimate the likely impact of a changed population base on service demands and facility requirements.

The model calculates the number of in-patient and day case beds required by each specialty to support a given volume of case mix adjusted activity. This is achieved by measuring the impact of alterations to the specialty's average lengths of stay, occupancy rates and day case rates with reference to a peer group of matched specialties. Thus, for a given specialty, activity is divided into elective and non-elective episodes and then into individual HRGs which are, in turn, banded by admission type, age group and discharge destinations. The specialty's average length of stay is then compared against that for the same HRG category from the relevant specialty peer group.

In order to calculate day case bed requirements, the model uses a Bed Utilisation Factor of 288 as defined by the Royal College of Surgeons, which allocates day beds on the assumption that each bed will handle 1.5 patients per day and be available for 48 weeks of the year.

In modelling in-patient and day case beds separately, FCEs are divided into those with at least one overnight stay ("in-patients") and those discharged on the same day ("day cases or emergency day"). This approach therefore excludes from the in-patient count emergency admissions that were discharged on the same day of admission. Whilst it is recognised that these patients may well have occupied an in-patient bed, which, as a consequence, was not available for the remainder of the day, their length of stay is counted as zero and their impact on in-patient beds is therefore ignored. Under the day beds section these patients are identified as *other beds* (in addition to regular attenders). In part, this approach has been adopted to reflect circumstances in which an admissions/assessment ward could be used to hold and monitor such patients prior to their being admitted to an in-patient ward or, alternatively, discharged.

The modelling predicates that those areas of hospital performance (principally length of stay) which are identified as already exceeding the best performance of the peer group remain unchanged. It is only those aspects showing a negative variance against peers which are optimised in line with the peer group performance. In the case of any uncoded or low volume activity the model does not apply peer performance.

It is also important to note that where the model shows, on current service volumes, a bed reduction for any particular specialty, it is merely identifying the number of beds the specialty would have required to treat those patients it admitted during the period. It is important to note that the model is based on optimal mean length of stay. There may be

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periods of additional pressures and the bed model must be able to accommodate the peaks and demands.

The result of this new capacity planning exercise confirms the requirement for an Acute Hospital provision of 312 beds, with a mix of inpatient beds, day case and ambulatory beds across various specialties and intermediate care as presented in Table 1.4 D.

1.2.4.3. Application of the Capacity Planning and impact on Clinical Model

The Trust now have an updated model to plan the delivery of high quality and efficient Acute Hospital services for the Southwest. In applying this model for a hospital opening in 2012 consideration has been also given to what capacity will be required for 2015 and 2018. Having analysed the information provided by CHKS the Trust has verified the following Table 1.4D for 2012, 2015 and 2018 outlining the most efficient and flexible use of the acute beds to meet the demands of higher activity levels associated with increased population, especially in the elderly groups and increased performance targets.

Table 1.4D Bed Modelling for 2012, 2015 & 2018

Western Trust Key Bed Model Scenario Outcomes	Specialty	2012			2015			2018		
		Inpatient beds 2012	Day Case Beds 2012	Total	Inpatient beds 2015	Day Case Beds 2015	Total 2015	Inpatient beds 2018	Day Case Beds 2018	Total 2018
	General Surgery	37	7		39	7		41	7	
	ENT	0	0		0	0		0	0	
	Oral Surgery	0	1		0	1		0	1	
	Anaesthetics	0	1		0	1		0	1	
	General Medicine	71	4		75	5		81	5	
	Rehabilitation	15	0		16	0		18	0	
	Cardiology	23	0		25	0		27	0	
	Paediatrics	13	2		13	2		13	2	
	Neonatology	5	0		5	0		5	0	
	Geriatric Medicine	51	0		53	0		60	0	
	Obstetrics	15	1		15	1		16	1	
	Gynaecology	6	2		6	2		6	2	
	Total	236	18	254	247	19	266	267	19	286
				5	Labour		5	Labour		5
				10	Critical Care		10	Critical Care		10
				10	Intermediate Care		20	Intermediate Care		20
				2	Palliative Care		3	Palliative Care		3
				-	Non Elective Surgery (Day Case)		4	Non Elective Surgery (Day Case)		4
				281	Sub Total		308	Sub Total		328
				-6	Evercare		-6	Evercare		-6
				-6	Transfer to TCH		-10	Transfer to TCH		-10
				269	Overall Total		292	Overall Total		312

Notes to Table 1.4D above:

- Labour beds are beds for consultant led deliveries, they are not as such inpatient beds
- The Trust currently has 7 critical care level 2 and 3 beds at the Erne site and 3 level 2 beds at the Tyrone County site.

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- Refer to subsequent section for explanation on Intermediate Care beds. 2012 shows an opening position of 10 beds moving to 20 beds in 2015. The Trust is currently establishing this service, planning to introduce it within the next year.
- Palliative Care beds as such do not currently exist within the Trust. This shows the development of a palliative care service as a respite and adjunct to the current community service. This is not to be developed as an end of life service. This meets with the Palliative Care consultant and MacMillan nurses service philosophy.
- Non Elective Day surgery is shown on the CHKS analysis as patients who stay less than a day and this is modelled into the combined assessment unit.

In developing this bed model for the opening position of 2012 acknowledgement is given to the Trust continuing to increase performance across all specialities and deal with year on year increase in activity in a flexible manner. Whilst the focus of the facility is on inpatient beds and predicting the number required, the design of the facility allows for more day case activity being catered for across all key specialities, surgery, medicine, paediatrics and obstetrics.

While it is recognised that it is unlikely that no hospital will be achieving this level of performance in all specialities. The scenario planning detailed above nevertheless provides a reasonable target for planning 10 years into the future and sets the benchmark for Trust year on year performance improvements.

Furthermore a robust Clinical Workforce Plan has been developed to sustain this model, with a integrated skill mix and expertise across all specialties. This Workforce Plan will have a staged approach to meet the years activity outlined above.

The phased opening of beds is not anticipated to present any delay or reduction in the Trust's recruitment requirements for the New Acute Hospital given the projected activity levels.

Intermediate Care

Essential to achieving future performance targets will be reducing the length of stay in the acute setting. With this in mind the Trust had already proposed the development of intermediate care beds and associated care teams to enable rapid step down into a rehabilitation facility. This is particularly pertinent given the age profile of the population of the Southwest, with a high percentage of people over 70 e.g. to 2015 there is a 31% increase in those over 70 and a 61% increase by 2021.

Intermediate Care is split across the two sites. The Trust has determined an allocation of 20 intermediate care beds to be co-located with acute hospital provision and 30 for local hospital provision.

The revised CHKS modelling validated this requirement as outlined in Table 1.4E below.

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Table 1.4E CHKS Modelling of Intermediate Care

Activity with a length of stay > 50 days 2007 - 2008 and acute phase excluded	Length of stay < 50 days	Length of stay > 50 days	Percent > 50 days	Length of Stay	Bed days > 50 days in 2007 -2008	Bed days > 50 uplifted to 2015	Beds @ 95% occupancy uplifted to 2015	Bed days > 50 uplifted to 2021	Beds @ 95% occupancy uplifted to 2021
Geriatric Rehabilitation (430)	567	101	15%	7,062	13,920	40	16,637	48	

This provides a ‘best fit’ for the proposed DBS model. In terms of the acute hospital, intermediate care will also support early step-down from it and from other regional centres (as per NHS – Keeping Services Local).

This model provides for a fully integrated service provision for elderly patients and allows the patient to have the continuity of the clinical and social care experts in the multidisciplinary team, including medical and specialist nurses.

1.2.4.4. Impact of increasing performance against current

The CHKS analysis demonstrated that performance improvement in all specialities is required. When this is analysed against 2015 approximately an additional 88 inpatient beds would be required based on current performance as shown in Table 1.4F below.

Table 1.4F 2015 Current performance vs. increased performance

Western Trust Key Bed Model Scenario Outcomes	Specialty	2015 Population		2015 Population	
		Current performance Inpatient	Day Case	Increased Performance Inpatient	Day Case
	General Surgery	46	6	39	7
	ENT	0	0	0	0
	Oral Surgery	0	1	0	1
	Anaesthetics	0	1	0	1
	General Medicine	93	4	75	5
	Rehabilitation	25	0	16	0
	Cardiology	26	0	25	0
	Paediatrics	13	0	13	2
	Neonatology	5	0	5	0
	Geriatric Medicine	88	0	53	0
	Obstetrics	27	0	15	1
	Gynaecology	12	2	6	2
	Sub Total	335	14	247	19
		2015 current performance		2015 with performance applied	
	TOTAL	349		266	

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The main drivers for achieving the new performance targets are:

- a) Successfully dealing with preventable admissions; and
- b) The decrease in length of stay.

As a result a higher activity of patient throughput is indicated in all areas of the New Acute Hospital in order to meet these efficiency targets.

The Trust shall be required to meet year on year performance improvements and regional efficiency targets, in line with those higher performing UK peers that CHKS used as a benchmark, in order to achieve the Acute Hospital bed profile. Key to these improvements are achieving the shorter lengths of stay indicated and an increase in the number of day case procedures, investigations and treatments. The challenge for the Trust is to achieve such efficiencies whilst maintaining flexibility to accommodate fluctuations in demand.

This is a challenge recognised by the Trust, who has put in place with its Commissioner a range of measures, some of which have been funded through the Health and Wellbeing Investment Plan:

- The appointment of young dynamic consultants e.g. in Cardiology and Care of the Older Persons;
- Starting Critical care outreach and interventions earlier, reducing LOS;
- Upgrading Diagnostics to enhance performance e.g PACS at the Erne Hospital;
- Recruitment of specialist nurse practitioners in Stroke, respiratory, Cardiac, Parkinson's Disease all contributing to earlier discharge and chronic disease management;
- Expansion of Chronic Disease and Integrated Care Teams, taking on greater case loads (A number of staff have been funded to operate a chronic disease management model);
- Establishment of Clinical Decision Unit in 2008/09;
- Clarity on Discharge destinations and protocols is improving throughput; and
- Development of intermediate care teams.

Evidence from the CHKS analysis of current activity demonstrates that improvements in performance is evident across some specialities, for example, Cardiology has an average length of stay of 3.8 days and higher performing peers have the same average length of stay of 3.8 days. General Surgery has an average length of stay 4.3 days against peers of 4.1 days.

The clinical model therefore reflects integrated ways of working to deal with the increased activity by means of the following:

- Year on Year performance improvements in relation to regional efficiency targets based on experience.

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- Application of a new emergency care model supported by expansion of community based interventions and service developments.
- Further efficiencies from systematic discharge planning.
- Application of the Hospital at Night initiative and resultant reduction in Length of Stay.
- Implementation of new Stroke Pathways across the Trust.
- Intermediate Care Teams incorporating rapid response nursing and specialist nurse input to drive disease management.

In addition, the Western Trust will work with DHSSPS to implement future efficiency policies, initiatives and service developments.

New Acute Hospital for the South West bed model:

- This meets the original objectives of AHRG, DBS and Planning for Change and in doing so it ensures that the Trust keeps in line with the Reform and Modernisation agenda and the strategic direction of the DHSSPS and WHSSB.
- It allows the Trust to sustain critical mass through the provision of a range of services across all key specialties;
- It demonstrates a shift from inpatient to daycase ;and
- It applies a 30 day trim to all specialties apart from acute stroke to which a 50 day trim is applied.
- The Evercare type model adopts a case management approach to those with long-term and complex chronic conditions and pro-actively manages these patients in the community, with the aim of reducing hospital admissions and improved health outcomes including quality of life;
- The age profile of the future service demand will impact on future medical outcomes and resulting length of stays, this is allowed for within an intermediate care facility.

Figure 1.4 New Acute Hospital for the South West Bed Model Summary

1.2.5. Key Functional Content of New Service Model

This Full Business Case confirms the required bed complement and clearly identifies acute in-patient beds, ambulatory and day case provision. A core guiding principle involved planning mainly around a ward template of 20 to 24 beds that could be used generically as medical, surgical and care of the older persons wards. Another key consideration was to split elective and non-elective surgery beds to improve the utilisation of bed spaces and to have dedicated day case and ambulatory areas. See Benefits of Service Model in Table 1.5 overleaf.

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1.2.5.1. Benefits of the Service Model

The proposed service model has not changed since Acute Phase 2 OBC and meets the modernisation agenda and National and Regional initiatives.

Table 1.5 below outlines the benefits of the proposed service model.

Table 1.5 Benefits of the proposed service model

Service Department	Benefits of proposed Service Model
A&E Department	<ul style="list-style-type: none"> • Patients assessed and streamed into Minor Injuries, A&E, Combined Assessment Unit or GP Out of Hours; • Emergency Nurse Practitioners model applied; • Senior decision makers at “Front of House”; • Achieves the 4 hour waiting target; • Part of Western Integrated Emergency Care Network (linking via telemedicine); • There is access to the psychiatric liaison service, which prevents inappropriate admissions; • Rapid Access to “Integrated Discharge Team” and “Rapid Response Nursing Team”; • A&E is closely adjacent to the Imaging Department; • Delivery of Greet and Treat Approach; • Single point of access for emergency care; • Co-location with GP OOH services with consequent efficiencies of service delivery; and • There is an observation area for patients who can be discharged or transferred quickly following assessment/treatment.
GPOOH	<ul style="list-style-type: none"> • Meets recognised direction of travel required by the WHSSB; • Co-located, which provides efficiencies in terms of nursing & the community mental health team; and • Allows for co-location of the rapid response discharge team who are currently not located within the hospital.
Combined Assessment Unit	<ul style="list-style-type: none"> • Will operate an average LOS of 24 hours; • Facilitates achievement of targets on preventable admissions; • Facilitates rapid diagnostic, treatment and discharge or transfer to appropriate specialty;

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Service Department	Benefits of proposed Service Model
	<ul style="list-style-type: none"> • Follows recommendation of Royal College of Physicians invited services review 2007; • Follows recommendation of Royal College of Physicians National Guidelines; and • Model underpinned by treatment protocols, discharge protocols and integrated discharge planning.
Critical Care (Level 2, 3 and Coronary Care)	<ul style="list-style-type: none"> • Part of Critical Care Network (area and regional); • Clinical risk reduced due to co-location of all high dependency patients in the one area (Level 3 and 2 and Coronary Care) and next to theatres, • This model will facilitate the development of critical care outreach and aid response to early warning systems and delivery of “Surviving Sepsis Care Bundle” • All ischaemic heart disease admitted directly to Coronary Care with reduced event to needle time thrombolysis.
Elderly Care Wards	<ul style="list-style-type: none"> • Specialist multidisciplinary care team (Consultant led); • Protocol and care pathway led; • Focus on aggressive therapy led rehabilitation; and • Reducing delayed complex discharges.
Stroke	<ul style="list-style-type: none"> • Rapid access to imaging (within 3 hours of admission); • Direct admission to stroke ward from A&E via imaging ; • Stroke ward is designed to deliver hyper-acute care incorporating thrombolysis, and acute rehabilitation • Care pathway to achieve optimal health outcome; • Multidisciplinary assessment, treatment and rehab; • Close working with Social and Intermediate Care Team to develop timely discharge; and • Recommendations as per DHSSPS ‘Improving Stroke Services in Northern Ireland 2005’ implemented.
General Medicine	<ul style="list-style-type: none"> • Formalised treatment plan integrated into protocol driven emergency patient care pathways with rapid access to senior decision makers; • Patients allocated to specialist consultant e.g. gastroenterology, diabetology, respiratory; • Direct link to enhanced diagnostic and Clinical support infrastructure; and • Integrated discharge planning.
Cardiology / Medical	<ul style="list-style-type: none"> • Protocol delivered care along National Service Framework Standards: - Treating heart attack and other coronary syndromes;

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Service Department	Benefits of proposed Service Model
	<ul style="list-style-type: none"> - Investigating and treating stable angina; - Implementing pathways for early Revascularisation; - Secondary prevention; - Managing Heart failure; and - Cardiac Rehab. • Developing roles for nurse led care-chest pain clinic; • Integrated working with technical and diagnostic services to aid rapid diagnosis; • CT and MRI Angiography to filter patients for Trust angioplasty services and regional cardiac surgery.
Intermediate Care Ward	<ul style="list-style-type: none"> • Multidisciplinary care planning; • Close working relationship with Social and Intermediate Discharge Team to develop timely discharge; • Dedicated rehab area; and • Nurse led discharge.
Maternity	<ul style="list-style-type: none"> • Consultant led care for high risk deliveries; • Increase in deliveries against Acute Phase 2 OBC mainly due to increase in immigrant population; • Midwifery led care for low risk deliveries; • Greater use of midwife led ambulatory care; • Birthing pools- greater choice for mothers; and • More patient/ family friendly environment.
Woman's Health Unit inclusive of Maternity Unit	<ul style="list-style-type: none"> • Women want services that are safe, provide high quality care and offer a real choice in the range of care available (DBS).The service includes Maternity Ward, LDRP (Labour, Delivery, Recovery and Postal-Natal) including birthing pools and outpatients. Alongside consultant-led care for those who require intervention and, or epidural anaesthesia. Effective management for obstetric emergencies will also require rapid response and transfer to the nearest obstetric units. A 24 hr epidural service will be offered, with water births available for clients if this is their choice of delivery. Parent-craft will be offered from a dedicated area within the unit. • Due to the sensitive and confidential nature of the service provided, the Women's unit must have an integrated team approach to the delivery of care for the client and her family (CESDI 2004/5). • With this in mind a women's outpatient clinic will provide for a dedicated confidential service for Maternal/Gynae

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Service Department	Benefits of proposed Service Model
	related conditions. The suite will allow for patients to be seen in an area that promotes dignity and privacy for women that would be difficult to achieve within a general outpatient department. Such as intimate examinations/procedures and women health related health education. This women's outpatients also allows for an obstetric ambulatory service.
Neonatal	<ul style="list-style-type: none"> • Works within a Clinical network with Altnagelvin and Royal Hospital for Sick Children; and • Provides isolation and high dependency facilities with family facilities.
Paediatrics	<ul style="list-style-type: none"> • Integrated with children's health unit; • One stop service; • Paediatric ambulatory care unit – co-located (trust currently developing this model as a method of avoiding inappropriate admissions); and • Chronic disease management in a child focused setting led by paediatric specialists - medical, nursing, social work and therapy.
Day Surgery Unit	<ul style="list-style-type: none"> • Assist in delivering new regional waiting lists targets; • Maximises the basket of day case surgery; and • Maximises efficient patient flow.
Theatres	<ul style="list-style-type: none"> • Maximum flexibility – emergency / elective / day surgery; and • Fully integrated Theatre Management System
Surgical Wards	<ul style="list-style-type: none"> • Separation of emergency and elective surgical activity; and • Maximum number of elective general surgical and gynae procedures performed on 23hr day surgical basis – optimal basket of day cases will be performed / achieved (Gynae beds incorporated into elective surgical ward).
Gynae	<ul style="list-style-type: none"> • Working within the Trust network; and • Increase in day case activity
Imaging	<ul style="list-style-type: none"> • New modalities e.g. MRI and Dexa - reduced patient travel times and delays; • Facilitates one stop service provision; • Efficient service delivery- separation of inpatient and outpatient flows; • Reduced waiting times; • Addresses regional waiting list targets and ICATS service delivery;

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Service Department	Benefits of proposed Service Model
	<ul style="list-style-type: none"> • Increases accessibility; and • Better outcomes with faster diagnostics - faster patient journey within area and regional cancer networks.
Outpatients	<ul style="list-style-type: none"> • Rapid access to one stop services with co-located diagnostics; • Facilitating ICATS service delivery; • Ability to continually reduce waiting times in line with new regional (PFA) targets; • Specialist consulting rooms combined with generic clusters of consulting and treatment rooms to maximise use of space; and • Further development of nurse led specialist services.
Clinical Investigations	<ul style="list-style-type: none"> • Ambulatory cardiovascular respiratory investigation unit will afford more accurate assessment, diagnosis and treatment of acute and chronic and respiratory and cardiovascular disorders; • Facilitates Specialist nursing roles in Chronic Disease Management; • Facilitates “Evercare” model of case management; and • Co-location with other OPD services maximises efficient one stop approach.
Education Suite	<ul style="list-style-type: none"> • In line with Department’s recommendations – training on governance, clinical procedures, clinical practice, mandatory training, IT training, infection control etc; • To provide appropriate education facilities to attract clinical staff and students; • To provide training which will support effective developments of health care, appraisal and validation; • To provide an integrated clinical educational facility programme which will facilitate multidisciplinary team working; • Delivering on expanding regional under graduate and post graduate training courses; • Clinical skills maintenance and development; and • Redesign and extending roles – advanced training for new practitioner roles.
Pharmacy	<ul style="list-style-type: none"> • Delivery of Integrated Medicines Management; • Ward based clinical pharmacy; • Reduction in medication errors; • Delivering on independent prescribing; • Developing patient group directives; and • Pharmacist led services, smoking cessation and chronic disease management.

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This Clinical Model and the associated design of the new facility presents an Integrated Model of Care where multi-professional teams work in a managed network across the Trust to provide acute care for the people of the South West. The Clinical Model facilitates team working and is designed by local clinicians and managers (primary / secondary / community) as the best mechanism to deliver on the challenge of high quality, safe, sustainable and affordable patient care.

1.3. RECOMMENDATIONS ARISING FROM ACUTE PHASE 2 OBC

1.3.1. Options considered as part of the Acute Phase 2 OBC

Based on the need for change, the Phase 2 Outline Business Case presented an analysis of options for future hospital provision for the South West, for the provision of modern healthcare facilities and for the procurement method to be applied.

The options required by the DHSSPS to be considered in detail in the Acute Phase 2 OBC were as follows:

- Option 2 – Do Minimum, required by the Green Book;
- Option 4a – the preferred option of the Phase 1A OBC - New build of hospital on the Orange site to the north of Enniskillen; and
- Option 7 – Remodel and expand the existing facilities on the Erne Hospital site, to provide a range of options for consideration.

The preferred option of Acute Phase 2 OBC was Option 4a. This option involved a new-build construction on a green-field site (known as the ‘Orange’ site) which embodied all aspects of the new service model. The construction programme was planned to be carried out over a three year period. The decant of all acute services and staff from the existing Erne Hospital and Tyrone County sites to the newly constructed hospital would be executed upon commissioning of the new hospital after the three year build period.

Table 1.6 overleaf provides a summary of the Preferred Option for the New Acute Hospital:

Table 1.6 Summary of Preferred Option for the New Acute Hospital

	Preferred Option
Option description	New-build hospital to be built on the Orange (Wolf Lough) site north of Enniskillen, replacing the Erne Hospital.
Size of site (acres)	34 zoned for development
Size of buildings (sq.m.)	55,855 (Excluded Key Worker Accommodation)
Design mode	All New build
Number of beds	312
Staffing levels	944
Car parking spaces	800
Works on site commencing	August 2008
Works complete	August 2011
Steady State service model achieved	August 2011
Equipment	25% of existing equipment to transfer, other equipment to be purchased new. To be replaced in accordance with recommended replacement cycles.

Source: Acute Phase 2 Outline Business Case – Table 7.5

An analysis of procurement options in the Acute Phase 2 OBC resulted in the recommendation to commence the procurement of the new acute hospital and related services under a PFI contract.

1.3.2. The Site

The site secured for the new Acute Hospital for the South West is situated at Drumcoo on the main A32 road linking Omagh and Enniskillen. The option to purchase this land was exercised on the 23 December 2006. This green field site offers a high quality environment in a quiet location, with distant views, and is within the town development limit.



The Site extends to c. 15.73 hectares with additional adjacent lands in the control of the DHSSPS.

The main proposed access to the site will be via the A32 (Irvinestown Road) and is restricted to one boundary frontage which provides the best opportunity for a safe and acceptable entrance in terms of visibility and appropriateness.

The key ‘amenity’ of the site is Wolf Lough, along with the northerly / westerly aspect to the surrounding greenbelt and hills, i.e. serene and peaceful views to the natural landscape and environment. Such a pleasant setting is an acknowledged therapeutic benefit in effective healing processes.

1.3.3. Enabling Works

Acute Phase 2 OBC outlined the need for an enabling works contract to prepare the site and install major service connections. A series of activities were to be undertaken to ensure that service and infrastructure projects were completed before the commencement of the main hospital contract. These activities, which were included in the capital costs (Refer to Table 1.7), were:

- Diversion of overhead electrical cables which will be relocated underground (to facilitate site clearance and helicopter access);
- Provision of a service duct across a wetlands area to facilitate the servicing of electrical cables and to minimise any adverse environmental impact on the wetlands;
- Provision of an access area for the Fire Brigade to the “Wolf Lough” side of the site (to meet planning issues) which will also provide services access for electrical cables;
- Cut and filling of the site and levelling to facilitate the new hospital construction; and
- Formation of a new access roundabout on the A32, and provision of service connections to the hospital site.

1.3.4. Capital and Revenue Costs Associated with Preferred Option

1.3.4.1. Capital Costs

The following section demonstrates the capital costs profile from Phase 2 OBC with the financial impact of changes at FBC illustrated in section 1.9 of this chapter. The capital costs presented in Acute Phase 2 OBC for the Acute Hospital are shown in Table 1.7 (Ref: Table 8.8 Acute Phase 2 OBC) overleaf:

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Table 1.7 Capital Costs in Acute Phase 2 OBC

Cost item	Option 4
	£
Site Acquisition	10,000,000
Construction costs	149,212,122
Fees - Pre-Contract	14,871,712
Fees – Post-Contract	7,510,106
Non – works costs	1,800,000
Equipment	18,769,008
Contingency	12,129,777
Sub-Total	214,292,725
Key Worker Accommodation	9,755,846
Road Improvements, A32	5,000,000
Total	229,048,571

Construction costs were at the relevant MIPS Forecast Index Level (MIPS VOP 450, EPI 113) and had a base date of March 2006;

The PFI relevant capital costs are shown in Table 1.8 below (Ref: Table 13.2 Acute Phase 2 OBC):

Table 1.8 PFI Relevant Capital Costs

Item	Cost £	Contingency £	Total costs £
Capital costs			229,048,571
Less:			
Land acquisition ⁴	10,000,000	600,000	10,600,000
Enabling Works**	5,742,000	344,520	6,086,520
Road improvements	5,000,000	0	5,000,000
Equipment (groups 2&3)	18,769,008	1,126,140	19,895,148
	39,511,008	2,070,660	41,581,668
Total PFI Capital Costs	-	-	187,466,903

** This includes the capital cost of the secondary access route

⁴ No contingency should have been applied to land as price had been agreed via an option agreement (some indexation however was applied - £145k). As this cost was deducted within the calculation of input costs into the PFI it has no impact on the calculation of the unitary charge.

1.3.4.2. Revenue Costs

The Acute Phase 2 OBC costs associated with building lifecycle, equipment lifecycle, and staff relocation costs are shown in Table 1.9:

Table 1.9 Costs associated with building lifecycle, equipment lifecycle, and staff relocation costs

Cost Item	Note	Acute Phase 2 OBC Reference	Cost '000
Building Lifecycle	1	Table 8.11	56,800
Equipment Replacement	2	Table 8.12	118,500
Equipment Maintenance	2	Table 8.12	44,000
Staff Relocation Costs	3	Table 8.13	75

Price Base 05/06

Notes to Table 1.9 are as follows:

Note 1 -Building Lifecycle

This cost represents the total lifecycle cost from 2006 to 2042 (end of contract period). From commencement of the PFI contract, the annualised lifecycle cost is £1,748k. This is shown in appendix 1.02.

Note 2 - Equipment Replacement

This cost represents the total equipment maintenance and replacement cost from 2006 to 2042 (end of contract period).

From commencement of the PFI contract the annualised equipment replacement cost is £1.3m.

Note 3 - Staff Relocation Costs

This cost represents the projected staff mileage costs which were forecasted for the four transitional years' arrangements.

It was anticipated that costs will be incurred from 2008/09 to 2012/13.

Recurrent Costs

Table 1.10 overleaf (Table 8.14 from Acute Phase 2 OBC) sets out the summary of revenue costs which combines the results of detailed analysis that was undertaken by the Trust's range of consultants in the areas of workforce, Facilities Management and other costs developed by the Trust.

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Table 1.10 Summary of revenue costs (Table 8.12 Acute Phase 2 OBC 2006)

	Cost £'000
Total Pay Costs	31,077
Goods & Services	5,030
Facility Management	4,455
Rent & Rates	573
Heat, Light & Power	678
Total costs	10,736
Total revenue running costs per Workforce Plan	41,813
Non-project related costs	3,059
Total Revenue Costs	44,872

Source: Sperrin Lakeland Trust

Refer to appendix 1.03 for full breakdown of Revenue Costs.

1.3.4.3. Other revenue costs included in Acute Phase 2 OBC

The costs outlined in Table 1.12 excluded a number of service developments being considered by the Trust at the time of OBC development. The underlying principle was that these were initiatives that would occur irrespective of the new facilities model and would require separate funding from the DBS funding stream. The Trust highlighted that these developments would form part of the normal planning process, whereby bids would be submitted for commissioner support. No assumption for automatic funding for these developments was made. To fully achieve the future service model these service development costs will have to be developed by individual service managers / departments and put forward as bids for commissioner support. The service developments are summarised in Table 1.11 below and detailed in appendix 1.04.

Table 1.11 Summary of Developments Acute Phase 2 OBC

Developments	£'000
Consultants Contract	361
Service Developments	2,618
Maintaining Existing Services	253
Reform & Modernisation	111
European WTD	486
Integrated Medicine Management	549
TOTAL	4,378

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1.3.5. Inputs to Value for Money Test and Outcome

As part of the Acute Phase 2 OBC, a Value for Money test was undertaken in line with Treasury guidelines to determine if value for money could be demonstrated through a PFI procurement route.

The Capital, Lifecycle and Facility Management cost inputs into the Value for Money Test at the time of Acute Phase 2 OBC are shown in Table 1.12 below.

NB: Costs are shown at both 05/06 and 08/09 prices as this represents the base cost and the VFM input costs respectively, that were used in Acute Phase 2 OBC.

Table 1.12 Acute Phase 2 OBC VFM Inputs

	OBC			
	PSC		PFI	
	05/06	08/09	05/06	08/09
Capital Costs	187,466,903	211,851,784	187,466,903	211,851,784
<i>Less Contingency</i>				
Net Capital Costs				
Capex Risk				
Detailed Planning Permission			3,749,338	4,237,036
Specific Construction Expenditure Risk			937,335	1,059,259
Construction Expenditure Inflation Risk			6,795,675	7,679,627
General Change in Law Risk - Capital Risk			4,921,006	5,561,109
Total Capex	187,466,903	211,851,784	203,870,257	230,388,815
Optimism Bias Adj Pre OB		7%		7%
Optimism Bias Adj Post OB		12%		
Annual Lifecycle Costs	1,748,310	1,872,875	1,748,310	1,872,875
<i>Lifecycle Maintenance Risk</i>			87,416	93,644
Total Lifecycle	1,748,310	1,872,875	1,835,726	1,966,519
Optimism Bias Adj Pre OB		7%		7%
Optimism Bias Adj Post OB		12%		
Facilities Management Costs	4,454,658	4,772,048	4,454,658	4,772,048
<i>Operating Expenditure Risk</i>			289,553	310,183
Total FM Costs	4,454,658	4,772,048	4,744,211	5,082,231
Optimism Bias Adj Pre OB		7%		7%
Optimism Bias Adj Post OB		12%		

The detailed Input and assumptions sheet from Acute Phase 2 OBC is shown in appendix 1.05.

The outcome of the base case Value for Money test using the Treasury Model was a margin of 0.74%⁵ and an annual unitary charge of £28.454m.

The VFM Output Sheet from the Acute Phase 2 OBC is shown in appendix 1.06.

The 0.74% margin which, whilst positive, did not in itself necessarily indicate that PFI was appropriate for the project.

The Treasury guidance is clear that the approval to proceed towards PFI procurement must balance the quantitative value for money with the qualitative factors. Thus several qualitative factors were considered:

- The significant advantages of whole-life cost control and budgeting post-contract signature;
- The use of standardised terms and procurement approach to minimise costs and timescales;
- Market interest in the project as a PFI;
- The delivery of the specified services within the agreed budget;
- The delivery of the specified quality of construction within a prescribed timetable; and
- Accountability for a continual standard and quality of service over the project life.

Having carried out a detailed quantitative VfM analysis, and having considered the qualitative factors outlined above, the Trust concluded that PFI was an appropriate procurement route for the new facilities.

Following assessment by DHSSPS, approval was given to the Trust to commence the procurement in July 2006 (approval letter available in appendix 1.07) via the PFI procurement route. This commenced with an advertisement for a PFI contractor in the Official Journal of the European Union (OJEU)⁶. Formal approval of the Phase 2 OBC followed in September 2006 (approval letter available in appendix 1.09).

1.3.6. Affordability Impact/Contributions

The affordability analysis at Acute Phase 2 OBC was presented in accordance with December 2005 guidance entitled *Consolidated Budgeting Guidance from 2006-2007*.

As part of the Acute Phase 2 OBC the affordability of the unitary charge was analysed in accordance with the following three stages:

- Stage 1: Shadow bid model

It is a requirement of the DAO23/05 that the HM Treasury VFM Model's unitary charge output is not to be relied upon for the purposes of affordability analysis and that a separate model should be constructed for that purpose. Thus at Acute Phase

⁵ The positive VfM margin of .074% was at an Internal Rate of Return (IRR) of 13%.

⁶ OJEU Advert can be referenced in Appendix 1.08

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2 OBC stage a shadow bid model was developed to provide an estimate of the unitary charge that would be paid to the private sector Contractor in each year of the operating phase of the Project. The first full year estimate of the unitary charge at Acute Phase 2 OBC was 31.7m (2012/13 prices).

- Stage 2: Identification of the cash affordability gap

A comparison of the unitary charge borne by the Trust against the funding that was currently available for the provision of accommodation for acute services within the Trust was analysed at Acute Phase 2 OBC. A cash affordability gap of £30m (05/06 prices) was identified where the allocation of unitary charge was in excess of the available funding.

Table 1.13 Affordability gap in cash terms in 2005/06 prices

	Phase 2 OBC Ref.	£k (2005/06 Price base)
Current Funding (Budget) (DEL allocation)	Table 8.14	-42,374
New Acute Hospital (DEL)	Table 8.14	41,813
		-561
Current budgets for services to be delivered under PFI		
FM services		-4,455
Building lifecycle maintenance		-623
Total contribution towards PFI costs (DEL)		-5,639
Add: revenue consequences of new service model		
Evercare	Table 8.14	274
Bed Reduction - 50 Day Trim	Table 8.14	581
Leakage to Altnagelvin & Craigavon	Table 8.14	1,204
Ambulance (to be funded separately)	Table 8.14	1,000
		3,059
Service Developments (required regardless of new hospital)	Appendix 20b	4,379
PFI Unitary Charge (2005/06 prices) (Cash)	Para 14.15	27,760
Agenda for Change (unquantified at this time)	Para 14.17	-
Unitary charge and related services affordability 'gap'		29,559

Source: Table 14.3 Phase 2 Acute OBC

- Stage 3: Resource accounting and budgeting analysis

An analysis of the impact of the PPP Project on the accounts of the Trust and on the capital and resource budgets of the DHSSPS was carried out at Acute Phase 2 OBC stage.

The purpose of showing an analysis of resource accounting and budgetary impact was to comply with the requirements of the DHSSPS and DFP as stipulated within the HMT VFM guidance which mandates that affordability is in DEL (Department

Expenditure Limit) terms. This resource accounting and budgeting analysis showed the impact on the financial accounts and budgets of the Trust of entering into a PPP arrangement. It was envisaged (at Acute Phase 2 OBC stage) that the constructed hospital would become the asset of the Trust and the resultant assets would be reflected on the balance sheet of the Trust.

Under the terms of the budgeting and accounting guidance different elements must be considered. These included depreciation, finance charges, service element and capital charges/credits.

The output of this analysis (at Acute Phase 2 OBC stage) showed a Total Resource DEL Impact of £1,052m, a Total Revenue DEL budget shortfall of £1,150m and a Total Capital DEL Impact of £267m.

On the basis of the affordability analysis carried out at Acute Phase 2 OBC stage it was recommended that the Trust and the DHSSPS would seek to secure additional Capital and DEL budgets, in order to meet the DEL consequences of the project. The Acute Phase 2 OBC highlighted that this, and the assurance that unitary payments were sustainable, would be vital to the success of the project.

1.3.7. Conclusion arising from Acute Phase 2 OBC

The Acute Phase 2 OBC concluded that the preferred option in terms of Quantitative and Qualitative issues for the Phase 2A hospital development is Option 4 – New build north of Enniskillen. This option is superior as it provides the flexibility to build an innovative solution with good access on one site close to Enniskillen. Under this option disruption will be minimal, and it reflects the agreed service model, being consistent with the recommendation set out in DBS.

In terms of Value for Money assessment the Qualitative assessment confirmed that there were no significant issues that would preclude the procurement of the project using a PPP approach. The Quantitative assessment base case analysis indicated a VfM factor of 0.74%. Hence the Trust concluded that PFI was an appropriate procurement route for the new facilities.

1.3.8. Approvals Received (Acute Phase 2 OBC)

Following the approval to proceed to initiate procurement through the Official Journal of the European Union (OJEU) for the New Acute Hospital in July 2006, the formal approval to proceed with procurement and development of the Full Business Case (FBC) was granted by DHSSPS on 12 September 2006. This approval covered the following:

- Approval of the Acute Phase 2 OBC;
- Approval to proceed with procurement; and
- Development of Full Business Case (FBC).

Approval was also granted for capital funding totalling £20.5 million as detailed below:

- Exercise option to purchase site (£9.5 million balance);
- Provide site enabling works (£6 million); and
- Contribute towards DRD road upgrade (£5m on implementation).

Refer to appendices 1.07 & 1.09 for the Phase 2 OBC Approvals Letters.

1.4. PROGRESS WITH ENABLING WORKS / SECONDARY ACCESS ROUTE

The Enabling Works approved by Acute Phase 2 OBC were taken forward by the Trust, (in conjunction with Health Estates Agency with a Professional Design and Project Management Team overseeing the works) in the form of two separate contracts, one with Northern Ireland Electricity for the diversion of the electrical cables and the other with P.T. McWilliams for the civil engineering and landscape works.

The two projects encountered some delays and additional expense due to unforeseen poor ground conditions, a landslip incident on low-lying ground towards the front of the site which resulted in some remedial works being removed from the contract, and late delivery of electrical cabling (see section 1.5.1).

Due these delays an extension of time was granted (by the Professional Design and Project Management Team) to the Contractor until mid August 2008⁷.

The revised Enabling Works Contract has been completed and thus will not impact on the PFI programme.

1.4.1. Secondary Access Road (Blue Light Route)

This Secondary Access Road has been designed by the Exemplar Design Team and is currently with Planning Service for planning approval. The Secondary Access Road planning application was delayed by the requirement for a Bat Survey, which could only take place during the first week of May 2008. Pre-Planning application drawings have been submitted to Planning Service.

The Secondary Access Road will be tendered by the Exemplar Design Team on behalf of the Trust in December 2008, with a Contract Programme running from February to April 2009. The Programme for the Secondary Access Road is shown in Table 1.14 below:

Table 1.14 Programme for the Secondary Access

No	Task	Deadline
1	Submit required plans and drawings to Planning	November 2008

⁷ This relates to time lost by the Contractor as a result of delays on site arising from an unplanned landslip and the late delivery of underground electricity cables. The original completion date of May 2008 was extended until July 2008.

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	department	
2	Planning approval period	Nov - Feb 2009
3	Tender Period	Nov - Jan 2009
4	Trust Board Approval	Feb 2009
5	Onsite	Feb - April 2009

This Secondary Access Route will not be part of the critical path of the PFI construction programme and indeed may remain fenced off until the final months of the hospital construction programme. This will remove any risk of impact on either the overall programme or any other impacts on the project. The capital funding for this scheme was secured through an addendum to the Acute Phase 2 OBC.

1.5. CHANGES IN SCOPE BETWEEN APPROVAL OF STAGE 2 OBC & ABC

There have been a number of changes in the scope of the project since the Acute Phase 2 OBC was approved in September 2006, and these are detailed below.

1.5.1. Land Slip

Following the commencement of the Enabling Works contract in April 2007, an unexpected ground slippage occurred on 13 September 07 which affected a portion of low-lying land towards the front of the site, planned for car parking.

The landslip affected an area of approximately 250m by 100m on plan in the South East section of the site during 'controlled up⁸' filling. It was estimated that lateral movement in the order of 20 m had occurred at the centre of the slip. The contractor was instructed by Health Estates to conduct no further work in this area which prevented some of the planned cutting from the south region of the site and filling over the slip region. Material was excavated out at the top of the slip to reduce the load on the slip plane and once the slope was stabilised detailed site investigations were commenced by the Exemplar Design Team (EDT) to determine the cause of the slip.

Discussions took place with all Bidders informing them of the landslip and the options for addressing the remedial work required. Concerns from the bid teams in terms of their funder's requirements for warranted survey information, transfer of risk to the Trust for future slippage in the landslip area and warranty associated with any proposed remedial works resulted in a decision to remove the remedial works from the Enabling Works Project. Health Estates in considering the above recommended that the least risk option to the Trust was to incorporate the remedial works in the PFI scheme. The option of including the landslip within the PFI was shown as an option by Doran Consulting in their October 2007 Report for the Remedial Works (Appendix 1.10A).

⁸ Filling of low lying land in layers of stone and fill material in controlled manner observed by resident site engineer.

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Following this Health Estates and the Trust took advice from the Exemplar Design Team on the new PFI Capital Cost (to include the cost of the remedial works and extension of time i.e. 3 months) . The DHSSPS was then advised of the updated PFI Capital Costs.

As a result, Bidders were given a new affordability envelope and construction programme.

All associated consequential risk with the landslip remedial work and the settlement of any future construction in that area was then transferred into the PFI Acute Hospital Project.

The landslip area was sealed over prior to the end of the Enabling Works Contract and left for remediation by the successful PFI Bidder in a manner that best suits their design solution.

This way forward was agreed with Exemplar Design Team Representative, Doran Constructing (Civil and Structural Engineers) and independent external advisors, Mott McDonald, who were commissioned to oversee aspects of design relating to the landslip remediation.

Following the advice of Health Estates to include the remedial works required by the landslip within the PFI, the Trust set up a series of meetings with Health Estates, the Exemplar Design Team (EDT) and Bidders' Design Teams. Approximately six landslide design solution proposals meetings were held in relation to the development of those proposals. Feedback was given to Bidders at each meeting by Health Estates and the EDT. As there was no 'one fit for all' solution, each bidder's solution was tailored to suit their particular building design solution. Each bidder agreed to include this as part of the remedial works in the PFI Acute Hospital Solution.

Currently the Trust are seeking legal advice through the Central Services Agency (CSA) regarding the claim from a third party land owner and also seeking advice in relation to pursuing a claim against the contractor and the Trust's technical advisors.

The Trust through CSA is in the process of appointing professional technical advisor and loss assessor. These will appointed jointly by the Trust and Health Estates to assess costs and seek recovery.

1.5.2. Soft FM

The chronology of soft FM from Acute Phase 2 OBC to the current position is set out in Appendix 1.10B. The key points of this report are summarised below.

“**Soft FM**” refers to the services that support the operation of the facilities and includes catering, cleaning, portering, telephony, reception, helpdesk, pest control, waste, security, car parking, linen and laundry.

The OJEU notice (appendix 1.08) and subsequent project documentation⁹ proposed the inclusion of Soft FM as part of the scheme scope, ‘where VfM can be demonstrated’

The approved procurement route and associated affordability in Acute Phase 2 OBC was based on the inclusion of Soft FM in the scope of services of the PFI provider, subject to Value for Money (VfM) assessment and in accordance with PFI procurement practice.

Accordingly all Bidders worked with the Project Team in developing both hard and soft facilities management service methodologies.

However, during the Competitive Dialogue process, the Trust advisors (Legal, FM, Strategic Investment Board (SIB) and Health Estates Agency) advised the Trust of the potential risk of Bidders being unable to ‘better’ the Soft Services Public Sector Comparator and therefore not demonstrate Value for Money (VfM). In a situation where VfM is not demonstrated, soft services could not be included in the scope of the PFI project and this could result in the entire Bid being invalid.

Whereby this Soft FM VfM position was not known until after the closure of the dialogue, new procurement regulations would require that the Trust go back to Stage 1 of the Procurement Process i.e. OJEU notice and subsequently re-run the entire procurement. This would result in the following negative impacts; significant nugatory spend from Bidders, advisors and internal project team; significant delays on project delivery; inflationary costs and loss of confidence from Bidders.

To safeguard against this, the Trust, in conjunction with Health Estates Agency and SIB, and following discussions with the DHSSPS, introduced a Mandatory Variant Bid at Stage 2D (final stage before closure of dialogue) for Hard FM only.

⁹ Sections of the IPID-SA and IPID that refer to ‘where value for money can be demonstrated’ is included in appendix 1.11.

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Therefore Bidders were required to submit two bids at Stage 2D:

- Core Bid - Include Hard & Soft Services (Value for Money Test would be applied to Soft Services – Refer to appendix 1.12A)
- Mandatory Variant Bid - Include Hard FM Services Only

The Facilities Management services for the Core and Mandatory Variant Bids at Stage 2D are illustrated in Table 1.15 below.

Table 1.15 – Services included within the scheme

<u>FM Services</u>	<u>Core Bid requirement</u>	<u>Mandatory Variant Bid</u>
Hard FM		
General management	✓	✓
Hard FM only Help Desk Service	✓	✓
Grounds and Gardens Maintenance Service	✓	✓
Utilities Service	✓	✓
Estates Service	✓	✓
Soft FM		
Soft FM Help Desk Service	✓	
Cleaning	✓	
Portering Service	✓	
Hospital Reception Service	✓	
Pest Control Service	✓	
Security Service	✓	
Car Parking Service	✓	
Catering Service	✓	
Linen Service	✓	
Waste Service	✓	
Telecommunications Service	✓	

1.5.2.1. Soft Services FM Value for Money test

The decision framework in Table 1.16 overleaf in respect of the Soft FM service element of the procurement was agreed by the Trust and its advisors.

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Table 1.16 Decision Framework for the Value for Money Test

Scenario	Decision
Soft FM element of all 3 Core Bids is VFM	<ul style="list-style-type: none"> • Include soft FM services in the Invitation to Final Bid (IFB) Core Bid; • Evaluate the Hard FM Mandatory Variant Bid submitted at Stage 2D; and • Require a Hard FM only Mandatory Variant Bid at Stage 3
Soft FM element of 2 Core Bids is VFM	<ul style="list-style-type: none"> • Include soft FM services in the Invitation to Final Bid (IFB) Core Bid; • Evaluate the Hard FM Mandatory Variant Bids submitted at Stage 2D; • Require a Hard FM only Mandatory Variant Bid at Stage 3; and • Determine whether the Bidder whose Soft FM service is not VFM should be given the opportunity to submit a Bid at Stage 3. This decision will be based on a number of factors including a view on the likelihood of the Bidder achieving VFM in the Soft FM element of its Core Bid at Stage 3 and the performance of the Bidder in other areas of the Stage 2D evaluation.
Soft FM element of only 1 Core Bid is VFM	<ul style="list-style-type: none"> • Evaluate the Hard FM only Mandatory Variant Bids; • Request Hard FM only Core Bids at Stage 3; and • Invite all 3 Bidders to submit an optional Variant Bid at Stage 3 which includes Soft FM services.
Soft FM element of no Core Bids is VFM	<ul style="list-style-type: none"> • Evaluate the Hard FM only Mandatory Variant Bids; and • Request Hard FM only Core Bids at Stage 3.

The above decision framework was based on the assumption that any Bidder who submitted a Bid that passes the Soft Services FM VFM Test at Stage 2D would also submit a Bid that passed this Test at Stage 3. In other words, whilst Stage 2D Bids were not legally binding¹⁰, the assumption was that Bidders' costs in respect of Soft FM services would not increase from Stage 2D to Final Bids.

The need for the Soft Services FM VFM test was discussed with bidders from the commencement of Competitive Dialogue. From June 2007 more detailed and informed discussions took place. The Soft FM Evaluation Methodology formed part of the Stage 2D (Preliminary Total Package Offer) and Stage 3 (Final Bid) Evaluation Methodology that was issued to bidders prior to their Stage 2D submissions on 03 August 2007. The Soft FM Costs (Public Sector Comparator) were developed by VFM Consultancy¹¹ and a VfM Hurdle Test was developed by the Trust. A 5% materiality was applied by the Trust as the margin required between

¹⁰It should be noted that Final Bids are also not legally binding although the EU regulations prevent substantial movement between Final Bids and Financial Close.

¹¹ VFM Consulting were appointed by the Trust in 2005 to produce the Public sector comparator. This has been used for the Value for Money test and is therefore independent from the other FM advisor (Davis Langdon).

the Public Sector Comparator and Bidder proposals following a balanced assessment taking into consideration the wider strategic issues of value for money for soft services.

The 5% materiality was the minimal acceptable percentage that would satisfy the Trust that a clear visible benefit could be realised by transferring Soft services to the private sector within the scope of the PFI project.

In addition the 5% considered the following factors:

- The political and social risk of transferring staff to the private sector whereby the Bidders price marginally 'beat' the PSC (Public Sector Comparator).
- To maximise competitive tension by pushing bidders prices down at Stage 2D.
- The Private sector, PFI Contractor can realise benefits from economies of scale, expertise and efficiencies that the Public Sector are unable to realise.
- To ensure that bidders would offer their 'real' price at Stage 2D, rather than delaying to final bids whereby bidders could 'sharpen their pencil'
- There is a risk that the PFI Contractor will increase their Soft FM prices via their annual unitary charge following market testing of soft services 5 years after service commencement. Therefore the 5% materiality provides some protection for the Trust in this regard.

The materiality level was communicated to bidders via the Stage 2D evaluation methodology in August 2007.

1.5.2.2. Outcome of the Soft Services VFM Test

The outcome of the Soft Services Value for Money Test at Stage 2D was that one Bidder demonstrated value for money (Refer to the Soft Services VfM Evaluation Report in Appendix 1.13 and Soft FM Chronology in Appendix 1.10B). Based on the framework above, this led to:

- The Request of Hard FM only Core Bids at Stage 3; and
- The Invitation to all three Bidders to submit a Voluntary Variant Bid at Stage 3, which includes Soft FM services.

During the course of the dialogue (pre-ministerial decision on removing cleaning from the scope of private sector contracts see section 1.5.3), the one Bidder who did demonstrate value for money confirmed their intention of submitting a voluntary variant for Soft FM at Stage 3, Final Bid. The other two Bidders confirmed that they would not submit a voluntary variant as they did not anticipate that they could achieve value for money.

The Facilities Management services for the Core and Voluntary Variant Bids at Stage 3 are illustrated in Table 1.17.

Table 1.17 FM Services for the Core and Voluntary Variant Bids at Stage 3

<u>FM Services</u>	<u>Core Bid requirement</u>	<u>Voluntary Variant Bid</u>
Hard FM		
General management	✓	✓
Hard FM only Help Desk Service	✓	✓
Grounds and Gardens Maintenance Service	✓	✓
Utilities Service	✓	✓
Estates Service	✓	✓
Soft FM		
Soft FM Help Desk Service		✓
Cleaning		✓
Portering Service		✓
Hospital Reception Service		✓
Pest Control Service		✓
Security Service		✓
Car Parking Service		✓
Catering Service		✓
Linen Service		✓
Waste Service		✓
Telecommunications Service		✓

1.5.3. Removal of Cleaning

Following a ministerial decision in November 2007, cleaning was removed from the scope of the PFI soft facilities management services. One Bidder (Bidder 2)¹², who throughout the process had demonstrated their enthusiasm for the inclusion of Soft FM in the scope of services, indicated that the removal of cleaning from the suite of services, had a significant impact on their bid. This was largely due to a dependency of multi-skilling¹³ in their previous Stage 2D bid, which was no longer feasible.

A period of intensive discussions with this bidder ensued. In the first instance the bidder indicated that they would not be submitting a Soft FM Voluntary Variant

¹² This bidder passed the Value for Money Test at Stage 2D

¹³ Multi-skilling is a term used to describe an individual whose job description may covered a number of different activities and services. The use of multi-skilling in a Total FM (TFM) contract is common practice as savings are made from limiting down time of individuals which a single service operative may have in their daily working life. A good example of multi-skilling is a cleaner who may clean departments in less busy times, but also has duties outside of cleaning such as serving meals etc.

(excluding cleaning services) but would resubmit the Mandatory Soft FM Variant including cleaning that they had submitted at Stage 2D.

The Trust responded at this time outlining that the bidder was required to respond to the deliverables set out in the Stage 3 Evaluation Methodology. As these deliverables addressed the exclusion of cleaning from the scope of the PFI, Bidder 2's proposal of submitting an 'all inclusive' bid was deemed unacceptable by the Trust and their advisors.

Consequently, following further discussion with the Trust and internally with the bid team they decided to retract their voluntary variant submission for Stage 3. They indicated in this correspondence that the removal of cleaning would limit the innovation and efficiencies that the full Soft FM model offered. This resulted in no voluntary variant bids being received at Stage 3.

The Trust did however provide an affordability target for this voluntary variant.

Correspondence between the Trust and Bidder 2 has been provided in Appendices 1.14 A to 1.14 G.

1.5.4. 100% Single Rooms

At Acute Phase 2 OBC, the design of the new hospital aimed to meet the standards that had been endorsed in Northern Ireland through Health Estates in PEL Letter 04(04) (Appendix 1.15).

These standards included:

- Single sex wards;
- 50% of beds should be single rooms;
- Privacy and dignity should be enhanced by the design; and
- Dedicated areas provided for children and young people.

With the Ministerial decision in December 2007 on the requirement to plan to 100% single rooms, discussions led by Health Estates took place with bidders concerning their proposal on the 100% single room ward model. These discussions were in line with the subsequent published DHSSPSNI PEL (08)07 (see Appendix 1.16) which advised the following: “It is the intention that the provision of single rooms, when coupled with more efficient design principles (e.g. beds arranged in cohorts of 8 with decentralised nurse’s stations and storage), will keep the nurse close to the patient and ensure the achievement of a much more person centred model of care”

The viability of the 100% single room proposals was endorsed by Health Estates as it meant minimal adjustment to the overall design format. This proposal was also endorsed by the Trust’s Commercial Group and Project Board.

1.5.5. Agenda for Change

Whilst Agenda for Change (AfC) was acknowledged in the Acute Phase 2 OBC, it was not quantified owing to the level of uncertainty at that time. It was also highlighted in the Acute Phase 2 OBC that Agenda for Change would be funded from a separate regional funding stream and, therefore, was considered a pressure that would occur irrespective of the new acute hospital. Finally, for the purposes of the VfM analysis at Acute Phase 2 OBC, it was recognised as a neutral factor as it applied equally to both Public Sector Comparator (PSC) and PFI costs.

1.5.6. One Off Cash Injection (OOCI)

In October 2007 the DHSSPS advised the Trust and its financial advisers that a one off cash sum of approximately £100m (£100.421m) would input into the payment structure for the PFI. Payment would be made post receipt of the independent tester's certificate signing off the practical completion of the facility. This ensured that payment was on achievement and delivery of a significant milestone with the effect that the cost of construction and related development fees financed over the PFI operational term would be reduced, leading in turn to a reduction in private sector financing charges over the operational phase of the contract as captured within a reduced unitary charge.

This mechanism known as a One Off Cash Injection (OOCI) (designated as the works payment within the project agreement) was developed by DHSSPS Finance. DHSSPS took the proposal from conception through development, quality assurance, approval by DFP and HM Treasury, and eventual adoption involving key stakeholders (DHSSPS senior management, DFP and SIB) within the process.

In developing the OOCI consideration was given to:

- legal principles within the standard form contract;
- accounting treatment under UK GAAP; and
- affordability and budgeting as aligned to the HM Treasury Consolidated Budgeting Guidance and DFP requirements.

These are discussed in further detail below.

The principles underpinning the one off cash injection were developed by DHSSPS outside of any specific project procurement, and were effectively concluded within the Omagh and Enniskillen projects.

1.5.6.1. Legal Principles within the standard form contract

The legal aspects considered included:

- **Requirements within the standard form contract - Delivery of a significant milestone**

The principles developed within the December 2004 to the standard form contract, required that payment within the contract structure should not be made until a significant or major milestone was delivered by the private sector. The OOCI is only payable post practical completion of the infrastructure asset necessary for the commencement of the operational phase of the contract and the delivery of the service, when practical completion has been certified by the independent tester. This is reflected within clause 35A of the project agreement.

- **The appropriate legal controls around termination**

In discussions with the Trust's legal advisors the provisions for payment of the one off cash injection in the event of a contract termination pre practical completion were established. The terms of the project agreement are such that where project termination occurs as a result of operator default the lower of the value of the one off cash injection and the fair value of the contract is payable.

1.5.6.2. Accounting Treatment under UK GAAP

As residual value risk and demand risk are expected to reside with the public sector it is envisaged that the project would be placed on the Trust's balance sheet under UK GAAP. Further detail on the accounting treatment of the project is included in Chapter 3.

The accounting treatment of the one off cash injection considered:

- The link to the delivery of the infrastructure asset necessary for the commencement of the service;
- The effect of the one off cash injection; namely to reduce the amount funded by the private sector post practical completion over the project term; and
- Sustaining risk transfer over the critical construction phase and the incentive to deliver. (This was achieved by having the full value of the financing requirements of the project at risk, up to the commencement of the operational phase post the independent tester sign off re the satisfactory completion; - this effectively sustains risk transfer and the incentive to deliver the facility on time and on cost).

Given the principles of the one off cash injection it was envisaged that the required accounting treatment for the OOCI was to allocate the one off cash injection to the on balance sheet liability. The OOCI was clearly only payable on the delivery of the facility i.e. a payment in respect of past performance and not future service delivery;

and its effect was to reduce the amount financed by the private sector over the operational term.

The proposed accounting treatment was discussed with the DFP including Supply, and the Chief Treasury Officer of Accounts where it was accepted.

International Accounting Standards

The current timetable for the introduction of international accounting standards into the public sector is set for 2009/10.

It is envisaged that the allocation of the one off cash injection to the on balance sheet liability will be sustained, as the principles surrounding the payment for past delivery on completion of the facility as opposed to future services persist.

1.5.6.3. Budgeting Treatment

The accounting treatment and affordability are linked. DHSSPS Finance determined the budgeting treatment based on a review of the HM Treasury's Consolidated Budgeting Guidance (Chapter 14).

Throughout the development of the budgeting treatment DHSSPS Finance engaged with DFP Central Expenditure Division (CED) in order to quality assure the proposal and agree the approvals needed and the most appropriate way of engaging with HM Treasury. This process involved DFP CED and OFMDFM culminating in HM Treasury's formal approval to DFP CED of the principles within the one off cash injection in July/ August 2007.

In summary the budgeting treatment of the one cash injection is:

- payment of the one off cash injection – outside of the budget as the payment is related to the reduction of the on balance sheet liability; and
- attendant reduction in the cost of capital credit derived from the on balance sheet liability which has reduced in value

This treatment is in line with the proposals and principles of the one off cash injection.

The recognition of the on balance sheet asset and treatment of the unitary charge each year remain as per on balance sheet PFI projects.

This HMT agreed budgeting structure has been updated to the affordability profiles for the PFI presented within this Appointment of Preferred Bidder Business Case at Chapter 3.

1.5.6.4. % one off cash injection payable

Through out the development of the OOCI, its £ value had always been envisaged as a percentage (%) of the value of the infrastructure asset funded. The DHSSPS Finance proposals had been developed to ensure that:

- an appropriate proportion of long term at risk finance remained within the project over the operational phase; and
- sufficient financing requirements existed to facilitate the continued availability of alternate bond and bank financing routes to enable the selection of the best VFM funding route.

As such DHSSPS had developed the proposal based on 40%.

Prior to finalisation of the proposal and its introduction into projects the SIB were asked to determine whether 40% or 45% was the appropriate level at which to set the one off cash injection. 40% and 45 % were considered as sufficient critical mass was needed to enable alternate private sector funding routes bond vs. bank to be in play and maintain the balance in favour in private funding to sustain incentive. The SIB confirmed the appropriate % at 40%.

In implementing the proposal within the Enniskillen project the Trust's project financial advisors debated whether to issue a definitive £ figure for the one off cash injection or a %. This evaluation, (as agreed by the Department) resulted in a given £ value based on 40% of the PSC at a given period of time being issued to bidders. The rationale was to ensure transparency in the competition and assessment process between the treatment of the one off cash injection by each bidder. As bidder's have individual solutions the value of the one off cash injection if released as a % of construction cost would vary from bidder to bidder making comparison and testing between individual bids difficult and less transparent.

An OOCI value of £100.421m based on the Trust's Public Sector Comparator as (6th December 08) was issued to bidders.

1.5.6.5. VFM

The VFM impact of the principles proposed in the one off cash injection was tested using unitary charges developed from the pre approval work on the Omagh OBC2. This VFM assessment was evaluated by DFP who agreed that the proposal did provide VFM.

1.5.6.6. Activities post introduction into the project

Once the decision had been made to introduce the one off cash injection of £100.421m into this project, further work and further refinements and developments occurred. These included:

a) Production of revised affordability envelopes and discussion with bidders

The Trust's project financial advisors reran their financial models to produce a revised target unitary charge and related affordability envelope for issue to the bidders. Bidders were required to re run their models to reflect the changes within the payment profile resulting from the one off cash injection. Significant dialogue was needed with bidders to embed the proposal within the procurement. As part of the dialogue bidders were advised of the following:

- Payment at actual practical completion will be from an Escrow account held by the Trust's Legal Advisers, L'Estrange and Brett into which the DHSSPS will have lodged funds at least [2 weeks] previously. Payment will be made 1 day after the receipt of an invoice for the amount. This invoice can only be raised once Actual Practical Completion has been agreed. Bidders were told to assume that the invoice would be raised [net] of VAT for the current submission. This has been further discussed below in section B deed of safeguard and payment process
- Payment at the long-stop date will be in line with the provisions of the project agreement.
- The Stage 3 submission should demonstrate ALL funders' understanding of the OOCI and its use of a floating date for payment. This should include any additional funders providing short term funding for the capital injection. The funding structure of the core bid should be deliverable as a stand alone package and should not rely on additional financial products or funders to be put in place after this submission.
- The Bidder should demonstrate how both it and its funders have taken regard of the risks to the SPV of a delay in Actual Practical Completion.
- The submission should show clearly the base date UP and NPV benefits of the OOCI in line with the method of calculating NPV clarified in Stage 2D.

As part of this process it was necessary to issue 2 revised affordability envelopes November 2007 and January/February 2008 to take account of the turmoil within the financial markets, the respective stage of the procurement and the discussions which were possible with bidders and their related funders at this stage.

b) Deed of safeguard

To provide the appropriate assurance, the DHSSPS agreed to provide a deed of safeguard to the PFI provider in respect of the one off cash injection (November 2007). This ensures that where the Trust are unable to meet their obligations that the Department will in effect step into their shoes making the one off cash injection payment, provided that the PFI provider has delivered their project agreement obligations.

It should be noted that deed of safeguard only covers the payment of the one off cash injection, and falls away post the delivery of the facility, sign off by the independent tester, invoicing and payment. It will not exist within the operational phase of the project and there is no deed of safeguard in respect of unitary charge payable over the 30 year operational term.

As part of this process DHSSPS Finance sought and obtained DSO sign off to the drafting of the one off cash injection and related terms. This resulted in the inclusion of DSO accepted provisions for the deed of safeguard within the final project agreement at closure of the dialogue (February 2008).

Payment Processes

Whilst the Department is confident that the draw down processes from DFP and electronic transfer are such that payment to the PFI provider can be made within the

specified time frame; consideration and conditional agreement was given to lodging the one off cash injection in escrow with the Trust's legal advisors prior to receipt of the practical completion certificate.

Under the agreed proposals, the Trust's legal advisors will hold the monies, remitting interest to the Department until receipt of a practical completion certificate and invoice at which point onward payment will be made.

This will give added assurance around the payment processes, whilst ensuring that income is not lost to the public sector.

DHSSPS agreed with the Trust's legal advisors that where payment approached a year end, payment in escrow would be reviewed.

Moving forward the Department will continue to liaise with DFP Supply/ CED on the expected timetable for the payment of the one off cash injection to ensure that the necessary timely cash draw downs are in place.

c) VAT

The VAT treatment of the one off cash injection was evaluated and discussed with the Trust's project financial advisors. Whilst it is the responsibility of the provider to apply the correct VAT treatment to their invoices, the Trust's project financial advisors have confirmed that the one off cash injection should fall within the auspice of s.99 of the VAT Act 1994 and VAT will be recoverable.

d) Adoption of CIAF (Cash injection adjustment factor) mechanism

The performance incentives within the project are sustained through the requirement for practical completion certificate and the adoption of a ratio applied to the Performance regime within the unitary charge payment mechanism, to reinstate the £ value of deduction to pre one off cash injection levels. (The inclusion of the one off cash injection reduces the unitary charge payable within a given year and hence the application of a straight % deduction would result in a lower £ value).

This CIAF adjustment factor which was developed by the Trust's project financial advisors was included within the Trust's final project agreement pre closure of the dialogue. The Trust and their legal advisors have indicated that the changes to the CIAF (with the exclusion of fine tuning) will not be accepted. Further detail on the CIAF is included within section 6.6.1.

1.5.6.7. Conclusion

This process has culminated in the principles of the one off cash injection and the related project agreement reaching sufficient certainty to enable each of the bidders to submit a mandatory bid including this structure.

1.6. RECOMMENDATIONS ARISING FROM APPOINTMENT BUSINESS CASE

The ABC presented the case for the appointment of a Preferred Bidder (NIHG) from the PFI consortia competing to provide a New Acute Hospital for the South West, and in line with the regional Developing Better Services (DBS) strategy.

The purpose of the ABC was to provide an overview of the procurement process, the results of the evaluation and to recommend a Preferred Bidder that the Trust would then partner with to deliver the New Acute Hospital for the South West. An update was provided on the key elements that underpin the procurement process such as the Value for Money assessment, financial modelling and affordability. The ABC was a precursor to this Full Business Case.

Recommendations from the ABC incorporated all the scope changes as outlined in Section 1.5 above .

1.6.1. Approvals Received (ABC)

The ABC was approved by the DHSSPS on 19 August 2008, which gave the Trust the approval to proceed with the appointment of the Preferred Bidder for the New Acute Hospital for the South West.

Refer to appendix 1.17 for the full detail of the ABC Approval letter.

1.7. CHANGES IN SCOPE SINCE APPROVAL OF ABC

Since approval of the Appointment Business Case (ABC) on 19th August 2008 there has been further refinements made to the PFI Project i.e. Mandatory Variant - European Investment Banks (EIB) funding contribution;

These refinements are detailed in Chapter 7 of this FBC and the financial implications are captured in Section 1.9, 'Financial impact of changes since Stage 2 OBC' and Chapter 3, Affordability and Accounting treatment.

1.8. DEVELOPMENT OF CAPITAL COSTS SINCE ACUTE PHASE 2 OBC

Capital costs have moved from Acute Phase 2 OBC and FBC owing to the following:

- **Adjustment to MIPS:**
Adjustments to MIPS were made at different stages to reflect the Department of Health's Quarterly Briefing Volumes.
- **Reduction in the size of Key Worker Accommodation:**
Following a further assessment of need, the Key Worker Accommodation was downsized.
- **Landslip:**
The landslip that occurred in September 2007 and described in Section 1.6.1 had a significant impact on costs.
- **Extension to programme:**
The introduction of a Mandatory Variant Bid for Hard FM only at Stage 2D led to a three month extension to the original programme. This had an impact on the timing of capital costs.
- **Change in risk adjustment to reflect the landslip:**
The landslip as referred to above required an adjustment to the specific risk values, reducing the Capex Risks from 8.75% to 8.5% as more knowledge on the ground conditions was acquired through extensive ground investigations completed following the landslip. More certainty could be provided with the Bidders design solutions.

No adjustment has been made to the Public Sector Comparator for 100% Single Room provision as the Trust, in conjunction with Health Estates, has assessed that this can be achieved within the existing cost envelope.

Table 1.18 overleaf details the audit trail of capital costs from Acute Phase 2 OBC to the Appointment Business Case (ABC).

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Table 1.18 AUDIT TRAIL OF PFI CAPITAL COSTS FROM ACUTE PHASE 2 OBC to ABC

Audit Trail	Note	£'000
Total PFI Capital Cost for Acute Phase 2 OBC*		266,795
<i>Less Risk @ 8.75%</i>		(18,537)
Restated MIPS	1	(21,588)
Total 1 (Appendix 1.18)		226,670
Reduction in Key Worker Accommodation	2	(1,661)
Total 2 (Appendix 1.19)		225,009
Updated MIPS	3	2,123
Total 3 (Appendix 1.20)		227,132
Extension of 3 months	4	3,722
Total 4 (Appendix 1.21)		230,854
Landslip	5	10,535
Non Risk Adjusted Costs (Appendix 1.22B)		241,389
Risk @ 8.5%	6	20,518
Total Revised Capital Costs		261,907

* This differs from the PFI Capital Costs in Table 1.9 (PFI Relevant Capital Costs) owing to the MIPS uplift to outturn costs and the appliance of PFI risk. Appendix 1.19 also illustrates this.

Table 1.18 has been prepared by the Trust with information provided by the Exemplar Design Team's Quantity Surveyor. The Capital Costs were signed off at ABC stage and there have been no changes since then. It has been fully quality assured by Health Estates Quantity Surveyor and Project Managers in November 2008.

Notes to Table 1.18 Audit Trail of PFI Capital Costs from Acute Phase 2 OBC to FBC

Note 1 – Restated MIPS

Following a further review of the Capital Costs, (post Acute Phase 2 OBC), the DHSSPS detected an error in the MIPS uplift from 3Q08 to 3Q10. It was discovered that the uplift (for 2 years) was over exaggerated at 15.802%. In February 2007, the Trust's financial advisors amended this by reducing the uplift to 6.4%, leading to a reduction in outturn costs of £21.588 million.

Refer to Appendix 1.18 for further detail.

Note 2 – Reduction in size of Key Worker Accommodation

A reduction of £1.6m on the base cost was related to the reduction in area of the key worker accommodation¹⁴. The Key Worker accommodation was downsized post Acute Phase 2 OBC, owing to a further investigation of the needs associated with Key Worker accommodation.

The MIPS levels were also reviewed as follows:

¹⁴ At Acute Phase 2 OBC stages it was acknowledged that refinement was required on the number of rooms etc. Thus the area reduced from 4960 m2 to 4199 m2.

- The new base cost was based on MIPS 450 (August 2005);
- Uplifts were taken from Department of Health Quarterly Briefing Volume 14 No.4 12/2005;
- MIPS to Contract start date (3Q08) was based on Variation of Price Tenders indices giving an increase of 12.89%; and
- MIPS for uplift from contract start to mid contract was not available at that time and therefore the Building Cost Index (BCI) indices were used resulting in an addition of 7.25%.

See cost breakdown in Appendix 1.19.

Note 3 – Updated MIPS

Following the restated MIPS and the reduction in Key Worker accommodation total costs were updated to reflect the latest MIPS based on Volume 15 No 3 Winter 06/07.

This resulted in the MIPS uplift to contract start increasing to 14.22%.

The MIPS forecast was still not available to mid contract therefore the Building Cost Index BCI was again used which reduced the uplift to 7.00%.

See cost breakdown in Appendix 1.20.

Note 4 – Extension to Programme

Owing to the revised procurement programme (introduction of the Mandatory Variant Bid at Stage 2D (Preliminary Total Package Offer) as per Section 1.6.2), the start date for the project was adjusted from 3Q08 to 4Q08 and therefore the costs needed to be updated accordingly. This update was carried out using the latest MIPS (Volume 15 No.4 Spring 07).

The MIPS uplift to contract start increased to 16.44%.

MIPS indices were now available for the uplift to mid contract which was now 4Q10. This resulted in the uplift reducing to 6.68%¹⁵.

See cost breakdown in Appendix 1.21.

Note 5 – Landslip

Costs¹⁶ were adjusted to allow for remedial works over the area of the landslip which occurred during the enabling works contract. The cost of the works was estimated at

¹⁵ The uplifts of 16.44% and 6.68% are two completely different items. The 16.44% uplift was to uplift the cost from the estimate base date to the actual start date which was 4Q08. The 6.68% was to uplift the cost to allow for inflation from the start date to 2 years into construction (4Q10).

4Q07 prices by WH Stephens (Quantity Surveyors as part of the Exemplar Design Team) in conjunction with Health Estates and uplifted to mid contract (4Q10). Indices used were from Volume 16 No.1 Summer 07.

The costs for the retaining wall¹⁷ which were omitted from the enabling works contract were added to the scheme. The cost used was the tender price which was 1Q07 and uplifted to 4Q10. Indices used were from Volume 16 No.1 Summer 07.

Due to the additional works required, the Exemplar Design Team advised that the contract was extended by a further 3 months taking the start date to 1Q09 and the mid contract to 1Q11. The costs were updated to reflect this using the MIPS from Volume 16 No.1 Summer 07.

Refer to Appendix 1.22A shows the movement in timeline from IPID to current status.

Refer to Appendix 1.22B for the cost breakdown.

Note 6 – Risk Quantification

An analysis of Risk Quantification led to the capital expenditure being assessed by the Trust's OBC advisor as 8.75% higher than the estimated costs of the PSC option included in the VfM assessment (prior to adjustment for Optimism Bias). This figure is analysed between the specific construction risks identified in the table below in conjunction with Health Estates. This reflects the fact that more cost and delay risk is transferred to the private sector under the PPP option and that, typically, the PPP partner succeeds in passing on many of these risks through sub-contract arrangements.

Since Acute Phase 2 OBC the Landslip has led to the greatest rise in costs and has also led to a marginal adjustment to the risk values identified at Acute Phase 2 OBC.

Discussions with the Trust, Health Estates and DHSSPS has reduced the specific construction risk of soft ground conditions, whereby 0.5% has been reduced to 0.25% as an element of this risk has already occurred and thus more knowledge of the site exists. Hence the overall total capex specific risks have been updated to 8.5% (the other risk values have remained the same). Refer to Table 1.19 overleaf.

¹⁶ MIPS values have been used under the advice of Health Estates and all capital costing work done by the QS has been quality assured by Health Estates.

¹⁷ The retaining wall was originally part of the enabling works tendered in 1Q07 and the value was £83,150. To avoid potential abortive works this work was omitted from the enabling works contract and added into the PFI project. A contingency of 6% was added to the construction cost and the total uplifted from 1Q07 to mid point (4Q10). A 15% allowance for fees was then added and the total of £118,540 added to the Public Sector Comparator.

Table 1.19 Specific Risk Values as per Acute Phase 2 OBC and FBC

Risk	Impact valuation % as per Acute Phase 2 OBC	Impact valuation % as per FBC
Detailed Planning permission	2.00 of capex	2.00 of capex
Specific construction risk of soft ground conditions	0.5% of capex	0.25% of capex
Construction expenditure inflation	3.625% of capex	3.625% of capex
General change In law	2.625% of capex	2.625% of capex
Total Capex specific risks		
Operating expenditure risk	6.5% of opex	6.5% of opex
Lifecycle maintenance costs	5.00% of lifecycle costs	5.00% of lifecycle costs

NB: Capex Risk was assessed at 8.75% at Acute Phase 2 OBC. It was agreed at a meeting held on 20th December 2007 (in attendance Deloitte, HEA, DHSSPS and the Trust) that this should be reduced to 8.5% as more knowledge on ground conditions exist as a consequence of the landslip that occurred in September 06. This was also confirmed in November 2008.

1.8.1. Non PFI Capital Costs

1.8.1.1. Information Communications Technology (ICT)

The Acute Phase 2 OBC included costs for the hard wiring of the ICT systems, but excluded costs associated with the operation of ICT as these costs were covered in a separate ICT Business Case¹⁸ submitted by the former Sperrin Lakeland Trust to the DHSSPS in September 2006. However this ICT Business Case is currently being reviewed by the new Western Health and Social Care Trust in the light of developing a Trust wide ICT Strategy. The Trust will resubmit this ICT OBC in a phased manner with Phase 1 to be submitted in July 2009. This Phase 1 ICT OBC will seek funding for the ICT elements that are fundamental to the operation of the new hospital.

The Trust has identified the following items as fundamental to the operation of the new hospital:

- Network Active Gear including Wireless Networks;
- UPS (Uninterruptible Power Supplies);
- Servers/Storage; and
- Re-termination of existing communication links.

Table 1.20 outlines the estimated capital costs requested for the fundamental items listed above.

¹⁸ *Towards an Outline Business Case, Information and Communications Technology, Enabling the implementation of 'Developing Better Services' for the Southwest*

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Table 1.20 Estimated Capital Costs of the Fundamental ICT items

Category	Estimated Capital Cost £
Switches	
Core Switches	52,500
Distribution Layer	100,000
Access Layer	340,000
Total Switches	492,500
Uninterruptible Power Supplies	
UPS	36,800
Total Uninterruptible Power Supplies	36,800
Servers	
Servers (11)	165,000
Total Servers	165,000
Communication Links	
Data Link - Existing Acute - New Enniskillen Hosp - 100MB	6,600
Data Link - New Acute - Omagh Hospital Complex - 100MB	10,300
Data Link - Move existing link from Gransha to Erne, from Gransha to New Acute	10,300
Data Link - HPSS Link from New Acute Hospital to Belfast	10,300
Re-termination of existing local connections - Enniskillen Site (13 sites)	6,500
Comms kits for existing connections - 13 sites	45,500
Fibre optic link between Main Equipment Room and Central Wiring Point	7,000
Total Communication Links	96,500
Telephone System	
Voice Over Internet Protocol (VoIP) system	420,000
Total Telephone System	420,000
Wireless Network	
Wireless Networks	200,000
Total Wireless Network	200,000
Total	1,410,800

NB: These costs are based on 07 / 08 prices

Whilst the Trust are not seeking approval for these ICT items in this FBC it is absolutely critical that the funding for these items is secured to ensure that the hospital can successfully operate.

These costs are estimated by the Trust ICT department and will form the basis of the revised / updated ICT OBC (Phase 1) to be presented to DHSSPS in July 2009.

In addition to the above capital costs a commissioning team of three TSO Band 5's will need to be in place at least six months prior to the commencement of commissioning and be in place for approximately 2 years. This will be fully detailed in the Trust's ICT Business Case.

The Trust recognise that, there are other ICT elements that will be required to integrate and support the above, but will possibly be funded by alternative regional

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funding streams i.e. the NiPACS system, theatre management systems (TMS) and the desktop procurement project.

1.8.1.2. Equipment (Non Medical)

The equipment requirements for the new hospital were detailed in Phase 2 Acute OBC.

The Trust is now seeking funding for the categories of equipment which will be funded outside the unitary charge and outside the Medical Equipment Business Case which is currently with the DHSSPS for consideration.

These items of equipment are shown in the Table 1.21 below, and reflect the bed numbers for the opening position of 2012, then 2015 and the final position of 2018 when all beds will be in use.

Table 1.21 Equipment which will be funded outside the unitary charge and outside the Medical Equipment Business Case

Category	Supply / Replace	Install, Commission & Maintain	Description	Examples	Value (£) 2012	Value (£) 2015	Value (£) 2018
C	Trust	Project Co.	Items of equipment which require installation/fixing on a Project Co. surface, but which would be more cost effectively supplied and replaced by the Trust.	This includes wall mounted equipment such as consumables dispensers, spill kits, and brackets for display screens.	195,525	12,541	8,709
E	Trust	Trust	All non-medical items of equipment which do not require fixing or installation on a Project Co. surface.	This includes: a) Ward and department furnishings b) Patient non-medical equipment, eg. patient transport, portering chairs, trolleys c) FM cleaning and catering equipment d) Office Equipment including PC printers etc. Communications devices, Training equipment	4,151,358	71,293	19,800
Subtotal					4,346,883	83,834	28,509
3 years Inflation @ 2.5%					326,016	6,288	2,138
Grand Total					4,672,889	90,122	30,647

This table has been updated following approval of the ABC and appointment of a Preferred Bidder. The new cost reflects an additional £116,000 following the review of the equipment requirements, department by department, room by room and has been completed in conjunction with Regional Supplies Service.

The Trust will require a Capital Allocation in the final year of construction to procure the above equipment.

1.8.1.3. Commissioning

Following a practical completion target date of March 2012, the three-month Trust commissioning period shall cover March to June 2012, with the facilities becoming fully operational by July 2012. The commissioning stage also includes a 5 month period of beneficial access prior to practical completion and extends into the first three months of operation.

The Commissioning stage is crucial and guides the project into operation following the construction completion and handover. Plans for the Commissioning Phase will be developed during the construction phase in close liaison with operational and technical staff that forms a core part of the Commissioning Team structures. Key outputs for this phase include the Commissioning Master plan, Commissioning Programme, Occupational Procedures, Transition plan including staff training and occupation programmes and Staff and Patient Transfers.

Non-recurring costs associated with the Commissioning Phase of the project are as follows:

Table 1.22 Non recurring costs associated with Commissioning Phase

New Hospital for the South West			
Non Recurrent Commissioning Costs			
		£	Duration
1	Commissioning Team 2011/12	640,200	12 months
	Commissioning Team 2012/13 (6 months)	314,600	6 months
	PPE Team 2012/13 (6 months) 2013/14 (3 months)	174,900	
2	Training (All Staff)	349,800	
3	FM Requirements (Security, Potering, Cleaning & Catering)	139,069	3 months
4	Double Running (Hump) Costs (Heat, Light, Power, Rates, Insurance)	188,000	
5	Transport Costs (Removals & Cages)	22,000	
	Medical Records Transportation (based on 250000 records)	16,500	
	Ambulance Patient Transfers	12,680	
6	Information & Publicity (Literature, Maps, Signage, Public Notices, Official Launch)	34,750	
	Total	1,892,499	

The breakdown of the above commissioning costs have been detailed in Appendix 1.23.

Commissioning costs have been compared with those incurred by the Causeway Hospital and the new Down Hospital and also incorporate recommendations provided in the post-project evaluation for the Causeway project. Such recommendations include the necessity to assign resources to manage the commissioning of the equipment which presented difficulties for the Causeway project. These costs also include the completion of the Post Project Evaluation and the Gateway Review process which will begin approximately 6 months after the completion of the Commissioning Phase and extend for a period of 9 months. This will be completed by a small core project team of 4 WTE's.

1. Commissioning Team Costs

Section 9.4 of this Full Business Case provides details on the role and responsibilities of the Trust's Commissioning Team. This team shall be formed from existing project workstream structures and operate under the direction of the Project Director. The Trust's project team has costs approved in the Project Cost Business Case up to the financial year 2010/11. Following guidelines provided in the NHS Capital Investment Manual, the Commissioning Team shall remain in place for a period of three months after the facilities become fully operational. Therefore the Trust team shall remain in place until September 2012. Project Team Members include;

- Project Lead
- Project Manager (Commissioning)
- Project Manager (Clinical and Design)
- Asst Project Manager
- Clinical (Nurse) Co-ordinator
- Facilities Management Co-ordinator
- Equipment Co-ordinator (to meet a recommendation from the Causeway Hospital)
- Finance
- HR Manager
- Technical Assistant
- Communications Manager
- Project Administrative Support

This equates to a total staff complement of 14 WTE's, which compares favourably with the Causeway Team of 12 staff.

Key responsibilities include formulating and delivering the commissioning plan and programme, developing detailed operational procedures and reviewing workforce plans with operational managers via the Commissioning Working Groups and ensuring project delivery in accordance with the guidelines and budgets established in this Full Business Case.

Staff Resource has also been assigned to the completion of the Post Project Evaluation and the Gateway Review, which shall begin six months after the commissioning phase and have a duration of 9 months. Based on current estimates this is due to commence in October 2012 and due to be complete by June 2013. This

requirement for a Post Project Evaluation follows OGC guidelines 'Achieving Excellence in Construction Procurement Guide 2008'. The scope of this may be defined as a 'Post Project Review', which is carried out after construction is completed and focuses on how well the project was managed. It considers how well the construction project performed against Key Performance Indicators such as cost and time predictability, safety, defects and client satisfaction. It also considers lessons learned from the teamworking/partnering approach taken. It is estimated that given the importance of the PPE for the first all hospital PFI project procured in Northern Ireland, that a total of 4 WTE's shall be required to complete this task. A breakdown of the staff costs are provided in Appendix 1.23 of this Full Business Case.

2. Staff Training and Familiarisation

The costs associated with staff training for the commissioning of the New Acute Hospital are based on 9.5 hours training for 1150 staff and will provide staff with familiarisation with the new facilities and departmental inductions including equipment training. Additional training has also been programmed for those staff working in critical areas. These costs include backfill for staff to both provide and attend training sessions, travel costs and to deliver a 'train the trainer' programme. The provision of training internally assists in minimising this cost. Appendix 1.24 of this Full Business Case contains a paper on 'Staff Training for the Commissioning of the New Acute Hospital).

3. FM Requirements (Site security, Portering, Cleaning & Catering)

Security shall be provided on both sites during the handover period with this service delivered by a team of multi-skilled portering/security staff. These staff shall also assist with the packing, moving and equipping of the new facilities. Costs will also ensure the cleaning of the new facilities to meet the highest clinical standards and delivered by the Trust's team of fully trained cleaning staff. A Catering Assistant has also been costed to provide this essential service on-site minimising staff travel costs and time.

4. Double Running 'Hump' Costs

To maintain effective patient services during the transition from old to new premises, it will be necessary to incur double running costs for a three month period including rates, insurance, heat, light and power.

5. Logistics; Transport, Storage and Packaging

Transport requirements for the Commissioning Phase for the New Acute Hospital include a requirement to transport a number of patients by ambulance. It is anticipated that this will involve approximately 100 patients and that this service will be provided by the Northern Ireland Ambulance Service (NIAS). The costs of logistics include removal, hire of cages for transportation and the appropriate handling of medical records including adherence to confidentiality. These costs have been kept to a minimum due to the utilisation of manpower provided by porters and the identification of storage areas with the new facilities reducing hire costs.

6. Information and Publicity (Leaflets, Public Notices, Signage & Official Opening)

Communications shall play an important role during the commissioning phase of the project. Both staff and the local community shall be kept informed on progress and prepared for the transition to the new buildings. Costs include maps of the new facilities, leaflets for each home within the catchment area, site signage, public notices, promotional boards and an official launch.

1.8.1.4. Decommissioning

The timetable for the disposal of the Erne Hospital Site is based on the following:

Completion of the New Hospital	March 2012
Decommissioning of Erne	March – June 2012
Demolition of Erne	June 2012 – June 2013
Disposal of Erne	2013 / 2014

Table 1.23 describes the estimated costs associated with the decommissioning of the Erne Hospital.

Table 1.23 Estimated decommissioning costs

Disposal Subject	Description and Values/Costs
Market Value	<p>The Erne Hospital is located on a site comprising 15.46 acres.</p> <p>Land and Property Services provided a value of £6 million for 11.48 acres of the site on 13th November 2008.</p> <p>The valuation is based on a clear site. It excludes the New Medical Centre (GP's) and the ambulance base and flood plains.</p> <p>Current Market Value £6 million</p>

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Disposal Subject	Description and Values/Costs
Conveyancing Costs	<p>Legal costs to include the following work as a minimum.</p> <p>Review the title to clarify if there are any potential impediments to a successful disposal e.g. restrictive covenants; any access issues; the history of the site – to make sure that if the site was originally acquired through vesting, that there is no requirement to offer the land back to original owners.</p> <p>Consideration should also be given to the insertion of overage provisions, should there be Developer Gain, protecting the Trust against windfall gain in the future.</p> <p>A quote of 0.3% of the Sale Value has been provided. This equates to £18,000 on the sale value of £6m</p> <p>Total Estimated Cost £18,000</p>
Planning Consultant	<p>The development of a Planning Application for an alternative use for the site will add value to the site and minimise the potential for a judicial review.</p> <p>Total Estimated Cost £30,000</p>
Marketing / Estate Agents Costs	<p>A Local Estate Agent based at Enniskillen have quoted a figure of 0.4% from the Sale Value. This equates to £24,000 based on the sale value of £6m.</p> <p>Any advertising costs will be additional to this e.g notices in publications, erection of signage. A budget of £2500 is to be allocated towards this.</p> <p>Total Estimated Cost £26,500</p>
Decommissioning Costs	<p>Appendix 1.25 provides a breakdown of the costs associated with the technical decommissioning of the Erne Hospital Site.</p> <p>The costs have been developed based on recent similar schemes on health care property and have been provided by Health Estates.</p> <p>Cost Assumptions have also been based on local knowledge of the Erne Hospital, provided by Estates Service Officers.</p> <p>Whilst costs have been developed based on local knowledge and recent schemes, it is not possible to be certain on the costs until detailed site specific surveys have been carried out e.g.</p>

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Disposal Subject	Description and Values/Costs
	asbestos, contaminated ground. Total Estimated Cost £2,614,494
Ongoing Maintenance and Inspection Costs	The following revenue costs will also be required until the site has been sold: Security guard random inspections £7,500 per year. Utility ongoing costs to include for low level security lighting £2,000 per year. Fire Alarm maintenance per annum to include base contract plus allowance for call outs £4,500 per year. Total Estimated Revenue Cost £14,000/annum

Table 1.24 overleaf outlines the current market value, less the estimated costs associated with the decommissioning and disposal of the Erne Hospital site by the end of 2014.

Table 1.24 Disposal Costs and Valuation of Erne Hospital site

	£
Current Market Value	£6,000,000
Less	
Conveyancing Cost	£18,000
Estate Agents Cost	£26,500
Planning Consultant	£30,000
Decommissioning Cost	£2,614,494
Total	£2,688,994
Balance	£3,322,006
Less	
Revenue Cost (1 Year)	£14,000
Total	£3,297,006

The costs in the above Table 1.24 are only estimated at this point in time and may change. They are based on the best available information from Health Estates and the Trust Estate Department.

In relation to impairment the current asset of the Erne Hospital will be depreciated over the next four years.

1.9. REVENUE COST CHANGES SINCE ACUTE PHASE 2 OBC

1.9.1. Non PFI Revenue Costs

This section provides an update on projected non PFI revenue costs from those presented in the Acute Phase 2 OBC. This includes all revenue costs, associated budget movements, CSR Proposals, Agenda for Change, superannuation increases, inflation and service developments.

Based on the updated bed modelling undertaken as part of this FBC, the Trust predicts that the new Acute Hospital will open with 269 beds in 2012, 292 beds in 2015 and 312 beds in 2018.

Accordingly, Non-PFI Revenue costs have been costed reflecting 269, 292 and 312 beds.

1.9.1.1. Non PFI Revenue Costs Summary

A summary of the affordability requirements for all these scenarios can be seen in the subsequent Table 1.25A:

Table 1.25A Summary of affordability requirements for bed scenarios

Table Reference	Affordability Requirement £000
1.26A – 269 beds reflecting 2012 position	£2,711
1.26B – 292 beds reflecting 2015 position	£3,784
1.26C – 312 beds reflecting 2018 position	£4,485

A summary of non PFI revenue costs shows that the total affordability gap which includes pay and non pay costs at 2018 of £4,485k. This is reduced to £3,784k in 2015 and further reduced in 2012 to £2,711k. Details of the affordability requirements for each year (2012, 2015 and 2018) are presented in Tables 1.27 (A-C) DBS Revenue Costs that follow in Section 1.9.2.

Table 1.25B: Non-PFI Revenue: Affordability Acute Phase 2 OBC to FBC

	£000
Net Annual Acute Phase 2 OBC Revenue Savings	(561)
Affordability gap increases:	
Nursing	1,678
Facilities Management	1,015
Heat, Light and Power	559
Rent and Rates	224
Contract Management	120
Affordability gap reductions:	
Admin and Clerical	(165)
Goods and Services	(278)
Other	119
FBC Affordability Gap: Opening Position	2,711

This £2,711K affordability gap over current budgets compares with an affordability gap at Phase 2 OBC stage of £561K.

Overall affordability has moved from (£561K) to £2,711K, an increase of £3,272K.

The key drivers for the cost movements for the opening position at 2012 are as outlined in the Table 1.25C overleaf:

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Table 1.25C: Non PFI Cost Movements: Acute Phase 2 OBC to FBC

	£000	£000
Non Pay Cost increases:		
Facilities Management	1,015	
Heat, Light and Power	559	
Rent and Rates	224	
Contract Management	120	
Non Pay Costs decreases:		
Goods and Services Savings	(278)	
Net increase in Non-Pay costs		1,640
Pay Costs increases:		
CSR Cash Releasing (since Acute Phase 2 OBC)	3,213	
Net nursing budgets transferred from Acute Hospital since Acute Phase 2 OBC	322	
Pay Costs decreases:		
Nursing Costs of 43 beds not opened (312 beds at OBC –269 beds at FBC opening)	(1,653)	
Contribution from TCH Transition Plan to Affordability	(182)	
Other	(68)	1,632
Total: Opening Position 2012		3,272

Acute Phase 2 OBC Affordability Assumptions

The Acute Phase 2 OBC net savings were heavily reliant on Facilities Management Savings (based on an integrated hard and soft FM service delivery model) and Nursing Savings. The original saving estimates are not now considered possible.

The Acute Phase 2 OBC assumed significant savings in nursing costs by applying enhanced working efficiencies and the development of new roles. These savings have now been included as part of Trust's Comprehensive Spending Review (CSR) initiatives and attendant budgets are not now available, as a saving contribution to the FBC.

FBC Affordability Drivers

Pay Costs

Pay costs affordability gaps from Acute Phase 2 OBC have increased by £1,632K, which is the difference between (£675K) affordability saving at Acute Phase 2 OBC and an FBC affordability gap of £957K.

As fully explored in Section 1.9.2 of this FBC, the principle cost drivers are as summarised in Table 1.25D following:

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Table 1.25D Pay Cost Affordability Drivers: Acute Phase 2 OBC to FBC

	Description	£000
1	The impact of releasing budgets, originally available at OBC, towards Comprehensive Spending Review proposals.	3,213
2	Nursing savings, from not opening full compliment of beds at opening. 312 beds at OBC less 269 at FBC equals 43 beds, which equates to 50 nurses at an average nursing cost of £33K per annum.	(1,653)
3	Other cost increases.	72
	Total	1,632

Non-Pay Costs

Non-Pay costs affordability gap from Acute Phase 2 OBC has increased by £1,640K, which is the difference between £114K affordability gap at Acute Phase 2 OBC and an FBC affordability gap of £1,754K.

The principle cost drivers are fully explored in Section 1.9.3 of this FBC and are summarised in Table 1.25E following:

Table 1.25E Non-Pay Cost Affordability Drivers: Acute Phase 2 OBC to FBC

	Description	£000	£000
1.	<p>Energy</p> <p>This cost is based on a revised method of calculation developed by the Trusts professional advisers in conjunction with Health Estates Agency (HEA) for the evaluation of Final Tenders in 2008. The cost is based on the exemplar design for the New Acute Hospital and represents the target to be achieved by the Preferred Bidder.</p> <p>Cost Shifts have resulted for three core factors:</p> <ul style="list-style-type: none"> • Application of an updated method of calculation reflecting the energy requirements for a modern Acute Hospital, following advice from HEA; • Increased energy costs; and <p>Increase in the metres squared to applied areas requiring energy from 55,855m² – 58,788m² and cubic metres from 1508m³ – 1769m³, following advice from HEA.</p>		559
2.	<p>Rates</p> <ul style="list-style-type: none"> • These costs have increased from Phase 2 OBC stage due to an increase in cost per m² from £1.45 per m² to £11.70 per m². <p>The application of a higher metres squared figure at FBC (55,835m² to 70,800m²). This reflects the</p>		224

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	Description	£000	£000
	change from nett floor area to gross floor area following advice from Land and Property Services (LPS).		
3.	Contract Management The creation of a PFI Contract Management Team of £120K, following National Audit Office (NAO) and Northern Ireland Audit Office (NIAO) advice regarding same.		120
4.	Facilities Management		
	Diseconomies of Scale/Enhanced Requirements Removal of economies of scale from Acute Phase 2 OBC associated with: <ul style="list-style-type: none"> • Separation of Hard/Soft FM; and • Loss of economies from cross site / multi skilling. Enhanced requirements including: <ul style="list-style-type: none"> • Cleaning associated with a Ministerial decision regarding 100% single room occupancy; • Cleaning associated with infection control requirements; • Onsite laundry on direction from Regional Advisor; • Enhanced Catering via increased ward level satellite kitchens. 	1,018	
	Facilities Management Budget variance - Acute Phase 2 OBC to FBC <ul style="list-style-type: none"> • A number of budgets included at Acute Phase 2 OBC could not be reconciled back to 05/06 budgets . • A number of budgets included in Acute Phase 2 OBC were subsequently not available at FBC, since these related specifically to community services. 	122 271	
	Transport and Logistics A reduction in investment in transport and logistics, which was assumed at Acute Phase 2 OBC.	(396)	1,015
5.	Goods and Services A reduction in planned Goods and Services expenditure since Acute Phase 2 OBC to reflect efficiency drives of CSR.		(278)
	Grand Total		1,640

Tables 1.26 (A-C) following demonstrate that in terms of Pay Costs, the affordability gap in 2018 is £2,610k. This is reduced to £1,937k in 2015 and further reduced to

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£957k in 2012. For Non-Pay Costs, the gap in 2018 is £1,875, which is reduced by £121k to £1,754k at the opening position in 2012.

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Table 1.26A Revenue Consequences – 269 Beds (2012)

Table 1.26	269 Beds					
	FULL BUSINESS CASE			PHASE 2 OBC		
Acute Revenue Consequences	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
	£'000	£'000	£'000	£'000	£'000	£'000
Pay Costs						
DBS	35,631	(2,190)	33,441	31,752	(675)	31,077
Comprehensive Spending Review	(3,409)	3,213	(197)	0	0	0
HWIP	0	0	0	0	0	0
TCH Resource Plan	1,175	(182)	993	0	0	0
RPA Admin	(230)	116	(114)	0	0	0
Total pay costs	33,167	957	34,124	31,752	(675)	31,077
Non pay costs						
DBS	10,500	1,754	12,254	10,622	114	10,736
Comprehensive Spending Review	(44)	0	(44)	0	0	0
HWIP	0	0	0	0	0	0
TCH Resource Plan	50	0	50	0	0	0
RPA Admin	0	0	0	0	0	0
Total non pay costs	10,507	1,754	12,261	10,622	114	10,736
Total DBS Costs	43,674	2,711	46,385	42,374	(561)	41,813

Table 1.26B Revenue Consequences – 292 Beds (2015)

Table 1.26	292 Beds					
	FULL BUSINESS CASE			PHASE 2 OBC		
Acute Revenue Consequences	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
	£'000	£'000	£'000	£'000	£'000	£'000
Pay Costs						
DBS	35,631	(1,210)	34,421	31,752	(675)	31,077
Comprehensive Spending Review	(3,409)	3,213	(197)	0	0	0
HWIP	0	0	0	0	0	0
TCH Resource Plan	1,175	(182)	993	0	0	0
RPA Admin	(230)	116	(114)	0	0	0
Total pay costs	33,167	1,937	35,104	31,752	(675)	31,077
Non pay costs						
DBS	10,500	1,847	12,347	10,622	114	10,736
Comprehensive Spending Review	(44)	0	(44)	0	0	0
HWIP	0	0	0	0	0	0
TCH Resource Plan	50	0	50	0	0	0
RPA Admin	0	0	0	0	0	0
Total non pay costs	10,507	1,847	12,354	10,622	114	10,736
Total DBS Costs	43,674	3,784	47,458	42,374	(561)	41,813

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Table 1.26C Revenue Consequences – 312 Beds (2018)

Table 1.26	Adjusted 312 Beds					
	FULL BUSINESS CASE			PHASE 2 OBC		
	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
	£'000	£'000	£'000	£'000	£'000	£'000
Acute Revenue Consequences						
Pay Costs						
DBS	35,631	(537)	35,094	31,752	(675)	31,077
Comprehensive Spending Review	(3,409)	3,213	(197)	0	0	0
HWIP	0	0	0	0	0	0
TCH Resource Plan	1,175	(182)	993	0	0	0
RPA Admin	(230)	116	(114)	0	0	0
Total pay costs	33,167	2,610	35,777	31,752	(675)	31,077
Non pay costs						
DBS	10,500	1,875	12,375	10,622	114	10,736
Comprehensive Spending Review	(44)	0	(44)	0	0	0
HWIP	0	0	0	0	0	0
TCH Resource Plan	50	0	50	0	0	0
RPA Admin	0	0	0	0	0	0
Total non pay costs	10,507	1,875	12,382	10,622	114	10,736
Total DBS Costs	43,674	4,485	48,158	42,374	(561)	41,813

1.9.2. Pay Costs

1.9.2.1. Pay Costs Overview

The Trust undertook a significant detailed examination of the revenue consequences of the implementation of the proposed service model within the Acute Phase 2 OBC and the development of the service model from 2012 until 2018.

The movements from Acute Phase 2 OBC to 2012, 2015 and through to 2018 are explained overleaf in Tables 1.27A – C.

The pay costs depicted at these years coincide with the Trust's approach to bed modelling for the New Acute Hospital to reflect the new evidence provided by CHKS on bed capacity planning (refer to section 1.2.3). In 2012, the New Acute Hospital will open with 269 beds, in 2015 this will increase to 292 beds and by 2018 full capacity at 312 beds. For each of these scenarios a thorough re-examination of workforce plans was undertaken again with Assistant Directors and Managers. As a result the only workforce plan affected by the staged opening of beds has been nursing. As nursing is the largest area in terms of budget, this has resulted in the development of different pay costs positions for each of these key years being presented within this Full Business Case as explained in Table 1.27.

In 2018 the nursing pay costs are £17,410k which is a variance of £2,458k from budget. At this position the total pay costs show a gap of £2,610k. The affordability gap for the total pay costs was reduced to £1,937k in 2015 and further reduced £957k

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in 2012. It is important to note that the costs for the Combined Assessment Unit nursing are included as a service development and are not reflected in these costs.

Other contributing factors to the affordability gap are the investments in a multi-disciplinary discharge team within AHP's of £247k and Pharmacy of £89k. Scientific and Technical costs show a saving of £206k which as at Acute Phase 2 OBC is driven mainly by the movement of microbiology to Altnagelvin Area Hospital as a result of a Regional Review of Pathology Services in December 2007 by the different skill mix requirement in the Future compared to current Budgets.

Table 1.27A Summary of current Non PFI DBS Revenue Costs – 269 Beds (2012)

Table 1.27A

DBS Revenue Costs	269 Beds					
	FULL BUSINESS CASE			PHASE 2 OBC		
	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
£'000	£'000	£'000	£'000	£'000	£'000	
Pay Costs						
Medical	11,676	0	11,676	9,168	(41)	9,127
Clinical Services Manager	0	0	0	88	0	88
Nursing	14,952	805	15,757	14,609	(873)	13,736
AHPS	1,986	247	2,233	3,431	214	3,645
Imaging Department	662	22	684	520	41	561
Scientific & Technical	1,281	(206)	1,075	1,472	(207)	1,265
Admin & Clerical	2,011	0	2,011	1,861	165	2,026
Pharmacy	599	89	688	603	26	629
Agenda for change probable funding	0	0	0	0	0	0
Total pay costs	33,167	957	34,124	31,752	(675)	31,077
Non pay costs						
Facility Management	3,277	255	3,532	5,215	(760)	4,455
Goods & Services	6,407	0	6,407	4,752	278	5,030
Heat, Light & Power	463	910	1,373	327	351	678
Rates & Rent	360	469	829	328	245	573
Contract Management Costs	0	120	120	0	0	0
Total non pay costs	10,507	1,754	12,261	10,622	114	10,736
Total DBS Costs	43,674	2,711	46,385	42,374	(561)	41,813

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Table 1.27B Summary of current Non PFI DBS Revenue Costs – 292 Beds (2015)

DBS Revenue Costs	292 Beds					
	FULL BUSINESS CASE			PHASE 2 OBC		
	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
	£'000	£'000	£'000	£'000	£'000	£'000
Pay Costs						
Medical	11,676	0	11,676	9,168	(41)	9,127
Clinical Services Manager	0	0	0	88	0	88
Nursing	14,952	1,785	16,737	14,609	(873)	13,736
AHPS	1,986	247	2,233	3,431	214	3,645
Imaging Department	662	22	684	520	41	561
Scientific & Technical	1,281	(206)	1,075	1,472	(207)	1,265
Admin & Clerical	2,011	0	2,011	1,861	165	2,026
Pharmacy	599	89	688	603	26	629
Agenda for change probable funding	0	0	0	0	0	0
Total pay costs	33,167	1,937	35,104	31,752	(675)	31,077
Non pay costs						
Facility Management	3,277	348	3,625	5,215	(760)	4,455
Goods & Services	6,407	0	6,407	4,752	278	5,030
Heat, Light & Power	463	910	1,373	327	351	678
Rates & Rent	360	469	829	328	245	573
Contract Management Costs	0	120	120	0	0	0
Total non pay costs	10,507	1,847	12,354	10,622	114	10,736
Total DBS Costs	43,674	3,784	47,458	42,374	(561)	41,813

Explanation for Cost Increase of Affordability from 269 beds to 292 beds.

The increase in affordability from 269 beds to 292 beds is £1,073K (£3,784K - Table 1.27B and £2,711K - Table 1.27A).

This reflects an increase in nursing costs of £980K, associated with an additional 23 beds and 30 nurses, and an additional £93K associated with Facilities Management for these 23 beds.

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Table 1.27C Summary of current Non PFI DBS Revenue Costs – 312 Beds (2018)

Table 1.27C

DBS Revenue Costs	Adjusted 312 Beds					
	FULL BUSINESS CASE			PHASE 2 OBC		
	Budgets 08/09	Variance	New Facility Costs 08/09	Budgets 05/06	Variance	New Facility Costs 05/06
	Cost	Cost	Cost	Cost	Cost	Cost
£'000	£'000	£'000	£'000	£'000	£'000	
Pay Costs						
Medical	11,676	0	11,676	9,168	(41)	9,127
Clinical Services Manager	0	0	0	88	0	88
Nursing	14,952	2,458	17,410	14,609	(873)	13,736
AHPS	1,986	247	2,233	3,431	214	3,645
Imaging Department	662	22	684	520	41	561
Scientific & Technical	1,281	(206)	1,075	1,472	(207)	1,265
Admin & Clerical	2,011	0	2,011	1,861	165	2,026
Pharmacy	599	89	688	603	26	629
Agenda for change probable funding	0	0	0	0	0	0
Total pay costs	33,167	2,610	35,777	31,752	(675)	31,077
Non pay costs						
Facility Management	3,277	376	3,653	5,215	(760)	4,455
Goods & Services	6,407	0	6,407	4,752	278	5,030
Heat, Light & Power	463	910	1,373	327	351	678
Rates & Rent	360	469	829	328	245	573
Contract Management Costs	0	120	120	0		0
Total non pay costs	10,507	1,875	12,382	10,622	114	10,736
Total DBS Costs	43,674	4,485	48,158	42,374	(561)	41,813

Explanation for Cost Increase of Affordability from 292 beds to 312 beds

The increase in affordability from 292 beds to 312 beds is £701K (£4,485K - Table 1.27C and £3,784K - Table 1.27B).

This reflects an increase in nursing costs of £673K, associated with an additional 20 beds and 20 nurses and an additional £28K associated with Facilities Management for these 20 beds.

These tables also include the affordability requirements at Phase 2 OBC, which showed a saving of (£561K).

1.9.2.2. Key Factors that have impacted on Base Case Budgets

- **Comprehensive Spending Review**

The NI Priorities & Budget for 2008-11 required all departments to achieve efficiency targets of 3% for each of the three budget years i.e. 9% recurrent savings by 2010/11. This has been translated to targets for the DHSSPS and further translated to cash releasing targets for WHSCT, whereby the WHSCT are required to make savings of £37m from 2008 – 2011.

The Trust's Comprehensive Spending Review (CSR) proposals have been analysed and any overlap with the DBS assumptions has been accounted for. The current budgets now show that CSR has been applied, refer to Tables 1.27A - C, Summary of current Non PFI DBS Revenue Costs.

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For this Full Business Case the Trust estimate this will result in a reduction of £3.2m on future budgets. Please refer to Appendix 1.26 for the CSR targets that relate to the new acute hospital.

- **TCH Resource Plan**

The Western Trust set up a Service Redesign Group to oversee the implementation of recommendations arising from service reorganisation and risk and governance reviews, in line with the overall strategic direction set within Developing Better Services. This group engaged with all relevant stakeholders in the implementation of the TCH Resource Plan.

The Plan was presented to the Commissioner and funding was secured to implement the necessary service redesign. The amount of funding applicable to this Full Business Case equates to an additional £1.2m, however the impact on affordability was £182k.

Appendix 1.27 provides an explanation of key changes that have also impacted on base case budgets.

1.9.3. Non Pay Costs

The affordability gap for non pay costs at the opening position in 2012 is £1,754k, representing an increase of £1,640k from the Acute Phase 2 OBC. This is due to two key factors, firstly an increase in energy, rates and Facilities Management (FM) costs and secondly a reduction in the available Soft FM budgets.

Table 1.28 Summary of non pay costs movements ACUTE PHASE 2 OBC to FBC

	£000	£000
Non Pay Cost affordability gap increases:		
Opening Position 2012		
Facilities Management	1,015	
Heat, Light and Power	559	
Rent and Rates	224	
Contract Management	120	
Non Pay Cost affordability gap decreases:		
Goods and Services Savings	(278)	
Net increase in Non-Pay Affordability Gap		1,640

Facility Management costs have moved by £1,015k from Acute Phase 2 OBC to FBC. It is important to note that budgets at Acute Phase 2 OBC reflected both Hard and Soft Facility Management Services. However at FBC, Hard FM Services (Estates, Maintenance and Grounds) shall be delivered by the Preferred Bidder and covered by the Unitary Charge, while Soft FM services remain as a revenue consequence for the Trust. While at Acute Phase 2 OBC, the Trust was showing a saving of £760k on Hard and Soft FM delivery against budget, the position at FBC is a deficit of £376k resulting from a reduction in budget and increase in costs.

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Energy costs presenting a deficit of £559k against current budget and Rates, a deficit of £224k. This is due to price increases and an overall increase in the size of the building.

Soft FM Costs

Summary

The following section of the Full Business Case presents the updated position for the delivery of Soft Facilities Management services within the New Acute Hospital. **Table 1.29** demonstrates an affordability gap of circa £376k, against current available budgets and a movement of -£9.3k on Soft FM delivery costs from the Acute Phase 2 OBC.

This position follows a detailed review of budget allocation and a re-costing of the service delivery from a bottom-up approach completed in November 2008 with Soft FM service managers. This has resulted in a revised delivery costs for Soft FM services within the New Acute Hospital of £3,653k. This represents a saving from the position at Appointment Business Case (ABC) where the PSC for Soft FM was £4,279k.

Table 1.29 Soft FM Affordability Gap

New Acute Hospital: Soft FM Revenue Affordability Gap							
	Budget			New Facility Costs			Affordability Gap FBC
	OBC 2 *	FBC **	Variance	OBC 2 ***	FBC	Variance	
	£'000	£'000	£'000	08/09 Prices £'000	08/09 Prices £'000	£'000	
Soft FM Budget	3,954	3,277	-677	3,662	3,653	-9	-376
Opening Position							
2012 (269 Beds)	3,954	3,277	-677	3,662	3,532	-130	-256
Position at							
2015 (292 beds)	3,954	3,277	-677	3,662	3,625	-37	-349
* OBC 2 Budget (Soft FM) Uplifted to 08/09 (applying 3 yrs inflation, AfC (8.84%), and Superannuation (8.13%)) ** FBC Budgets reflect required RPA savings *** Represents OBC 2 Costs expressed at 2008/09 prices as illustrated below.							
FM Cost OBC 2 (SDM 10) 2005/06	Plus 3 Years Inflation	Plus AfC	Total FM Cost 08/09	Soft FM @ 08/09 Prices (71% of FM)			
£'000	£'000	£'000	£'000	£'000			
4,455	373	331	5,159	3,662			

These costs reflect the full operation of the total 312 beds. Table 1.29 above illustrates:

- For the opening position of 2012, the affordability gap is reduced by £120k from £376k to £256k; and
- At 2015, delivery costs are £3,625k for the 292 beds, representing an affordability gap of £349k.

There is future potential to offset the affordability gap with income from key worker accommodation and efficiencies from the provision of Soft FM in the Omagh Hospital project.

The primary drivers for cost changes and budget shifts relate to the evolution of the FM service delivery model. This reflects the change from the potential of one PFI provider for both the Acute and Omagh hospital projects to two separate procurements. In addition, hard FM and soft FM services were separated so the Trust could apply a soft FM value for money test to the soft FM element of the service. At final bid no soft FM bids were received. The FBC position now shows the Trust delivering the soft FM service.

Soft FM Budget Variance: Acute Phase 2 OBC to FBC

The Soft FM revenue budget available for the New Acute Hospital has reduced by £677k from the budget presented in the Acute Phase 2 OBC in 2006. This is the outcome of a detailed budget review that has taken place in conjunction with Service Managers and has resulted in the presentation of revised FBC budget of £3,277k as detailed in Table 1.29.

The reduction in the available budgets has been largely due to the following factors:

- the reapportionment of the Soft FM budgets to provide a more accurate split than the 4/7 and 3/7 split across the Acute and Omagh Hospital projects that was applied at Acute Phase 2 OBC. The bottom-up review has resulted in a three way budgetary split, with an allocation of the budgets required for the Trust to continue to deliver community services in the catchment area. A budget of £1.1 million has therefore been retained to enable the delivery of Soft FM services in the community within the Southern Sector in line with the Trust's model of health and social care delivery.
- included in Acute Phase 2 OBC budget figures were a number of budgets that were not dedicated Soft FM Budgets. This included budgets for clinical and domestic waste disposal, security, materials management and telephony call charges. These costs are apportioned to other Trust budgetary sources.

Soft FM Delivery Costs (FBC): New Acute Hospital

In November 2008, for the Full Business Case, the Trust's FM team conducted a detailed review of new facility costs from the bottom-up to capture all developments that have taken place since Acute Phase 2 OBC. (Appendix 1.28 summarises key changes to the PSC for Soft Services from Acute Phase 2 OBC to ABC). Updated Soft FM delivery costs reflect the Preferred Bidder's design, professional advice from the Trust's FM advisers, benchmarking with best practice from other projects and accounting for the benefits of working within the wider Trust.

Table 1.30 presents the Soft FM delivery costs of for the 2018 position of the full bed complement for the New Acute Hospital at £3,854k. These FBC costs favourably compare with UK benchmarks provided by FM advisers Davis Langdon and are below the PSC that was applied during the procurement phase as outlined in the Appointment Business Case.

Whilst the cost of delivering Soft FM services has increased by £192k, this increase has been offset by £201k of car parking income, resulting in a reduction of £9.3k on the Acute Phase 2 OBC costing. Core drivers in cost changes are as follows:

- a reduction in efficiency savings arising from the separation of the project into two procurements (Acute and Omagh Hospital projects) and the separation of hard and soft FM services.
- an increase in the applied size of the buildings that now includes Key Worker Accommodation and design developments in compliance with health facility design standards. (55,855m² total net floor area Acute Phase 2 OBC, 66,561m² at FBC)
- costs reflect the meeting of increased requirements including the cleaning of 100% single rooms, enhanced infection control procedures, an on-site laundry and enhanced method of catering provision according to the service specification, which brings the service to the patients via increased ward level satellite kitchens.
- cost increases have been partly offset by reinstating management and multi-skilling efficiencies (portering and switchboard) and revised costs incorporate aspects of cross-site working (switchboard).

Soft FM Cost Reductions at Opening Position of 269 beds:

- Soft FM delivery costs have been updated to reflect saving against the 269 bed opening position. These savings, which total £120k relate to cleaning costs (51k based on m2 reduction), catering (39k based in fewer in-patient meals) portering (£22k based on 1 WTE) and laundry (£8k based on 0.5 WTE).

Soft FM Cost Reductions at Opening Position of 292 beds:

- Savings of £27.5k are reflected in the 292 bed position for 2015. These savings relate to cleaning (£12.4k), catering (£10.9k) and laundry (£4k, based on 0.25 WTE).

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Table 1.30 New Facility Soft FM Costs: Service By Service

SOFT FM Service	New Facility Costs 2008/09			Notes
	Staff Costs	* Goods & Services	TOTAL	
Management Soft FM	260,354	26,270	286,624	1
Catering (patient and non patient)	915,127	354,220	1,269,346	2
Catering Income			-421,039	3
Cleaning	1,489,299	76,056	1,565,355	4
Portering	665,926	5,795	671,720	5
Transport	14,321	7,372	21,693	6
Waste management	0	0	0	7
Linen and laundry	199,618	35,220	234,838	8
Switchboard /Telecoms	223,313	2,704	226,017	9
Sub Total	3,767,957	507,635	3,854,553	
Deduct Car Parking Income			-201,600	
Soft FM Total			3,652,953	

The total cost of providing Soft FM services as outlined in the Table 1.30 above shall be £3,854k. Car parking income of £201k has been offset against this resulting in a cost for FM delivery of £3,652k.

Note 1: Management of Soft Facilities Management

This demonstrates cross-site working by Managers and applies efficiency savings from the Review of Public Administration. Costs also include clerical support.

Note 2: Catering (Patient & Non-Patient)

This includes staff canteen/public café and assumes cook fresh hybrid model as currently being delivered. The costs reflect the Trust's new service delivery model for catering that shall include satellite kitchens shared between wards, meeting the new service standards by bringing this service to the patient.

Note 3: Catering Income

This figure has been revised from the Acute Phase 2 OBC figure which was over-projected and is now based on a 65% increase in catering income from current. This projected increase shall arise from opportunities from the Trust investment in the new catering facilities.

Note 4: Cleaning

The cost per m² is £23.52 and favourably compares with UK benchmarks provided by the Trust's FM advisers Davis Langdon (ranging from £19.65 to £30.55). While the size of the building has increased, the Trust has managed the impact on cleaning costs by reviewing the Soft FM area and deducting those areas cleaned from other resources (laundry, catering, hard FM and Key Worker Accommodation). This figure also reflects the move from 50% to 100% single rooms which adds an additional cleaning requirement due to the increase in the number of en-suites provided in the New Acute Hospital. Costs do not reflect new regional DHSSPS NI

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Cleaning Standards being developed that shall apply across all Health and Social Care Trusts.

Note 5: Porterage

This includes the multi-skilling of porters. This role shall also include waste handling, night security, reactive night cleaning and the movement of the deceased to the designated facility.

Note 6: Transport

This cost is based on 25% of the current Fermanagh Group Transport budget which reflects the activity to Acute Hospital services.

Note 7: Waste Management

It should be noted that these costs do not include the cost of domestic or clinical waste disposal which are provided from Non FM Goods and Services budgets. (Therefore waste disposal is also not reflected in the current available FM budgets but shall be funded as is current practice from the general Goods and Services budget.) The cost of waste handling was not reflected in the Acute Phase 2 OBC costs and is now included under portering.

Note 8: Linen and Laundry

These costs are based on the provision of an on-site laundry service, based on the recommendation of the DHSSPS regional laundry adviser and the use of 'Sleepknit' products.

Note 9: Switchboard and Telecoms

The telephony service is a 24 hour, 365(6) day operation and is a first point of contact for off-site enquiries to the Trust. Telephony staff answer calls to the main hospital number, relay calls as necessary, report telephony faults, bleep/page staff, monitor alarm systems and instigate emergency procedures as per protocol. Switchboard staff shall also provide basic reception duties as current practice. There is potential within these costs to deliver this service for the southern sector and cover both the New Acute and Omagh Hospital Complex to create further economies of scale.

Other Soft FM Services.

Additional services totalling £180k shall be funded by the Trust from other budgets as there are no existing dedicated Soft FM budgets. These services are shown in the Table 1.31 below, with funding source identified in the explanatory notes.

Table 1.31 Soft FM Services delivered from other Trust Budgets

<i>Non Soft FM Budget Services</i>	Staff Costs	* Goods & Services	TOTAL	Notes
Helpdesk	0	0	0	10
Reception	0	0	0	11
Security / Car Parking: New Service	157,212	15,721	172,933	12
Pest Control: No current budget	0	6,863	6,863	13
Sub Total	157,212	22,584	179,796	

Note 10: Helpdesk

The need to provide a Helpdesk for Soft FM was removed as a result of the Trust now providing Soft FM services. At Acute Phase 2 OBC, this need had been based on the requirement to monitor Soft FM response times and effectiveness as part of the PFI. At FBC, a Hard FM helpdesk shall be provided by Project Co. while Soft FM calls will be based on a direct dial operational policy.

Note 11: Reception

Currently some reception duties are delivered within the Erne Hospital by the switchboard / telecoms staff. This shall continue in the future with a shared reception service being delivered closely adjacent to the Admissions Office. The design of the New Acute Hospital supports this method of service delivery.

Funding Source: Soft FM Budget (Switchboard), New Acute Hospital

Note 12: Security/Car Parking

This is a service for which there is a no dedicated recurrent budget. One of the key recommendations of the Risk and Governance review of the former Sperrin Lakeland Trust in 2005, related to security issues, particularly around the A&E area of the Erne Hospital. A spend of approximately £96k per year from a non recurrent budget has been required to provide night time security in that identified area. This continues to be funded non-recurrently.

Funding Source: Trust Acute Services Budget

Note 13: Pest Control

This cost is based on current budgets and is currently funded on the basis of need from the Trusts Acute Directorate goods and services budgets. (This costs compares favourably with other hospitals.)

Funding Source: Trust Acute Directorate goods and services budget.

1.9.3.1. Energy Costs – Heat, Light & Power

Energy costs of £678k were presented at Acute Phase 2 OBC showing a gap of £351k in comparison with available budget. This gap has increased to £910k for this Full Business Case based on a total cost of energy at £1.37m. This cost is based on a revised method of calculation developed by the Trusts professional advisers in conjunction with Health Estates Agency for the evaluation of Final Tenders in 2008. This cost is based on the exemplar design for the New Acute Hospital and represents the target to be achieved by the Preferred Bidder.

Cost shifts have resulted from two core factors:

- Application of an updated method of calculation reflecting increased energy costs.
- Increase in the applied areas (m²) requiring energy.

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Calculating Energy Costs

Energy costs have been calculated on the basis of 3 figures:

1. Cost of purchasing fuels per Gj;
2. Average Gj produced; and
3. Cubic metres of building requiring energy.

Each of these 3 elements of the cost has changed as outlined below. To explain the variance, the Bidders Energy Calculations have been broken down and expressed in the same terms as the figures at Acute Phase 2 OBC (Refer to Table 1.32).

Table 1.32 Energy Costs: Heat, Light & Power

Energy Costs: Heat, Light & Power	ACUTE PHASE 2 OBC	FBC Bidders Energy Calculation	Variance	Trust Energy reduction target	Note
Fuel Cost per Gj (Electricity, Oil and Biomass)	8.17	16.29	8.12		1
Gj production target (energy efficiency) per 100m3.	55	50	-5		2
m3 applied (in 100 m3)	1508	1769	261		3
Total Cost £'000's	678	1,441	763	67	
Revised variance: Target reduction applied				696	4

Note 1: The shift in costs reflects increased costs in purchasing energy. Acute Phase 2 OBC calculation was based on 04/05 prices and reflect variations in the type of fuels used. Acute Phase 2 OBC costs were also based on different energy requirements as these were benchmarked against the existing Erne and Omagh hospitals i.e. a standard hospital that does not benefit from a mechanically ventilated system.

In 2008, a review of the energy costs was conducted by the Trust in order to provide a benchmark during the procurement phase to assess Bidder costs. This review applied recent benchmarks from BMI RCIS Health Acute and General Facilities gives a cost of £24/m² for energy costs of a similar type of hospital that that are mechanically ventilated and comfort cooled, which adds a significant increase to energy costs. This review was conducted by the Trust's advisory team of Davis Langdon and Mechanical and Electrical advisers White Young Green who concur with the revised calculation. An average of 15m² was applied to the Key worker accommodation.

This revision reflects increasing energy costs. (For example, Oil and electricity prices provided in May 08 show an increase of £5.90/m² since Acute Phase 2 OBC.)

Note 2: A more stringent energy target of 50 Gj per 100m³ was set on the advice of Health Estates Agency for compliance with government efficiency targets, prior to Final Bid Submissions, and has therefore been applied to these FBC costs.

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Note 3: Acute Phase 2 OBC prices were based on a m3 of 1508, while the FBC is based on 1769m3. The difference is explained by an increase in the size of the exemplar design from 55,855m2 to 58,954m2 based on the Preferred Bidder design, and also an increased ceiling height which was 2.7m at Acute Phase 2 OBC and at FBC is 3m. The change to comply with standards in Health Building Notes on the advise of Health Estates Agency. **(55855m2 x 2.7m = 150808 at Acute Phase 2 OBC. 58954m2 x 3 = 176862 at FBC.)**

Note 4: Application of Target Reductions: For the purposes of the FBC, the Trust has applied a target figure of £1.373m based on the benchmarked rates for energy production at £24m2 for hospital buildings and £15m2 for key worker accommodation.

This has resulted in the new facility costs as follows:

54,329m2 x £24 = 1,303,632

4636m2 x £15 = 69,540

Total = £1.373,172

The Trust is currently working with the Preferred Bidder to finalise the mechanisms for achieving a reduction in energy costs.

1.9.3.2. Rates

Acute Phase 2 OBC indicated a 'gap' of £245k on rates which has increased to £469k for this Full Business Case. An explanation for the increase is set out below.

These costs have increased from Acute Phase 2 OBC Stage due to the following two reasons.

- Firstly the cost of rates has increased by 14% from £1.45 per m2 to £11.70 per m2.
- Secondly, the calculations at Acute Phase 2 OBC were based on a total nett floor area of 55,855m2, while at FBC the GROSS floor area of 70,800m2 has been applied following advice from Health Estates Agency. The gross floor area applied at FBC now includes Key Worker Accommodation and Plant Space.

The affordability movement has been reduced by £32,400 in additional budget, resulting in a movement of £223k.

Table 1.33: Rates Costs, Acute Phase 2 OBC to FBC

	Cost/m2	Area	Total
	£	M2	£'000
OBC	10.25	55855	573
FBC	11.70	70800	828
Increase in cost from Acute Phase 2 OBC			256
Minus Increased Budget			32
Variance			223

1.9.4. Non Recurring Revenue Costs

Additional non-recurrent costs for transport are detailed below.

Transport Costs

A service from Enniskillen depot to the new acute hospital

This relates to the cost of transporting staff, patients and general public from Enniskillen town centre to the new acute hospital (Translink services from Omagh will not stop outside the Acute Hospital, the only service that will stop at the Acute hospital will be the local town service, therefore we have to seek the funding to extend the town bus service). There is an option to extend the current Cherrymount Link service, that would cost £56,000 per annum. These are based on current year costs with the contract being reviewed after 2 years, with a view to Translink then adopting the service at no cost to Trust.

Potential Transport Costs are shown in Table 1.34 below.

Table 1.34 Potential Transport Costs

Description	Source	£'000 p.a.
Enniskillen Depot to New Hospital Service Shuttle Bus Service	Translink	56*

* Cost required for two years. Bus fees collected could be off-set against costs.

1.9.4.1. Contract Management Costs

The creation of a PFI Contract Management Team is outlined following advice from the National Audit Office and Northern Ireland Audit Office. The proposed structure for the operational stage of the Project is show in Figure 1.4 overleaf and detailed in Chapter 9.

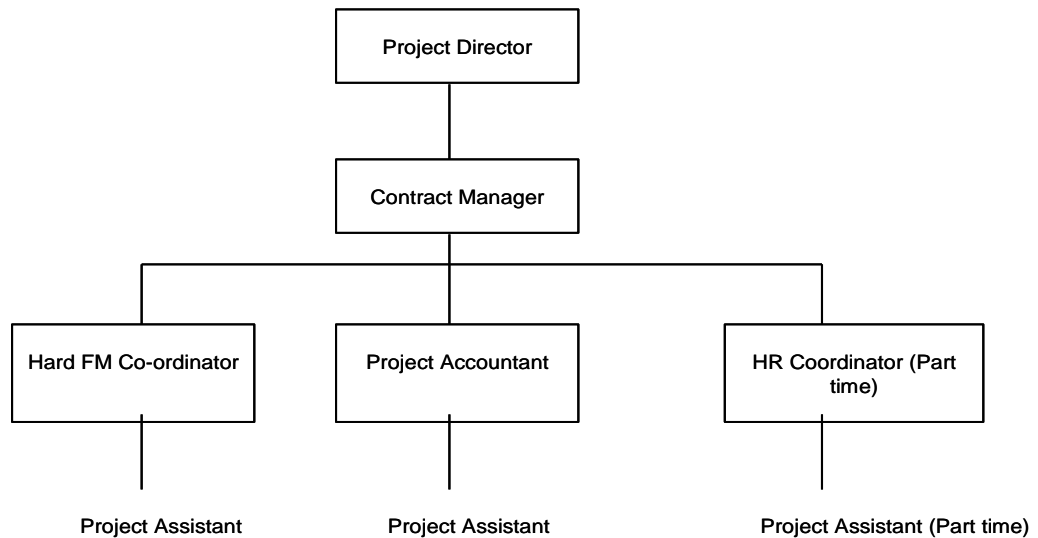


Figure 1.4 Project Structure during Operational Phase

This translates to the following costs in Table 1.35 below.

Table 1.35 Cost for the proposed structure for the operational stage of the Project

Role	AFC Banding	Salary @ Midpoint + 1	WTE	Total Cost
Project Director	Band 8C	£80, 134*	0.1	£8, 013
Contract Manager	Band 8A	£56, 842*	1	£56, 842
Hard FM Coordinator	Band 7	£47, 369*	0.25	£11, 842
Project Accountant	Band 7	£47, 369*	0.25	£11, 842
HR Coordinator	Band 7	£47, 369*	0.25	£11, 842
Project Assistant	Band 4	£25, 642*	0.75	£19, 232
Total			2.6	£119, 613

* Salary Includes Goods & Services at 10%

1.9.4.2. Other Funding Considerations

An earlier funding requirement identified at Acute Phase 2 OBC was Evercare. The impact of the Evercare type model initially related to the cost on the community of the reduction of 6 medical beds.

The Evercare type model required specialist chronic disease management nurses in the community. This initiative has been introduced across this Trust to deliver this model of care, and funding has been allocated for assisted technology therefore no additional funding will be required.

Other funding requirements that require Commissioner support are:

- Service Developments

While dialogue with the Commissioner has commenced on these issues, the Trust will endeavour to continue this process and secure funding prior to the New Acute Hospital becoming operational.

The revenue impact of the Service Developments is discussed in the subsequent paragraph:

Service Developments

The Trust are seeking funding from the commissioner for various developments that will occur between now and 2015. These developments are particularly relevant to the development of the Combined Assessment Unit, a Clinical Pharmacy Service and an MRI Service.

These developments span across all the functional headings (medical, nursing etc) and separate bids will be made by the relevant departments.

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Table 1.36 Summary of Non PFI Costs

	£K	Comments	Notes
Non-PFI Costs			
Capital Costs			
Commissioning Costs	1,892	Based on current estimates	Costs required to transfer services from existing facilities and bring the New Acute Hospital into full operation. This included commissioning team costs, staff training, and logistics.
Decommissioning costs (nett of disposal proceeds)	(3,400)	Based on current estimates	The cost associated with the sale and disposal of existing Erne Hospital site.
Non-Medical Equipment	4,794	At 08/09 prices	Group 2 and 3 equipment including fixtures and fittings required to bring the new hospital into use.
Total Capital	3,286		
Recurring Revenue Costs			
Non-PFI Revenue Costs	2,711	Opening position 269 beds at 08/09 prices	Revenue consequences that remain with the Trust and are outside the PFI contract. This includes Pay Costs and Non-Pay Costs of Goods and Services, Soft Facilities Management, Energy, Rates and Contract Management.
Non Recurring Revenue Costs			
Shuttle bus service	56	For 2 years at 08/09 prices	Extension of current Enniskillen Town bus service to transfer staff, patients and visitors from the Enniskillen Bus Depot to the site of the New Acute Hospital.

1.9.5. PFI Revenue Costs

The indicative Unitary Payment of £13,385k reflects the bidders inclusion of a club of four banks to optimise the delivery of funding. This figure reflects their specific funding terms and current market conditions. This Unitary Payment figure shall remain indicative up the point of Financial Close. The terms are subject to market conditions at the point of closure and to final credit committee approval anticipated in early March 2009.

Mandatory Variant – EIB

The EIB has confirmed that it is committed to providing 50% of the senior debt funding. This variant presents a much more competitive rate than commercial lenders, who are pricing at levels significantly higher than seen in recent years, due to the current difficulties in the international infrastructure financial markets.

The club of banks and the EIB are finalising any outstanding requirements in order to have a full integrated funding package well in advance of the projected financial close date.

EIB terms remain more competitive than the commercial lenders, as would be expected, though they have also worsened since the submission of the final bids and the selection of the preferred bidder.

In running the most recent version of the Unitary Payment model, all of the effects of the inclusion of the EIB have been separately identified. These effects include the margins and debt tail indicated in the section above, but also includes the additional legal costs associated with their inclusion. The impact is summarised in the table below:

Table 1.37 Impact of EIB on the Unitary Payment

	£'000
Indicative Unitary Payment (real terms) excl the EIB	13,813
Impact of all EIB changes	(428)
Revised Unitary Payment	13,385

This shows that it is clearly beneficial in terms of reduction of the Unitary Payment to include the EIB, and that this delivers much better Value for Money for the Trust. This figure also takes account of any savings in the first three years of operation based on the profiled bed numbers.

Position at Financial Close

Unitary Payment at Financial Close	£'000
Unitary Payment	13,831

The unitary charge achieved at Financial Close was £13,831k. This was based on the funding terms outlined in Chapter 7 of this FBC which were subject to independent verification. The terms were based on a funding package based on a contribution from the European Investment Bank approaching 50%, with NordLB, Bank of Ireland (Corporate Banking) and Barclays Bank combining to provide the remaining 50%. The impact of including EIB was to reduce the Unitary charge by approximately £600k.

1.9.6. Strategic Context: Conclusion

Key to the affordability is the non-PFI recurring revenue costs, which have increased since Phase 2 OBC and the Appointment Business Case approved in August 2008.

As the table below indicates, the overall affordability gap for the New Acute Hospital for the South West is now £2,711k at 2012, which represents a shift from the Acute Phase 2 OBC position of a forecast saving of £561k. This increases to £4,485k at 2018.

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	Affordability Requirement £000
1.27A – 269 beds reflecting 2012 position	£2,711
1.27B – 292 beds reflecting 2015 position	£3,784
1.27C – 312 beds reflecting 2018 position	£4,485

DHSSPS were made aware a number of these increases at ABC, which showed an increase in affordability of £2,070k over Acute Phase 2 OBC. Accordingly the further increase in affordability in Acute Phase 2 OBC to FBC for the 2012 position is £641k.

2. PFI VALUE FOR MONEY TEST

2.1. VALUE FOR MONEY DURING PROCUREMENT PROCESS (STAGE 3 ASSESSMENT)

In line with the HM Treasury Value for Money Assessment Guidance November 2006 (“HMT Guidance”), this section contains an overview of the VfM assessment process that was conducted throughout the procurement process. The aim of this assessment (equivalent to the Stage 3 assessment in the HMT Guidance), which runs continuously from the issue of the OJEU notice to contract award, is to ensure that both procuring authorities and sponsoring departments are fully apprised of market conditions and can identify any market problems early on in the procurement process, in order to effectively evaluate whether there is any erosion of VfM.

Areas considered throughout Stage 3 were:

- Quality of Competition;
- Risk Sharing;
- Stability of Costs;
- Financial Flexibility;
- Financial Structures; and
- Contractor Distress.

Further detail on each of these areas is set out in the following sections.

2.1.1. Quality of the Competition

Market Failure

PFI needs a robust competitive process to deliver fully its benefits. Delivering the long term outcomes at a good price relies on competitive tension during the procurement phase. The HMT Guidance sets out specific issues to be considered as part of the assessment in Stage 3. These are addressed as shown overleaf.

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Issue	Question	Trust Response
Market abuse or failure	<p>Is there any evidence from similar projects (in scope or location) to suggest that there will be a shortage of good quality financially robust Bidders?</p> <p>Any evidence of market abuse?</p>	<p>There was no evidence to suggest a shortage of good quality Bidders and in actuality four Bidders were taken to Competitive Dialogue with one de-selected at Stage 2A – Strategic Approach. Three Bidders have remained throughout the remainder of the process to submission of Final Bids, following which a preferred bidder was appointed.. The overall quality of bids was good.</p> <p>No evidence of market abuse</p>
Procurement Issues	<p>Was there a good response to the Prior Information Notice/OJEU Notice?</p> <p>How many potential Bidders passed the PQQ Criteria? Are the financial robustness and capacity of the Bidders sufficient?</p> <p>Is there evidence of good competitive tension in pricing of risks etc?</p>	<p>There were 34 responses to the OJEU notice, requesting a copy of the Prequalification Questionnaire (PQQ) and Project Information Memorandum (PIM) documents.</p> <p>4 responses to the PQQ were received and all 4 Bidders passed the PQQ criteria indicating sufficient financial robustness and capacity.</p> <p>3 Bidders were involved in the Competitive Dialogue process, and demonstrated value for money within the affordability parameters. Final Bids have been evaluated, and value for money has been maintained.</p>
Overall	<p>Overall, in considering procurement, is the project team satisfied that there is a sound competition?</p>	<p>Yes – 3 Bidders were retained to submission of Final Bids thereby generating competitive tension</p>

Efficient Procurement Process

A good procurement is important to sustain market interest. The Trust addressed the specific issues in terms of Efficient Procurement Process as follows:

Issue	Question	Trust Response
<p>Efficient Procurement</p>	<p>Is there a realistic project plan, has this been adhered to without undue delays?</p>	<p>This was a pathfinder project for the first major hospital scheme to be taken forward under Competitive Dialogue. While a realistic project plan was developed on commencement of the procurement, delays were experienced due to changes in scope of the scheme arising primarily from the land slip, the inclusion of the One Off Cash Injection (OCCI) and the decision to include a Mandatory Variant Bid to examine a Hard FM only option. These are further detailed at section 1.6 of this FBC. Revised project plans were developed when each of these issues arose and these have been adhered to.</p>
	<p>Are bid costs likely to be proportionate to the contract value?</p>	<p>The 3 Bidders highlighted the fact that bid costs are high, however they have all remained in the procurement process to submission of Final Bid indicating satisfactory levels. As an example the preferred bidder bid costs are approximately 2.3% of capital costs.</p>
	<p>Will any aspect of the procurement impact adversely on market interest? (e.g. restrictions imposed by competitive dialogue procedure)</p>	<p>Amendments to Bid requirements during the Dialogue phase i.e. changes in approach to Soft FM, OOCI, land slip, had the potential to affect market interest. However, all 3 Bidders remained keen and submitted Final Bids.</p>
	<p>Are there any problems emerging with the way the procurement is structured?</p>	<p>There were 4 stages in the Competitive Dialogue process. Although the Trust managed each stage effectively there were tight timescales.</p> <p>One of the issues was that the project</p>

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Issue	Question	Trust Response
		<p>was the first to seek to deliver such a significant project using competitive dialogue. To the extent any such issue arose, professional advice was taken if relevant in order to agree an appropriate way forward which took account of key factors such as the legal limitations, cost implications and timing.</p>
Authority resources	<p>Does the procuring authority have the necessary resources to conduct good procurement?</p> <p>Are sound project governance arrangements in place?</p>	<p>Yes – See Appendix 2.01 showing Acute Team / support staff structures.</p> <p>Yes – See Appendix 2.02 entitled Project / Programme Board. This has been supported by independent assessment and a Gateway Review of the project.</p>
Overall	<p>Overall is the way that the procurement process is proceeding likely to have adverse impact on the delivery of VfM?</p>	<p>No - Bidders' interest has been retained throughout. There is no indication that the Preferred Bidder, will change approach in a way that is likely to adversely impact VfM.</p> <p>The purpose of Competitive Dialogue, and the fine-tuning dealt with in the Preferred Bidder Letter, is to tie the Bidder down to the solution submitted (as amended by clarification) and to deal with any outstanding issues requiring refinement or clarification. The Preferred Bidder would not be permitted to change approach save only if something unforeseen were to occur.</p>

2.1.2. Risk Sharing

The decision to proceed with PFI is dependant on the market appetite for the project. HM Treasury VfM guidance sets out specific issues to be considered as part of the continuous assessment in Stage 3. These are addressed as shown below.

Issue	Question	Trust Response
Wider issues	Is the competition delivering the proposed risk transfer being?	Yes – the risk apportionment is outlined in Chapter 5 and the Trust is content that appropriate risk transfer has been achieved.
	Does the Authority confirm that the nature of the deal and/or the strategic importance of work still make it suitable for delivery through PFI?	The content of the proposed deal i.e. construction and long-term maintenance of a facility with ongoing hard FM support is standard for procurement under PFI.
	Is there still confidence that all the key VfM drivers will be preserved.	The use of the NI version of the standard form Project Agreement transfers all the usual risks.
Overall	Overall, is the risk transfer achievable, given an assessment of the competition, and the procuring authority's constraints?	The Trust considered the implications of any changes from Stage 2 OBC. In summary risk transfer is included in Chapter 5 and this has been agreed with Bidders through the negotiation of the project agreement.

2.1.3. Stability of Costs

Since Stage 2 OBC in 2006, there have been a number of updates to the capital cost estimates. Associated Revenue cost implications are included in Chapter 1 of this FBC.

The change in capital costs has been as a result of:

- Adjustment to MIPS;
- Reduction in Key Worker Accommodation;
- Landslip;
- Extension to programme; and
- Risk adjustment

In November 2007 the Minister for Health announced that as a point of policy, cleaning services would be excluded from the scope of FM services that could be provided under the Private Finance Initiative, and would be delivered by the NHS.

In addition the Core Bid for the project excluded all other Soft FM services. Bidders had the option to include a Voluntary Variant bid to include the remaining Soft FM services within the scheme. However, no Voluntary Variant Bids were received.

The HM Treasury model for Value for Money (VfM) was rerun at ABC stage for the revised project scope and demonstrated that PFI continues to provide value for money. In addition, bids submitted at Stage 3 were well within the affordability and VfM thresholds required by the Trust (see Chapter 7 – Stage 3 evaluation.).

2.1.4. Financial Flexibility

The HMT guidance requires an assessment of the impact that the use of different financial structures has on the flexibility of the project to accommodate changes to the requirements.

The Preferred Bidder has a bank debt funding structure, with a “club” of banks providing half of the funding requirement for debt of both tenors, and with the EIB providing the required funding for the other half.

This is a change from the funding solution initially proposed and is in response to the current volatility of the global financial infrastructure markets. The Trust had retained the right to revisit the funding solution with the Preferred Bidder, once appointed, in order to mitigate some of the inherent difficulty in generating and maintaining Value for Money in the selected funding package in this environment.

Bank debt is the most flexible form of funding, in that changes can be incorporated easily both before and after financial close. It is not expected that there will be significant changes prior to financial close, as dictated by the Competitive Dialogue process. Variations for changes post financial close are easily accommodated into the funding structure, with an agreed protocol for the hierarchy of funders in the event of any additional debt being required.

2.1.5. Financial Structures

There are three specific areas where the financial structures of the project could have an impact on flexibility:

- Contract Variations;
- Refinancing; and
- Authority Voluntary Termination.

Each of these areas are covered in the Project Agreement, extracts are shown below.

Contract Variations

If additional works are needed, extra finance may be required. The finance may be provided by the Trust alone, the Contractor alone or in combination. The Trust will ultimately decide on the funding arrangements and the party responsible for obtaining finance must use best efforts to obtain it. If finance cannot be obtained, the additional works will not proceed (Schedule 22 of the Project Agreement).

After a variation, there may be an alteration to the Contractor's service charge or payment of a lump sum of compensation to the Contractor. The principles on which these alterations to the price are made are:

- The Contractor must be placed in a position that is no better, but no worse, than that in which it would have been had the change not occurred. The Contractor should not receive a "windfall" due to the change (Schedule 22 Part 3 of the Project Agreement);
- if the Contractor wants to make changes, the Trust has complete discretion to agree or refuse the alteration. There is no formal structure for the Contractor to compel the Trust to accept a "Contractor change", or even to have the matter decided by a Dispute Resolution Procedure.

Refinancing (Schedule 29 of Project Agreement)

The cost of borrowing funds to construct the Facilities is a major expense of the Contractor. It may be that, due to changing market conditions or an improved credit rating of the project due to its success, the credit terms which the Contractor can obtain improve through the life of the Contract. Obtaining such improved credit terms is known as a "Refinancing". The potential for refinancing may also be impacted upon by the funding route chosen by the bidder. Bonds are expensive to break; bank debt is much more flexible. The finance route chosen by the preferred bidder will therefore be advantageous in this case.

The Contract states that, generally, the proceeds or savings which result from a Refinancing should be split equally between the Contractor and the Trust. This recognises that the Trust plays a significant part in the success of the project which, in turn, allows more favorable finance terms to be obtained.

The Trust will also generally have the right to consent to a proposed Refinancing but must act reasonably in doing so.

Authority Voluntary Termination

Compensation on termination (Clause 48 and Schedule 23 of the Project Agreement)

The Contract details the compensation payable to the Contractor on termination which varies depending on the reason for the termination.

2.1.5.1. Default of the Trust

Where the termination is due to a default of the Trust or voluntary termination by it, then the Trust will have to pay the Contractor an amount equal to:

- the balance of the monies borrowed by the Contractor to fund the project and which will now have to be repaid (“senior debt” to the banks, and “junior or subordinated debt (higher returns than normal debt but more risky)” to the equity providers – shareholders in the company set up to run the project);
- losses which the Contractor will face due to the early termination, such as redundancy payments;
- an amount equivalent to the profit that the Contractor would have made but for the early termination (determined by referring to the agreed financial calculations at the start of the Contract); but
- minus the value (if any) of assets and account balances left in the hands of the Contractor on termination.
- The financial calculations aim to put the Contractor in a position that is “no better, no worse” than it would have been had the Contract run for its full length.

2.1.5.2. Default by the Contractor

If the reason for termination is default by the Contractor, then the Trust pays compensation equal to or equivalent to the “transfer value” of the Contract. That is, the amount which a third party will pay for the remaining benefit of the Contract. Where the Contract is retendered then the proceeds are passed to the original Contractor. Where retendering is not possible (for example, where there are insufficient Bidders), or the Trust elects not to permit this, the “Fair Value” of the remaining Contract will instead be assessed on a hypothetical basis and this fair value will be the compensation payable to the Contractor. Hence, the Trust will not receive a windfall through “selling” the rest of the Contract to a successor Contractor, but will not have to pay any other compensation.

2.1.5.3. Force Majeure

In the case of Force Majeure leading to termination (see paragraph 22), neither party is at fault and the downside of early termination is shared between the parties. Therefore, the Contractor is paid sufficient to enable it to pay off its senior and junior or subordinated debt and amounts due to shareholders, but not the Contract’s wider value (in other words, excluding future expected profits in the form of returns to shareholders).

2.1.6. Contractor Distress

All Bidders were assessed at PQQ stage in terms of their financial robustness. There have been no changes to the consortia throughout the procurement process with the exception of the removal of soft FM providers.

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Prior to Financial Close the Trust's financial advisors will update the tests undertaken at PQQ to ensure that no factors have arisen in the intervening period that would impact on the financial robustness of consortia members.

The Trust will also take comfort from the due diligence work undertaken by the Preferred Bidders senior debt providers.

A realistic timetable was set out in the OBC and was monitored throughout the procurement process. The Trust will monitor the time taken between the selection of preferred Bidder and Financial Close and if there are substantial changes to the timetable, value for money will be re-assessed.

3. AFFORDABILITY AND ACCOUNTING TREATMENT

3.1. POTENTIAL ACCOUNTING TREATMENT OF PFI DEAL

A key consideration for any PFI project is how its purchaser should account for any existing and/or newly-created or procured assets within the project. An off balance sheet accounting treatment generally arises for such assets where the private sector bears a significant part of the scheme and service risks relating to the assets. The purchaser consequently will, in substance, be seen as receiving a service, not owning or acquiring assets. This accounting treatment assessment applies the accounting guidance in Financial Reporting Standard 5 (FRS5) "Reporting the Substance of Transactions" and its Application Note F.

It is relevant to note that the Chancellor announced in his 2007 Budget Report in March 2007 that it is intended to apply International Financial Reporting Standards ("IFRS") in the public sector from 2008/09. In the 2008 Budget Report, on 12 March 2008 the Chancellor announced a one year delay to this timetable, with full implementation to take effect from 2009/2010. This change to IFRS is likely to result in the need to reassess the accounting analysis for the Project in due course.

However, this analysis does not fall to be part of the scope of this engagement. It is important to note that the decision on the accounting treatment for the newly-created assets in the Project is a matter for the Trust's directors/senior management and for the external auditor in the context of the financial statements. The Trust has sought the Accounting View of the Northern Ireland Audit Office (NIAO) and its external auditors on the accounting treatment. NIAO has concluded that as guided by SSAP21, FRS5 (particularly Application Note F), Treasury Taskforce Technical Note 1 and other Treasury and DFP guidance the assets should be accounted for as on balance sheet.

The Trust shall prepare its 2009/10 accounts applying International Financial Reporting Standards (IFRS). At this point the balance sheet treatment of this PFI scheme will be revisited. This process shall be implemented with the full engagement of the Trust's external auditors.

3.1.1. Accounting Opinion

Based on the information made available to Deloitte, the Trust's Financial Advisors, their view, after applying the key principles, and considering the indicators and methodologies that make up the accounting guidance in the Application Note, is that **the newly-created assets in the project should be accounted for as on balance sheet for the Trust.**

Underlying this judgement, their analysis is set out in their full report at Appendix 3.01 and indicates the following:

Separability of the contract

Set out below is our analysis of the separability of the contract as required by the Application Note. These indicators have been analysed in detail in the attached Appendix 3.01.

The operator will provide no soft FM Services. The contract is for the construction of the asset together with the associated hard FM services. The Hard FM services are not separable from the main contract and the contract is therefore required to be analysed as a contract for services under FRS 5 Application Note F.

Assessment of risks (and reward)

The key commercial risks (and rewards) that, according to the Application Note should be included in the risk analysis, and our assessment of who bears them, are shown in the table 3.1 below:

Table 3.1 Risk Analysis

Risk and Reward	Trust	Private Sector Operator
Demand risk	•	
Third party revenue risk		•
Who determines the nature of the property (design risk)	•	•
Performance & Availability risk		•
Change in relevant costs risk	•	•
Obsolescence and technology risk	•	
Residual value risk	•	
Positions of the parties to the transaction (nature of financing, operator default)		•

The Trust retains demand risk which is deemed significant. Third party revenue risk resides with the operator. The Operator receives a unitary payment based on meeting specific performance targets and therefore bears performance risk. Obsolescence and Technology and residual value risks are borne by the Trust and finance risk is borne by the Operator.

Shared risks arise where the commercial risk is not deemed to rest solely with one party, although one of the parties might be assessed to carry a greater risk than the other. Design risk is shared with the Trust and Operator. Changes for costs risk is also shared between the Operator and Trust. This is due to the operator being exposed to inflation risk in the construction phase, but on the service element the risk of inflation increases primarily rests with the Trust.

Demand and residual value of risks are identified by FRS 5 as being the two key indicators in determining who holds the risks and rewards of the newly-created asset and consequently who accounts for the asset. Both of these risks are deemed significant and borne by the Trust.

The Operator receives a £100m payment at the completion of the Construction. While this will be used to reduce the construction finance obligations and consequently lessens the risk to the project from the Operator's perspective, this is consistent with our overall conclusion. The £100m cash injection will be allocated to the on balance sheet liability in the total net asset figure in the Trust accounts.

The quantum of risk transferred to the Operator via the entirety of the Project Agreement follows the Northern Ireland specific standard form and is therefore in line with health PFI market norms. The consideration of the risks transferred and retained as a consequence of this contract results in an on Balance Sheet treatment.

3.2. AFFORDABILITY

The procurement of the new hospital through a PPP arrangement converts up front capital and ongoing maintenance costs into a monthly unitary charge which results in a smoother profile of expenditure. The proposed unitary charge has been extracted from the Preferred Bidder's financial model at Financial Close achieved on 20th May 2009.

Table 3.2 overleaf presents the overall capital and revenue funds required for the PFI elements of the new project. It also includes the revised running costs for operating the new facility. The base year for running costs is 2008/9. Inflation at 2.5% per annum has been applied to these costs to bring them up to 2012/13 figures. The same estimate for inflation (2.5%) has then been applied for each subsequent year of the project. It is currently anticipated that the beds in the new hospital will be opened in a phased basis – 269 beds on 1/09/2012, 292 beds on 01/04/2014 and 312 beds on 01/04/2017. The calculation of Non PFI Revenue costs has taken this phasing into account (see details in Chapter 1 of this FBC).

In presenting this analysis, the following assumptions have been made:

- given the proposed on-balance sheet accounting treatment for the project outlined in Section 3.1 above, the capital cost of the PFI building is included as a capital DEL requirement. Per the bidder's financial model, total funding of £223,908k (including pre-operating costs) is required in year ending 31st March 2013 to cover construction costs and fees;
- the unitary charge has been extracted from the Preferred Bidder's financial model. This has been calculated to take account of the One Off Cash Injection (OOCI) of £100,421k to be paid to Bidders on Actual Practical Completion (estimated to be 31 May 2012). However it is important to note, although the

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contract to construct the hospital is for 36 months, all of the key stakeholders are committed to achieving Actual Practical Completion within 33 months (by March 2012). Therefore the OOCI and Capital DEL consequence are expected to be met in 2011/12. Whilst this continues to constitute a risk during the construction phase, the situation will be monitored closely by both the Western HSC Trust and the Department during this period.

- The value of the unitary charge in real prices as at 01/04/2007 is £13.831m. This is well within the affordability parameters set by the Department of £15.2m. The unitary charge presented in the affordability analysis is based on the prices that will be paid by the Trust (i.e. nominal values including inflation). The split of building related charges between capital repayment and finance lease interest has been calculated on an actuarial basis;
- the hospital is expected to have a useful economic life of 60 years, at the end of which the value of the building will be treated as nil. Depreciation has been charged on a straight line basis over this 60 year period;
- cost of capital for the PFI building has been calculated based on 3.5% of the average asset balance each year;
- for the PFI building, a corresponding capital credit of 3.5% has been applied to the average amounts outstanding on the finance creditor;
- this excludes the impact of current pricing (confirmed by HM Treasury as applying to on-balance sheet PFI's) and revaluation; and
- Non-PFI running costs are based on the analysis undertaken in Chapter 1, Section 1.9 of this FBC. This gives annual running costs of £46,385k for 269 beds, £47,458k for 292 beds and £48,158k for 312 beds based on 2008/9 price levels. These costs have been uplifted by inflation of 2.5% for each year between 2008/9 and the date of the beds opening. This results in Non-PFI running costs of £51,200k for 269 beds for a full year as at 2012/13 prices, £29,867k for the period September 2012 – March 2013, £55,037k in 2014/15 for 292 beds and £60,143k in 2017/18 for 312 beds.

The Capital and Revenue implications of the new hospital for the first fifteen years of the project are included in Table 3.2 overleaf. The implications for the full 30 years of the concession are included in Appendix 3.02. The calculation of capital charges associated with the new facility is also illustrated in Table 3.3.

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Table 3.2 Capital and Revenue Consequences 2012 – 2026

On balance sheet including one off cash injection

	TOTAL 30 YRS £'000	yr 1 £'000	yr 2 £'000	yr 3 £'000	yr 4 £'000	yr 5 £'000	yr 6 £'000	yr 7 £'000	yr 8 £'000	yr 9 £'000	yr 10 £'000	yr 11 £'000	yr 12 £'000	yr 13 £'000	yr 14 £'000	yr 15 £'000
RESOURCE DEL YR ENDED		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Project / scope/ bid																
Non Cash Costs																
depreciation	111,954	-	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732
cost of capital charge	176,328	-	7,771	7,641	7,510	7,380	7,249	7,118	6,988	6,857	6,727	6,596	6,465	6,335	6,204	6,074
cost of capital credit	- 103,191	- -	4,322 -	4,322 -	4,322 -	4,322 -	4,320 -	4,318 -	4,309 -	4,283 -	4,244 -	4,192 -	4,130 -	4,056 -	3,955 -	3,888
total non cash costs	185,090	-	7,181	7,051	6,920	6,789	6,661	6,532	6,411	6,306	6,214	6,136	6,067	6,010	5,981	5,917
NEAR CASH COSTS																
Financing costs	324,409	-	9,994	12,675	12,971	13,319	13,518	13,508	13,506	13,448	13,344	13,207	13,015	12,821	12,554	12,187
Lifecycle	84,599	-	-	-	4	-	14	500	304	312	436	447	951	885	585	4,237
FM	117,533	-	1,697	2,473	2,552	2,638	2,722	2,810	2,900	2,993	3,089	3,188	3,290	3,396	3,505	3,618
OP ex (SPV Costs)	33,820	-	929	888	910	892	915	873	889	911	934	957	981	1,006	1,031	1,057
TOTAL NEAR CASH RESOURCE DEL	560,361	-	12,620	16,036	16,437	16,849	17,169	17,690	17,598	17,663	17,802	17,798	18,238	18,108	17,675	21,098
TOTAL RESOURCE DEL	745,451	-	19,801	23,087	23,357	23,638	23,830	24,222	24,009	23,970	24,016	23,934	24,305	24,118	23,656	27,015
CAPITAL DEL	223,908	-	223,908													
TOTAL DEL	969,359	-	243,709	23,087	23,357	23,638	23,830	24,222	24,009	23,970	24,016	23,934	24,305	24,118	23,656	27,015
CASH FLOW																
UNITARY CHARGE	683,848	-	12,620	16,036	16,437	16,849	17,269	17,701	18,144	18,598	19,062	19,539	20,027	20,529	21,040	21,567
ONE OFF PAYMENT	100,421	-	100,421													
TOTAL CASH	784,269	-	113,041	16,036	16,437	16,849	17,269	17,701	18,144	18,598	19,062	19,539	20,027	20,529	21,040	21,567
Non PFI Revenue Costs	2,305,961	-	29,867	52,480	55,037	56,413	57,823	60,143	61,646	63,187	64,767	66,386	68,046	69,747	71,491	73,278

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Table 3.3 Capital Charges

PFI Element	1 2012	2 2013	3 2014	4 2015	5 2016	6 2017	7 2018	8 2019	9 2020	10 2021	11 2022	12 2023	13 2024	14 2025	15 2026
Opening Capital	-	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908
Additions (from Appendix H)	223,908														
closing Capital	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908	223,908
depreciation	-	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732
Total Depreciation Charge	-	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732
Opening NBV	-	-	220,176	216,444	212,713	208,981	205,249	201,517	197,785	194,054	190,322	186,590	182,858	179,126	175,395
Closing NBV	220,176	216,444	212,713	208,981	205,249	201,517	197,785	194,054	190,322	186,590	182,858	179,126	175,395	171,663	
Cost of Capital	-	7,771	7,641	7,510	7,380	7,249	7,118	6,988	6,857	6,727	6,596	6,465	6,335	6,204	6,074
Capital Charges	-	11,503	11,373	11,242	11,111	10,981	10,850	10,720	10,589	10,458	10,328	10,197	10,067	9,936	9,805

The above profile is based on the assumption that the Trust will take over the new hospital on 01/06/2012. In line with Departmental policy, capital charges would apply for all of 2012/13 i.e. the full year in which the asset is acquired. However as illustrated in section 3.2 above all stakeholders are working to a Practical Completion target date of March 2012 which would result in the application of Capital Charges in 2011/12. It should be noted that capital charge calculations have been presented for the building capital costs and pre-operating costs only (ie non-medical equipment and commissioning costs have not been included in these calculations). The implications for the full 30 years of the concession are included in Appendix 3.03.

3.2.1. Other Costs

A number of other funding considerations for the new hospital have been identified in Chapter 1 of this FBC and included in the affordability analysis to enable the Trust to have a composite view of the overall cost of the new acute hospital. These are summarised in Table 3.4 below for the first 15 years of the project.

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Table 3.4 Other Costs

RESOURCE DEL YR ENDED	TOTAL 30 YRS £'000	yr 1 £'000 2012	yr 2 £'000 2013	yr 3 £'000 2014	yr 4 £'000 2015	yr 5 £'000 2016	yr 6 £'000 2017	yr 7 £'000 2018	yr 8 £'000 2019	yr 9 £'000 2020	yr 10 £'000 2021	yr 11 £'000 2022	yr 12 £'000 2023	yr 13 £'000 2024	yr 14 £'000 2025	yr 15 £'000 2026
OTHER COSTS																
Capital																
Commissioning	2,067	901	1101	66	0	0	0	0	0	0	0	0	0	0	0	0
Decommissioning	- 3,776	0	2471	-6247	0	0	0	0	0	0	0	0	0	0	0	0
Non Medical Equipment	4,814	4681	0	0	97	0	0	35	0	0	0	0	0	0	0	0
Impairment on Building	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Other Capital Costs	3,105	5,583	3,571	- 6,181	97	-	-	35	-	-	-	-	-	-	-	-
Revenue																
Staff Relocation	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Shuttle Bus	127	0	36	64	27	0	0	0	0	0	0	0	0	0	0	0
Total Other Revenue Costs	127	0	36	64	27	0	0	0	0	0	0	0	0	0	0	0

3.2.1.1. Commissioning Costs

These are detailed in Chapter 1, Section 1.8.1.3 above and relate to the following:

- Commissioning team
- PPE team
- Staff training
- Additional FM requirements
- Double running costs
- Transport costs
- Information and publicity

These costs are presented at 2008/9 price levels in Section 1.8.1.3 so inflation of 2.5% per annum has been applied to convert to 2011/12, 2012/13 and 2013/14 levels.

3.2.1.2. Decommissioning Costs

The make up of decommissioning costs is included in Section 1.8.1.4 in Chapter 1 of this FBC. These costs are at 2008/9 price levels so inflation of 2.5% per annum has been applied between 2008/9 and 2012/13 and 2013/14.

3.2.1.3. Non-Medical Equipment Costs

Non Medical equipment costs of £4,459k are included in Chapter 1, Section 1.8.1.2. These costs are at 2008/9 price levels so inflation of 2.5% per annum has been applied between 2008/9 and 2011/12.

3.2.1.4. Impairment on the Building

Sales proceeds of £6m have been included in the decommissioning costs in 2013/14 for the Erne site. This is based on the latest VLA valuation. It should be noted that the NBV of the land and buildings is currently £19m, and the difference of £13m will be written off as an impairment between 2008/9 and 2011/12

3.2.1.5. Shuttle Bus

Costs for the shuttle bus of £56k for a full year have been identified in Chapter 1, section 1.9.4 These are based on 2008/9 price levels so inflation of 2.5% per annum has been applied to bring these up to 2012/13 prices. Cost of 7 months has been included in year 1, a full year in year 2, and 5 months in year 3.

3.2.2. Budgets Available for Set-Off

2008/9 Budgets available in respect of the above are as follows:

- Capital £0k;
- Capital charges £2,030k per annum relating to the Erne Hospital. These will be available for set-off against the capital charges on the new facility from Q1 2014 (i.e. 01/01/2014) as the Erne Site will be disposed of in 2013;
- Hard FM Running Costs – the current budget for hard FM services, based on 2008/9 price levels is £1,286k. This has been uplifted by 2.5% per annum, giving a full year budget of £1,420k in 20012/13. 10 months worth of this budget has been taken into year 1 of the project to reflect the unitary charge which applies from 01/06/2012. Inflation of 2.5% per annum has been applied for each subsequent year;
- Lifecycle - £250k per annum is currently available for lifecycle expenditure, based on 2008/9 price levels. This has been uplifted by 2.5% per annum, giving a full year budget of £276k in 2012/13. 10 months worth of this budget has been taken into year 1 of the project to reflect the unitary charge which applies from 01/06/2012. Inflation of 2.5% per annum has been applied for each subsequent year; and
- The current budget, based on 2008/9 price levels for Non-PFI Revenue Costs is £43,674k. A full break down of current budgets is outlined in Section 1.9.2, Tables 1.27. This has been uplifted by 2.5% per annum, giving a full year budget of £48,208k in 20012/13. 7/12 of this budget has been taken into year 1 of the project to reflect the beds opening on 01/09/2012. Inflation of 2.5% per annum has been applied for each subsequent year.

Current budgets are illustrated in Table 3.5 below for the first 15 years of the project. Details for the full 30 years of the concession are included in Appendix 3. 04

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Table 3.5 Capital and Revenue Current Budgets

Current Budgets																
	TOTAL 30 YRS	yr 1	yr 2	yr 3	yr 4	yr 5	yr 6	yr 7	yr 8	yr 9	yr 10	yr 11	yr 12	yr 13	yr 14	yr 15
RESOURCE DEL YR ENDED	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Project / scope/ bid																
Non Cash Costs																
depreciation	36,967	-	-	-	1,320	1,320	1,320	1,320	1,320	1,320	1,320	1,320	1,320	1,320	1,320	1,320
cost of capital charge	19,881	-	-	-	710	710	710	710	710	710	710	710	710	710	710	710
cost of capital credit	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
total non cash costs	56,848	-	-	-	2,030	2,030	2,030	2,030	2,030	2,030	2,030	2,030	2,030	2,030	2,030	2,030
NEAR CASH COSTS																
Financing costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lifecycle	12,071	-	230	283	290	297	305	312	320	328	336	345	353	362	371	380
FM	62,105	-	1,183	1,456	1,492	1,529	1,567	1,607	1,647	1,688	1,730	1,773	1,818	1,863	1,910	1,957
OP ex (SPV Costs)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL NEAR CASH RESOURCE DEL	74,176	-	1,413	1,738	1,782	1,826	1,872	1,919	1,967	2,016	2,066	2,118	2,171	2,225	2,281	2,338
TOTAL RESOURCE DEL	131,024	-	1,413	1,738	3,812	3,857	3,902	3,949	3,997	4,046	4,097	4,148	4,201	4,256	4,311	4,368
CAPITAL DEL	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL DEL	131,024	-	1,413	1,738	3,812	3,857	3,902	3,949	3,997	4,046	4,097	4,148	4,201	4,256	4,311	4,368
CASH FLOW																
UNITARY CHARGE	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ONE OFF PAYMENT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL CASH	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non PFI Revenue Costs	2,096,375	-	28,121	49,413	50,649	51,915	53,213	54,543	55,907	57,304	58,737	60,205	61,710	63,253	64,834	66,455
OTHER COSTS																
Capital																
Commissioning	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Decommissioning	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical Equipment	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Impairment on Building	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Other Capital Costs	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Revenue																
Staff Relocation	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Shuttle Bus	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Other Revenue Costs	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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These budget amounts (at 2008/9 levels) have been used to offset against the predicted charges to calculate the affordability gap in 2011/12 and subsequent years. The resultant affordability gap for the first fifteen years of the project is outlined in Table 3.6. Details for the full 30 years of the concession period are included in Appendix 3.05. Table 3.6 indicates that there is a significant affordability gap for each year of operation of the project, however it should be noted that the value of the unitary charge as at 01/04/2007 is £13.831m This is well within the affordability parameters set by the Department of £15.2m.

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Table 3.6 Affordability Gap

Affordability Gap																
RESOURCE DEL YR ENDED	TOTAL 30 YRS £'000	yr 1 £'000	yr 2 £'000	yr 3 £'000	yr 4 £'000	yr 5 £'000	yr 6 £'000	yr 7 £'000	yr 8 £'000	yr 9 £'000	yr 10 £'000	yr 11 £'000	yr 12 £'000	yr 13 £'000	yr 14 £'000	yr 15 £'000
		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Project / scope/ bid																
Non Cash Costs																
depreciation	74,987	-	3,732	3,732	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412
cost of capital charge	156,446	-	7,771	7,641	6,800	6,670	6,539	6,408	6,278	6,147	6,017	5,886	5,755	5,625	5,494	5,363
cost of capital credit	- 103,191	-	- 4,322	- 4,322	- 4,322	- 4,322	- 4,320	- 4,318	- 4,309	- 4,283	- 4,244	- 4,192	- 4,130	- 4,056	- 3,955	- 3,888
total non cash costs	128,242	-	7,181	7,051	4,890	4,759	4,630	4,502	4,381	4,276	4,184	4,106	4,037	3,980	3,951	3,887
NEAR CASH COSTS																
Financing costs	324,409	-	9,994	12,675	12,971	13,319	13,518	13,508	13,506	13,448	13,344	13,207	13,015	12,821	12,554	12,187
Lifecycle	72,528	-	- 230	- 283	- 286	- 297	- 291	- 187	- 16	- 17	99	102	598	523	213	3,856
FM	55,429	-	514	1,018	1,060	1,109	1,155	1,203	1,253	1,305	1,358	1,414	1,472	1,533	1,595	1,660
OP ex (SPV Costs)	33,820	-	929	888	910	892	915	873	889	911	934	957	981	1,006	1,031	1,057
TOTAL NEAR CASH RESOURCE DEL	486,185	-	11,207	14,298	14,656	15,023	15,297	15,771	15,632	15,647	15,736	15,680	16,067	15,883	15,394	18,760
TOTAL RESOURCE DEL	614,427	-	18,388	21,349	19,545	19,782	19,927	20,273	20,012	19,923	19,919	19,786	20,104	19,863	19,345	22,647
CAPITAL DEL																
CAPITAL DEL	223,908	-	223,908	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL DEL	838,335	-	242,296	21,349	19,545	19,782	19,927	20,273	20,012	19,923	19,919	19,786	20,104	19,863	19,345	22,647
CASH FLOW																
UNITARY CHARGE	683,848	-	12,620	16,036	16,437	16,849	17,269	17,701	18,144	18,598	19,062	19,539	20,027	20,529	21,040	21,567
ONE OFF PAYMENT	100,421	-	100,421	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL CASH	784,269	-	113,041	16,036	16,437	16,849	17,269	17,701	18,144	18,598	19,062	19,539	20,027	20,529	21,040	21,567
Non PFI Revenue Costs																
Non PFI Revenue Costs	209,586	-	1,746	3,067	4,388	4,498	4,610	5,600	5,740	5,883	6,030	6,181	6,336	6,494	6,656	6,823
OTHER COSTS																
Capital																
Commissioning	2,067	901	1101	66	0	0	0	0	0	0	0	0	0	0	0	0
Decommissioning	- 3,776	0	2471	-6247	0	0	0	0	0	0	0	0	0	0	0	0
Medical Equipment	4,814	4681	0	0	97	0	0	35	0	0	0	0	0	0	0	0
Impairment on Building	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Other Capital Costs	3,105	5,583	3,571	- 6,181	97	-	-	35	-	-	-	-	-	-	-	-
Revenue																
Staff Relocation	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Shuttle Bus	127	0	36	64	27	0	0	0	0	0	0	0	0	0	0	0
Total Other Revenue Costs	127	0	36	64	27	0	0	0	0	0	0	0	0	0	0	0

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3.2.3. Income and Expenditure Account

The impact of the new hospital facilities on the Income & Expenditure Account of the Trust for the first fifteen years of the project is shown in Table 3.7 below. Details for the full 30 years are shown in Appendix 3.06.

Table 3.7 Income & Expenditure Account

Income and Expenditure Account

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Non PFI Running Costs	29,867	52,480	55,037	56,413	57,823	60,143	61,646	63,187	64,767	66,386	68,046	69,747	71,491	73,278
Finance Charges	9,994	12,675	12,971	13,319	13,518	13,508	13,506	13,448	13,344	13,207	13,015	12,821	12,554	12,187
SPV Running Costs	929	888	910	892	915	873	889	911	934	957	981	1,006	1,031	1,057
Lifecycle	0	0	4	0	14	500	304	312	436	447	951	885	585	4,237
Hard FM	1,697	2,473	2,552	2,638	2,722	2,810	2,900	2,993	3,089	3,188	3,290	3,396	3,505	3,618
Depreciation	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732
Cost of Capital	7,771	7,641	7,510	7,380	7,249	7,118	6,988	6,857	6,727	6,596	6,465	6,335	6,204	6,074
Cost of Capital Credit	-4,322	-4,322	-4,322	-4,322	-4,320	-4,318	-4,309	-4,283	-4,244	-4,192	-4,130	-4,056	-3,955	-3,888
Total Expenditure	49,668	75,567	78,394	80,051	81,653	84,365	85,656	87,157	88,783	90,320	92,351	93,865	95,147	100,294

3.2.4. Balance Sheet Entries

The proposed on-balance sheet accounting treatment for this project outlined in Section 3.1 above means that the Trust will have an asset of the property and there will be an associated finance lease creditor for the first 30 years of the project. The accounting entries for the first 15 years of the project are outlined in Table 3.8 overleaf. The entries for the full 30 years of the concession are included in Appendix 3.07.

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Table 3.8 Balance Sheet Entries

FIXED ASSETS	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Assets														
Opening NBV	-	220,176	216,444	212,713	208,981	205,249	201,517	197,785	194,054	190,322	186,590	182,858	179,126	175,395
Additions	223,908	-	-	-	-	-	-	-	-	-	-	-	-	-
Depreciation	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732	3,732
Closing NBV	220,176	216,444	212,713	208,981	205,249	201,517	197,785	194,054	190,322	186,590	182,858	179,126	175,395	171,663
CREDITORS	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Opening Creditors	223,908	123,487	123,487	123,487	123,487	123,387	123,376	122,831	121,896	120,636	118,895	117,106	114,685	111,319
Addition														
One Off Cash Injection	100,421													
Capital Repayment	123,487	-	-	-	100	11	545	935	1,260	1,741	1,790	2,421	3,365	469
Closing Creditor	123,487	123,487	123,487	123,487	123,387	123,376	122,831	121,896	120,636	118,895	117,106	114,685	111,319	110,850

4. DETAILED OUTPUT SPECIFICATIONS

Specifications were developed together with Trust Staff, Health Estates and Trust Advisors using an integrated approach to capture the Trust Specific Requirements in relation to:

- a) Clinical issues – Clinical Output Specifications (COS);
- b) Facilities Management; and
- c) Construction (Trust Construction Requirements – TCR's)

4.1. CLINICAL OUTPUT SPECIFICATIONS

The suite of Clinical Output Specifications (COS) have been developed and reviewed to capture the Trusts specific service requirements for each individual department, within the new facility. They have been developed in conjunction with the clinical model and using Health Technical Memorandums (HTM's) and Health Building Notes (HBN's), also good practice guidance in relation to infection control and benchmarked against Royal Colleges recommendations, and relevant National Patient Safety Agency guidance.

In addition to input from the Project team, the process has included the views and requirements of both clinicians and ward / department staff alongside expert advice from Health Estates Agency. They have been linked to Facilities Management in order to obtain a 'whole systems approach' thus ensuring 'patient focused' care is provided throughout the new facility.

The COS's have been based on best practice guidance and benchmarked with other projects and acknowledge all the latest guidance from Health Estates. See appendix 4.00 for recent PEL guidance.

These COS have been prepared to form part of the overall Trust scheme requirements and should therefore not be viewed in isolation. They define the scope and objectives of the services to be provided and the standards that the Trust requires from the consortia.

Table 4.1 overleaf outlines the Clinical Output Specifications for the new facility and specifies where they are included in the Appendices.

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Table 4.1 Facility Requirements

COS Number	Acute Hospital Service/department	Appendix Number
1	A&E	4.01
2	Administration Accommodation – Offices	
	Consultants Offices Administration/Business Services	4.02
3	Allied Health Professionals	4.03
4	Catering	See FM Specification
5	Non Invasive Cardiology / Respiratory suite	4.04
6	Children’s Services	
	Paediatric Ambulatory Care Paediatric Outpatients (excl. integrated services) Combined Integrated Paediatric Service Paediatric Inpatients	4.05
7	Equipment Library	4.06
8	Critical Care Unit including Coronary Care Unit	4.07
9	Chronic Disease Management	4.08
11	Distribution centre	4.09
12	Education	4.10
13	Facilities for deceased	4.11
14	HSDU	4.12
15	Imaging	4.13
16	INPATIENT WARDS	
	Ward 1 Combined Assessment Ward 2 Cardiology Elective General Medical Ward Ward 3 Acute Medical Ward Ward 4 Acute Medical Ward Ward 5 Stroke Ward Ward 6 Care of older persons Ward 7 Care of older persons Ward 8 Acute Surgical Ward A Ward 9 Acute Surgical Ward B (Elective) Ward 10 Intermediate Care	4.14
18	Women’s Health Unit	4.15
19	Main Entrance	4.16
20	Maternity	

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COS Number	Acute Hospital Service/department	Appendix Number
	Maternity Inpatients- Midwifery led beds Consultant Led Delivery Rooms HDU / Recovery	4.17
21	Medical Records	4.18
22	Neo-natal	4.19
23	Outpatients Department incl. Cardiac Inv., Diet., etc	4.20
24	Pharmacy	4.21
25	Social Services	4.22
26	Staff Facilities	
	Staff Auto Valet Staff Changing Staff Social/Rest	4.23
27	Operating Theatres	4.24
28	Occupational Health/GPOOH	4.25
29	Discharge Lounge	4.26
30	Laboratory	4.27

4.2. FACILITIES MANAGEMENT SPECIFICATIONS

For all FM Services, Output Based Specifications (service specifications) were developed in line with the current issue of the NHS Standard Service Specifications amended to meet the new Payment Mechanism as issued by the NHS in February 2006. These service specifications were prepared to form part of the overall Trust scheme requirements and should therefore not be viewed in isolation. These service specifications defined the scope and objectives of the services to be provided and the standards that the Trust requires from the consortia's service partner.

The suite of FM service specifications were developed and reviewed to capture the Trust's specific service requirements of each of the individual service specifications. In addition to input from the Project Team, the process included the views and requirements of both service managers and clinicians to provide for a patient focused Facilities Management service, responsive to clinical and patient needs. Furthermore the current Stage 3 revised service specifications reflect the service development which was a product of the Competitive Dialogue Procedure with Bidders.

Listed overleaf in Table 4.2 are the Facilities Management Service Level Specifications for the Acute Hospital, which Bidders are required to meet.

Table 4.2 FM Service Specifications

FM Service Specification	Appendix Number
Core Bid	
General Service Specification	4.28
Estates Service Specification	4.29
Grounds and Gardens Service Specification	4.30
Utilities Service Specification	4.31
Help Desk Service Specification	4.32
Voluntary Variant Bid	
General Service Specification	4.33
Estates Service Specification	4.34
Grounds and Gardens Service Specification	4.35
Utilities Service Specification	4.36
Help Desk Service Specification	4.37
Pest Control Service Specification	4.38
Portering Service Specification	4.39
Hospital Reception Service Specification	4.40
Security Service Specification	4.41
Car Parking Service Specification	4.42
Catering Service Specification	4.43
Linen Service Specification	4.44
Waste Service Specification	4.45
Telecommunications Service Specification	4.46

4.3. CONSTRUCTION SPECIFICATIONS

Recognising that the New Facilities will be one of the most significant new structures in Northern Ireland, and particularly in the South West, the Trust under the guidance of Health Estates expects that the proposed development should:

- Incorporate contemporary architecture that will resonate with local tradition, and shall expect Project Co to offer designs of international standard;
- Satisfy the clinical and non-clinical, operational and functional requirements;
- Be environmentally restorative by functioning efficiently, effectively and economically, and so in its design meet and, where possible, exceed the minimum standards for:
 - Energy efficiency and the reduction in the use of fossil and nuclear fuels and water; and
 - Waste generation and disposal.
- Present a secure and reassuring environment;.
- Be built to a scale to which humans can relate, promote green space and biodiversity, and so contribute to creating an environment conducive to the healing and treatment of patients;

- Integrate building and landscape to create a rich and intelligible system of internal and external spaces, within which visitors can find their way about, relying as little as possible on signage; and
- Develop a style and theme of design that can be incorporated into further stages of the hospital site strategy.

The Trust's Construction Requirements (TCR's) set out clearly and in unambiguous terminology the minimum design requirement with respect to:

- Design and Construction Requirements;
- Approach to Schedules of Accommodation;
- Site Information;
- Design Quality Requirements;
- Specific Site Requirements (in relation to the undertaking of the works);
- Design and Construction (compliance with standards and regulations);
- Design and Build Quality, Specifications and Performance Building; and
- Information Communication Technology (ICT) Network.

Each of which in turn go into greater detail on a complex range of design issues but in particular important evidence based design issues ranging from:

- The therapeutic value of landscape design on patient recovery;
- The use of architectural lighting both internal and external to de-stress;
- An applied arts strategy both internal and external as a means of reassurance to both visitor and patient;
- Acoustic impact on patient recovery; and
- Localised environmental control and its impact on clinical outcomes.

Much of the TCR document itself has been translated into a clearly defined set of Design and Technical Deliverables at each stage of the Project.

Refer to Appendices 4.47 and 4.48 for the Trust's Construction Requirements.

5. RISK ALLOCATION

The following sections contain an overview of risk allocation within the proposed contract. It should be noted that this Risk Matrix is an overview of the main risks and responsibilities under the South West Acute Hospital Draft Project Agreement issued to all Bidders as part of the Invitation to Submit a Final Bid document. It is not a substitute for a detailed examination of the issues covered by the South West Acute Hospital Draft Project Agreement

5.1. DESIGN RISKS¹⁹

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
1.1	Failure to design to brief	Failure to translate the requirements of the Trust into the design.		✓		Cl. 17.1 (except for Clinical Functionality which the Trust signs off – Cl. 17.6)
1.2	Continuing development of design	The detail of the design should be developed within an agreed framework and timetable. A failure to do so may lead to additional design and construction costs.		✓		Cl. 17.7 – obligations to continue to develop the design. The cost is set at financial close and Project Co bears the risk for any increase unless it is the result of a Trust Variation or results from a Relevant Change in Law.
1.3	Change in requirements of the	The Trust may require changes to the design, leading to additional design and	✓			Cl. 40 and Sch. 22 (Variation Procedure)

19 PLEASE NOTE THAT THE NATURE OF DESIGN RISK WILL NEED TO BE FINALISED. THIS SECTION FOCUSES ON THE MAIN BODY OF THE PROJECT AGREEMENT. PLEASE NOTE THAT AN EXTENDED LIST OF REVIEWABLE DESIGN DATA COULD LEAD TO DESIGN RISK TRANSFERRING TO THE TRUST.

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
	Trust	construction costs.				
1.4	Change in design required by Project Co	This is the risk that Project Co will require changes to the design, leading to additional design costs.		✓		
1.5	Change in design required due to external influences specific to HPSS	There is a risk that the designs will need to change due to legislative or regulatory changes specific to the HPSS.	✓			Cl.39.2 (but if only a low cost, Project Co to bear cost of change – Cl.39.3(a))
1.6	Failure to build to design	Misinterpretation of design or failure to build to specification during construction may lead to additional design and construction costs.		✓		Cl. 17.1 and the fact that the cost is set at financial close and will only increase as a result of indexation, Trust Variations, and Relevant Changes in Law.

5.2. CONSTRUCTION AND DEVELOPMENT RISKS – PRIOR TO ACTUAL COMPLETION

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
2.1	Incorrect time estimate	The time taken to complete the construction phase different from the estimated time.		✓		Cl. 35.1 – The Trust only becomes liable to make any payment to Project Co once Actual Completion has been achieved on the Payment Commencement Date. If Actual Completion delayed, then the Trust will not be liable to pay any Service Payments or the Works Payment.
2.2	Unforeseen ground site conditions	Unforeseen ground/site conditions may lead to variations in the estimated cost.		✓		Cl. 15.1
2.3	Delay in gaining access to the site	A delay in gaining access to the site may put back the entire project.			✓ ²⁰	<p>However, if the access is delayed due to a breach by the Trust / Trust Party of its obligations (including giving access to the Site) or an obstruction of any Ancillary Rights granted by the Trust to Project Co, the Trust will be liable to compensate Project Co (Cl. 41.10 and 41.11).</p> <p>If access is delayed due to a Relief Event (e.g. discovery of fossils, blockade or embargo, flooding, earthquake) or a Force Majeure Event (e.g. chemical / biological contamination of the Site, nuclear contamination or war), then the Trust will grant Project Co an extension of time</p>

²⁰ Depending on circumstances.

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
						to construct the facilities (i.e. will postpone the long stop date) but no compensation will be payable to Project Co unless the Project Agreement is terminated (Cl. 41).
2.4	Responsibility for maintaining on-site security during construction	Theft and/or damage to equipment and materials may lead to unforeseen costs in terms of replacing damaged items, and delay.		✓		The responsibilities relating to the construction site compound will be placed on Project Co in the Trust's Construction Requirements (Sch. 8).
2.5	Responsibility for maintaining site safety	The Construction, Design and Management (CDM) regulations must be complied with.		✓		Cl.9 and Sch. 8 Part 2.
2.6	Third party claims	This risk refers to the costs associated with third party claims due to loss of amenity and ground subsidence on adjacent properties.		✓		Cl. 15.1(b) and 15.1(e) coupled with indemnity at Cl. 8.1(d).
2.7	"Compensation Events"	An event of this kind may delay or impede the performance of the contract and cause additional expense.	✓			Cl. 41.10 – 41.14 (These include Trust Variations, Discriminatory and NHS Specific Changes in Law); and Delay Events caused by: <ul style="list-style-type: none"> • Breach by Trust/Trust Party of Trust's PA obligations (including access to Site); • execution by Trust of works on the Site which are not part of PA Works; and • opening up of the Works by the Trust where

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
						such Works were not then found to be defective and where was not reasonable for Trust to have opened up the works given previous defects.
2.8	“Delay Events”	An event of this kind may delay or impede the performance of the contract and cause additional expense.			✓	Delay Events are listed at Cl. 41.3 and the Trust must allow an extension of time to Project Co (i.e. the Trust must postpone the Long Stop Date) but compensation is only paid by the Trust where the Delay Event is also a “Compensation Event” listed Cl.41.11.
2.9	Force Majeure	In the event of Force Majeure additional costs will be incurred. Facilities may also be unavailable.			✓	Cl. 43. Prior to the Actual Completion Date, the Force Majeure will be a Delay Event so an extension of time will be granted by the Trust. Compensation will only be payable by the Trust where the Project Agreement is terminated as a result of the Force Majeure (see below). Note – the extension of time does not mean that the Project Term will be extended so the total amount of Service Payments will be reduced (Cl. 41.1.2).
2.10	Termination due to force majeure	There is a risk that an event of force majeure will mean the parties are no longer able to perform the contract.			✓	Cl. 48.1 and Sch. 23 Part C. Briefly, the Trust will be liable to pay Project Co compensation to cover Project Co’s bank debt, redundancy payments and subcontractor losses payable under the Subcontracts (but excluding loss of profits).

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
2.11	Legislative/ regulatory change: HPSS specific	A change in HPSS specific legislation/regulations, leading to a change in the requirements and variations in costs.	✓			Cl. 39.2.
2.12	Legislative/ regulatory change: non-HPSS specific	A change in non-HPSS specific legislation/regulations taking effect during the construction phase, leading to a change in the requirements and variations in costs.		✓		Cl. 39.8.
2.13	Changes in taxation	Changes in taxation may affect the cost of the Project.		✓		Cl. 39.8.
2.14	Changes in the rate of VAT	Changes in the rate of VAT may increase the costs of the project. VAT should generally be refundable to the Trust.	✓			Cl. 53.8 – 53.9 and also note definition of Discriminatory Change in Law which expressly excludes tax laws.
2.15	Other changes in VAT	Changes in VAT legislation other than changes in the rate of VAT payable.	✓			Cl. 53.8 – 53.9 and also note definition of Discriminatory Change in Law which expressly excludes tax laws.
2.16	Project Co default / Building Contractor default	In the case of building contractor default, additional costs may be incurred in appointing a replacement, and may cause a delay.		✓		Cl. 44 and Sch. 23 Part B with regard to termination of Project Co as a result of Project Co Default. Also note the fact that no payments will be made by the Trust until the Payment Commencement Date after the Actual Completion Date has been achieved (Cl.35 and Sch. 18 (Payment Mechanism)). Therefore if the building contractor is terminated, finding another to complete the

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
						Works will be at Project Co's risk.
2.17	Poor project management	There is a risk that poor project management will lead to additional costs. For example, if subcontractors are not well co-ordinated, one subcontractor could be delayed because the work of another is incomplete.		✓		No payments (including, for the avoidance of doubt, the Works Payment) will be made by the Trust to Project Co until the Payment Commencement Date after the Actual Completion Date has been achieved (Cl.35 and Sch. 18 (Payment Mechanism)). Any delays are therefore at Project Co's risk.
2.18	Contractor / subcontractor industrial action	Industrial action may cause the construction to be delayed, as well as incurring additional management costs.		✓		A delay in the Actual Completion Date is at Project Co's financial risk as stated above. However, please note that if industrial action is affecting the construction industry generally (not just the building contractor or Project Co), then this will be a Relief Event for which the Trust will grant to Project Co an extension of time but no compensation (Cl. 42.1.7).
2.19	Protestor action	Protestor action against the development may incur additional costs, such as security costs.	✓			There is no specific Project Agreement reference unless this is raised on a Project Specific level.
2.20	Incorrect time and cost estimates for commissioning new building	The estimated cost of commissioning new buildings may be incorrect, there may also be delays leading to further costs.		✓		Cl. 22. Note: where the Trust has commissioning obligations, it will take the risk in respect of such items. We understand from the Equipment Team that a limited number of items will be supplied by the Trust to Project Co to install. Under the Project Agreement (Schedule 12) a failure to supply such items in accordance with the Final Commissioning Programme so that Project Co can

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
						install the same shall not stop Project Co from attaining the Actual Completion Date. Any failure to supply such equipment by the Trust would not amount to a Delay Event.

5.3. PERFORMANCE RISKS – POST ACTUAL COMPLETION – I.E. DURING THE OPERATIONAL PHASE

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
3.1	Latent defects in new build	Latent defects to the structure of the building(s), which require repair, may become patent.		✓		Cl. 22.16 and Sch. 18 (Payment Mechanism) which ensures the Trust will only be paying for the facilities that are available to it.
3.2	Change in specification initiated by the Trust	There is a chance that, during the operating phase of the project, the Trust of the services will require changes to the specification.	✓			Cl. 40 and Sch 22 (Variation Procedure).
3.3	Performance of subcontractors	Poor management of subcontractors can lead to poor co-ordination, and under-performance by the contractors. This may create additional costs in the		✓		Cl. 35 and Sch. 18 (Payment Mechanism), The price is set (subject to indexation, market testing of soft services, Trust Variations, and Relevant Changes in Law) at financial close and so any additional costs are at Project

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
		provision of services.				Co's risk. Under performance can lead to deductions / service failure points under the Performance Monitoring set out in the Payment Mechanism. A certain level of Service Failure points allows the Trust to issue warning notice and ultimately allows the Trust to terminate. Note - the Trust also has a right to require that Project Co terminates a poorly performing subcontractor (Cls. 44.6-44.8).
3.4	Default by Project Co or FM subcontractor	In the case of default by a contractor or subcontractor, there may be a need to make emergency provision. There may also be additional costs involved in finding a replacement.		✓		Cl. 44 and Sch. 23 Part II with regard to termination of Project Co. The Trust can require that Project Co terminates a subcontractor and finds a replacement. In the meantime Project Co must put forward interim proposals and if not (or if the proposals are not adequate) the Trust can perform the Services or procure that a third party performs them and can claim the costs back from Project Co (Cl. 44.6 – 44.9).
3.5	Industrial action	Industrial action by the staff involved in providing facilities services would lead to higher costs and/or performance failures.		✓		Cl. 35 and Sch 18 (Payment Mechanism). As stated above the price is set at financial close and if facilities are unavailable or service not provided then deductions can be made from the Service Payments.
3.6	Failure to meet performance standards	There is a risk that facilities management (FM) will not provide the required quality of services. This may be costly to correct, and Project Co may incur		✓		Sch. 18 (Payment Mechanism). Project Co will be liable to deductions from Service Payments for Performance Failures. Service Failure points will lead to warning notices and ultimately a right for the trust to Terminate.

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
		financial penalties.				As stated above, the Trust has a right to require that Project Co terminates poorly performing subcontractors.
3.7	Availability of facilities	There is a risk that some or all of the facility will not be available for the use to which it is intended. There may be costs involved in making the facility available.		✓		Sch 18 (Payment Mechanism). Project Co will be liable for Deductions for Unavailability.
3.8	“Relief Events”	An event of this kind may delay or impede the performance of the contract and cause additional expense.			✓	Cl. 42. As stated above, the Service Payments are set at financial close. The Trust grants Project Co relief from termination to Project Co but Project Co will still be liable for deductions under the Payment Mechanism.
3.9	Force Majeure	In the event of Force Majeure additional costs will be incurred. Facilities may also be unavailable			✓	Cl. 43. The Trust grants Project Co relief from termination but the Payment Mechanism still applies to reduce the Service Payments for Services / Facilities that are not available. Therefore the Trust will only pay for what Project Co can provide. There is also a right for either party to terminate after 6 months of the Force Majeure event subsisting (Cl. 46.1).
3.10	Termination due to force majeure	There is a risk that an event of force majeure will mean the parties are no			✓	Cl. 48.1 and Sch. 23 Part C. The Trust will be liable to pay Project Co its bank debt,

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
		longer able to perform the contract.				redundancy payments and subcontractor losses that Project Co is reasonably liable to pay under the subcontracts but not including loss of profits.

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5.4. OPERATING COST RISKS

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
4.3	Legislative/regulatory change having capital cost consequences: HPSS specific	HPSS specific changes to legislation/regulations may lead to additional construction costs, and higher building, maintenance, equipment, or labour costs.	✓			Cl. 39.5
4.4	Legislative/regulatory change: non-HPSS specific	Non-HPSS specific changes to legislation/regulations may lead to additional construction costs, and higher maintenance, equipment, or labour costs.			✓	Cl. 39.3(c) (this would be a Relevant Change in Law) and Cl. 39.6 and Table B in the definition of Trust's Cost Share would apply. Project Co will share costs of such works with the Trust to a lessening extent the higher the value of the works. Where the value of the additional works reaches over 20% or more of the total capital value of the Facilities, the Trust must pay for such works.
4.5	Changes in taxation	The scope and level of taxation will effect the cost of providing services.		✓		Cl. 39.8
4.6	Changes in VAT	This may increase the cost of the provision of services to the Trust. However changes in VAT are generally refundable to the Trust.	✓			Cl. 53.8 – 53.9.
4.7	Incorrect estimated cost of providing clinical services	The cost of providing clinical services may be different to the expected. These costs include: staff, recruitment, training,	✓			Project Co only has obligations with regard to non-clinical services and therefore risks relating to clinical services are retained by the Trust.

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
		equipment, and supplies.				
4.8	Incorrect estimated cost of maintenance	The cost of building and engineering maintenance may be different to the expected costs.		✓		The Service Payments are set at financial close so this risk is with Project Co.
4.9	Incorrect estimated cost of energy used	Failure to meet energy efficiency targets or to control energy costs.		✓		Cl. 17.4
4.10	Patient infection caused by Project Co / Project Co Party	There is a risk that a patient infection could be traced directly to the actions of staff employed and managed by Project Co. This risk may lead to increased treatment costs, and, possibly, legal costs if the patient takes legal action.		✓		If caused by Project Co / Project Co Party, the Trust benefits from an indemnity at Cl. 8.1(b) and 8.2(b) for claims by patients. Otherwise, if caused by the Trust or a Trust Party, then the Trust would not have recourse to Project Co's indemnity.
4.11	Patient infection – other	Patient infection caused by staff employed by and controlled by the Trust. This risk may lead to increased treatment costs, and, possibly, legal costs.	✓			Clinical services are provided at the Trust's risk and the Trust indemnifies Project Co against any such claims at Cl. 8.2(b).

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5.5. VARIABILITY OF REVENUE RISK

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
5.1	Non- performance of services	Payment will only be made by the Trust for services received.		✓		Sch. 18 (Payment Mechanism)
5.2	Poor performance of services	Project Co will incur deductions from the Service Payment for the poor performance of services.		✓		Sch. 18 (Payment Mechanism)
5.3	Changes in the size of the allocation of resources for the provision of health care	There is a risk that the resources allocated to the area are reduced or increased. If such changes do occur, there may be a need to re-scale the provision of services.	✓			These will take effect as Trust Service Variations under Sch 22. Note - the Trust may exercise its right of Voluntary Termination of the Project Agreement (Cl. 46.2) but compensation to place Project Co in the position it would have been had the Project Agreement run its full course would then be payable by the Trust.
5.4	Changes in the volume of demand for patient services	There is a risk that the volume of demand for health care will change, because of changes in the size of the catchment area. This may occur because there is, for example: an unexpected increase in the size of the population, leading to an increase in demand; or the provision of a new alternative provider health care, leading to a reduction in demand.	✓			These will take effect as Trust Service Variations under Sch 22. Note - the Trust may exercise its right of Voluntary Termination of the Project Agreement (Cl. 46.2) but compensation to place Project Co in the position it would have been had the Project Agreement run its full course would then be payable by the Trust.

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
5.5	Unexpected changes in medical technology	Unexpected changes in medical technology may lead to a need to re-scale or reconfigure the provision of services.	✓			These will take effect as Trust Variations under Sch 22.
5.6	Unexpected sudden increases in demand, due to major incident	There is a risk of large unexpected increases in demand (eg due to a major incident).			✓	Sch. 5 (Disaster Plan)

5.6. TERMINATION RISKS

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
6.1	Termination due to default by the Trust	The risk that the Trust defaults leading to contract termination and compensation for the private sector.	✓			Cl. 48.3 and Sch. 23 Part 1.
6.2	Default by Project Co leading to step-in by financiers	The risk that Project Co or individual service providers default and financiers step-in leading to higher costs than agreed in the contract.		✓		
6.3	Termination due to default by Project Co	The risk that Project Co defaults and step-in rights are exercised by financiers but that they are unsuccessful leading to contract termination.		✓		Cl. 48.2 and Sch 23 Part 2.

5.7. TECHNOLOGY AND OBSOLESCENCE RISKS

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
7.1	Technological change/asset Obsolescence	Buildings, plant, and equipment may become obsolete during the contract.			✓	Sch 13, Sch 14 and Sch 24.
7.2	Technological change	Technical changes may cause the Trust to revise its output specifications.	✓			Sch 22 (Trust Variation).

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5.8. CONTROL RISKS

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
8.1	Control of clinical services	The Trust retains control of clinical services which means that it retains significant control of the nature of the services provided by Project Co.	✓			
8.2	Control of services provided under the PFI contract	Project Co should retain control of these subject to 8.1 above.		✓		

5.9. RESIDUAL VALUE RISKS

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
9.1	The Trust no longer requires assets at end of contract	The risk that the Trust will wish to vacate the asset at the end of the contract period.	✓			Sch 24

5.10. OTHER PROJECT RISKS

No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
10.1	Incorrect cost estimates for planning approval	Estimated cost of receiving detailed planning permission is incorrect, including the cost of satisfying unforeseen planning requirements.		✓		Cl. 16
10.2	Delayed planning approval	A delay in receiving planning permission may have broader cost implications for the project, as well as the loss of potential savings.			✓	Cl. 16
10.3	Criminal Damage	An event of this kind may delay or impede the performance of the contract and cause additional expense.			✓	Cl.36.25 – 36.26 and Schedule 35 Project Co is obliged to make a claim or assist the Trust in making a claim under the Compensation Order following occurrence of a Criminal Damage Event. To the extent that it fails to meet its obligations in this regard, then the Trust may elect not to pay Net Monthly Revenue Losses or where the Trust has elected to treat the event as a Force Majeure Event pursuant to paragraph 6.2.2, it may retain an amount from the Force Majeure Termination Sum. Project Co is to repay Net Monthly Revenue Losses paid to it by the Trust in accordance with paragraph 10. Project Co will be protected from

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No.	Risk Heading	Risk Description	Allocation			Relevant Project Agreement Clause Reference and Comments
			Public Sector	Private Sector	Shared	
						termination or Service Failure Points provided it meets its obligations under Schedule 35. Any delay of the Completion Date resulting from a Criminal Damage Event will be treated as a Delay Event provided, once again, Project Co meets its obligations under Schedule 35.

NOTE: No material changes have been made to the risk profile since Acute Phase 2 OBC.

6. COMMERCIAL STRUCTURE

The South West Acute Hospital Draft Project Agreement and forty schedules are based on the form of agreement proposed by the Strategic Investment Board (SIB) for use in health PFI projects in Northern Ireland. The SIB in effect are keepers of the Project Agreement having published it on behalf of DHSSPS. The Trust's PFI Legal advisors L'Estrange & Brett have been in constant contact with the SIB Lawyer and discussions have been arranged around the key issues identified by each bidder.

The Project Agreement together with a list of derogations was sent to the SIB for approval.

The South West Acute Hospital Draft Project Agreement is referred to in this report as the "Contract".

6.1. PROJECT AGREEMENT

This chapter discusses the Contract which is based on the Northern Ireland Standard Form Project Agreement for Health Projects and follows extremely closely the equivalent document in GB. The GB document is one of the most standard PFI documents utilised in PFI in the UK and has evolved during the preceding years to minimise the areas which are negotiated thus reducing time and costs for all. The Contract was the basis on which the legal dialogue was focused.

The form of Contract was the subject of a public consultation led by the SIB in conjunction with the DHSSPS prior to formal publication. The SIB have subsequently reviewed the Invitation for Final Bids (IFB) version of the Contract together with a list of project specific derogations, this is evidenced in Appendix 6.01. This version outlined the position at the Closure of the Dialogue with the bidders.

This chapter outlines the key contractual terms agreed between the Trust and all Bidders as at the date of the IFB. References in this section are to clauses within the Contract.

The Contract has been negotiated in all material respects with each of the Bidders as well as the EIB. In order to record the negotiation of the Contract with each of these parties an "Agreed List" was produced in each case which ultimately became a final bid deliverable. Essentially the purpose of the Agreed List was to provide an audit trail for each issue identified and the rationale for agreeing them or otherwise. At Final Bid, each Bidder was asked to confirm that they had no further points on the Contract and to provide confirmation from key members of their consortium including, in particular, their funders. It would not have been possible to complete or indeed agree in totality each of the schedules to the Contract as several of these are driven by for example, the refinement of the design.

It is also note worthy that this chapter is an overview of the main risks and responsibilities under the Contract issued to all Bidders as part of the IFB and is not a substitute for a detailed examination of the issues covered by the Contract.

Within this chapter the discussion of the Project Agreement does not explain why each risk rests where it does but it does however, identify any movement away from the standard form and why this was felt necessary.

It is also note worthy that there has been no material changes to the Contract post closure of the Dialogue and it is not anticipated that there will be in the period up to financial close.

6.2. SECTION 1 - THE PLANNING AND DEVELOPMENT PHASE

Before service commencement, the relevant buildings must be designed and constructed. This section explains the design and construction aspects of the Contract.

6.2.1. Responsibility for the land (Clauses 14, 15, 16)

The Contract reflects the Trust's ownership of the site on which the building will be situated.

Planning permission will be required. It is the Contractor's responsibility to obtain this and pay any costs involved (Clause 16).

The Trust grants a license of the site to the Contractor to enable the Contractor to carry out all building work as well as allowing the provision of full service provision (once works have been completed). In order for the Trust to grant a licence of the secondary access route, it must receive a suitable easement from the owner(s) of the relevant land. The land referred to is DHSSPS retained estate. The Department will grant a right of way to the trust and the Project Co to complete the construction of the blue light secondary access road and have access over the road to the hospital site. The road will also serve as a road access to the retained estate. If this is not completed then the Trust could purchase a strip of land from DHSSPS to construct an alternative route. Any license or right of way made to Project Co would be coterminous with the Contract. All property rights will belong to the Trust, (or, in the case of a parcel of land on which the secondary access route is to be constructed, to the relevant owner(s) of such land) at expiry of the Contract or on termination prior to expiry of the Contract (Clause 14).

The Contract obliges the Contractor to comply with the provisions of the title deeds to the land (Clause 14) and places responsibility on the Contractor to investigate the site and take the risk of unforeseen problems with the site's condition. The Contractor has taken the risk on the site having had the opportunity to carry out site investigations etc and been provided with copy investigations procured by the Trust. This is a key issue in light of the landslide and one which was identified and

addressed in the Preferred Bidder Letter. There will not be an opportunity to pass this risk back to the Trust.

The Trust (or, in the case of the secondary access route the owner of the relevant parcel of land) will own any valuable or important fossils or antiquities discovered at the site. Although the Contractor takes the financial risk of delays resulting from the excavation or protection of any important items, their discovery will constitute a Delay Event (see Section 6.4) and give the Contractor some relief from its obligation to complete the works on time and also from termination of the Contract should the discovery cause the Contractor to fail to perform its contractual obligations as a direct consequence.

There are project specific provisions relating to the retail activities which may be offered at the New Acute Hospital. The Preferred Bidders proposed retail activities have been detailed in Table 6.1 below:

Table 6.1 Preferred Bidders proposed retail activities

Retail Activity	Cost per annum
Retail Units	£60,000
Pods	£6,000
Charity Shop	£5,000
Start-up area	£5,000

The retail units currently comprise of:

- Mixed retail unit located in the main entrance, with the main retail unit (circa 175m²) being provided by Henderson group. The other 2 smaller units will be occupied by 2 of the following: charity shop, hairdresser, health food provider, cosmetic facility or jewellery / cosmetics. The main retail unit provided by Henderson is to include a juice bar.
- Pods based in the main atrium to be used by small businesses etc.
- Charity Shop based in the main atrium to be leased to a charitable organisation (still to be confirmed)
- Start-up area - assumed to be based in the main atrium (limited detail on this).

With regard to the Trust retaining any share, Bidder 2's proposal doesn't highlight anything over and above that of the guaranteed underwritten figures stated above, which are deducted from the annual unitary charge for which Bidder 2 take the risk of meeting year on year.

The Trust will grant a licence to the Contractor and allow the Contractor to sub-let the retail units which are being provided at the hospital. The identity of the prospective providers of retail services is different for each Bidder. The lease contains restrictions to ensure that the retail offering is appropriate to the purpose and functions of the New Acute Hospital.

The Contract places responsibility on the Contractor to investigate the site and take the risk of unforeseen problems with the site's condition.

The Contractor has taken the risk on the site having had the opportunity to carry out site investigations etc and been provided with copy investigations procured by the Trust. This is a key issue in light of the landslide and one which will be identified and addressed in the Preferred Bidder Letter. There will not be an opportunity to pass this risk back to the Trust.

6.2.2. Responsibility for design

The Contractor must produce designs to meet the Trust's requirements as set out in Schedule 8 Part 3 to the Contract. These designs have been considered by the Trust during the bid process and will be a major factor in selecting the Contractor. Subject to the procedure on design review discussed in more detail below, the risk of failing to translate the requirements of the Trust into the design lies with the Contractor (Clause 17).

Furthermore, the Contract places a duty on the Contractor to use reasonable skill and care in its design and, in particular, to:

- ensure that the buildings meet the Trust's energy efficiency requirements. If, after monitoring this for two years, poor design means these standards are missed, then the Contractor must compensate the Trust (Clause 17)²¹; and
- change its designs or any resulting construction that does not satisfy the Trust's construction requirements and to ensure that the performance and functionality of the buildings remain at the agreed standard, with the Contractor bearing the cost of these changes (Clause 17).

The Trust is responsible for the clinical effectiveness of the designs and, shortly before the project is signed, must review their clinical functionality and confirm to the Contractor at contract signature that the designs satisfy the Trust's requirements (Clause 17). The Trust should, at all times, only sign off clinical functionality of the designs. The Trust is content with the Preferred Bidder's design. The likelihood of issues arising from the Preferred Bidders design has been assessed and these can be dealt with through fine tuning. This has been verified by Health Estates. The technical advisers to the Project must ensure that the list of reviewable design data is appropriate and does not result in design risk transferring to the Trust, again this has been overseen by Health Estates. The list of reviewable design data is set out in Part 5 to Schedule 8.

21 In relation to energy consumption the Project Agreement, schedule 18 allows for a 'pain and gain' scenario. If Energy Consumption is not less than 97% and not greater than 103% of the Adjusted Annual Energy Target, no adjustment to Service Payments shall be made or if Energy Consumption is less than 97% of the Adjusted Annual Energy Target, a Gainshare Adjustment shall become due to Service Payments, calculated in accordance with the Project Agreement.

Certain aspects of the design (such as wall finishes and signage) are “reviewable”²². The Contractor must not start work on these aspects until they have been reviewed and approved (either unconditionally or with amendments) by the Trust. Except for the clinical aspects, this approval does not pass the risk of design errors to the Trust but allows it a “supervisory role” prior to the building work (with the exception of the clinical aspects) (Clause 17). This supervisory role will be assumed by Health Estates who have appointed key members of the Exemplar Design Team as the Trust’s technical advisors in relation to the construction process. This is in line with the Project Agreement.

6.2.3. Constructing the buildings

The Contractor must provide to the Trust a construction programme which is sufficiently detailed to enable the Trust to ensure construction is proceeding as planned. The Trust can demand a revised construction programme if the actual programme has fallen significantly behind schedule and details of any steps proposed to eliminate or reduce delay. Since the Contractor receives no payment until the services begin, there is a powerful incentive to ensure that buildings are completed on time.

The Contract allows the Trust to scrutinise the construction. If it believes that there may be defects in the works, it can begin to monitor the works more closely, with the Contractor paying the Trust’s additional costs. However, if the Trust causes a delay to the Contractor’s work through an unjustified inspection, this could constitute a Delay Event where the Contractor may receive compensation (see Paragraphs 6.4.2) (Clause 18).

The Contract does not provide compensation if the buildings are completed late. There is always a “long-stop date”²³ and, if construction is not completed by this time, the Trust can end the agreement and seek compensation (see Paragraphs 6.3.2.1 and 6.4.4). This provides an exit route for the Trust if the Contractor is unwilling or unable expeditiously to complete the buildings (Clauses 19.1 and 44).

6.2.4. Commissioning

Before the buildings are “commissioned”, or the Contractor is paid for the Services, the parties must agree that the buildings are ready for use. Commissioning aims to ensure that:

- all checks needed to confirm that the construction is completed are carried out; and
- any final work that either party must undertake (such as installing and testing equipment) is completed.

22 If the Trust does not approve, then a process is commenced where depending on the nature of the comments, Project Co is to resubmit the item for approval. Ultimately, if the parties do not reach agreement, then the dispute resolution procedure will apply.

23 The long stop date is 18 months following the Completion Date (as per standard form). The Completion Date is the date upon which construction is scheduled to complete.

The Trust should provide the Contractor with a commissioning programme. This will identify necessary commissioning both before and after completion by both the Trust and Contractor (in order to allow the decant of patients into the new or refurbished buildings) (Clause 22).

Pursuant to Schedules 12 (Outline Commissioning Programme) and 13 (Equipment), the Trust agrees to undertake certain commissioning activities (e.g. construction of the secondary access route and the supply of certain items of equipment for the Contractor to install). Where the Trust fails to carry out the tasks set out in paragraph 4.3 of Schedule 12, the Trust will not be liable for a Delay Event (see paragraph 6.4.2). However, any such failure by the Trust will not prevent the independent tester from certifying that the facilities are complete unless the Trust's failure to undertake the relevant activities is caused by any act or omission of Project Co.

Prior to completion the Contractor must notify the Trust of the date on which completion will occur. An independent tester will inspect the building and notify the parties of any outstanding matters. When any such matters are completed, the independent tester will issue a certificate stating that the building is complete.

The building does not have to be perfect for the independent tester to declare it complete. He is likely to issue a list of "snagging matters"; minor flaws that the Contractor must rectify shortly after completion whilst causing minimal disturbance to the operation of the facility. If these snagging matters are not rectified within the relevant timescale, the Contract allows the Trust to deal with them and pass the relevant costs on to the Contractor (Clause 22).

Post completion commissioning is work which can only take place in parallel with the Trust making the building ready to receive patients. The Contractor is responsible for commissioning those post completion tasks allocated to it under Schedule 12. The parties must co-operate with each other and facilitate performance of these tasks (Clause 22). The nature and scope of activities to be completed after the Actual Completion Date has been kept short to incentivise Project Co to commission to get payment. Those items left until after the Actual Completion Date are, therefore, only those items that need to be left to this point because they are dependant upon the Trust performing its commissioning activities (e.g., transfer or initial Supply of Equipment to the new facilities).

Non performance of these obligations (as with any other Project Co obligation during the Project Term) would amount to a breach of Project Co's obligation under, for example, clause 5.1 (under which Project Co confirms that it will perform the Project Operations (defined as including, amongst other matters, the Works and pre and Post-Completion Commissioning)).

Therefore, there is an express undertaking that these tasks will be performed.

If, and to the extent, Project Co refused to complete the post-completion activities within the timescale set out in the final commissioning programme, the Trust would need to use the Dispute Resolution Procedure to compel performance.

Please note the Trust has the right, pursuant to clause 44(c)(i) be able to terminate Project Co where it commits a material breach of its obligations under the Project Agreement and this breach has a material and adverse effect on the provision of Clinical Services.

The Trust may undertake commissioning both before and after completion (Clause 22). If the Trust's works interfere with the Contractor's performance of the Services the Contractor can request relief and/or compensation (see Paragraph 6.4.2).

At some point, all commissioning works (whether before or after completion) will be completed. After this, the main phase of the Contract (the provision of services by the Contractor), will begin.

With reference to the One Off Cash Injection this is payable within 5 days of the Actual Completion Date i.e. after pre-completion commissioning is complete but before the post-completion commissioning is undertaken.

6.2.5. Equipment

The specification of the equipment and responsibility to provide and maintain it is project specific. Where the Contractor maintains equipment supplied by the Trust, the Contract establishes a clear division of responsibilities between the parties for:

- loss and damage to the equipment during and after installation;
- replacing the equipment at the end of its useful life; and
- delay in providing or installing any item of equipment (Clause 21 and Schedule 13).

6.3. THE CONTRACT GOING FORWARD - HOW CAN IT CHANGE AND HOW WILL IT END?

Although the Contract is intended to last for 30 years (in addition to a fixed construction period), it may have to change or even end earlier so the Contract includes variation and termination procedures.

6.3.1. Variations (Schedule 22)

The Trust may want to vary the contract for practical reasons. For example, an increased demand for operating theatres or a change in the cleaning specification. Where the Trust requires building works with a value in excess of £8,000, or wishes to amend the existing running or maintenance services provided by the Contractor, the variation procedure set down in the Contract must be used. "Small Works" below

£8,000²⁴, which will not hinder the Contractor's performance of the Services, must be carried out by the Contractor on request without a formal procedure. The Trust will pay the Contractor for its labour and materials used in carrying out these works, plus a profit element set out in the Contract (Schedule 22).

If additional works are needed, extra finance may be required. The finance may be provided by the Trust alone, the Contractor alone or in combination. The Trust will ultimately decide on the funding arrangements and the party responsible for obtaining finance must use best efforts to obtain it. If finance cannot be obtained, the additional works will not proceed (Schedule 22).

6.3.1.1. Changes of Law

A change in the law may make the project impossible to continue or more expensive for the Contractor to carry out. To decide who pays the extra costs, changes in law are divided into:

- changes which affect PFI or the HPSS in particular, or general changes which happen after the completion date and require the Contractor to carry out additional works, ("Relevant Change in Law") unless, in either case, the change would have been reasonably foreseeable by an experienced Contractor or has an impact worth under £1,000 (Clause 39); and
- any other changes ("General Changes in law").

An example of a Relevant Change in Law would be a change in health and safety legislation, in relation to fire escapes in all public buildings, which only become a draft bill some time after the Contract began.

Where a Relevant Change in Law occurs, the Trust can insist that services are changed to meet the new legal requirements. The Trust may have an obligation to meet the resultant increased costs (see Paragraph 6.3.1.3). The Contractor takes the risk and cost of changes arising from a General Change in Law.

6.3.1.2. The variation process

Where a variation to the Contract is needed, including those arising from a Relevant Change in Law, the Trust and the Contractor must follow a particular procedure to decide how, if at all, the Contract needs to change (Schedule 22 Part 1)

Firstly, the Trust issues a Variation Enquiry giving details about the change, such as whether it relates to works or services and by when the Trust expects it to be made (Schedule 22 Part 1 paragraph 2). The Contractor must then:

- give a preliminary indication of costs, timescale and, where necessary, the availability of any finance needed for the change; or
- respond formally to the Trust, stating whether it objects or agrees to the proposed variation (Schedule 22 Part 1 paragraph 3).

²⁴ Professional opinion from Health Estates and Deloitte agreed that a sum of £8,000 was appropriate before resorting to the formal works procedure. This limit was agreed with the Trusts procurement advisors.

The Contractor can only object to a variation on a limited number of grounds, including:

- health and safety concerns;
- where the variation would result in a breach of law; and
- where the variation would fundamentally change the nature of the hospital (Schedule 22 Part 1 paragraph 3).

If a variation is required in order to reflect a change in law, the Contractor can only refuse the variation to the extent that it would not give effect to the relevant law (Clause 39). Any dispute in respect of this can be dealt with by the Dispute Resolution Procedure (see Paragraph 6.7.2).

If the Contractor agrees to the variation, it must provide a detailed estimate of the likely timescale, costs and any alteration to the terms of the Contract (particularly, any alteration needed to the Payment Mechanism) to accommodate the change. After these issues have been agreed by the parties, the Trust will decide whether to confirm the proposed variation.

The Trust, if the Contractor requires, must show how it will pay any extra cost of the proposed variation and that it has the appropriate internal consents to proceed. The Contractor must obtain all other consents, such as planning (Schedule 22 Part 1 Clauses 4 & 5).

6.3.1.3. *The effect of variation on price*

After a variation, there may be an alteration to the Contractor's service charge or payment of a lump sum of compensation to the Contractor. The principles on which these alterations to the price are made are:

- the Contractor must be placed in a position that is no better, but no worse, than that in which it would have been had the change not occurred. The Contractor should not receive a "windfall" due to the change (Schedule 22 Part 3);
- if works are involved, the "cost" will include the cost of any additional finance needed. In respect of Relevant Changes in Law, the risk of these costs is shared between the parties in accordance with specified percentages set out in the Contract. Essentially, the Contractor is at risk up to a certain cost of works and, after this, the Trust pays for them (Clause 39);
- where there has been a General Change in Law which only affects the services, and does not require additional works, the Contractor is not entitled to any payment or compensation (Clause 39). If additional works are required there is provision for the costs to be shared by the parties (although the more expensive the works the more the Trust will pay);
- if the variation is not the result of a change in law, the process set out in paragraph 6.3.1.2 above is followed, but any relevant changes to the Contract or to payment terms must be agreed between the parties. The Trust has less need to force the change through in order to comply with law. However, the Trust can still rely on the Dispute Resolution Procedure (see Paragraph 6.7.2) to

ensure that the Contractor will implement the Trust's new requirements or policies on reasonable terms; and

- if the Contractor wants to make changes, the Trust has complete discretion to agree or refuse the alteration. There is no formal structure for the Contractor to compel the Trust to accept a "Contractor change", or even to have the matter decided by a Dispute Resolution Procedure.

6.3.1.4. *Building works carried out after the initial construction works are complete*

The Trust, in accordance with procurement law, may have to put new works out to tender. If, having sought any necessary advice, the Trust believes this tender process is required, it must notify the Contractor of its intention to put the work out to tender and the Contractor's bid will be considered on the same criteria as the other Bidders.

6.3.2. Termination of the Contract

The Contract sets out the circumstances in which it can be ended, the compensation, if any, to be paid on termination and what assets will transfer to the Trust.

6.3.2.1. *Failure to perform by the Contractor (Clause 44)*

Termination by the Trust is a last resort but is available if the Contractor:

- abandons the works or fails to complete them before the long-stop date;
- is convicted for a breach of Health and Safety law;
- ceases to provide the Services and effectively abandons the Contract;
- breaches its obligations so that the provision of clinical services is materially and adversely affected;
- accumulates a certain level of "service failure points" due to poor performance of the services;
- fails to pay a sum which is due to the Trust within a specified period of time;
- tries to transfer ("assign") the Contract without the permission of the Trust;
- refinances the Contract without the Trust's approval (see Paragraphs 18 to 20 of Section 6);
- becomes unqualified for the purposes of Fair Employment and Treatment (Northern Ireland) Order 1998;
- changes ownership so that it is controlled by a company of a type which the Trust has stated is unacceptable (say - a tobacco or armaments manufacturer);
or
- ceases to carry on business, or is unable to pay its debts.

Where rectification is possible (for example, where the Contractor has failed to pay a sum to the Trust) the Contract allows the Trust to serve a "notice of default" on the Contractor giving it chance to rectify the event. If this last chance is not appropriate (say, where the Contractor has ceased to carry on business), the Trust may immediately terminate the Contract.

Where the Trust serves a notice of default, the Contractor has a “last chance” to either remedy the event within 20 days, or, within the same time period, produce a plan (to which the Trust must reasonably agree) detailing how it proposes to do so. If the Contractor fails to remedy, fails to produce the plan on time or fails to comply with it, then the Trust may terminate. Where the relevant event was the accumulation of service failure points there will be a “probation period” of, typically, three months. If, during this period, a given number of Service Failure Points (SFP’s) continue to be accumulated by the Contractor, then the Trust may terminate. These provisions address the funders’ concern that the Contract cannot be terminated on a “hair trigger”, without an opportunity to resolve the relevant problem.

Figure 6.1 below provides an example of a termination:

The threshold for termination is 16699 SFPs in a 3 month period e.g.

If the Critical Care Unit was without power for a week, this would trigger a termination event - however it's likely that Project Co would bring in backup supply rather than risk that sort of scenario.

In general, to get enough SFPs in a single event to trigger termination it would need to affect a large area of the facility and for a reasonable period of time. This would give the Project Co time to come up with a solution.

Figure 6.1 Example of a termination

6.3.2.2. Removal of Sub-Contractors (Clause 44)

Termination of the Contract is likely to be a last resort for the Trust. Therefore, where the failure is specific to a particular Service, the Contract gives the Trust the right to require that the sub-contractor responsible be replaced.

6.3.2.3. Failure to perform by the Trust (Clause 45)

The Contractor has the right to terminate the Contract if the Trust:

- materially breaches its contractual obligations (regarding access during construction and operation) so that the Contractor’s ability to perform is significantly affected for a continuous period of at least 30 days;
- fails to pay to the Contractor a sum of money in excess of an agreed limit within 30 days; or
- is prevented from performing its obligations due to new discriminatory legislation.

If such an event occurs during construction then the Contractor may suspend building works until the Trust can show it is capable of carrying out its obligations or it can serve a notice on the Trust requiring it to remedy the event in question. If the Trust fails to remedy within a set period then the Contractor may terminate the Contract.

6.3.2.4. *Corrupt Gifts and Payments (Clause 54)*

The Contract deals specifically with corrupt gifts and fraud by the Contractor. If such a fraud is committed by the Contractor, or an employee not acting independently of it, then the Trust may immediately terminate the Contract.

If an employee or sub-contractor, acting independently of the Contractor, commits fraud, the Trust may terminate the Contract unless the Contractor dismisses or replaces the employee or sub-contractor within a specified period (20 days).

6.3.2.5. *“Non-Default” Termination (Clause 46)*

The Contract recognises that there are circumstances justifying termination where neither party is at fault. This may be because one party cannot perform its obligations for a specified period (6 months) due to a Force Majeure Event (see Paragraph 6.4.4), in which case either party may terminate.

The Trust may also terminate the Contract at any time by giving notice to the Contractor, even if there is no breach. However, the Contractor must be fully compensated for its loss (see Paragraph 6.3.2.7).

Finally, the Contract will terminate (expire) automatically at the end of the project’s stated length.

6.3.2.6. *The effect of termination (Clause 47)*

On termination the Facilities (i.e. - the hospital buildings) revert to the Trust. The Trust may also require the Contractor to transfer:

- relevant documents and employee information;
- certain contracts and intellectual property; and
- (at a fair value) the equipment and property owned by the Contractor but still needed to perform the Contract.

For a reasonable time before and after termination the Contractor must:

- cooperate to ensure the smooth transfer of the project to the Trust (or successor Contractor);
- minimise the health and safety risk to employees of the Trust and the general public; and
- assist with any competition held by the Trust to select a successor Contractor.

These provisions are designed to ensure that, when the Contract ends for whatever reason, the relevant Facilities and services can revert to the Trust (or its chosen successor Contractor) with minimum disruption.

6.3.2.7. *Compensation on termination (Clause 48 and Schedule 23)*

The Contract details the compensation payable to the Contractor on termination which varies depending on the reason for the termination.

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Where the termination is due to a default of the Trust or voluntary termination by the Trust, then the Trust will have to pay the Contractor an amount equal to:

- the balance of the monies borrowed by the Contractor to fund the project and which will now have to be repaid (“senior debt” to the banks, and “junior or subordinated debt (higher returns than normal debt but more risky”) to the equity providers – shareholders in the company set up to run the project);
- losses which the Contractor will face due to the early termination, such as redundancy payments;
- an amount equivalent to the profit that the Contractor would have made but for the early termination (determined by referring to the agreed financial calculations at the start of the Contract); but
- minus the value (if any) of assets and account balances left in the hands of the Contractor on termination.

The financial calculations aim to put the Contractor in a position that is “no better, no worse” than it would have been had the Contract run for its full length.

If the reason for termination is default by the Contractor, then the Trust pays compensation equal to or equivalent to the “transfer value” of the Contract. That is, the amount which a third party will pay for the remaining benefit of the Contract. Where the Contract is retendered then the proceeds are passed to the original Contractor. Where retendering is not possible (for example, where there are insufficient Bidders), or the Trust elects not to permit this, the “Fair Value” of the remaining Contract will instead be assessed on a hypothetical basis and this fair value will be the compensation payable to the Contractor. Hence, the Trust will not receive a windfall through “selling” the rest of the Contract to a successor Contractor, but will not have to pay any other compensation.

In the case of Force Majeure leading to termination (see Paragraph 6.4.4), neither party is at fault and the downside of early termination is shared between the parties. Therefore, the Contractor is paid sufficient to enable it to pay off its senior and junior or subordinated debt and amounts due to shareholders, but not the Contract’s wider value (in other words, excluding future expected profits in the form of returns to shareholders).

When corrupt gifts or fraud is the reason for termination, the Trust will pay the outstanding balance of the senior debt, less the value of any assets that the Contractor retains after termination. This is provided because funders require some certainty of repayment, even where the Contractor’s conduct has led to early termination. The Contractor will however lose all of the equity that it put into the project, and its anticipated future profits.

No compensation is paid to the Contractor where the Contract expires at the end of its full length.

6.4. RELIEF AND DELAY - WHO TAKES RESPONSIBILITY WHEN THE UNEXPECTED HAPPENS?

The Contract places responsibility on the Contractor to complete the buildings on time and, until buildings are completed, it will not receive any payment. Also, if the works are not completed by the “long-stop” date, the Trust may be able to end the Contract (clause 44). However, some events which delay the works and which are outside the Contractor’s control do not lead to termination or financial sanction. These are described as “Delay Events”, “Relief Events” and “Force Majeure Events”, and are discussed in the following sections.

6.4.1. Delay Events (clause 41)

A Delay Event is an occurrence that has a material and adverse effect on the Contractor’s ability to complete the buildings by the agreed date. Examples of these events are:

- a) an agreed variation to the works which prevents the works being completed on time;
- b) a breach of the Trust’s obligations (for example failing to give the Contractor proper access to the site (provided such breach is not the result of the Contractor’s actions). Please note that those activities/responsibilities listed in paragraph 4.3 of Schedule 12 (including supply of category C equipment and construction of the secondary access route) are exempt from Delay Events. However, a failure to carry out such activities will not prevent the independent tester from issuing its certificate of completion. Table 6.2 below details how the Trust intend to mitigate any risks to this process;

Table 6.2 Mitigation of the Trust’s Obligations

No	Mitigation of Trust’s Obligations
1	The Trust are confident that secondary access route will be complete prior to the date of completion and that therefore this will not be an issue. Initial indications from planners are that planning approvals are imminent and this will not be an issue. This work will be complete long before the hospital is built. It should be noted that this is an additional access road that will only be used in the event that the main road is blocked.
2	The site will be available at the point of Financial Closure.
3	Health Estates agree that supply of category C equipment and construction of the secondary access route are exempt from Delay Events.
4	Planning conditions are met in relation to cycle route and pedestrian access to site via the secondary road access.
5	The Trust can confirm they are confident that no risks around the secondary access route will crystallise. The planning application is being processed by the planning department who have confirmed they do not anticipate any delays. The Trust do not envisage any failure to carry out these activities.

- c) interference from works carried out by the Trust which do not form part of the Contract;

- d) the Trust using its rights of access to the site where such access is not justified or reasonable such as opening up of works which are not subsequently found to be defective; or
- e) a Relief Event (see Paragraph 6.4.3), event of Force Majeure (see Paragraph 6.4.4) or Relevant Change of Law, whether discriminatory or HPSS specific (see Paragraph 6.3.1.1).

The Contractor must inform the Trust of any likely delay in finishing the works. If this delay is due to a Delay Event, then the date originally set for completion of the works will be extended by a period decided by the Trust. Importantly, the ultimate length of the entire Contract (which runs from the date on which it was signed) will not be altered by any Delay Event. This means therefore, the actual period that the Contractor provides services to and receives payment from the Trust will be reduced. The Contractor is contractually bound to take all reasonable steps to eliminate or reduce the effects of the Delay Event. If it does not do so, it will lose the benefit of the extension to the completion date.

The Contract does not provide for the extension of the contract term unless there is for example a Trust's Works Variation, a breach of an express obligation by the Trust such as for example, failure to provide access to the site or opening of works which are not found to be defective. However the Trust is aware of the risks around such issues but is confident that with the assistance of Health Estates and the other advisors, that it can manage these risks in accordance with the Contract. Refer to table 6.2 above.

To claim the benefit of a Delay Event (an extension to the completion date) the Contractor must give details of the Delay Event to the Trust. Such details must include details of the records to justify the claim, the consequences that the Delay Event will have on completion of the Facilities, and any measures which the Contractor will take to minimise the effects of the Delay Event. The Contractor must also provide any information that later comes to light together with any supporting information that the Trust may reasonably require. This includes allowing the Trust to investigate the Contractor's claim if required.

If the parties are unable to agree whether or not a Delay Event has occurred, or what the extended date should be, the matter may be referred to the Dispute Resolution Procedure (see Paragraph 6.7.2).

6.4.2. Financial consequences of different types of Delay Event

Where the Delay Event is the Trust's "fault" (paragraph 6.4.1 (b), (c) and (d)), because a breach by the Trust interferes with the works, then the Contractor may also be entitled to some compensation.

In the circumstances set out in the previous paragraph, the Contractor's compensation will be calculated on the "no better no worse" principle. That is, any expenses incurred by the Contractor must be reimbursed by the Trust so the Contractor is in as good a financial position as if the Delay Event had not occurred. This amount will be reduced by the amount (excluding any excesses) the Contractor

recovers under any insurance policy it has (or would have had if it had complied with its obligations to insure set out in the Contract). The Contractor must also act in such a way to minimise the amount of compensation payable, the amount of compensation will be reduced if the Contractor does not “mitigate” its loss in this way. Compensation is payable within 60 business days of reaching agreement on the amount due.

6.4.3. Relief Events (clause 42)

“Relief Events” are a sub-set of Delay Events and again the Contract does not provide for the extension of the full contract term. They are circumstances beyond the control of either party. Neither the Trust nor the Contractor can terminate the Contract for a failure by the other, that is a result of a Relief Event.

Examples of Relief Events include :

- fire, explosion, flood, radiation (to the extent it does not amount to Force Majeure (see below)), riot or earthquake;
- failure by a utility provider or local authority to provide services (say, a power cut);
- accidental damage to the works or the roads that service them;
- blockade or embargo (falling short of Force Majeure - see below);
- the discovery of fossils or antiques;
- unofficial strike or other industrial action affecting a large sector of the buildings maintenance or facilities management industry; or
- any other factors which, due to the special and specific nature of the project, are specifically included.

Such occurrences only constitute Relief Events if they are not a result of the act or default of the party claiming relief.

As with other Delay Events, the party affected by a Relief Event must take all reasonable steps to reduce the effects and continue to perform its obligations under the Contract, otherwise relief will not be available. The party claiming relief must serve notice on the other detailing the Relief Event and setting out the effect that the Relief Event has on that party’s obligations. The notice must also state the actions being taken to reduce the effects of the Relief Event and give an estimate of the time needed to overcome it.

As with Delay Events, the party claiming relief must also give the other any subsequent information which arises in relation to the Relief Event.

6.4.4. Force Majeure (Clause 43)

Force Majeure events are also a sub-set of Delay Events. “Force Majeure Events” are events even more “uncontrollable” by the parties than Relief Events. The party affected by the Force Majeure Event will be relieved from all of its obligations under the Contract.

Force Majeure include such matters as:-

- war, armed conflict and terrorism;
- nuclear, chemical or biological contamination; or
- pressure waves caused by supersonic devices which directly cause either party to be unable to comply with its obligations under the Contract.

Although not obliged to agree any modifications, the parties will try to agree any adjustments to the Contract which are equitable given the relevant Force Majeure. If agreement is not reached, no change to the Contract will be made and the issue will not be referred to the Dispute Resolution Procedure. Ultimately, either party has the right to terminate the Contract if the Force Majeure Event continues (see Paragraph 6.3.2.5).

Clause 46.1 provides that if the parties cannot reach agreement on the modification of the Project Agreement following service of a notice of a Force Majeure event within 6 months of service of such notice then either party may serve a termination notice (provided that the event of Force Majeure continues to prevent either party from performing their obligations).

6.4.5. Payment Mechanism (see footnotes to clauses 42 and 43)

Delay Events, Relief Events and Force Majeure Events means that the Contractor does not assume the risk of termination due to matters beyond its control. However, the Contractor still bears the majority of the financial risk for these events²⁵. Only where the Trust is at fault will the Contractor receive compensation (see Paragraph 6.4.2). Furthermore, the Payment Mechanism will continue to operate so that the Contractor will only be paid to the extent it is able to provide Services. Generally, the Contractor receives no payment to the extent that it provides no services. Financial deductions for poor performance will continue to apply even though Relief, Delay or Force Majeure Events adversely affect the Contractor's ability to perform.

However, Relief Events tend to be covered by insurance, and the Contractor will recover at least some of its losses through its insurance policies (for which the Trust has paid through the Service Payment).

The Contract ensures that service failure points resulting from the Delay, Relief or Force Majeure Events will not immediately result in termination of the Contract. However, if the Contractor continues to be unable to perform its obligations, the Contract can eventually be terminated (clause 46 non-default termination). The Trust

²⁵ This sentence draws the distinction between delay events which give the contractors time and compensation events which gives time and money. For example, the contractor gets relief but no financial compensation from the discovery of archaeological effects therefore, it will not suffer deductions (if during the operational phase) or be terminated but will have to bear the financial cost of the associated delays.

is not expected to accept minimal performance of the Contract indefinitely even though it does not have to pay for the services whilst they are not provided.

6.5. PROVISION OF THE SERVICES

The core of the Contract is the provision of Services and, during the service period, the Contractor must perform them. If it does not do so, the Trust may make deductions from the Service Payment it pays (see Section 6.6). Continual under-performance by the Contractor may even result in termination (clause 44) (see Paragraph 6.3.2.1).

6.5.1. The Levels of Service (Clause 27)

The required levels of service are set out in Schedule 14 of the Contract (“the Service Level Specifications”) and are based upon the specific requirements of the project.

The services must also be provided by the Contractor in accordance with approved “Method Statements”, which detail the way in which the services will be performed. In any event, when providing the services, the Contractor must take all reasonable care not to disrupt the Trust’s work.

6.5.2. Method Statements and Review Procedure (Clause 27)

The Contract recognises that Method Statements are not fixed for the duration of the Contract. Instead, they are operational matters which may be subject to change if necessary to optimise the services.

If the Contractor believes a change to the Method Statements is appropriate, it may submit the proposed revision to the Trust. The Contract sets out a procedure for the Trust to review such proposals. The Trust may either make no comment about the Contractor’s proposal (in which case the revised Method Statement is approved) or reject/amend the proposal on a number of specified grounds, which are that the proposal:

- is not in accordance with good industry practice; or
- provides for services materially different from those set out in the existing Method Statement, less likely to achieve the Service Specifications, or have an adverse affect on the Trust’s provision of clinical services; or
- would adversely affect the health or safety of any user of the Facilities; or
- would result in levels of service provision inferior to those provided under the existing Method Statements (Schedule 10 Clause 3).

Therefore, although the Contractor can propose better ways of carrying out its activities, the Trust will not be forced to accept an inferior service. Furthermore, no change to the Method Statement will entitle the Contractor to any increase in payment. If the parties are unable to agree whether the proposal should be accepted,

rejected or amended, the matter may be referred to the Dispute Resolution Procedure (see Paragraph 6.7.2).

6.5.3. Maintenance (Clause 28)

During the Contract, the Contractor will have to carry out maintenance of the Facilities. It is up to the Contractor to schedule this maintenance in the most effective way and, before the start of each year of the Contract, it must provide a proposed programme of maintenance for that year. At the same time, it must also provide its updated five year maintenance plan. The Trust Assistant Director of Facilities Management and the Trust's Head of Hard FM Services were involved (along with the Trust's FM advisors – Davis Langdon) in every significant stage of this aspect of the Project including in the drafting of the Service Level Specifications, the Dialogue with Bidders and the evaluation and quality assurance of the final bids. Health Estates are content with this approach and maintenance provision.

The Planned Preventative Maintenance (PPM) programmes will include all assets which Project Co are to retain responsibility for throughout the concession e.g. all elements of the building including M&E services and equipment as far as Project Co's responsibility lies as defined within schedule 13 of the Project Agreement. The Trust agreement of the PPM programme is an important aspect of the project as this is where the Trust can control aspects of PPM with regard to programming so the PPM activity doesn't extensively impact on clinical services be delivered. The drafting the Trust has adopted is standard in projects of this nature and is not considered to expose the Trust with regard to Project Co holding the risk for maintenance, all that is being agreed here is a time period for undertaking the programme.

Within the Project Agreement (clause 29) it states that 'The Trust's Representative may at all reasonable times observe, inspect and satisfy himself as to the adequacy of the monitoring procedures' without limit i.e. carrying out sample checks with no prior notice. In addition further monitoring provisions are requested of Project Co in the helpdesk service level specification - this being to ensure 'the Trust's Representative is given full electronic access to the Helpdesk system at any time. This shall be available in each of the Trusts departments, allowing real time progress to be monitored by the Helpdesk User.' This will give the Trust added monitoring data to help with inspections and sampling against service standards etc.

When the Contractor follows the maintenance programme, usually no deductions will be made for any resulting under performance of the services during the maintenance works.

The maintenance programme is subject to review by the Trust. The Trust may object to the Contractor's proposed maintenance programme on the grounds that:

- the proposed maintenance would interfere with the operations of the Trust in a way that could be avoided or reduced by rescheduling the works;
- the proposed hours of maintenance are inconsistent with the Trust's principles. For example, maintenance involving dust or loud noise would not be appropriate in areas which are at that time being used for surgery;
- the proposal would not be in accordance with the Service Level Specifications;
- the safety of patients or other users of the Facilities would be adversely affected by the proposed programme; or
- the period proposed for the maintenance works exceeds that reasonably required to carry them out (Schedule 10 Clause 3).

If the parties cannot agree on an appropriate programme of maintenance, then the matter may be referred to the Dispute Resolution Procedure (see Paragraphs 6.7.2).

Nearer to the time of the proposed maintenance the Contractor may, on a quarterly basis, propose changes to the agreed schedule. The grounds on which the Trust may object are the same as those set out above.

Regardless of the programme of maintenance agreed, the Trust retains the ability to instruct the Contractor to accelerate or defer its planned maintenance. However, the Trust will compensate the Contractor for any additional costs incurred by it up to an estimate of costs agreed between them. Also, no performance deductions can be made if the reason for the Contractor's non-performance is deferral of the maintenance works in accordance with the Trust's instructions.

Where the need arises (other than in an emergency) for maintenance works not set out in the agreed programme, the Contractor must agree the time and duration of these works with the Trust. The Trust can object to these proposals as set out above.

Where an emergency occurs which requires immediate maintenance, the Contractor merely has to notify the Trust of the action it is taking and seek to minimise any disruption caused. The difference between such "emergency" or "ad hoc" works, and those carried out in accordance with the agreed programme, is that the Contractor is not relieved from any performance deductions that may result in the former case.

If maintenance requirements are not complied with financial deductions can be made (see Section 6.6). Additionally, the Trust reserves the right periodically to inspect the ongoing maintenance. In addition, a separate regime of inspection of the Facilities will take effect towards the end of the Contract to ensure the assets are "handed back" to the Trust in a satisfactory condition (see Paragraph 6.7.4).

6.5.4. Monitoring Performance (Clause 29)

It is important, that the Trust can monitor the maintenance of Facilities. The performance of the whole range of services, as set out in Schedule 14 Service Requirements, must also be monitored to ensure and enforce compliance and to allow any appropriate deductions to be made from the Contractor's payments.

The Contractor must provide details of performance failure to the Trust, and the Trust can inspect the adequacy of the contract performance monitoring arrangements and carry out sample checks.

The New Acute Hospital project remedial actions associated with levels of poor performance are in some instances triggered by SFP's to gain the best possible results for the Trust over the concession, whilst maintaining an agreed market position. Warning notices will not trigger increased monitoring but it will be triggered by a set number of service failure points (SFP) over a rolling 3 month period attributed to each service. The net benefit here being that one very poor month can impact on the overall 3 month figure instead of relying on a number of warning notices (which are also calculated on a set number of SFP's per month) but once breached would not capture very poor performance as the trigger, under this scenario would be against the warning notice threshold breaching and not a set number of SFP's. The agreed process is that the accumulation of SFP's will trigger both warning notice thresholds over any one month period per service (warning notices will be used as an indication of performance levels declining) and also increased monitoring provision over a rolling 3 month period on a service by services basis.

If the Performance Parameters within the Service Level Specifications (as per Part 1 of Schedule 14) are not met, financial deductions are made from the Service Payment in accordance with the requirements set out in Schedule 18.

In addition to deductions, SFP's are incurred for service failures. If more than a specified number of SFP's are incurred, or the Contractor commits a serious breach of its obligations, then the Trust may issue a "Warning Notice" setting out the reason for its issue.

If a stated number of SFP's are issued in a particular period (determined on a project specific basis) then the Trust may increase the level of monitoring until the Trust is reasonably satisfied that the Contractor is performing, and will continue to perform, its obligations. The measures which constitute this enhanced monitoring procedure must be agreed between the parties or, if agreement cannot be reached, decided under the Dispute Resolution Procedure (see Paragraph 6.7.2). Where such measures include additional actions by the Trust the Contractor will meet the Trust's additional expenses.

Where a more serious level of SFP's has been incurred by the Contractor, or there is a breach of any contractual obligation which:

- may lead to an immediate and serious threat to the health and safety of any user of the facilities;
- may lead to a material interruption to the services;
- is prejudicial to Clinical Services; or
- the Trust considers to be an emergency, then the Trust may either require the Contractor, by notice, to rectify the problem (say, by engaging temporary staff in relation to the affected service) or take action itself.

- The Trust can take such action where it considers that the Contractor is unwilling or unable to do so, or if the Contractor has failed to undertake the relevant steps.

If the Trust is unreasonable in asking the Contractor to take additional measures, it must compensate the Contractor for any loss incurred. The provision seeks to ensure that the Trust does not raise frivolous comments on Project Co's performance such that it impedes its ability to meet its obligations. Project Co is protected from this in a variety of ways including the availability of compensation (for example) where the Trust require that it opens up works which are subsequently ruled as not being defective. In any event, the Trust will bear any expenses over and above those incurred by the Contractor in the proper performance of its obligations under the Contract. Otherwise, the Contractor will be responsible for any costs incurred in carrying out the Trust's instructions and will pay any costs incurred by the Trust taking the relevant action itself.

The monitoring and associated rights are in addition to the financial incentives set out in the Payment Mechanism (see Section 6.6) and the Trust's ultimate right of termination (see Paragraph 6.3.2).

6.5.5. Site Security and Personnel (Clause 32)

The Contract gives the Trust some control over the Contractor's personnel working at the site, given the particular sensitivities involved in interacting with potentially vulnerable groups such as patients.

The Trust can refuse access to the site to any employee or sub-contractor of the Contractor who the Trust believes is not a fit and proper person or who is likely to have a detrimental effect on the Clinical Services. The Trust may also require written information about those whom the Contractor proposes will have access to Trust premises.

The Contractor must also ensure that its staff comply with the policies of the Trust.

The Contractor must ensure that the number and quality of staff employed are sufficient to meet the Service Level Specifications and that all staff receive any training necessary. If reasonably requested by the Contractor, the Trust must agree for Trust staff to receive training prior to TUPE (as defined below) transfer.

The Contractor is obliged to "screen" potential staff. The Contractor will be required to comply with the Protection of Children and Vulnerable Adults (NI) Order 2003 [and if it is in force prior to financial close, The Safeguarding Vulnerable Groups (NI) Order 2007] and will also have to register with Access NI. All those employees likely to have contact with children or patients must be questioned regarding criminal convictions and those who will have access to children will have to consent to an Access NI check and complete any necessary forms. If convictions are disclosed, that potential employee shall not be employed by the Contractor unless the Trust, acting reasonably, consents. The Contractor must inform the Trust of any convictions occurring after a member of staff is employed.

Furthermore, the Trust may reasonably require the Contractor to take disciplinary action against an employee for negligence or misconduct. The Contractor must also set up and maintain proper personnel policies (such as health and safety and equal opportunities) and keep proper records in relation to its staff. The Trust has the right to access those records.

The Contractor may only appoint or replace such a manager with the Trust's reasonable consent.

6.5.6. TUPE and Pensions (Clauses 30 and 31)

In a PFI scheme, such as the Enniskillen Project, the Contractor (together with supporting private sector service providers which form part of the SPV consortium) is engaged to deliver the hard facilities management services. The contracts of employment (together with all attendant rights and liabilities) of those employees of the Trust currently employed in the delivery of those services would normally transfer to the private sector partner (or one of their service providers) under the Transfer of Undertakings (Protection of Employment) Regulations 2006 and/or the Service Provision Change (Protection of Employment) Regulations (Northern Ireland) 2006 ("TUPE").

There are a number of employees currently engaged by the Trust in delivery of hard facilities management services who will transfer under TUPE to the private sector hard service provider.

The Project Agreement also includes provisions to implement the Code of Practice on Workforce Matters in Public Service Contracts in order to avoid a two-tier workforce developing in the service delivery team employed by the Contractor. Additionally, there is a specific New Employee Dispute Resolution procedure included in the Contract should there be any claims that the Contractor is not complying with its obligations under the Code. Consultation with employee representatives has been an extensive and ongoing process. Employee Representatives were given the opportunity to comment on the terms and conditions and pension provisions proposed by all 3 bidders throughout the entire competitive dialogue process.

Consultations with staff and employee representatives will continue to be an ongoing process up to the actual date of service transfer.

Given that there are likely to be transfers of employees under TUPE back to the Trust or on to a new service provider following expiry or termination of the arrangements under the Contract, clauses are included to address this including requirements to provide employee information for the purposes of re-tendering and also appropriate indemnities from the Contractor to cover any employment liabilities which transfer back to the Trust or on to a new provider at this time. It seeks to cover all liabilities likely to arise however, it would be impossible to pre-empt everything that might arise at a time that could be more than 30 years following financial close. However, what the drafting seeks to do is protect the Trust from for example claims

issued by employees or former employees in respect of matters arising prior to their transfer back to the Trust or to a subsequent service provider.

Of particular importance in Northern Ireland are the compliance requirements for Fair Employment and Equality Legislation. The Contractor is placed under specific obligations to promote equality of treatment and opportunity in the Contract and to also implement all necessary equality policies and practices as required. The Contractor is also required to comply with Section 75 of the Northern Ireland Act 1998 as if they were a public authority for the purposes of that Act and must assist the Trust in achieving its duties to promote equality.

As employees will be transferring under TUPE and in accordance with the requirements of the HM Treasury Guidance, A Fair Deal for Staff Pensions, the Contract places specific requirements on the Contractor to protect both the already accrued and the future pension rights of those transferring employees. The future pension rights are protected by a requirement on the Contractor to provide those staff with membership of a pension scheme which has been certified by the Government Actuary's Department ("GAD") as offering broadly comparable benefits to those enjoyed in the HPSS. The transferring employees' accrued rights in the HPSS will also be protected by offering them the opportunity to transfer those accrued rights from the HPSS to the broadly comparable pension²⁶ scheme by means of an agreed bulk transfer arrangement.

All of the Bidders pension provision proposals have been scrutinised in detail by the GAD. The Trust has met with the GAD representative who also had a question and answer session with manager and staff representatives on pension provision. All of the bidders pension proposals including those proposed by the preferred bidder have been certified by GAD.

6.5.7. Stock, equipment and other materials (Clause 33)

The Contractor must procure equipment and stock capable of meeting the Service Level Specifications. The Contract sets out certain minimum standards (for example, that all equipment must be used in accordance with good industry practice) and requires sufficient stock and consumables to be held by the Contractor.

Materials, apparatus or equipment, which might damage the Facilities, or cause vibration or noise pollution or be hazardous should not be kept or used in the facilities and generally the Contractor should use equipment etc in such a way that detrimental effects are minimised. Unless such items are of the sort commonly used in hospitals, the Contractor must obtain the Trust's agreement to bring them onto the premises and must keep them as safe and secure as possible.

²⁶ The "Broadly" comparable pension scheme is the description used within the Code of Practice on Workforce matters. This term is used when referring to the protection of transferring employees' pension provision and future pension provision. "Broadly" comparable means offering the same range and similar balance of benefits.

6.6. PAYMENT, INSURANCE AND OTHER FINANCIAL MATTERS

6.6.1. Payment Mechanism (Schedule 18)

The payment mechanism facilitates the payment to the PFI Contractor for the provision of service. The Service Payment is the annual Unitary payment apportioned over the 12 months. This payment includes the costs for financing, equipment lifecycle and service provision . (see Figure 6.2 below)

Unitary Payment

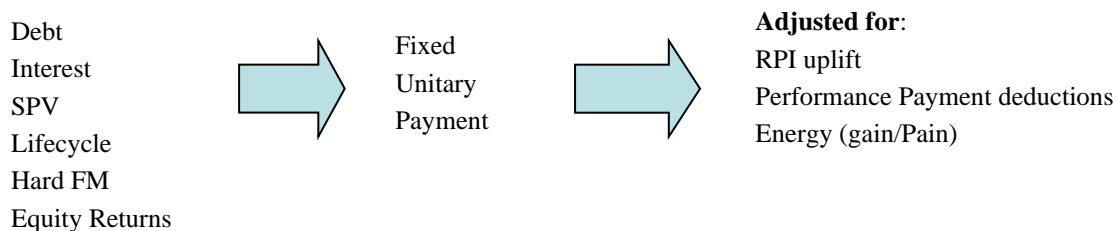


Figure 6.2 Unitary Payment

The Payment Mechanism is the only contractual means of incentivising good performance or penalizing bad performance by the Contractor i.e. if the Contractor fails to provide any services, they will not receive any payment.

The key features of the Payment Mechanism are as follows;

- a) **No Hospital No Payment** - The Contractor does not receive payment from the Trust until the works are complete and the provision of services commence. Thereafter, it will be paid a monthly “Service Payment” until the end of the Contract. In addition to the Service Payment, the Contractor is entitled to receive a one off cash injection (OOCI), designated within the Contract as a works payment, from the Trust on the earlier of:
 - The fifth business day after the Actual Completion Date; or
 - The last business day prior to the long-stop date.
- b) **Performance Measurement** - It enables the monthly service payment to be reduced if the service delivery falls below the required standard i.e. throughout the Contract the payment will be adjusted to reflect the performance of the Contractor.

The standards that the service is monitored against are detailed in Schedule 14 as;

- Service Specifications;
- Performance Monitoring System; and
- Contractors Method Statements.

These documents are based on Standard Form but have been fine tuned to meet

this projects' specific requirements.

- c) **Risk transfer** – This is an underlying principle of PFI. Risks that are transferred by the Payment Mechanism are:
- Pricing risk;
 - Performance risk;
 - Inflationary risk; and
 - Design risk

The payment mechanism follows the Standard Form approach and as such this should give the Northern Ireland Audit Office (NIAO) comfort that the transfer of risk is real.

Project Specific Issues

The payment mechanism which forms part of the Contract (Schedule 18) was developed initially by the Trust and its advisers. The Service specifications (schedule 14) were the product of discussion between the Trust service managers and Davis Langdon (FM advisers).

The Functional Area Functional Units (FAFU) table was populated by the Trust with the guidance of the Trust FM and financial advisers. The draft was released to the bidders along with example scenarios. This was used as the basis for the dialogue with the bidders.

The approach to availability of lifts followed a slightly different path. The initial consequential availability lift mechanism was felt by the bidders to be too punitive. The Trust and its advisers agreed with that assessment and a less aggressive mechanism was developed which was explained to the Bidders.

The payment mechanism follows Northern Ireland Standard Form.

6.6.2. Payment Mechanism and the OOCI

The One Off Cash Injection (OOCI)²⁷ of approx £100m is payable on the delivery of a significant milestone within the Contract; namely the satisfactory delivery of the infrastructure asset necessary for the commencement of the service as certified by independent tester in the practical completion certificate. The OOCI has the effect of reducing the amount financed over the operational phase of the Contract, which in turn results in a lower unitary charge (service payment) per annum.

The provisions surrounding the payment of the OOCI incentivise the provider to ensure that the infrastructure asset is delivered on time and on cost. The OOCI will only be payable on receipt of the independent tester practical completion certificate.

²⁷ *DHSSPS Finance have confirmed that the SIB and DSO are content with the drafting within the One Off Cash Injection. The Trust and their advisors have not made any changes to this drafting since the closure of the dialogue and no changes will be made unless they have approved by the DHSSPS.*

This means that the inclusion of the OOCI has not reduced the output specifications and standards required within the Contract to reach practical completion as verified by the independent tester.

Whilst this creates benefits in the reduced costs of private sector financing, it is arguable that the operational performance incentives could be lessened had the CIAF (defined below) not been introduced. The deductions applied in respect of unavailability over the operational phase of the PFI are linked to the value of the service payment (unitary charge). Hence deductions would have been calculated on a lower total service payment than would have been the case had the OOCI not been included within the project.

To address any risk of reduced performance incentives a Cash Injection Adjustment Factor (CIAF) has been included. The CIAF uplifts the £ value of the deduction to the same level as it would have been at prior to the introduction of the OOCI.

This will mean that risk transfer and performance incentive are fully sustained within this project.

The OOCI figure is accounted for on the Trust's balance sheet as described in section 1.6.7. It is allocated to the on balance sheet liability reducing its value over the project term, as the effect of the OOCI is to reduce the amount being funded by the private sector as reflected within the on balance sheet liability. This will mean that the OOCI is included in the net assets of the Trust.

The adjustments that can occur to the service payments as identified in the previous diagram are detailed overleaf.

1. RPI uplift

All performance payment deductions are index linked to RPI. Adjustments take place annually in line with other RPI uplifts to the Contract.

2. Performance Failure Deductions

The following diagram (Figure 6.3) explains how the deductions can arise;

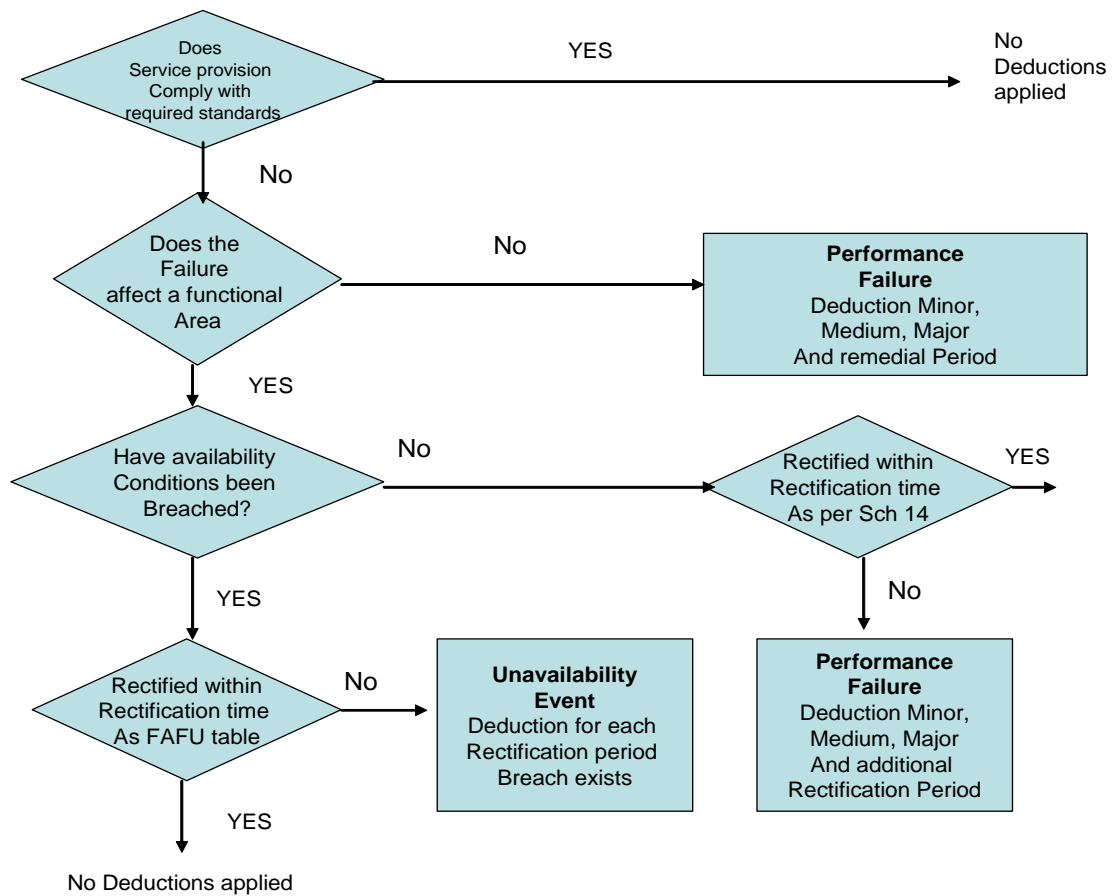


Figure 6.3 Performance Failure Deductions

Service standards

As discussed above, the Service Level Specification (Schedule 14) were the product of discussion between the Trust service managers and Davis Langdon (FM advisers) They provide detail on the level of service provision and identify the various performance parameters against which the Contractor will be monitored.

Functional Area

The Facility has been divided into Functional Units and Functional Areas. Functional Units are part of the larger Functional Areas, i.e. a Triage room is a functional unit within the Functional Area of the A&E.

Availability

The definition of Availability is divided into the following conditions:

- (a) The Accessibility Condition
- (b) The Safety Condition;
- (c) The Use Condition; and

- (d) The Prescribed Health Function Condition or as appropriate, the Prescribed Operational Function Condition.

The “Prescribed Health Function Condition” means a state or condition (other than the Accessibility Condition, the Safety Condition and the Use Condition) of the relevant Functional Part which allows the Prescribed Health Function for that Functional part to be carried on and performed in accordance with Law and generally accepted clinical practices for such Prescribed Health Function and having regard to the practicalities of carrying on and performing such Prescribed Health Function.

A practical example of how the Availability Deductions and Service Failure Points operate is provided at Appendix 6.02.

Unavailability Event

Should a Functional Unit suffer unavailability, which is triggered by the breaching of the above availability criteria, then a deduction for that space and period of unavailability is triggered. This unavailability deduction is adjusted by the weighting.

Each period of unavailability for each Functional Unit also receives a Service Failure Point accrual of 20 points.

If the problem remains unrectified at the end of the Unavailability Rectification Time (2,4 or 6 hours) there is a new unavailability event and further deductions will be applied.

Performance Failures

The structure of the performance regime is based on the performance system developed by the Trust, which is then reflected in the Service Level Specifications.

The amount of deduction in respect of performance failures is as follows:

- Minor £5
- Medium £15
- Major £30
- System 1 £250
- System 2 £500

All of the above are indexed linked to RPI. Adjustments take place annually in line with other RPI uplifts to the Contract. Each type of deduction leads to Service Point accrual which triggers Trust rights under the Project Agreement

For the minor, medium and major deductions these keep accruing for each lapse of the associated rectification or remedial period.

Rectification Period

The period specified in the relevant Service Level Specification for rectification of a fault, unless the fault causes a functional unit to be unavailable, if this is the case it then becomes an Unavailability Event.

All timescales associated with ad hoc requests for FM services which are specified as a service standard within the FM service level specifications are based on the general principles of the Standard Form FM service level specifications which have been reviewed and amended accordingly to meet the Trusts scheme and site specific requirements. This has been achieved through detailed discussion and review with the project team and Trust service managers. The timescales alone will not transfer risk, however when managed correctly along side the other specific elements of the Contract appropriate risk, in our opinion, is transferred. e.g. specific clauses in the main body of the Contract and Schedules 14 and 18.

Remedial Period

This is the length of time specified in Schedule 14 within which the Contractor is to demonstrate, to the reasonable satisfaction of the Trusts representative, that it has remedied the Performance Failure.

The remedial period applies to all failures categorised as Major, Medium and Minor and is performance parameter specific as per Schedule 14.

Service Failure Points

SFP shall be awarded for every Performance Failure and every Unavailability Event.

The amount of SFP's in respect of performance failures is as follows:

- Minor – 2
- Medium – 6
- Major – 20
- System 1 – 50
- System 2 - 100

For Unavailability Events 20 SFPS will be applied.

SFP thresholds are outlined which would trigger the following rights:

- Issue of Warning Notices
- Increased Monitoring
- Step in
- Project Co Default
- Termination

Based on Clause 29 4(b) – Monitoring of Performance, in the event of the Contractor committing a breach of the Contract, or accruing more than a level to be listed in a table in Schedule 18, Service Failure Points (SFP's) for a one month rolling period, then the Trust will be entitled to issue a Warning Notice.

In the event of the Contractor receiving a certain number of SFP's within a 3 month period (Clause 29.5), then the Trust will be entitled to increase their monitoring of the Contractor.

If the Contractor accrues more than a certain number of SFP's in a rolling one month period (Clause 29.6 (b)), then the Trust will be entitled to step in and provide the Service. The Trust will be entitled to receive reimbursement from the Contractor in relation to reasonable costs, expenses, losses or damages caused by having to step-in.

Based on Clause 44 (Project Co Events of Default) if the Contractor achieves a certain level of SFP's in a 3,6,or 12 month period, then this will be an event of "Project Co Default". The different levels are set on a sliding scale.

In the event of the Contractor breaching the level of SFP's within clause 44.3, then the Trust will be entitled to terminate the Agreement in the event the Contractor being awarded a further SFP's in the following 3 month period from an event of Project Co Defaults.

SFP's (Service Failure Points) are on a rolling basis. The SPV (Special Purpose Vehicle) does not get a "clean sheet" if a service provider is replaced, they retain "old" SFP's as an additional incentive.

100% of the UP is at risk, long before 100% of the building becomes unavailable, due to the gearing mechanism in the FAFU tables. There is no mechanism for the SPV to force the Trust to accept unacceptable temporary fixes or accommodation as acceptance is at the Trusts discretion.

Maximum Deductions

The maximum aggregate of all Deductions that the Trust can make from the Service Payment in respect of any Contract Month shall be the Monthly Service Payment (The Standard Form position is that the maximum that the SPV can be penalised is 100% of the UP).

Bedding In periods

In respect of each service there will be a period of 3 months for Bedding-In from the commencement of services in the new build. During the New Provider Bedding-in Period, the following provisions shall apply:

- during the first month no deductions may be made in respect of Performance Failures
- during the second and third months, the amount of any Deductions in respect of Performance Failures shall be reduced by 50%.

Temporary Alternative Accommodation

Where unavailability occurs in a location, then the Contractor may deem it more cost effective to provide temporary alternative accommodation, than to suffer the payment deductions associated with the unavailability of the space. The Trust may or

may not occupy the alternative accommodation, and if they do then there will be specific conditions on the nature of the space practically matching that vacated, with return dates agreed. The Trust has to act reasonably in accepting or rejecting temporary accommodation. If the Trust does not accept, then deductions would apply for the original accommodation at 100% (unavailable) but the Trust would not be able to use it. If the Contractor disagreed with the rejection they could resubmit the item for approval or challenge on grounds of unreasonable rejection by Trust. Ultimately, if the parties do not reach agreement, then the dispute resolution procedure will apply. If the return dates are not met then the Trust can choose to stay in the Temporary accommodation - deductions are made at 50% (unavailable but used) or leave the accommodation - deductions are made at 100% - unavailable.

Temporary Repairs

The Trust may allow the Contractor to provide a temporary repair when they consider it reasonable under the circumstances, as long as the repair meets reduced requirements for availability. A full rectification date is given and the onus is on the Contractor to meet the revised date or the Failure Event will be fully applied.

Lift availability

Lifts are categorised as Clinical, Public, Dirty FM, Clean FM or Hotlift. A fixed deduction is applied where more than one lift in a category is unavailable, or if there is only one lift in a category, when that single lift is unavailable. This is to reflect the operational difficulties caused by poorly functioning lifts.

3. Energy Payments

The mechanism is based on the principle that the Trust carries the energy or utility contracts and pays the associated bills. Over the monitoring periods, where the facility has its energy usage recorded a trend of energy consumption against heating days each month is recorded. This produces a graph whereby the number of heating days along the X axis is measured against the GJ/100m³. This gives a trend against which projected energy usage and associated price may be estimated for the following year.

At the end of each year the actual energy consumption and the estimated are compared. Should the energy have varied by + or – 3% then there is no painshare or gainshare. Trust and the Contractor share 50:50 either excess bill over 3% volume (added as gainshare to the Services Payment) or over 3% under deducted from the Service Payment.

Force Majeure and relief events

In the event of Force Majeure or a Relief Event, the Trust will not pay the Contractor for any affected areas. This will be achieved by making deductions for the affected areas as if they were the subject of a Failure Event rendering them Unavailable and not used by the Trust.

6.6.3. Invoicing and Payment (Clause 35)

A draft invoice is sent to the Trust within five business days of the end of the relevant contract month. This invoice sets out the standard payment due to the Contractor minus any agreed deductions for poor performance in the previous month. Therefore, February's invoice (issued at the start of March) would contain any deductions in respect of January and would be due for payment by the Trust at the end of March (at the latest).

The Contractor must use the data in respect of the services collected through its monitoring process (see Paragraph 6.5.4) to calculate the deductions. However, the Trust (which has the right to check the performance of the services, audit and inspect the Contractor's results) may disagree with the Contractor's findings. Where either party disagrees with the invoice amount, the Trust will pay the undisputed element. The disputed part must be agreed by the parties, or decided by the Dispute Resolution Procedure (see Paragraph 6.7.2). If it is subsequently agreed or decided that the Trust ought to have paid any or all of the disputed sum, then that sum must be paid to the Contractor plus interest.

The Trust can deduct up to the value of 100% of the UC for the relevant contract month. Therefore, it will apply any deductions accruing to the final monthly payment in the usual form. If (and to the extent) that the Contractor owes the Trust some money during or, indeed, at the end of the Project Term, the Trust could utilise the provisions of clause 35.6 (Set-Off) of the Contract.

Invoicing for the OOCI

The invoicing arrangements for the OOCI require that the Contractor submit a [VAT] invoice at least 10 business days in advance of the Actual Completion Date but is not entitled to payment until the earlier of the 5th business day after the Actual Completion Date or the last business day prior to the longstop date.

6.6.4. Insurance and Criminal Damage (clause 36)

On a project specific basis, the Trust has set out specific insurance cover (Schedule 21) that the Contractor must have and the length of time for which it must be maintained. The Contract also sets out a "risk management" procedure under which the parties appoint representatives to manage and report on the risks inherent in the scheme.

The parties will also agree at the outset the form of the relevant policies and the Contractor must continue to maintain insurance in this form. Furthermore, the insurance must always be with an insurer acceptable to the Trust. When such policies are to be renewed or revised, the Trust (acting reasonably) must consent to this. The Contractor must also supply the Trust with evidence that the appropriate insurances have been maintained.

To protect the Trust against any cancellation of a policy without its knowledge, the insurance policy must remain valid for a certain period after notice of the impending cancellation is sent to the Trust. This means that the Trust can exercise its rights to procure insurance itself. Alternatively, the Trust could be named as an insured party,

retaining the benefit of the insurance even if the Contractor fails to make a payment or causes the policy to be invalidated. The Trust will also require a letter from the Contractor's insurance brokers stating that they will inform the Trust of any change to or cancellation of any of the policies.

The Contract specifies that the insurances must waive the insurers' rights of "subrogation" against the Trust. This means that, where there is a liability to a third party in circumstances where the Trust may have been negligent, the insurance company will not have the right to pursue the Trust for a proportion of the loss caused by its negligence.

If the Contractor is insured for a loss it suffers due to an action of the Trust (or would have been so insured had it complied with the terms of the Contract) it cannot claim this compensation from the Trust. Thus, if the Contractor effects appropriate insurance, the risk arising from some types of claim are passed to the insurers. It is the Contractor's responsibility to manage its insurances: any failure to do so will not reduce its liability to compensate the Trust for any loss.

The Contract contains provisions to deal with a risk when it becomes "uninsurable". This might happen because of changing global conditions (for example, the insurance market in respect of terrorism risk changed radically after 11 September 2001). If a risk which the Trust requires the Contractor to insure against under the Contract (rather than one against which the Contractor must insure by law) does become uninsurable, the Contractor will no longer have an obligation to insure against it. In this case, payment made by the Trust to the Contractor will be reduced by the amount of the relevant premiums.

If an event has become uninsurable and actually occurs, the Trust can choose to pay to the Contractor the amount that it would have received from the insurance company. Alternatively, it can terminate the Contract under clause 46 (Force Majeure). If the Trust chooses to pay the Contractor, these proceeds will be dealt with in the same way as any other insurance claim. Firstly, a decision will have to be made about whether to "reinstate" the project; for example, rebuilding the relevant Facilities so that the scheme can carry on as it did before the uninsurable event. The Contractor's lenders will often have input into this decision, by virtue of their "Direct Agreement" with the Trust.

The proceeds of any claim (or payment from the Trust in respect of uninsurable risks) will first be used to pay off any liability to any third party or employers' liability or, in the case of other types of insurance (say, insurance of damaged buildings) to ensure that the Contractor can continue to fulfil its obligations by restoring and replacing any necessary Facilities or goods. Where it is decided that the project should not be "reinstated" the Contract will terminate as if a Force Majeure Event had occurred and the insurance proceeds will be used to compensate the Contractor for the termination, with the balance of any such compensation to be paid by the Trust.

The Criminal Damage (Compensation) (Northern Ireland) Order 1977 (the “Compensation Order”) established a statutory scheme whereby compensation would be paid for loss arising from physical damage caused by terrorist or certain other unlawful activities. The scheme does not extend to loss arising where no physical damage has occurred, i.e. in circumstances where there has been intimidation of workers by, for example, paramilitary groups, threats of terrorism and/or joy-riding. The Contract sets out a mechanism that must be followed if a criminal damage claim is to be made.

In essence, Schedule 35 requires the Contractor to seek to make a claim under the Compensation Order either in its own name or in the name of the Trust. Whilst such a claim is being pursued, both parties are, so far as is practicable, to ensure the continued provision of the Works and/or Services. The proceeds of a successful claim belong to the Trust save for any element of a claim which relates to the Contractor’s costs or in respect of any other costs associated with the interruption of the Contractor’s business.

Following commencement of the claim process, the Contractor must prepare a Reinstatement Plan for the repair, reinstatement or replacement of the Facilities. It must include certain key information including completion dates, step-in arrangements (if any) and payment provisions and must be agreed with the Trust within a defined period. If the Criminal damage Event is of such a magnitude as to render more than a defined area of the Facility “Unavailable” for a period in excess of six months, then the Trust may elect to treat the occurrence as a Force Majeure Event and terminate the Contract in accordance with the provisions relating thereto.

In certain defined circumstances, the Trust will pay to the Contractor an amount equal to the Net Monthly Revenue Loss to ensure it can, amongst other things, continue to meet its obligations under the funding documentation. During this period, the Trust would not exercise its right to terminate the Contract or award SFPs to the extent that these arise as a result of such an occurrence. Furthermore, to the extent that the Completion Date is delayed by such an event, then it will be treated as a Delay Event.

Schedule 35 to the Contract outlines the defined circumstances in which the Contractor will be paid an amount equal to the Net Monthly Revenue Loss. In essence, this is where the Contractor has met and continues to meet its obligations under Schedule 35 such as for example, seeking to make or assisting the Trust with making a claim under the Compensation Order.

6.7. OTHER MATTERS

6.7.1. Warranties, indemnities and liability (clause 8)

The Contractor will often set up a special company, known as an “SPV”, or special purpose vehicle, the only job of which will be to perform the Contract. The Contractor must guarantee to the Trust that its SPV will not conduct any other business during the Contract and that it will perform the works and services safely.

The Trust, however, expressly gives no guarantees to the Contractor about the project. The Contractor should carry out all investigations that it thinks appropriate before entering into the agreement.

The Contract recognises that certain actions of the Contractor may lead to a loss to the Trust, regardless of whether such actions are also dealt with under the Payment Mechanism. For example, if the Contractor failed to clean up a spillage within the stipulated period, a performance deduction might be incurred. However, if the Contractor's failure also led to a visitor slipping and injuring himself, the cost of any resulting claim against the Trust (and the Trust's associated expenses) must be met by the Contractor.

The compensation mentioned above will be due if the Contractor's actions lead to a claim against the Trust for death or personal injury, or to physical loss or damage to the Trust. This ensures that, regardless of the Payment Mechanism, the Trust is entitled to compensation if the Contractor's performance causes actual loss to the Trust.

Similarly, the Trust must compensate the Contractor for certain losses suffered due to actions of the Trust, which are:

- a claim in respect of the death or injury to a third party (specifically including persons employed or engaged by the Contractor) arising from the clinical services at the Facilities, a breach of Contract by the Trust or an act of the Trust which is contrary to guidance/instructions for running the Facilities; and
- physical damage to the Facilities or to the assets or the property of a third party arising from breach by the Trust of any Contract provisions or any deliberate act by it.

The matters set out above mean that the Trust will not, generally, have to compensate the Contractor for loss which it suffers merely as a result of the Trust's negligence or from the actions of patients or visitors.

The Trust will not have to compensate the Contractor to the extent that the loss is caused or contributed to by the Contractor. Similar provisions apply in respect of the Contractor's indemnities to the Trust.

6.7.2. Liaison committee and dispute resolution (clause 12 and 56 and schedule 26)

A committee will be set up by the parties, consisting of 3 members appointed by each party, to review the daily operation of the Contract and, where appropriate, make recommendations. The committee's recommendations are not binding on the parties.

Where a binding decision is required for a matter on which the parties cannot agree, there is a formal process to resolve these issues without the need for formal legal action.

The “Dispute Resolution Procedure”, which applies to most disputes that may arise under the Contract, states that the Liaison Committee will consider the matter first. If this does not result in agreement then either party may appoint an adjudicator to consider the matter, and the Adjudicator’s opinion will be binding unless overturned by the courts.

In parallel with the process outlined above, the parties may agree to mediation – in effect, a nonbinding process which attempts to find a mutually acceptable resolution.

There may also be cases where even the process outlined above is too lengthy. In such cases a limited number of disputes can be dealt with by bypassing the early stages of the Dispute Resolution Procedure and proceeding directly to adjudication.

6.7.3. Quality assurance (clause 25)

In addition to the services and construction requirements set out under the Contract, the Contractor must put into place a quality management system to give greater comfort to the Trust that the project is being performed to an appropriate standard. These quality management systems must comply with the recognised quality standard and take the form of plans which relate to design, construction and service provision.

The quality management system proposed by the Contractor is subject to review by the Trust, which must also approve the identity of the Contractor’s quality manager. The quality manager, who will not have daily involvement in the project, must ensure the effectiveness of the Contractor’s quality system, audit and review it and report his findings to the Trust’s representative.

6.7.4. Handback procedure (clause 49 and schedule 24)

Regardless of how or when the Contract ends, there are provisions obliging the Contractor to transfer the Facilities and, possibly, other assets to the Trust and to “hand back” the Services to the Trust in an orderly way.

Primarily, the Facilities must be in such a condition that they can be used adequately to perform the Contract. Before the Contract ends, the parties will conduct an inspection to determine whether or not this is the case. If the Facilities do not meet these requirements, then the Contractor must propose (and the Trust review) the works it proposes to undertake to address this.

It is the Contractor’s responsibility to bring the Facilities up to the required standard. The Trust requires that the Contractor provide a “bond” from a third party (such as a bank or insurer) guaranteeing to the Trust that sufficient money is available to rectify any deficiencies should the Contractor not resolve them.

The Contractor will meet the cost of the Handback Works in the first instance. If these are carried out to the Trust’s satisfaction, then the handback bond will be returned to the Trust. If the works are not completed to the Trust’s satisfaction, then the matter can go to dispute resolution. Ultimately, the drafting provides that the

Trust can look to Project Co for all costs necessary to ensure that the handback requirements are met.

6.7.5. Refinancing (schedule 29)

The cost of borrowing funds to construct the Facilities is a major expense of the Contractor. It may be that, due to changing market conditions or an improved credit rating of the project due to its success, the credit terms which the Contractor can obtain improve through the life of the Contract. Obtaining such improved credit terms is known as a “Refinancing”.

The Contract states that, generally, the proceeds or savings which result from a Refinancing should be split equally between the Contractor and the Trust. This recognises that the Trust plays a significant part in the success of the project which, in turn, allows more favorable finance terms to be obtained.

The word “generally” reflects the fact that the 50:50 sharing of a refinancing gain is not of the gross amount but rather is adjusted in accordance with the terms of Schedule 29 to take into account, for example, both parties reasonable and proper professional costs.

The Trust will also generally have the right to consent to a proposed Refinancing but must act reasonably in doing so.

6.7.6. Vires of the Trust to construct a new hospital on a new site

During the course of the dialogue, one of the bidders raised a concern regarding the vires of the Trust to construct a new hospital on a new site. This matter was discussed with amongst others, the SIB and the Departmental Solicitor’s Office (DSO). Although it was never raised by the other two bidders (including the Preferred Bidder), it was agreed that as the legislation was in the process of being amended following the Review of Public Administration (RPA), this matter could be dealt with at the same time. The SIB have been liaising with DSO in this regard and we understand that the new legislation, addressing this perceived issue, will be in place in advance of financial close..

6.7.7. Conclusion

The Contract has been negotiated in all material respects with each of the Bidders (and the EIB) and all points have been identified and agreed where possible. The purpose of the Agreed List is to identify such points. Each Bidder was asked to confirm that they had no further points on the Contract and to provide confirmation from key members of their consortium including, in particular, their funders. It would not have been possible to complete all schedules to the Contract as certain of these are driven by for example, the refinement of the design.

Broadly speaking, the Bidders appeared happy with the Contract and during the course of dialogue, it was felt that agreement was reached with each of the bidders in respect of all material issues on the draft agreement.

7. OVERVIEW OF THE TENDERING PROCESS

7.1. INTRODUCTION

The New Acute Hospital for the South West is being procured in accordance with treasury guidance under the Private Finance Initiative (PFI) and utilising the new Competitive Dialogue procurement procedure.

The procurement process for complex projects of this scale begins with an advertisement in the Official Journal of the European Union and proceeds through four stages of dialogue and negotiations before a call for final tenders is issued. After tender evaluation, a Preferred Bidder is appointed and the finer details of the contract agreed before the deal reaches Financial Close and the contract signed. For the New Acute Hospital for the South West, this process, which began in July 2006 and is planned to conclude in March 2009, has a duration of 2 ³/₄ years. Throughout this period SIB & Health Estates have been fully involved in the process and their significant contribution will continue to financial close (March 2009) and beyond.

7.1.1. The Essentials of Competitive Dialogue

Competitive Dialogue was introduced into England, Wales and Northern Ireland by the Public Contracts Regulations 2006 and has been mandatory from 31 January 2006 for major complex projects of this nature and where discussion of the requirement is needed to develop final specifications. This is a procedure whereby the contracting authority conducts dialogue with bidders, with the aim of developing one or more suitable alternatives capable of meeting its requirements.

Competitive Dialogue is therefore an interactive process where discussions are based on the private sector bidders utilising their expertise in a competitive environment to present innovative ideas that best meet Trust requirements. The Trust's project team was required to work in partnership with each Bid Team to maximise the benefits of each of the solutions. The outcome to be achieved by the dialogue is to develop ALL bids to a stage where they would be acceptable and meet Trust requirements and quality standards for all aspects of the project.

An essential aspect of Competitive Dialogue is that *all key issues* are addressed during the dialogue as the regulations do not permit the re-opening of issues once dialogue is closed. This is the core difference between Competitive Dialogue and its predecessor, the Negotiated Procedure. Once dialogue is closed, Competitive Dialogue regulations permit to Trust to 'clarify, specify and fine tune' only. Therefore it was essential that the project progressed to a level of detail where commercial certainty would be reached on all key aspects prior to Closure of Dialogue.

After the Closure of Dialogue, and during the stage from Appointment of Preferred Bidder to Financial Close, the 'fine tuning' will involve picking up elements that it

was not appropriate or possible to finalise prior to closure. Any alterations emanating from this, should not impact upon the solution or the price and it is also not anticipated that such work will impact upon the planned date for Financial Close.

For the sake of completeness we attach in Appendix 7.01 a guide on Competitive Dialogue Procedure by the Office of Government Commerce.

7.1.2. Preparations for Procurement

In preparation for the procurement stage of the New Acute Hospital for the South West, the Trust established the procurement structures. The Project Team were organised into workstreams to work with Bidders to develop all aspects of their proposals. These workstreams reflected the key aspects of the project including Design and Technical, Legal, Financial, Facilities Management, Human Resources, Insurance, ICT, Socio Economic, Equipment and Project Management as described in more detail in the following paragraphs. Each workstream consisted of members of the Trust's project team and key, appropriate members of Trust staff, supported by procurement advisers, Health Estates Agency and specialist external advisers, including those with specific PFI and healthcare project experience.

This work-stream structure supported the more interactive process that was essential for the success of the Competitive Dialogue process and ensured best use of project team skills and specialist advisors.

During the 1st Quarter of 2006, a communications plan was implemented to generate awareness of the PFI project among the European investment and construction industries that culminated in a series of Market Information events held in London and Belfast.

This was followed in July 2006 with an advertisement in the Official Journal of the European Union (OJEU) for expressions of interest on the New Acute Hospital project. This advertisement marked the launch of the procurement process.

The sections below outline each of the stages carried out by the Trust in more detail.

7.1.3. The Procurement Stages

The following diagram describes at a high level the four key stages of the Competition. The detailed description of each of the stages is set out in sections 7.2 to section 7.4.

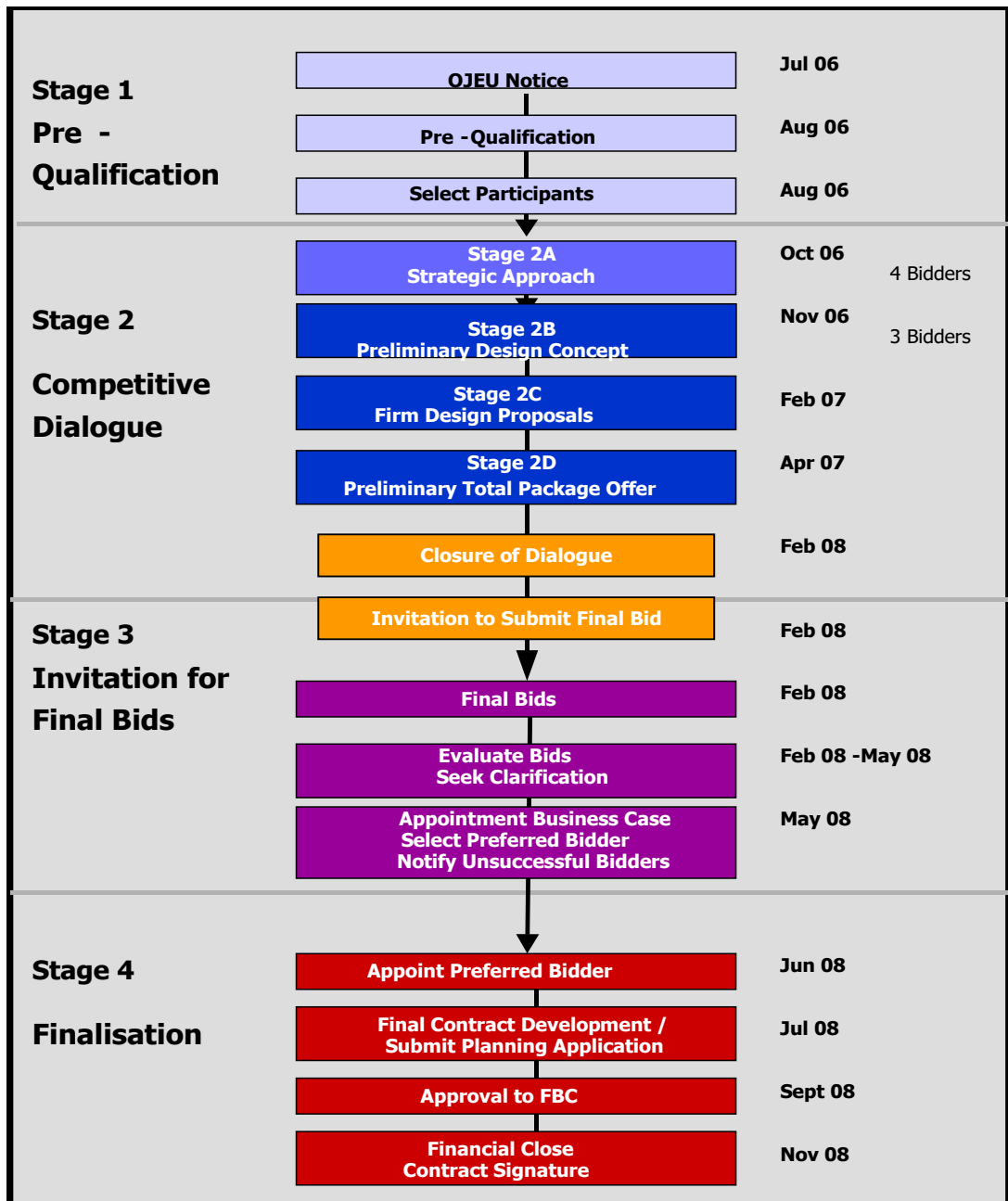


Figure 7.1 Stages of the Competitive Dialogue Process

At each stage of the process, Bidders responded to agreed deliverables and to a pre-determined evaluation methodology that reflected the principles of the project, as set out in the underlying principles (Refer to section 7.3.2 ‘Stage 2A’) and the Award Criteria outlined in Table 7.9. The project work-stream team structure also reflected these Award Criteria.

7.2. STAGE 1 - PRE QUALIFICATION

7.2.1. Overview of Process

The first stage of the PFI procurement process is the Pre-Qualification. This involves selecting those Bidders that are evaluated as being suitable to bid for the project, based primarily on their status and experience. This stage required Bidders to respond to a set of pre-qualification questions covering areas such as make up, financial standing, previous experience of healthcare PFI and relevant resources of the consortium, construction company, FM company and advisors.

It was determined in advance by the Trust, in conjunction with Health Estates and the Strategic Investment Board that a maximum of five Bidding Consortia (“Bidders”) would be taken forward from the PQQ stage to the first stage of Competitive Dialogue. There would then be a further de-selection at Competitive Dialogue Stage 2A in order that the Trust would engage in full dialogue with a maximum of three Bidders who would remain in the process through to the stage of Final Bids, when the final evaluation would result in the selection of one Preferred Bidder.

7.2.2. PQQ Evaluation process

The PQQ evaluation comprises two elements:

- **Preliminary Evaluation** – the aim of which is to determine whether Bidders’ responses comply with the PQQ’s basic requirements and whether Bidders have the ability to undertake the project and are eligible to undertake the Project, and
- **Detailed Evaluation** – the aim of which is to score Bidders’ responses to a series of structured questions. This results in an overall qualitative assessment of Bidders’ technical capability, capacity and financial and economic standing.

All Consortia who passed the Preliminary Evaluation were taken forward to the Detailed Evaluation. The purpose of the Detailed Evaluation was to reduce the number of Consortia to a maximum number of five and/or, depending on the number of Consortia passing the Preliminary Evaluation, develop a better understanding of the relative strengths of the Bidders at an early stage of the procurement.

PQQ responses were obtained from four Bidders. Details of each Bidding Consortia as provided in the PQQ are outlined below in figures 7.2 to 7.5.

Consort Healthcare includes the Shareholding Companies of John Graham (Dromore) Ltd and Balfour Beatty Capital Ltd.

Construction Contractors are: Graham Martin, Balfour Beatty Construction Northern Ltd. and Haden Young Ltd.

The Consort Healthcare team in Northern Ireland is a joint venture between Balfour Beatty Capital Limited and John Graham (Dromore) Limited. Consort Healthcare is the leading PFI healthcare provider in the UK winning seven major projects incorporating nine hospitals and three mental health units.

Consort's operational projects include the Edinburgh Royal Infirmary and University College Hospital London. Earlier this year it successfully closed the largest PFI hospital deal outside London - the £523m Birmingham New Hospitals Project.

The partnership with Graham, one of Northern Ireland's leading contractors brings crucial local experience to the team. Graham, in joint venture with H&J Martin, has recently completed two landmark hospital developments at the Royal Victoria Hospital, Belfast and the new Cancer Centre at Belfast City Hospital. Consort's new Belfast office opened in October of this year.

Figure 7.2 Consort Healthcare

DirectHealth which includes the Shareholding Companies of Skanska Infrastructure Investment UK Limited, Innisfree Limited, Lagan Holdings Limited and John Sisk & Son.

Construction Contractors are: Skanska Construction UK, John Sisk & Son and Lagan Construction.

The DirectHealth Consortium is a new organisation that brings together a number of companies which have worked together successfully in previous ventures. These companies each have a demonstrable track record of success. The consortium's Chairman is Gerry Cawley, from the Lagan Construction Group, which is based in Northern Ireland. The other companies include John Sisk & Son, Skanska UK and Innisfree. In addition, a number of local companies are supporting the consortium's bid including Design Partner Ferguson McIlveen, and Mechanical and Engineering Design company Delap and Waller.

DirectHealth provides a wide range, scope and experience of project delivery across the U.K. and Ireland. Its consortium members have a wide range of healthcare and hospital building experience with a number of operational hospitals and hospitals under construction at the present time.

The DirectHealth consortium will be a long term partnership between the four main parties, with each company acting as a shareholder and investing in the Project Companies established. The consortium intends to bid other healthcare PFI projects in Northern Ireland together in the future.

Figure 7.3 DirectHealth

Northern Ireland Health Group which includes the Shareholding Companies of FCC Construction S.A., Interserve Investments Plc and Allied Irish Bank.

Construction Contractors are: FCC Construction S.A., P Elliott & Co., Heron Brothers Ltd., Mercury Engineering, Harvey Group, Sharpe Mechanical Services and Dowds Electrical.

The Northern Ireland Health Group has been set up to design, build, finance and operate new modern hospital facilities. The Group will work in partnership with the local health economies and their stakeholders to deliver excellent healthcare to the people of Northern Ireland.

The consortium has 3 stakeholders: FCC Construcción SA, Allied Irish Bank and Interserve Investments. Each has a proven record of success in delivering large acute hospitals under the Private Finance Initiative. Our consortium approach will combine the best of local skills, international experience and industry-leading innovative practices.

Facilities Management services will be provided by Interserve FM, a well-established provider of support services in Northern Ireland.

Figure 7.4 Northern Ireland Health Group

Erne Healthcare Consortium included the Shareholding Companies of Michael McNamara & Co., McAleer & Rush Ltd and Iridium Concesiones de Infraestructuras, S.A.

Construction Contractors are: Dragados S.A., Michael McNamara & Co., McAleer & Rush Ltd

The Erne Healthcare Consortium is a combination of leading companies in the concessionary and construction fields: Iridium Concesiones de Infraestructuras (former Dragados Concesiones de Infraestructuras – ACS Group, a worldwide reference in the construction and services activities), Michael McNamara & Company (ranked in the Top Three Irish Building Contractors) and McAleer & Rushe (one of the main building contractors in Northern Ireland).

Figure 7.5 Erne Healthcare Consortium

Owing to the commercial sensitivity of this document the Bidders are referred to as Bidder 1, 2, 3 and 4. It is not disclosed who the corresponding Consortium is to the Bidder Number.

The Preliminary Evaluation was divided into three strands of work undertaken separately by the following evaluation teams:

Table 7.1 PQQ Evaluation Teams

Preliminary Evaluation Strand	Lead responsibility
Completeness of information	Trust
Ability to undertake the Project (financial hurdles)	Deloitte & Touche LLP
Eligibility	L'Estrange and Brett

The Detailed Evaluation was divided into six strands of work being undertaken separately by the following evaluation teams:

Table 7.2 PQQ Stands of Work / Responsibilities

Strand	Lead responsibility
Overview	Trust
Procurement / compliance and SPV legal adviser	L'Estrange and Brett
Finance and SPV financial adviser	Deloitte & Touche LLP
FM	Davis Langdon
Design and SPV technical advisers	Health Estates
General	Trust

Work in respect of the PQQ evaluation was conducted in September and October 2006.

7.2.2.1. Preliminary Evaluation

The Preliminary Evaluation involved reviewing the Bidders' responses to ensure that they complied with certain minimum legal and financial standards and that they have the financial capacity to undertake the project.

Following a number of Trust clarifications with Bidders, all Bidders passed the Preliminary Evaluation and were taken forward to the Detailed Evaluation.

The Trust's Legal Adviser, L'Estrange and Brett tested the eligibility of the Bidders with a series of pass/fail questions as part of the Preliminary Evaluation. All Bidders were awarded a "pass" in respect of these questions.

As part of the Preliminary Evaluation, the Trust together with Health Estates assessed the structure of the Bidders to ensure that there were no key members missing. All Bidders included construction and hard and soft FM companies and all

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had the principal advisers on board (including experienced architects) and, as such, were seen to be complete and suitable for progression.

Deloitte, the Trust’s Financial Adviser, undertook a number of financial “hurdle” tests as part of the Preliminary Evaluation, which were used to assess the financial suitability of the Bidders to undertake the project. These tests comprised:

- Turnover;
- Independent Credit Rating;
- Qualified Accounts; and
- Worrying Trends.

All Bidders passed these hurdle tests.

7.2.2.2. Detailed Evaluation

The Detailed Evaluation involved a qualitative assessment of Bidders’ responses to the PQQ questions. A summary of the weighted scores from the Detailed Evaluation of each Bidder are shown in Table 7.3 below:

Table 7.3 Summary of weighted scores from the Detailed Evaluation of PQQ Responses

		Bidder 4	Bidder 3	Bidder 2	Bidder 1
PQQ Section:	Maximum possible score	Weighted Score	Weighted Score	Weighted Score	Weighted Score
A – Consortium	370	288	312	287	326
B - Building Contractor	250	153	183	226	213
C - FM Service Providers	310	172	223	231	192
D – Advisers	70	51	50	48	53
Sub total	1,000	664	768	792	784
Weighted to 95%	950	630	729	752	745
E – Quality of Submission	50	25	40	50	50
Total Score	1,000	655	769	802	795
Rank		4	3	1	2

As the above table 7.3 indicates, Bidder 2 was the highest scoring Consortium in the detailed evaluation, closely followed by Bidder 1. Bidder 3 achieved the third highest score and Bidder 4 was the lowest scoring Consortium. The detailed evaluation work did not highlight any substantive issues that would prevent any of the four Bidders being taken forward to the dialogue stage of the procurement. However, the following comments in regard to each consortium should be noted:

Bidder 1

Bidder 1 came second of the four Consortia, showing relative strength across the board. The only area of slight weakness came in the provision of accident statistics for both FM providers in their FM joint venture.

Bidder 2

Bidder 2 scored highest overall with relatively high scoring against each area evaluated. The only slight weakness was in relation to the Consortium's experience of raising finance and the provision of equity for PFI schemes, with the Construction Contractor having not worked in the UK PFI market before, although its experience of project finance was extensive.

Bidder 3

Bidder 3 scored well as a Consortium and in respect of its FM providers but ranked third out of the Consortia for its building contractors, a result of a weak submission relating to relevant non-PFI projects and Health and Safety. The inclusion of a smaller partner in the construction joint venture in the financial strength tests, reduced the overall consortium score due to its smaller size. The Trust's FM Adviser indicated that Bidder 3 scored strongly throughout the FM section of the response with few weaknesses.

Bidder 4

Bidder 4 consortium scored lowest in relation to the Building Contractor, the FM Service Providers and the General Section relating to the quality of the submission. In relation to the building contractor, the lack of a submission on safety audits and the prevalence of major incidents and fatalities involving consortium members resulted in 0 being scored for each of questions B15, B16 and B17. The FM provider's provided a poor response on Health & Safety and the lack of details on staff training led to lower scoring on FM questions. The consortium scored well for financial strength which, to some extent, offset poor scoring in respect of working together previously.

The overall quality of submissions was scored out of 10 by the Trust for each Consortium and assigned a weighting of 5, so that overall it accounted for 5% of the aggregate scores. Bidder 4 scored relatively poorly in this area as indicated by a score of 25 out of 50 compared to 40 out of 50 (Bidder 3) and 50 out of 50 (Bidder 2 and Bidder 1).

7.2.3. Main findings from the PQQ Evaluation Process

The main findings from the Detailed Evaluation are presented in the following tables.

Table 7.4 Main Findings from the Detailed Evaluation for Bidder 4

PQQ Section	Score	Comments
A – Consortium	288	Strong consortium members but with little experience of working together. Wide experience of project finance but little PFI specific financing or equity experience.
B – Construction	153	Bidder 4 was unable to give satisfactory answers with regard to Health & Safety, this could be due to the fact that they are located outside the UK and perhaps similar Health & Safety legislation is not applicable. The same applies to training, supervision and equal opportunities, where again they scored poorly.
C – FM	172	In the main acceptable responses, however they did not provide details on staff training, as required; and their Health & Safety response was vague.
D – Advisers	51	The only adviser that scored weakly was the health planners with 21 out of a potential 70. This was principally as a result of a lack of experience on PFI deals. The remainder all scored well with architects, legal and financial advisers all scoring over 60 out of 70.
Sub Total	664	
Weighted to 95%	630	
E – Overall	25	Poor quality response which was difficult to navigate. Significant additional information had to be requested after the submission date.
Total Score	655	
Rank	4	

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Table 7.5 Main Findings from the Detailed Evaluation for Bidder 3

Section	Score	Comments
A – Consortium	312	Very strong consortium submission with strong experience both separately and working together. Score reduced slightly by the averaging of the smaller construction company financial strengths.
B – Construction	183	Consistent scoring across all questions with the exception of relevant non-PFI Projects and Health & Safety submissions. The construction company scored very strongly in regard to Health PFI projects, their capacity and environmental policies.
C – FM	223	Consistently strong scoring across all the questions with only non-PFI experience and accident statistics being the exceptions.
D – Advisers	50	All advisers scored consistently being in the range from 45 to 56 out of 70. All advisers scored 10 out of 10 for Healthcare PFI experience.
Sub Total	768	
Weighted to 95%	729	
E – Overall	40	Generally acceptable submission with little need to request additional information.
Total Score	769	
Rank	3	

Table 7.6 Main Findings from the Detailed Evaluation for Bidder 2

Section	Score	Comments
A – Consortium	287	Strong consortium only scoring weakly in the areas of raising PFI finance and equity (though it has plenty of experience of raising project finance) and in experience of working together. Both of these are to be expected from a new entrant.
B – Construction	226	Strongest of the Construction submissions with all aspects of the Pre-Qualification Questionnaire satisfactorily covered.
C – FM	231	Again the strongest of the 4 submissions with relatively strong responses throughout.
D – Advisers	48	Weakest of the financial advisers but principally as they could show little relevant PFI experience in health or elsewhere. The Structural Advisers had a score of 29 out of 70 as a result of having no Health PFI experience, although their experience of non-Health PFI was extensive.
Sub Total	792	
Weighted to 95%	752	
E – Overall	50	Complete submission with excellent presentation.
Total Score	802	

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Section	Score	Comments
Rank	1	

Table 7.7 Main Findings from the Detailed Evaluation for Bidder 1

Section	Score	Comments
A – Consortium	326	Very strong consortium with high financial strength, good experience of financing of PFI deals and a good history of working together.
B - Construction	213	Similarly strong Construction submission, scored well demonstrating significant competence in acute health PFI builds. All policies and initiatives regarding Quality Assurance, Health & Safety, Environmental and employment appeared to be satisfactory.
C – FM	192	The Trust’s FM Providers described this as a solid response in most areas, however the question of how joint service delivery is to work in practice provides an area of potential concern which will need to be addressed during the dialogue phase.
D - Advisers	53	All advisers scores were satisfactory with a minimum score of 47 out of 70.
Sub Total	784	
Weighted to 95%	745	
E – Overall	50	Complete submission with excellent presentation.
Total Score	795	
Rank	2	

A. Consortium:

Each of the consortia appear complete in terms of both members and principal advisory teams.

All are more complex as a result of both, a use of local firms and, in two cases, new market entrants. All of the Consortia, with the exception of Bidder 2, use Joint Venture structures to deliver elements of the contract. The guarantees around these were explored where the companies comprising the proposed joint venture were not sufficiently large to deliver the relevant contract on their own.

B. Construction:

Bidder 4 scored lowest in this section with a weighted score of 153 from a maximum of 250. The other Consortia scored as follows, Bidder 3 -183, Bidder 1 - 213 and Bidder 2 - 226. All scores were generally consistent across all the scored questions, however Bidder 4 did not answer the questions relating to health and safety and staff turnover so scored 0 on questions B15, B16, B17 and B23.

C. FM Services:

Each company undertaking the FM services was scored and the scores averaged to produce an overall score for FM services. Only Bidder 2 used a single provider for both Hard and Soft FM services. The Consortia scored as follows, Bidder 4 - 172, Bidder 3 - 223, Bidder 2 - 231 and Bidder 1 - 192.

D. Advisers:

All Consortia had their key advisers in place and all were scored against the following sections (architect, health planner, M&E, structural, legal and financial). The Consortia's architects were weighted for 30% of the score for Section D, all other advisers 15%, with the exception of structural advisers which were attributed 10%²⁸. Where Consortia had proposed joint advisers the lead adviser was scored. No advisers' scores gave cause for concern. The scores from the Detailed Evaluation in respect of advisers are detailed in Table 7.8 as follows:

Table 7.8 Scores from the Detailed Evaluation of in respect of advisers

Adviser	Bidder 4	Bidder 3	Bidder 2	Bidder 1
Architectural	63	46	57	47
Health Planner	21	45	48	55
M&E	41	48	43	53
Structural	41	54	29	50
Legal	63	53	55	52
Financial	61	56	42	63
Weighted Total	50.9	49.5	48.2	52.5

7.2.4. Conclusion of PQQ Evaluation Process

Following this intensive scrutiny of their PQQ Responses, it was deemed appropriate to invite all 4 Bidders into the next stage (Stage 2A) of the Competitive Dialogue process. Through the process of competitive dialogue, discussion would take place on the areas identified as potential weaknesses and issues addressed.

The detailed PQQ Evaluation Methodology and Report are detailed in appendix 7.02 and 7.03.

²⁸ Based on Standard Form PQQ Questionnaire for GB Projects
Final Version
Date: 6th August 2009

7.3. STAGE 2 - COMPETITIVE DIALOGUE

As stated in the OJEU notice (Chapter 1, Appendix 1.08) it was envisaged that a maximum of five bidders and a minimum of three bidders would be invited into the Competitive Dialogue Stage. Thus the four pre-qualified bidders entered this stage. The principles under which the Trust would run the competition were clearly specified as follows;

- **Fair:** Bidders would be treated with equity and each afforded the same opportunities throughout the competition.
- **Transparent:** The methodology would be clearly outlined and shared. Rationale for all key decisions underpinning the methodology would be shared.
- **Auditable:** The process would be robust and stand-up to external scrutiny with build-in quality assurance for both internal and external sources.
- **Confidential:** The Trust would operate the competition in a manner that would respect the high level of commercial confidentiality inherent in the process.

7.3.1. Competitive Dialogue

The Trust was directed to use the Competitive Dialogue following the new procurement regulations, mandatory since January 2006. As already stated, this new procedure was to be used to deliver the Project, given its complex nature. In light of this, the Trust has had to develop bespoke documentation, as a great deal of precedent developed with the old negotiated procedure was no longer relevant. Beyond this, as the procedure is entirely new, this Project in effect the ‘pathfinder’ for Competitive Dialogue in Healthcare Projects in Northern Ireland, which inevitably has meant a lot of new considerations and issues to be dealt with and solutions developed. Finally, as a procedure, Competitive Dialogue requires that the processes seek to achieve commercial certainty as to the proposed solutions offered by each of the bidders prior to closure of the dialogue as the Public Contract Regulations 2006 prohibit negotiation / dialogue with a bidder after the closure of that phase.

Throughout the Competitive Dialogue process the Trust has strived to treat all bidders fairly, to afford each of them the same opportunity for dialogue and have sought to ensure that the process is transparent.

The sections below outline each of the stages carried out by the Trust in more detail.

7.3.2. Stage 2A- Strategic Approach

The four Bidders were shortlisted from the PQQ process and were issued with the Invitation to Participate in Dialogue – Strategic Approach document (IPID-SA) which incorporated a list of ten questions that the Bidders had to respond to within six weeks. During this phase Bidders were afforded some high level interaction with the Trust in order to develop their responses to the ten questions in relation to Design, Human Resources, Facilities Management, Finance, Project Management and Socio Economic. The evaluation of responses determined which three Bidders were invited to participate further in the dialogue and, therefore, which Bidder was

deselected from the procurement process at Stage 2A. This resulted in Bidder 4 being de selected at this stage as they achieved the lowest overall score.

Each question/response was separately scored, taking into account one or more of the following key criteria:

- *Approach* – how far the project would be run in accordance with the Trust’s values and working philosophy;
- *Deliverables* – how far the Bidder understands what the Trust wants and is prepared to deliver it; and
- *Innovation* – to what extent can the Bidder offer solutions which offer the potential for increased capacity, efficiency and value for money.

The detailed methodology for Stage 2A is set out in appendix 7.04.

As a result of Stage 2A, three Bidders (Consort, DirectHealth & Northern Ireland Health Group) were issued the Invitation to Participate in Dialogue document (IPID) and invited into Stages 2B to 2D of the Dialogue. Erne Health Care Group were de selected at this Stage as they achieved the lowest overall score.

The Evaluation Report for Stage 2A is detailed in appendix 7.05.

7.3.3. Invitation to Participate in Dialogue (IPID)

The Invitation to Participate in Dialogue document (IPID) was issued to the 3 Bidders.

This was a detailed document containing 7 volumes of information, with the purpose of:

- Reaffirming the background to the Project;
- Confirming the scope of the Project;
- Providing an explanation of the conduct of the IPID process and procedures to be followed during the remaining Stages of the Dialogue (Stages 2B-2D) and culminating in the Final Bid submission (in response to the Invitation for Final Bids (IFB));
- Outlining details of responses and Deliverables required during stages 2B to 2D and an indication of what will be required during Stage 3, IFB;
- Setting out Trust Requirements for the Project, including clinical and non-clinical Output Specifications; and
- Issuing the South West Acute Hospital Draft Project Agreement.

Western Health and Social Care Trust
Full Business Case

This IPID was structured as follows:

Volume No	Volume Title
1	Introduction
2	Clinical Services
3	Design & Construction Requirements
4	Facilities Management
5	Equipment
6	Legal
7	Finance
8	Bid Deliverables
9	Exemplar Design

Whilst the IPID and previous Trust documentation had contained certain high level objectives and aspirations (including the four underlying principles outlined in bold below) ultimately it was only by the application of the Evaluation Criteria set out in Table 7.9 that a decision could be made as to which Bidder would be successful on this Project. Bidders were asked to be mindful of this when formulating their response to the various stages of the competition and ultimately the IFB.

Underlying Principles:

- **Approach** – to what extent the project would be run in accordance with the Trust’s values and working philosophy;
- **Deliverables** – to what extent the Bidder understands what the Trust wants and is prepared to deliver it;
- **Innovation** – to what extent can the Bidder offer solutions which offer the potential for increased capacity, efficiency, sustainability and value for money; and
- **Compliance** - acceptance of the South West Acute Hospital Draft Project Agreement and Payment Mechanism.

The evaluation of submissions in respect of the IPID Stage 2D and IFB stages was be based on the following Evaluation Criteria:

Western Health and Social Care Trust
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Table 7.9 Award Criteria / Weightings

Award Criteria	Weighting
Organisational Fit	5%
Project Management	5%
Design and Construction (including equipment& ICT)	35%
Facilities Management	20%
Human Resources	10%
Legal	10%
Financial (including insurance and payment mechanism)	15%
Total	100%

NB: Included within Design & Construction, Facilities Management, Human Resources and Project Management are the socio-economic criteria with a combined total of 5%.

To enable a more interactive process with Bidders and make best use of project team and specialist advisors the award criteria were sub-divided into associated specialised work streams, each work stream was allocated a number of deliverables as outlined overleaf.

Table 7.10 below shows the allocation of the award criteria and how they are evaluated over the work streams / deliverables.

Table 7.10 Allocation of award criteria / weightings over work streams / deliverables

Award Criteria	Weighting	Workstreams / Deliverables
Organisational Fit	5%	A - Design & Technical (1%) B - Facilities Management (1%) C - Finance (1%) D - Legal (1%) E - Project Management (1%).
Project Management	5%	E - Project Management (4%) E - Socio-economic (1%)
Design and Construction (including equipment& ICT)	35%	A - Design & Technical (including commercial) (26.44%) A - Equipment (3.06%) A - Socio-economic (2%) G - ICT (3.5%)
Facilities Management	20%	B - Facilities Management (19%) B - Socio-economic (1%)
Human Resources	10%	B - Human Resources (9%) B - Socio-economic (1%)
Legal	10%	D - Legal (including commercial) (10%)
Financial (including insurance and payment mechanism)	15%	C - Finance (13%) F - Insurance (2%)
Total	100%	

Social and Economic Regeneration Planning

As indicated in Table 7.10, a total of 5% was allocated for socio-economic. Bidders were required to make it clear that they would work with local communities, for the social and economic benefit of local communities. Bidders were required to provide a Social and Economic Regeneration Plan (SERP) for the project covering the following:

- Provision of employment, skills training and placement opportunities
- Tackling social exclusion and long term unemployment
- Promoting equality and diversity
- Maximising supply chain opportunities for social enterprise, micro organisations and SME's
- Providing opportunities for meaningful community engagement

A further breakdown of the evaluation sub-group weightings (by deliverable) and reconciliation with the overall award criteria is provided in Appendix 7.06 detailed weightings and breakdown²⁹.

7.3.3.1. Workstream Deliverables

The Bid Deliverables (workstream requirements) were devised by the Project team and its specialist advisors within the ten dedicated workstreams. The Deliverables were fine-tuned for each Stage of the project and initially incorporated into the IPID (Stage 2B, 2C & 2D deliverables).

Workstreams
Design & Technical
Equipment
Facilities Management
Human Resources
Finance
Legal
Project Management
Insurance & Commercial
ICT
Socio-economic

Organisational fit had no specific deliverables, but was evaluated within the Design, Legal, Financial, Facilities Management & Project Management workstreams. Each workstream was tasked with awarding a score in relation to organisational fit based upon their experience with each bidder during the course of the dialogue.

²⁹ This criteria was developed by SIB based on evidence of best practice and in conjunction with key project stakeholders. In overall terms 5% of the overall weighting was allocated to socio and economic factors which was felt to provide adequate emphasis on this element of the project.

Bidders were asked to comply fully with the detailed requirements within the deliverables and told that failure to provide the requisite information could result in the Bid submission being deemed non-compliant and the Bidder being excluded from the remainder of the competition.

During the remainder of the Dialogue process (Stages 2B-2D) more detailed information was required from the remaining three Bidders as detailed in the subsequent sections.

7.3.4. Stage 2B – Preliminary Design Concept

Following the completion of Stage 2A, three Bidders were invited into Stages 2B to 2D of the dialogue.

The Project Team engaged with Bidders for an eight week period via regular workstream meetings prior to the Bidders' Stage 2B submission - Preliminary Design Concept. Following the evaluation of the Bidders submissions, the Trust provided formal feedback to the Bidders.

The Stage 2B Interim Submission was intended to achieve a number of deliverables including the following:

- identify the Preliminary Design Concept;
- gain confirmation from Bidders that they agree with the FM Specifications;
- provide an assessment of the Bidders' FM service cost for the proposed services specified in the FM Specifications;
- identify a Project Management Plan for the Bid Stage and beyond; and
- provide an ICT Strategy Paper on the Procurement of ICT networks within the scheme.

At this stage each bidder was asked to submit it's comments on the first draft of the project agreement for the first time. To ease the understanding of these comments, they were asked to submit both a mark up of the project agreement and associated commentary explaining the project specific rational for each comment.

The Stage 2B evaluation methodology is set out in appendix 7.07.

Bidders demonstrated a professional approach in their submissions and presentations of their Stage 2B Preliminary Design Concepts. Evaluation teams were established for each work stream (Design & Technical, Project Management, ICT, Equipment and Facilities Management). Evaluation Teams were made up of Project members, clinical staff, project advisors and Health Estates staff.

The Evaluation required input from the Project Team, Health Estates and Specialist PFI Advisors and an agreed evaluation under each work stream. The team agreed on the positive points, negative points and areas for improvement for each deliverable and for each consortium. The lead person from each work stream was responsible for compiling a report summarising the submissions. The entire evaluation team held a meeting to agree the overall evaluation and feedback for Bidders. Representatives

from each work stream justified their evaluation to other representatives who had not been involved in reviewing the submission.

Feedback was given to Consortia on each of the deliverables. Project Team representatives summarised to the Bidders the positive and negative aspects of their proposal and areas where they would like to see the consortium improve and further develop for the next stage submission. With regards to design this largely related to internal patient flows, ward layouts, clinical adjacencies and departmental relationships. Bidders welcomed the feedback, and indicated that it would help them in the next stages of the process.

The evaluation report for Stage 2B is set out in appendix 7.08A and appendix 7.08B.

7.3.5. Stage 2C – Firm Design Proposals

The Project team engaged with the Bidders (across all workstreams) for a further five weeks prior to the submission of, amongst other things, the Firm Design Proposals. These were reviewed by the Trust, who then provided formal feedback to each Bidder.

Interim Submission 2C was intended to achieve the following:

- Provide a commentary on Draft Payment Mechanism calibration issues;
- Submit Firm Design Proposals including approximate elemental construction cost breakdown and preliminary proposals for whole life costs, replacement, maintenance and sustainability of the building and plant (a number of 1:200 departmental drawings³⁰);
- Provide re-confirmation from Bidders that they agree with the FM Specifications;
- Provide an overview of Bidders' proposed service delivery provision;
- Identify FM costings on a service by service basis;
- Submit high level proposals on mobilisation and service set-up; and
- Provide a review of the Project Management Plan.

The detailed methodology for Stage 2C is set out in appendix 7.09A and 7.09B.

As per Stage 2B the evaluation required input from the Project Team, Health Estates and Specialist PFI Advisors and an agreed evaluation under each work stream. Once again the team agreed on the positive points, negative points and areas for improvement for each deliverable and for each consortium. The lead person from each work stream was responsible for compiling a report, summarising the submissions. The entire evaluation team held a meeting to agree the overall evaluation and feedback for Bidders with representatives from each work stream justifying their evaluation to other representatives who had not been involved in reviewing the submission.

³⁰ 1:200 's are departmental room relationship drawings

Bidders demonstrated significant progress in design development since Stage 2B. They further refined their proposals and in most cases incorporated the feedback given at Stage 2B. Whereby feedback at Stage 2B was not addressed in the Stage 2C submission, the Trust highlighted the requirement for additional dialogue to ensure that each solution met the Trust's needs. On the whole, the submissions at Stage 2C generally moved from conceptual proposals to specific specifications for design and building systems. Similarly their FM proposals demonstrated an improvement from Stage 2B, whereby service delivery proposals were further developed and their FM structures were more detailed.

In the Finance and Payment Mechanism workstream, Bidders generally demonstrated a good understanding of funding proposals. They provided a useful commentary on the Payment Mechanism Calibration model. The Bidders also addressed their short comings of Stage 2B by providing their Project Management Plans.

Following feedback to the bidders (from the Trust and its advisors) on Stage 2C of the Competitive Dialogue, the project team actively engaged with Bidders to address any weaknesses in their submissions and prepared for Stage 2D.

The Evaluation Report for Stage 2C is detailed in appendix 7.10.

7.3.6. Stage 2D - Preliminary Total Package Offer

7.3.6.1. The Stage 2D Process

The Trust engaged with Bidders from April 2007 on Stage 2D – the Preliminary Total Package Offer. At this Stage, Bidders were required to submit a fully priced Bid to the Trust. The detailed requirements for this Bid are set out in the Stage 2D Deliverables in appendix 7.11. These mirror the Stage 3 deliverables that would form the Final Bid requirements and thus covered all aspects of the Project in extensive detail; design and technical, equipment, facilities management, human resources, finance and payment mechanism, legal, project management, commercial and insurance , ICT and socio economic.

The initial submission date for Stage 2D (01 June 2007) was extended as further dialogue was required owing to the introduction of a Mandatory Variant Bid for Hard FM only as detailed in Chapter 1. Consequently, after extensive dialogue across all workstreams, the Stage 2D - Preliminary Total Package Offer was submitted on 03 August 2007.

Each workstream was required to review and evaluate the Bidders' submission for that workstream. This was quality assured by the appropriate person(s) responsible, who challenged where necessary. The person designated as quality assesor was usually the most senior person within the team. For example, in the finance workstream, the Assistant Director of Finance (Capital Planning), in HR, the Assistant Director of Employee Relations and in FM, the Assistant Director of Facilities Management. Where possible each of the Assistant Directors were assisted in the evaluations by a senior advisor from the appropriate workstream. Evaluation

reports were subsequently amended to reflect the quality assurance process and issued to the Project Team.

This process reflected the detailed Stage 2D evaluation methodology set out in appendix 7.12.

7.3.6.2. Stage 2D Evaluation

This evaluation was regarded as a very important stage in the process. It was the Project Team's intention to evaluate the submissions, provide the feedback to Bidders and progress to the next stage of the procurement process. Progressing to the next stage (Stage 3) would mean that the Trust was satisfied that; solution or solutions offered would meet the Trust's needs and objectives and commercial certainty was established. This means that in all material respects, the Trust felt that during the course of the dialogue and in Final Bids it had gained a detailed understanding as to what the Bidders were proposing in terms of all the key elements of their Bids; design, finance, legals, human resources, facilities management, socio economic, etc. The need for such certainty arose because of the restrictions upon negotiation following Bid Submission and the need to reach Financial Close whilst only clarifying, specifying and fine tuning the Preferred Bid. The recently published OGC guide to Competitive Dialogue confirms this and states that the 'the Contracting Authority must be confident that the likely form of final solutions which Bidders have indicated during the dialogue phase that they will provide, are likely to be acceptable.'

Further to evaluating Stage 2D Submission (August 08), the Trust and its advisors were not satisfied that commercial certainty had been achieved. This was due to a number of unresolved workstream issues and unforeseen issues that came to the fore following the Bidder Stage 2D Submission in August 2008. In particular the following required extensive dialogue with bidders:

- the Impact of the Landslip;
- the One off Cash Injection;
- the Ministers' decision on the removal of cleaning from the suite of Soft FM services; and
- the impact of the decision in relation to 100% single room provision.

The key issues that were pertinent to each workstream during Stage 2D and the action taken by the Trust are set out in the following paragraphs

7.3.6.3. Design & Technical Workstream:

The design and technical proposal by each of the three bidders at Stage 2d was such that the Trust and its technical advisors were unable to establish certainty on the content of each Bidders technical proposal and some aspects of design. The lack of technical certainty largely related to the Trust's Construction Requirements that was insufficiently worked up by the bidders. Also the design of the FM areas were not sufficiently developed, nor was there appropriate consideration given to interface issues with the Trust Soft FM provision. Thus further dialogue was required with all bidders (post Stage 2D submission) to achieve a design freeze that met the Trust's

objectives prior to closing the dialogue. The dialogue was largely related to 1:200 and 1:50 designs, patient/public routes, patient flow department to department, patient supervision, lift cores and design of external FM areas.

Staff and Community Engagement

Crucial to the design development was the involvement and interaction with staff across key specialties. To enable this, a programme of progressive engagement has been implemented since 2004 to involve staff, as well as representatives of the local community in design developments. This engagement has proved to be instrumental in pre-empting issues and in developing the design to the highest standards of best practice by working with those who will be staffing and using the facilities. A prime example of this is the involvement of people with a disability and officers from disability action groups who have been working with the project team to ensure that the buildings will meet the needs of a diverse range of users of all abilities. (Refer to Table 7.11 below).

Table 7.11 Meetings that took place to involve staff and community groups in design developments

Group	Role	Membership (No's)
Sketch Design Groups	Review and Develop Design at Departmental Level. (1:200 drawing)	105 - Reps from all key hospital departments.
Staff Design Forum	Whole Hospital Review of Design. Application of ASPECT design evaluation tool.	34 Members - Reps from all key hospital departments.
Clinical Reference Group	Senior Clinical Staff that lead Departmental design reviews. Act as key liaisons with all staff within their relevant departments.	16 Members
DBS Communications Group	Oversee the implementation of a comprehensive programme that includes regular staff and community engagement.	8 Members
Patient Environment & The Arts Committee	Maximise the contribution of art within the hospital.	6 Staff Members
Community Design Evaluation Forum	Includes 4 political reps, one from each local political party nominated through Fermanagh District Council. Also representatives from multi cultural groups, older peoples, disability and women's groups. It includes people with a disability. Review whole hospital design and apply ASPECT Design Evaluation tool.	Approx 12 Members

Many engagement forums for the New Acute hospital have been in place from the early stages of the project and have provided a constant and interactive feedback throughout the development of the project. This feedback has been captured in

minutes of meetings and actions lists. Samples of these are provided in the Engagement Summary document set out in Appendix 7.13. The AEDET and ASPECT evaluation reports also provide details of the Community and Staff design evaluations of final tenders.

The AEDET Toolkit (Achieving Excellence Design Evaluation Toolkit) was applied to design proposals for the New Acute Hospital for the South West (NI) to enable a holistic view of bidder submissions. AEDET is designed to address all aspects of design and does this by focusing on three core layers, Impact, Functionality and Build Quality, divided into 10 categories. The AEDET toolkit can be referred to in appendix 7.14.

ASPECT enables an evaluation of staff and patient environments and covers key areas that can impact on staff and patient satisfaction, the health outcomes of patients and the performance of staff. This includes perspectives of internal spaces, layout, wayfinding, quality of interior environment, adequacy of facilities and a focus on staff areas. ASPECT looks very specifically at staff and patient environments, and delivers a profile that indicates the strengths and weaknesses of the design. This toolkit is detailed in appendix 7.15.

Competitive Dialogue: Key Issues

Extensive dialogue was also required throughout Stage 2D on the following key design and technical issues:

a) Landslip

Following the commencement of the enabling works contract in April 2007, an unexpected ground slippage occurred on 13 September 07 which affected a portion of low-lying land towards the front of the site, planned for car parking.

The landslip affected an area of approximately 250 metres by 100 metres on plan in the South East section of the site during ‘controlled up filling’³¹. It was estimated that lateral movement in the order of 20 metres had occurred at the centre of the slip. The contractor was instructed by Health Estates to conduct no further work in this area which prevented some of the planned cutting from the south region of the site and filling over the slip region. Material was excavated out at the top of the slip to reduce load on the slip plane and once the slope was stabilised, detailed site investigations commenced to determine the cause of the slip.

Discussions took place with all Bidders informing them of the landslip and the options for addressing the remedial work required. Concerns from the bid teams in terms of their funders requirements for warranted survey information, transfer of risk to the Trust of future slippage in the landslip area and warranty associated with any proposed remedial works resulted in a decision to remove the remedial

³¹ *Filling of low lying land in layers of stone and fill material in controlled manner observed by resident site engineer.*

works from the Enabling Works Contract³². Health Estates, in conjunction with the Exemplar Design Team advised the Trust and DHSSPS that Capital Costs should be updated to include for landslip remedial works. As a result, Bidders were given a new affordability envelope and a new construction programme (extension of three months). This resulted in an uplift to the PFI Capital Costs to facilitate additional expense and time required for the remedial works of the landslip. All associated consequential risk with the landslip remedial work and the settlement of any future construction in that area was then transferred into the PFI Hospital Project.

The landslip area will be sealed over prior to the end of the Enabling Works Contract and left for remedial works by the successful PFI Bidder in a manner that best suits their design solution.

This way forward was agreed with an External Advisor to Health Estates, who was commissioned to quality assure the aspects of design relating to the landslip remediation. The Trust's legal advisors were also involved throughout the process.

Following significant dialogue with the Bidders to discuss their individual design proposals in dealing with the landslip, their design solutions were reviewed by members of the Exemplar Design Team (EDT) and Health Estates and these were considered to be satisfactory.

b) Planning

An Outline Planning Application for the New Acute Hospital facilities and associated parking, landscaping and ancillary functions, together with an Environmental Statement, was submitted to DOE Planning Service (Omagh Office) on 5 August 2005. Refer to Appendix 7.16 for the Planning Conditions.

An 'Article 31' determination was made and the application referred to DOE Headquarters for a Notice of Opinion resulting in the granting of Outline Planning on 13 September 2006.

During the Competitive Dialogue process the Bidders liaised with Planners on an ongoing basis on their individual design solutions. Two Bidders were advised they would be required to submit a full Planning Application as their design was not deemed to be similar to the exemplar layout. The other Bidder was advised that they could submit a Reserved Matters Application, as their design was deemed to be similar to the exemplar design. All Bidders applications have now submitted. Health Estates lead on this process for the Trust.

Bidders will be required to submit a separate planning application for the removal of materials offsite but this is entirely dependent of their design solution. The risk

³² *The Enabling Works Contract is on-going with the area of the landslip removed from the contract for repair under the PFI project. The cost of uncompleted work in this area has been deducted and the loss may be recoverable under the insurance provisions.*

associated with this is borne by Project Co and relates to their hospital design. If they need to remove further soil/fill material from the site to suit their design then they will require planning/waste licensing approval to dump this material off site.

The original Outline Planning Approval placed conditions on the development and this included the requirement to provide a secondary access and route for pedestrians and cyclists from the Cherrymount Roundabout (several hundred metres from the site). The Secondary Access Route (Blue Light Route) is best served via Drumcoo as shown on the original exemplar design, due to the layout of the existing roads and the difficulties in getting secondary access routes that provide a true alternative if the main A32 entrance became obstructed. As this area is outside the site boundary of the PFI site layout and involves a right of way over the existing DHSSPS retained estate it was decided that the cleanest way to handle this was for the Trust to provide this outside of the PFI process. As this work is outside the original planning approval boundary the Trust are currently progressing a separate application for this work and the route for a cycle path along the A32 road.

The Secondary Access tender report will be issued to Trust Board, for approval, prior to the Trust Board meeting scheduled for 8th January 2008.

c) *Trust Construction Requirements*

In very simple terms the Trust Construction Requirements (TCR's) details '*what the Trust wants in technical specifications*'. The TCR's is an overarching document which defines the design quality specifications for the project. In the document, the Trust details what the Bidder is expected to provide in terms of the following areas:

- Design quality requirements;
- Site requirements;
- Compliance with standards and regulations;
- Build quality, including specification and building performance; and
- ICT network

The TCR is a legal document that binds the Bidder to deliver on the above.

The TCR requirements were more stringent at this stage of the process than existed under the old negotiated procedure. Consequently considerable Dialogue between Health Estates, PFI Technical Advisors, the Trust team and the Bidders was required to ensure that certainty was achieved at an earlier stage in the process than under the negotiated procedure.

d) *Single Rooms*

In line with DHSSPS guidance and clinical forward planning, the Trust requested Bidders to consider the flexibility of their designs to accommodate a higher percentage of single rooms (at minimal cost impact). Thus, during the course of the dialogue the position of 100% single room provision evolved. 100% single room provision will generate several benefits for the new acute hospital. It will

improve clinical outcomes and result in a reduction in the incidence of clinical errors including healthcare associated infection. In addition, it provides for enhanced privacy, dignity; and overall satisfaction for the patient. Finally 100% single bed provision will provide flexibility in the utilisation of bed spaces and will potentially increase patient activity. The case for 100% single room provision is supported in DHSSPSNI PEL (08)07³³

e) Energy

Considerable dialogue involving Health Estates, Exemplar Design Team, Trust, Technical advisors and Bidders was required to reach an agreed position with regards to Energy. This has been important, especially in relation to Biomass solutions, in that Bidders were required to meet new, stringent Government energy targets.

Following extensive dialogue it was agreed (and endorsed by Health Estates advisors) that Project Co would not be required to take on the tariff or supply risk for biofuels,. Thus there are no costs within the PFI unitary charge with regards risk. The Trust takes all risk on price fluctuation and availability in relation to Biomass, similar to all traditionally procured hospitals in NI. However, the Trust will require Project Co to set up supplier purchasing agreements on behalf of the Trust with invoices to be paid directly by the Trust.

In addition it was agreed and is covered in the Project Agreement that:

- Project Co should also make all reasonable efforts to acquire locally produced bio fuels, but where independently validated that the fuels are not available, then the Trust reserves the right to either purchase from another supplier or relax the Carbon Target and direct the operation of an oil fired boiler plant. The Trust reserves the right to review any bio fuel supplier purchasing agreement and test the same for value for money on an annual basis.
- Project Co will be responsible for managing fuels and any resulting waste including the correct removal and disposal from site of such waste.
- The Trust will not take on an obligation in relation to compliance with Encode.³⁴ However, the Trust does acknowledge that, as part of the staff awareness of energy use, and conservation, there should be certain measures adopted. Therefore, the Project Agreement does contain some ‘good housekeeping³⁵’ measures which will form the basis of a best endeavour requirement on behalf of the Trust.

f) Patient Environment and Arts

³³ DHSSPSNI PEL (08)07 " the following standards are applicable: All new build general ward accommodation should be planned on the basis of 100% single rooms; (separate standards are applicable to speciality areas such as critical care and maternity); Pg 1 of 2

³⁴ Encode is a Health Technical Memorandum (HTM), which provides primary guidance on energy efficiency. It is not prescriptive, but provides best practice.

³⁵ Such as closing windows and turning off electrical appliances when not in use.

Some dialogue was required on the Trust's expectations in relation to Patient Environment and Arts. Further to receiving advice from Health Estates and the DHSSPS the Trust set out their requirements - to develop a successful programme of integrated arts for the New Acute Hospital for the South West, bidding Consortia were expected to:

- articulate a clear artistic vision for the new developments outlining what they propose to do, how they propose to do it, and the intended outcomes;
- to provide a vision that was 'artist led' and drive resulting interventions with a cohesive approach to the Patient Environment & The Arts Programme;
- to provide added value in the design of the facilities by incorporating creative treatments in the fabric of the building; and
- to demonstrate the incorporation of artistic involvement in the areas of interior design, wayfinding and landscaping as a minimum requirement. These interventions, which are in-built in the construction of the building will be referred to as 'Built-In' Artistic interventions. Examples of such interventions could include ceilings, floorings, glassworks, landscaping, fixed furnishings etc.

Overview of Design & Technical Workstream

There were many interfaces with the Design and Technical workstream, including, Equipment, ICT, Facilities Management, Finance, Legal and Workforce. Prior to closing the dialogue, the Project Team and Health Estates ensured that all of the other workstreams had identified and resolved key issues that would have an impact on design.

The Dialogue led to development of the Exemplar Design and all the Trusts supporting requirements to high standards and specifications.

The exemplar design. review resulted in some changes in department SOA's such as;

- Single room provision;
- Clean utility increased to accommodate pharmacist base - service dev, patient accommodation;
- Assisted WC adjacent to relatives WC;
- Nappy changes - standard no longer allow for nappy changes to be included in WC;
- Endoscopy scope clean increased to achieve standards as required per Hine Report 2004;
- IT Hubs increased - service requirement;
- Cleaners / disposal hold - more required through design development; and
- External / Receipt and distribution area was left out at beginning.

Health Estates were fully involved in design process throughout Competitive Dialogue. Other key stakeholders included Project Team, Exemplar Design Team, Clinical Staff and Technical Advisors. The overall design process was overseen by Health Estates and quality assured at key stages by Mr John Cole, Chief Executive, Health Estates who acted in the role as 'Design Champion'

Following extensive dialogue with the Bidders on the matters identified above and general Design & Technical issues, Health Estates and the exemplar design team felt that satisfactory design and technical proposals had been developed and a sufficient level of certainty had been achieved to close the dialogue in February 2008. However we anticipate that Health Estates will continue to work with the Preferred Bidder on final design up until Financial Close. There is a procedure built into the process (in the Project Agreement) to allow for refinement of the design in conjunction with Health Estates and the Trust – Schedule 8 Part 5, Reviewable design data and Schedule 10, Review Procedure.

7.3.6.4. Facilities Management Workstream:

The approved procurement route in Acute Phase 2 OBC was based on the assumption that Soft FM would be included in the scope of services of the PFI provider.

The OJEU notice (Chapter 1, Appendix 1.08) and subsequent project documentation³⁶ proposed the inclusion of Soft FM as part of the scheme scope, however this was quantified with ‘where VfM can be demonstrated’

Accordingly all Bidders worked with the Project Team in developing both hard and soft service methodologies throughout the competition.

However, during Stage 2D, the Trust advisors (Legal, FM, Strategic Investment Board (SIB) and Health Estates Agency) advised the Trust of the potential risk of Bidders being unable to ‘beat’ the Soft Services Public Sector Comparator and therefore not demonstrating value for money. In such circumstances, soft services could not be included in the scope of services.

Whereby this position was not known until after the closure of the dialogue, new procurement regulations would require that the Trust go back to Stage 1 of the Procurement Process i.e. OJEU notice and subsequently open up dialogue again. This would result in: very significant nugatory spend from Bidders, advisors and internal project team; significant delays on project delivery; inflationary costs and loss of confidence from Bidders.

To safeguard against this, the Trust, in conjunction with Health Estates Agency and SIB, and following discussions with the DHSSPS, introduced a Mandatory Variant Bid at Stage 2D for Hard FM only.

Therefore Bidders were required to submit two bids at Stage 2D:

- Core Bid - Include Hard & Soft Services (Soft FM Value for Money Test would be applied to Soft Services – Refer to Chapter 1, appendix 1.1A)

³⁶ Sections of the IPID-SA and IPID that refer to ‘where value for money can be demonstrated’ is included in Chapter 1, appendix 1.11.

- Mandatory Variant Bid - Include Hard FM Services Only

The Facilities Management services for the Core and Mandatory Variant Bids at Stage 2D are illustrated in Table 7.12 overleaf.

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Table 7.12 – Services included within the scheme

<u>FM Services</u>	<u>Core Bid requirement</u>	<u>Mandatory Variant Bid</u>
Hard FM		
General management	✓	✓
Hard FM only Help Desk Service	✓	✓
Grounds and Gardens Maintenance Service	✓	✓
Utilities Service	✓	✓
Estates Service	✓	✓
Soft FM		
Soft FM Help Desk Service	✓	
Cleaning	✓	
Portering Service	✓	
Hospital Reception Service	✓	
Pest Control Service	✓	
Security Service	✓	
Car Parking Service	✓	
Catering Service	✓	
Linen Service	✓	
Waste Service	✓	
Telecommunications Service	✓	

At Stage 2D the Trust required the Services above to be provided within the new hospital. These services were required for the PFI buildings only within the site of the scheme i.e. not required for any of the Trust's retained estate. This is with exception of the catering service where Bidders were expected to provide the cooked meals for community facilities around Enniskillen, with the Trust delivering these to the community facilities. This is in line with current practices whereby meals are cooked in the Erne hospital and distributed to the various community facilities. If meals were to be cooked at the respective facilities, significant capital investment would be required to produce the food, notwithstanding the resource requirement to complement this

The Stage 2D evaluation focused on the Core Bid first (i.e. Bids inclusive of Soft FM services). Once the Soft FM VFM Test was completed on each Core Bid (including any clarifications that were necessary), the Trust then determined whether it was necessary to evaluate the Hard FM Mandatory Variant Bids.

The outcome of the Soft Services Value for Money Test at Stage 2D was that one Bidder demonstrated value for money (Refer to the Soft Services VFM Evaluation

Report in Chapter 1, Appendix 1.12B and Soft FM Chronology in Chapter 1, Appendix 1.13). Based on the framework above, this led to:

- The Request of Hard FM only Core Bids at Stage 3; and
- The Invitation to all three Bidders to submit a Voluntary Variant Bid at Stage 3, which includes Soft FM services.

As the Core Bid would eventually be the Hard FM only bid, it was paramount that the Trust were satisfied with the Bidders Stage 2D proposals. Whilst the service delivery methodologies for Hard FM did not pose significant problems, the FM team were not satisfied that the interface with the in-house provision for Soft FM was appropriately addressed.

Consequently further dialogue was required on issues such as FM accommodation design to ensure that the in house provision of soft FM could be performed in an efficient manner in keeping with the Trust Operational Policy. This involved Trust service managers reviewing Schedules of Accommodation for the FM areas in discussion with the DBS design team. Due to the fact that bidder designs were at this stage well developed some compromises were made between Trust FM staff and the bidders. A series of meetings for FM design review had to be arranged.

The attendees at these meetings were Trust FM advisors, Trust service managers, Project design manager and the Design and FM teams from the bidders.

In preparation for Stage 3, the Trust sought clarity from the Bidders on their intention or otherwise to submit a voluntary variant for Soft FM. The one Bidder who did demonstrate value for money confirmed their intention of submitting a voluntary variant for Soft FM at Stage 3, whilst the other two Bidders confirmed that they would not submit a voluntary variant as they did not anticipate that they could demonstrate value for money.

However this position changed following the ministerial decision (in November 2007) to remove cleaning from the scope of the PFI soft services. The Bidder, who throughout the process had demonstrated their enthusiasm for the inclusion of Soft FM in the scope of services, indicated that the removal of cleaning from the suite of services, had a significant impact on their bid. This was largely due to the dependency of multi-skilling in their previous Stage 2D bid, which was no longer feasible. Consequently, following intensive discussion with the Trust and internally with the bid team they decided to retract their voluntary variant submission for Stage 3.

At the end of Stage 2D, no Bidder was indicating that they would submit a Voluntary Variant for Soft FM.

Third Party Income:

There was considerable dialogue with Bidders in relation to Third Party Income (TPI). The level of income that Bidders guarantee for their TPI proposals will improve their affordability and thus lead to a lower unitary payment for the Trust.

Some of the Bidders proposals were:

- Retail activities;
- Cash dispensers; and
- Retail Pods.

Bidders were asked to pay cognisance to the following points in their TPI proposals:

- TPI proposals should have been discussed in advance with the Trust to ensure that there is a sufficient degree of detail at the point of submission. The dialogue process will have been completed and further negotiations cannot be entered into. If the Trust considers that a TPI proposal is not sufficiently well developed, to be taken forward without significant changes, it may at its absolute discretion choose to set aside the proposal and to not evaluate it.
- The sale of goods such as; alcohol, tobacco, firearms, pharmaceutical products; pets; pornographic products; any substance of a noxious or harmful nature; formula baby milk; baby goods; dummies and flowers are prohibited.
- Third Party Income proposals must not conflict with the Trust activities. This means that the items that Project Co sell must not compete with the Trust's catering provision. (Core Bid Only).
- Products should not be sold at prices which are far in excess of the average prices of such products at similar commercial retail developments.

Owing to these restrictions Bidders were required to refine their proposals. For example, some Bidders proposals to offer vending was deemed to conflict with the Trust's catering activities³⁷ and thus it was clarified with Bidders that the Trust would be responsible for this and retain any income associated with it.

In summary, dialogue within the FM workstream led to a greater understanding by all parties of the FM priorities. Consequently the FM workstream were satisfied that these key priorities had been sufficiently dealt with during the Dialogue and that commercial certainty had been achieved. As a result they confirmed in February 2008 that they were content to Close the Dialogue.

7.3.6.5. *Equipment Workstream:*

The Project Team recognises that an equipment strategy is vital to the successful operation of the project. The majority of Medical Equipment will be procured through a separate Business Case³⁸, which is currently with DHSSPS.

³⁷ *Catering will be retained by the Trust as Soft Services will not be included in the scope of the PFI. Therefore the Bidders TPI proposals should not conflict with the Trusts catering provisions ie they should not sell similar products as the Trust would offer via the catering provision as this would represent direct competition.*

³⁸ *Outline Business Case for Medical Equipment - November 2007.*

Therefore the Trust agreed the following requirements:

- A service for the Equipment provided by Project Co; and
- Project Co to work with the Trust and their selected Managed Service Provider (MSP) (if applicable) for medical equipment services regarding design, and mechanical and electrical provision of the medical equipment required in the New Facilities and standards of operational services. This relates to aspects of the design that requires the Bidder and Trust to ensure that the equipment and relevant rooms are 'fit for purpose' such as rooms within Imaging e.g. USS rooms- the mechanical services/ventilation requirements must be agreed. This will include such aspects as servicing and replacement strategy, environmental controls within agreed preset parameters e.g. cooling requirements. There has been intense discussions with HE specialist equipment advisor in relation to all 'specialist equipment'

The Project Team compiled an Equipment Responsibilities Matrix (ERM) based on the accommodation schedules of the Exemplar Design.

The Trust had determined that it wanted to place the responsibility for selected equipment with Project Co. All Category A equipment (traditionally known as Group 1 plus specified items of fixed equipment in Group 2– e.g. notice boards; cupboards; dispensers and worktops) and Category A* (specialist fixed medical equipment, e.g. theatre pendants and theatre lights) and Category FM* Equipment (e.g. fixed equipment such as cookers) would require a complete service (including replacement) from Project Co. Due to the nature of A* Equipment the Trust required that Trust representative will be highly involved in the equipment specification for such items of equipment which will be procured in accordance with the procedure set out in Schedule 13 (Equipment) to the South West Acute Hospital Draft Project Agreement.

Every effort was made to ensure that lessons learned³⁹ from other Projects were taken on board to ensure that the responsibility for equipment purchase, installation, commissioning, maintenance and lifecycling were incorporated.

In summary, Competitive Dialogue led to a greater appreciation of the complex PFI issues pertinent to the equipment workstream. As a consequence, this workstream confirmed in February 2008 that they were content to Close the Dialogue.

7.3.6.6. *Human Resources Workstream:*

As the procurement process moved through its various stages, the human resources dialogue enabled a comprehensive insight into what is to be expected from Project Co.

³⁹ Through hospital visits the Trust have obtained information relating to lessons learned from other builds such as showers in ensembles, equipment interface with mechanical engineering issues. The need to cross reference with other workstreams in relation to design review e.g. Fire drawings.

The Competitive Dialogue process was conducted in an open and constructive manner. It enabled the Trust to receive from each Bidder an acceptable submission which met the standards as required by the Code of Practice on Workforce Matters, the Government Actuary Department (GAD) and the Trust Equality Advisors. The initial responses from the Bidders on the Stage 2D deliverables highlighted a number of shortcomings that required further dialogue to achieve commercial certainty. This largely related to the shortfall for bulk transfer pension arrangements that GAD were not content with. GAD were given a key role in directing, negotiating and liaising on behalf of the Trust with each of the bidders actuaries to ensure that all issues regarding bidder pension provision were resolved to GADS satisfaction. An acceptable position was agreed by all parties (Bidders, Trust & GAD) by the end of Stage 2D.

There was also a lack of detail on the workforce issues i.e. terms and conditions and avoidance of two tier workforce. This meant that at Stage 2D the bidder had not provided enough detail in their submission on the terms and conditions to be offered to new recruits. Although the bidder stated their commitment to the avoidance of a two tier workforce there was insufficient clarity within the submission to support this. Bidders were then requested to complete a pro-forma which clearly outlined their terms and conditions and how this compared to the terms and conditions provided by the Trust.

Finally evaluation feedback from the Equality Advisors, indicated that further details were required from each bidder to satisfy the equality requirements of the project. These concerns were raised through the clarification process. Each bidder then subsequently provided an improved response indicating greater awareness and understanding.

The outcome of the HR Dialogue led to:

- clarity of the proposed FM workforce and associated costs;
- full details of the “no less favourable” terms and conditions to be offered to new recruits;
- an avoidance of a two-tier workforce;
- improved demonstration by Bidders on how they intend to fully meet and assist the Trust in meeting their equality objectives;
- a mechanism put in place for dealing with the redeployment of any surplus FM Omagh employees The PSC for Omagh indicates that a reduction in FM staff will arise in the delivery of FM services within the new Omagh hospital. To enable the Trust to offer any surplus staff an opportunity for redeployment a mechanism was put in place to ensure the preferred bidder for the new Acute Hospital considered surplus FM Omagh employees for any vacant positions within their workforce before recruiting on the open market.; and
- assurance from GAD in relation to Bidder pension provision.

Trade Unions were given access to the Bidder submissions, relating to HR aspects and asked for their comments. Meetings also formed part of this dialogue phase, with

opportunities for the Trade Union representatives to meet and discuss Bidders' HR submissions at Stages 2C and 2D. Trade Union representatives also had the opportunity to meet with GAD to gain a better appreciation of the type of pension schemes being provided. Trade Unions were asked to provide feedback on the information they received. This feedback was dealt with by incorporating it into the competitive dialogue process with bidders and into the evaluation process.

Any issues that may arise in the future with the preferred bidder will be dealt with via the consultative forums that will be set up both prior and post service transfer.

In summary dialogue led to a greater understanding by all parties in gaining a better appreciation of what the key priorities are in relation to the HR issues. As a result deliverables were amended for Stage 3 and strengthened to ensure fuller and more detailed explanations were given at Final Bids. The HR work stream confirmed that they were content to Close the Dialogue in February 2008.

7.3.6.7. Finance & Payment Mechanism Work Stream:

Payment Mechanism

The payment mechanism calibration model was developed during the dialogue to ensure that the unitary payment would be reduced in circumstances where service delivery falls below standard.

The unitary payment would be adjusted for the following reasons:

- RPI/ROE Uplift⁴⁰;
- Performance payment deductions;
- Energy; and
- ROE/Market Testing⁴¹.

Refer to appendix 7.17 for further detail on the above points.

Considerable work was done in relation to performance payment deductions and energy. Performance payment deductions occur in circumstances that rooms are unavailable or when quality thresholds have not been achieved. Significant dialogue occurred with Bidders to ensure an appropriate level of risk would be transferred to the private sector.

One-Off Cash Injection (OOCI)

In October 2007 the DHSSPS advised the Project Team and Financial Advisers that a one off cash sum of £100,421,000 would be issued to the preferred Bidder at practical completion⁴² as a means of reducing the 30 years annual unitary payment to the PFI provider. The OOCI was calculated at 40% of the relevant capital cost of the Exemplar Design, and was fixed at a point in time (October 2007) i.e. is not subject to change regardless of any subsequent changes in the estimated capital cost of the

⁴⁰ Relates to Soft FM only

⁴¹ Relates to Soft FM only

⁴² Following sign off by the independent tester

Exemplar Design. This followed an intensive period of Financial Modelling and discussions with the Trust Financial Advisors and DHSSPS, to establish the appropriate treatment of the OOCI within the financial planning process for the DHSSPS.

Consequently, the Project's Financial Advisors were required to re-run complex Financial Models to ascertain a new target unitary payment and thus a new affordability envelope. A new indicative affordability target was issued to the Bidders in December 2007, reviewed by DHSSPS in January 2008, and approved in February 2008. In addition to the OOCI this revised target incorporated other changes (see section below "Affordability").

In parallel, Bidders were required to re run their models to reflect this change of position. Their revised modelling was issued to the Trust's Financial Advisors (via the Project Team) in a Stage 2D + submission, for review and further dialogue. Feedback was given to DHSSPS on Bidder's treatment of OOCI.

Affordability

The Project Team (via all workstreams) continued to reiterate throughout the dialogue that the affordability ceiling was a hurdle test and that bids above the ceiling would not be accepted and would therefore not be evaluated by the various workstreams. Therefore if one bidder's Final Bid price (based on NPV) was higher than the Trust target price, this bidder would be eliminated from the competition. The only exception being if there were no bids capable of acceptance that fell below the hurdle, then bids above the hurdle would be considered.

The affordability envelope materially changed in December 2007 for two reasons:

- One off Cash Injection; and
- Impact of Landslip

In addition the assumptions for funding terms were revised to more accurately reflect the market position following the turbulence in the financial markets at the end of 2007. The Indicative affordability in terms of annual unitary payment of £15.2m was issued to Bidders in December 2007.

This new affordability envelope was reviewed by the DHSSPS and approval was granted in February 2008 (Refer to appendix 7.18 and 7.19 for Approvals letters from Dr Jim Livingstone).

Whilst the 3 Bidders did not confirm their Final Bid price during Dialogue, they implied that their Final Bid price would be within the affordability envelope. The Finance work stream confirmed in February 2008 that they were content to Close the financial aspects of the Dialogue.

7.3.6.8. Legal Workstream:

The South West Acute Hospital Draft Project Agreement is based on the NI Standard Form, the same having been tailored to reflect specific commercial and Project issues.

The South West Acute Hospital Draft Project Agreement was developed during the dialogue and focused on project specific design, commissioning, technical and service issues. The Project Agreement has been negotiated in all material respects with each of the Bidders (and the EIB) and all points have been identified and agreed where possible. The purpose of the Agreed List is to identify such points. Distinctions were drawn between green issues which were issues that were agreed with the Trust but which were particular only to that bidder, grey issues which were either dropped or which were incorporated into the project agreement for all bidders and finally red issues which were issues upon which final agreement had not been achieved. It is worth noting that by close of dialogue there were very few red issues and that these related almost exclusively to matters which had arisen fairly late in the process i.e. the Secondary Access Route.

Each Bidder was asked to confirm that they had no further points on the PA and to provide confirmation from key members of their consortium including, in particular, their funders. Broadly speaking, the Bidders appeared happy with the Project Agreement and during the course of dialogue, it was felt that agreement was reached with each of the bidders in respect of all material issues on the draft agreement.

There are a range of provisions to be finalised within the Project Agreement but it is felt that all of this can be done within the limitations of Competitive Dialogue. These range from the very minor such as the name of the preferred bidder and the completion of addresses / contact details in the notice provisions to more important matters such as the incorporation of the financial information and finalisation of the Project Co Proposals. In the main, the work that is still to be done on the technical schedules is in respect of the technical schedules which can only be completed as the finalisation of the design takes shape.

Whilst extensive dialogue was required right up until the end of Stage 2D, the Trust's legal advisors were satisfied that the three Bidder's agreed list's had been developed to an acceptable position for the Trust. The legal advisors also advised that the Trust were in a position to Invite the Final Bids as commercial certainty had been achieved.

7.3.6.9. ICT Workstream:

The initial ICT position in respect of the PFI hospital was that Project Co would be responsible for all the hard wiring to enable the Trust to operate an efficient ICT system. The funding stream for the systems was covered in the ICT business case developed in 2006 and submitted by the former Sperrin Lakeland Trust to the DHSSPS.

The Project Team are now proceeding under the guidance of the WHSCT ICT department to resubmit a redraft of the ICT Business Case to seek approval for the

funding for the ICT equipment that is pertinent to the effective operation of the new hospital only.

In summary the ICT workstream had a greater understanding and a better appreciation of key priorities with all Bidders. As a result, the ICT workstream were content to close Dialogue and final deliverables were amended and strengthened for Stage 3, to ensure fuller and more in depth response was required at Final Bids.

7.3.6.10. Commissioning:

The Trust took a simple approach to Commissioning of the Facilities, as part of the Project Agreement. To this end, Project Co would be expected to complete its Pre Completion Commissioning activity prior to the Actual Completion Date. Project Co shall note that due to the importance of the Data Network in the final commissioning of the IT network to the full building services commissioning, that this system will be required and available in good time. This will require Project Co to have completed works within the Imaging Department, the Computer Suite containing the Main Equipment Room (MER) and patient entertainment server room and all the Central Wiring Points (CWP's), and that these rooms and areas are clean, commissioned and the climatic conditions are maintained. Beneficial access to these areas shall be

- 4 Months prior to Practical Completion:
Trust access to all rooms in the Computer Suite, which includes the Main Equipment Room and the Patient Entertainment Server room. Trust access to the furthest central wiring point from the Computer Suite. Trust access for the Trusts Telecom service provider to install their comms cables to both the MER and the remote CWP and between the MER and the remote CWP.
- 4 Months prior to Practical Completion:
Trust access to all rooms within the Imaging Department and Trust access to all associate Central Wiring Points for the Imaging Department.
- 3 Months Prior to Practical Completion:
Trust access to the remainder of the Central Wiring Points and designated beneficial access storage areas.

Hard FM staff will transfer to Project Co immediately following the Actual Completion Date. The proposed Commissioning plan allows for the Hard FM staff to take part in the Commissioning process and be trained in the relevant areas prior to the actual completion.

The Trust will undertake its Post Completion Commissioning in the three month period commencing on the Actual Completion Date. During this period, Project Co will deliver the Hard FM Services and, as regards Snagging Matters and Commissioning Damage, Project Co must complete such activities in accordance with the terms of the Core Bid Project Agreement.

7.3.6.11. Socio-economic:

Further to dialogue during Stage 2D bidders were required to outline a clear and quantifiable plan to ensure that the project impacts positively on the social and economic regeneration of the area. This plan needs to demonstrate that clear measures designed to leave a positive lasting legacy primarily within the catchment areas of Fermanagh/West Tyrone and further afield⁴³ in Northern Ireland have been

⁴³ 'Further afield' refers to the areas outside the catchment area that the project will have a positive impact on in terms of use of the supply chain, indirect jobs etc. Such impacts will also be gathered through the monitoring systems.

planned for all phases of the development. This Social and Economic Regeneration Plan (SERP) should also identify:

- steps to address local deprivation and target underrepresented groups;
- offer new jobs;
- develop the local supply chain;
- offer re-skilling and up-skilling opportunities;
- establish mutually beneficial links with the community and voluntary sector; and
- establish the New Acute Hospital for the South West as a vibrant and living contributor to the local economy.

In the Final Bid Deliverables, Bidders were required to complete detailed Training and Employment proforma as part of their Social and Economic Regeneration Plan (SERP) to provide sufficient clarity in relation to above, and support their written submission. The Training and Employment proforma required information on the number and source of employment opportunities, training programmes, graduate and under-graduate placements and apprenticeships. This clear quantification of key targets was required to enable the development of SMART objectives and a robust evaluation methodology for this key element of project. The entire SERP would form part of the legally binding Project Agreement that the Preferred Bidder would be required to deliver.

The Socio Economic work stream confirmed in February 2008 that they were content to Close the Dialogue.

7.3.6.12. Staff and Community Input:

Throughout the development of the New Acute Hospital project, clear mechanisms were provided for the engagement of staff and the local community and a comprehensive consultation and engagement programme implemented. Staff engagement included the Clinical Reference Group and Staff Design Forum, while a series of open days, workshops and exhibitions were held for staff from all hospital departments. A series of meetings also took place on a Departmental level through the Sketch Design Groups formed for the project. Community involvement was championed by the projects Community Liaison and Community Design Evaluation Forums.

This engagement enabled a continual stream of feedback to be recorded and actioned by means of issue lists.

7.3.7. Overview of Stage 2D

Competitive Dialogue led to a greater understanding of key issues and priorities surrounding each work stream. Significant Dialogue was required in freezing solutions (for all Bidders) that satisfied all stakeholders. A Design Freeze was important both for the Trust and bidders; to ensure accurate pricing was achieved, to achieve commercial certainty and thus invite final bids. In addition, Competitive Dialogue led to a greater appreciation of key Private Finance Initiative (PFI)/

Commercial issues associated with each work stream. To ensure the 'Dialogue' was translated to Final Bids, the stage 2D deliverables were refined to ensure that responses received at Stage 3 included all information anticipated by the Trust. Lessons were learned following completion of the Stage 2D evaluation and it was acknowledged that in certain cases that the Trust could have been clearer in identifying their requirements. In addition some amendment was made to reflect , for example the introduction of the OOCI, the effect of the Landslide, the ministerial decision in respect of cleaning and single rooms.

7.3.8. Outcome of Stage 2D

The Trust, Health Estates and its Advisors were pleased to work with three high quality Consortia. The Dialogue led to development of the Exemplar Design and all the Trusts supporting requirements to high standards and specifications.

The Project Team were also pleased at the high level of involvement from staff, staff representatives, Trade Unions and Community Groups and representatives. Their level of understanding, research and quest for good practice has led to a high level of interaction with all work streams to ensure an integrated approach and solution for the New Acute Hospital for the South West.

Senior Trust Officers and the Project Team also welcomed the support from key stakeholders in the Procurement Process i.e. DHSSPS in particular Health Estates and the Infrastructure Investment Directorate, and Strategic Investment Board.

7.3.9. Closing the Dialogue / Issuance of Invitation for Final Bids

One of the distinctions between Competitive Dialogue and the Negotiated Procedure (which was the process that was previously used to deliver PFI) is that there is only a very limited window to agree the commercial deal once the dialogue is closed, the procurer is restricted in the manner in which it can discuss and agree the Project with the Bidders . The key therefore was to seek to achieve commercial certainty with each of the Bidders before the dialogue closed.

Broadly speaking, Closure of the Dialogue meant that in respect of each of the key disciplines, a level of certainty had been achieved which would enable the Trust to proceed to financial close within the limitations of Competitive Dialogue and through a process of clarification, specification and fine tuning only. In design terms this means establishing a complete and cross co-ordinated understanding of both the building(s) and landscape form, finish and content in both written and drawn form, with supporting detailed specification, schedules and programmes. In finance terms this covers funding and payment mechanism. Closing the commercial negotiations concerning the payment mechanism left no material issues outstanding, though a number of minor issues remain to be resolved. The intention is to do this through the Preferred Bidder Letter. Funding was not a subject of negotiation as such, since bidders are in direct competition and this drives Value for Money. However post selection of Preferred Bidder the VfM of bank vs bond finance will be revisited if

required⁴⁴. From a legal perspective, there are a range of provisions to be finalised within the Project Agreement but it is felt that all of this can be done within the limitations of Competitive Dialogue. These range from the very minor such as the name of the preferred bidder and the completion of addresses / contact details in the notice provisions to more important matters such as the incorporation of the financial information and finalisation of the Project Co Proposals. In the main, the work that is still to be done on the technical schedules is in respect of the technical schedules which can only be completed as the finalisation of the design takes shape.

As the Project Team, in conjunction with its advisors, was satisfied that commercial certainty had been achieved and that they would receive three bids each or any of which would be acceptable, they recommended to Trust Board in January 2008 that Competitive Dialogue with the three Bidders be brought to an end in respect of the key commercial issues, pending final confirmation of the affordability target by DHSSPS. Following confirmation of the affordability target by the DHSSPS the formal Closure of the Dialogue phase of the procurement took place on 21st February 2008 followed by the issuance of the Invitation for Final Bid. This document invited each Bidder to Submit a Final Bid to the Trust, containing all the elements required and necessary for the performance of the Project, taking account of the dialogue they have had with the Trust and its advisors since the start of the Competitive Dialogue procedure, by 29th February 2008.

Please refer to the Closure of Dialogue report in appendix 7.20.

7.4. STAGE 3 - INVITATION FOR FINAL BIDS

The *Invitation for Final Bids (IFB)* built on the terms and conditions of the procurement process set out in the *Invitation to Participate in Dialogue (IPID)* and specifically provided further details in respect of the protocols and timings envisaged by the Trust for the submission and evaluation of Final Bids.

The IFB was issued to three Bidders on 21 February 08. It contained all the elements required and necessary for the performance of the Project, incorporating the final Affordability Target (confirmed by the DHSSPS) and taking account of the Dialogue the Bidders had with the Trust and its advisors since the start of the Competition.

Bidders responded to the IFB with their Final Bids on 29 February 08.

7.4.1. Stage 3 Evaluation Process

The Stage 3 Evaluation Process was carried out in accordance with the Stage 3 Evaluation Methodology that was agreed by the Trust, Health Estates, DHSSPS, SIB and the Trust's advisors (legal and financial). The Stage 3 Evaluation Methodology

⁴⁴ It is the Trust's intention to commence this immediately after the appointment of Preferred Bidder

is set out in Appendix 7.21A⁴⁵. The key elements of this methodology is summarised below.

Public procurement rules indicate that when utilising the competitive dialogue procedure, the procurer should select the “most economically advantageous bid”.

The Trust, Health Estates, SIB and the Trust’s advisors (Financial and Legal) determined that a weighting of 90% should be applied for quality scoring and a weighting of 10% should be applied for affordability to achieve the most economically advantageous bid. However this criteria would only be applied after the affordability check was carried out. This entailed a comparison of the Bidders adjusted net present value and the Trust’s target net present value that was issued to bidders prior to closing the dialogue. Unaffordable bids would not be considered further, unless there were no bids capable of acceptance that fell below the hurdle⁴⁶.

Thus the Stage 3 evaluation process involved the following stages:

- **Quantitative** comparison to the relevant affordability hurdle for all Bids.
- **Qualitative** scoring of all Core Bids that were affordable; and
- **Ranking** of Core Bids based on the combined quantitative and qualitative scores.

7.4.1.1. Quantitative Comparison Summary

The Trust’s financial advisors carried out the Quantitative analysis, whereby they reviewed the Bidders Financial Models and quality assured the non finance input costs (capital, lifecycle, FM & Insurance) with the relevant advisors (Facilities Management, Insurance and quantity surveyors) to determine if the Bids were affordable. Further to this analysis the Trust’s financial advisors confirmed that the three bids submitted an affordable Core Bid and were therefore considered compliant in that respect. Only affordable bids can be considered acceptable by the Trust.

Affordability forms 10% of the overall combined score. The Bidder’s Unitary Charge is adjusted for any errors, inconsistencies or consequential additional costs or benefits that accrue to the Trust as a result of the specific characteristics of the Bid. This adjusted figure is compared to the Trust hurdle and a series of bandings determines how much of the 10% is awarded to each Bidder. The maximum possible score for affordability is 10%.

The overall affordability scores, based on the Net Present Values (NPV) indicated within the Bids as adjusted are detailed in Table 7.13.

⁴⁵ The Appendix 7.21B contains the version of the Stage 3 Evaluation Methodology that was shared with the Bidders on 16 January 2008 and was formally agreed between them and the Trust prior to closing the dialogue.

⁴⁶ If any of the bids had been deemed unaffordable, they would have eliminated from the evaluation i.e. not carried forward to the qualitative assessment. The only exception being if there were no bids capable of acceptance that fell below the hurdle, then bids above the hurdle would be considered.

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Table 7.13 Overall affordability scores, based on the Net Present Values (NPV) indicated within the Bids as adjusted

Consortium	Bid NPV (£'000)	Hurdle NPV (£'000)	Diff NPV (£'000)	Score (%)
Bidder 1	228,138	244,537	16,399	10%
Bidder 3	240,929	244,537	3,608	2%
Bidder 2	201,533	244,537	43,004	10%

A number of adjustments have been made based on the outcome of the evaluation of other elements of the Bidders' submissions. These adjustments have been supplied to Deloitte by the Trust and the Trust's other advisers.

The adjustments relate to the following areas of the submissions:

- **Energy** – the cost of energy is borne by the Trust. The characteristics of the Bidders' designs, primarily size, affect this cost and the submissions have been adjusted to reflect differences in the running cost, calculated by the Trust in conjunction with Health Estates and its energy adviser, White Young Green, compared to the Exemplar Design as per the Trust Evaluation Methodology.
- **Facilities Management: Agenda for Change** – all the Bidders had made assumptions regarding the cost of Agenda for Change as applied to the staff that would be subject to a TUPE transfer in their Bids that was at odds with what the Trust had instructed all Bidders to assume. In order to ensure a true "like for like" comparison the Trust and FM adviser, Davis Langdon, estimated the likely level of adjustment per annum that would need to be made to the Bids.
- **Facilities Management: Soft services adjustment.**- Soft FM services are provided by the Trust. The characteristics of the Bidders' designs, primarily size and quality of management of the interface, affect the cost of this provision. The submissions were adjusted to reflect differences in the running cost calculated by the Trust and the FM adviser, Davis Langdon, compared to the Exemplar Design as per the Trust's Evaluation Methodology.
- **Insurance** – Two Bidders (Bidder 3 and Bidder 2) had errors in their submission assumptions that were identified by the Trust insurance advisers, Marsh. However, only Bidder 2's Bid was adjusted as the changes to the Bidder 3 Bid were considered immaterial by the Trust's insurance adviser.

Following adjustments the affordability percentages are:

Table 7.14 Affordability percentages following adjustments

Consortium	AFF_i(%)
Bidder 1	10%
Bidder 3	2%
Bidder 2	10%

This is described in more detail in the comprehensive Finance Evaluation Report in Appendix 7.30.

7.4.1.2. Qualitative Assessment Summary

The detailed evaluation involved a qualitative assessment of Bidders' responses to deliverables within each workstream.

The qualitative assessment was completed using the award criteria in Table 7.15. These criteria were shared with Bidders on release of the IPID and again on issue of the IFB.

Table 7.15 Award Criteria for Stage 3 Evaluations⁴⁷

Award Criteria	Weighting
Organisational Fit	5%
Project Management	5%
Design and Construction (including equipment& ICT)	35%
Facilities Management	20%
Human Resources	10%
Legal	10%
Financial (including insurance and payment mechanism)	15%
Total	100%

As before, the deliverables were developed over ten specialised workstreams, each having an associated number of deliverables, detailing the requirements within that workstream.

⁴⁷ This award criteria was taken from the Sherwood Forest PFI Project and discussed with Health Estates, SIB and the Trust.

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Workstream	Number of Deliverables
Design & Technical	55
Equipment	4
Facilities Management	14
Human Resources	9
Finance	30
Legal	21
Project Management	20
Insurance & Commercial	9
ICT	5
Socio-economic	4

(Organisational fit had no specific deliverables, but was evaluated within the Design, Legal, Financial, Facilities Management & Project Management workstreams.)

Bidders were asked to comply fully with the detailed requirements within the deliverables and told that failure to provide the requisite information could result in the Bid submission being deemed non-compliant and the Bidder being excluded from the remainder of the competition.

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These workstreams were divided into sub-groups and quality assurance roles as identified in Figure 7.2 below.

Evaluation Sub-Groups and Quality Assurance Stage 3										
	A	A	B	B	C	D	E	F	G	A, B & E
DELIVERABLE:										
WORKSTREAM:	Design and Technical	Equipment	Facilities Management	HR	Finance	Legal	Project Management	Insurance	ICT	Socio Economic
Evaluation Sub-Groups	Trust Health Estates Exemplar Design Team	Trust Health Estates Davis Langdon	Trust Davis Langdon	Trust Davis Langdon Bevan Britton Trade Unions Denise Wheatley Associates, GAD	Trust Deloitte	Bevan Britton L'estrage & Brett Trust Health Estates	Trust Davis Langdon Health Estates	Marsh L'estrage & Brett Trust Deloitte Health Estates	Trust IBS Health Estates	Trust
Quality Assurance	Health Estates, Chief Executive White Young Green	Equipment Advisor Regional Supplies Service	Assistant Director for Facilities Management	Assistant Director of HR & HR Manager	Deputy Director of Finance, Assistant Director of Capital Planning & Development	Internal Legal Advisor QA BB	Davis Langdon	Marsh	DIS Director of ICT	Deloitte

Figure 7.2 Stage 3 Evaluation Subgroups and Quality Assurance Roles

Each workstream encompassed the following people within their team:

- **Evaluation sub-group** – Trust staff, Advisors & Health Estates staff. Each sub-group was responsible for evaluating the responses provided by Bidders against the Stage 3 Deliverables; and
- **Quality Assurance** – A key person from each workstream that was not part of the Evaluation. This role was identified in respect of each evaluation sub-group to enhance the integrity of the evaluation process. The individuals responsible for quality assurance were responsible for providing an independent analysis within their area of expertise in order to verify results, before final reports were issued. The person designated as quality assessor was usually the most senior person within the team. For example, in the finance workstream, the Assistant Director of Finance (Capital Planning), in HR, the Assistant Director of Employee Relations and in FM, the Assistant Director of Facilities Management. Where possible each of the Assistant Directors were assisted in the evaluations by a senior advisor from the appropriate workstream.

Appendix 7.22 provides further detail on the Stage 3 Evaluation Subgroups and Quality Assurance Roles.

The evaluation sub-groups adhered to the following framework in Table 7.16 whilst carrying out their qualitative assessment.

Table 7.16 Qualitative scoring framework

Assessment	Allocated Score
Very Poor - completely fails to demonstrate technical capacity and capability.	0
Poor - some, but very limited evidence of technical capability and capacity.	1-3
Satisfactory - provides evidence of sufficient capability and capacity to undertake the project.	4-6
Good - shows capacity and capability that meet the project requirements and in some areas, shows innovation in excess of the project requirements.	7-9
Very good - shows capacity and capability in all areas that are in excess of the project requirements.	10

This scoring framework, the quality assurance process, evaluation subgroup meetings and weekly conference calls (involving all workstreams) were used as a mechanism to ensure consistency in scoring across all groups. Scores awarded to bidders were based on the information provided together with responses to clarifications sought. therefore, the score reflects any issues/matters that require further refinement if that bidder was selected.

Qualitative Assessment Results

The weighted scores from the detailed evaluation of each Bidder are shown in appendix 7.23 and summarized in Table 7.17:

Table 7.17 Summary of the weighted scores from the qualitative assessment

	Weighting	Bidder 1	Bidder 2	Bidder 3
Organisational Fit	5%	3%	3.3%	3.10%
Project Management	5%	3.38%	3.01%	2.08%
Design & Technical (incl Equipment and ICT)	35%	17.06%	21.76%	17.22%
Facilities Management	20%	11.14%	11.35%	11.96%
Human Resources	10%	4.7%	6.25%	7.25%
Legal	10%	5.65%	5.88%	6.7%
Financial (incl payment mechanism and Insurance)	15%	10.9%	10.73%	11.98%
TOTAL	100%	55.83%	62.28%	60.30%
Total Weighted out of 90%	90%	50.25%	56.05%	54.27%

NB: 5% was allocated for socio-economic. The 5% spanned across Design & Technical (2%), Facilities Management (1%), Human Resources (1%) and Project Management (1%).

7.4.1.3. Ranking - Combined Quantitative and Qualitative Scores

In order to decide which bid constituted the most economically advantageous tender, the NPV of the Bid⁴⁸ was combined with the score from the qualitative analysis.

The combined score for a Bid was derived on the basis of a 90/10 split. A maximum of 90% being awarded for quality and a maximum of 10% for price. This is illustrated in the formula below:

$$CS_i = (0.90 \times QS_i) + (AFF_i)$$

Where:

CS_i means the Combined Score for the Bid

QS_i means the Qualitative Score for the Bid as determined by the Bidders responses to the deliverables

AFF_i means the Affordability score as determined in accordance with the table below:

NPV_i means the Net Present Value of the Bid

⁴⁸ Expressed as the Net Present Value of the cost of the Project to the Trust i.e. Unitary Charge plus any incremental costs or benefits of soft FM provision or clinical or other non-clinical service provision e.g. a heat, light and power adjustment

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NPV_{base} means the Net Present Value of the affordability hurdle as notified to Bidders by the Trust

NPV_{diff}⁴⁹ means the absolute value of the difference between NPV_{base} and NPV_i, where NPV_i is less than NPV_{base}

OR

zero, where NPV_i is greater than or equal to NPV_{base}

Table 7.18 NPV Table

NPV _{diff} Is Greater than (£K)	NPV _{diff} Is Less than or equal to (£K)	Equivalent Value In Day 1 Unitary Payment (£K)	Score (%) AFF _i
0	1,609	100	0
1,609	3,217	200	1
3,217	4,826	300	2
4,826	6,434	400	3
6,434	8,043	500	4
8,043	9,652	600	5
9,652	11,260	700	6
11,260	12,869	800	7
12,869	14,477	900	8
14,477	16,086	1,000	9
16,086		>1,000	10

In simple terms the table is illustrating that the NPV diff is the difference between the bid and the target in NPV terms. We use NPV rather than base date unitary payment since the three bids have different construction periods and therefore different start dates for unitary payment. Wherever the NPV lies within the incremental limits set out in the table, that is the affordability percentage that is given - maximum 10%, minimum 0%. The unitary payment increments column is for information so that non-financial readers can understand roughly what the NPV figures equate to.

Thus the qualitative score has been recalculated to reflect each Bidders score out of 90% and added to the Bidders quantitative score. The overall scores are shown in Table 7.19.

Table 7.19 Combination of Qualitative and Quantitative Scores

	Weighting	Bidder 1	Bidder 2	Bidder 3
Qualitative	90%	50.25%	56.05%	54.27%
Quantitative	10%	10%	10%	2%
TOTAL	100%	60.25%	66.05%	56.27%
RANK	-	2	1	3

⁴⁹ In simple terms this means it is based on the bidders unitary payment and any incremental adjustments for say energy or Soft FM that arise as a result of the bidders specific design.

The Table 7.19 clearly indicates the ranking of each bidder in the competition, however it is important to emphasise that competitive dialogue does not permit a second bidder to be held in reserve post appointment of preferred bidder. The Trust is therefore aware of the importance of ensuring:

1. The right bidder is appointed; and
2. That the preferred bidder letter deals with issues that require further clarification and fine tuning.

7.4.1.4. *Commentary on each Bidders scoring*

In fitting with the concept of PFI, the main drivers of the Final Bid results were the Bidders response to the Design and Technical and Facilities Management deliverables. The importance of these is indicated in the award criteria, accounting for 35% and 20% respectively of the total qualitative score. In addition, the Bidders final price proved to be a significant factor in the ranking of bids. A short synopsis of each bidders results is set out below, with further detail provided on each workstream set out in 7.4.2.

Bidder 1

Bidder 1 scored satisfactorily in the Design and Technical workstream, with a score of 17.06% out of 35%. This was the lowest mark achieved by the Bidders in the Design and Technical workstream. They also scored marginally lower than the other Bidders in Facilities Management. Other workstreams they performed poorly in included Human Resources and Legal. On a positive note they achieved the highest score of all the Bidders in some of the lower weighted workstreams; Project Management (5%), Socio Economic (5%) and Insurance (2%).

In overall qualitative terms, Bidder 1 achieved the lowest score.

Bidder 1 achieved the maximum score of 10% in their quantitative assessment.

It is largely due to their score in the quantitative evaluation that placed Bidder 1 in overall **second** place.

Bidder 2

Bidder 2 scored well in their Design and Technical workstream, with a score of 21.76% out of 35%. This was the highest mark achieved by the Bidders in the Design and Technical workstream, scoring 4.45% above Bidder 3 and 4.7% above Bidder 1. Bidder 2 scored marginally lower than Bidder 3 in Facilities Management and marginally higher than Bidder 1. Bidder 2 achieved the highest overall qualitative score.

Bidder 2 scored highest in the quantitative assessment, whereby they achieved the max 10% as their NPV was in excess of £1m below the target unitary charge.

Owing to achieving the highest score in both the quantitative and qualitative assessments, Bidder 2 has been placed **first**.

Bidder 3

Bidder 3 scored satisfactorily in their Design and Technical workstream, with a score of 17.22% out of 35%. This was the second highest mark achieved by the Bidders in the Design and Technical workstream, although scoring marginally higher than Bidder 1. Bidder 3 scored the highest in the following workstreams: Facilities Management, Human Resources, Legal and Finance workstreams. However they scored lowest in Project Management and Equipment workstreams.

Bidder 3 scored considerably lower than the other Bidders in the quantitative evaluation as their bid was the most expensive, scoring 2%.

It is largely due to price that this Bidder has achieved the lowest overall score and is therefore placed **third**.

7.4.2. Stage 3 Evaluation Results by workstream

As part of the evaluation process, each workstream was required to produce a detailed report on their findings together with the scores awarded to each Bidder for each deliverable. The detailed reports are appended to this FBC in Appendices 7.24 to 7.33.

A summary of the Bidder submissions by workstream is set out in the following sections.

7.4.2.1. Organisational Fit

Table 7.20 below shows the qualitative scores for the Organisational Fit workstream.

Table 7.20 Qualitative Scores for the Organisational Fit workstream

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Organisational Fit				
Design & Technical (including equipment and ICT)	1.00%	0.40	0.70	0.70
Facilities Management (including HR)	1.00%	0.60	0.60	0.60
Finance	1.00%	0.70	0.70	0.70
Legal	1.00%	0.60	0.60	0.60
Project Management	1.00%	0.70	0.70	0.50
TOTAL	5.00%	3.00	3.30	3.00

Design & Technical

The Dialogue Process with the three Bidders has been robust through each stage of the Dialogue Process, increasing in intensity at the latter stages and prior to IFB. This in part was due to the Trust tightening and refining its Bidder deliverables and seeking to eliminate ambiguity from the design process

The scores were determined by taking into consideration bidders responses to the design and technical deliverables, their response to clarifications issued throughout the process, their response to the development of the Trusts construction requirements and the response to the development of the project brief by the client.

FM

Whilst all three Bidders adopted slightly different service delivery solutions and therefore slightly different ways of developing and discussing their service delivery solutions through Competitive Dialogue, ultimately each Bidder engaged with the Trust to achieve a service solution which met the Trust requirements. In the case of each Bidder this achieved an FM submission which in the main met the Trusts requirements. On this basis, as each of the Bidders were similar in their Organisational Fit it was not considered appropriate to differentiate between the Bidders and therefore each Bidder was awarded a score of 6 which, on the basis of the agreed scoring methodology, represents the top end of Satisfactory.

Finance

All 3 Bidders showed a willingness to listen to the feedback given to them during the Dialogue phase, and to act on that feedback, leading to three very good quality finance submissions. All three sets of financial advisers showed a positive attitude, were proactive in raising issues at appropriate points in the dialogue, and were practical and pragmatic in reaching solutions with the Trust and its financial advisers. All three scored equally well on the basis that it seems likely, based on the evidence of the Dialogue phase, that it would be possible to reach a successful financial close with any of the three teams.

Legal

Whilst all three Bidders adopted different approaches to the Competitive Dialogue, ultimately each Bidder engaged with the Trust on the South West Acute Hospital Draft Project Agreement and the associated legal deliverables thus ensuring that the legal submission from each of the Bidders was felt to be broadly acceptable to the Trust. On this basis, it was not considered appropriate to differentiate between the Bidders as regards Organisational fit and therefore each Bidder was awarded a score of 6 which, on the basis of agreed scoring methodology, represents the top end of 'Satisfactory'.

Project Management

Whilst all three Bidders adopted different approaches, ultimately each Bidder engaged with the Trust. Bidder 1 & Bidder 2 scored the same with Bidder 3 scoring slightly less.

The scores were determined by taking into consideration Bidder's responses to the Project Management deliverables and by considering the way in which the three Bidders responded to clarifications throughout the process to Final Bid stage. It was also determined by the extent to which the Bidders did or did not reflect on previous negative comments (at Stage 2D) in the stage 3 submission. Owing to Bidder 3's performance in these areas they scored slightly less than the other two bidders.

7.4.2.2. Design & Technical

As part of the evaluation process the Design and Technical Workstream were required to produce a detailed report on their findings together with the scores awarded to each Bidder for each deliverable. The executive summary for this detailed report is in Appendix 7.24 .

Qualitative Scores

Table 7.21 overleaf shows the qualitative scores for the Bidder's Design & Technical submissions.

Table 7.21 Qualitative Scores for Bidders D&T Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Design & Technical				
Design	15.27%	5.64	8.77	6.51
Engineering	6.11%	3.12	2.99	2.79
Construction Procurement	3.06%	1.72	2.29	1.46
Technical	2.00%	1.04	1.32	1.12
Equipment	3.06%	-	-	-
ICT	3.50%	-	-	-
Socio-Economic	2.00%	-	-	-
TOTAL	35.00%	11.52	15.37	11.88

NB: The Scores for Equipment, ICT and Socio-Economic are shown separately in the subsequent sections below.

Bidder 1

The overall quality of the Bidders Stage 3 Submission is consistent to that presented at Stage 2D and generally satisfactory. However there has been little improvement in the level of detail information presented by from the previous stage with the exception of engineering services . This is reflected in the scheme design scoring the highest mark for this section within the four award criteria, second highest in construction procurement and the third highest score in design and technical.

Design issues remain both within the general and detail design which would require further development.

Having examined the supporting detailed information included within the submission the evaluation design team conclude that the Architectural,

Landscape, Interior Design, Art and Way Finding information was insufficiently presented to allow a satisfactory evaluation on the Bidders design. Therefore Bidder 1 did not score as highly as the other Bidders.

All members of the evaluation design team are satisfied that the quality of materials, finishes and components in general are of a satisfactory level and therefore consider that the quality set in the Bidders design proposal is achievable and represents the quality level set by the exemplar design.

Bidder 1's approach to the design process has been acceptable, typified with a practical approach in developing their design solutions in response to the Trust's requests. It is felt that this approach would remain unchanged if the Bidder was selected.

Bidder 2

The overall quality of the Bidders Stage 3 Submission is in marked contrast to that presented at Stage 2D and has seen a significant improvement on all aspects of their design. This is reflected in the scheme design scoring the highest mark in three out of the four award criteria, on design, construction procurement and technical and the second highest score on engineering services.

The level of information provided in the submission is generally satisfactory. The supporting detail information included is good and would form a satisfactory basis upon which to develop the design. However there are areas of general planning within the design which require further development

Having examined the supporting detailed information included within the submission the evaluation design team conclude that the Architectural, Landscape, Interior Design, Art and Way Finding include some innovative solutions however if this Bidder was chosen as Preferred Bidder some refinements would be required.

All members of the evaluation design team are satisfied that the quality of materials, finishes and components in general are good and we therefore consider that the quality set in the Bidders design proposal is achievable and represents the quality level set by the exemplar design.

Bidder 2 approach to the design process has displayed a positive attitude, and was practical and realistic in developing their design solutions in response to the Trust's requests. It is felt that this positive approach would remain unchanged if the Bidder was selected

Bidder 3

The overall quality of the bidders Stage 3 Submission is consistent to that presented at Stage 2D. However there has been little improvement in the level of "detail information" presented from the previous stage.

The level of drawing information supporting the bid was in general satisfactory, however the level of detailed information was rather less well developed. This is

reflected in the scheme design scoring and the second highest in two out of the four award criteria on design and technical, and the third highest score in engineering services and construction procurement.

Design issues remain within the detailed design which would require further development if this bidder was selected.

Having examined the supporting detailed information included within the submission the evaluation design team conclude that the Architectural, Landscape, Interior Design, Art and Way Finding included have not been demonstrated to be deliverable with certainty and would require further development.

All members of the evaluation design team have a concern that limited information was presented, setting the quality of materials, finishes and components to large sections of the design and therefore consider that this Bidder's design proposal would require further development.

Bidder 3's approach to the design process has displayed a positive attitude, and was practical and realistic in developing their design solutions in response to the Trusts requests. It is felt that this positive approach would remain unchanged if the Bidder was selected.

7.4.2.3. Equipment

Qualitative Scores

Table 7.22 below shows the qualitative scores for the Bidder's Equipment submissions.

Table 7.22 Qualitative Scores for Bidders Equipment Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Equipment				
Equipment	3.06%	2.02	2.08	1.79
TOTAL	3.06%	2.02	2.08	1.79

Bidder 1

Bidder 1 submitted a good response, their approach to imaging equipment and their assurance on the fixed price for category A items was considered positive. Areas of weakness included their disappointing approach to completing the lifecycle tables for A* and FM*⁵⁰, and not all of their Category A equipment reflected exemplar standards. In addition minimal reference was made to FM delivery and installation.

⁵⁰ A* and FM * relate to categories of equipment that the Trust provide a specification for and also provide the bidders with a list of potential suppliers (ie 2 or 3 companies) that the Trust would be happy to use. The piece of equipment is then supplied, installed and commissioned, maintained and replaced by Project Co. A* relates to Clinical equipment eg theatre pendants and lights. FM* relates to Facilities Management equipment eg catering and Laundry equipment

Bidder 2

Bidder 2 submitted the strongest response which incorporated a good response on method statements and a good review of the ERM with the inclusion of sensible comments. Their completion of A* lifecycle was however poor as they assumed less than 100% replacement. The Trust and RSS will further investigate this issue under the process of clarifying and fine tuning from Preferred Bidder to Financial Close.

Bidder 3

Bidder 3 submitted the weakest response. The main areas of weaknesses was their refusal to give price certainty assurance on Category A equipment which was a big requirement for the Trust and ultimately led to them being placed third overall in this workstream.

They provided a good response in relation to the design of areas and rooms for M2 (major fixed imaging) equipment. Whilst their lifecycles were completed well, cross checks were required with other deliverables (A111 – Lifecycle) to ensure accuracy.

Please refer to appendix 7.25 for a more detailed report of the Equipment Evaluations.

7.4.2.4. ICT

Qualitative Scores

Table 7.23 below shows the qualitative scores for the Bidder's ICT submissions.

Table 7.23 Qualitative Scores for Bidders ICT Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
ICT				
ICT	3.50%	2.14	3.12	2.56
TOTAL	3.50%	2.14	3.12	2.56

Bidder 1

Overall the response was satisfactory in most areas, and outstanding issues can be resolved post selection of PB. However the bid on the whole does not exhibit innovation.

A key concern is that whilst the responses rely heavily on the benefits of a specific locally based installer, there is no concrete commitment to use such a company.

The unworkable nature of the design of the hub areas is an issue which will have to be resolved as part of the post PB design process. However the inclusion of cooling for these rooms is a positive point which in part mitigates poor scoring in other areas.

Bidder 2

The submission is to an extremely high standard, in both presentation and content, and this has been reflected in the scoring.

Bidder 2 has made clear commitments to specific standards, manufacturers and installers, and has provided multiple levels of resilience and significant spare capacity for future expansion.

In terms of disaster recovery they have exceeded expectations and they are the only Bidder to offer a warranty for the full term of the concession. This is an all-inclusive, industry standard compliant warranty, that guarantees zero bit-error rate performance throughout the structured cabling channel. All of the ICT passive network copper and fibre optic components including; cables; outlets; intelligent fibre and copper patch panels and fibre and copper patch cords are manufactured by ADC KRONE. All of these network components are covered by the manufacturers warranty for the entire network installation

Bidder 3

Overall a satisfactory Bid, with a number of positive aspects, but also a number of concerns that will need to be addressed before appointment of Preferred Bidder.

Bidder 3 has made no commitment to specific manufacturers and has not demonstrated an understanding of the degree of liaison with the Trust that will be required.

The question of interfaces was poorly addressed despite the requirement being clearly articulated in the TCR's, and they have consequently scored poorly in this area.

Please refer to appendix 7.26 for a more detailed report of the ICT Evaluations.

7.4.2.5. *Facilities Management*

Qualitative Scores

It is considered that all three Bidders have provided a robust and comprehensive response to the requirements of the bid. The service delivery proposals are considered to be appropriate and respond to the requirements of each of the outputs identified in the Trust's service level specifications. As such we are confident that each of the three Bidders would be capable of delivering the requirements of the scheme from a Hard FM perspective.

Table 7.24 provides a summary of the FM scores in relation to the Stage 3 evaluation:

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Table 7.24 Qualitative Scores for Bidders FM Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Facilities Management				
Compliance with service level specifications	3.00%	1.80	1.80	2.10
Service delivery proposals	6.50%	3.99	3.75	3.96
Third party income proposals	1.00%	0.30	0.60	0.50
Service delivery commencement	1.00%	0.60	0.60	0.70
FM cost	3.00%	1.50	2.10	2.10
Interface	4.50%	2.25	1.80	2.10
Socio-Economic	1.00%	-	-	-
TOTAL	20.00%	10.44	10.65	11.46

NB: The Socio-Economic scores are shown separately in the subsequent section below.

Bidder 1

Bidder 1's Hard FM service offering was acceptable and showed that they are capable of delivering the Hard FM services to a health facility. This was bolstered by the acceptance of the service level specifications with exception of a small number of previously agreed drafting adjustments (agreed through competitive dialogue at the early stages of the procurement process).

Bidder 1's FM space design for the Trust retained Soft FM services meets the Trust's requirements and is the strongest of the 3 Bidders submissions.

Bidder 1 lost marks regarding the FM costs and third party income. Mobilisation and FM service costs were in some instances considered higher than would be expected, with Bidder 1 failing to provide detailed breakdowns on larger lump sum costings. In addition to this, Bidder 1's third party income provision lacked detail on their guaranteed income assumptions and costing make up. This had an impact on Bidder 1's overall score and is the main reason for them being the lowest overall of the 3 Bidders.

Bidder 2

Bidder 2 was the middle score of the 3 Bidders overall, however their scores for Hard FM delivery and Soft FM space requirement for Trust deliverable services were the lowest of the 3 Bidders. Primarily the rationale for this was that Bidder 2's submission lacked additional information to substantiate higher scores compared to the other 2 Bidders in certain instances. In addition, gaining out right agreement from all parties of the consortia on the service level specifications was tedious, however was eventually achieved. On the whole, the initial IFB submission from bidder 2 was not as strong as we had wished with regard to agreement of the service level specifications. However through the clarification stage prior to final scoring of the IFB submission an adequate response was received.

Bidder 2 excelled in the FM costings and third party income, with cost transparency provided for all Hard FM service costs which are considered

competitive in their nature. In addition to a strong well considered third party income provision which included a number of innovative provisions such as start business stalls, crèche etc.

Bidder 3

Bidder 3 was overall the highest score primarily due to a detailed Hard FM service delivery offering providing a high level of detail identifying how services would be run and managed through the concession. This is in addition to a strong FM cost provision giving a competitive service cost with transparency to support the costings. The third party income provision is basic, however cost assumptions and a rationale has been provided to support the guaranteed levels of income being offered.

Further to the above, all members of the consortia confirm acceptance of the service level specifications.

Bidder 3's Soft FM space design was considered fair with areas of developed and minor adjustment needed to totally meet the Trust's required delivery strategy. However, Bidder 3 was strong with regard to the interface aspect between the differing Hard and Soft FM service providers which substantiated their score.

Please refer to appendix 7.27 for a more detailed report of the FM Evaluations.

7.4.2.6. Human Resources

Qualitative Scores

Table 7.25 below shows the qualitative scores for the Bidder's Human Resources submissions.

Table 7.25 Qualitative Scores for Bidders HR Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Human Resources				
Staff Transfer Strategies	3.00%	1.05	1.95	2.40
Proposed Transfer strategy, training, development etc.	1.50%	0.90	1.05	1.20
Approach to HR management	1.00%	0.50	0.60	0.70
Acceptance of Policies and Procedures	1.00%	0.40	0.60	0.60
Recruitment and Retention of Staff	1.00%	0.30	0.40	0.70
Pensions Proposals	1.50%	1.05	1.05	1.05
Socio-Economic	1.00%	-	-	-
Total:	10.00%	4.20	5.65	6.65

NB: The Socio-Economic scores are shown separately in the subsequent section below.

Bidder 1

Bidder 1 scored the lowest of all Bidders. This result was due to a poor response on many of the deliverables. Their response lacked detail and did not provide the information that the group were expecting to see from an organisation of their experience in PFI and of dealing with staff transfers. There were concerns regarding the joint venture approach and their approach on trade union recognition as they stated that one of their consortia companies who would be employing FM staff had no formal union recognition agreements. It was also unclear on what HR Support that they would provide during the transfer/transition process and how they would minimise the impact of this process on the Trust. Finally Bidder 1 failed to include the information on equality issues that was requested previously in Stage 2D and through subsequent clarifications.

On a positive note, Bidder 1 provided good proposals for staff training, although some concern existed on their timing as it was listed as post mobilisation. Bidder 1 has experience of transferring significant numbers of staff and has the necessary pension schemes in place for the transferring employees. They have also given commitments regarding the Code of Practice, although it was unclear what their intentions are on some aspects of implementation of the Code.

Bidder 2

Bidder 2 submitted a satisfactory response, providing commitments regarding the Code of Practice and demonstrating an understanding of applicable requirements, together with a good timeline and programme from Preferred Bidder to Service Commencement. They have an 'Investors in People' award, along with various accreditations for their training. They provided a good response with examples on DDA and Equality issues (including a commitment to assist the Trust with its duties).

In the HR submission, there was a requirement to describe the HR support that would be provided post preferred bidder. Bidder 2 described its HR support but it appeared that they were based in England. The Trust sought clarification on how this support was to be provided by staff who were not based locally. The Bidder responded by stating that their HR support staff would be hotel based in Northern Ireland from Monday to Friday.

There were also concerns regarding their workforce proforma and 11 WTE Trust staff not being accounted for. However Bidder 2 has confirmed through clarifications that all staff on the TUPE list will be accommodated in their workforce structure. As staff who are transferring, they will be eligible for the protection of their terms and conditions by the TUPE legislation.

It was unclear what measures they would take to minimise impact on the Trust during transition/mobilisation and what problems/issues there may be as part of that process.

Finally Bidder 2 failed to include the information on equality issues that was provided in stage 2D and subsequent clarifications, however they did submit a response to equality issues which showed an understanding of the requirements in relation to their general approach to equal opportunities, section 75, DDA requirements and Fair Employment issues. The project agreement will ensure compliance to equality issues moving forward.

Bidder 3

Bidder 3 submitted a good response. They demonstrated considerable experience of dealing with TUPE from their other schemes such as Derby and Sherwood Forest and provided a good draft timetable for the transfer/transition process. They consistently demonstrated a high quality approach to staff and trade union involvement, with appropriate HR Support to be made available. This Bidder had a good insight into the staff mapping issues that will be needed for mobilisation, recruitment, relocation and training. As well as offering good proposals to minimise the impact on the Trust during this process.

However, they failed to include the information on equality issues that was requested in Stage 2D and through subsequent clarifications. Further clarity on the operation and role of their occupational health department and how this fits in with the Trust occupational dept will be required.

Please refer to appendix 7.28 for a more detailed report of the Human Resources Evaluations.

7.4.2.7. Legal

Qualitative Scores

Table 7.26 shows the qualitative scores for the Bidder's Legal submissions.

Table 7.26 Qualitative Scores for Bidders Legal Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Legal				
Nature and extent of any: (i) mark-up of the Project Agreement and related commentary; and/or (ii) comments remaining on an Agreed List of outstanding points as confirmed with/by the relevant Bidder	6.00%	3.15	3.68	4.20
Consortium and Sub-contractor arrangements	1.00%	0.60	0.30	0.70
Demonstration of an ability to progress to Financial Close	1.00%	0.60	0.60	0.70
Legal Adequacy and robustness of financing	1.00%	0.70	0.70	0.50
Approach to Change in Law Risk	1.00%	0.60	0.60	0.60
Total:	10.00%	5.65	5.88	6.70

Bidder 1

Whilst ultimately all three legal submissions were considered broadly acceptable to the Trust, it was felt that Bidder 1's was the weakest overall. The two key elements of the legal submission (and therefore the elements with the highest weighted score) were the submission of an Agreed List⁵¹ and the covering letter. In both areas, this Bidder failed to submit certain elements of the information required or in the form required. For example, on the Agreed List, Bidder 1 incorporated a number of outstanding issues on elements of drafting in the Project Agreement and marked them as having been agreed with the Trust when this was not the case. The Covering Letter submitted contained a number of errors and omissions although the Bidder did confirm in response to a clarification that they would be prepared to amend the letter and re-submit if they were to be appointed preferred Bidder.

Bidder 2

Bidder 2's legal submission was felt to be superior to that of Bidder 1. The Agreed List broadly reflected the commercial dialogue which had been held prior to the closure of the Dialogue and to the extent that there was uncertainty, the matter was cleared up through the clarification process to the Trust's satisfaction. Bidder 2 had agreed certain derogations from the form of cover letter with the Trust prior to closure of the Dialogue which were not considered

⁵¹ Agreed lists were the commentary submitted by bidders at stage 2B and developed during the course of the legal dialogue. Distinctions were drawn between green issues which were issues that were agreed with the Trust but which were particular only to that bidder, grey issues which were either dropped or which were incorporated into the project agreement for all bidders and finally red issues which were issues upon which final agreement had not been achieved.

unreasonable. The agreed derogation referred to is in respect of the due diligence confirmation which bidders were asked to make. In that confirmation, they were asked to state that they and their funders had completed their due diligence process in all respects. However, it was felt appropriate to permit Bidder 2 to carve out from this a limited amount of DD related to the secondary access route which they could not have completed given that the grant of the licence over this area of retained estate had not yet been made. In respect of the FM sub-contractor heads, the bidder is aware of the Trust's view on this, it was reflected in the score awarded to the bidder and will be dealt with in the PB Letter. The key concern with this Bidder, which ultimately impacted upon their legal score, was their approach to the FM Sub-contract Heads of Terms which contained reference to a position which had not been discussed and agreed with the Trust and which was not felt to be "market norm". The bidder is aware of the Trust's view on this, it was reflected in the score awarded to the bidder and will be dealt with in the PB Letter

Bidder 3

Bidder 3 submitted the most comprehensive legal submission which most accurately reflected the legal dialogue and which was felt to present the clearest and most considered approach to agreeing the Project Agreement. Only limited clarification of their submission was required (in contrast to the other two submissions) and the number of points remaining to be finally agreed was minimal. Bidder 3 did not seek to derogate from the form of Covering Letter (again in contrast to the other two Bidders) which was reflected in the score awarded. Overall, this submission as a whole was felt to be the strongest as indeed was Bidder 3's approach throughout the legal elements of the Dialogue, which was ultimately borne out in the legal scores awarded.

Please refer to appendix 7.29 for a more detailed report of the Legal Evaluations.

It is worth highlighting that all derogations have been signed off by the Strategic Investment Board's (SIB's) legal advisor. The SIB in effect are keepers of the Project Agreement having published it on behalf of DHSSPS. Legal advisors L'Estrange & Brett have been in constant contact with SIB Lawyer and discussions have been arranged around the key issues identified by each bidder. A copy of the IFB of the Project Agreement together with a list of derogations from the standard form was provided to Gregor Hamilton SIB Lawyer.

7.4.2.8. Financial & Payment Mechanism

Qualitative Scores

The quality scores were awarded in three distinct areas summarised in table 7.27.

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Table 7.27 Finance & Payment Mechanism Quality Scores in three distinct areas

Bidder	Max	Bidder 1	Bidder 2	Bidder 3
Funding	5.25%	4.12%	4.42%	3.98%
Model Review	1.75%	1.37%	1.58%	1.53%
Payment Mechanism	6.00%	3.90%	3.40%	5.00%
Insurance	2.00%	-	-	-
Total (13% max)	15.00%	9.39%	9.40%	10.51%

NB: The Insurance scores are shown separately in a subsequent section below.

Bidder 1

Bidder 1's use of 3 banks, each providing one third of the funding requirement, introduces the possibility of post Preferred Bidder complications. However, this panel structure does introduce a degree of additional comfort that liquidity issues with one funder will not impact on the deliverability of the overall structure.

The Bidder lost marks regarding the payment mechanism because the Technical Adviser's due diligence report did not show a sufficient level of consistency with their written statements, they ignored the Trust statement that the Cash Injection Adjustment Factor (the "CIAF") would not be subject to negotiation, and had unresolved issues with the Energy proposals. This was the main weak point in their finance submission.

Bidder 2

Bidder 2 scores highest in the funding section as their package demonstrates good competition delivering VfM and adopts an appropriate structure (bank) that minimises likely deliverability issues (single point of funding). They have one primary funder (HSBC) who is proposing to take 100% of the senior debt, with a second bank (HBoS) in reserve having signed a similar letter of support. This is a positive factor in mitigating the risk of liquidity problems with the primary funder. In terms of funding competition the main intention of the competition is to enable the team to run bank vs bond if there is a sea-change in the market position. Having two banks on board is not relevant to that competition. If the team felt that the terms being offered did not represent VfM in the current market, the team could get them to run the current preferred bank against one or more other banks

Similar to Bidder 1, the Bidder lost marks regarding the payment mechanism because the Technical Adviser's due diligence report did not show a sufficient level of consistency with their written statements, they ignored the Trust statement that the Cash Injection Adjustment Factor (the "CIAF") would not be subject to negotiation, and had included two issues regarding the allocation of Service Payment Points (SFPs). The Trust Due diligence adviser had, via the bidders project team, been informed that the CIAF had been set and would not

be subject to negotiation. However, they referred to the recalibration of the CIAF post-selection of Preferred Bidder.

The Preferred Bidder Letter will directly address this issue - i.e. a condition of the appointment of the Preferred Bidder is the sign-up to the Preferred Bidder Letter.

Bidder 3

Bidder 3's use of a bond solution is a cause for concern and significant doubts remain over the deliverability of the structure, given the current uncertainty around the financial robustness of the monoline insurance market, and this is the main reason why they have scored lowest of the three.

The Bidder showed an excellent degree of commitment to the Trust payment mechanism proposals. The only adverse point in this element of the submission was the desire to re-visit the Cash Injection Adjustment Factor (the "CIAF") post selection of Preferred Bidder⁵². Consequently Bidder 3 scored excellent marks in this section, and this is the reason why they scored highest overall, despite concerns about the deliverability of the funding package.

Please refer to appendix 7.30 for a more detailed report of the Finance Evaluations.

7.4.2.9. Project Management

Qualitative Scores

Table 7.28 shows the qualitative scores for the Bidder's Project Management submissions.

Table 7.28 Qualitative Scores for Bidder's Project Management Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Project Management				
Consortium Structure	0.00%	0.00	0.00	0.00
Project Management Plan and Programmes	1.20%	0.77	0.86	0.71
Long term partnering arrangements	1.40%	1.01	0.90	0.58
Change management and post project evaluation	1.40%	0.90	0.85	0.59
Socio-Economic	1.00%	-	-	-
TOTAL	5.00%	2.68	2.61	1.88

NB: The Socio-Economic scores are shown separately in a subsequent section below.

Bidder 1

⁵² They would probably want to re-run the calculation to set the ratio (CIAF) by running some sort of "dummy" model at or near financial close i.e. have the model including the OOCI and some other model without it. However, it would be a distraction and difficult to tell how "real" the outputs were.

Bidder 1 provided a satisfactory response. Their timescales were realistic and clear and they presented a realistic critical path. Their CV's illustrated a good previous background in PFI and hospitals. They confirmed that existing key members stay constant and showed examples of previous continuity on projects. In general, where possible they managed to provide extra working examples to reinforce their bid.

Programmes

Bidder 1's programmes have improved overall. The additional landslip remedial works has been included and Bidder 1 believes that this will have minimal impact on their overall duration due to the proposed phasing of the works. They provided a good, clear and precise programme, consistent with the Management Programme. All design and planning was considered and they demonstrated a clear understanding of design information and milestone dates.

Bidder 2

Bidder 2 provided a satisfactory response. The overall layout and presentation of their bid was impressive, their approach and style to answering the questions has been very good and has built positively on their Stage 2D submission. This Bidder has been relatively successful in incorporating previous comments.

Their Project Management Plan, Quality Management Plan and CV's style and content are of particular value in enhancing the key elements of their approach. They provided a detailed breakdown of teams and individual involvement allowance showing the continuity of personnel and team involvement.

Programmes

Overall Bidder 2 has made significant improvements to the project programmes incorporating most of the issues raised during Stage 2D. The additional landslip remedial works have been included within the programme. The format and presentation of the programmes is generally very good.

Bidder 3

Bidder 3 failed in providing a submission that has substantially improved from their previous submission for Stage 2D. The majority of their answers remained the same with minor improvements or inclusions.

Bidder 3 illustrated continuity of existing key personnel/groups and showed clear lines of responsibility/communication, but in general their submission lacked examples from previous experience.

Programmes

Bidder 3's programmes have improved overall with many of the issues raised at Stage 2D being addressed. However, dates and durations remain largely unchanged. The inclusion of a dedicated beneficial access programme in response to our previous comments is good. The additional landslip remedial works have been included.

Please refer to appendix 7.31 for a more detailed report of the Project Management Evaluations.

To aid comparison the expected Practical Completion Date for the three bidders is shown in the table below:

Table 7.29 Practical Completion Dates

Bidder No	Stage 2D	Stage 3
Bidder 1	28/11/2011	18/01/2012
Bidder 2	30/01/2012	05/12/2011
Bidder 3	03/02/2012	03/02/2012

7.4.2.10. Insurance

Qualitative Scores

Table 7.30 below shows the qualitative scores for the Bidder's Insurance submissions.

Table 7.30 Qualitative Scores for Bidders Insurance Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Insurance				
Insurance	2.00%	1.51	1.33	1.47
TOTAL	2.00%	1.51	1.33	1.47

Bidder 1

Bidder 1 submitted the most comprehensive response in relation to the Stage 3 insurance bid deliverables, including acceptance of Clause 36 and Schedule 21 drafting with very few amendments. Bidder 1 also scored highly due to the fact that it accepted the insurance cost sharing mechanism contained within Part 6 of Schedule 21 without the inclusion of an insurance contingency, and its confirmed broker fees are extremely competitive given prevailing insurance market conditions.

Bidder 2

Bidder 2 submitted a comprehensive response in relation to the Stage 3 insurance bid deliverables although there were a number of discrepancies within their bid which required further clarification. This Bidder lost marks due to the fact that it requires an insurance risk contingency of 25% to support the operation of the insurance cost sharing mechanism. This contingency equates to an extra £65,337.50 (indexed) per annum cost to the Trust within their bid price for the purchase of the required insurances. In addition, their broker commissions were thought to be high given current market conditions, but they were unwilling to consider the matter further. As Competitive Dialogue is now closed and these conditions are part of the bidders final bid submission they cannot be negotiated further and must be accepted by the Trust if Bidder 2 becomes preferred bidder.

Bidder 3

Bidder 3 again submitted a comprehensive response to the Stage 3 insurance bid deliverables although a number of areas required further clarification. Bidder 3 accepted clause 36 and Schedule 21 of the Project Agreement with very few amendments. In addition, Bidder 3 also scored highly due to the fact that it accepted the insurance cost sharing mechanism contained within Part 6 of Schedule 21 without the inclusion of an insurance contingency. The Bidder's proposed broker remuneration was deemed to be high in relation to the operational phase insurances, although they were not prepared to reduce these costs.

Please refer to appendix 7.32 for a more detailed report of the Insurance Evaluations.

7.4.2.11. Social & Economic

Qualitative Scores

Table 7.31 below shows the qualitative scores for the Bidder's Socio-Economic submissions.

Table 7.31 Qualitative Scores for Bidder's Social & Economic Submissions

Award Criteria	Weighting	Bidder 1	Bidder 2	Bidder 3
Social & Economic				
Design & Technical	2.00%	1.40	1.20	1.00
Facilities Management	1.00%	0.70	0.70	0.50
Human Resources	1.00%	0.50	0.60	0.60
Project Management	1.00%	0.70	0.40	0.20
TOTAL	5.00%	3.30	2.90	2.30

Bidder 1

Bidder 1 provided a good response in relation to training and employment, supply chain and community engagement proposals. They achieved 1.4% from the 2% available in the Design and Construction category. This was achieved with the quantification of targets that include the creation of 210 new jobs, a range of training opportunities and a methodology for the identification and utilisation of suitable local contractors. Additional detail on measures to promote equality and diversity would have increased the scores in this evaluation.

A good response was also achieved in relation to Facilities Management and Project Management, while additional detail on the outcomes of staff training initiatives and incentives for advancement would strengthen the Human Resources rating of satisfactory.

Bidder 2

Bidder 2 provided a satisfactory response achieving 1.2% in the Design and Construction category, with the exception of Community Engagement where a

good response was received. This consortium articulates plans to create 174 new jobs, with additional potential within the supply chain expressed, but not counted. Additional detail on the capacity, outputs and tailoring to target need from proposed initiatives expressed with quantifiable targets would strengthen this Social and Economic Regeneration Plan.

A good response was achieved in relation to Facilities Management and a satisfactory response in relation to Human Resources and Project Management.

Bidder 3

Bidder 3's evaluation of the Social and Economic regeneration plans reveal variations across the categories of this review, resulting in a satisfactory rating and score of 1% for Design & Construction. This consortium provided a good response to the addressing social exclusion with ring-fenced Training to Employment opportunities for the long term unemployed, while the absence of measures to address a range of targets resulted in a poor rating for community engagement.

A lack of quantification of potential impact and failure to submit the employment target template required for this deliverable impacted on the results of this evaluation. Clarification reveals an intention to create 233 new jobs. The failure to quantify plans and objectives also resulted in a poor rating of 0.2% for Project Management.

Please refer to appendix 7.33 for a more detailed report of the Social & Economic Evaluations.

7.4.3. Conclusion of Stage 3 Evaluations

It was clearly evident from the scores that Bidder 2's submission represented the most economic advantageous bid. This final bid demonstrates significant savings for the Trust and the public purse as they have achieved a price in excess of £2.5 million below the unitary charge. In addition this Bidder achieved the top overall score in the qualitative assessment.

Thus the conclusion from the Stage 3 evaluation was that the Trust were satisfied that Bidder 2's submission represented a deliverable and high quality solution which the Trust can work with to financial close.

The Trust therefore recommended Bidder 2 as preferred Bidder to the DHSSPS for approval. The was announced by the Health Minister on 18th September 2008.

7.5. ACTIVITIES POST APPOINTMENT OF PREFERRED BIDDER

7.5.1. Mandatory Variant Bid – European Investment Bank Funding

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Bidders were required to submit a Mandatory Variant Bid for the European Investment Bank's (the "EIB") prospective contribution to funding the Project.

Discussions have taken place between the EIB and the Trust on a number of occasions since the appointment of the preferred bidder and EIB have confirmed that they are still committed to providing funding for this Project.

In September 08 EIB issued the following statement: *'The European Investment Bank (EIB) has confirmed its involvement in the UK Social Infrastructure PPP Market on two significant deals – Enniskillen Hospital PPP and Greater Manchester Waste PFI'*. They also stated that *"EIB has consistently followed the Enniskillen Project with the Northern Irish authorities and has always kept in contact"*.

The EIB has confirmed are confident that they will be able to provide funding within the Trust's timetable to Financial Close. Importantly, they have already performed a significant amount of due diligence on the Project documentation and therefore are unlikely to have large numbers of commercial points that need to be resolved prior to Financial Close.

The club of banks and the EIB have started to discuss any outstanding requirements in order to have a full integrated funding package well in advance of the projected financial close date.

EIB terms remain more competitive than the commercial lenders, as would be expected, though they have also worsened since the submission of the final bids and the selection of the preferred bidder.

Table 7.32 Headline Comparison

	EIB	Commercial Banks
Margins - During Construction	104 bps	200 bps
Margins - During Operating Phase yr 1-10	64 bps	190 bps
Margins - During Operating Phase yr 11-20	64 bps	200 bps
Margins - During Operating Phase yr 21-30	64 bps	210 bps
Debt tail	36 months	36 months

In addition, the inclusion of the EIB reduces the required underwriting commitment from other lenders by 50%. The unwillingness of lenders to commit to large tranches of long term debt is as significant an issue for achieving a deliverable funding solution as the lack of competitive terms on offer.

One of the positive factors in attracting a club of funders with the appetite and liquidity was the inclusion of the EIB.

7.5.1.1. Quantitative evaluation

In running the most recent version of the Unitary Payment model, all of the effects of the inclusion of the EIB have been separately identified. These effects include the margins and debt tail indicated in the section above, but also includes the additional legal costs associated with their inclusion. The impact is summarised in the table 1.25 :

Table 1.25 Impact of EIB on the Unitary Payment

		£'000
Unitary Payment (real terms) excl the EIB		13,813
Impact of all EIB changes		(428)
Revised Unitary Payment		13,385

This shows that it is clearly beneficial in terms of reduction of the Unitary Payment to include the EIB, and that this delivers much better Value for Money for the Trust.

Taking all the beneficial aspects of the inclusion of EIB – reduced Unitary Payment, pricing and underwriting risk – with the absence of a significant number of points that might adversely affect the timetable, the Trust has decided to include the EIB as part of the final package that will be evaluated in the Full Business Case and subsequently taken to Financial Close.

7.5.2. Preferred Bidders Variants

All 3 bidders presented variants at Stage 3 submissions. The evaluation methodology set out the process, where only the core bids were evaluated and the top scoring bid would be designated as preferred bidder. Only once this had been determined were the preferred bidder variant proposals to be evaluated. After a preliminary evaluation by Health Estates, the Trust has established that both of the variants proposed by the Preferred Bidder (Bidder 2) are viable proposals, and worth the Trust's consideration. Bidder 2's variants are as follows:

1. 2-Tier car park
2. Wind Turbine

The Trust did not want to begin any clarifications with Bidder 2 on their variant proposals, lest they determine from that their status as Preferred Bidder. Due to the relatively low value of the variants the Trust felt it would be more prudent to wait until the decision on the Preferred Bidder has been approved by the DHSSPS, to have further discussion with the bidder.

Following the appointment of Bidder 2, further discussions took place with the Preferred Bidder, the outcome of these discussions has been detailed in the following sections.

7.5.2.1. Two Tier Car Park

As part of the final tender received from NIHG, a variant proposal for a two tier car park was offered.

This two tier car park can be included within the construction of the hospital at no additional cost whilst meeting the service and the construction output specifications required. There are a number of qualitative benefits to visitors, patients, staff and the environment. The solution frees up approximately 1 acre of land (within the developable area of the site) and provides potential for future development on the site which has a current value of £350K/acre.

Following this analysis, the Trust and Health Estates consider this to be a better value for money solution for car parking around the site and would intend to adopt this solution.

7.5.2.2. Wind Turbine

The Bidder initially proposed a wind turbine as a variant, but following discussions and clarifications with Health Estates and White Young Green (Trust's technical advisors). The proposal was withdrawn due to the risks associated with planning and the need to make the most of the sustainable energy provision in the core bid – a combined heat and power plant.

7.5.2.3. Overall Conclusion

Initial Evaluations indicated that both variants should be subject to a preliminary evaluation. The Trust and its advisors carried out a clarification and fine tuning process across the Design and Technical, Finance, Legal and Commercial workstreams, and as a result NIHG's variant bid; the two tier car park was deemed by all parties (Trust, Health Estates and the Exemplar Design Team) as an advantageous proposal that would enhance the New Acute Hospital. The Trust recommended that the 2-tier car park be incorporated into the PFI contract.

The EIB is now being included as part of the core bid.

The Technical Team concluded that the NIHG's Wind Turbine variant would not be a viable proposal to take forward due to planning restrictions and the need to make the most of the sustainable energy provision in the core bid, and as a result the bidder withdrew this variant proposal.

7.5.3. Ongoing appointment of Design & Technical Advisors

The Exemplar Design Team of specialist technical advisors will remain in place to continue to advise the Trust. This process is managed by Health Estates. These specialist technical advisors will advise the Trust in relation to the Preferred Bidder compliance with design and technical specifications set out in the TCR document. The EDT Team in conjunction with Health Estates and the Trust will ensure that Design and Technical issues identified within the preferred bidders submission will be resolved through the normal process of design development, at the

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commencement of the Preferred bidder, so as to ensure a timely resolution prior to Financial close. The issues identified are merely a refinement of the design from which further clarification and fine tuning is required. The time frame for this has already been included within the period between preferred bidder and financial close and therefore will not impact on the overall project delivery.

7.6. STAGE 4 - FINALISATION

7.6.1. Introduction

The Finalisation Stage of the procurement process involves four key steps;

1. Appoint Preferred Bidder:

The Preferred Bidder appointment followed receipt of DHSSPS approval of the recommendations outlined in the Appointment Business Case and the signing of the Preferred Bidder letter by the selected tenderer. The Preferred Bidder letter outlines the requirements that the Trust wishes to impose on the Preferred Bidder as a result of the tender evaluation process and was signed on 16 Sept. 2008. Following the alcatel period, the preferred bidder was appointed on 28 Sept. 2008

2. Submit Planning Approval/ Final Contract Development

Submit Full Planning Approval:

The second element of finalisation is receipt of Full Planning Approval. This element of the project represents a critical path to Financial Close and is under constant management and review by Health Estates Agency. Bidders submitted Full Planning Applications after Final Tender submissions in May 2008.

Regular meetings have also been held with the Planning Service and their main consultees, Roads Service. Through these meetings, it has been possible to discuss options and solutions to emerging issues.

Full Planning Approval was received on 23rd December 2008. Allowing for statutory period of 3 months for a potential judicial review, the Trust will be in a position of achieving Financial Close the week commencing 23rd March 09.

Final Contract Development

The main activities in terms of the finalisation of the contract post Preferred Bidder are as listed below:⁵³

- Finalisation of the Preferred Bidder Letter;
- Completion of the Project Agreement including technical schedules;
- Review of all Finance Documentation;
- Review and agreement of all Shareholder and Sub-Debt Documentation;
- Review of all Construction Documentation;
- Review of all FM Documentation;

⁵³ There are a range of provisions to be finalised within the Project Agreement but it is felt that all of this can be done within the limitations of Competitive Dialogue. These range from the very minor such as the name of the preferred bidder and the completion of addresses / contact details in the notice provisions, to more important matters such as the incorporation of the financial information and finalisation of the Project Co Proposals. In the main, the work that is still to be done is in respect of the technical schedules which can only be completed as the finalisation of the design takes shape.

- Review and agreement of all Shareholder Documentation;
- Finalisation of all other Trust Documents;
- Finalisation of Property Documentation⁵⁴; and
- Finalisation of Insurance Documentation.

3. Full Business Case Approval:

Part three of Finalisation is the development and approval of this Full Business Case. Following WHSSB and Trust Board approval, the Full Business Case shall then be submitted to the Department of Health, Social Services and Public Safety for approval

4. Financial Close:

The final part of the procurement process is Financial Close, which is the fixing of the Unitary Payment based on market interest rates at that date. Funding terms from the banks will have been confirmed in advance of the Financial Close and will be fixed. Financial Close is completed immediately after the signing of the final contract documentation.

Financial close was achieved on 20th May 2009 with a Unitary Payment of £13,831k with a commercial bank interest rate swap of 4.2425% and a RPI swap of 3.015%.

Each of these steps requires careful management to ensure that timely approvals are received as each represents a core part of the critical path that will bring the project through to successful Financial Close, and to the beginning of the construction phase of the project from April 2009.

7.6.2. Timetable for Stage 4 - Finalisation Stage

The timetable for the Finalisation Stage is outlined in Table 7.34A overleaf:

⁵⁴ *Property Documentation includes: licence over the retained estate and the finalisation of the certificate of title.*

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Table 7.34A Timetable for the Finalisation Stage

Activity: Finalisation Stage	Current Target Dates
DHSSPS Approval of Appointment Business Case	21st August 2008
Preferred Bidder Letter Signed	16 th September 2008
Appoint Preferred Bidder (After expiry of Alcatel period)	28 th September 2008
Submit Full Business Case to Trust Board for approval	4 th December 2008
Submit Full Business Case to WHSSB	5 th December 2008
Submit Full Business Case to DHSSPS for approval with Trust Board recommendation	8 th December 2008
Full Planning Permission required	10 th December 2008
Submit addendum to Full Business Case (Funding Terms)	16 th February 2009
End of Judicial Review Period on Full Planning Permission	March 2009 – 3 months from planning
Sign-off of contractual documents by DHSSPS	March 2009
DHSSPS Approval of Full Business Case	March 2009
Financial Close	March 2009

The Trust will have to ensure that it has available on the day of contractual close, two appropriately authorised individuals to sign the necessary documents on behalf of the Trust. The individuals should have been properly authorised in accordance with the Trust's Standing Orders. Clearly it is also important that all other necessary signatories are appropriately authorised to sign the documents on that day.

7.6.3. Stage 4 - The Project Structure

The project structure for the Finalisation Stage is outlined in Figure 7.3 below.

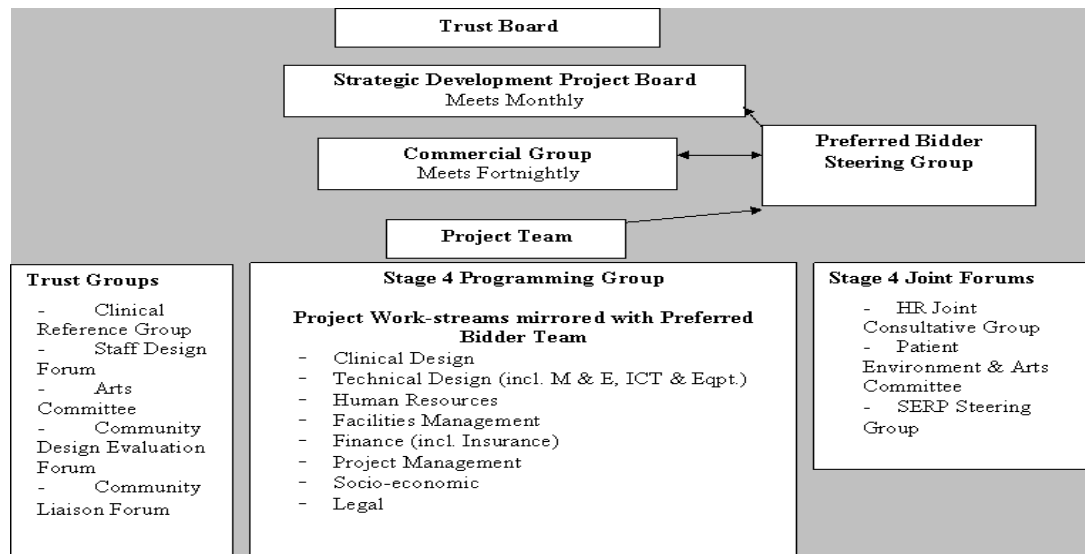


Figure 7.3 Project structure for the Finalisation Stage

7.6.3.1. Stage 4 Programming Group

Weekly Project Team Meetings: The Trust's Project Team meet on a weekly basis bringing together all project workstreams to share information and ensure that the appropriate interfaces are maintained. The project team work in partnership with Health Estates Agency, and key members of Trust staff and are regularly joined by external advisors e.g. weekly conference calls with key advisors. These meetings serve to agree and regularly review the project programme against all key work-stream actions.

Fortnightly Programming Group Meetings: The Programming meetings with the Preferred Bidder were initially weekly, moving to fortnightly from November 08. The purpose of these meetings is to provide the project momentum and drive the project forward in accordance with the established timeframe for key milestones. The standing agenda for Programme Group meetings include the review of actions, issues, requests for information, clarification logs, progress against programme, and change control. Actions are managed through the action log process. A key information source for these meetings is the Trust's fortnightly work-stream summary reports (Sample reports provided in Appendix 7.34). These reports are shared among all project team members, both the Trust and Project Co.

Work-stream Meetings: In addition to frequent engagement on project issues, meetings are scheduled for each of the project work-streams as required and in accordance with the demands of the Stage 4 deliverables and information required for Financial Close. An outline of these meeting schedules is as follows;

- Design & Technical: Fortnightly with clinical issues programmed for Thursdays and technical for Fridays. Meeting for various design disciplines such as landscape, architectural, energy etc. also run parallel.
- Finance: As required, to increase in frequency prior to Financial Close
- Facilities Management: Fortnightly for design issues. Specification and other issue meetings held ad hoc as required and in conjunction with Human Resources work-stream.
- Human Resources: Weekly initially and moving to fortnightly in the latter quarter of 2008.
- Equipment: Fortnightly for design issues.
- Socio-economic: Ad hoc as required and anticipated monthly.
- Legal: As required, to increase in frequency prior to Financial Close.

7.6.3.2. Preferred Bidder Steering Group

The Preferred Bidder Steering Group acts as a high level inclusive forum drawing together the strategic partnership required to bring the New Acute Hospital for the South West through to financial close.

The purpose of this group is to agree the overall project plan and closely monitor progress against key milestones with all stakeholders, to promptly resolve any issues and mitigate against any of the key risks.

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The Preferred Bidder Steering Group draws membership from the following key members and is chaired by the CEO, Health Estates:

- Health Estates Agency: John Cole (CEO) and Harry Thompson (Project Director)
- Western Health & Social Care Trust: Alan Moore
- New Hospitals for the South West: Mary Maguire
- Strategic Investment Board: Leo McKenna and David Gilmour
- Preferred Bidder Consortium Sponsor Stakeholders: Representation from FCC, Interserve, P. Elliott and AIB.

The purpose of the group is as follows:

- To establish and review the programme for delivery
- To communicate key decisions and secure agreement on the programme from all core stakeholders and sponsors, and enable this information to be disseminated through each of the member organisations.
- To coordinate input form key stakeholders on the key elements of the programme, design & technical, financial, planning and business case essentials, managing critical paths.
- To review workstream updates for programme
- To monitor progress against targets and milestones

7.6.3.3. Preferred Bidder Meeting Structures

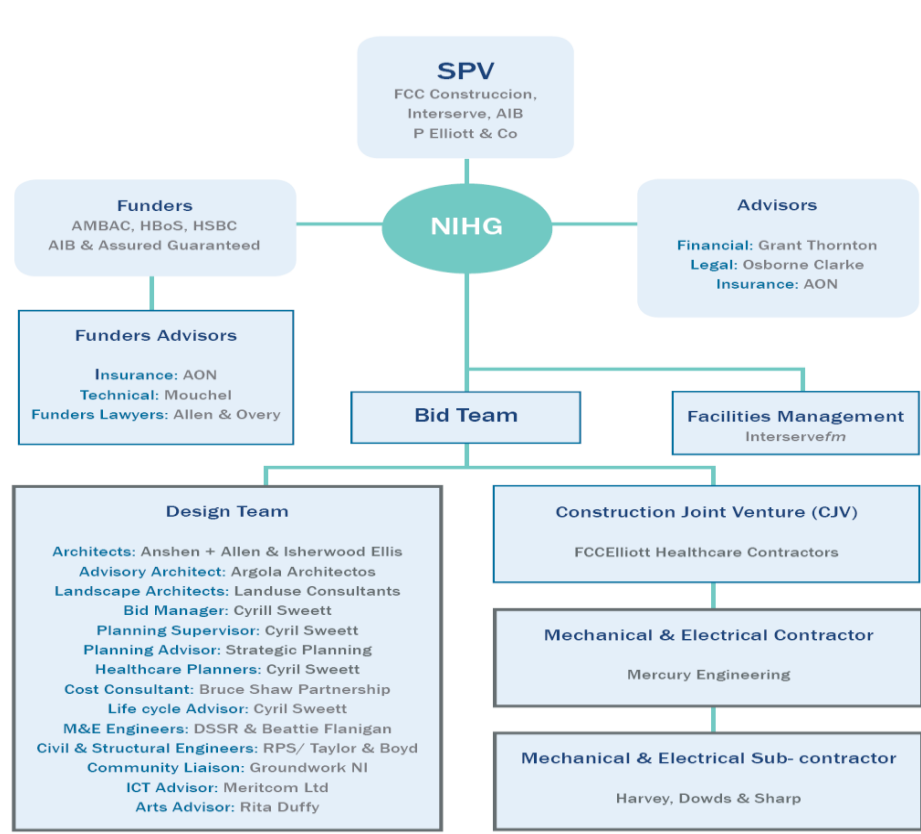


Figure 7.4 Preferred Bidders Summary Organogram

The preferred bidder submitted their organogram which was reviewed and agreed by the Trust and its advisors. Once the organogram was agreed the Trust then matched the project team lead members / advisors against what had been provided by the preferred bidder. The purpose of this was to ensure that moving forward with the project each workstream had clear direction in terms of the roles and responsibilities both on the Preferred Bidder team and the Trust / Advisor team. The detailed organogram can be referenced in Figure 7.5A overleaf.

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Workstream	Programme Delivery	Design and Technical and Construction Procurement	Equipment	Facilities Management	Human Resources	Finance	Legal	Insurance	ICT	Project Management	Art and travel Plan and disability	Socio Economic
Advisors	Health Estates	Health Estates	Health Estates	Davis Langdon		Deloitte	L'estrange & Brett	Marsh	IBS Health Estates		Health Estates	
Project Team Lead Member	Mary Maguire, Rosie Bryan	Etain Traynor	Etain Traynor & Doreen McIntyre	Margaret Hemphill	Shauna Ward	Rhys Davies	Anita McConnell	Rosie Bryan	Shane McNamee	Rosie Bryan	Anita McConnell	Anita McConnell
NIHG Team structure for liaising with Preferred Bidder												
Workstream	Programme Delivery	Design and Technical and Construction Procurement	Equipment	Facilities Management	Human Resources	Finance	Legal	Insurance	ICT	Project Management	Art and travel Plan and disability	Socio Economic
SPV Lead Member	Brian Furlong	Brian Furlong / Conor McCrory	Conor McCrory	Brian Furlong	Brian Furlong	Bob Marsden	Brian Furlong	Brian Furlong	Brian Furlong	Conor McCrory	Conor McCrory	Brian Furlong
Project Team Lead Member	Conor McCrory	Gary Bell / Mario Ramos	Gary Bell / Mario Ramos	Christophe Duale	Christophe Duale	Miguel Garcia	Brian Quinn / Oliver Keown	AON	Gary Bell / Mario Ramos	Gary Bell / Mario Ramos	Design Team	Tony McCusker
Other Team Members	Design Team and CJV	Design Team and CJV	Design Team and CJV	Interserve FM	Interserve FM	Grant Thornton	CJV Board	AON	Merit Com	Design Team and CJV	Design Team	CJV Interserve FM and Supply Chain

Figure 7.5A Preferred Bidder & Trust / Advisor team detailed Organogram

Progress is reported by workstreams at Preferred Bidder Programme meetings.

7.6.4. Workstream activities post Preferred Bidder to Financial Close

The following section outlines the key actions required to bring the project to successful and timely financial close and are presented on a work-stream basis. Below is a summary for each workstream, a detailed list has been outlined in the Stage 4 deliverables which can be referenced in Appendix 7.35.

These actions are also broken down into tasks and achievement of these actions is being managed through the Stage 4 Programme Meetings with the Preferred Bidder, joint work-stream meetings, and monitored by the Preferred Bidder Steering Group with reporting lines through to the Commercial Group, and Project Board.

Position at Financial Close

The process of reaching Financial Close was carefully managed through a programme of planning, documentation of responsibilities and deadlines, and daily meetings with progress reporting. This planning ensured the required liaison across the project workstreams to finalise the contractual documentation and established systems for communication with the key Trust staff, the DHSSPS Infrastructure Investment Directorate and Health Estates Agency.

Assurance of Procurement Process

The Trust implemented a verification process to ensure that the Trust's requirements and specifications had been reflected in the primary contractual documentation, 'the Project Agreement'. Assurance was provided from the Trust's key external professional advisers, namely Legal, Financial, Design & Technical and Facilities Management. This is evidenced in letters received from these advisers as contained in appendix 7.36 A -D of this Full Business Case.

Verification of Contractual Documentation

The detail of the Project Agreement and associated schedules were developed throughout the procurement in conjunction with relevant professional and technical advisers, Trust Director/Assistant Directors and Managers and under the guidance of the Trust's PFI legal advisers. This process was managed by the Trust's project team and supported through an engagement programme with relevant Trust staff and guidance obtained from external bodies where necessary. (for example; Regional Supplies Service, Government Actuary Department).

Following a series of briefing sessions and quality assurance meetings, the schedules to the Project Agreement were signed off by the appropriate Trust Director/Assistant Director and professional adviser. This preliminary sign-off was completed in advance of Financial Close and then presented as documentary evidence of the completed preliminary sign-off to the Trust signatories at Financial Close.

Management of Financial Close Programme

A programme for achieving Financial Close was developed and shared with stakeholders and was kept under review and updated on a daily basis. This programme outlined the key milestones in the achievement of the timetable to Financial Close.

Furthermore a briefing document was developed that outlined the required tasks and actions on a day by day basis. This included a detailed order of play establishing roles and responsibilities for concluding the Financial Close process. A copy of the Financial Close planning document can be found in Appendix 7.36 E.

7.6.4.1. Finance

Selection of Preferred Bidder

At the point of selection of preferred bidder, the NIHG funding structure was based on bank senior debt, with 100% of the funding requirement provided and underwritten by HSBC. It was proposed that any syndication risk was taken by the bank, post financial close. This was seen to have the advantage of simplicity in the run-up to financial close, with the majority of the risk taken by the private sector.

The Preferred Bidder was selected on the Core Bid i.e. excluding any funding from the European Investment Bank (the “EIB”), as set out in the evaluation methodology and agreed with all three bidders prior to the submission of final bids. Regardless of which bidder was selected, it was always the Trust’s intention to evaluate whether the inclusion of the EIB offered improved Value for Money, in the period immediately after the selection of the Preferred Bidder. This was agreed with all bidders and the relevant approving bodies in advance of the submissions.

The Unitary Payment in the NIHG core final bid in real terms was £12.5m per annum. The second placed bid had a unitary payment (in real terms) of £14.2m per annum. (The Unitary Payment target was set at £15.2 million following approval by the DHSSPS in February 2008.)

Changing Market Conditions

- **“Credit Crunch”**

The global credit crunch i.e. the situation created when banks significantly reduced their lending to each other because they were uncertain about how much liquidity they had, and how much exposure other financial institutions had to low quality loans, had three main direct impacts on the project funding.

Firstly because the appetite of the banks to lend money was greatly reduced the Preferred Bidder’s original funder (HSBC) announced that it would be unable to underwrite the whole of the required funding.

Secondly, because the international money markets were reluctant to lend, the bank’s own cost of funds had risen and it was therefore unable to provide its funding at the rates quoted in the final tender. In addition, the lack of available finance in all sectors had pushed up the margins in other sectors, for example corporate lending. Banks with a limited amount of available capital would only lend to the public sector where the returns were similar to the returns that could be achieved by redirecting the scarce funding to other types of business.

Finally, because significant and fundamental changes were happening on an almost daily basis, the banks were not prepared to hold their offered terms for long periods

of time. Typically in PFI deals the elapsed time between submission of final tender and financial close is up to a year, and funders have held a fixed price for this length of time. In the current environment, terms are being held for a matter of weeks only.

- ***Impact on the Competitive Dialogue Process***

This change in the position of HSBC was a fundamental feature of the financial markets' reaction to the credit crunch, and would have affected all Bidders to a similar degree i.e. no bank would have been prepared to hold their fixed terms in the manner envisaged by the Invitation to Submit Final Bids (the "IFB"), virtually no bank would be prepared to underwrite more than approximately £50m, and no bank would remain committed to the terms submitted in February 2008.

Further evidence of this can be gained by examining the current position of the banks that had provided commitments to the second placed bidder – namely Depfa and SMBC.

- SMBC took part in the initial expressions of interest to provide funding as part of the "club" of banks. They stated explicitly that the terms they would be able to provide in the current market conditions would be significantly worse than those offered at the final bid stage. These terms were also significantly worse than terms currently available from other funders who are still active in the PFI market.
- Depfa are part of Hypo Real Estate bank from Germany, who were very public recipients of large scale support from the German government and are no longer lending in this market as a direct consequence of the global conditions.

It seems evident that the turmoil in the funding markets would have applied equally to all bidders, and it seems unlikely that any of the three could have absorbed the increased funding cost without passing it on to the Trust via the Unitary Payment. It is the view of the Trust and their Financial / Commercial and Legal Advisors that the resultant changes would most likely have been equally applicable to each or any of the bidders. Therefore, having considered the matters at length and following detailed discussions with in particular Health Estates and the SIB, it was not felt to be discriminatory. The changes are, therefore, not prejudicial to the unsuccessful bidders.

It is also clear that the changes in the market were outside of the control of the Trust and could not have been reasonably foreseen - the scale and speed of the problems was unforeseen by central banks and governments across the world's largest financial centres.

The OGC guidance on Competitive Dialogue suggests that there are circumstances where it might be acceptable to change the characteristics of the bid post selection of preferred bidder - termed "exogenous changes". The presumption is that the changes must have been unforeseeable at the time of submission – which would seem to

apply to this project. (Reference – “Competitive Dialogue in 2008 – HMT/OGC joint guidance on using the procedure” – paragraphs 5.5.9 and 5.5.10)

However, it is unclear whether the CD Regulations envisage a similar interpretation.

- ***Impact on the Funding Package***

HSBC initially announced that whilst they could not underwrite the whole of the debt, and could not provide finance at the terms submitted at Final Bid stage, they were still committed to the project.

The NIHG consortium and HSBC suggested the following solution:

- Confirm the involvement of the EIB. The EIB had indicated that they would be willing to take 50% of the total funding requirement. This had the advantage to the Trust of reducing the Unitary Payment, as the terms available from the EIB were much better than those available from the commercial banks. A second advantage was that it reduced the funding required from the commercial sector, making it more likely that the funding could be obtained.
- Create a funding “club”. The club would be formed from a small number of banks (given the likely maximum appetite of £50m each and the funding requirement of £125m excluding the EIB contribution, this indicated a club of three or four banks).
- HSBC would act as structuring bank i.e. they would obtain a consensus amongst the club members, and provide a one-to-one interface with both EIB and the Trust.
- HSBC would have the right to match the terms of the remaining members of the club so that they could retain some involvement in the final funding package.

However, following internal management decisions within HSBC they subsequently announced that they would be unable to act as structuring bank, or to participate in the funding club.

Despite the decision of HSBC to opt out of the funding process, the most appropriate structure remains a club of funders, each providing a portion of the debt on an equal basis, alongside a 50% funding commitment from the EIB.

- ***Impact on the Process to Financial Close***

The main activities that are being undertaken in the wake of the market changes and HSBC’s decision to withdraw its support are listed below with a short explanation:

1. Achieving the best financial terms

The Trust, Health Estates, its advisers and SIB are working with NIHG and its advisers throughout the period between their appointment and financial close in order to provide a funding package which delivers the maximum possible benefit to the Trust, whilst remaining achievable in the current volatile market. NIHG believe that this will be best achieved through the creation of a club or panel of banks to provide the funding.

The process for creating the club is designed to optimise the deliverability of the funding in an ever contracting market whilst at the same time managing the value for money of the funding in light of the current market.

While HSBC continued to support the project, it was considered appropriate for them to undertake a structuring bank role i.e. they would provide a lead role in setting up the club, obtain a consensus amongst the club members, and provide a one-to-one interface with both EIB and the Trust. When they withdrew their support as a result of their strategic change in direction, it was considered appropriate to maintain the structuring bank role - even if for only a short period of time until the club of funders was put in place. To that end Allied Irish Bank which is one of the sponsors agreed to undertake this role. Now that the club of funders is in place, this role is being undertaken by the club itself. Responsibility for the various elements of the structuring role is being shared between the banks.

NIHG have made significant effort into ensuring that a wide range of funders has been included in the process. A long list of banks was invited by NIHG to preliminary discussions, 9 were provided with the Project Information Memorandum ("PIM") containing high-level project information, and 6 submitted responses. This process enabled the consortium to assess which of the banks remained capable of providing project funding with the required tenor of thirty years.

It is necessary to ensure that terms and structure are attractive to all in the club and therefore a book building process has been adopted i.e. the lowest terms for the project that will enable sufficient banks to be interested to provide the required funding are offered to all club members.

A club of three funders is the minimum number, based on the required funding and the maximum hold levels being indicated by funders. In order to keep the club whole in the event of one falling away, it was agreed that a club of four would be advisable, each taking 25% of the funding required, but with a commitment to take 33% should the need arise. The inclusion of six funders in the submission process allowed for unacceptable requirements (to the Trust or NIHG) or late changes in appetite to rule one or more banks out without jeopardising the club structure required.

The club of four has now been appointed by NIHG, based on the terms submitted, namely Barclays, Bank of Ireland, Helaba and Nord LB. The intention is to complete the project with these four funders unless one of them withdraws from the process (for whatever reason) whereby we would be able to complete with only three.

A summary of the experience and current position of the four banks included in the club is attached as Appendix 7.36.

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The terms that have been included are realistic based on current market information, and are summarised in the Table below. However, the volatility of the market is such that the possibility remains that there may be further market changes between the submission of this paper and financial close.

In order to give the Trust and DHSSPS comfort that these changes should not have a material impact on the affordability of the scheme, the Trust has asked that 50 basis points continues to be modelled into the Unitary Payment to provide a “buffer” against any changes. This buffer had been previously modelled by all bidders in all submissions, as a contingency against adverse interest rate movements, and does not represent a change in the modelling requirements. The value of the buffer is approximately £600k. The exact value depends on the inputs to the model, but that is a reasonable approximation at this point. Hence the real UP would be £13.1m.

The buffer is only intended to cover adverse movements in the underlying cost of interest rate and inflation rate swaps, and not any of the other changes in the model. The interest rate swap at FBC stage (Dec 08) (including the buffer) was 4.82%. The interest rate swap in the current model (including the buffer) is 4.66%. This is a reduction of 16 basis points.

The RPI swap at FBC (Dec 08) was 3.02% and is currently 3.33%. This is a reduction of 32 basis points.

The effect of a 1 basis point change in each of the Swaps is currently approximately the same i.e. 12K. As I’m sure you are aware, reductions in interest rate swaps reduce the UP, reductions in RPI swap increase the UP, so the net effect of the above changes is, approximately, an increase in the UP of $(32 - 16) \times 12 = 192\text{K}$.

This increase is less than the value of the buffer.

Any unused portion of the buffer will be removed at financial close, with any benefit being received by the public sector. The Trust and its advisers will regularly review the situation as required.

Despite the increased costs caused by the market conditions, the real Unitary Payment currently stands at £13.4m, which is still significantly lower than the unadjusted next best submission at £14.2m, which would undoubtedly rise significantly if the funding banks for that bid were asked for current market prices.

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Northern Ireland Health Group							
New Acute Hospital for the South West							
Conformed Terms							
	Club of Funders			EIB			
	Final Bid/ ABC	FBC	FBC Addendum	Final Bid/ ABC	FBC	FBC Addendum	
Facility Margins							
Senior Term Facility							
Construction Period	0.85%	1.75%	2.00%	0.55%	0.86%	1.04%	
Operating Period yrs 1-10	0.70%	1.75%	1.90%	0.25%	0.46%	0.64%	
Operating Period yrs 11-20	0.80%	1.75%	2.00%	0.25%	0.46%	0.64%	
Operating Period yrs 21-30	0.80%	1.75%	2.10%	0.25%	0.46%	0.64%	
Equity Bridge Facility	0.25%	1.25%	1.50%	n/a	n/a	n/a	
Change In Law Facility							
Construction Period	0.85%	1.75%	n/a	n/a	n/a	n/a	
Operating Period yrs 1-10	0.70%	1.75%	n/a	n/a	n/a	n/a	
Operating Period yrs 11-20	0.80%	1.75%	n/a	n/a	n/a	n/a	
Operating Period yrs 21-30	0.80%	1.75%	n/a	n/a	n/a	n/a	
Debt Service Facility							
Construction Period	0.85%	n/a	n/a	n/a	n/a	n/a	
Operating Period yrs 1-10	0.70%	n/a	n/a	n/a	n/a	n/a	
Operating Period yrs 11-20	0.80%	n/a	n/a	n/a	n/a	n/a	
Operating Period yrs 21-30	0.80%	n/a	n/a	n/a	n/a	n/a	
Debt Service Reserve Account Required	No	Yes	Yes	Yes	Yes	Yes	
Change in Law Reserve Account Required	No	No	Yes	No	No	Yes	
Hedging Margin and Mandatory Cost							
% per annum on the Interest Rate Swap	0.07%	0.16%	0.20%	0.07%	0.16%	0.20%	
% per annum on the RPI Inflation Swap	0.07%	0.20%	0.25%	n/a	n/a	n/a	
Arrangement Fees							
Senior Term Facility	1.00%	1.50%	2.00%	0.50%	0.50%	0.50%	
Equity Bridge Facility	0.50%	1.50%	1.50%	n/a	n/a	n/a	
Change in Law Facility	0.80%	1.50%	n/a	n/a	n/a	n/a	
Debt Service Facility	0.80%	n/a	n/a	n/a	n/a	n/a	
Commitment Fees							
Senior Term Facility							
Construction & Operating Period	0.34%	0.70%	1.00%	0.28%	0.28%	0.52%	
40.00%	40.00%	40.00%	50.00%	50.00%	50.00%	50.00%	
Equity Bridge Facility	0.10%	0.50%	0.75%	n/a	n/a	n/a	
40.00%	40.00%	40.00%	50.00%				
Change in Law Facility	0.43%	0.88%	n/a	n/a	n/a	n/a	
50.00%	50.00%	50.00%					
Debt Service Facility	0.43%	n/a	n/a	n/a	n/a	n/a	
50.00%							
Other Roles Fees							
Agent Bank							
Construction	25,000	£25,000	£50,000	n/a	n/a	n/a	
Operations	15,000	£15,000	£40,000	n/a	n/a	n/a	
Maintenance Reserve Account							
100% of the following 12 months	100%	100%	100%	100%	100%	100%	
50% of the forecast lifecycle expenditure (month 13-24)	50%	50%	50%	50%	50%	50%	
25% of the forecast lifecycle expenditure (month 25-36)	25%	25%	25%	25%	25%	25%	
Gearing (allowed)							
	93.7	92.8	92.8	93.7	92.8	92.8	
Cover Ratios							
Minimum ADSCR	1.150	1.150	1.180	1.150	1.150	1.180	
Average ADSCR	1.150	1.150	1.200	1.150	1.150	1.200	
Lock up ADSCR	1.100	1.100	1.100	1.100	1.100	1.100	
Default ADSCR	1.050	1.050	1.050	1.050	1.050	1.050	
Minimum LLCR	1.175	1.175	1.230	1.175	1.175	1.230	
Lockup LLCR	1.150	1.150	1.150	1.150	1.150	1.150	
Default LLCR	1.100	1.100	1.100	1.100	1.100	1.100	
Tail (months)	6	36	36	12	42	36	
Base Rate	5.61%	4.82%	4.66%	5.61%	4.82%	4.66%	
RPI Swap Rate (after deduction of RPI hedging margin)	3.330%	3.020%	3.09%	3.33%	3.02%	3.09%	
Unitary Payment (£ million, real terms, base date 1 April 2007)	12.466	na	na	12.246	12.647	13.385	

Figure 7.5B Conformed Terms for the Club of Funders

As illustrated in Figure 7.5B above, the increase in the Unitary Charge from ABC to FBC is attributable to the current commercial bank funding terms that have worsened in the current economic climate. Some of the increased cost has been offset by falls in the underlying interest rate. The Unitary Charge of £13.4m remains under the target unitary charge at ABC of £15.2m. The Final Unitary charge shall be confirmed prior to Financial Close following the funders Credit Committee Approval.

2. Achieving the timetable

The timetable to Financial Close is a challenging one and will require significant effort from all parties. Progress to date has been good. The sponsors and their advisers consider that good communication and flexible attitude to resolving issues will be key to ensuring the project and its funding are delivered in order to

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achieve Financial Close by 23rd March 09. To that end weekly meetings with the bidder have been set up and conference calls arranged as necessary and attended by the relevant parties capable of assessing and settling any matters requiring resolution.

Overarching the whole of this process is the need to ensure that the Trust, Health Estates and the SIB are fully satisfied with the process and its results. Close communication has been established and this will be maintained throughout the period to Financial Close.

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The process that has been followed to date in bringing together the banks that will form the club is set out in the timetable below, together with an indication of the key milestones that will be achieved in the run-up to financial close:

Table 7.34B: Programme to create club of funders

Task	Description
Funders' meetings – 24th & 25th Nov 08	<p>In order to create a long list of banks who will be asked to submit terms to the consortium, NIHG arranged meetings with a number of the commercial banks who are actively lending into the UK PFI/PPP market. The meetings were attended by the Trust's financial advisers and SIB to provide oversight. The banks who attended were:</p> <ul style="list-style-type: none"> - Bank of Ireland; - Helaba; - Barclays; - Nationwide; - SMBC; - Fortis; - Santander; - Nord LB; - ING; - Natixis; and - AIB. <p>In addition, Lloyds TSB and the Co-operative Bank were invited, but declined to attend due to commitments to other projects, which restricted their lending capacity.</p> <p>The purpose of the meetings was to:</p> <ul style="list-style-type: none"> • gauge the appetite of the banks for the scheme; • gain an indication of the likely terms available from the market; • understand whether the banks would accept the conditions of joining the club e.g. accepting all due diligence performed to date with no attempt to introduce negotiation;

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Task	Description
	<ul style="list-style-type: none"> • provide general information for the banks about the state of the scheme, the degree of work performed to date, and the commitment from the public sector to achieve financial close; and • test out the reasonableness of the proposed timetable to financial close.
Issue Project Information Memorandum 1st Dec 08	Based on the outcome of the meetings 9 banks were selected to receive the Project Information Memorandum (the “PIM”). This set out the key features of the scheme including details of the construction and design, clinical content, funding requirements, summary of the Project Agreement, status of the due diligence reports, outstanding issues to be resolved, and timetable.
Funders respond to PIM	<p>The banks had the opportunity to ask clarification questions (during clarification meetings held on 10th and 11th December, attended by SIB for oversight) regarding the information included within the PIM in order to be able to submit terms sheets.</p> <p>A generic term sheet was prepared and issued to the funders to respond to. This had a common set of conditions, but with the key commercial terms e.g. margins, left blank for the banks to complete.</p> <p>Responses to the PIM were required no later than 19th December 08.</p> <p>Six funders submitted terms that supported a tenor of debt of 30 years. These six funders were :-</p> <ul style="list-style-type: none"> - Bank of Ireland; - Helaba; - Barclays; - Nationwide; - NAB and - Nord LB.
Evaluation & Clarification	<p>The six responses to the PIM were evaluated by NIHG and its advisers. Where required, clarifications were raised with the banks who responded and NIHG and its advisers took an active role in ensuring the greatest degree of acceptance and consistency between the commercial banks.</p> <p>Further clarification meetings were held with the six funders on 6th and 7th January. These meetings were attended by the Trust's Financial Adviser for oversight.</p>

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Full Business Case

Task	Description
<p>Confirmation of Club memberships</p>	<p>At the end of the evaluation process, it was agreed that a club of four funders would be appointed in order to ensure that the club could remain whole in the event that one of the funders withdrew from the club.</p> <p>The terms were set at a level to allow a club of four to be achieved. It should be noted that the level at which the terms were set was not adversely affected as a result of having four in the club rather than three. The Deliverability of the funding solution was a key consideration of the appointment process.</p> <p>Confirmation of the club was originally due to take place no later than 19th January 09. This was accelerated with a core club of three being appointed on 7th January 09 and the fourth member being appointed following further clarification on 12th January 09.</p> <p>A funding club “kick off” meeting was held on Monday 12th January in order to facilitate the forming of the club and agreement of roles and responsibilities in the process to Financial Close and thereafter.</p>
<p>Credit committee approval</p>	<p>Depending on the individual bank’s funding processes, the timing of the achievement of final credit committee approval will differ slightly.</p> <p>It is recognised that a significant factor in the funders’ credit processes will be the stage of development of the legal documents and due diligence. To that end it is the intention that all matters will be raised by the funders by the end of January 09 in order to facilitate early resolution and the credit process progresses as necessary. An Issues List has been compiled by NIHG and shared with the Trust, DHSSPS, Health Estates and SIB.</p> <p>The intention is to ensure that funding terms are confirmed and reconfirmed on a regular basis in order to ensure that an up to date position is known. Based on indications provided it should be possible to have credit committee approved terms in place by early March. Each of the funders credit process has been commenced and good progress is being made to date.</p>

3. Reviewing the Bidder's final financial model and term sheet

Throughout the final stages of the procurement, it will be necessary to review the financial model in order to verify that the inputs remain as agreed. During the Preferred Bidder stage it is vital that changes to the model are monitored, and that all changes are confirmed in advance.

This will ensure that any amendments to the scheme (only refinements will be allowed⁵⁵) are accurately reflected in the model and interest rates and other funding terms are updated as appropriate to provide an accurate estimate of the likely Unitary Charge at financial close. Clarifications will be raised with the Bidder on any unusual or inaccurate elements and assumptions will continue to be challenged.

4. Finalising the Payment Mechanism

The final calibration of the Payment Mechanism relates primarily to the fact that the Functional Area and Unit weightings developed during the Competitive Dialogue were based on the exemplar design. These need updating immediately prior to financial close to reflect the Preferred Bidder's design solution based on the Schedule of Accommodation. Any changes to the FBC will be justified by the Trust and approved by DHSSPS. The Trust and PB and respective advisers will work jointly to ensure that the risk profile of the scheme remains the same as that which was bid against.

5. Assessing the tax position of the project

The Trust financial adviser's tax specialists will perform a final review of the models, firstly, to assess whether the stated assumptions remain viable and efficient, and secondly, to check the way in which the assumptions flow through the model. This process aims to improve tax efficiency through continued refinement with Bidders.

6. Benchmark the funding rates at financial close

The Trust, with the assistance of its financial advisers, will engage the services of a broker to benchmark those financial terms that vary on the day of financial close.

7. Managing the Financial Close process:

Financial close occurs once the PFI Contract has been signed and refers to the process whereby the funding terms (i.e. interest rates) for the scheme are fixed.

As this financial close process is complex, the Trust will put in place a carefully controlled and structured programme around this phase.

The Trust, Preferred Bidder and respective financial advisers will participate in several "dry runs" prior to the day of financial close.

⁵⁵ As permitted under competitive dialogue

The SPV's financial model is audited by someone appointed by them. The Trust will want to see a copy of the final letter to ensure that the process has been properly completed, even though the model auditor has no duty of care to the Trust.

The final activity for the financial workstream is the verification that the correct figures from the financial close model are inserted into the correct places in the Project Agreement.

Submission of information to the Department:

As indicated in the FBC, this paper has been prepared immediately after NIHG's creation of the funding club of banks, as this represents the first point at which there is a reasonable degree of certainty about the likely funding terms that will be available for the project. The Trust and the SPV now have a reasonable indication of the terms of that the funding club is prepared to operate at and whilst there are minor points of detail to be resolved the fundamental and underlying principles of the club are established.

Pre- Financial Close Conclusion

The Trust and its financial advisers Deloitte, together with Health Estates and SIB, continue to monitor closely NIHG and how it has proposed to deliver the final funding terms. In the final iterations of the model a set of inputs will be extracted the Trusts Financial advisors and agreed verified by Trust staff and advisers to ensure that these inputs fairly represent the agreement e.g. FM costs will be sent to the Trust and Davis Langdon.

Financial terms will be agreed to the funders' term sheets to ensure that the model fairly reflects the agreed position.

The Trust will use a broker to oversee the pricing of the RPI and interest rate swaps to help ensure there are no "hidden" margins and that the pricing protocol agreed in advance is used at the point of financial close.

NIHG has produced the following timetable (Table 7.34C) to achieve Financial Close.

Table 7.34C: NIHG's Indicative timetable to Financial Close

Date	Description
30th January 09	NordLB to commence their credit committee process
10th February 09	Helaba to commence their credit committee process
13th February 09	Barclays & Bank of Ireland to commence their credit committee processes
02nd March 09	Funders (Bank Club & EIB) to reconfirm terms subject to any outstanding approval committees such as liquidity committees (if terms have moved Financial Models to be revisited and new models circulated)
16th March 09	Funders to reconfirm all of the terms
17th March 09	Legal documents to be finalised
W/C 23rd March 09	Financial Close

Numerous weekly meetings and conference calls take place with NIHG and fortnightly Steering Group meetings take place with all sponsors, the Trust, Health Estates and SIB. DHSSPS will be kept informed of progress and of any changes resulting from changing market conditions.

Position at Financial Close

1. Achieving the best Financial Terms

The funding package for the New Acute Hospital for the South West reflects a contribution from the European Investment Bank approaching 50%, with the corporate banks of NordLB, Bank of Ireland (Corporate Banking) and Barclays Bank combining to provide the remaining 50%.

Each of the three commercial banks took a third share of the interest rate swap and Barclays and Bank of Ireland took equal shares of the RPI swap.

2. Achieving the timetable

Financial Close was achieved on 20th May 2009, which was approximately six weeks later than initially planned. This was impacted by the following factors;

- the time required for agreement to be reached by the banks on their relative roles.
- the progress of the project through the stages of the credit committee approvals by each of the banks
- the dates of Final Credit Committee approval for each bank.

These factors were outside of the control of the Trust.

3. Reviewing the Bidder's final financial model and term sheet

The Bidder's final financial model and term sheet was subject to rigorous review prior to closure. Inputs into the financial model were checked and verified by the

Trust in conjunction with the relevant external professional advisers and quality assured by Trust Financial Advisers Deloitte.

Deloitte provided a report on the principle funding terms offered by Northern Ireland Health Group (Ref: Appendix 7.36B) Value for Money of Funding Terms; 7th July 2009 which concluded that;

‘The above terms for senior, subordinated and equity funding are below the levels we have seen offered or reported for some larger projects in other sectors and are broadly in line with the pricing we have seen offered by banks and investors in accommodation PFI projects of comparable size in the current market’.

The banks and the Northern Ireland Health Group also engaged an independent Model Auditor, PKF Accountants and Business Advisers in line with good PFI practice which provide further assurance..

4. Finalising the Payment Mechanism

The Functional Area and Unit weightings were updated prior to Financial Close to reflect the Preferred Bidder’s design solution.

5. Assessing the tax position of the project

A tax review of the Financial Model was completed by the Trusts financial advisors, Deloitte, who provided assurance that the tax treatment was appropriate prior to Financial Close. This task was also within the scope of the independent Model Auditor and formed part of their report..

6. Benchmark the funding rates at financial close

In addition to the role of the Trust Financial Advisers, Deloitte, further quality assurance was sought in relation to benchmarking the funding rates. Investment banker JC Rathbone were engaged by the Trust to review the funding terms and conduct a series of benchmarking exercises with the club of banks to establish the fair market price for the bank debt. This role involved ensuring the hedging of the relevant interest rate and inflation rates were competitive in the current market place and that the structures agreed to calculate cash flows and interest were correct, and that these structures were maintained throughout the process. To complete this, a series of dry runs were conducted in liaison with the Trust Financial Advisers, Deloitte and the Preferred Bidder's financial advisers (Grant Thornton) to ensure that the pricing was in line with market rates.

The benchmarking process was conducted over a period of weeks running up to financial close during a series of dry runs to establish the fair market rate for the required hedging. The pricing on all dry runs and at Financial Close was pre-benchmarked on an individual basis with one or more bank separately in order to avoid any doubt on the underlying market pricing. The result of this exercise was that JC Rathbone concluded that the execution process for the hedging was completed at fair and reasonable market pricing and therefore represented fair value based on prevailing market rates. (Appendix 7.36F: JC Rathbone Funding Terms Verification).

7. Managing the Financial close process

The process of reaching Financial Close was carefully managed through a programme of planning, documentation of responsibilities and deadlines, and daily meetings with progress reporting. A briefing document was developed that outlined the required actions on a day by day basis. This included a detailed order of play establishing roles and responsibilities for concluding the Financial Close process. A copy of the Financial Close planning document can be found in Appendix 7.36E.

Prior to Financial Close nine dry runs were undertaken to assure the process. At Financial Close JC Rathbone confirmed that the execution process represented fair value based on market prices and the Trust's Financial Advisors, Deloitte and the model auditor PKF confirmed that the Financial Model optimised the inputs to generate the unitary charge. A series of briefings were held with the DHSSPS to ensure that they were kept apprised of progress which proceeded up to the point of financial close. Following the completion of the verifications and upon recommendation by Deloitte, the Trust authorised Financial Close and the final Unitary Charge of £13,831k was generated.

Following insertion of the Final Unitary Charge figure into the Project Agreement documentation, Deloitte and the Model Auditors conducted a verification that these figures were true and correct, enabling the Project Agreement to be signed.

7.6.4.2. Legal

The key to reaching contractual close is securing absolute agreement from all the respective parties to each of the many documents necessary to finalise the Project. Broadly speaking, the documents fall into the following categories:

- The Project Agreement Documentation;
- Sub-contractor Documentation;
- Direct Agreements and Collateral Warranties;
- Property Documentation;
- Finance and Security Documentation;
- Corporate Documents; and
- Ancillary Documentation.

In total this will entail the finalisation and engrossment of in excess of 100 documents. In addition to agreeing each of these documents, it is also imperative that in each case the document is approved by the respective parties to that document and that signatories are appropriately appointed to sign the document on behalf of the body they represent. In the final days prior to Contractual close, this will be an important task which will require that board meetings be scheduled by each of the bodies to undertake this approval function. Another approval which will be required is a certificate from the Department issued pursuant to the Health and Personal Social Services (Private Finance) (Northern Ireland) Order 1997. As we approach this stage, separate discreet tasks will also have to be undertaken including the formal appointment of both the Independent Tester and the Custodian.

7.6.4.3. Design & Technical

The following key tasks have been identified for the Design & Technical workstream. There are a number of these tasks that have been identified as reviewable design data, this level of detail is detailed in the Stage 4 Deliverables (Appendix 7.35).

Key tasks include:

- Review of the site location plan and landscape site plan;
- Review of all 1:200's, 1:50's and 1:100's;
- Updating of the Activity Database for all rooms;
- Review of the fire strategy;
- Wind model analysis of the site and building;
- Report with sign off from the Civil Aviation Authority for the design of the helicopter pad;
- Review of interior design proposals sample boards for all wards, departments and communication areas for all public spaces and hospital main entrance;
- Report on the internal / external signage and way finding strategies;
- Community consultation forums to be organised to review way finding proposals.
- Review of the mechanical and engineering reviewable design data;
- Review of all internal finishes;
- 'C' sheets to be provided for all rooms, areas and corridors;
- The following schedules / specifications are to be completed:
 - Schedules of Accommodation;
 - Equipment schedules;
 - NBS landscape specifications;
 - Mechanical ventilation and fire damper schedules;
 - NBS building specifications;
 - Lift engineering specifications;
 - Structural steel work specifications; and
 - M&E engineering services specifications.
- Disability access report to be concluded and the relevant organisations consulted;
- Sustainable copy of the travel plan to be updated;
- Equipment matrix to be completed;
- Full planning permission to be obtained;
- Confirmation of agreement to the relevant schedules in the Project Agreement;
- Full and detailed capital costs to be as at Stage 3 IFB submission;
- Lifecycle costs to be as at Stage 3 IFB submission; and
- Final copy of the 'Patient Environment & Arts' strategy to be provided.
- Patient Environment & Arts consultation event to be organised;
- Arts Co-ordinator to be appointed

7.6.4.4. Equipment

Compliance with Schedule 13 of the Project Agreement is a key task for the Equipment workstream. This takes account of the following:

- Detailed project co equipment lists to be provided;
- Detailed strategy and timetable for the procurement of all Project Co. equipment for particularly A* and FM* to be completed; and
- Final confirmation of Project Co. worst case design parameters for category M2 equipment to be obtained.

7.6.4.5. Facilities Management

The key tasks for FM between now and financial close are as follows;

- Finalisation of the Service level specification for inclusion in the project agreement;
- Finalisation of the Method statements for inclusion in project agreement;
- Finalisation the Quality Plan for inclusion in project agreement;
- Sign off and agreement of the Payment Mechanism (link with finance);
- FM design areas to be signed off. (link with design).

7.6.4.6. Human Resources

The following outlines the key tasks within the Human Resources workstream:

- Consultation Programme with Union Representatives and Hard FM staff;
- Clarification to be obtained on Workforce Proforma and TUPE data to be updated;
- Plan Equality Screening in conjunction with Trust Equality Advisor;
- Terms and Conditions handbook to be reviewed
- Approval from Trust's HR Director for Terms and Conditions handbook
- Consultation with Trade unions on Terms and Conditions handbook;
- Liaise with Project Co to progress Stage 4 deliverables;
- Agree Terms of Reference for Joint Consultative Group with Unions & Project Co.
- TUPE data to be updated.

7.6.4.7. Insurance

Within the insurance workstream the key tasks are as follows:

- Schedule 21 to be finalised;
- Preferred bidders detailed insurance proposals to be reviewed;
- Review on proposed methods of dealing with uninsured exposures deductibles and policy extensions as applicable;
- Appropriate contract mechanisms to be put in place in relation to insurance proceeds and reinstatement plans;
- Update on relevant changes in the insurance market sector, if appropriate, to be provided;

- The signed Brokers Letter of Undertaking for the completions table is to be secured;
- Final agreed insurance costs with financial model is to be aligned.

7.6.4.8. ICT

Key task for the ICT workstream include the following:

- Meetings to take place with the Preferred Bidder to discuss the following:
- Design of the server rooms to be refined and information on the cooling systems to be presented by Project Co and agreed by the Trust.
- Confirmation of Hub Room design / Central Wiring Points layout / Cooling to be provided and agreed by Trust;
- Interfaces between the Trust wireless communication device and the Hard-wired engineering systems to be presented;
- Approach to cabling to be agreed.
- Drawings / schematics demonstrating points from above to be submitted.
- Server / Hub Room layouts within Deliverable G11 to be developed.
- Assumptions relating to heat gain and its dispersal to be shared with and agreed by the Trust.
- A more definitive description of how Project Co's Hard-Wired engineering systems will interface with the Trusts wireless communication device to be demonstrated in response to deliverable G13.

7.6.4.9. Project Management

Key tasks for the Project Management workstream are as follows:

- Project management plan for post financial close to be developed;
- Resource schedule for design development post financial close to be developed;
- Regular project management meetings to be scheduled and facilitated;
- Ongoing maintenance and updating of the issue log and risk register.

7.6.4.10. Socio Economic

Key tasks for the Social and Economic Regeneration Planning (SERP) workstream are as follows:

- SERP programming document to be developed
- SERP objectives to be expressed in clearly quantifiable terms for inclusion in the Project Agreement. These objectives cover all 5 core aspects of the SERP (Training and Employment, Supply Chain Opportunities, Addressing Needs of Under-represented Groups, Addressing Equality and Diversity and Community Engagement).
- Consultations to take place with key stakeholders and SERP delivery partners including DSD Jobs and Benefits Office, South West College and construction training providers and local regeneration agencies.

- Jobs Fair and Meet the Buyer events to be held in Tyrone and Fermanagh
- Recruitment call centre and single project resource schedule to be developed.

7.6.5. Conclusion

Stage 4 is the final part of the procurement process with Financial Close being the last step.

Careful management is required throughout this stage to ensure that timely approvals are received as required in each workstream, in order to progress through financial close.

8. POST PROJECT EVALUATION & BENEFITS REALISATION

8.1. INTRODUCTION

The Post Project Evaluation's (PPE) can be tailored to take account of this particular project, the Trust's requirements and budget. As a minimum, a PPE must collect lessons learnt on each stage of the project and whether the project has achieved its objectives, using the benefits realisation table as a tool. It should ensure that as a minimum the guidelines and requirements set out in the Department of Health's Good Practice Guide (Appendix 8.01) to PPE are met.

The Trust, along with Project Co will assess recent PPE's undertaken at similar schemes, to assess the lessons learned and apply strategies for incorporating these lessons into the New Acute hospital for the South West scheme.

The Trust has learnt from experience on local successful projects such as The Causeway Hospital & Labs and Pharmacy PFI at Altnagelvin Hospital, that significant benefits can be gained from conducting a comprehensive and adequately resourced Post Project Evaluation (PPE). These benefits are listed below:

- Improve the future design, organisation and strategic management of future projects;
- Take corrective action if the project is not running to plan;
- Enable other organisations to learn from the project and subsequently avoid costly mistakes, use resources effectively, consider a broader scope of methods/approaches;
- Achieve best value for money from public resources and avoid costly mistakes;
- Improve decision-making and resource allocation;
- Improve accountability by demonstrating to internal and external parties that resources have been used effectively and efficiently;
- Highlight problems with the new build (including health and safety issues) and offer appropriate resolution strategies; and
- Provide confirmation that the project objectives have been met delivering a demonstrable improvement in services.

The Trust will use the 'Good Practice Guide to PPE' produced by the Department of Health as a template for the Post Project Evaluation report. The following sections will give examples of the monitoring methods proposed.

The PPE team

The PPE is the responsibility of the Commissioning Team. Commissioning Team members are outlined in Section 1.8.1.3 of this report. To ensure an unbiased view, the Trust will establish a PPE team ensuring that the members of the team are independent from the project and that evaluations are conducted by personnel who have not been involved in the management or implementation of the proposals under

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consideration. If necessary, to ensure independence, this will involve members external to the Trust itself.

While the Trust project team and Project Co will gather information to allow the team to evaluate the success of the project they will not be responsible for evaluation. The evaluation will take place 6 months after the completion of the Commissioning Phase. Based on current estimates this would mean that PPE would begin in October 2012 and be complete by June 2013. The Commissioning team will be responsible for the evaluation which will be carried out using the methodology set out in Section 8.2 below.

8.2. STAGES OF THE EVALUATION

Stage 1 – Planning the Evaluation:

Prior to the completion of the building, the Commissioning Team will develop an Evaluation plan and cost the scope of the project evaluation work at this initial appraisal stage. This stage will involve:

- Establishing Trust requirements.
- Reviewing the Full Business Case, including the Benefits Realisation Plan.
- Choosing the appropriate methodologies ensuring that the purpose of the evaluation can be satisfied.
- Developing the project programme.
- Commencing preparation of documents specific to the chosen methodologies.
- A launch workshop.

Stage 2 - Evaluation during the Construction Stage

During the Construction period the PPE team will:

- Monitor the progress of the project at regular intervals for time, cost and service performance.
- Issue questionnaires to patients and staff to obtain views on existing facilities.

Stage 3 - Initial Post-Project Evaluation. (6-12 months after commissioning):

After commissioning is complete the team will be responsible for reviewing the performance of the project objectives. This will take place between six and twelve months post completion. The steps that will be taken will be:

- Obtaining benefits data and performance analysis.
- Stakeholder meetings/ interviews.
- Questionnaires to patients and staff.
- Building audit.

Performance will be reviewed at Commercial Group, Clinical Reference Group, Clinical Design Forums and Staff Design Forums.

Stage 4 - Follow-up Post-Project Evaluations

Approximately two years after commissioning completion, the team will review the longer-term outcomes of the project and/or the extent to which the short-term outcomes have been sustained. The following tasks will help ensure that the project objectives are evaluated:

- Obtaining benefits data and performing analysis.
- Stakeholder interviews.

Beyond this period, project outcomes will continue to be monitored. The Trust will use a series of key informant interviews, questionnaires, document reviews and file

reviews designed to gain feedback on the degree of success of each of the stages above.

8.3. POST PROJECT EVALUATION REPORT

The contents of our evaluation report will address the following issues:

- Were the project objectives achieved?
- Was the project completed on time, within budget and according to your specifications?
- Are staff, patients and other stakeholders satisfied with the project results?
- Were the business case forecasts (success criteria) achieved?
- Overall success of the project – taking into account all the success criteria and performance indicators, was the project a success?
- Organisation and implementation of the project – did we adopt the right processes?
- What lessons were learnt about the way the project was developed and implemented?
- What went well? What did not proceed according to plan?
- Project team recommendations – a record of lessons and insights.

These items will be evaluated through the following:

Documentary Analysis

- Review of project documentation (business case, contract, project specification, payment mechanism, other project documents);
- Previous feasibility studies; and
- Review of routine records, project files, and monitoring information.

Other Methods

- Face to face interviews;
- Telephone surveys;
- Postal or self-completion surveys; and
- Observation.

8.3.1. Proposed Proformas

The proforma used for the Post Project Evaluation reports will be developed by the PPE team and agreed in advance with the Trusts Project Team and Project Co. A tailored version of the Good Practice Guide's 'Project Framework Matrix' together with questionnaires is used to establish a view of the project from a range of stakeholders.

Appendices 8.02-8.08 set out a number of suggested proformas, monitoring forms and questionnaires covering different aspects of the project that we would propose using in the post project evaluation. These are not an exhaustive list and are intended to give an illustration of the proformas that can be used.

8.3.2. Project Document Reviews

A number of key documents will also be scrutinised in order to gain a full and complete understanding of the project objectives and expected outcomes and to collect information relevant to the Evaluation. These documents will include:

- New Acute hospital for the South West, **Acute Phase 2 OBC**, September 2006;
- New Acute hospital for the South West, **Full Business Case**, April 2009; and
- Healthcheck – Gateway review 3 - Investment decision, February 2009.

8.3.3. Programme File Reviews

Project files will be reviewed in order to gather qualitative data on the Procurement Process and Post Commissioning and Operational Matters. These files will include:

- Exemplar Design
- 1:50 Design sign off
- Operational Policies
- Schedules of Accommodation
- Room Data Sheets
- Project Programmes
- Testing & Commissioning documentation
- Operational Monitoring Group – minutes of meetings

8.4. TRUSTS OBJECTIVES

At this stage, the first action is to identify the factors which the Trust wish to be measured against the PPE stage. These were first highlighted in the Acute Phase 2 OBC and are listed Table 8.1 overleaf:

Table 8.1 OBC Primary & Secondary Objectives

Primary Objectives
<ul style="list-style-type: none">• Ensuring that services are delivered in a clinically effective and safe manner;• Developing and retaining a workforce that enables the delivery of the level of patient activity forecast for the future to the appropriate professional standard and within the agreed affordability ceiling;• Delivery of accessible services based on the principles set out in DHSSPS policy and strategies;• Provision of sustainable hospital services, reflecting the level of need and complementing other service providers;• Establishing a coherent set of services demonstrating value for money, which are financially sustainable and are within agreed levels of affordability; Overarching objectives or guidelines; and• Ensuring continuity of care and patient services throughout the development stages of the new service model and minimisation of disruption during the period of development.
Secondary Objectives
<ul style="list-style-type: none">• Promotion of service delivery that is sustainable yet flexible and responsive to changes, professionally and organizationally;• Implementation of the key objectives of Investing for Health to improve health and reduce health inequalities and addressing new TSN; and• Delivering a new acute site using space, materials and resources with imagination and efficiency and minimising waste of energy and materials in construction and use.

The extent to which these have been met will be addressed throughout our report, in our Recommendations and Conclusion.

8.5. LESSONS LEARNT FROM ALTNAGELVIN

The section below highlights Lessons learnt from the previous Trust Post Project Evaluation 'Altnagelvin Hospital'. This was a £15 million privately financed project to provide the Laboratory & Pharmacy Services centre. The project was completed in January 2007, three months ahead of the planned schedule. Total spend on the project was within approval limits.

The lessons learnt are highlighted below with a 'Counter Action' identified for each, to ensure the New Hospital for South West takes on board Altnagelvin's recommendations.

a) DHSSPS Approval Requirements

Prior to financial close a number of approval processes were completed by the DHSSPS. These included, for example, signing of a Deed of Safeguard, which had to be undertaken at a specified time and date immediately before financial close (when swap rates were finalized for the financial model).

Planning for the availability of required legal documents and availability of senior civil servants is essential to avoid delays at financial close.

New Hospital for South West Counter-Action

The Deed of Safeguard will have to be signed by two authorised signatories of the DHSSPS. The document will have to be signed on the day of financial close by the DHSSPS but could be signed earlier and held in escrow (by L'Estrange & Brett) and released for signature by the remaining parties upon the approval of the DHSSPS or its advisers. (We do not necessarily require DHSSPS representatives present on the day.)

b) Remain Aware Of The Risks Prevalent Up To The Point Where The Contract Is Signed At Financial Close

Be aware that financial close is at risk through external factors even following agreement, over which neither the bidding consortia nor the Trust will have any control.

In the final hours of the negotiation the FM Holding Company entered into negotiations for a management buyout.

This caused significant stress and last minute delays and put the negotiations at risk, albeit the issue was ultimately resolved and financial close achieved.

New Hospital for South West Counter-Action

A preferred bidder steering group has been setup chaired by the chief executive of Health estates – this group includes senior Trust staff and representatives from the Consortia's SPV (FCC, Interserve, Elliott's) – meet every 3 weeks. The aim of this group is to anticipate and counter act any risk areas.

c) Timely Appointment of Independent Tester

The Selection process for the Independent Tester was made late in our process (2 months before financial close).

An early engagement in the selection and appointment process for I.T. Services would mitigate the risk of delays in reaching agreement in financial close.

New Hospital for South West Counter-Action

The Trust sought funding for this role in the Project Cost Business case, approved in March 08.

October 08 – Trust along with Health Estates have actioned the advertisement for Independent Tester which will be issued into the European Journal by the end of November 08. The Independent Tester ‘Capita Consulting’ was appointed in May 2009.

d) Construction Inflation Risk

Given project delays the Trust faced an inflation cost risk. The key lesson here is that the methodology for addressing future inflation risk, should be included in the Invitation to Negotiate.

New Hospital for South West Counter-Action

The competitive dialogue ensured issues like this were picked up. This issue was also addressed in the PB letter which protects the Trust against increases in construction cost up and until a set date (26 May 2009).

Closure of the Dialogue was only achieved when commercial certainty was achieved.

The Trust is aware that the programme to Financial Close must run to time so that inflation costs are not incurred – weekly meetings are scheduled with the Preferred Bidder and Steering Group meetings take place every 3 weeks.

e) Information Management

The final months of negotiations were very intense with multiple concurrent email correspondence, which had a consequential risk of issues being overlooked. The key lessons learned were as follows:

- Have robust information and decision-making processes in place with regular reviews.
- Resource this with additional staff/ Data Capture system
- Use of Public Sector Exemplar (PSE) particularly to inform Public Sector Comparator (PSC)

New Hospital for South West Counter-Action

The Trust has many processes in place to ensure all correspondence and decisions are being logged and confirmed (including logs for RFI’s, Clarifications, Change Control, Actions). The Trust also run fortnightly Programme Management meetings to ensure all issues are brought to the table and discussed at agreed timescales. Weekly meeting with Project Team, which include Health Estates

f) Benefits of Exemplar up to Financial close:

The use of comprehensive specifications and PSE provided bidders with the fullest understanding of client needs and reduced bidder costs.

Comprehensive specifications and PSE were not found to inhibit innovation, but were seen to bring clarity.

The PSE provided reassurance to client groupings as to the nature and quality of what was being sought and assisted in winning staff groupings and trade union reps to the proposals. It also helped inform trigger point decisions which are key components in payment mechanism schedules which keep the Project Company working effectively over 25 year life of the project (see point 8 below).

New Hospital for South West Counter-Action

The Exemplar design was developed as a benchmark with consultation with a wide number of staff and community user groups. It has continued throughout the procurement process as a reference for quality, specifications, clinical planning & capital cost make-up. The Bidders Designs were evaluated against this benchmark.

g) Benefits of Public Sector Comparator up to Financial close:

The Production of good quality ITN documentation, Exemplar Design & output specifications allowed the Trust and its advisors to develop a robust PSC.

The Development of a robust PSC cost comparison proved crucial in final negotiations, particularly in the absence of a reserve bidder.

The continued use of the Public Sector Comparator through to agreement on Financial Close was essential particularly after the reserve bidder declined the nomination.

The PSC was used as a negotiation tool in order to achieve maximum value for money as negotiations proceeded.

New Hospital for South West Counter-Action

The Trust's Financial Advisors reran their financial models to produce a revised target unitary charge and related affordability envelope for issue to the bidders. This was signed off by the DHSSPS in January 2008. Bidders were required to re run their models to reflect the changes within the payment profile resulting from the one off cash injection. Significant dialogue was needed with bidders to embed the proposal within the procurement.

h) Understand the importance of Payment Mechanisms and Performance Monitoring

We quickly learned that a workable Payment Mechanism regime is critical if the Trust needs is to be met post hand-over.

We invested significant time with user departments developing our payment mechanism model, at the outset, which gave confidence to our users that robust

mechanisms would be in place to maintain quality service delivery for the 25 year life of the project.

Negotiations proved complex in relation to Penalty Mechanisms (funders were particularly interested in this). Applying common sense in the final negotiation, coupled with our earlier investment in time, meant that we transferred appropriate risk to Project Company to ensure service delivery.

New Hospital for South West Counter-Action

Through the process of competitive dialogue several meetings and workshops (These worked through scenarios) were held between the bidders and the Trust to ensure a full understanding of the proposed Payment Mechanism. At Stage 3 submission the bidders signed up to the payment mechanism.

i) Project Resourcing

The Trust should ensure that sufficient dedicated resourcing is put in place for all major capital developments and that sufficient resilience is inbuilt to ensure that the project is not put at risk through the departure of key staff within the process.

The Trust should also ensure that project resource input is separately measured for each project in order to ensure an appropriate audit trail exists for future audit of the process

New Hospital for South West Counter-Action

An Outline Business Case for the establishment of a Project Management staff structure to manage the implementation of “Developing Better Services” was submitted to DHSSPS in March 2005 and subsequently approved on 24th August 2005.

An addendum to the above Business Case was submitted to DHSSPS in February 2008, and was approved on 7th March 2008.

8.6. CONCLUSION

The Acute hospital for the South West project has already been reviewed at the following stages of the project:

- PUK review on the Outline Business Cases (review of documentation before release of IPID) – May / June 05
- OGC Gateway 2 – Delivery Strategy – Oct 06
- OGC Gateway 3 – Investment decision is planned for Feb 2009

These reviews have ensured that the project is meeting its objectives and requirements and that lessons learnt at each stage of the project have been adapted and applied to future stages.

The PPE will evaluate all stages of the project and collect lessons learnt on each of these stages to determine whether the project has achieved its objectives, using the benefits realisation table as a tool. The PPE will ensure that as a minimum the guidelines and requirements set out in the Good Practice Guide (Appendix 8.01) to PPE are met and in line with FD(DFP) 01/09 in ensuring that the evaluation is independent.

The Trust must report on progress at the Western Strategic Investment Group.

8.7. BENEFITS REALISATION - APPROACH TO EVALUATION PROCESS

Following the completion of the hospital, a PPE will be carried out to assess the effectiveness of the project. The main objective of this evaluation will be to assess the benefits that are being, or have been, derived from the project, compared with those that were envisaged at its conception.

Benefits Realisation Management (BRM) is “the process of organising and managing, so that potential benefits, arising from investment in change, are actually achieved”, it is a “continuous management process running throughout” the life of the project.

BRM encompasses the identification, planning, measurement, tracking and reporting of potential project benefits. It includes the assignment of roles and responsibilities from project initiation through to benefit realisation.

The BRM process has five main stages:

- identifying and modelling the benefits;
- planning the benefits;
- executing the Benefits Realisation Plan;
- evaluating the benefits achieved; and
- Feedback for adjustment, correction and refinement of the process implementation.

The Trust identified the key benefit for inclusion in the BRP via a workshop with key stakeholders, including representatives from DBS project team, Clinicians, Estates and IT departments, nursing and AHPs, amongst others. A full list of stakeholders consulted as part of the BRM process is included in Appendix 8.09A.

The benefits included in the Benefits Realisation Plan are those which have been identified as significant in measuring the success of the delivery of the main objectives of the project. Key benefits link to the primary objectives as shown in Table 8.2 overleaf.

Table 8.2 Primary Objectives Used in Benefits Mapping

No	Primary Objectives	
1	Ensuring that services are delivered in a clinically effective and safe manner;	Links shown in Benefits Map, Figures 8.1a and 8.1b overleaf.
2	Developing and retaining a workforce that enables the delivery of the level of patient activity forecast for the future to the appropriate professional standard and within the agreed affordability ceiling;	Links shown in Benefits Map, Figures 8.1a and 8.1b overleaf.
3	Delivery of accessible services based on the principles set out in DHSSPS policy and strategies;	Links shown in Benefits Map, Figures 8.1a and 8.1b below.
4	Provision of sustainable hospital services, reflecting the level of need and complementing other service providers;	Links shown in Benefits Map, Figures 8.1a and 8.1b overleaf.
5	Establishing a coherent set of services demonstrating value for money, which are financially sustainable and are within agreed levels of affordability; Overarching objectives or guidelines; and	Sustainability is considered as part of the sustainability objective above. Affordability of the project is considered in detail in Chapter 3 of this FBC
6	Ensuring continuity of care and patient services throughout the development stages of the new service model and minimisation of disruption during the period of development.	Minimising disruption to services is a key objective in differentiating options, however is not a key objective which will create key benefits resulting from the investment. Therefore this objective is not included in benefits maps below.

The project benefits identified by the project team have been modelled using benefit modelling techniques to ensure that they result directly from the identified project enablers and are aligned to the stated project objectives as per the following benefits modelling Tables 8.1a & 8.1b overleaf. Given the large number of benefits identified, we have shown them on two diagrams.

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Figure 8.1a Benefits Map

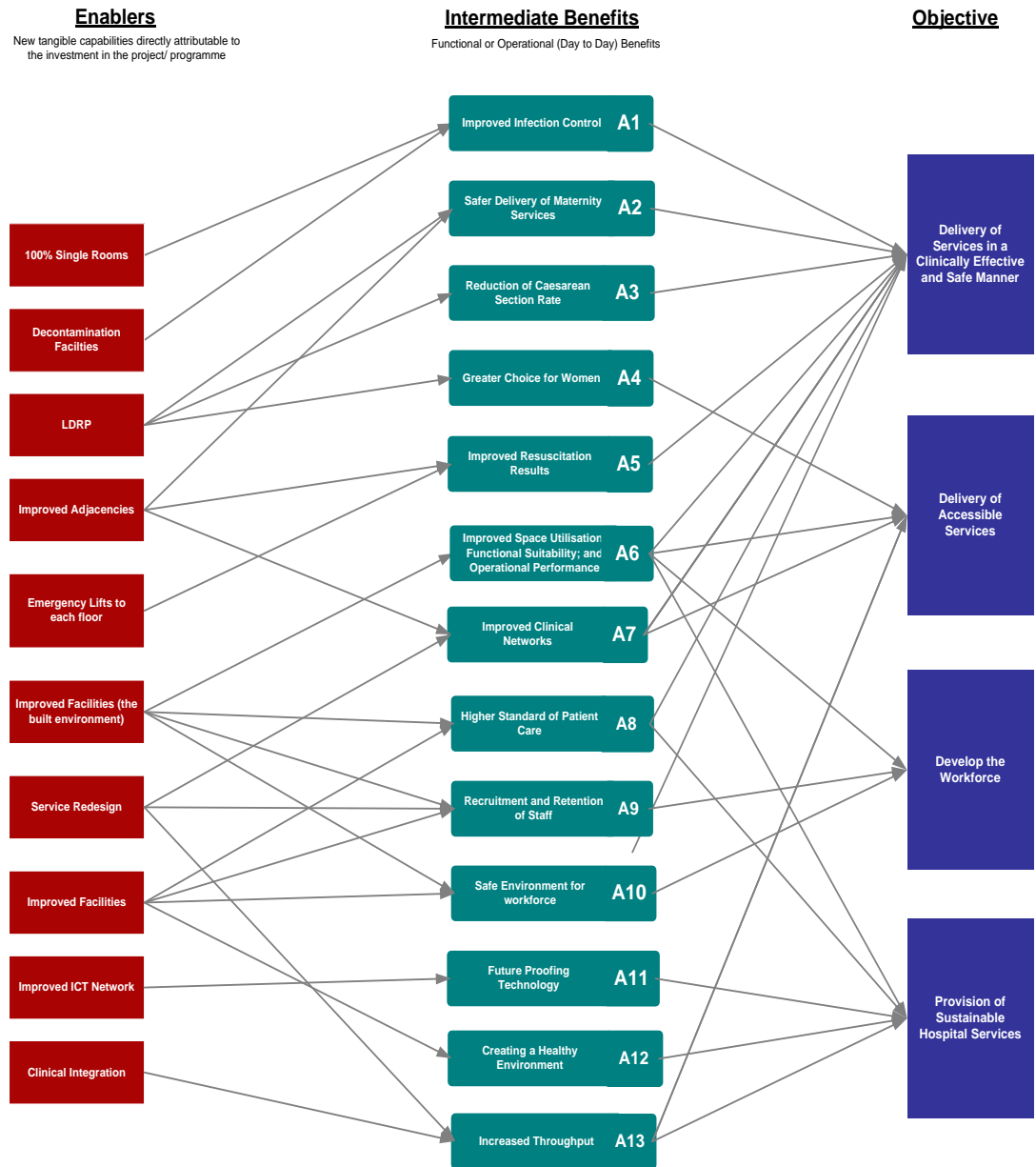
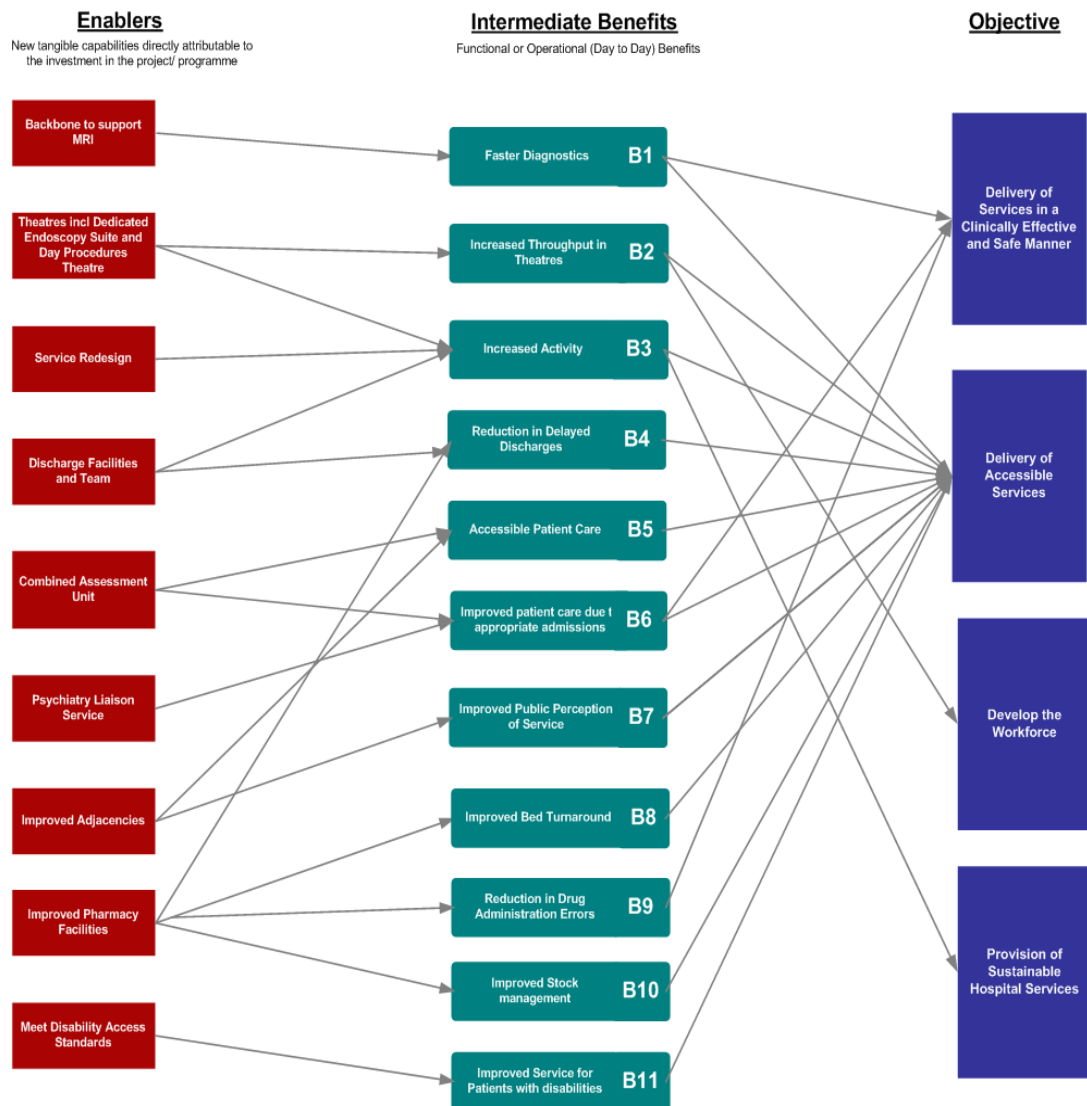


Figure 8.1b Benefits Map



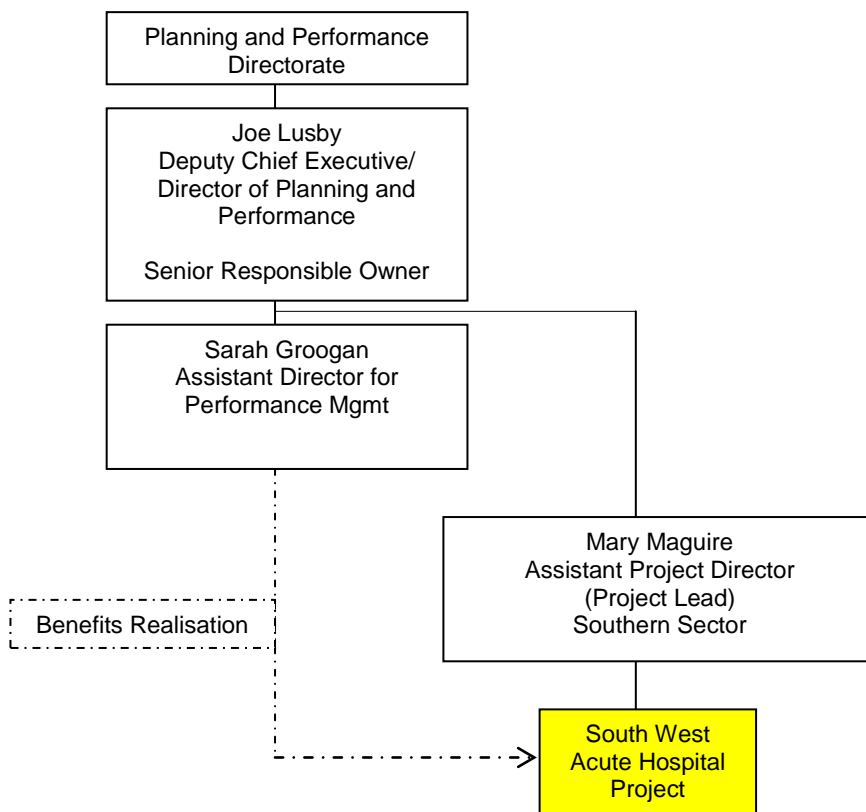
From this key benefits have been selected for profiling, baselining and measurement going forward.. The profiling of the selected benefits will form the basis of the Benefits Realisation Plan (BRP) which in turn will identify when and how the benefits should be measured and who is responsible for measuring them.

We have included 2 additional key benefits, not shown in the benefits map above that will be measured by the Trust, which meet some of the secondary objectives, but are significant enough to warrant inclusion in the list of key benefits for profiling (ref profiles **C1**, New employment, enhanced local skills base resulting in positive impact on local Social & economic status and **C2**, Increased spend and indirect employment impacting positively on local economy).

8.7.1. Benefits Realisation Planning

The main purpose of the Benefits Realisation Plan (BRP) is to facilitate the realisation of the agreed benefits of the New Acute hospital for the South West. It is created by the project team, and adopted by Assistant Director for Performance Management who shall be responsible for the monitoring and reporting of the BRP Plan. The Plan has been developed in liaison with Directorate Business Managers, who shall be responsible for the measurement of benefit progress and ultimately demonstrate benefits realisation. Figure 8.1C below illustrates the Benefits Realisation Management Structure.

Figure 8.1C Benefits Realisation Management Structure



The BRP illustrates how and when the agreed benefits are expected to be realised. It is constructed based on the information contained in the benefit profiles (detailed in appendix 8.09B) which were created during the benefit workshops and the benefit profiling meetings with the benefit owners.

The BRP is to be constructed from the information contained in the benefit profiles and as such will identify:

- the personnel responsible for tasks or activities (WHO);
- the timing of activity, tasks and actual benefit realisation (WHEN);
- the activities required to realise the identified benefits (WHAT); and
- the measurement/value (Baseline, Target & Actual).

8.7.2. Benefit profiling

A Benefit Profile has been developed for each of the key benefits. The information included in these profiles is as follows:

- **Enablers:** identification of the actions that must be completed to allow the benefit to be realised;
- **Measurement:** Each benefit was assigned an appropriate means of measurement that will enable identification of a baseline. The baseline is used for evaluating progress post project implementation. The timescales for reporting were also identified along with report frequency.
- **Baseline value:** The definition of the pre project implementation measurement of the benefit was agreed. The measurement of the baseline will take place in the period prior to the opening of the new hospital;
- **Current Value:** given the baseline will be measured at a future date, the current value has been recorded to allow targets to be set and for reference when measuring progress and updating against targets;
- **Target value:** The post project implementation measurement expected by the time of Post Project Review is carried out;
- **Timing of Measurement:** the profiles each include the measurements dates that are deemed appropriate for each of the benefits (e.g. weekly/ monthly/ quarterly). Ongoing monitoring will allow corrective measures to be put in place if the progress to meet to benefit does not appear to be acceptable;
- **Responsibility:** for Monitoring and identifying corrective measures if benefits are not met;
- **Risks and dependencies:** Some potential risks to the benefit being achieved were identified for each benefit and dependencies between benefits were also identified, where appropriate;
- **Countermeasures:** identified to counteract risks identified;
- **Sign off of profile:** the individual benefit owners who sign each of the profiles to show that they accept the benefit and assumptions included in the profile.

Measurements will then be taken at the prescribed intervals and comparison with baseline made. The initial baselining and the subsequent ongoing measurement is the responsibility of the corresponding benefit owner.

The BRP may require modification and updating during and post project implementation. Some benefits may have to be modified, redefined or have specific attributes changed in light of changing circumstances or pressure from external forces that were not foreseen.

The benefits management process will form part of the Trusts Performance Management; it does not end with the creation of the BRP, it will continue throughout the life of the project to ensure that benefits are realised. Continued assessment of progress towards ultimate realisation is essential and where the progress is unsatisfactory action plans should be developed to address the situation. As part of the BRP a programme identifying the time line for the continuation of the assessment process over the life of the project will be established.

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A summary of key benefits identified is shown in Table 8.2 overleaf. The benefit profiles are contained in Appendix 8.09B.

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Table 8.2 Summary of Key Benefits for Profiling

Primary Objective	Benefit Description	Benefit Owner	Measurement	Benefit Ref
Delivery of Services in a clinically effective and safe manner.	Improved Infection Control	Head of Infection Control	Infection Control Rates	A1
	Safer Delivery of Maternity Services	Director of Women's & Children's Services	Ability to meet recommendations of National Caesarean section audit	A2
	Reduction in Caesarian Section Rate	Director of Women's & Children's Services	Caesarian Section Rate (% of total births)	A3
	Greater choice for women	Women and Children's Services; Asst Director of Healthcare	Patient satisfaction Survey	A4
	Improved Clinical Outcomes due to successful Resuscitation	Resuscitation Officer	Timely response to emergency calls in line with best practice regulations. % of resuscitations that have positive outcomes and timely response to emergency calls in line with best practice regulations	A5
	Safer Delivery of Services through Improved Utilisation of Space; Improved Functional Suitability, Improved Operational Performance	Director of Capital Planning and Development	Safety: Number and type of incident; risk profiles; number and type of H&S notices Performance: Downtime and reliability of plant equipment and services; Energy Utilisation; CO2 production; condition surveys. Utilisation/Suitability of Space: Space Utilisation and Functional Suitability report	A6
	Improved Clinical Services	Service Directors	Recommendation from Acute Medical Care - The Right Person, in the right setting - first time	A7
	Higher Standard of Patient Care and More Appropriate Use of Beds. More prompt access to senior clinical decision makers.	Medical Director	ALOS; Daycase rates and % Occupancy targets	A8
Develop the Workforce	Improved Recruitment and Retention of Staff	Director of HR	A senteeism rates; ration of qualified to unqualified staff; Locum Costs	A9
	Provide a safer working environment for workforce, visitors and patients	Head of Risk Management	* Reduction in incidents against staff, inline with best standards. * Meet requirements of Better By Design, * AEDET NHS Design Toolkit, and * ASPECT NHS Design Toolkit	A10
Provision of Sustainable Hospital Services	Future Proofing for use of more high specification technology with less downtime	Head of ICT	Reduction in network downtime	A11
	Creating a Healthy Environment leading to better clinical outcomes (as detailed in NHS Report)	Director of Capital Planning and Development	Building Control Regulations; HEN's, HTM's; PELS Health & Safety Regulations Environmental Protection Act Disability Discrimination Act Current British and European Standards and codes of practice	A12
	Increased Throughput	Director of Acute Services and Director of Primary Care and Older People Services	ALOS; Discharge times; % Occupancy; Daycase rates	A13

Source: WHSCT

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Table 8.1 Summary of Key Benefits for Profiling continued.

Delivery of accessible services	Delivery of Faster Diagnostic Services	Director of Acute Services	Number of MRI scans carried out within Trust (rather than outsourced); Trust Access Targets	E1
	Increased Throughput in theatres	Director of Acute Services	Waiting Lists; Cancelled Operations; Daycase rates; theatre utilisation; % of endoscopy carried out in dedicated theatre	E2
	Increased Throughput due to Service Redesign (Adult Medical And Surgical	Director of Acute Services	Waiting lists; targets for time to treatment for cancer; delayed discharges; LOS and Outpatient attendance	E3
	Reduction in Delayed Discharges leading to increased throughput (Older Peoples Services)	Director of Primary Care and Older People	Delayed Discharge Targets	E4
	Improved Accessibility to Services	Director of Acute Services	Meet Less than 4 hour wait target in A&E Inappropriate zero length stays Occupant levels	E5
	Appropriate Admissions	Director of Adult Mental Health and Disability Services	Reduction in inappropriate admissions of Mental Health patients	E6
	Improved Public Perception of Service	Director of Capital Planning and Development	Number of Complaints and Number of Complements	E7
	Improved Bed Turnaround	Head of Pharmacy and Medicines Management	Discharge targets; bed turnaround	E8
	Reduction in Drug Administration Errors	Head of Pharmacy and Medicines Management	Adverse Incidents	E9
	Improved Medicines Stock Management	Head of Pharmacy and Medicines Management	Reduction in Stock write offs	E10
	Equality for Disabled people	Director of Capital Planning and Development	Disability Access Statutory Requirements and requirements set out in "Addressing issues in the New Acute Hospital for the South West (NI)" Trust disability action plan	E11
Equality and New TSN (construction contract)	New employment, enhanced local skills base resulting in positive impact on local Social & economic status	Director of Capital Planning and Development	*Total construction workforce statistics. *New job creation statistics *SERP training plan report	C1
	Increased spend and indirect employment impacting positively on local economy	Director of Capital Planning and Development	Local subcontractor & supply chain statistics including contract values	C2

Source: WHSCT

9. MANAGEMENT CONSIDERATIONS

9.1. INTRODUCTION

This chapter of the FBC describes the structures and procedures that have been established to manage the PFI contract to this stage of the process and the procedures that will be established from this point forward.

This chapter first sets out the organisational structures that have been put in place to support and monitor the procurement phase of the Project. It then summarises the remaining phases of the project, and discusses a number of specific issues that are relevant to this Project.

On moving this Chapter from ABC to FBC, Commissioning & Decommissioning phases have been detailed with the costs associated with these phases being detailed in Chapter 1 of this FBC.

The indicative Project Timetable is also set out in this Chapter of FBC.

There are four key phases in PFI projects, namely procurement, construction, operation and contract end. Each of these phases requires different management considerations and activities to be undertaken, and a description of the principal activities that have been and will be undertaken during each phase is presented in the paragraphs that follow.

9.2. PROCUREMENT PHASE

The OJEU Notice in July 2006 marked the commencement of the Procurement phase. This phase will continue until award of contract (Financial Close). Therefore the Procurement phase reflects the Stages 1-4 as summarized below and detailed in Section 7.1.

Stage 1: Pre-qualification

Stage 2: Competitive Dialogue

Stage 3: Final Bids and Bid Evaluation

Stage 4: Finalisation

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9.2.1. WHSCT Trust Management Structure

The following key decision making groups manage the project:

- Trust Board;
- Western Strategic Investment Group;
- Strategic Development Project Board;
- Commercial Group; and
- The Project Team

Figure 9.1 illustrates the organisational structure that the WHSCT have put in place to manage the PFI procurement process and to oversee project delivery.

An outline of how these groups have assisted in the management of the project during the procurement has also been outlined in the following sections.

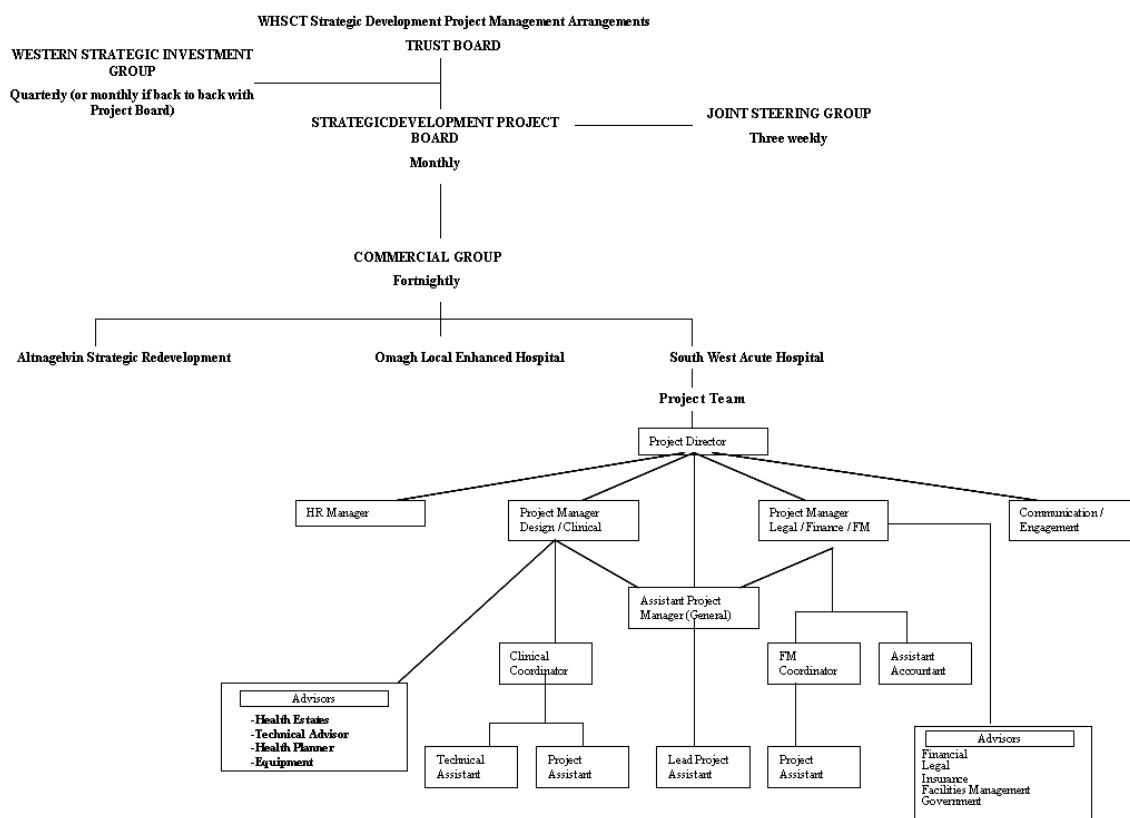


Figure 9.1 WHSCT Strategic Development Project Management Arrangements

The DHSSPS has put in place a Western Strategic Investment Group to co-ordinate decisions within the DBS project between organisations represented. The remit of this group is detailed in the subsequent section.

9.2.1.1. *The Western Strategic Investment Group*

The DHSSPS Infrastructure and Investment Unit set up the Strategic Investment Group meetings following the publication of RPA proposals and one of its remits is to co-ordinate decisions within the DBS project between organisations represented in order to produce a collaborative approach to issues and more informed, rapid decisions.

The Western Strategic Investment Group meets bi-monthly and is chaired by the Director of Infrastructure and Investment, Dr Bernie Stuart.

The group addresses all matters of relevance to infrastructure investment, capital expenditure and asset management in the Trust. In programme management terms it is intended that the Group will, as far as possible, provide a basis for decision making on programme matters as well as discussion on matters raised.

In performance management terms, the Trust is required to report to the DHSSPS on current in-year capital expenditure activity and plans, project proposals and project plans.

The Group meetings provide a forum at which the DHSSPS, Health Estates advisors and the Strategic Investment Board can provide advice, guidance or direction to the Trust on performance, programme management and policy advice issues.

The Western Strategic Investment Group membership also includes Trust representatives i.e. the Deputy Chief Executive; Assistant Director of Capital Planning and Development; Director of Capital, Costing and Efficiency; Assistant Director of Capital Development; as well as Health Estates advisors; DHSSPS representatives; and Strategic Investment Board representatives.

9.2.1.2. *Trust Board*

Trust Board forms the top-tier of the organisational chart. The Trust Board has ultimate responsibility for approving the recommendations of the Project Board/Commercial Group on the key issues, for example Soft FM Value for Money test and the selection of Preferred Bidder. Formal approval is provided at the monthly Trust Board, where a summary of the Project Board/Commercial Group's findings can be presented and any questions clarified.

9.2.1.3. *Capital Development Project Board*

The Project Board reports to the Trust Board through the Project Senior Responsible Owner and its role is to:

- provide support to the Project Owner;
- provide a strategic overview of the project;
- ratify, or otherwise, recommendations submitted by the Project Director;
- ensure the project is adequately resourced; and

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- provide formal approval to the key stages of the project plan.

The Project Board's membership consists of Trust Deputy Chief Executive (SRO), Project Director, Assistant Director of Capital Costings and Efficiency, Assistant Director of Capital Planning and Development, CMT members, Project Leads, Senior Project Manager Advisors and a representative from Regional Supplies Services.

9.2.1.4. *Commercial Group*

The role of the Commercial Group is to protect the integrity of the PFI process and manage the Trust's financial interests.

Commercial Group membership includes Trust Deputy Chief Executive (SRO), Assistant Director of Capital Planning and Development, Assistant Director of Capital, Costing and Efficiency, Project Lead, Project Manager and Health Estates advisors.

The Commercial Group is responsible for:

- Recommending Variant Bids submitted by Bidders to Project Board;
- Recommending Third Party Income proposals to Project Board;
- Managing the clarification process to ensure that the competition is not put at risk;
- Monitoring the project's affordability issues;
- Reviewing project timescales;
- Monitoring targets and progress;
- Reviewing commercial issues; and
- Addressing project conflicts.

9.2.1.5. *Project Team*

Responsibility for day-to-day management of procurement of the PFI contract rests with the Project Director.

A suitably experienced Project Management Team supports the Project Director. The Project Director is responsible for coordinating the inputs of the various members of the Project Management Team, and the range of skills that are required include:

- Design and construction;
- Facilities and service management;
- Planning and statutory processes;
- Health and safety and other regulatory requirements;
- Financial;
- Legal and contractual;
- Insurance / Commercial;

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- Human Resources;
- Communication;
- Project Management;
- Health Planning;
- Equipment; and
- ICT.

The internal project staff structure is shown in the diagram overleaf:

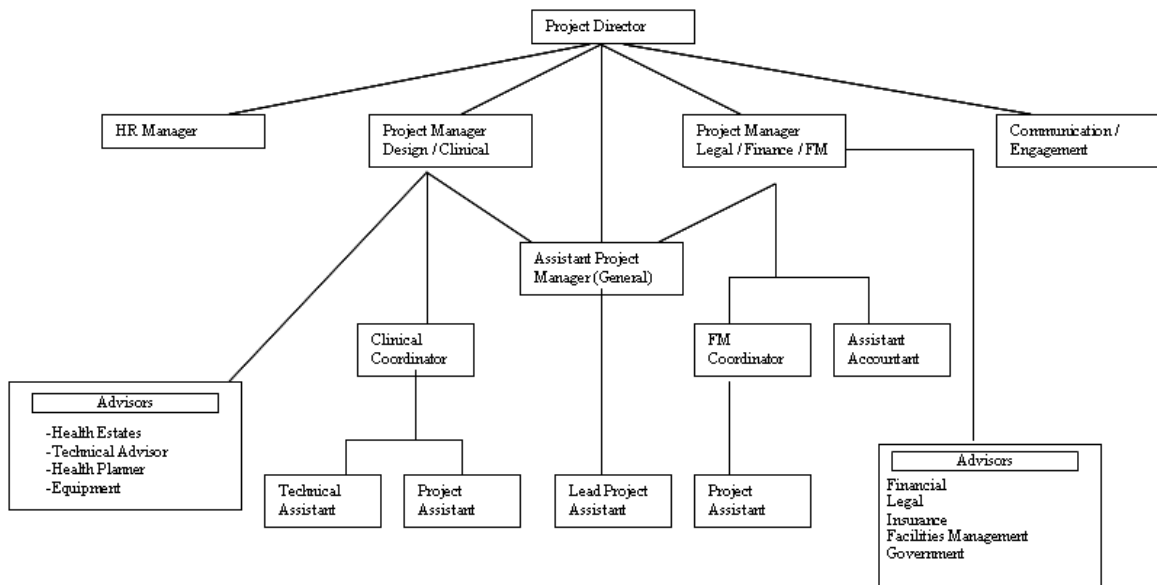


Figure 9.2 SW Acute Project Staff Structure

An Outline Business Case for the establishment of a Project Management Structure to manage the implementation of “Developing Better Services” was submitted to DHSSPS in March 2005 and subsequently approved on 24th August 2005 at a total value of £4.6m. (£3.6m relating to the Internal Project Team costs.)

An addendum to the above Business Case was submitted to DHSSPS in February 2008, requesting an additional £4m, and was approved on 7th March 2008 equating to a total value of £7.6m for Internal Project Costs up to year ending 2010/11.

9.2.1.6. Support Staff

Support staff and advisors will give back up and provide the necessary information to the project teams when required, the main areas covered as Support Staff are, Project Administration, Clinical and Managerial, and support team.

9.2.1.7. Specialist advisors

For the Project to be delivered in an effective and efficient manner it is necessary to employ the services of some specialist advisors.

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The advisors specific to the Project are listed and a summary of their roles given below;

- *Financial Advisors*

Deloitte were appointed as the Trust Financial advisors for the New Acute Hospital for the South West. Deloitte's main activities at the key stages of the projects are explained overleaf.

- **Stage 1 Pre-qualification**

Deloitte were responsible for developing an evaluation methodology for the pre-qualification stage. Following this, they led the evaluation of the financial aspects of pre-qualification submissions as part of the evaluation process leading to the pre-qualification of Bidders. This included issuing a report to document the views provided to the Trust in relation to this matter and provided Trust Board reports/ presentations. They assisted the Trust and other advisers on other aspects of evaluating pre-qualification submissions.

- **Stage 2 Competitive Dialogue**

Deloitte acted as the advisors in relation to all the financial and payment mechanism aspects of the dialogue. This included covering the financial and payment mechanism elements of Bidder documentation, attending finance, payment mechanism and project management meetings with Bidders, responding to Bidders requests for information, issuing clarifications to Bidders, evaluating Bidders submissions, issuing reports to the Trust in relation to Bidders submissions, and providing feedback to Bidders.

- **Stage 3 Final Tender and Bid Evaluation**

Deloitte were responsible for all the financial and payment mechanism elements of the Invitation for Final Bids (IFB) document and liaising with other work streams to ensure consistency. They led the evaluation of the financial aspects of final tender submissions, including but not limited to Funding and Financing proposals and the Payment Mechanism, including the production of an evaluation report to document the opinions provided and provide Board reports/ presentations. They provided a written and verbal debrief to unsuccessful Bidders on the financial aspects of their bid.

- **Stage 4 Finalisation**

Deloitte are supporting the Trust and the legal advisers in the finalisation of all financial project documentation, provide advice regarding consortia proposals and providing clarification to Bidders and funders.

Deloitte are providing financial analysis of the deal for inclusion in the FBC, including but not limited to the VFM of Funding and the payment mechanism; and are assisting the Trust and the other members of the advisory team to Financial Close including:- advising on and inputting (where appropriate) into the financial elements of the final contractual structure. They are providing a

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review of the preferred partner's Financial Model, reviewing iterations of the model as they are produced. Deloitte are assisting the Trust in finalising its financial discussions with the preferred Bidder to reach commercial close.

- *Legal Advisors*

L'Estrange & Brett and Bevan Brittan were appointed in 2005.

L'Estrange & Brett and Bevan Brittan's time is largely attributed to developing the Project Agreement, and thus liaising with all relevant parties; Trust, Bidders, Strategic Investment Board, and DHSSPS to reach an agreed position. Bevan Brittan bring their expertise and experience gained from other PFI projects in the UK, whilst L'Estrange & Brett bring their expertise on Northern Irish law and local knowledge to the project.

The services required from the legal advisors in relation to the core acute programme are detailed below:

- **Stage 1 – Pre-qualification**

L'Estrange & Brett led the evaluation of the legal aspects of pre-qualification submissions as part of the evaluation process leading to the pre-qualification of Bidders. This included issuing a report to document the views shared with the Trust in relation to this matter and provided Trust Board reports / presentations. They assisted the Trust and other advisers on other aspects of evaluating pre-qualification submissions.

Bevan Brittan's services were required from the outset, in developing the Project Agreement with the Trust, whilst keeping third parties (SIB) informed throughout.

- **Stage 2 – Competitive Dialogue**

This is the most intensive period for legal work, as under Competitive Dialogue, commercial certainty must be achieved before Final Bids can be submitted. Therefore it was paramount that the Project Agreement was fully developed, agreed with Bidders and signed off by the appropriate third parties before Stage 3 could commence.

In doing so, both Bevan Brittan and L'Estrange & Brett spent considerable time in dialogue with Bidders and consequently several drafts of the Project Agreement were developed before an agreed position was achieved.

L'Estrange & Brett also led the legal aspects of Bidder documentation, and acted as an overall quality assurance role before documents were released. Their attendance was also required at regular project management meetings to provide general procurement advice.

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In addition, the legal advisors were required to evaluate the interim submissions (Stage 2A – Stage 2D), provide reports for the Trust, and issue feedback to Bidders.

- **Stage 3 Final Tender and Bid Evaluation**

L'Estrange & Brett led the legal elements of the Invitation for Final Bid documentation and acted as a quality assurance for other elements of the document.

L'Estrange & Brett and Bevan Brittan evaluated the legal submissions at Final Bid stage. L'Estrange & Brett played a pivotal role in the appointment of Preferred Bidder, whereby they engaged with the relevant approval bodies; Trust Board, Strategic Investment Board and DHSSPS.

L'Estrange & Brett also took the lead role in developing the alcatel letters, in debriefing unsuccessful Bidders and agreeing the Preferred Bidder letter.

- **Stage 4 Finalisation**

L'Estrange & Brett are responsible for finalisation of the Project Agreement with the Preferred Bidder (including schedules and fine-tuning same to reflect the funding solution). They will review the Preferred Bidder's funding documents, subcontracts, corporate authorizations etc. They will provide the necessary advice to the Trust on what is permissible under Competitive Dialogue and will thus play an integral role in contractual close.

- ***Facilities Management Advisors***

Davis Langdon were appointed as the Trust's Facilities Management (FM) advisors under the Deloitte contract. The FM advisory service is in line with Deloitte's proposal for all services associated with FM i.e. their contract covers Stage 1 – Stage 4 of the procurement process.

VFM Consultancy, who developed the Public Sector Comparator (PSC) pre OBC approval, also rendered services throughout the Competitive Dialogue Stage. This is largely attributed to the assurance that a fair value for money test could be applied to Soft Services, by ensuring that Bidder's pricing assumptions matched the PSC's assumptions. Consequently the PSC was updated throughout dialogue.

VFM Consultancy also played an integral role in the VFM test for Soft Services at Stage 2D of the Competitive Dialogue.

- ***Human Resources Advisors***

Davis Langdon and Bevan Brittan provided the specialist advice to the Human Resource aspect of the project.

Davis Langdon provided the support that links the developments in FM throughout the project to ensure that each Bidders' workforce resources allocated to meet

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service specifications are benchmarked and fit for purpose. They attended Bidder meetings, throughout the competitive dialogue process and advised on the HR project deliverables and contributed to the evaluation process.

Bevan Brittan provided expertise on employment law matters in relation to TUPE staff transfers, the application of the ROE Model and compliance with the Code of Practice on Workforce matters in Public Service Contracts.

This advice, when added to the Trust HR resource allocated within the project, ensured that Bidder Submissions were in keeping with precedents set within the Trust and ensured that the Trust avoided any industrial relations issues arising at preferred Bidder stage.

Bevan Brittan also ensured that HR requirements were written into the legal Project Agreement document to ensure Bidder compliance. In addition Bevan Brittan contributed to the evaluation of bids and gave feedback to Bidders.

- *Technical advice, Project Management, ICT*

Davis Langdon's contract was extended in the Competitive Dialogue Stage to cover technical, project management and ICT issues that are pertinent to PFI procurements. This was because expertise in these areas was unable to be provided internally (including by Health Estates). Davis Langdon were required to engage in dialogue with Bidders in the project management and ICT work streams, QA of technical design issues, evaluate submissions, provide feedback to Bidders and provide ongoing support to the Trust.

- *Insurance*

Marsh were appointed in May 07 to cover the Insurance workstream for both the Enniskillen Acute Hospital and Omagh Local Enhanced Hospital projects..

Their activities included setting Bidder requirements, engaging with Bidders on the same, evaluating Bidders submissions and providing feedback to Bidders.

They are also working with the financial and legal advisors to contractual close.

- *Government Actuary*

This is a government department that deals with pension transfer requirements for staff who are required to TUPE transfer.

GAD provides ongoing pension advice and support to the project by ensuring that consortium members provide a GAD approved "broadly comparable" pension scheme. They also have a role in liaising with the consortium pension actuaries to establish terms for the bulk transfer of pensions and advise the Trust accordingly.

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- *Equality Impact Assessment*

Equality Advisors, Denise Wheatley Associates, have provided expertise and advice on assisting the Trust to conduct an EQIA on the method of financing the project as a PPP and on the relocation of staff.

Due to the equality obligations of Public Sector bodies, expertise on equality has been provided throughout the project with an equality screening of the FM structure and a possible full EQIA on the structure of FM delivery at preferred Bidder.

Also, as some of the bidding consortia are not from NI, equality refigurement has been built into the project deliverables and Bidder submissions scrutinised to ensure they meet the Statutory obligations under Section 75 of the Northern Ireland Act 1998.

9.2.1.8. *Support Advisors*

Support advisors have provided back up and the necessary information to the relevant project teams when required.

- *Communication*

Communications Advisors, Davidson Cockcroft, provided Public Relations and Media Advice/Support to DBS communications Team and Project Director during the early stages of procurement prior to the appointment of a communications manager.

- *Health Planning*

The Health Planner provided guidance on development of Clinical Output specifications; provided quality assurance (sign off) of completed specifications in conjunction with the design of the eight exemplar departments.

9.2.1.9. *Reporting Line for External Advisors in DBS projects*

Table 9.1 below illustrates the external advisors that are associated with each workstream during the procurement. The associated Trust Workstream Manager is responsible for managing these advisors.

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Table 9.1 Reporting Line for External Advisors

External Advisors	Project Manager Clinical	Project Manager FM/Financial/ Legal/ Insurance	Communications Manager	Equipment Project Manager	HR Manager
	Exemplar Design Team	Facilities Management	Media Management	RSS	Workforce Planning
	Health Estates	Legal	PR	Equipment procurement	Equality Consultants
	Way finding signage	Insurance	Arts Co-ordinator	Legal for MES	HR Legal Specialist
	Health Planning	Financial Advisors		Financial for MES	
	ICT	Business Case Advisors			
		Project Management Project Manager FM/Financial/Legal			

9.2.2. Stage 4 (Finalisation of Procurement)

The Finalisation Stage of the procurement process involves four key steps;

1. Appoint Preferred Bidder
2. Receipt of Full Planning Approval
3. Full Business Case Approval
4. Financial Close

Each of these steps requires careful management to ensure that timely approvals are received as each represents a core part of the critical path that will bring the project through to successful Financial Close, and to the beginning of the construction phase of the project from April 2009.

The structures that have been established to manage this critical period build on the management structures from the procurement phase, which have been supplemented with the following partnership arrangements with the Preferred Bidder;

Preferred Bidder Steering Group: Drawing memberships from Preferred Bidder Sponsor organisations, the Trust and the Strategic Investment Board and chaired by the Chief Executive of DHSSPS Health Estates Agency.

Joint Programme Management Group: Workstream leads from the Trust's Project Team and the Preferred Bidder meet fortnightly to provide the project with the momentum required to achieve the targets and milestones.

Programme Management Meetings (Internal): The Trust's Project Team and Advisers meet fortnightly between the Joint Programme Management Group

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meetings to provide the critical interfaces and ensure actions are progressing in accordance with established timeframes.

Further information on the management and requirements of Stage 4 of the procurement are provided in Chapter 7 of this Full Business Case.

9.3. CONSTRUCTION PHASE

During the construction phase, the Project Director and Project Managers, in conjunction with Health Estates and Design & Construction Technical Advisors will monitor the development of the hospital against the quality and timetable objectives set out in the Project Agreement. The project management structure for the Construction Phase will be similar to the Procurement Phase and is set out in Figure 9.3 overleaf.

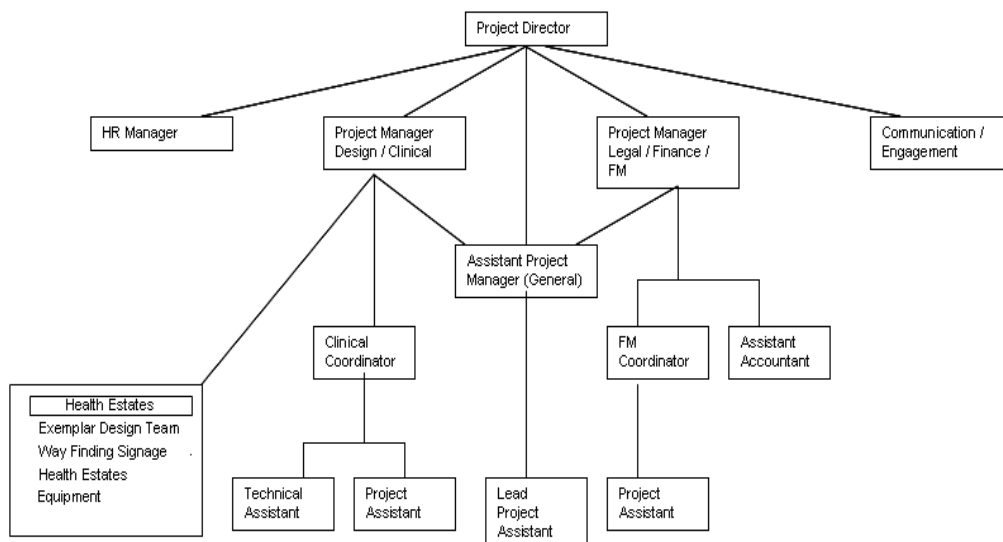


Figure 9.3 Project Structure during Construction Phase

The Project Team will develop a close working relationship with the Consortia, attending progress meetings, inspecting and commenting on plans, responding to the Consortia's programme for the approval of reviewable design data/information, confirming compliance with the specification (as appropriate) and generally ensuring that the planned service commencement date will be achieved. At the same time, care will be taken to ensure that the approach to monitoring will not inhibit the Consortia in the delivery of the project or result in the Trust or Department taking back risks that had been allocated to the Consortia in the Project Agreement.

The main issues to be dealt with during the construction phase include:

- Aspects of the design of the new accommodation, or of the service requirement, where these have not been completed in detail prior to contract award. Under these circumstances, the client side Project Manager / Health Estates Technical

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Advisor will be responsible for approving further design proposals on behalf of the Trust;

- Monitoring the construction of the new accommodation. Project Director, Project Manager / Health Estates Technical Advisor and their representatives will have the right to enter the site, attend regular site meetings, receive relevant correspondence and minutes of Consortia meetings and highlight contractual failures whilst works are continuing;
- Monitoring delays or changes to the construction programme, particularly where these are likely to affect the service commencement date. The Project Director and Project Manager / Health Estates Technical Advisor will be provided with details of any delays and, after consultation with the Senior Responsible Owner, will confirm if an extension of time is permitted. This will be ratified by the Project Board; and
- Managing any variations to the works required by the Trust during the construction period. The Project Director and Project Manager / Health Estates Technical Advisor will act as the channel through which requests are made, and will subsequently negotiate with the Consortia regarding design details, workmanship, price and any resulting adjustment in the unitary payment.

Reporting to Trust Board will be managed in a similar way to that of the Procurement Stage.

The following support advisors will be appointed during the Construction Phase to provide the necessary information to the project team when required:

- *Arts Co-ordinator*

The Arts Co-ordinator will be responsible for developing and implementing an Arts Programme for the New Acute Hospital for the South West (NI). They will be responsible for the development and implementation of a partnership approach to arts working closely with the PFI contractor and other key stakeholders within the Project to successfully deliver an effective Arts Strategy.

- *Way finding Signage Co-Coordinator*

A key challenge will be developing an effective way finding strategy for the new hospitals. Way finding is much more complex than simple signage, it requires expertise in design architecture. The way finding co-ordinator will be required to use sophisticated techniques to assist patients and visitors to orientate themselves within the building. The use of colour and careful positioning of landmarks will need to be considered.

- *Independent Test Commissioning*

The Independent Test Commissioner will assist with the Commissioning of Facilities and Equipment and to act as an independent assessor to the Trust.

The role of the independent tester is to monitor the quality and appropriateness of the design, building and commissioning processes (e.g. compliance with planning

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law, building regulations, industry good practice guidelines etc). The remit includes not just the fabric of the building and services (e.g. electrics, plumbing, air conditioning etc) but also the installation of equipment. The Independent Tester will ultimately certify that the building is fit for the purpose of delivering the requisite services to patients.

The role is dispensed through bi-monthly site visits which comprise a combination of visual checks, documentation checks and the witnessing of certain key tests e.g. those involving the functioning of the mechanical and electrical installations. There is a series of final checks and assurances – formally referred to as the “tests on commissioning” – that will take place just prior to the planned date of service delivery and will result in the issuance of the Certificate of Availability.

- Equipment General

RSS will provide the Trust with more specialist knowledge in relation to equipment issues .

9.4. COMMISSIONING PHASE

9.4.1. Introduction

The Western Health & Social Care Trust has developed plans to take forward the commissioning phase of the project. This is the crucial phase that guides the project into operation and follows the construction completion and handover. Plans for the Commissioning Phase will be developed in close liaison with operational and technical staff who form a core part of the Commissioning Team structures. Key outputs for this phase include the Commissioning Master plan, Commissioning Programme, Occupational Procedures, Transition plan including staff training and occupation programmes.

Commissioning planning for the New Acute Hospital for the South West began during the procurement phase, with responsibilities applying to Project Co. clearly specified and articulated in the legal documentation, the Project Agreement.

The Commissioning Phase has been broken down into the following stages (Table 9.2 overleaf):

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Table 9.2 Stages in the Commissioning Phase

Key Tasks	Stage	Time-line
	1. Planning	April 2009 – March 2010
Project Management	Establish Commissioning Team and Commissioning Working Groups Develop Commissioning Master plan and establish Commissioning Budgets. Develop communication plans involving all stakeholders & representatives of the Community	
Operational	Implement consultation programme for TUPE staff. Develop Operational Procedures from Policies. Review workforce plans and budgets.	
Technical	Review Equipment Specifications, Begin Equipment Procurement Produce ICT installation plan, Complete Reviewable Design Data Monitor Construction Programme, Establish beneficial access	
	2. Programming	April 2010 – March 2011
Project Management	Develop Commissioning Programme with Commissioning Working Groups Review Workforce Plans and Revenue Budgets against new policy developments. Review commissioning budgets and ‘hump fund’ requirements.	
Operational	Sign-off Operational Procedures and Complete Staff Mapping Develop Programme for Occupation of facilities.	
Technical	Produce Beneficial Access plan. Complete ICT and Equipment Procurement and Produce Equipping Schedule	
	3. Transition	April 2011 – March 2012
Project Management	Finalise de-canting procedures. Implement de-commissioning programme. Monitor independent testing arrangements. Implement Transition Communication Plans	
Operational	Implement Staff Training Programme. Develop Patient Transfer Plan Complete Clinical Commissioning Staff Familiarisation Events Stakeholder/Public Open Days	
Technical	M & E and plant commissioning and testing. Equipment Installation, Commissioning & Testing. Install and Commissioning ICT infrastructure.	
	4. Operational	April 2012 – Full Operation
Project Management	Implementation of Staff Occupation Programme and Patient Transfer Plans. Launch post-project evaluation and benefits realisation monitoring.	
Operational	Facility Handover: January 2012 Patient Transfers and Implement new Staff Rotas.	
Technical	Complete Snagging Lists	

Each of the key tasks identified for the main four stages of the commissioning stage can be broken down into a range of actions. These actions will be provided in the Commissioning Master Plan.

9.4.2. Developing the Commissioning Master plan

The Commissioning Master plan will guide the commissioning process and will be jointly developed and agreed by the Trust and Project Co. representatives on the Joint Commissioning Steering Group.

Outline of Commissioning Master Plan

- Operational Procedures
- Workforce Plan
- Revenue Budgets
- Transitional Plan and Occupational Strategy
- Equipment Installation Schedule
- Patient Transfer Schedule
- Snagging Procedures
- De-commissioning Strategy
- Information and Communications

9.4.3. Commissioning Team Structures

One of the initial requirements of the commissioning phase is the identification of the Commissioning Resource Structures. The Human Resources with responsibilities for the Commissioning Phase of the project will be structured to include three key groups;

- Joint Commissioning Steering Group
- Project Commissioning Team
- Commissioning Working Groups

Reporting structures are outlined in the Figure 9.4 overleaf.

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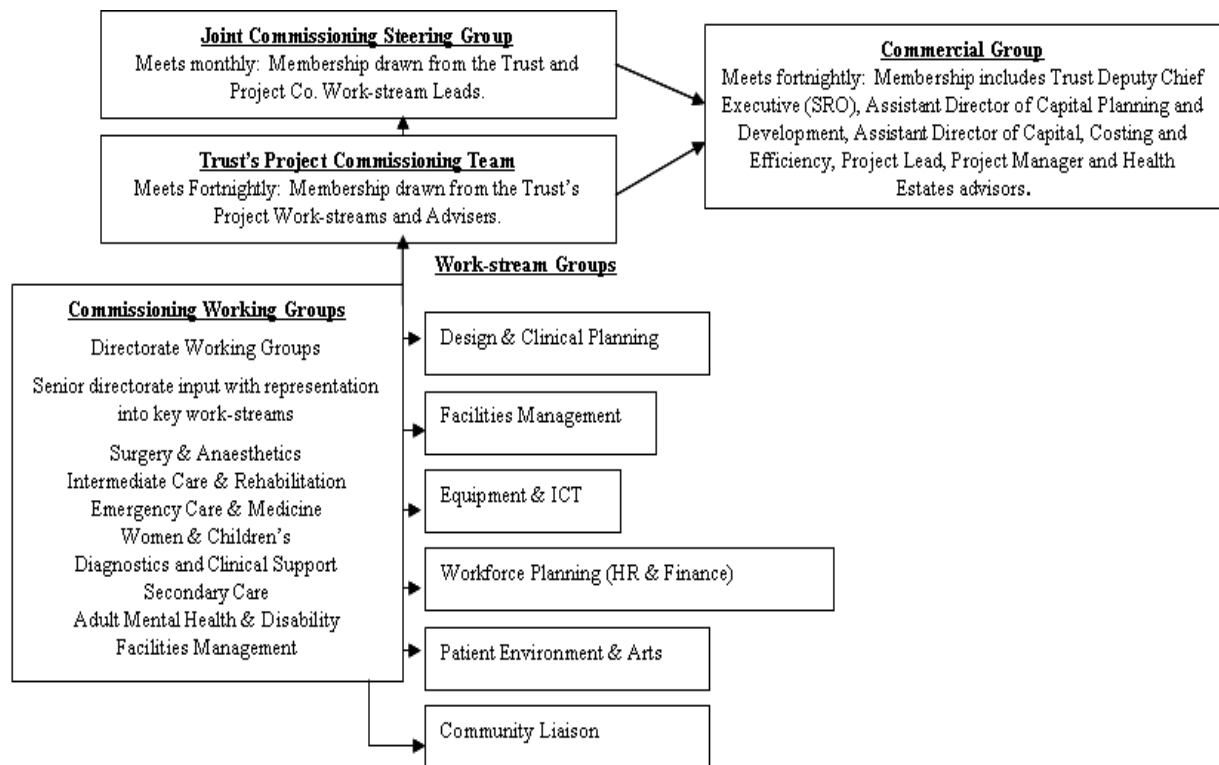


Figure 9.4 Commissioning Reporting Structures

9.4.3.1. Joint Commissioning Steering Group

The Joint Commissioning Steering Group will provide the key link between the Trust's Commissioning Team and Project Co. and the Construction Joint Venture. This Group will hold responsibility for the development and implementation of a three year commissioning master plan for the project. The Joint Commissioning Steering Group will be chaired by the Trust's Commissioning Manager with membership drawn from work-stream leads representing the Trust's Project Commissioning Team and Project Co work-stream leads. (Refer to Organograms in Chapter 7, Section 7.6.3.3 for work-stream structures)

The Joint Commissioning Steering Group will meet monthly to agree a detailed Commissioning Programme, review progress on all elements of delivery and ensure that potential issues, risks and variances are identified and addressed. The Steering Group will report to the Project Board which also meets monthly. The Project Board shall ensure ownership of the project across all directorates and ensure that Trust business and operational plans are aligned with the Full Business Case objectives.

Quarterly commissioning progress reports will be provided to Project Board benchmarked against the requirements of the project implementation plan and the Full Business Case. The reports will update the position on the commissioning master plan and highlight potential variances to the commissioning project with analysis of resulting impacts with specific reference to cost and programme.

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Project Co. representatives on the Joint Commissioning Group will include;

- Northern Ireland Health Group (NIHG): Project Director and Manager
- Construction Joint Venture: Project Managers
- Design Manager
- Equipment Manager
- M & E Co-ordinator
- Facilities Management and Human Resources Manager

The first meeting of the Joint Commissioning Steering Group shall take place in the second half of 2009, and no later than twenty four (24) months prior to the target Completion Date of January 2010. A draft of the Final Commissioning Programme for the first phase of Commissioning, namely Technical Commissioning, will be presented to Project Co by no later than eighteen (18) months prior to the Completion Date.

9.4.3.2. *The Project Commissioning Team*

The Trust's Project Commissioning Team will be drawn from the Trust's existing full-time project team and will report to the Commissioning Manager. Team members will bring knowledge and experience from the previous stages of the project including initiation, specification, bid development and evaluation. The Project Commissioning Team will continue to follow a work-stream structure which runs in parallel with Project Co. structures where personnel are also assigned on a workstream basis. (Refer to Chapter 7, Section 7.6.3.3 for Organogram details). This workstream structure which includes quality assurance mechanisms ensures appropriate liaison with key members of Trust staff, including directors and assistant directors and the Project's Clinical Lead and key clinical staff drawn from the Project's Clinical Reference Group.

The Trust's Commissioning Team will also be supported by external professional advisers for each of the key project workstreams and bring experience from other PFI projects throughout the UK. This will include Technical and Procurement advisers from Health Estates Agency and Regional Supplies Service (RSS).

External Quality Assurance will be provided in the form of Independent Testing of the Building and Environment, including testing of the Mechanical and Electrical systems. Independent testers shall be appointed jointly by the Trust and Project Co through a procurement and selection procedure overseen by Health Estates.

The testing of clinical equipment and specialist areas such as laboratories and theatres, pneumatic tubes and such items shall be performed as part of the commissioning element of the equipment procurement.

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Role of Project Commissioning Team

The key role of the Project Commissioning Team is to;

- Formulate the three year commissioning master plan and commissioning programme.
- Liaise closely with Project Co and Construction Joint Venture.
- Agree master plan and commissioning programme with Project Co. and the Commissioning Working Groups.
- Secure the engagement of operational managers and co-ordinate input into plan through the Commissioning Working Groups ensuring cross-group issues are addressed.
- Establish with operational management detailed operational procedures including service description, predicted activity levels, patient flows, departmental workforce plans, supplies, income and expenditure, fire plans and definition of security access protocols.
- Review workforce plans and establish new staffing levels matching these to assumptions in Full Business Case.
- Establish working group for transfer of TUPE staff.
- Establish detailed transitional arrangements and occupational strategy, including staff transfers, recruitment and training plans.
- With operational managers, review revenue budgets; workforce, goods and services.
- Manage commissioning costs and minimise double running costs (hump costs)
- Procure and install equipment and ICT.
- Analyse and report FBC variances.
- Highlight matters of policy which should be brought to the attention of Project Board.
- Maintain the assets register.
- Provide regular updates and reports to key stakeholders.

9.4.3.3. Commissioning Working Groups

Operational Managers, both clinical and support, will be fully engaged in Commissioning Working Groups to provide essential input into the commissioning process. This will be implemented by extending the project's engagement process that is currently successfully operating. This is organised on a Directorate structure with regular liaison and sign-off procedures in place with Senior Directors, supported by overarching Staff Groups and a system of work-stream subgroups as illustrated overleaf in Figure 9.5.

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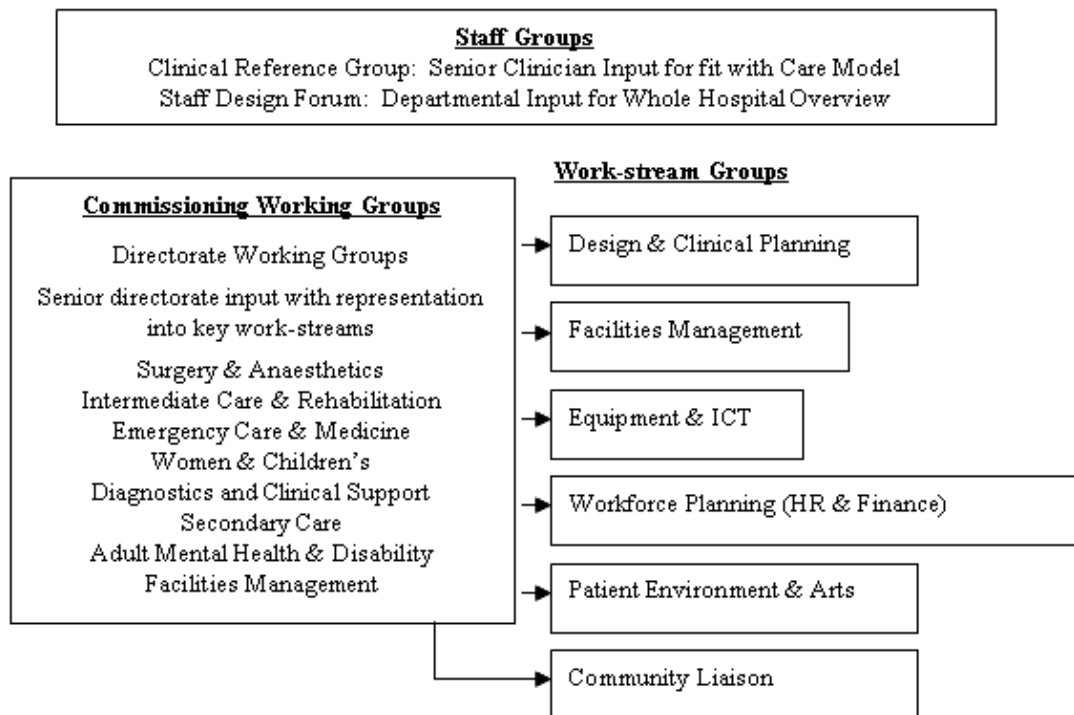


Figure 9.5 Commissioning Working Groups

The core role of the Commissioning Working Groups is to develop plans under the direction of and facilitated by the Trust's Project Commissioning Team. Input into each Working Group will be provided at Senior Directorate level, with responsibilities assigned to ensure appropriate representation on each work-stream; design, facilities management, equipment, human resources, finance etc. The Commissioning Team will provide a link and reporting line to the Commissioning Manager.

Key tasks will include:

- Draft detailed operational procedures based on operational policies
- Incorporate policy issues into plans
- Review workforce plans in line with Full Business Case
- Review revenue budgets in line with Full Business Case
- Identify staff training needs and develop training plans
- Agree equipment requirements and develop equipping programme
- Develop the occupational programme
- Manage and implement the transfer process

9.4.4. Project Co. Commissioning Responsibilities

The responsibilities for Project Co. during the commissioning phase of the project are specified in the legal contract for the project, the Project Agreement. This defines the responsibilities in two key categories, namely Technical Commissioning and Operational Commissioning. Key responsibilities for each category are outlined below:

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9.4.4.1. Technical Commissioning

Technical Commissioning is bringing into use the mechanical and electrical services and equipment for the building. Key Tasks for Project Co. during Technical Commissioning include:

Human Resources

- To commence training of the Project Co Staff and/or Transferring Employees in the Mock-Up Facilities;
- To permit the Trust to have access to the Mock-Up Facilities and the Facilities and carry out training of Trust staff members;

Design & Technical

- To provide calibration of mechanical and electrical building equipment and/or other equipment and services including adjustment and final connection in relation to all building equipment and Equipment required to be Installed & Commissioned by Project Co;
- Purging of the medical and specialist gas systems in accordance with HTM 02-01.

Equipment and ICT

- To provide to the Trust and/or any Trust Party Beneficial Access to the Facilities during the Works, to enable the Trust to Supply and/or Install & Commission Beneficial Access Equipment without disturbance, interruption or impediment;
- To obtain all approvals/licences as listed in the Project Agreement;
- To install & commission such items of Equipment that are defined as the responsibility of Project Co;
- To install & commission the Passive ICT Network;

9.4.4.2. Operational Commissioning

Operational Commissioning will be carried out after the issue of the Certificate of Practical Completion. The core task is to ensure the smooth integration and transfer to the new facilities. Key Trust responsibilities will be carried out by Health Estates and the Project Team and are as follows:

Human Resources

- Ensuring the establishment of service management and reporting systems, setting up monitoring arrangements and establishing procedures for certification;
- The continued training of Trust staff (whether conducted by the Trust or by Project Co in accordance with the agreed Final Commissioning Programme and if conducted by Project Co, at no additional cost to the Trust).

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Design & Technical

- Ensuring that all client side duties are undertaken in relation to ‘Construction, Design and Management’ regulations;
- Determining when the new accommodation is ready for use. The Project Director and Project Manager / Health Estates Technical Advisor will ensure that all the specified “Tests on Completion” are satisfied prior to occupation and will make a recommendation to the Senior Responsible Owner, who will then trigger the commencement of service payments to the Consortia in accordance with the Payment Mechanism;
- Monitoring the building defects liability period; and
- Auditing the Consortia to ensure that it meets all necessary obligations in respect of insurance and indemnities, performance bonds, health and safety procedures and other statutory obligations.

Equipment & ICT

- To co-ordinate installation, commissioning and testing schedules ensuring all areas are fully prepared for operation in accordance with the overall programme.

9.4.5. Project Management Issues

The following key project management issues shall be provided careful attention during the commissioning phase to ensure delivery of the facilities on time and within costs. Management shall ensure that the planned implementation systems are applied, interdependencies are identified and accounted for and an early alert system addresses any potential for over-run on cost and time.

Financial Management

Revenue Costs: Revenue Budgets have been projected for the new facilities and these shall be monitored closely to ensure achievability of the Full Business Case objectives. Monitoring shall take place by the Project Accountant in conjunction with the HR team and take account of updates to workforce plans resulting from the production of operational procedures. Work will also take place to establish new financial codes for the new facilities.

Commissioning Costs: The costs of the commissioning phase are profiled in Chapter 1, Section 1.8.1.3 of this Full Business Case. The Commissioning Team will ensure that budgets are monitored against spend and costs are kept to a minimum. Staff costs shall be kept to a minimum through the identification of existing staff members to perform basic training and familiarisation duties. Logistic and storage requirements will be managed within existing facilities where possible with just-in-time purchasing and phased fit-out.

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Commissioning costs have been profiled based on the following cost headings:

- Commissioning Team Costs;
- Staff Training and Familiarisation;
- FM requirements (Site Security, Portering, Cleaning & Catering);
- Logistics including patient ambulance transfers, transport, storage and packaging;
- Double running costs; and
- Information and Publicity.

Double running costs (hump funds): To maintain effective patient services during the transition from old to new healthcare facilities, it is necessary to identify the double running costs required to cover this period. This will include arrangements for the short-term employment of additional staff, as well as general running costs. The Commissioning Team will work to ensure that double running costs or hump funds are kept to a minimum.

Risk Assessment & Monitoring

A key part of the Commissioning Master plan will include a risk assessment to identify and assess the potential impact of key risks including delay to the construction programme, problems arising during technical commissioning and late delivery of the healthcare facility. The risk management strategy as outlined in our Risk Register, will be updated and account taken of impacts on Benefits Realisation.

Handover to Operational Management

The Commissioning Team and Manager shall remain to support the handover to Operational Management for at least three months after the facility has been brought into use to deal with any emerging issues.

9.4.6. Information and Communications

A key project consideration has been ensuring that effective communication links are maintained with key stakeholders including sponsors, staff and the local community. Staff ownership of the project is key and much work shall take place with Operational Management to ensure that ownership of key tasks such as the Transfer process is embraced.

Existing communication structures will be maintained during the Commissioning Phase of the project to ensure that staff are kept abreast of developments and are provided with information offering reassurance as well as building anticipation and welcome for the New Hospital. The following communication tools will continue;

- Quarterly Staff Bulletin;
- Project Web Site;
- Project Exhibitions and Road Shows (including Public Road Shows);

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- Staff Engagement: Staff Forums & Commissioning Working Groups including Trade Unions;
- Community Engagement: Community Forums and Patient Environment & Arts Committee; and
- Media Liaison and Press Conferences.

These general communication activities will be supported by additional activities for this phase as outlined below;

- Support Programme for Transferring Staff (Including Help Desk);
- Media Event: Laying of Foundation Stone;
- Familiarisation visits for Staff;
- Hospital Open Days (Including specific events for GP's & Community Forums including disability groups);
- Site Signage (Erne Hospital and New Hospital Site);
- Naming the Hospital: Public Relations Competition;
- Develop 'Friends of Hospital' with Fermanagh Trust;
- Public Leaflet and Promotional Materials including Information and Maps;
- Media Information Campaign: Transition: Public Notices in local press and radio; and
- Official Opening.

9.5. DE-COMMISSIONING

The opening of the New Acute Hospital for the South West will see the transfer of Trust services from the existing Erne Hospital site. The vast majority of services will transfer to the site of the New Hospital, with some retained estates and community services to be delivered from existing satellite locations in the area. Following handover and occupation, the Erne Hospital site will be de-commissioned. The site will be vacated and prepared for disposal working to a target date of 31st May 2013.

To support the communication strategy for the transfer, a sign will be placed on the site for a total of six months providing directions to the New Acute Hospital which lies approximately one mile from the Erne site.

Key tasks for the de-commissioning phase are as follows;

- A decommissioning strategy will be developed by the Commissioning Manager and signed-off by the Strategic Development Project Board. This will include a policy for the disposal of surplus equipment, site decontamination and disposal of hazardous materials.

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- A decommissioning action plan will be developed by the Commissioning Team based on information from the Commissioning Working Groups and Regional Supplies Service and will be signed-off by the Project Commercial Group.
- The retained estates management team will implement a decommissioning action plan. The estates team will be supported by a Finance Office who will be responsible for updating the assets register.
- The Action Plan will outline the steps necessary to de-commission each section of the Hospital facilities, which will be separated into sequential blocks for this task.
- Attention will be taken to maintain the security and safety of the buildings from closure and disposal.

9.5.1. Disposal Strategy for Erne hospital.

The aim of the disposal strategy is to maximise the capital value of the Erne hospital site. The disposal strategy work will take account of the DHSS strategy for disposal. Reference will be made to Health Estates Land Transactions Handbook and the Disposal of Surplus Public Sector Property Guidelines of the Central Advisory Unit.

The decommissioning of services from Erne Hospital is a crucial area of this strategic work and is linked to the commissioning of the new South West Hospital as set out under Chapter 9, Section 9.4 of the Full Business Case.

It is important to establish a strategy with objectives that are attainable and within agreed timescales. A project group chaired by Alan Moore, Assistant Director of Capital Development will take this process forward with suitable representation from Trust Management, Health Estates Property Management, Department of Health Capital Development all with clear lines of accountability. The group is due to meet again in mid November 2008 and thereafter on a quarterly basis. The overall objective is to achieve a position whereby the Erne hospital site is ready for disposal by 31st May 2013.

9.5.2. Legal Title

It is important to consider at an early stage any issues surrounding legal title of the hospital including:

- 1) How and when the land/property was acquired.
- 2) How it is held i.e. leasehold, freehold etc.
- 3) Whether there is anything in title deeds which could adversely affect disposal i.e. restrictive covenants.
- 4) Is the land/property registered? If so a copy of folio should be provided. If not a copy of title documents should be provided.
- 5) Details of any Wayleaves/Easements that affect the land/property.

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The clarification of title process involves getting deeds of premises along with territory maps forwarded to Central Services Agency Legal Directorate. In regard to disposal, it is better to deal with the total Erne hospital site.

9.5.3. Land Disposal Strategy

9.5.3.1. Land and Property Service

Once Legal Title is clarified, assuming there are no complications, appropriate Trust Board approval will be sought to declare its intention for formal disposal of the Erne hospital site. This process is conducted through a Proforma “Disposal of Surplus Land Request for Preliminary Advice” through the Central Advisory Unit for Land and Property Agency from which the advice of Land and Property Services is required. It is a mandatory requirement that other public bodies are trawled to see if they are interested in the property.

9.5.3.2. Historic Building Searches

Investigation will also be required into Listed Building Searches for the Erne hospital site. The Northern Ireland Environment Agency will provide this information.

9.5.4. Identification of Staff Groups or Functions Requiring Future Accommodation

The mapping across of Erne hospital departments to their future location has taken place with the remaining issues to be resolved set out as the following:

- Parking bays for 30 Trust owned transport vehicles currently based at the Erne hospital site
- A number of Estates Services staff managed by the Trust providing cover for facilities in the Fermanagh area other than the new acute hospital. Although it is estimated that 17 staff will be required, a definitive figure will depend on when and how Primary and Community Care Infrastructure strategy is implemented.
- The Northern Ireland Ambulance Service (NIAS). Meetings are taking place with NIAS senior management. It is anticipated that NIAS will be sourcing suitable accommodation as part of their strategic development plan. It is important however from the Trust’s perspective to consider what is a feasible solution for these functions including whether a portion of the Erne hospital site be zoned off to facilitate such functions.

9.5.5. Decommissioning of Estate

The issue of technical decommissioning will require further clarification on what state the Trust leaves the Erne hospital after May 2013. Advice will be sought from Health Estates taking cognisance of what has happened for other sites to help in its commercial viability including disposal of hazardous materials, demolition of buildings and securing of premises. For example Belvoir Park Hospital had a ring fence erected with the Trust locking up and leaving the premises. Coleraine Hospital

conducted a similar approach with windows boarded up to further secure its facilities.

9.5.6. Future Way Forward

Following a review and taking into consideration the current financial climate, the DHSSPSNI and the Land and Property Services agency have initially advised the Trust seeks outline planning permission to ensure the site is more viable whether it be for commercial or residential purposes. This will involve the employment of a planning consultant to conduct the relevant surveys and interfaces with other agencies. It is important to state that if a planning consultant is appointed, it will take an absolute minimum of 1 year to do the necessary work for submitting planning applications. It is estimate that it will subsequently take 2 years for decisions on these applications.

However, at the phase of trawling for public interest, if there is public interest which gets the necessary approvals for acquisition there is no need to obtain planning permission as it is only deemed necessary if the site is being sold on the open market.

A communication strategy is required to ensure stakeholders are effectively informed throughout the process and to take on board any issues.

9.5.7. Conclusion

The Trust will wish to avoid, where possible, the running costs of the Erne hospital site once its existing functions have been formally relocated and the site declared ready for disposal.

Any costs associated with the marketing aspects of the decommissioning process will be of-set against the overall end-sale value of the hospital site.

9.6. OPERATIONAL PHASE

The proposed structure for the Operational Phase is shown in Figure 9.4 .

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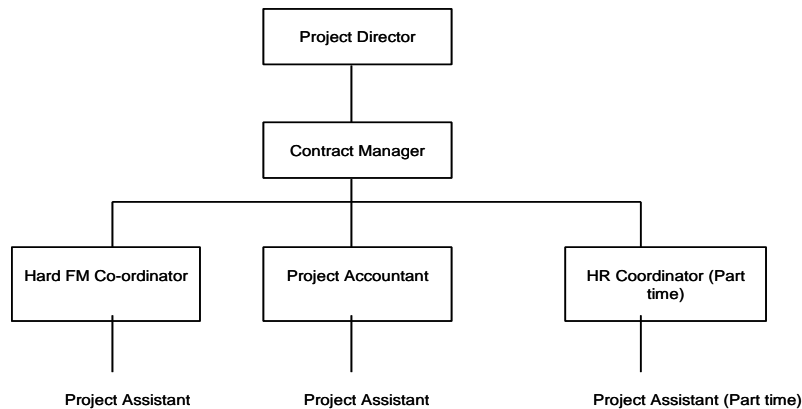


Figure 9.6 Project Structure during Operational Phase

Preparations for the long term management of the PFI contract occurred during Stage 2 of the procurement process, whereby robust mechanisms were put in place for measuring (and where necessary rectifying) the performance of the Contractor over the life of the PPP contract.

Contract management and performance monitoring requirements were specified within the Information and ‘Terms and Output’ Specifications. A full methodology was sought from Bidders as part of their bids and thus formed an integral part of the evaluation process.

The contract management and performance monitoring arrangements agreed with Bidders during dialogue will be set out in the Project Agreement. This includes a substantial element of self-monitoring by the Contractor, which will be subject to periodic compliance audits and inspection by the Trust to ensure that the Contractor is measuring and reporting its performance reliably, accurately and comprehensively. The Project Agreement requires a system to be established to enable users of the hospital (e.g. business managers, admin staff and clinical staff) to report failures if and when they occur. Additional monitoring will be undertaken by the Trust on an exceptional basis, for example when staff identify and report performance failures. These will be summarised in the FBC once finalised for Preferred Bidder.

The contract management and performance monitoring arrangements defined in the Project Agreement will enable the Trust to easily and cost-effectively monitor the performance of the Consortia against the availability and performance targets set out in the Project Agreement. The arrangements will be tailored to meet the particular requirements of the Trust and the Department, and there will be a clear connection between the data collected by the monitoring process and the financial penalties included in the payment mechanism for unavailability or substandard performance.

During the operational phase, the Project Director and Contract Management Team will have to deal with a range of issues including:

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- Implementing and operating a direct monitoring system on behalf of the Trust and the Department, which is in addition to the self-monitoring undertaken by the Consortia;
- Handling the “settling in” period immediately following the service commencement date. During the settling in period, the Consortia may be afforded a certain degree of flexibility from the full performance regime in recognition of the fact that teething problems are inevitable as defined in the Project Agreement and Payment Mechanism;
- Monitoring the provision of the Consortia services, including the availability of accommodation, to ensure that the Consortia is conforming to the specified performance standards as outlined in the payment mechanism;
- Receiving, checking and authorising invoices for payments under the Payment Mechanism, at the specified frequency and within the period allowed for payment. This will include the periodic recalculation of service payments to take account of indexation arrangements, changes to service requirements and deductions for substandard performance in accordance with the terms of the Payment Mechanism;
- Ensuring the Consortia’s books are audited in accordance with the provisions of the contract;
- Jointly inspecting repair and maintenance obligations, both periodically and in particular towards the end of the contract term to ensure that the accommodation, furniture and equipment is maintained to the specified standards;
- Monitoring the Consortia’s approach to rectifying incidents of underperformance and the achievement of rectification periods;
- Monitoring compliance with appropriate regulations including health and safety, building and fire regulations;
- Monitoring (by way of sampling) the Consortia’s quality management systems, ensuring that management information is made available by the Consortia and that all records are updated in a timely manner;
- Periodically inspecting the Consortia’s asset and equipment registers to ensure that all of the specified equipment is in place;
- Dealing with any price variation adjustments and agreeing any market testing or benchmarking arrangements with the Consortia;
- Monitoring and approving any third party use and resulting revenue;
- Monitoring that insurance and indemnities are maintained in force;
- Managing changes to the contract, whether this be issuing instructions for change on behalf of the Trust, processing any requests for change received from the Consortia, or responding to external changes such as changes in the law;
- Dealing with third party and public relations issues in conjunction with the Consortia;
- Establishing and periodically reviewing contingency plans in the event of major failures in service delivery;
- Planning how HR issues will be dealt with within the project, with particular attention to Equal Opportunities (including all Section 75 categories);

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- Reviewing all existing equal opportunities policies and procedures to take account of the Northern Ireland context, especially where monitoring is concerned. Furthermore, the contractor must equally proof their policies relating to secure delivery and employment;
- Planning to address any possible equal opportunity issues that arise from the TUPE transfer of Hard FM staff;
- Planning to ensure that a two tier workforce is not created when staff are transferred and new recruits appointed by complying with the Trust's requirements for monitoring terms and conditions for staff;
- Monitoring that the contractor is fulfilling their obligations under the Disability Discrimination Act by addressing issues such as access, communication, information management and by making equipment to assist disabled staff;
- Ensuring administrative systems are put in place in relation to staff to enable the collection of equality monitoring information for all Section 75 categories;
- Complying with the reporting requirements of the Fair Employment and Treatment Order (FETO) and that action is taken to address any under-representation of people from either of the main communities;
- Monitoring the use of sub-contractors appointed by the contractor to ensure they comply with the requirements of FETO;
- Monitoring and reporting arrangements to oversee the implementation of the project's Social and Economic Regeneration Plan (SERP). This shall include the foundation of quantified objectives and the formation of a SERP steering group with membership including Trust , Bidders and Union representation; and
- Management of Benefits Realisation Process.

9.7. CONTRACT END

The Project Director and Project Team will have to deal with an additional set of concerns as the end of the contract term approaches. These include:

- Ensuring that the accommodation and equipment remain fit for purpose, where they are to continue in operation;
- Re-tendering for the provision of the service, where this is appropriate;
- Assessing and making arrangements for any liabilities arising from the return of the assets to the Trust;
- Considering the implications of employee transfers from the Contractor to either the Trust or a successor Contractor; and
- Implementing hand-back procedures.

9.8. SPECIFIC CONTRACT MANAGEMENT ISSUES

There are a number of specific issues that the Project Team must address during the procurement and construction phases. These include the:

- Arrangements for managing the enabling works **secondary access route** under separate contracts which are critical to the timetable for this project;
- Arrangements for the transfer of hospital activities into the new accommodation at the end of the construction period;
- Timing of transfer of activities into the new accommodation at the end of the construction period; and
- **Arrangements for Independent Testing.**

These issues will be managed by the Project Director in conjunction with Health Estates.

The Trust has established structures to enable the smooth transition to the new model of patient care, as established by the regional Developing Better Services guidance.

This process is under the direction of the Trust's Director of Acute Services and led by the Service Redesign Programme Manager. A Reform & Modernisation Group has been established and meets on a monthly basis to progress the Reform & Modernisation agenda for Acute Services in the Western Trust. The key purpose of the Reform & Modernisation Group is to take forward service improvement within Acute Services in partnership with our colleagues in Primary Care and Older Peoples Services, the WHSSB, GP's and Community Pharmacists who are all represented on the Group and at its meetings.

9.8.1. Independent Tester Summary

The role of the Independent Tester is to ensure Project Co. compliance with the specifications and quality standards established in the Project Agreement and Quality Plan and to inspect and certificate the successful completion of works to acceptable standards. Key requirements are as follows;

- **To witness equipment, building, build services and pre-completion commissioning for compliance with specified standards, including for example Health Building Notes and Health Technical Memoranda, Codes of Practice and British Standards.**
- **Review the Final Commissioning Programme.**
- **Witness tests to be performed in accordance with the Final Commissioning Programme (i.e. generator and building performance such as thermal, acoustic, fire, M & E, airflows, communication systems, way finding).**
- **Confirm receipt of necessary consents (i.e. Building control, Compliance with Planning Conditions, Fire Inspection, for Final Commissioning Programme.**
- **Perform regular inspections of Works.**

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- Issue a Certificate of Practical Completion
- Specify snagging matters and issue a Snagging Notice(s) following inspections.
- Issue a Commissioning Completion Certificate.

The Independent Tester shall be appointed by an open procurement procedure that shall involve an OJEU advertisement. It is planned that the OJEU advertisement shall be placed in December 2008, with the process resulting in an appointment in March 2009 to enable familiarisation with the contract documentation prior to construction commencing. The process shall involve an interview panel with representatives from the Trust, Health Estates Agency (Centre of Procurement Excellence) and Project Co.

9.9. DEVELOPING BETTER SERVICES IMPLEMENTATION PLAN

In terms of implementing the Developing Better Services agenda through this project, the WHSCT is developing an Implementation Plan and will set out the framework that describes the journey that will be taken to move existing services through a phased and integrated development plan, within the given timescales, to move towards the new service profiles set out in the business case and within the strategic direction of the Trust.

The Implementation Plan will be managed within an agreed Project Management Organisational Structure, adopting well established project management methodology. In addition the Implementation Plan will have a dedicated Project Manager with an Implementation Planning Project Group. The Corporate Management Team, chaired by the Chief Executive will act as Project Board, and will oversee the whole of the plan ensuring a joined up approach.

A project manager has been recently appointed to begin the process of developing this Implementation Plan and a service Reform & Modernisation Group has been established within the Trust, chaired by the Director of Acute Care. One of the immediate priorities for this group is to reconfigure service to deliver a safe and sustainable level of patient care at the Tyrone County Hospital within the network of acute services across the Trust.

9.10. PROJECT TIMETABLE

The Trust wish to commence the delivery of services in the new accommodation at the earliest possible date, and an indicative development timetable is presented in Table 9.3 that follows.

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Table 9.3 – Indicative development timetable

Activity	Target Date
Award Preferred Bidder	September 2008
Contract Award / Financial Close	March 2009
Practical Completion Date	March 2012
New hospital becomes operational	June 2012

Source: Health Estates

9.11. STATUTORY PROCESSES

9.11.1. The Western Health and Social Services Trust (Establishment) Order (Northern Ireland) 2006 (the “2006 Order”)

9.11.1.1. Review of Public Administration

On 22nd November 2005, the reorganisation of Northern Ireland’s health and social services was announced as part of the Review of Public Administration.

Under these reforms the existing 19 HSS Trusts were merged into 5 integrated health and social care Trusts, with the Northern Ireland Ambulance Service remaining as is. These new Trusts became operational on 1 April 2007.

9.11.1.2. Establishment and Nature

As part of the implementation of the Review of Public Administration, the 2006 Order created the Western Health and Social Services Trust (“the **Trust**”) with an operational date of 1 April 2007 (the “**Operational Date**”). It was established pursuant to Article 10(1) of The Health and Personal Social Services (Northern Ireland) Order 1991 (the “**1991 Order**”) which states that the Department may by order establish bodies to be known as Health and Social Services Trusts. The Trust was established for the purposes specified in Article 10(1) of the 1991 Order, namely to:

- assume responsibility, in accordance with the 1991 Order, for the ownership and management of hospitals or other establishments or facilities which were previously managed or provided by a relevant body (i.e. a Health and Social Services Board, the Northern Ireland Central Services Agency for Health and Social Services, or a special agency);
- to provide and manage hospitals or other establishments or facilities; or
- carry out limited functions to do such things prior to the Operational Date as are necessary for the purpose of enabling it to begin to operate satisfactorily from the Operational Date including the ability to enter into HSS contracts and other contracts including contracts of employment.

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9.11.1.3. Functions

The Trust's functions include functions which the Department considers appropriate in relation to the provision of services by the Trust for one or more relevant bodies, and are stated in the 2006 Order to be:

- to provide hospital accommodation and services provided at Altnagelvin Area Hospital, Glenshane Road, Londonderry BT47 1SB, Erne Hospital, Cornagrade Road, Enniskillen, Co. Fermanagh BT74 6AY, Gransha Hospital, Clooney Road, Londonderry BT47 1TF, Tyrone County Hospital, Hospital Road, Omagh, Co. Tyrone BT79 0AP, Tyrone and Fermanagh Hospital, 1 Donaghanie Road, Omagh, Co. Tyrone BT79 0NS, Waterside Hospital, 16 Gransha Park, Londonderry BT47 1WH and associated premises;
- to manage community-based health and personal social services provided from the trust headquarters and associated premises; and
- to exercise, on behalf of Health and Social Services Boards, such relevant functions as are so exercisable by the trust by virtue of authorisations for the time being in operation under Article 3(1) of The Health and Personal Social Services (Northern Ireland) Order 1994 (the “1994 Order”).

9.11.2. Externally Financed Direct Agreements (EFDA)

Pursuant to Article 3 of The Health and Personal Social Services (Private Finance) (Northern Ireland) Order 1997 (the “**1997 Order**”), the powers of a Health and Social Services Trust now include a power to enter into agreements which are certified by the Department as externally financed development agreements. As set out above, the Trust was established as a Health and Social Services Trust pursuant to Article 10(1) of the 1991 Order.

The 1997 Order deals with certification, facilities and direct agreements which are elements commonly found in PFI/PPP projects.

An amendment has been forwarded by the Department of Health, Social Services and Public Safety relating to Article 3 (2)(a) of the Western Health and Social Services Trust (Establishment) Order (Northern Ireland) 2006. This amendment will ensure that there is no legal reason why the Department cannot issue a Vires Certificate under the Health and Personal Social Services (Private Finance) (Northern Ireland) Order 1997 for the Trust to provide new hospital accommodation and services from a new site. This will bring the legislation into line with the equivalent legislation in GB. As this is a regional issue, the Strategic Investment Board has been liaising with the Departmental Legal advisers relating to this. A recent update suggests that this amendment should become law by the end of 2008.

9.11.2.1. Certification

The Department may give such a certificate if:

- in its opinion the purpose or main purpose of the agreement is the provision of facilities in connection with the discharge by the Trust of any of its functions; and
- a person proposes to make a loan to, or provide any other form of finance for, another party in connection with the agreement.

9.11.2.2. Facilities

The 1997 Order describes the nature of the facilities that may form the subject of an externally financed development agreement for the purposes of the Order as including:

- works, buildings, plant, equipment, or other property; and
- services.

9.11.2.3. Direct Agreements

Article 3(5) specifically gives a Health and Social Services Trust the power to enter into agreements with the Project's lenders.

9.12. EQUALITY IMPACT ASSESSMENT UPDATE

An EQIA was undertaken during 2004/2005 to assess the implications for Equality of Opportunity on:

- the effects on staff of the possibility of financing the project (i.e. both the acute and local hospitals) through PPP initiatives; and
- the effects on staff of posts being permanently relocated to the new acute hospital or temporarily changing base to ensure skills are maintained across both hospitals.

The Trust, having taken into account all equality implications, proceeded with the PPP approach and indicated the decision of transferring Facilities Management (FM) services to the private sector partner.

It was necessary to prove value for money to include FM services in the PPP project and as part of this process Service Delivery Model (SDM 10) was developed as a public sector comparator.

SDM 10 illustrated how services might be delivered in future with increased multi-skilling to improve efficiencies. The SDM 10 model resulted in a reduction in staffing levels.

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The equality implications of a potential reduction in staffing were not assessed during the initial EQIA exercise. Therefore, in April 2007 an Equality Screening exercise of SDM 10 was carried out.

The conclusion of this screening exercise was that the reorganisation of FM services was likely to raise some equality issues. These would only arise if the combination of turnover, retirement and proactive management of vacancies did not succeed in reducing the numbers of employees within respective locations and services.

Subsequently our Equality Advisors, Denise Wheatley Associates, recommended in the Screening Report to undertake a full EQIA on the delivery of FM Services. However at this stage the analysis was based on theoretical data in the SDM10 model; it was acknowledged that it would be necessary to reconsider the data when actual numbers were available. At this stage a decision to conduct an EQIA at preferred Bidder stage when the actual delivery of FM Services and the effects on staff would be known, was planned to be undertaken if necessary.

Northern Ireland Health Group have now been appointed as the preferred bidder and in the intervening period since the screening exercise was undertaken three factors have changed:

- the preferred bid includes the provision of Hard FM only with the Trust retaining responsibility for Soft FM staff
- the preferred bid relates to staffing at the new acute hospital in Enniskillen only
- the preferred bid does not indicate a reduction in staffing levels for Hard FM staff

In light of these developments, our Equality Advisors recommended that as the original decision to undertake an EQIA was based on the premise that there would be a reduction in staffing levels for FM and as it is now clear from the preferred bid that this will not be the case, the way forward is to update the original screening report incorporating NIHG's final staffing figures and the conclusions circulated for comment. The conclusions from this rescreening exercise would indicate whether an EQIA was necessary.

However the findings of this updated screening report was that no adverse equality implications was likely and that it was no longer necessary to conduct a full EQIA.

It should also be noted that the Trust asked for a considerable amount of information from NIHG during the competitive dialogue stage regarding their approach to various issues with implications for equality of opportunity, fair treatment for disabled staff and visitors, Section 75, fair employment and promotion of good relations. The Trust will continue to work with NIHG beyond financial close to ensure the full implementation of all equality proposals.

9.13. DEPENDENCIES

There are a number of other initiatives occurring within the Southwest in parallel with the Acute Hospital development for the Southwest. These include:

- The procurement of the Omagh Hospital Complex;
- The implementation of Regional Strategies;
- The development of Information Communications Technology (ICT); and
- The Outline Business Case for Major Medical Equipment Provision.

9.13.1. Omagh Hospital Complex

The Omagh Enhanced Local Hospital is at the preliminary stages of the PFI procurement process. The Project incorporates circa £190m in primary and community healthcare facilities and will work closely with the Acute Hospital for the Southwest and Altnagelvin in delivering patient care and will link closely with future health and care centres as part of the PCCI proposals.

The Omagh Enhanced Local Hospital is redesigning the delivery of local health care around a local hospital type model, integrating acute, community and primary care services. Developed using a concept similar to a 'Health Village', it will consolidate services on one site, enable integrated working among health professionals and build effective regional and national healthcare networks.

The total complex is expected to have almost 200 beds. The new Omagh Enhanced Local Hospital will provide urgent care and treatment, intermediate care, renal services and day surgery.

A state of the art Centre for Mental Health, designed to create a holistic healing environment, will lead to the modernisation and enhancement of current practice and services. The mental health facilities will provide acute mental health provision for the South West of Northern Ireland.

The Health and Care Centre will enable primary care staff to offer an increased level of support to patients and provide more care to patients away from a hospital setting and in their own homes. The Centre will be the focal point for multi-disciplinary team working and integrate primary care staff with hospital and community health professionals.

There are several key interfaces that must be considered in the Omagh Local Enhanced and New Acute Hospital Projects. These are set out in the paragraphs that follow.

- It is paramount that the Omagh Local Enhanced Hospital becomes operational as soon as possible after the New Acute Hospital to prevent diseconomies of scale in running costs, staff transfer, complexities and clinical risks;

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- The public perception of the New Acute Hospital Project will be enhanced by the timely implementation of the Omagh Local Enhanced Project. Clinical safety for the population of Tyrone and Fermanagh will only be achieved with the completion of the New Acute Hospital and the Omagh Local Enhanced Hospital.

In order to ensure that the interfaces between the Acute and Omagh Hospitals are managed appropriately, the Acute and Omagh project teams are interlinked, with personnel working across both projects. Whilst the Omagh Procurement is somewhat behind the Acute Procurement, every effort is being made to accelerate the Omagh procurement, for example the deselection will occur at Stage 2B and there is a reduction in the number of stages. This will help to minimize the time period between operational dates of the two hospitals.

9.13.2. Implementation of Regional Strategies

The Regional Strategies that will influence the New Acute Hospital are described in the paragraphs set out below:

- **Primary Care and Community Infrastructure (PCCI) Project:**
The Primary and Community Care Infrastructure agenda will create a network of health and care centres which will provide a range of services close to clients in their own communities. The proposed health and care centres are Belleek, Irvinestown, Lisnaskea and Enniskillen in the Fermanagh Sector. In the Omagh Sector health and care centres will be located in Castlederg, Carrickmore, Fintona and Omagh.
- **Integrated Clinical Assessment and Treatment Services (ICATS) Project:**
ICATS have been introduced from April 2006 as part of the Departmental reform of outpatient services. They consist of new services for patients that are provided by healthcare professionals such as GPs with Specialist Interests (GPwSI), Nurse Specialists and Allied Health Professionals.

ICATS sits between primary and secondary care to deal with the significant number of patients whose problems, while requiring a higher level of expertise than is normally available in primary care, do not require the expertise of a consultant. ICATS provides a timely and effective service to a significant number of patients with less complex needs, and free up consultant time to spend on patients with more complex needs.

The system means that once a patient has been seen by their GP, their referral will be triaged by an appropriate health care professional and there will be 5 possible next steps:

1. Referred for a diagnostic test, such as MRI, X-ray, ultrasound or CT scan;
2. Patients may be sent directly for treatment;

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3. Some patients may be returned to primary care with advice for their ongoing management or with a request for further information;
4. Patients may be directed by the ICATS team to a range of new primary care based outpatient services known as Tier 2; and
5. Patients may be sent for a traditional hospital outpatient appointment to see a consultant.

ICATS is a regional initiative and focused in the first instance on the areas of orthopedics, ophthalmology and urology. As a result of the Departmental announcement, the WHSSB produced 'Taking the Way Forward in the Western Board area (ICATS)', November 2005. This identified that local initiatives would also be considered in cardiology, rheumatology, ENT and general surgery.

The Trust has implemented ICATS for orthopaedics, ophthalmology, urology, ENT and cardiology. The Trust also held a GPwSI pilot for rheumatology for a 3 months period. The clinics are held throughout the Western Trust area in health centres, as well as on hospital sites.

The Trust is currently developing models for rheumatology, dermatology and general surgery. ICATS is rolling programme of redesign and development therefore other specialty models will be developed and implemented in the future.

- **Integrated Service Delivery (ISD):**
ISD models for all service users, place greater emphasis on fully integrated multidisciplinary teams working at local level, ensuring services that are better co-ordinated, delivered more flexibly and promoting increased levels of independence. These new service models will work at the interface between acute, primary and community care which will:
 - Provide intensive, short term response to maintain people in their own homes;
 - Prevent inappropriate admissions thereby reducing admissions to secondary care;
 - Facilitate planned and supported discharge from hospital;
 - Provide rehabilitation and promote independence; and
 - Provide services for people with long term conditions in primary and community care settings including health and care centres.

Integrated Service Delivery dovetails with the service models outlined in the Acute Phase 2 OBC developing further the scope and scale of Intermediate Care, maximising efficient patient flows, improved care pathways, and facilitates the DBS modelled reduced Length Of Stay (LoS) .

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ISD is the framework to support/enable the new more dynamic and efficient service models including reduced delayed discharges, 4 hour A&E targets and alternatives to inpatient care.

ISD also includes Evercare type Chronic Disease Management.

Overall supports the delivery of the regional DBS assumptions and the new performance targets from DHPSS.

9.13.3. ICT Project

The ICT business case was submitted to the DHSSPS in September 2006 by the former Sperrin Lakeland Trust.

The ICT project is intrinsically linked to the New Acute Hospital Project. The ICT project covered a programme of work that would run to 2013/14. It had several key aims but the key focus was to improve service delivery across the two hospital sites, with a modern infrastructure and appropriate equipment to support such services, in delivering suitable healthcare in the future.

To ensure that the interfaces between the ICT project and the New Acute Hospital Project is managed effectively, Phase 1 of this Business Case will be resubmitted to the DHSSPS by July 2009 dealing mainly with infrastructure requirements fundamental to the operation of the new buildings. These are identified below:

- Switches;
- UPS (Uninterruptible Power Supplies);
- Servers;
- Communication links;
- Provide Basic Telephone Services (VOIP Phones etc); and
- Wireless networks.

The approval of this ICT Business Case will be vital to the commissioning and operation of the new hospital. Without the approval of this funding the new facility cannot become operational.

9.13.4. Outline Business Case for Major Medical Equipment Provision.

The Trust has submitted a business case to procure a separate PFI/PPP contract for a Managed Equipment Service (MES) for medical equipment. It is possible that responsibility for the total portfolio of the Acute Hospital for the Southwest and Omagh Local Enhanced Hospital, medical equipment for the Facility may be shared between a managed equipment service provider and the Trust.

There are several key interfaces that must be considered in the MES and the Acute projects. These are set out in the paragraphs that follow:

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- The acute PFI provider must be aware of the key items of medical equipment required in the new Hospital so that it can design accommodation accordingly.
- The Trust requires the acute PFI provider to take responsibility for the design, and mechanical and electrical services of the accommodation where such key medical equipment will be located.
- When the Trust selects key medical equipment, it will receive the detailed planning guides and pass these to the acute PFI provider to ensure that the design includes the requirements of the medical equipment planned for that location. The acute PFI provider will be required to liaise and cooperate with the Trust and its MES Provider.
- The Trust will require, on behalf of its MES Provider, early access rights for certain items of large fixed medical equipment and provisions to this effect are included in Schedule 12 (outline Commissioning Programme) to the South West Acute Hospital Draft Project Agreement.

When large items of fixed equipment are due for replacement, some reconfiguration to the building may be required. Provisions to this effect are included in Schedule 13 (Equipment) to the South West Acute Hospital Draft Project Agreement.

Table 9.4 below outlines the programme for the MES project.

Table 9.4 MES Programme

Stage	Target Date
Project Information Notice (PIN)	April 2009
OJEU	May 2009
PQQ	July 2009
IPID	August 2009
Dialogue	September 09 – May 2010
Receive tenders	July 2010
Bid Evaluation	July 2010 – Sept 2010
Financial close	December 2010

It is vital that this programme is maintained in order to deliver to the timescales agreed with the Bidder through the project agreement in relation to specific equipment details and beneficial access.

9.13.5. Conclusion

The success of the New Acute Hospital Project is impingent on the effective management of the interfaces with the other projects; Omagh, ICT and MES. Whilst separate project teams exist, some personnel span all projects and careful considerations is given to project timetables for all projects.

10. CHECK LIST AGAINST DFP FBC REQUIREMENTS

In the following sections, we have indicated how the Trust has dealt with DFP's FBC requirements as per DAO (DFP) 02/07.

10.1. ECONOMIC APPRAISAL

The Acute Phase 2 OBC included an Economic Appraisal prepared in accordance with the NI Practical Guide and the instructions of the Department. A summary of the findings of the Acute Phase 2 OBC is included in Chapter 1 of this FBC.

10.2. PFI VFM TEST

The FBC requires a Stage 3 HMT Nov 2006 Value for Money test to be completed. This is included in Chapter 2 of this FBC.

10.3. AFFORDABILITY

Affordability is addressed in Chapter 3, Section 3.3 above. This section highlights that there is a significant affordability issue associated with the PFI solution which must be addressed by the Trust in conjunction with DHSSPS and Commissioners if the PFI procurement is to proceed.

Through its discussions with DHSSPS, it is the Trust's understanding that the recurrent funding to bridge the affordability gap from 2014/15 onward is recurrently included within the DHSSPS comprehensive spending review.

10.4. OUTPUT SPECIFICATION

Chapter 4 above summaries the output specifications for the project. This includes Clinical Output Specifications, Facilities Management Specifications and Construction Specifications. Copies of all specifications are provided in the Chapter 4 appendices.

10.5. RISK ALLOCATION

Risk Transfer is considered in Chapter 5 above. Table 5.1 summarises the major risks associated with the project and details how the risks have been allocated between the public and private sector and where they have been included in the Project Agreement.

10.6. INDICATION OF BANKABILITY

The current market position of the commercial banks means that a single source solution is no longer deliverable. The Preferred Bidder's structure minimises these deliverability issues through the use of a club of three banks, who have each committed to provide a third of the required commercial debt, the remainder being provided by the EIB. The commercial banks were selected through a rigorous selection process to ensure the highest level of commitment.

10.7. KEY TERMS AND CONDITIONS

A summary of the Project Agreement is included in Chapter 6 above.

10.8. SUITABILITY OF ADVISORS

Financial, legal and technical advisers were appointed for the project. Appointments were made following a tendering process and evaluation criteria for appointment included the experience of the proposed advisers.

10.9. TIMETABLE

An indicative timetable for the project is outlined in Chapter 9, Section 9.10 above.

10.10. PROJECT TEAM

A project team has established to monitor the implementation and ongoing service delivery of the New Acute Hospital and is shown in Chapter 9, Section 9.2.

10.11. STATUTORY PROCESSES

An outline of the Statutory processes are included in Chapter 9, Section 9.11 above.

10.12. COMMITMENT OF SPONSORS/USERS

This project has received sponsorship at senior levels within the Western Trust. Consultation with stakeholders was carried out throughout the procurement process, and a summary of this is included in Chapter 7, Section 7.3 above.

In addition, the DHSSPS have been fully informed of project progress through the Western Strategic Investment Group.

10.13. TENDERING PROCESS

The tendering process is described in Chapter 7 above.

10.14. ACCOUNTING TREATMENT

An Accounting View for the project has been prepared by the Trust's Appointment Business Case Advisers, Deloitte. This concludes that under FRS5 Note F, the Western HSC Trust should account for the underlying assets of the Acute Hospital at Enniskillen on balance sheet. Details are shown in Chapter 3, Section 3.1 above.

In accordance with Treasury guidance, the Trust now needs to discuss and agree this Accounting View with the Northern Ireland Audit Office and their appointed external auditors.

10.15. ARRANGEMENTS FOR POST PROJECT EVALUATION

Arrangements for Post Project Evaluation are set out in Chapter 8 above.

11. CONCLUSIONS & RECOMMENDATIONS

The Western Health and Social Care Trust, supported by our Partners in the Department of Health Social Services and Public Safety (DHSSPS), Health Estates Agency and Specialist Advisors present this Full Business Case which represents the accumulation of almost 5 years work to develop the New Acute Hospital for the Southwest.

The high level of involvement from a wide range of staff, Trade Union Representatives and local community organisations has had a significant and positive impact on the project. Their level of understanding, research and quest for good practice has led to a high level of interaction across all project work-streams. This has enabled the Trust and its advisors to resolve issues and has led to an innovative and integrated approach for the New Acute Hospital for the South West.

Senior Trust Officers and the Project Team have also welcomed the support of our partners throughout the development of the project, the DHSSPS and in particular it's Health Estates Agency and Infrastructure Investment Directorate, as well as the Strategic Investment Board.

11.1. RECOMMENDATION

Pre Financial Close Position

Taking into consideration the factors outlined in this FBC, it is recommended that the project is brought to Financial Close and a thirty year contract is signed with the Preferred Bidder, Northern Ireland Health Group.

Table 11.1 presents the resultant affordability gap for the New Acute Hospital for the South West based on the remodelled Unitary Charge, including 50% funding from EIB. The real value of the indicative unitary charge, subject to update at the point of Financial Close is £13,385k at a base date of 01/04/2007. Nominal values are included in Table 11.1 below.

The bidder has put in place a club of four banks to optimise the delivery of funding due to the volatility of the current funding market as a result of the global credit crunch.

As a result of the On-Balance Sheet accounting treatment, there will be a net increase in capital charges of approximately £5m per annum following disposal of the Erne Hospital. In addition, capital DEL of £222m is required in March 2012, together with a one off cash payment of £100m.

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Near cash costs (finance lease interest, lifecycle costs, hard FM and SPV running costs) show a net increase of £13.2m in 2012/13 (this is inclusive of the impact of the £13,385k unitary charge noted above), together with additional non-PFI running costs of £3.0m. Additional costs for commissioning, decommissioning, Non-medical equipment etc. are also included.

Position at Financial Close

Table 11.1 presents the resultant affordability gap for the New Acute Hospital for the South West based on the remodelled Unitary Charge, including 50% of the senior debt funding from EIB. The real value of the final unitary charge, achieved at Financial Close is £13,831k at a base date of 01/04/2007. Nominal values are included in Table 11.1 overleaf.

The bidder has put in place a club of four banks (comprising three commercial banks and the EIB) to optimise the delivery of funding due to the volatility of the current funding market as a result of the global credit crunch.

As a result of the On-Balance Sheet accounting treatment, there will be a net increase in capital charges of approximately £7.1m per annum in 2012/13 and 2013/14, reducing to £4.9m in 2014/15 following disposal of the Erne Hospital. In addition, capital DEL of £224m is required in May 2012, together with a one off cash payment of £100m.

Near cash costs (finance lease interest, lifecycle costs, hard FM and SPV running costs) show a net increase of £14.3m in 2013/14 (this is inclusive of the impact of the £13,831k unitary charge noted above), together with additional non-PFI running costs of £3.1m. Additional costs for commissioning, decommissioning, Non-medical equipment etc. are also included.

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Table 11.1: Affordability Gap: New Acute Hospital for the South West

Affordability Gap	TOTAL 30 YRS £'000	yr 1 £'000 2012	yr 2 £'000 2013	yr 3 £'000 2014	yr 4 £'000 2015	yr 5 £'000 2016
RESOURCE DEL YR ENDED						
Project / scope/ bid						
Non Cash Costs						
depreciation	74,987	-	3,732	3,732	2,412	2,412
cost of capital charge	156,446	-	7,771	7,641	6,800	6,670
cost of capital credit	- 103,191	-	- 4,322	- 4,322	- 4,322	- 4,322
total non cash costs	128,242	-	7,181	7,051	4,890	4,759
NEAR CASH COSTS						
Financing costs	324,409	-	9,994	12,675	12,971	13,319
Lifecycle	72,528	-	- 230	- 283	- 286	- 297
FM	55,429	-	514	1,018	1,060	1,109
OP ex (SPV Costs)	33,820	-	929	888	910	892
TOTAL NEAR CASH RESOURCE DEL	486,185	-	11,207	14,298	14,656	15,023
TOTAL RESOURCE DEL	614,427	-	18,388	21,349	19,545	19,782
CAPITAL DEL	223,908	-	223,908	-	-	-
TOTAL DEL	838,335	-	242,296	21,349	19,545	19,782
CASH FLOW						
UNITARY CHARGE	683,848	-	12,620	16,036	16,437	16,849
ONE OFF PAYMENT	100,421	-	100,421	-	-	-
TOTAL CASH	784,269	-	113,041	16,036	16,437	16,849
Non PFI Revenue Costs	209,586	-	1,746	3,067	4,388	4,498
OTHER COSTS						
Capital						
Commissioning	2,067	901	1101	66	0	0
Decommissioning	- 3,776	0	2471	-6247	0	0
Medical Equipment	4,814	4681	0	0	97	0
Impairment on Building	-	0	0	0	0	0
Total Other Capital Costs	3,105	5,583	3,571	- 6,181	97	-
Revenue						
Staff Relocation	-	0	0	0	0	0
Shuttle Bus	127	0	36	64	27	0
Total Other Revenue Costs	127	0	36	64	27	0

Conclusion

The DHSSPS approval of this Full Business Case, received on 18th May 2009 and the signing of the contract at Financial Close on 20th May 2009 will result in the construction of the new facilities as per agreed specifications and latest accommodation standards for healthcare facilities with the facilities planned to open in 2012. The contract establishes the unitary charge for the operation of the new hospital at £13,831k (1/04/07 prices), which is within the affordability target. This unitary charge figure reflects the inclusion of the EIB variant which has been demonstrated as Value for Money for the Trust in Chapter 3 of this Full Business Case.