



FULL BUSINESS CASE

FOR

**AMBULATORY CARE AND DIAGNOSTIC
CENTRES (ACAD)**

NOW REFERRED TO AS

THE NEW VICTORIA HOSPITAL

THE NEW STOBHILL HOSPITAL

June 2006

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Introduction

The Board of NHS Greater Glasgow and Clyde (the “Board”) welcomes the opportunity to enter into a public/private sector partnership with Canmore Consortium (the “Consortium”) to design, build, finance and operate the Board’s two ambulatory care hospitals at the Victoria and Stobhill sites for the residents of the surrounding areas.

The Board fully supports the project and looks forward to providing modern, well-designed accommodation for this group of clients.

The Board wishes to acknowledge the efforts and work of the Consortium team in bringing this project forward

The Board is confident that with the continued co-operation and good working relationships built up during the procurement process, the partnership will continue through the construction phase and 30 year contract period to provide a state of the art service to those people requiring the services provided in the new hospitals.

Tom Divers

Chief Executive

NHS Greater Glasgow and Clyde

1.0 Executive Summary

1.1 Purpose

- 1.1.1** The purpose of this Executive Summary is to set out the case for the design, build and operation of 2 new Ambulatory Care and Diagnostic Hospitals, (the “Project”), one in the North of the City of Glasgow at the Stobhill site, and one in the South of the City of Glasgow at the Queen’s Park site (the “Hospitals”).
- 1.1.2** The Full Business Case (the “FBC”) conforms to the Scottish Capital Investment Manual (SCIM) guidance and the layout is in accordance with the guidance in NHS Circular HDL(2002)87. The content of the FBC is designed to demonstrate to the Scottish Executive Health Department (“SEHD”) that the Board’s proposals are robust, affordable and provide value for money. The contents should also assist the Board’s private sector partner, the Consortium, and their funders, Dexia Bank, with information to begin their due diligence work in preparation for Financial Close.

1.2 Background

- 1.2.1** The Strategic Context of this project is set out in Section 2.0 of the FBC.
- 1.2.2** The Project is the first stage of implementation of the NHS Greater Glasgow Acute Services Review (the “ASR”) process, the recommendations of which gained Ministerial and Parliamentary approval in September 2002, (Appendix 2). The Outline Business Case (the “OBC”) for the Development of Ambulatory Care for Greater Glasgow was approved in January 2003 by SEHD.
- 1.2.3** The choice of an ambulatory model of clinical care was a result of the desire to ensure local access to ambulatory care and diagnostic facilities and to an improved patient experience. These represent the key service objectives.
- 1.2.4** The 2 Hospitals will provide similar services, with comparable models of care, and will bring the following benefits:
- Providing local access for the majority of ambulatory care patient episodes.
 - Preventing emergency work at inpatient sites impacting on the delivery of elective care.
 - Enhancing the quality of care provided through the introduction of redesigned and new models of care.

- Streamlining the patient journey by improving planning of care, including the development of one-stop clinic methodologies as services develop.
- Supporting 21st century health care delivery with 21st century facilities and technologies.

1.2.5 The Board considered a full range of service options through the ASR process, and came to its decisions regarding ambulatory care on the basis of the above benefits.

1.2.6 The development of the Project has been driven from the acute services providers closely involving primary care services throughout to ensure that the redesign process meets the needs of the entire health economy.

1.2.7 This project has had a single strand of strategic project management as part of the overall acute services implementation, with clear and coherent arrangements for detailed operational implementation and management.

1.3 Overview.

1.3.1 The combined capital cost of this FBC is circa £178 million. This investment is provided by a Public Private Partnership/Private Finance Initiative (PPP/PFI) procurement.

1.3.2 The Board is satisfied that the revenue cost of this Project is affordable for the health economy.

1.3.3 It is intended that the 2 Hospitals should be fully operational by Summer 2009.

1.3.4 The Board's Public Sector Comparator (the "PSC") at OBC has been reviewed throughout the process from approval to FBC stage. As the Board's service imperatives have been revised, and the service delivery models have been developed into operational philosophies for delivering ambulatory services, a number of changes in the PSC were applied. The PSC now represents a more appropriate scheme for the delivery of the ambulatory models of care and is in line with developments to support the NHS Plan, local planning requirements and predicted growth from meeting the SEHD's waiting times targets. The changes to the schedule of accommodation from OBC, through to the adjusted PSC have been tracked and a table showing these changes is provided in Section 3.3.

1.4 Economic & Financial Summary

1.4.1 Results of Economic Appraisal

All key elements of the project (design and build, facilities services and finance) have been subject to rigorous appraisal by the Board and its advisors. This has included an economic evaluation by the Board's Financial Advisors to assess the value for money of the proposed PFI project solution against a Public Sector Comparator (PSC) based on the preferred option approved at OBC stage. The appraisal has been conducted with reference to the relevant HM Treasury Guidance and the Scottish Executive PFU Practical Application Note (September 2005) on implementing the Treasury guidance. In addition the Scottish Executive Health Department has requested that the Board follow the guidance for the use of the Generic Economic Model developed by the Department of Health in England & Wales.

1.4.2 Qualitative assessment

The main non-financial advantages of the PFI project relate to the provision of an innovative design solution to support the Board's preferred models of patient care. The design of the PFI accommodation provides improved departmental relationships and communications links and offers increased environmental and stakeholder benefits compared to the PSC. Also, the PFI Project Agreement provides a sustainable economic solution for the delivery of facilities management services and building repairs designed to maintain the quality of the hospital environment throughout the contract period.

1.4.3 Quantitative assessment

The PSC has been reviewed regularly and updated by the Board to ensure it delivers outputs broadly comparable to the PFI option, but delivered through a Treasury funded solution modelled in line with SEHD and HM Treasury guidance. Results of the economic analysis are summarised in Table 1.1.

Table excluded – commercial information

The economic analysis takes into account adjustments for risk transferred under the Project Agreement and optimism bias.

The GEM has been developed in accordance with the guidance issued by the Department of Health in England & Wales. On optimism bias the position in the guidance is that by FBC stage any remaining optimism bias will be as low as potential underestimation of costs should be well reflected within the risk analysis. The Board believes that the risk analysis process has been rigorous and robust. It has been developed through a 'bottom up' approach and reflects the input from the various specialists within the project team. The Board believes that this approach has allowed it to fully consider the risks specific to this procurement, and to ensure that value for money is achieved on risk transfer. No adjustment has therefore been made for optimism bias as the Board believes that it has been fully considered within the risk assessment.

Appraisal results indicate that the PFI project represents value for money over the 30 year appraisal period, reflecting the construction and operating periods, and over a 60 year appraisal period representing the economic life of the facilities, plus the initial construction period.

1.4.4 Results of Financial Appraisal

The annual Unitary Charge to be made by the Board to its PFI partner, Canmore for full availability of all facilities and delivery of all PFI services to the specified standards is £20.7 million at March 2011 prices.

The Unitary Charge will be phased in to reflect the phased handover of new facilities. The full Unitary Charge becomes payable as from 2010/11 when all facilities are commissioned in line with the requirements set out in the Project Agreement.

The Board has undertaken a detailed assessment of the financial implications of the PFI project to demonstrate that it is affordable within existing resources. The actual cost of the PFI project solution will depend on the sums agreed in the PFI financial model at Financial Close, but for the purposes of testing value for money and demonstrating the affordability of the project, the foregoing Unitary Charge figure is considered robust.

Overall, the project has been assessed as affordable by the Board. Details of the affordability analysis provided in Table 1.2.

Table excluded – commercial information

The table illustrates that the project remains within the affordability envelope set by the Board.

Overall there remain various managerial actions that will ensure the project remains affordable.

In subsequent years the unitary charge payments will increase by a proportion of inflation. The Board has been advised by the Executive to budget on the basis that its level of available resources will inflate at 4.5% - 5.5% pa from 2008/09. Accordingly the Board considers that its level of resources will increase at a greater rate than the unitary charge payments and the project should remain within the affordability envelope.

The project has been assessed by the Board's financial advisors as an "Off Balance Sheet" transaction and therefore suitable for delivery under a PFI contract arrangement.

1.5 Procurement Process

1.5.1 The Board placed an Official Journal of the European Union (OJEU) advertisement for the Project in March 2003. The advertisement invited, in accordance with the European Union's Negotiated Procedure, suitably qualified consortia/companies to express interest in the provision of the Project.

1.5.2 Several expressions of interest were received and an Open Day was held for interested parties. At the deadline for submission of Pre-Qualification Questionnaire ("PQQ"), only one PQQ was submitted. This submission was assessed and evaluated against the PQQ criteria and the consortium shortlisted. This was -

- Canmore Partnership Ltd

1.5.3 The Board then reviewed the desirability of continuing the procurement process with a single bid. In conjunction with legal, financial and technical advisors, a single bid process was developed. This process was then reviewed by the Board's external auditor, Price Waterhouse Coopers who stated that they were content with the openness of the Board's process and direction of travel. Following agreement by The Board the process was then agreed with the Scottish Executive Health Department (SEHD).

1.5.4 The shortlisted consortium submitted a bid which was subjected to a rigorous evaluation by the Board in accordance with the single bid process. Section 5.3 of the FBC shows in more detail the methodology and criteria used.

1.5.5 The Board's project team conducted negotiations with the bidder to ensure that their bid was affordable and represented value for money as well as to ensure that there was a significant level of risk transfer from the public sector to the private sector. The conclusion of the negotiations was subjected to review by the Board's external auditors.

1.5.6 The Board adopted a rigorous but equitable methodology in evaluating the bids in both financial and non-financial aspects. The conclusion, after negotiation and clarification showed that the bid provided value for money and was affordable.

1.5.7 The Consortium were selected as Preferred Bidder by the Board's Performance Review Group, (subject to completion of the Key Stage Review with the SEHD) at its 17th May 2005 meeting and the decision was made public at the regular Board meeting on 26th July 2005.

1.6 Key Stage Review Process

1.6.1 The SEHD has improved the PPP procurement process through standardisation and the introduction of the Key Stage Review (the "KSR") process. The KSR is a self assessment process assessed and backed up by a report by Partnerships UK, ("PUK") to SEHD at defined key stages in the PPP/PFI procurement. It has already significantly improved the quality of readiness of schools PPP/PFI projects coming to the market, and is now being used in the health, waste, and justice sectors. The Project has been the subject of two satisfactory PUK KSR reviews (Pre-FITN and Pre-preferred bidder). The KSR process continues post-financial close to support long term management and monitoring of PPP/PFI contracts.

1.7 Risk Transfer

1.7.1 A summary of the risk management strategy is shown in Section 14 of this document. The Board has endeavoured to ensure transfer of risk where appropriate from the public sector to the private sector.

1.8 Planning consent

1.8.1 The Board obtained Campus Plan approval for the Victoria and Stobhill sites in April 2004, and subsequently the Glasgow City Council were minded to grant outline planning consent for the Victoria site in December 1996.

The Consortium obtained full planning consent for the Stobhill site on 13th June 2006 and for Victoria site on 15th August 2006.

1.9 Timetable

- 1.9.1** The Board will endeavour to reach financial close by August 2006. A phased construction over a period of some 32 months is planned which will allow Stobhill to be completed by March 2009, followed by the Victoria in April 2009. Section 6.5 shows a more detailed timetable.

1.10 Conclusion

- 1.10.1** The Board has pursued a rigorous and competitive evaluation and selection procedure for the Project which met with the approval of the Board and the SEHD's Private Finance and Capital Unit, through evaluation by PUK.
- 1.10.2** The Board recognises that qualitatively the provision of the Hospitals will provide service users with accommodation which will meet with the Board's objectives and which has taken into account suggestions voiced at the various user and staff group meetings held as part of the procurement process.
- 1.10.3** The FBC demonstrates that the Consortium's bid will provide the Board with value for money and that the bid is affordable to the Board.
- 1.10.4** The Board recommends that the SEHD approves the FBC thereby approving the partnership of the Board and the Consortium and thus allowing the Board to proceed to Financial Close and contract signing.

2.0 Strategic Context

2.1 Overview

2.1.1 This section of the FBC describes:

- The strategic context and objectives underpinning the Board's ambulatory care services;
- Changing expectations about health services;
- The changes in modern medicine that require local investment in appropriate supporting facilities;
- The role of the new Hospitals as part of a local network of care;

2.1.1 The section provides the context in which these developments now sit. Section 3.0 provides the OBC context in which these developments were originally planned. These two sections in conjunction demonstrate the synergy of the investment proposal for the Board.

3.1.1 Additional information on the Board's service plans is provided in the reference to the Board's Local Delivery Plan 2006/07 that can be accessed on the Board website reference:

<http://library.nhsgg.org.uk/mediaAssets/board>

2.2 Background

2.2.1 The investment proposal for two Ambulatory Care and Diagnostic Hospitals on the Stobhill Hospital site and on the site adjacent to the Victoria Infirmary was a strategic commitment by the Board to modernise and improve local health services to its catchment population. These Hospitals are a key first stage for delivery of the Board's Acute Services Strategy that provides 21st Century health care delivery with 21st Century facilities and technologies.

2.2.2 The new Hospitals are the first step in unlocking the transformation of Glasgow's acute hospital services.

2.3 Catchment Population

2.3.1 The Board serves a population of 1,196,335 people living in the City of Glasgow, East Dunbartonshire, West Dunbartonshire, South Lanarkshire, North Lanarkshire, East Renfrewshire, Greenock, Renfrewshire and Dumbarton, and has an income of approximately £2.2billion for the year commencing 1 April 2006.

2.4 National Strategic Context

2.4.1 The White Papers *Designed to Care* and *Towards a Healthier Scotland* set out a number of clinical and strategic priorities for the NHS in Scotland including the reshaping of hospital services around the needs of the patients.

2.4.2 *Our National Health: A plan for action, a plan for change* (the “Plan”), provides a clear statement of national priorities for health and for the NHS and is an action plan for delivery against these priorities. Key points from this Plan relating to this FBC are:

- The development of a modern, high quality environment for the delivery of care to be seen as an integral part of a modern healthcare system;
- The need to improve the patient's journey;
- Commitment to creating a new generation of walk in/walk out hospitals;
- Investment priorities which include
 - modern health facilities in local communities;
 - a major investment in, and development of information management and technology to provide benefits for patients
- the need for an NHS which
 - works in partnership with other organisations to achieve joint objectives
 - is patient-centred, with different parts of the service connecting up properly
 - has the resources to do its job properly

The plan states that fresh emphasis will be placed on the patient's whole journey through the system to ensure that this is made as responsive and smooth as possible. This means improving communication as well as services.

2.5 Pressures on medical staffing

2.5.1 The European Union Working Time Directive applies to hospital consultants. In summary, they must not work more than 48 hours a week on average over a 26 week period. There are also requirements for daily and weekly rest periods. Doctors on call giving telephone advice or having to go in to the hospital for an emergency are regarded as working.

2.5.2 Although individuals can voluntarily forego their rights and so work longer hours, the NHS cannot organise our system on the presumption that specialists (consultants) will forego their rights voluntarily.

2.5.3 Consultants' rotas in future need to be designed so that their time is spent on the right balance between:

ambulatory care work (such as out-patients or day surgery)	which should be timetabled in advance to ensure minimum delays for patients.
in-patient waiting list work	
emergency cover	which needs dedicated time so that consultants are promptly available for emergencies without disrupting their ambulatory care and elective work.
time spent on education, research clinical audit and running the clinical team	which also needs to be timetabled to avoid clashing with other responsibilities.

2.5.4 The government is also committed to ensuring that Junior Doctors' maximum working week should not exceed 56 hours. (The European Parliament is pressing for the EU maximum working week of 48 hours to apply). In any event the intensity of work should not be so great that it squeezes out the time and space for quality communication with patients and relatives. It is also recognised that tiredness increases the risk of mistakes. The pressing need to achieve these standards is widely recognised.

2.5.5 Simply increasing the number of junior doctors is not the answer. Although the output of Medical Schools will increase in the UK that will not increase the supply of junior doctors for several years. Nor will Postgraduate Deans who oversee junior doctors' training approve training recognition of posts unless they can be sure that the junior doctors will achieve a rich enough mix of clinical experience. The changes in service organisation achieved by the Project will greatly help to reduce the competing demands on junior doctors' hours.

2.5.6 Just as large teams of specialists will give better assurance of specialist cover and greatly reduce mutually damaging conflict between the demands of emergency and elective work, so those same larger teams will give better scope for properly organising the time, work and education of Junior Doctors. These changes will mean a dramatic improvement for Junior Doctors and as a consequence a better quality of experience between patients and junior doctors.

2.6 Local Access and Ambulatory Care

- 2.6.1** The Plan states that nationally many of our current hospital buildings are outdated, inflexible, and in the wrong place to meet current population needs. We need to change the configuration of hospital services. Buildings and bed numbers must be right but they are only a part of the picture. The aim must be to provide individuals and communities with access to the range of health services they need. Advances in medicine such as minimally invasive surgery have meant dramatic reductions in the proportion of treatments which require a stay in hospital and in length of the hospital stays. For example, over 60% of all non-emergency surgery is now performed as day cases.
- 2.6.2** The Plan's commitment to creating a new generation of walk in/walk out hospitals is underpinned by the requirement to separate elective and emergency treatments. By establishing the Hospitals to deal with only planned treatment and not emergencies, this will benefit patients through ease of access and speedy diagnosis and treatment. This will also facilitate another stated aim to reduce waiting.
- 2.6.3** The inclusion of facilities for overnight surgery will enable the Board to further reduce pressure on inpatient beds by extending the range of procedures which can be provided in the separate elective Hospitals.

2.7 Strategy and Objectives of the Board

- 2.7.1** The Board, at its meetings of January, (Appendix 2.01) March and August 2002, approved the Acute Services Strategy which is underpinned by extensive consultation with local communities and planning partners, locally and nationally, and identifies a future configuration of services in Greater Glasgow.
- 2.7.2** The strategy is based on retaining adult acute services on 5 sites with a network of 3 adult in-patient hospitals (at Glasgow Royal Infirmary, Gartnavel General Hospital and Southern General Hospital sites), supported by 2 ambulatory care hospitals. The first phase of which is to commission the 2 Hospitals as detailed in this case. Phases 2, 3 and 4 will deal with the reconfiguration of in-patient services.

2.7.3 A cornerstone of the strategic vision was to deliver the new models of care by developing the Hospitals on the Stobhill Hospital site and adjacent to the Victoria Infirmary site, which would bring together diagnostic and treatment facilities for the majority of the hospital's patients and enable many conditions to be treated without inpatient admission, retaining some 85% of existing patient services in their local area.

2.8 The Need for Investment

2.8.1 Glasgow's acute services provide, not only local services on a day-to-day basis, but also tertiary services for regional and national populations.

2.8.2 The main problems associated with delivering Glasgow's acute services are:

- **Outdated buildings**, unsuitable and unfit for modern healthcare - 21st century healthcare in 19th century buildings.
- **In-patient sites** which are unable to provide the one stop/rapid diagnosis and treatment models for the large volumes of patients treated in Glasgow hospitals.
- **Fragmentation of care** as patients are required to move around sites and different buildings, an inevitable loss of continuity and difficulties in transferring information, for example laboratory results and x-rays between sites.
- **Unsuitable diagnostic and imaging facilities** which restrict capacity, create bottlenecks and inevitable delays in treatment.

2.8.3 These problems make it very difficult to deliver on the key national and local policy imperatives, including The Scottish Health Plan and The Cancer Plan which include waiting list guarantees, reductions in waiting times, improved access to rapid diagnosis and treatment, the provision of services designed around the needs of patients and improved integration with primary and social care.

2.9 Local Health Plan/Local Delivery Plan

2.9.1 As described in the OBC, the Local Health Plan for 2002-2005 identifies significant challenges in the areas of cancer, coronary heart disease, smoking, alcohol and drug misuse, teenage pregnancy and dental health, all of which contribute to the much-quoted impression of Glasgow as an area of poor health. All of these problems are linked to high levels of deprivation throughout Greater Glasgow.

2.9.2 The Board's key strategic objectives, as outlined in its Local Health Plan 2002-2005, and re-inforced in the local Health Plan update 2004-2008, are as follows:

- Improving the health of children
- Promoting health and tackling inequalities
- Modernising mental health services
- Joint community services with Local Authorities
- Strengthening primary care
- Tackling addictions
- Regional planning arrangements
- Modernising acute hospital services

2.9.3 This year the SEHD is seeking to take a more rigorous approach to performance management by introducing in 2006-07 a new system of Local Delivery Plans (“LDP”). This is built upon a set of key objectives, targets and measures and the commitment to modernising acute services is underpinned in the Board’s LDP for 2006-07 through targets for daycase surgery, cataract surgery and A&E waiting times targets.

2.10 Cutting Waiting Times

2.10.1 One of the key elements of the Plan and one of the public’s main concerns, is waiting for treatment. The Project addresses this problem in a number of ways: -

- *Improved appointment booking* - The introduction of new models of care which include electronic “booking” systems will improve substantially the waiting list situation by reducing the number of cancelled operations and outpatient appointments.
- *New Models of Care* - The introduction of new models of care will see an increase in protocol-based referrals thereby improving the flow of patients through the system by better organising appointments for assessments, tests and treatments and clinics.
- *Increased day surgery* - By using new minimally invasive techniques and the changing anaesthetic techniques and assessment criteria, the range of services, which can be offered as day procedures is expected to continue to develop and improve.
- *Increased endoscopy facilities* – Increasing the facilities available for endoscopy sessions by both clinicians and specialist nurse endoscopists will greatly increase the number of patients treated, thereby reducing waiting times and lists.
- *ACAD facility* - The new modern state of the art Ambulatory Care Hospitals with a range of modern equipment and additional staff will provide much needed additional capacity for modern day services. This will increase the number of elective procedures, which can be treated as day cases.

- *MRI and CT scanners* - New MRI scanners and an additional CT scanner in each of the Hospitals will reduce substantially the current wait for a scan.

2.11 How the new Hospitals help deliver

2.11.1 The development of these two new hospitals will enable us to continue to provide local access to appropriate modern care in facilities designed for that purpose, that is more specialised and delivers better access to services for future healthcare needs. To support this, and facilitate improved communication services the use of modern technology and a move towards electronic patient records and booking of services will be advanced.

2.11.2 This Project addresses the agenda as identified by the plan in the following ways:

- Better facilities – modern 21st century healthcare buildings.
- Improve the patients' journey – the introduction of new patient pathways and models of care with dedicated facilities – designing the services around the patient and the buildings around the services.
- Create a new generation of Walk in/Walk out hospitals – improved facilities for day case, fast access diagnostic services, to provide quicker and more accessible services.
- Higher quality of care – new facilities incorporating 'state of the art' technology and equipment.
- Reduced waiting times – increasing facilities for day surgery, towards 'one stop' care and separation of elective and emergency care will reduce waiting times.
- Better local services – new facilities and services accessible by the local community combined with all of the above will substantially improve local services.
- Improved links with other healthcare providers in acute and primary care settings to deliver a more 'joined up' approach to the delivery of healthcare.

3.0 The Outline Business Case

3.1 Introduction

3.1.1 The OBC was submitted by the Board and approved by the SEHD's Capital Investment Group in January 2003.

3.2 Options

3.2.1 The OBC outlined the proposal for the two new hospitals in the context of Glasgow's ASR strategy which had been approved by the Minister for Health in August 2002. The OBC did not lay out, as is traditional, a series of options as the proposed development had already been determined through the ASR and the SEHD's approval of Glasgow's overall ASR Strategy, and the OBC represented the case for implementation of the first phase of this.

3.3 Changes from OBC

3.3.1 A number of service changes have been applied since the OBC to enhance the clinical objectives and the building environments.

3.3.2 Surgical and diagnostic facilities at Stobhill - At the time of writing the OBC, it was intended that the Stobhill elements of the project would entail incorporation of existing, refurbished day surgery theatres and endoscopy rooms. Comparison of both the level of service and facility that this scheme would offer in comparison to the purpose-built facilities to be provided for the Victoria scheme led the project team to recommend that both developments should include new, purpose-built day surgery and endoscopic investigative facilities.

3.3.3 Rehabilitation Beds at Victoria - In the overall plan for the ASR modernisation the Board had planned to replace 60 Elderly Slow Stream Rehabilitation beds from the Mansionhouse Unit alongside the new Victoria Hospital during its second phase. The opportunity was taken to review the campus development plan and programme and the recommendation was made to include these beds with the ambulatory care procurement enabling the whole campus to be completed in a single phase.

- 3.3.4 Soft FM services** – The procurement included Soft FM services in the OJEU notice in order to demonstrate that the criteria of value for money and transfer of risk were being met. Taking into account the SE/STUC Staffing Protocol and following a series of discussions with staff representatives, the Board and senior managers from the SEHD, it was agreed that the consortium be required to submit a mandatory variant bid excluding soft FM services and as such allowing an “in-house” bid for Soft FM services to be considered alongside the price included in the PPP consortium’s submission for construction and Hard FM services. The “in-house” bid was successful and therefore Soft FM services will be provided by the Board.
- 3.3.5** All three recommendations were approved by the Board at its meeting on 20th January 2004 (Appendix 5.01).
- 3.3.6 Comfort Cooling** - The Board requested a mandatory variant bid to include comfort cooling throughout both buildings to address temperature fluctuations and the future impact of climate change.
- 3.3.7 Underground Car Park** – The solution proposed by the Consortium for the Victoria site included underground car parking. The Board accepted that this sits well with the Board’s Green Policy, the Campus Development Plan, the Glasgow City Plan and the Board’s car parking management regime.
- 3.3.8 Overnight Surgery Beds** – The ASR Programme Board at its meeting on 19th January 2006, and endorsed by the Board at its meeting on 21st February 2006, decided to add overnight stay surgery to the services provided from the ACADs. This would give the advantages of extending the range of surgical procedures offered; allowing fuller utilisation of the facilities; extending the working day by allowing surgery later in the day; allowing surgery on patients who cannot meet social criteria, such as access to a phone or a reliable carer to stay with them post operatively and encouraging the development and extension of day surgery into new areas by allowing the piloting of new procedures in the knowledge that a bed is available post operatively.

4.0 The Public Sector Comparator

4.1 Introduction

4.1.1 This section sets out the main developments and components of the public sector comparator. The single bid process agreed with the Scottish Executive, placed a higher than normal emphasis on the use of the PSC and the Shadow Bid model as proxies for the Conventionally Procured Asset Model, and a competitive bid. The role of the Shadow Bid mode is discussed further in the assessment of affordability.

4.1.2 The Outline Business Case

The previous section has discussed the development of the OBC, in particular the method of assessing the impact of the ACAD development on Board Resources. The table below shows the main components of the capital costs of the project at the time of the OBC.

Table excluded – commercial information

4.1.3 Development of the Public Sector Comparator

The OBC was in effect the amalgam of two separately developed schemes. This reflected the trust structure that existed at that time. Following the approval of the OBC and the amalgamation of the trusts into Greater Glasgow Health Board, the project has been developed under a single control mechanism.

As part of the development of the scheme significant additions were made to the project. These included

- Elderly Slow Stream Rehabilitation Beds
 - It was decided to include 60 rehabilitation beds for elderly patients in the Victoria facility.
- Surgical Theatres
 - It was decided that the clinical effectiveness would be enhanced to allow surgery to take place at Stobhill, thereby replacing surgical facilities at Stobhill.

4.2 Capital Costs

4.2.1 Development of the Exemplary Design

The OBC was based upon outline designs and space requirements. These were used as the basis of developing exemplary designs. These were substantially more detailed than the OBC work and allowed for the development of accurate capital costs.

The PSC excluded land and equipment costs as it was decided that these would be sourced from existing capital funds within the Board.

The material increase in cost was driven by the overall increase in the size of the buildings, the inclusion of additional facilities as described above, and increases in indexation.

This was the capital value that underpinned the PSC at ITN.

4.2.2 Development of Capital Costs post ITN Issue

Following the issue of the ITN, it was a key part of the single bid process that the capital values of the public sector better reflect developments in the public sector requirements and indexation.

The significant causes of cost increases are as follows:

November 2004 Movements

The costs increases in November 2004 reflect the inclusion of the following elements in the public sector comparator.

- Car parking facilities
- Specific Cooling in sensitive areas
- Drainage works

In the view of the Boards Technical Advisors, all of the above items would have been necessary had the public sector procurement route been followed.

March 2005 Movements

The main contributing factors to the increase at this stage are:

- Increases in space to accommodate planning constraints
- Changes in estimated design fees for the public sector build option

April 2005 Movement

In April 2005 the following amendments to the PSC were identified by the technical team:

- Amendment to car parking facilities
- Additional magnetic shielding to meet Health and Safety requirements

May 2006 Movements

The most significant movements in PSC costs occurred in May 2006. The major movements in costs were driven by the following adjustments:

- Inclusion of temperature control throughout the buildings
- Costs to remediate recently identified ground contamination
- Additional health and safety requirements
- Adjustments to areas driven by planning and other amendments

Up to May 2006 significant ground condition risks had been included in the PSC risk adjustment. In light of the greater certainty relating to these risks, and the cost of remediation, these costs were removed from the risk adjustment.

Indexation

The PSC was initially costed on the basis of a capital cost index of 220. This has increased due to the real costs of construction in the market place to 234. This increase was reflected in the indexation adjustment.

4.3 Hard FM and Lifecycle Costs

Planned Preventative Maintenance (Hard FM) and Lifecycle costs were estimated by the Boards technical advisors. These costs have been adjusted in line with the changes in the estimated capital costs in the PSC.

Table excluded – commercial information

- 4.3.1** The Hard FM elements were also adjusted to correct the costs to market benchmarks, on the basis that these costs were understated in the original PSC.

4.4 *Soft FM Costs and Insurance*

Included in the PSC was an estimate of the soft FM and insurance costs appropriate to the public sector design. These costs were based upon a detailed benchmarking exercise.

5.0 The Procurement Process

5.1 *The Project Team Structure*

5.1.1 The Board, at all times, has followed the SCIM guidance on procurement as well as all relevant EU Directives and UK Regulations. The Board project team worked closely with the PFCU team and was guided by them in complying with the guidance, directives and regulations.

5.1.2 A Project Executive was set up consisting of: -

Mr. Robert Calderwood, Director of Acute Services Implementation (Chair)
Mr. Peter Gallagher, Director of Finance, South Glasgow Division
Dr. Brian Cowan, Medical Director, GGNHS
Ms. Margaret Smith, Director of Nursing Services, North Glasgow Division
Mr. Alex McIntyre, ACAD Project Manager

The remit of the Project Executive is to oversee the full Project and approve Project Team recommendations prior to submission to the ASR Board or the Board for corporate approval.

5.1.3 The Project Team consisted of: -

Mr. Alex McIntyre, ACAD Project Manager
Ms. Jane Sambrook, Deputy ACAD Project Manager
Dr. Brian Cowan, Medical Director, GGNHS
Ms. Margaret Smith, Director of Nursing Services, North Glasgow Division
Ms. Mairi Macleod, Project Officer
Ms. Margaret Campbell, Project Officer
Mr. Andy Bell, Project Administrator
Ms. Janet Richardson, Senior Finance Officer
Mr. Tony Coccozza, Senior Finance Officer
Ms. Mary Anne Kane, Acting General Manager for Facilities
Mr. Tommy Gemmell, Senior Estates Manager
Ms. Anne McClure, Personal Assistant
Ms. Carol Craig, Administrative Assistant
Ms. Lin Calderwood, ACAD IT Manager
Ms. Alicia Young, ACAD IT Project Manager
Mr. Robert Armstrong, Procurement Officer
Mr. Doug Allan, Human Resources Officer

The Project Team which reported to the Project Executive through the ACAD Project Manager is responsible, in liaison with their professional advisers, for project development and delivery and management of the interface between the Board and the Consortium.

5.1.4 Project Advisers

The ASR Executive agreed the appointment of:-

Ernst and Young as financial advisers and Bevan Brittan, (formerly Bevan Ashord) and Sheppard & Wedderburn as legal advisers for the entire ASR project.

5.1.5 The Project Team enlisted the technical services of: -

- Currie and Brown, Keppie Architects, and Atkins as Technical Advisors.
- In addition the services of Keppie Town Planning (Town and City Planning), Faber Maunsell (Roads and Transport) McLay Collier (Drainage) and the Willis Corroon Group (Insurance), were commissioned to assist the Technical Advisers in specific areas.

5.1.6 The Project Team was mandated to enlist other technical expertise as required.

5.2 *Expressions of Interest*

5.2.1 The Board agreed that the procurement of the Hospitals at Stobhill and the Victoria should proceed as a services contract under the Negotiated Procedure at its meeting on 18th March 2003, (Appendix 3.01). A Prior Information Notice was placed in the OJEU followed by an advertisement on the 20th March 2003, (Appendix 3.02), which clearly showed that the Negotiated Procedure would be followed. The notice also stated that a bidders' Open Day would be held on 1st April 2003 at which the Memorandum of Information (MOI) and a PQQ pro-forma would be issued.

5.2.2 The Open Day was extremely well attended, by 47 companies representing construction, finance, legal and project management interests.

5.2.3 The advertisement advised those interested that the scheme would be in accordance with the UK Private Finance Initiative (PFI) or an alternative Public Private Partnership (PPP).

5.2.4 The OJEU advertisement invited expressions of interest along with a completed PQQ to be submitted to the Board's procurement department by 28th April 2003 in order to comply with the time limits specified in the Regulations, 37 days.

5.2.5 By the deadline of 28th April 2003 only one Expression of Interest via a PQQ was returned from Canmore Partnerships Limited.

The Board's Project Team, supported by their financial and legal advisers met during May and June 2003 to ascertain whether the continuation of the procurement was desirable and feasible with a single bidder.

5.3 *Single Bidder Process*

- 5.3.1** The submission of only one Expression of Interest was unexpected in light of the high level on interest displayed at the Open Day.
- 5.3.2** The Board commissioned its external financial and legal advisers to research the background and market position that led to the emergence of a single bidder for the project. This involved a market intelligence report commissioned from the advisors and the PFCU.
- 5.3.3** The steps taken by the Board to understand the single bidder process to July 2003 were subjected to scrutiny by the Board's External Auditors, Price Waterhouse Cooper, (PWC), acting as agents for Audit Scotland. PWC's report confirmed that all reasonable steps were undertaken to ensure sufficient market interest, and that there was no indication that the project was unattractive to bidders.
- 5.3.4** The report, however, emphasised that the Board still needed to ensure that it had sufficient safeguards in place to demonstrate that the project represented and continued to represent value for money.
- 5.3.5** The Board discussed the various options for progressing the procurement. All solutions had an adverse impact on the planned timetable through delay.
- 5.3.6** One option was to "batch" the project with other schemes to provide a larger scheme as had been adopted in similar situations in England. A review by the SEHD indicated that there were no other suitable schemes to "batch" with.
- 5.3.7** A second option was to withdraw the project and relaunch at a later date. This would delay the provision of ACAD facilities with no guarantee that more interest would be forthcoming at a second launch.
- 5.3.8** The third and preferred option for the Board was to continue with the single bidder.
- 5.3.9** Following PWC's review and report a further two documents were produced for the Board by the Board's Legal and Financial Advisors on the Single Bid Development Process and the Strategy of Proceeding with a Single Bid. These were subjected to review by the SEHD and the Board's External Auditors.

- 5.3.10** PWC also confirmed in a letter that there were no adverse public procurement issues from a legal perspective in proceeding with a single bidder.
- 5.3.11** As a result of the work undertaken the Board's Performance Review Group approved the strategy to move forward with a single bid process in October 2003, subject to the External Audit Team overseeing how the project was taken forward. This decision was endorsed by the Board at its meeting of 18th November 2003. (Appendix 4.02)
- 5.3.12** The proposal to engage with a single bidder was then submitted to the Scottish Executive and they confirmed that the Board's approach provided a "reasonable basis to complete the procurement successfully while demonstrating value for money". (Appendix 4.03)

5.4 *Invitation to Negotiate*

- 5.4.1** The ITN was submitted to the Consortium on 12th March 2004 with an instruction that the bid required to be delivered in 3 stages with a full bid by 27th August 2004. The ITN documentation consisted of 3 volumes as detailed below: -

Volume 1 – Overview
Volume 2-1 – Construction Requirements
Volume 2-2 – Service Requirements
Volume 3 – Contract and Commercial Issues

- 5.4.2** The Consortium was instructed to provide a standard bid and 2 mandatory variant bids as detailed in Section 5.10. Following the issue of the ITN, the consortium was offered the opportunity to meet with the Project Team to give them the occasion to seek explanation where necessary to assist them in the completion of their bid.

5.5 *ITN Volume 1 - Overview*

The Overview provided the Consortium with the background to the Board and the project. This section expanded upon the information previously given to the bidders at the PQQ stage. The ITN outlined the overall framework and structure for the full ITN document by summarising the content of the other sections.

- 5.5.1** The ITN provided the following information:-

- Confidentiality & legal disclaimer notice
- Introduction and background to the project

- Introduction to the Board’s key personnel and advisers
- Overall vision and philosophy of the Board
- Enabling Schemes
- PFI and its key objectives
- Bid process and timetable
- Proposed contract structures
- Proposed payment and pricing arrangements

5.5.2 The ITN provided bidders with detailed instructions which encapsulated the following information: -

- Mandatory bid and variants
- Specification of the format of the bid including proformas
- Proposed payment mechanism
- Funding structures
- Financial projections

5.5.3 The ITN also gave bidders details of the evaluation process the Board intended to follow for the bid, as detailed in Section 5.11.

5.6 *ITN Volume 2.1 - Requirements Specification*

5.6.1 This volume set the scene for bidders in relation to the Board’s output requirements for the new facility and explained the clinical and non-clinical functions the Board intended to carry out in the building that the bidder required to take into account in preparing their bid.

5.6.2 The Board ensured that the documentation gave bidders a clear picture of its core design values. The Construction Requirements contained the following statements:

- Designs must take account of the need for building to be inherently flexible and able to respond to changes in adjacency and methods of delivery of the full spectrum of health care services over the life of the development.
- The overall ambience of the new developments must engender a positive sense of “well-being” and designers must demonstrate, with evidence from proven exemplar solutions, the achievement of a therapeutic and healing environment.
- Intuitive way finding must be an inherent and fundamental element of design. Its integration within the design and arts concepts for the development must ensure that a clear rationale of process and progress is guaranteed for users, in a manner that minimises reliance on visual signage.

- The design of landscape and building must be approached in a holistic manner that results in their seamless integration, thereby achieving clear paths of infiltration of soft landscape into the heart of the built environment.

5.6.3 The Bidder was advised that materials to be used and finishes applied had to meet the general and preferred requirements of the Board. However, bidders were encouraged to be creative in their interpretation of the Board's requirements.

5.6.4 Despite the freedom given to designers, the Board did stress that the security of patients and staff is of prime importance and the design should minimise exposure to crime and facilitate security within and external to the building.

5.6.5 Specific requirements for the individual Victoria and Stobhill schemes were given in detailed appendices which included the clinical briefs for each clinical services, and room data information.

5.6.6 The Board's requirements were made known to bidder in relation to:-

- General Technical Compliance and Requirements
- Engineering Systems Requirements
- Construction and Structural Requirements

5.6.7 In developing the PSC, ITN and Campus Plans members of the Board's Project Team held discussions with the Glasgow City Council Planning Department the result of which was conveyed to bidders.

5.6.8 The Public Sector Comparator (PCS) designs were described along with feedback on areas for further development from an review performed using the Achieving Excellence Design Evaluation Toolkit (AEDET).

5.7 *ITN Volume 2.2 - Services Specification*

A full description of the Facilities Management services the bidders would be required to provide was given in a Service Level Agreement (SLA) format. The following services were included:-

- Estates Services (Hard FM)
- Helpdesk Services (Hard FM)
- Grounds and Gardens Maintenance Services (Hard FM)

- Pest Control Services (Hard FM)
- Utilities Management (Hard FM)
- Domestic Services (Soft FM)
- Portering Services (Soft FM)

5.7.1 The Bidder was required to provide the Board with details of their approach to the development of service proposals associated with the Project together with detailed service delivery proposals as specifically required at the different stages of the Project. Information supplied to include details of management, supervision and administrative structures and to clearly show how compliance with the Hard and Soft FM Service Output Specifications will be achieved.

- The FM provider was obliged to commit to meeting statutory obligations and complying with all Board policies.
- The Board's expectations in relation to the quality of the services and the monitoring of the quality of the services was detailed including the requirement to rectify defects within strict timescales.
- Bidders were expected to ensure that the FM provider provided a suitably trained workforce whose appearance and behaviour met the Board's high expectations.

5.8 *ITN Volume 3 - Contract and Commercial Issues*

5.8.1 In accordance with Scottish Executive requirements the Board required the use of the Standard Form Project Agreement with amendments to reflect project-specific issues. This was prepared in liaison with their Legal adviser.

5.8.2 The draft contract was issued to the Bidders and full discussions subsequently took place. The document will be altered, where acceptable to the Board, as a result of representations made by the bidders during this period and, other than project-specific issues, agreed with the PFCU.

5.8.3 Section 10 of the FBC shows a full summary of the legal documentation.

5.9 The Commitment Process

5.9.1 In the absence of competition from other bidders, the Board wanted to ensure that there was sufficient incentive on the Consortium to deliver a fully developed bid within certain timescales. In line with the agreed single bid process and to ensure the development of appropriate design and commercial solutions, the adopted process incorporates two commitment stages prior to the final ITN submission which is the final bid Development Commitment Stage. Each commitment stage was designed to:

- give the opportunity for the Board and the Bidder to constructively work together throughout the procurement process
- allow the Board to understand the Bidder's progress to date
- provide rapid feedback that will help shape the Bidder's final ITN submission
- obtain definite commitments from the Bidder to key aspects of the Project as the bid process develops
- provide a framework for the post-Bid evaluation process

5.9.2 The bidder was asked to produce deliverables for each stage culminating in a full bid in by Stage 3.

5.10 Standard bid and variant descriptions

The Invitation to Negotiate (ITN) contained a standard bid and two variant bids described below.

- Standard Bid

The Standard Bid was for the provision of two Hospitals and the provision of Soft and Hard Facilities Management (FM) services. (ITN Volume 1, para 7.03)

- Mandatory Variant Bid 1

The first mandatory variant bid was for the provision of two Hospitals and the provision of Hard FM services with Soft FM services being provided by an In-house Team if they were successful in competition with the Consortia soft FM provider, Mitie. (ITN Volume 1, para 7.04.01)

- Mandatory Variant Bid 2

The second variant bid was for the provision of two Hospitals, the provision of Soft and Hard Facilities Management (FM) services with the

provision of comfort cooling, temperature control to control internal summer maximum temperatures to 26C. (ITN Volume 1,para 7.04.02)
A third variant bid, which represents the preferred offer, was invited from the Consortia.

- Mandatory Variant Bid 3

The third variant bid was for the provision of two Hospitals, the provision of Hard Facilities Management (FM) services with the provision of comfort cooling, temperature control to control internal summer maximum to temperatures to 26C. (ITN Volume 1,para 7.04.02) Soft FM services would be provided by the In-House Team.

5.11 The Evaluation Process

5.11.1 The Board undertook to award a contract on the basis of the most economically advantageous tender received taking account of quantitative and qualitative aspects of the bid. In light of the single bid process the Board decided to evaluate the bid against the PSC to ensure that the Bid was more economically advantageous than the Board's own solution, and also against the shadow bid model to ensure market competitiveness.

5.11.2 The proposals submitted by the Consortium at each commitment stage were evaluated against defined criteria. A positive outcome at each commitment stage was needed before progressing on to the next commitment stage.

5.11.3 The Board's planned approach to the evaluation process had been finalised in advance of the receipt of tenders. Evaluation Groups consisting of internal senior managers and external advisers were established for:

- Project Management Approach
- Legal Response
- Financial Response
- Approach to Design and Construction
- Facilities Management Response

5.11.4 To ensure that a like for like comparison was achieved, the evaluation process was performed on the Standard bid. Options contained in Variant bids were considered only after the feasibility of the Standard bid had been assessed.

5.11.5 Several clarification meetings were held between the Board and consortia during the evaluation period and all correspondence has been kept and is available for review at the Project Office.

5.11.6 The process involved a three stage evaluation process each with defined criteria to be complied against which each bid was measured.

- Check for compliance
- Comparison with PSC
- Evaluation by groups

5.11.7 Following evaluation of the full bid by the sub-groups, their findings were summarised. The Main Evaluation Panel then met to review the individual reports and scorings, the overall impression of the Bid and the general approach demonstrated by the Bidder.

Compliance

5.11.8 The bid was assessed for compliance. The work was performed primarily by the Board's legal, financial and technical advisors who reported back to the Project Team. The legal and financial evaluation was primarily concerned with the risk assessment and financial aspects of the evaluation process, together with the adherence by the consortia to the contract terms.

5.11.9 The advisors verified the compliance or otherwise of the tenders, and where non-compliant, advised the Board in detail of the areas where clarification should be sought. Compliance was measured against the bid requirements identified in the ITN. The following consultants were engaged:

- Architects
- Mechanical & Electrical Engineering Consultants

Comparison with PSC

5.11.10 The bid was then assessed against the PSC by the sub-groups and a report produced. This was performed in the most appropriate format for each area.

5.11.11 The Approach to Design the review was carried out using Achieving Excellence Design Evaluation Toolkit (AEDET). This was overseen by the Project Design Sub-Group and the Board's professional advisers. The technical and FM disciplines also defined the criteria to be used in the evaluation for their interests and completed their sections of the evaluation accordingly.

Evaluation by Groups

5.11.12 Each sub-group then met to assess the outcome of their review of the bid and produce a final report.

5.11.13 These reports were then submitted to the Main Evaluation Team comprising the Project Team with professional advisers as appropriate. The Main Evaluation Team met to consider the sub-group reports and undertake the scoring of each submission from a global perspective of the overall solution.

Evaluation Results

5.11.14 Extensive discussions/negotiations took place between the Board and the bidder as they had not submitted a bid which was able to demonstrate value for money when compared with the PSC.

5.11.15 As a result of the full and frank discussions, the bidder reduced their costs to bring them closer to the PSC.

5.11.16 On receipt of a revised offer, further evaluations, discussions and negotiation took place to ensure that value for money and affordability was demonstrated by the bidders.

5.11.17 The results of these evaluations demonstrated that the Canmore bid was technically compliant and that it demonstrated value for money.

5.11.18 The conclusion of the exercise was that the Bid represented an acceptable position for the Board in Value for Money terms.

5.12 Evaluation Conclusion

- 5.12.1** After a series of negotiations and clarification regarding the Consortium's bid in general, the Board concluded that it had a Value for Money and an affordable project and at its meeting on the 17th May, 2005 formally approved the appointment of the Consortium as Preferred Bidder, subject to completion of Key Stage Review with the SEHD (duly completed). This decision was made public at the Board Meeting on the 26th July 2005.

6.0 PFI Solution

6.1 *Introduction*

- 6.1.1 The PFI solution is for the Consortium to design, build, finance and operate two Hospitals on brownfield/greenfield sites owned by the Board, adjacent to the current Victoria Infirmary and Stobhill Hospitals, for a 30 year contract period post-completion of construction/commissioning excluding the provision of clinical services and soft FM services which will remain with the Board.
- 6.1.2 The PFI solution will result in the transfer of a significant portion of the risks of constructing and operating the facility from the public sector to the private sector. The solution will also meet the affordability requirements of the Board and will provide better value for money than the traditional procurement route.
- 6.1.3 The assessment of the bid has been reviewed taking full account of the quantitative and qualitative aspects of the offer received.

6.2 *Selection of Preferred Bidder*

- 6.2.1 The selection process leading to the appointment of preferred bidder spanned a period of 15 months and involved rigorous financial, technical and legal reviews of the bidders' proposals and associated negotiations at the various stages of the evaluation process.
- 6.2.2 The Consortium were appointed Preferred Bidder on 31st May 2005.
- 6.2.3 The appointment of the Consortium as Preferred Bidder was announced at the public Board Meeting of 26th July 2005.

6.3 *Preferred Bidder Details*

- 6.3.1 The Consortium will establish a Special Purpose Vehicle (SPV) to design, build, finance and operate the facility.
- 6.3.2 The Consortium will comprise PFI Infrastructure Finance Ltd., Barclays Private Equity, UME Investment Co. and Canmore Partnership Ltd.
- 6.3.3 The Consortium will appoint: Balfour Beatty Construction (UK) Ltd and Parsons Brinckerhoff FM Ltd as its subcontractors for the Project.
- 6.3.4 Canmore Projects Limited will, in addition to their in-house team and external funder, utilise the services of the following specialists:

Maclay Murray and Spens as Legal Adviser
Quayle Munro as Financial Adviser
Contractsure as Insurance Adviser
Capita Symonds as Independent Tester
Capita Symonds for bid co-ordination

6.4 *Planning Consent*

- 6.4.1** The Board obtained Campus Plan approval from Glasgow City Council for Victoria and Stobhill sites in April 2004.
- 6.4.2** The Board's officers held a series of meetings and talks with the city planners that identified and subsequently resolved any impediments.
- 6.4.3** Full planning consent has been obtained by the consortia.
- 6.4.4** The detailed planning application for Victoria Hospital was submitted to Glasgow City Council (GCC) in November 2005. A number of meetings have been held with council managers to progress the application. Following amendments to the site plans as a consequence of comments received from Architecture Design Scotland (ADS) an amended site development drawing was submitted by the Consortium on 3rd May 2006. The planning consultation process has been concluded and full planning permission was achieved on 15th August 2006.
- 6.4.5** The detailed planning application for Stobhill Hospital was submitted to GCC in December 2005. A number of meetings have been held with council managers to progress the application. Site plans have been amended to reflect comments made by ADS and planning approval was obtained on 13th June 2006.

6.5 *Timetable*

Key Dates:	<u>Stobhill</u>	<u>Victoria</u>
Preferred Bidder	May 2005	May 2005
Planning Consent	June 2006	August 2006
Financial Close	August 2006	August 2006
Construction Start	November 2006	November 2006
Construction Finish Stobhill	March 2009	
Construction Finish Victoria		April 2009
Board Commissioning Stobhill	June 2009	
Board Commissioning Victoria		June 2009
Opening Stobhill	June 2009	
Opening Victoria		June 2009

6.6 *Financing The Project*

6.6.1 Introduction

This section sets out the details of the financing for the project. It covers the key aspects of the funding structure, the terms of the financing and provides details on the financial modelling that supports the project.

6.6.2 Key Elements of the funding structure

Canmore initially proposed senior debt facilities as the funding structure for this project. These facilities were combined with equity and subordinate debt funds provided by the equity holders. The key components of the funding structure are as follows:

Table deleted – commercial information

6.6.3 In addition to the initial funding shown in the table above, the bidder has proposed the use of an RPI swap as a means of hedging its future inflation risks. This is discussed further in the section.

6.6.4 Selection of funding structure

In recognition to the scale of the project and lack of competition resulting from the single bidder position, the bidder was asked to provide proposals for bond financing. Both the senior debt and bond proposals were compared to benchmark terms derived from comparable projects to ensure that no abuse of the preferred bidder position had occurred. The benchmarking exercise carried out at preferred bidder found that the funding proposed by consortium was comparable to benchmarks, and in some respects more favourable to the Board than comparable projects.

6.6.5 Level of Debt and Equity Support

Funders' support letters and term sheets have been provided for, and are consistent with the funding structures described above and reflected within the financial models. These confirm the funders' fees, terms and conditions where appropriate and also confirm that the funders:

- reviewed and accept Canmore's funding plan and financial models;
- confirm their acceptance of the current NHS standard form Project Agreement, subject only to the points raised by Canmore's submission; and

- have undertaken the technical, legal and financial due diligence expected at the Preferred Bidder stage for a project of this nature.

The final funder due diligence was concluded prior to Financial Close.

6.6.6 The providers of equity will be taken from the following list

1. Canmore Partnership Limited
2. Barclays Private Equity
3. Quayle Munro Limited
4. UME Investment

It has been assumed in the financial model that equal equity and sub-debt stakes will be taken by each of the above.

Letters of commitment from equity providers have been received as part of the ITN process, and commitment to be bound by the terms of the preferred bidder appointment have been received.

6.6.7 Level of debt and of principal terms

The senior debt will be provided by Dexia Limited. As stated above, funding terms from Dexia were subject to benchmark analysis up to the appointment of preferred bidder.

6.6.8 Details of when all funding is to be drawn down

The order of priority for funding drawdowns is as follows:

- 1 Equity
- 2 Subordinated Debt from equity providers
- 3 Senior Debt

6.6.9 It is envisaged in the financial model that the Stobhill Hospital will be completed and available for occupation before the completion of the Victoria Hospital. As a result unitary charge payments will commence on a phased basis. These payments have been used by the consortium to reduce the level of senior debt drawn to below the level expected had no unitary payments been made.

6.6.10 Details of the lending terms

Table excluded – commercial information

These terms have been provided to the Board on a Commercial in Confidence basis.

6.6.11 Inflation in the Financial Model

Construction costs are quoted on a fixed price basis and development costs are input in nominal prices.

The Unitary Charge, operating costs, lifecycle costs and third party revenue income are input into the financial model in May 2005 prices, in accordance with the Board bid instructions, and are assumed to index annually on the 1st April. In the case of the Unitary Charge, only 50% of the charge has been forecast to inflate, reflecting the fixed price nature of a substantial proportion of the costs.

RPI is assumed to be 2.5% per annum in accordance with the Board bid instructions

6.6.12 Details of the financial model

Table excluded – commercial information.

6.6.13 Details of the financial model - Hedging policy

The Consortium put in place both interest rate and inflation hedging instruments that were benchmarked at Financial Close.

6.6.14 Term Loan implications for Hedging

Excluded – commercial information

6.6.15 Calculation of Unitary Charge

The Unitary Charge is adjusted to the minimum level required to ensure that the project is able to meet all the net operating costs, and senior debt service and shareholder return requirements. This is an iterative process

in that the quantum of Unitary Charge will impact upon the funding requirements which in turn impacts upon the Unitary Charge required to repay the level of funding required. As part of the solving process, the relative levels of debt and equity (i.e., the gearing) will be allowed to float to enable the balance that achieves the lowest Unitary Charge to be found.

6.6.16 Dividend policy

Dividends payable in any semi-annual period are calculated on the lower of:

- profit after tax for the period plus the retained profits brought forward; and
- net cashflow for the period plus distributable cash balances brought forward.

6.6.17 Bank cover ratios

Excluded – commercial information

6.6.18 Length of contract

The base case financial model assumes the following contract length:

- Construction period 3.25 years
- Total contract length 33.25 years.

6.7 Taxation assumptions

6.7.1 Finance debtor

Canmore has assumed in the financial model that the project fully qualifies for finance debtor accounting and taxation treatment. The Board is receiving the full benefit of this treatment through a lower unitary charge.

6.7.2 Tax rate and calculation basis

The company is assumed to be a large company for corporation tax purposes and therefore the corporation tax rate assumed in the model is 30% per annum.

6.7.3 The corporation taxation liability for any year is calculated by taking into account the taxable profits/losses in the relevant semi-annual periods and deducting the trading losses brought forward. The resulting corporation tax liability is then payable in accordance with applicable taxation rules: half in the second half of the current year and in the first half of the year following.

6.7.4 Loan fees and interest

Interest and fees incurred on the debt raised to fund construction of each phase are capitalised into the finance debtor during the construction of the relevant phase. Capitalisation of the relevant proportions of total interest and financing fees which meet the criteria set out in Financial Reporting Standard 4 (FRS4), Capital Instruments, will cease on completion of each phase.

Capitalised interest during construction will be netted off against interest income for finance debtor purposes as such interest would not have been earned without the interest deduction being incurred.

Loan fees during construction are amortized over the life of the loan for taxation and accounting purposes. Loan fees during operations are charged for taxation and accounting purposes in the period in which they are incurred.

6.7.5 Operating and maintenance costs

All operating and maintenance costs are charged in full for taxation purposes in the period in which they are incurred.

One hundred percent of maintenance costs are expensed as the proportion of lifecycle and maintenance costs treated as 'capital' or 'revenue' will not have any tax impact in this model as under composite trade 100% will be deductible in either event. The current treatment is acceptable as all subsequent expenditure post construction completion is to keep the assets in a 'steady state' (i.e. no new assets or improvements)

and therefore should be expensed as normal repairs & maintenance costs.

6.7.6 Interest Income

Interest income, Schedule D Case III, is not sheltered by trading losses brought forward and is shown as taxed separately in the corporation tax computation. Where current period trading losses arise, these are set off against Schedule D Case III income.

6.7.7 VAT

The Unitary Charge in the financial model is stated exclusive of VAT. The model excludes all recoverable VAT on costs except for the working capital associated with a one month delay in reclaiming the VAT paid on the construction costs.

6.8 *Confirmation from the NHS Board's financial advisors that they have reviewed the financial model.*

Ernst and Young, the Board Financial Advisor, has reviewed the financial model as a part of the financial evaluation prior to selection of preferred bidder. The financial model has also been audited prior to Financial Close by Ernst & Young and represents a Value for Money position.

7.0 Financial Appraisal

7.1 Introduction

Throughout the procurement the Board has been committed to assessing the affordability position of the project at key milestones. This assessment has focused on meeting the first full year of unitary charge payments. The main components of the affordability assessment are the:

- Assessment of the level of resources made available by the Board
- Unitary charge payment to the contractor
- Cost of soft FM provision from the in house bidder
- Provision of equipment

This chapter sets out in more details each of these main components.

7.2 Assessment of available resources

The level of available resources comprises the following:

- level of funding paper agreed by the Board
- impact of inflation uplifts
- treatment of equipment
- consideration of efficiencies from divisions

7.2.1 Funding levels agreed by Board

The Board has monitored the required level of funding for the project throughout the procurement. The latest position is summarised in the following table: -

Table excluded: commercial information

7.2.2 Inflation uplifts

As noted above all Income and Expenditure contained within the May 2005 Affordability paper is shown at a price base of 2009/10. This included inflationary uplifts at 2.5%pa. Due to the present forecast of not reaching Financial Close until mid 2006 and anticipated handover not happening until Stobhill ACAD April 09 and Victoria ACAD June 09 the first full year's Unitary Charge in Canmore's financial model is expressed at 2010/11. In order to show all Income and Expenditure at a consistent price base inflation has been applied to express all income assumptions at a 2010/11 price base.

7.2.3 Efficiencies from Divisions

A further area considered in the construct of the available resources was efficiencies deliverable from divisions to supplement additional Health Plan Income. The Board has a strong desire not to seek only additional resources but to understand the need for greater efficiencies. Such efficiencies would lead to current costs release from present services. A review of the January 2004 funding paper identified additional potential cash releasing efficiencies which enabled the Project to remain within the overall affordability envelope.

7.3 *Unitary charge payable*

The timetable for the project results in a phased delivery of the facilities. In order to ensure that the Board has sufficient resources to meet the unitary charge payments for all services on an annual basis the affordability assessment has been focused on the first full year of operations. This is the year ending March 2011 with a unitary charge of £20.7m.

7.4 *Soft FM Services*

The scope of services excludes the provision of soft FM. These services will be provided by the in house provider. The cost of these services for the first full year of the facilities operations amounts to £1.606m.

7.5 Provision of equipment

The scope of the project does not require the contractor to provide equipment, other than group one equipment, for the new facilities. As such the Board will be responsible for the supply of all other equipment.

7.6 Affordability position

The revised affordability position incorporates all of the above elements and is summarised in the following table:

Table excluded – commercial information

The table illustrates that the project remains within the affordability envelope set by the Board.

In terms of released estate capital charges further reviews of realisable costs will continue until the date of opening ACAD's. Indexes to date has shown a slightly better realisable saving than originally forecast and therefore there should be further potential gains over the next three to four years.

Overall there remain various managerial actions that will ensure the project remains affordable.

In subsequent years the unitary charge payments will increase by a proportion of inflation.

7.7 Summary

The affordability position has been central to the procurement process. It has been monitored by the Board from the OBC stage through the preparation of this FBC. Prior to the receipt of bid submissions the affordability position was monitored through the use of a shadow bid model. Following bid submissions the bidders financial model was subject to detailed evaluation. In order to meet these unitary charge payments the Board has allocated a sufficient level of resources to meet the first full year unitary charge. In subsequent years the unitary charge payments will increase by a proportion of inflation. The Board has assumed that its level of available resources will inflate at the rate of inflation. Accordingly the level of resources will increase at a greater rate than the unitary charge payments and the project should remain within the affordability envelope.

8.0 Economic Appraisal

8.1 *Introduction*

This section covers the economic appraisal of the value for money implications of the project. The appraisal has been conducted with reference to the relevant HM Treasury Guidance and the Scottish Executive PFU Practical Application Note (September 2005) on implementing the Treasury guidance. In addition the Scottish Executive Health Department has requested that the Board follow the guidance for the use of the Generic Economic Model developed by the Department of Health in England & Wales.

The economic appraisal has two main elements, a qualitative and a quantitative element. The following paragraphs set out the analysis undertaken in assessing each element.

8.2 *Qualitative Analysis*

The qualitative analysis covers the non financial benefits of the project. The main non-financial advantages of the PFI project solution relate to the provision of an innovative design solution to support the Board's preferred models of patient care. The design of the PFI accommodation provides improved departmental relationships and communications links and offers increased environmental and stakeholder benefits compared to the PSC. Also, the PFI Project Agreement provides a sustainable economic solution for the delivery of facilities management services and building repairs designed to maintain the quality of the hospital environment throughout the contract period.

The following qualitative analysis has been based upon the HM Treasury guidelines for assessing value for money in PPP projects issued in August 2004. The value for money guidance suggests that the test be carried out first at Stage 1, i.e., the programme level. The tests at project level should refer back to the findings of the programme level assessment. This project commenced before the introduction of the programme level assessment and as a result we have as far as possible considered the tests as they apply at present.

8.2.1 *Viability*

The aim of the test of viability is to ensure that;

“Overall, in deciding to proceed with PFI, is the accounting officer satisfied that an operable contract with built-in flexibility can be constructed, and that strategic and regulatory issues can be overcome”

The elements of the assessment are as follows.

8.2.2 Programme Level Objectives

The aim of this project is to construct and service accommodation that will contribute to the overall review of health care in the Greater Glasgow area as it is described in the Acute Service Review. A key element of that review is the reconfiguration of health accommodation so that they accord with current and future demands of service provision.

Greater Glasgow NHS Board is satisfied that the Standard Form contract used in PPP is an appropriate and operable contract for the requirements of this project. In particular that contract contains clear, objective and output based service requirements.

The payment mechanism contained within the contract allows for a clear assessment on the achievement of these outputs to be made.

The negotiations with the preferred bidder have ensured that a robust match of the output specifications to the needs of the Board have been achieved.

8.2.3 Operational Flexibility

The rapid changes in clinical practice require that operational flexibility is a key requirement of the Board. As a result significant emphasis has been placed on the flexibility of design. The spaces defined can be used for a range of functions, and only where health and safety requirements must be met, for example radiation shielding, has this flexibility been compromised.

8.2.4 Equity Efficiency and Accountability

In considering the equity, efficiency and accountability aspects of the project, no factors were identified that would preclude the private sector from providing the services required in this procurement. The soft service elements of the project were tested through competition between in house

and private sector providers, and the public sector provider was successful in demonstrating better value for money.

8.2.5 Conclusion on Viability

PFI is appropriate as a procurement method on the grounds that a suitably flexible, operable contract can be put in place which meets all the regulatory and accountability criteria set out in HM Treasury guidance.

8.2.6 Desirability

The aim of the desirability test is;

“Overall, is the accounting officer satisfied that PFI would bring sufficient benefits that would outweigh the expected higher cost of capital”

The elements of the assessment are as follows:

8.2.7 Risk Management

The project involves the building of large medical facilities. Where PFI has not been used to construct assets of this type, significant time and cost overruns have been normal. It is the view of GGHB that PFI offers a better mechanism for controlling these risks.

8.2.8 Innovation

The principle of an Ambulatory Care and Diagnostic facility is relatively new and as such no set design model has been developed. It was therefore important that innovation in clinical methods be matched by innovation in design. Given the significant variation in design between the private sector solution developed, and the public sector comparator, innovation in design would appear to have been enhanced through the use of PFI.

8.2.9 Service Provision

The service provision aspects of the project were tested under the protocols developed by the Scottish Executive and the STUC. The public

sector proposals were accepted on the basis on costs and value for money being better than the services offered by the private sector.

8.2.10 Incentives and Monitoring

The required outputs of the programme in general, and this project in particular have been set out in contractual terms through negotiation of the project agreement. The use of PFI, and in particular the payment mechanism as part of that project agreement have enabled a clear set of incentives and monitoring procedures to be developed.

This incentive regime will enable the board to ensure continued quality of service throughout the term of the contract.

8.2.11 Lifecycle Costs

There are expected to be significant lifecycle costs over the duration of the contract. The use of PFI has enabled the responsibility of design, construction and lifecycle risks to be borne by the contractor. This should ensure that the quality of the build solution has not been compromised at the expense of lifecycle costs in the future. This should ensure a better value for money solution compared to traditional procurement.

8.2.12 Conclusion on Desirability

The ability of PFI to provide strong performance incentives over the life of the contract, and the innovation that has been shown by the private sector in design should ensure enhanced value for money over traditional procurement methods.

8.2.13 Achievability

The initial review of achievability carried out at the programme level is designed to assess the following

“That a PFI procurement programme is achievable, given client side capability and the attractiveness of the proposals to the market”

We are satisfied that at this stage of the procurement an effective contractual arrangement which appropriately apportions risk and reward can be completed.

8.2.14 Conclusions on qualitative analysis

On the basis of the assessment the Board is confident that the project demonstrates the required characteristics of the qualitative analysis.

8.3 Quantitative Analysis

The purpose of the economic appraisal is to compare the relative costs of the scheme options by ranking them in terms of their net present value (NPV) appropriately adjusted for the risks inherent to each option. The NPV calculation adjusts future cash flows for the time value of money by applying an appropriate discount factor.

In accordance with the Capital Investment Manual and PFI guidance, a discount rate of 3.5% is applied to all cash flows for the first 30 years of operations and 3% thereafter. Where the PFI option has been stated at nominal values, a 2.5% deflator is applied to adjust them to reflect real cash flows.

The NPV evaluation only takes account of the economic consequences of an investment option. Indirect taxes and non-cash transfers, such as capital charges, are excluded from the calculation as these represent circular flows of money within Government.

The economic cost of each option comprises two main components:

- NPV of the projected cash flows associated with the scheme; and
- NPV of the expected values of the risks.

The NPV of the projected cash flows has been derived from the total projected cost for each option. The basis on which these costs were compiled is stated within the financial appraisal section of the FBC [(see Chapter 11)].

Both the PFI and PSC have the same life spans, therefore it has not been necessary to supplement the NPV calculation with a calculation of the equivalent annual cost (EAC) to accommodate differences in lifespan.

The purpose of using the NPV comparison is to allow for fairness and consistency. In using the NPV calculations, the effects of different timing of cash flows can be taken into account, e.g. value can be given to the earlier achievement of savings (even if the absolute value is unchanged).

The NPV analysis also consistently incorporates the cost to the public sector of raising funds to pay for the development, and allows this to be simply and fairly factored into the evaluation.

The two options considered by the Board, namely the Public Sector Comparator (PSC) and the Private Finance Initiative (PFI) were described in Chapter 4 and Chapter 6 respectively.

The PSC is based on the Board's preferred option as set out in the Outline Business Case and, as described in Chapter 4, has been regularly reviewed and updated by the Board, the in-house Project Team and professional advisers to ensure that a fair comparison is being undertaken which delivers the same requirements as those which have been sought from the PFI scheme.

8.3.1 NPV Comparisons of the Board Options

Table 9.1 below summarises the results of the NPV analysis of the two options. It highlights the fact that after evaluation of the level of risk to be transferred to the private sector the PFI option provides the greater value for money over the two appraisal horizons required under the relevant guidance.

Table excluded – commercial information

Economic analysis in PFI uses two appraisal horizons for the following reasons:

- An operational period of 30 years covers both the build and commissioning period plus the period for which the contract will remain in place between the Board and the PFI consortium – in this case 30 years. The total duration of the project is rounded up to the next whole year. As a result, one of the key tests becomes a comparison of value for money over this period
- An operational period of 60 years provides an analysis covering the typical period over which public sector investments are made according to Treasury guidance. A typical building of this nature is deemed to have a normal life-span of 60 years before a complete replacement should be considered. This period, plus the build and commissioning period gives the second key comparison for value for money to be demonstrated.

8.4 Cost inputs

The GEM has been populated with the following costs inputs:

8.4.1 Property & opportunity costs

These costs cover the purchase of additional land at the Victoria site and the opportunity cost of land already owned by the Board.

Table excluded – commercial information

8.4.2 Capital costs

The capital costs covers the construction at both sites and the provision by the Board of the necessary equipment. In accordance with the GEM guidance it excludes any contingency commonly built into the capital cost estimates. Capital costs are summarised in the following table:

Table excluded – commercial information

The capital costs for the PFI option are incurred by the contractor and included within the unitary charge payment to the Board. Under the PFI option the Board will be required to provide equipment to the same extend as identified in the table for the PSC.

8.4.3 Lifecycle costs

The following table sets out the lifecycle cost assumptions in respect of both sites.

Table excluded – commercial information

8.4.4 Revenue costs

The revenue costs for operating the facilities include amounts in respect of:

- Clinical and non clinical costs
- Building related running costs
- Forecast savings
- Transitional costs
- Embedded accommodation costs

Each of these costs is considered below.

8.4.5 Clinical and non clinical costs

The annual revenue costs in respect of clinical and non clinical costs are set out below:

Table excluded – commercial information

8.4.6 Building related running costs

The building related running costs cover the period of construction and operations. These costs cover insurance of the facilities, the cost of soft FM services and of contract management.

Tables excluded – commercial information

8.4.7 Forecast savings

All revenue costs above have been calculated net of any forecast savings.

8.4.8 Transitional costs

Two assumptions have been made in respect of transitional costs:

1. There will be decanting costs amounting to £0.500m in the year of opening the new facilities.
2. The following double running costs will be incurred until 2011/12:
 - At the Victoria site there will be annual costs amounting to £0.186m and £0.600m pa in respect of radiology and minor injuries services.
 - Costs in respect of utilities and facilities management services of £0.300m pa.

8.4.9 Embedded accommodation

It has been assumed that there are no embedded accommodation costs within the revenue cost assumptions.

8.4.10 Unitary payment

The unitary payment has been sourced from the financial model provided by the bidder and summarised in the following table:

Table excluded – commercial information

This amount represents the total unitary charge payable by the Board over the period of the concession.

8.4.11 Displacement costs

It has been assumed that no displacement costs will arise as a result of the project.

8.5 *Purpose of Risk Adjustment*

It is a key tenet of public sector projects that all the key risks which are inherent in the development of major change projects should be fully assessed and their impact quantified.

Chapter 11 of this Full Business Case deals fully with the analysis which has been undertaken on the risks inherent in the project and Chapter 14 deals with how any risks which are to be retained by the public sector can be effectively managed.

One of the key principles underlying PFI is that risks should be managed by the organisation, whether public sector or private sector, who can manage them most effectively. A significant element of the risk analysis relates to the design and construction of the new hospitals.

These key risks are assessed and values associated to them in order that the overall economic effect of the risks can play a full part in deciding which option – public funding or PFI – provides best overall value for the public purse.

The track record of the NHS across the UK in delivering major capital projects to time and to budget is not generally considered to be successful. There are examples of projects which have been delivered successfully to time and within cost, predominately projects under £25m, but these are the exception rather than the rule for projects on the scale being considered by this FBC.

PFI transfers the risk of cost and time over-runs firmly to the private sector under the Contract.

These key risks are assessed and values associated to them in order that the overall economic effect of the risks can play a full part in deciding which option – public funding or PFI – provides best overall value for the public purse.

Hence, the economic appraisal includes the overall assessment of risk in the project and allocates it to the party best placed to manage the risk.

8.6 Summary on economic appraisal

On the basis of the assessment the Board is confident that the project demonstrates the required characteristics of the qualitative analysis. All options have been appraised in terms of projected revenue and capital costs. Prior to risk evaluation, the PFI option represents less value for money than the PSC option. However, after considering the levels of risk transferred to the private sector, PFI represents the greatest value for money over both appraisal horizons.

9.0 Risk Analysis

9.1 Introduction

9.1.1 The objective of performing a risk analysis is to assess the total cost to the public sector of the PFI investment option under consideration. It has several uses, in particular:

- To ensure that the allocation of risks between the Board and the private sector is clearly established and demonstrated within the contractual structure; and
- To demonstrate value for money.

A risk is defined as an event that may or may not occur.

There are a number of such events that could arise during the design, construction, commissioning and operation of the new facilities.

9.1.2 Risks are assessed and valued to ensure the Public Sector Comparator (PSC) can be compared with the PFI option on a 'like-for-like' basis, ensuring that the value of risk retained by the Board under both options is evaluated and understood.

9.1.3 Whether under a traditional design, build and operate format (the PSC) or under a PFI contract, the Board is exposed to an element of risk in project delivery and maintenance.

9.1.4 The PSC exposes the Board to a greater degree of risk in terms of price variations, poor performance, late delivery, etc. since the Board is directly managing the contractors and procurement process. Under PFI, the contractor is managing the entire process and the Board only pays when satisfactory service is delivered. Under the PFI contract, the Board is, therefore exposed to less risk.

9.1.5 There are two core principles that should govern risk transfer in PFI projects:

- Risk should be allocated to whoever is best able to manage and control it, and
- The aim is to secure optimal risk transfer (it should be noted that optimal risk transfer is not maximum risk transfer). These principles have been

incorporated into the methodology underpinning the risk analysis for the project.

9.1.6 The approach undertaken for capturing and evaluating the risks for this project is detailed in the following paragraphs.

9.2 Approach

9.2.1 The Board has performed a risk analysis based on a detailed assessment of the risks at each stage of the process. This section of the FBC:

- Identifies project specific risks relating to the project, and
- Provides an analysis comparing the PSC and PFI options, demonstrating that they are robust and determining which option delivers best value for money.

9.2.2 To understand the quantification of risk transfer under both the PSC and PFI procurement options, a detailed Risk Register has been compiled by the Board. The primary tool used to collect information and opinions for the risk register and to evaluate the various risks was through a number of workshops and subsequent follow-up actions. These workshops were attended variously by the Board's project team and its advisors.

9.2.3 The approach at each workshop was to discuss each risk event in turn and to make a decision as to whether the risk was quantifiable or non-quantifiable.

9.2.4 Where a risk was considered to be quantifiable, the Board management and appropriate advisers considered the likely impact and probability of each event on the basis of available evidence and their experience.

9.2.5 The Board has identified the likely financial impact and value of the risks it will retain under each option and has adjusted the base cash flow NPVs for the PSC accordingly.

9.2.6 The primary steps undertaken at the risk workshops were as follows:

- Identify the risks in the project
- Carry out a scoring of these risks in terms of probability and impact to allow a Risk Map to be created
- Allocation of Risk Owners and the development where possible of mitigation strategies.

- Review of the allocation of risks between public and private sector.
- Each risk was then valued by assessing the likelihood of occurrence and the scale of impact on Board activities. From this information, an NPV cashflow was prepared on the risks using a multi-point analysis.

9.2.7 The risk adjusted cost of the PSC and PFI was calculated by adding the NPV cashflows of each risk to the base NPV.

9.2.8 The risk analysis was completed for the two appraisal periods required for the GEM model. Although the valuation of risk is subjective, the valuations presented in this FBC are the opinion of the Board supported as appropriate by the legal, technical and financial advisors, and based on extensive discussion through risk workshops. Result of the risk evaluation are summarised in the following table:

Table excluded – commercial information

9.2.9 The key risks that were assessed are summarised in the following paragraphs.

9.3 Key Risks

9.3.1 The risks have been analysed and reviewed under four categories. The nature of each category is described below:

- Design, construction & development: this covers the period from commercial/financial close through the construction phase of the project to the point prior to the new facilities becoming operational.
- Lifecycle and Hard FM: covers risks in the operational period and largely considers risks affecting the availability of the facilities, the quality of management and performance of services.
- Soft FM Costs: this covers the operational period, however the risks considered are those attaching to incorrect estimates of future costs, inflation, etc. These are retained by the Board.
- Other project risks: these risks were identified during the course of the risk workshops and capture risks specific to this project which are not otherwise captured in the risk matrix. Included here are risks of equipment becoming outdated and not fit for purpose.

9.4 Summary and Conclusions

- 9.4.1** The Board has identified the likely financial impact of the risks it will retain under each option (i.e. PFI and PSC) and adjusted the NPVs for these options accordingly.
- 9.4.2** The risk-adjusted cost was calculated by adding the expected value of each risk to the base NPV for the PSC. The risks transferred and shared are already in the private sector's costs under a PFI scheme.
- 9.4.3** The difference between the value of the risks retained by the public sector under each of the PFI and PSC schemes provides a proxy figure for the value of the risks transferred to and borne by the private sector.
- 9.4.4** The results indicate that the private sector assumes most of the risks under the PFI option, thereby reducing the Board's exposure to the risk associated with the development and operation of the new facilities.
- 9.4.5** The majority of risks during construction and operations have been transferred to the private sector, specifically those associated with design, construction and development and operating cost. The risks retained, in full or part, by the Board are generally those involving changes in requirements by the Board and external changes e.g. demand and specific legislation.

10.0 Summary of the Contract Structure

10.1.1 This Section of the Full Business Case details the main provisions of the Project Agreement as at May 2006, and the position reached on the key issues.

10.2 Contract structure and documentation

Confirmation that standard form contract being used.

10.2.1 The current SEHD Standard Form Project Agreement (the Standard Contract) has been adopted by the Board. The Board will be seeking the approval of the Scottish Executive Health Department for any amendments proposed to the Standard Contract.

Length of contract and details of any break points.

10.2.2 The duration of the Project Agreement will be approximately 30 years. The construction of the Facilities will be completed in three phases. The first phase will be the construction of the Stobhill Hospital. The second phase will be the construction of the Victoria Hospital and the third phase will be the construction of car parking facilities at the Stobhill site. Project Co will be obliged to commence delivering the Services for each phase once the construction of the phase is completed and the relevant facilities are available for the Board to use which will, in turn, trigger the Board's payment obligations in respect of that phase.

Extensions of time for construction are provided in line with the Standard Contract.

Description of the main provisions within the contract documentation:

10.2.3 **Design and Construction:** The Board has set out its requirements in a series of documents comprising the Board's Construction Requirements. Project Co is contractually obliged to design and construct the Facilities in such a way so that the Board's Construction Requirements can be met.

10.2.4 The Board has a monitoring role during the design and construction process but shall not be entitled to interfere with, or instruct Project Co directly except by way of the Review Procedure and the Variation Procedure. Project Co will be entitled to an extension of time and additional money if the Board requests a Variation.

10.2.5 Project Co will be entitled to an extension of time on the occurrence of Delay Event and to an extension of time and additional monies on the occurrence of Compensation Events. Project Co is relieved of the Board's right to terminate the Project Agreement for non-performance on the occurrence of Relief Events.

- 10.2.6 Services:** Project Co shall provide the Hard FM Services and the Inhouse Team the Soft FM Services. The Board has produced output based specifications in respect of hard facilities management encompassing utilities management, building fabric, building services maintenance, ground and gardens maintenance, pest control and the provision of a helpdesk and in respect of the soft facilities management encompassing portering and domestic services (the "**Services**").
- 10.2.7** The Service Requirements detail the standard of services required together with performance indicators. Project Co's entitlement to receive the Service Payment is at risk whether there are instances of poor performance or non-performance.
- 10.2.8** Project Co may provide the Services in any way it wishes, provided the specifications are met. Project Co will supply the Board with its Method Statements indicating the manner in which the Services will be provided. The Board is entitled to review and comment upon the methods Project Co propose to employ in providing the Services but only in so far as it affects the delivery of the Service Requirements.
- 10.2.9 Maintenance:** Project Co is responsible for maintenance of the Facilities, however, the Board may comment on and require amendment of Project Co's Schedule of Programmed Maintenance. The financial model for the Project includes capital sums attributable to life cycle replacement of fixtures, fittings and equipment within the Facilities for the duration of the Project.
- 10.2.10** The effect of poor or non-maintenance of the Facilities by Project Co will be carried through to the Payment Mechanism and deductions will be made from the Service Payment.
- 10.2.11** The Board will not be responsible for the costs of any additional maintenance and/or corrective measures if the design and/or construction of the Facilities and/or the components within it do not meet the Board's Construction Requirements. Where appropriate, Project Co will be subject to deductions from the Service Payment under the Payment Mechanism.
- 10.2.12 Equipment:** Group 1 Equipment will be provided and maintained by Project Co throughout the contract. Group 2 Equipment will be installed by Project Co, but provided and maintained by the Board. Group 3 Equipment, i.e. moveable equipment will be provided and placed by the Board.
- 10.2.13 Methods of monitoring and measures of performance:** Project Co is obliged to monitor its own performance and maintain records documenting their provision of the Services. The Board may carry out performance monitoring on its own account and may audit Project Co's performance monitoring procedures.

10.2.14 Direct Agreements and Design Warranties: The Board will have the benefit of direct agreements with key sub-contractors. The building contractor will provide a warranty and design warranties will be obtained from all consultants and sub-contractors with design input. The direct agreements and warranties will give the Board the right to step-in to the contracts in the event of termination of the Project Agreement.

10.2.15 Insurance and treatment of Uninsurable Risks: Project Co is required to carry the following Insurances:-

During the construction phase:

Construction All Risks
Advanced Loss of Profits
Public Liability
Professional Indemnity
Employer's Liability

During the Service Period:

Material Damage All Risks
Business Interruption
Public Liability
Machinery Breakdown
Business Interruption following Machinery Breakdown
Employer's Liability
Motor Insurance

Uninsurable Risks are dealt with in accordance with the provisions set out in the Standard Contract.

Summary of key areas of non-conformity with the standard form contract.

10.2.16 The Board will be seeking the approval of the Scottish Executive's Private Finance and Capital Unit for all derogations from the Standard Contract. The Project Agreement is still under negotiation between the parties. A copy of the latest draft of the Project Agreement has been submitted to the Scottish Executive under separate cover together with a list of proposed derogations for approval. The Board will submit further versions of the Project Agreement and proposed derogations as negotiations between the parties progress.

Summary of commercial issues to be agreed between the Board and Project Co.

10.2.17 Payment Mechanism:

- The final calibration of the payment mechanism has still to be agreed.

10.2.18 Site Conditions

- The risk allocation of certain site conditions is currently under negotiation. These site conditions include the growth of Japanese Knotweed, the discovery of artefacts and items of archaeological interest and the discovery of medical waste on the Sites.

10.2.19 Planning

- Detailed planning permission has not yet been obtained for either Site. The parties are therefore currently in discussions regarding the risk of obtaining detailed planning permission and the subsequent risk of judicial review.

10.3 *Payment mechanism*

- 10.3.1** The Board has adopted the Payment Mechanism set out in the Standard Contract with project specific amendments to reflect the relative size of the Project and range of services.

10.3.2 Summary of any benchmarking provisions

Due to the nature of the Services no benchmarking provisions are required in the Project Agreement.

10.3.3 Description of the indexation provisions, including the base date to which these will be applied.

The Service Payment payable under the Project Agreement is subject to indexation, as set out in the Standard Contract, by reference to the retail prices index published by the Government's National Statistics Office. Indexation will be applied to the unitary payment on an annual basis. The base date will be the date on which the project achieves Financial Close.

10.3.4 Invoicing and payment terms

The Board must pay Project Co the Service Payment on a monthly basis. The Board must settle sums due to Project Co within 30 Business Days of receipt of an invoice. Where any payment is in dispute the party disputing the payment shall pay any sums which are not in dispute.

10.3.5 The Board has a contractual right to set-off any sum due to it under the Project Agreement.

10.4 *Change of law and variations*

Confirmation that standard form contract provisions have been used.

10.4.1 The terms of the Standard Contract have been adopted in relation to Variations.

Summary of allowable expenses provisions as shared between the Board and Project Co.

10.4.2 The levels of Allowable Expenses are shared between the Board and Project Co as follows:

Table excluded – commercial information

10.5 *Delay Events, Relief Events and Force Majeure*

10.5.1 Confirmation that the standard form contract definitions of delay events, relief events and force majeure has been used.

The definitions of delay events, relief events and force majeure events as set out in the Standard Contract have been used. Any project-specific amendments to these definitions will be approved by the SEHD.

10.5.2 There have been no project specific changes to the definition of relief events. Any project-specific amendments to this definition will be approved by the SEHD.

Description of the compensation payable to the project company following termination for force majeure during:

10.5.3 Compensation payable following a force majeure event is calculated in accordance with the Standard Contract.

10.6 Corrupt gifts

Confirmation that standard form contract clause has been used

- 10.6.1 Corrupt gifts are dealt with in accordance with the provisions set out in the Standard Contract.

Description of compensation payable to project company following termination under corrupt gifts clause.

- 10.6.2 Compensation payable following corrupt gifts is calculated in accordance with the Standard Contract.

10.7 Termination and step-in

Explanation of the circumstances under which Project Co may terminate for Board default.

- 10.7.1 Project Co may terminate the Project Agreement in the following circumstances:

- material breach by the Board of its obligations in terms of the Licences;
- non-payment of any sum/s due to Project Co totalling the equivalent of one month's Service Payment (index-linked); or
- the passing of an Adverse Law.

Details of compensation and timing of payment(s) to funders/ Project Co in the event of Board default.

- 10.7.2 Compensation payable following Board default is calculated in accordance with the Standard Contract.

Treatment of property interests/right to occupy on termination for Board default.

- 10.7.3 The Project Agreement contains a mechanism dealing with the handback of the Facilities to the Board. On expiry of the Project Agreement the Facilities will always revert back to the Board.

Explanation of the circumstances under which the Board may terminate for Project Co default.

- 10.7.4 The Board may terminate the Project Agreement in the following circumstances:

- Project Co insolvency;
- Project Co's Failure to complete the Facilities within eighteen months of the proposed Completion Date;
- Material breach of the Project Agreement by Project Co;
- Abandonment;
- Failure to provide a material part of the Services;
- A Health and Safety Conviction Project Co during the Operational Term;
- Change in Control or Assignment prohibited by Clause 50 (*Assignment, sub-contracting and Changes in Control*);
- Project Co being awarded a set number of Service Failure Points in any six (6) month period or;
- Failure to pay any sum over £10,000 following 60 days of demand.

Summary of step-in rights for the Board.

10.7.5 The Board may step in to deliver the Services where Project Co's breach of its obligations under the Project Agreement:

- may create an immediate and serious threat to the health or safety of any user of the Facilities;
- may result in a material interruption in the provision of one or more of the Services; or
- is prejudicial to the ability of the Board to provide Clinical Services, or where:
- Project Co has accrued more than an agreed level of Service Failure Points in a one (1) month period in respect of any Service; or
- Project Co is not in breach of its obligations as described in the above points but the Board considers the circumstances constitute an emergency.

Details of compensation and timing of payment(s) to funders/Project Co following Project Co default:

10.7.6 Compensation payable following Project Co default is calculated in accordance with the Standard Contract.

10.8 *Expiry of contract*

Description of break options for the Board, indicating what benefits these give and what costs, if any, may be incurred if they are exercised.

- 10.8.1** The Project Agreement provides the Board with the right to terminate at any time throughout the duration of the Project Agreement upon giving not less than six (6) months' notice. On such termination the Board pays compensation on the same basis as if a Board default had occurred.
- 10.8.2** This break option provides the Board with the contractual flexibility to terminate the Project Agreement at any point throughout its duration without having to prove to Project Co that the Board should have that right or that Project Co will not be adversely prejudiced by the exercise of such a right.

Description of the different options available to the Board on expiry of contract and what costs are involved.

- 10.8.3** On expiry of the Project Agreement, the Facilities will revert to the Board at no charge to the Board. The terms of the Project Agreement do not preclude the Board from asking Project Co whether it would wish to extend the Project Agreement or re-tender all or some part of the Services (subject to any restrictions under general procurement law).

Description of handback requirements.

- 10.8.4** Thirty months prior to the Expiry Date a survey will be carried out to identify works required to bring the Facilities into line with the Handback Requirements. The Handback Requirements state that the Facilities must be maintained in accordance with the terms of the Project Agreement and constructed in accordance with the design life requirements contained in the Board's Construction Requirements.
- 10.8.5** A programme will be agreed to ensure that all necessary works are carried out by Project Co prior to the expiry of the Project Agreement and a Handback Amount will be identified setting out the cost of meeting the Handback Requirements. The Board will build up a Handback Retention Fund, through making deductions from the unitary charge, to cover the Handback Amount.

10.9 *Human Resources*

Confirmation that TUPE provisions will apply to any staff transferring to the private sector as a result of the project.

- 10.9.1** It is anticipated that due to the nature of the Services no staff will in fact transfer. It is accepted by the parties, however, that Project Co will accept any staff that do choose to transfer and the Standard Contract provisions have been retained as they are flexible enough to deal with this situation arising.

Details of any terms regarding subsequent transfers at market testing intervals.

- 10.9.2** Due to the nature of the Services there is no provision in the Project Agreement for market testing.

Description of terms regarding requirement for broadly comparable pensions for staff upon transfer.

- 10.9.3** As per 8.1 above.

10.10 Land Matters

Description of the land holding arrangements i.e. initial licence, long term leases, timing of grant and termination provisions.

- 10.10.1** The Board will procure the grant of a licence from the Scottish Ministers to Project Co in line with the Standard Contract position.

Details of how surplus land transfers are treated in contract.

- 10.10.2** There are no surplus land transfers being made by the Board to Project Co in connection with the Project. The Board is acquiring the Site for the Victoria ACAD facility from Glasgow City Council. This land will be acquired prior to Financial Close.

11.0 Accounting Treatment of the PPP/PFI Scheme

11.1 Introduction

11.1.1 The accounting treatment of this scheme has been determined by reference to the Treasury Taskforce Technical Note No. 1, How to Account for PFI Transactions, issued in September 1997.

11.1.2 In order to meet the Accounting Standards Board (ASB) guidance on the accounting treatment of PPP/PFI projects, an evaluation of the sensitivity of the project Internal Rate of Return (IRR) will be undertaken to assess the effect of key risks to the project, particularly of:

- availability of accommodation
- performance of the related services
- residual value of the assets at the end of the concession period
- the costs to the SPV of providing the accommodation and associated services.

11.1.3 The accounting treatment has been considered using the stages set out in the Technical Note as described in the following paragraphs.

11.2 Application of Financial Reporting Standard (FRS5)

11.2.1 It is concluded that FRS5 rather than Statement of Standard Accounting Practice 21 (SSAP21) will apply to the scheme for the following reasons:

- There will be a single contract for a serviced facility, payment for which is via a single Unitary Charge.
- The initial capital cost of the underlying asset is between 10% and 90% of the Net Present Value (NPV) of the expected payments.

11.3 Analysis key risks

11.3.1 The following table summarises the key commercial risks in the transaction:

Demand risk	The Unitary Charge is a fixed payment for specified serviced accommodation. Any activity variations within the specified accommodation which affects input costs will not be reflected in the Unitary Charge and is therefore a Board risk.
Availability/Performance risk	The whole of the Unitary Charge will be subject to percentage deductions if part of the

	accommodation becomes unavailable or falls short of strict performance criteria. Deductions are set at such a level that failure would result in significant loss to ProjectCo.
Third Party Revenues risk	Any third party revenues will accrue to the operator. The risk of shortfalls in third party income is therefore borne by ProjectCo.
Pricing risk	The risk that actual changes in underlying costs will be different from GDP, a proportion of which is used to index the Unitary Charge, lies with the ProjectCo.
Operating Cost risk	There will be no upward adjustment to the Unitary Charge other than under indexation or benchmarking provisions or to compensate for discriminatory legislation.
Design risk	The Board has specified outputs for the new facility with specific requirements in relation to Imaging Services. These relate to equipment loadings, servicing requirements and radiation emission control. As the responsibility for meeting these requirements lies with ProjectCo the design risk lies with ProjectCo rather than the Board.
Obsolescence risk	The risk of the facility being affected by obsolescence is borne by the operator. This risk therefore lies with ProjectCo.
Residual Value risk.	At the end of the contract period the Board has the option to acquire the facility at zero consideration or to walk away. The residual value risk therefore lies with ProjectCo.

11.4 Funding Structure of ProjectCo.

11.4.1 In order to assess the commercial impact of the key risks it is necessary to consider the funding structure of ProjectCo.

11.5 Accounting for the transaction.

11.5.1 On the balance of the above evidence, it is the Board's view that it should not recognise an underlying asset. There appears to be sufficient risk transfer to conclude that the operator will be exposed to potential variability in returns. Therefore the transaction will be accounted for by the Board by reporting the Unitary Charge against its Revenue Reserve Limit.

11.5.2 The Board's Auditors, Audit Scotland, to confirm proposed accounting treatment.

12.0 Project Management Arrangements

12.1 Introduction

12.1.1 Project management and control arrangements are to be put in place at two key stages of the project, namely:

- Post financial close through commissioning,
- and during operation.

12.2 Commissioning Phase Project Management

12.2.1 The management and monitoring responsibilities following Financial Close and up to Full Service Commencement will be within the Board's Acute Division and the Directorate of Acute Implementation and Planning.

12.2.2 A schematic of the Board Structure is shown in Appendix 12.01 confirming the reporting relationships of the Chief Operating Officer (Acute Division) and the Director of Acute Implementation and Planning to the Board Chief Executive. The structure of the Acute Division Structure is also provided in Appendix 12.02.

12.2.3 Post Financial Close the PPP will be co-ordinated through the Director of Facilities of the Acute Division in accordance with the commissioning arrangements set out in Appendix 12.03. The Director of Facilities as the Lead Director will co-ordinate and manage the Post Financial Close Commissioning Programme and will report into the Acute Division Operational Management Group which is chaired by the Chief Operating Officer who in turn will inform the process of Acute Service Planning.

Management and contractor liaison during the construction period will be led by the Head of Capital Planning and Procurement who reports directly to the Director of Acute Implementation and Planning.

12.2.4 Given the involvement of the resources of the Acute Division in preparing the ground for clinical redesign and the standard procuring elements of equipping the lead will lie with the Acute Division. This is a change from the traditional route of dedicated resource and team handing over the keys to a new building and develops a more interactive process with the operational service leading whilst retaining a central focus for delivery.

12.3 Commissioning Tasks

12.3.1 The commissioning tasks can be grouped under 3 broad headings;

- Facilities including equipment, FM, operational policies, contractor liaison, adviser co-ordination physical transfer of staff and equipment and decommissioning of existing services.
- Human Resources including manpower planning, Consultant job planning, training and development and general T&C's issues.
- Clinical redesign including new systems of service delivery envisaged for ACAH, operational policies, IT requirements and systems of work, medical records systems etc.

12.3.2 The commissioning structure links all three activities into a single point of management provided by the Director of Facilities. The linkage, reporting and management arrangements for Post Financial Close to handover are shown in Appendices 12.03,12.04 and 12.05.

12.4 Construction to Full Service Commencement

12.4.1 Clause 18 of the Project Agreement contains provisions governing liaison and monitoring during the construction period. The Board's representative has unrestricted access during normal working hours to view the Works (on giving reasonable prior notice) or visit any site or workshop where material, plant or equipment are being manufactured, prepared or stored. Project Co is obliged ensure that there are monthly progress meetings and site meetings to which the Board's representative is invited.

12.4.2 During the construction period the Board lead for interface with the contractors on construction issues will be the Head of Capital Planning and Procurement supported by in-house staff from the Capital Planning & Procurement Department and the Board Technical Advisers.

12.4.3 The appointment of the Independent Tester will be undertaken jointly by the Board and Project Co to ensure that the construction is consistent with the approved design and Board Construction Requirements.

12.4.4 Continuing Technical Adviser Support

The Board Financial, Legal and Technical Advisers are all contracted to provide continuing support to the Board until the Service Commencement Date. Legal and Financial Teams have ACAH as part of their NHSGG Acute Strategy commission and as such their continuity post Financial Close is assured. The commitments of the Board Technical Advisers are as follows:-

Civil and Structural Engineers role

- Provide advice throughout the duration of the construction stage as required on construction issues, relative to build and external works.

Project Manager

- Manage commissioning process, programme and co-ordination of team.
- Actively participate in Post Project Evaluation process throughout life of the project, and assist Board Project Manager to prepare full PPE report circa 9 months post occupation.

Architect

- Participate in Post Project Evaluation process throughout life of the project, and assist Board Project Manager to prepare full PPE report circa 9 months post occupation.

Surveyor

- Throughout the construction stage provide cost advice and guidance as required on design and other related change orders.
- Provide input to PPE documentation as required.
- Fulfil the role of Monitoring Surveyor in accordance with the Project Agreement.
- Monitor the construction programme against the Project Agreement and produce monthly reports to the board which give the current status of progress, statutory consultations and highlight any non compliances with the Project Agreement.
- Provide Health and Safety advice to the Board during the construction period.
- Assist the Board in PPE in accordance with the NHS SCIM.

12.5 Operational phase

12.5.1 Post Full Services Commencement the Board's nominated officer for contract and service matters will be the Director of Facilities. The day to day management of the sites will be managed by the Facilities Directorate Site Managers for Stobhill and Victoria Infirmary. Monitoring of performance and compliance will be reported to the Director of Facilities and subsequently the Operational Management Group of the Acute Division.

12.5.2 At full services commencement the provisions of the Project Agreement in terms of liaison will be implemented. In practical terms this provides for the following liaison/management meetings:

Meeting	<i>Frequency</i>
Liaison Committee	2 monthly
Dispute Resolution Process	As required
Site Management Group	Monthly
Departmental Meetings – FM Review	3 monthly

12.5.3 Clause 12 of the Project Agreement provides for the Liaison Committee to exist throughout the project. The Liaison Committee will consist of 3 Board representatives and 3 Project Co representatives. One of the Board representatives will be Chairman of the Liaison Committee.

12.5.4 The Liaison Committee must meet at least once every two months. It is free to adopt its own procedures and practices, subject to complying with certain requirements set out in Clause 12 of the Project Agreement.

12.5.5 The Liaison Committee has the following functions:

- Joint review of day to day issues relating to the contract;
- Joint strategic discussion looking at actual and anticipated changes in the market and possible variations to the contract to reflect those changes or for more efficient performance of the contract;
- Amicable resolution of disputes or disagreements.

12.5.6 The Liaison Committee makes recommendations to the Board and Project Co but does not itself have authority to vary the contract or make any decision that is binding on the parties.

12.5.7 Appointment of the members of the Liaison Committee is made by written notice delivered to the other party. Members of the Liaison Committee may appoint alternates.

12.5.8 The Board Manager will establish formal means to:

- enable effective monitoring to ensure compliance with the Project Agreement
- verify or ascertain any changes which may occur
- confirm compliance with all statutory regulations and good industrial practice
- confirm that all insurance obligations are met
- establish and maintain a comprehensive system to record all action taken and changes authorised throughout the project.

In the event of termination the Board Manager will be responsible for:

- hand-over arrangements including the receipt of keys
- the Project Company vacation of the site
- if applicable advising the Board of any outstanding financial implications associated with the termination

12.5.9 Day to day management of sites will be co-ordinated by the General Managers – Facilities for South Glasgow and North/East Glasgow respectively for Victoria and Stobhill Hospitals.

12.5.10 The Board Manager will be responsible for initiating any necessary action for non-compliance, breach of rules and regulations, poor quality of performance, events of default, termination events etc. in relation to the Construction Contract.

12.6 Service Contract monitoring

12.6.1 Each service will have a Specification detailing frequencies, task and response times. Details of each service specification will be made available to each Department within the site. The guidelines for use of the FM Helpdesk will be widely available within departments and each request will have a reference number generated and given to the requesting department.

- 12.6.2** It is anticipated that the monthly KPI monitoring report drawn from the Helpdesk will be shared with Heads of Departments.
- 12.6.3** In the event that there are Adjustments/amendments to the monitoring mechanisms these will be communicated to departments through a structure of departmental meetings co-ordinated by the General Manager-Facilities.
- 12.6.4** The 3 monthly departmental service meetings will include service reviews and performance reviews and the meetings will be attended by the FM provider.
- 12.6.5** Wider stakeholders in the service e.g. patients and visitors will have access to the Board's Suggestion and Complaints procedure that will apply in both locations. This identifies an individual manager on each site to which patients and members of the public can be directed to discuss any matters pertinent to the building and its services. The outcome of the initial contact will determine the route taken to resolve the issue raised.

12.7 *Post project evaluation*

- 12.7.1** A formal post-occupancy evaluation will be undertaken in compliance with the Scottish Capital Investment Manual (SCIM).
- 12.7.2** The POE process has 3 main stages:
- Stage 1: Planning and costing the scope of the POE exercise at project appraisal stage. This will tie into Project Agreement requirements.
 - Stage 2: Monitoring progress and evaluating the project outputs on completion of construction, including phased work.
 - Stage 3: Reviewing the outcomes (service aspects) of the project once it is operational.
- 12.7.3** The evaluation of the project will be expressed in terms of its objectives i.e. realisation of expected benefits as defined Appendix 13.
- 12.7.4** The project framework approach will be adopted for evaluation of capital projects i.e. matrix listing project objectives against indicators capable of measuring change. Project risks are also evaluated and discussed.
- 12.7.5** The POE will be carried out within 9 months of construction completion.

- 12.7.6** A Post Occupancy Evaluation report will be called for some two to three years after taking occupation. The focus of the P.O.E. report is on whether the building is performing satisfactorily and is meeting needs and whether there are any lessons to be learned.
- 12.7.7** The outcome of the P.O.E. will be reported to the Acute Division Operational Management Group and the Acute Service Review Board.

13.0 Benefits Assessment

A detailed description of the benefits the Board believe will be delivered from the Project is outlined below.

13.1 Description of Benefits

13.1.1 The benefits of the Project were considered at Outline Business Case and have been reviewed for the FBC. The Project, whether publicly or PFI/PPP funded, delivers the same benefits because the Clinical Briefs and the Schedule of Accommodation to deliver the service and activity were the basis for both the PSC and the PFI scheme's development. This level of design input through the planning development stages ensures that the scheme can deliver the benefits identified at OBC and which are critical to the scheme's objectives. The differentiating factor being the costs and value-for money analysis.

13.1.2 PFI process has allowed for an involvement of clinical staff, potential patients, patients and carers in determining the operational and clinical specifications to ensure required design features rather than the application of a pre-designed unit within a given price then adjusting services to suit the building as has been common in conventional procurement.

13.1.3 PFI procurement will provide construction cost certainty, a quicker construction programme and as such an earlier Services Commencement Date.

13.1.4 Access to public capital funds is by-passed by the PPP process.

13.2 Strategic Benefits

13.2.1 Resulting from the Project the following strategic benefits will be accrued by NHS Greater Glasgow and Clyde:

- Provides the first stage of the Acute Services Review Implementation Plan which will transform the delivery of acute services in Glasgow.
- Unlocks the clinical redesign of patient care services by providing an environment and system that underpin the change in existing practices.
- Complies with the Health Improvement Programme in which it is a key development.

- Addresses the medical manpower pressures that are apparent from changes to working hours and Junior Doctor training requirements.
- Provides a clear separation of elective and hot clinical services with the resultant certainty for patients in waiting times and reduces pressure on in-patient beds.
- Provides a key to the delivery of the Board's Local Health Plan and Local Development Plan objectives.

13.2.2 BENEFITS TABLE

BENEFIT CRITERIA	DETAIL	PSC	PFI
PATIENT SERVICES	<ul style="list-style-type: none"> • Rapid, quality patient services – one-stop, rapid access, integrated diagnosis and treatment • An Increase in protocol-based referrals thereby enabling better organisation of appointments for assessments, tests, treatments and clinics. • new MRI and CT scanners will reduce substantially the current wait for a scan. • Elimination of cancellation due to the requirements of emergency surgery and investigations. • Coherent arrangement of clinical facilities to minimise patient journey 	✓	✓
ACCESS	<ul style="list-style-type: none"> • Retains local access to the majority of services • Easy access by road, including adequate parking, drop-off/pick-up zones. • Adequate number of lifts, corridors wide enough for patients and equipment • Escalator access to first floor 	✓	✓
QUALITY SURROUNDINGS	<ul style="list-style-type: none"> • Purpose-designed building will ensure appropriate and clearly indicated access (disabled, parents with children), • Wayfinding will be intuitive, with clear signage and a logical layout • The main entrance will be welcoming and fit for purpose. • The building will meet the needs of a diverse community – (age, ethnicity, disability issues, religion) • Enhance security will be provided for patients, staff and visitors. • The building will be designed to minimise staff and patient journey times • Art in Hospitals will enhance the clinical environment and healing qualities within the building. 	✓	✓

FLEXIBILITY	<ul style="list-style-type: none"> • Capable of adapting to changes in clinical techniques, services and technologies. • Capable of physical expansion in key areas to meet increased demand • Capable of flexible use to accommodate fluctuating service demands. • Increased flexibility of response to changing demand for services • Capable of alternative uses to accommodate decreases in demand • Designed to support major equipment upgrade/replacement with minimal disruption to overall building 	✓	✓
STAFF FACILITIES	<ul style="list-style-type: none"> • Contribute positively to staff recruitment and retention through new, purpose-built accommodation • Facilitate a multi-disciplinary team approach • Support effective and efficient clinical staffing arrangements • Avoid duplication of clinical staff arrangements • Contribute positively to staff learning and training through library facilities and flexible conference/seminar/meeting areas • Greater satisfaction associated with the delivery of a high quality service. • New staffing arrangements that most closely reflect national best practice 	✓	✓
ENVIRONMENTAL CONSIDERATIONS	<ul style="list-style-type: none"> • Provides a therapeutic and healing environment • Pleasant outlook and external surroundings for patient, carers, visitors and staff • Well-maintained, purpose-designed facilities. • Meets health and safety and statutory requirements to provide a safe and secure environment. • Contributes to 'Green' issues such as efficient energy usage, re-cycling possibilities and positive impact on surroundings, environmentally friendly. • Enhanced security provision • Design issues address requirements of Disability Discrimination Act, single-sex accommodation and paediatric requirements 	✓	✓
IT	<ul style="list-style-type: none"> • Provides infrastructure to support Board's IM&T strategy • Act as the flagship implementation sites for the Board's IM&T strategy including: <ul style="list-style-type: none"> ○ Improved booking of appointments - The introduction of new models of care which include electronic "booking" systems will substantially improve the waiting list situation by reducing the number of cancelled operations and out-patients appointments. ○ Provision of "disease management" tracking to monitor patients 	✓	✓

	<ul style="list-style-type: none"> throughout their care pathway ○ Provision of a streamlined interface with GPs ○ Elimination of film in Radiology by provision of electronic access to archived digital images ○ Provision of computer equipment, cabling and business continuity arrangements to support the day-to-day operation ○ Provision of patient tracking through ACADs 		
CLINICAL SERVICES	<ul style="list-style-type: none"> • Improved Clinical efficiency • Increased/enhanced facilities – MRI, CT, Endoscopy leading to improved waiting times • Increased day surgery - By using new, minimally invasive, techniques and the changing anaesthetic techniques and assessment criteria, the range of services which can be offered as day procedures is expected to continue to develop and improve. • Closer working with secondary care clinicians through increase protocol-based referrals and improved test result and investigation response communication • Inter-related clinical departments located adjacent or in close proximity • Necessary clinical support services in close location • Well-equipped, appropriate facilities to provide quality of care • All relevant specialties available to patient • Creation of overnight beds will provide an environment for greater scope of short stay procedures to be undertaken and developed. 	✓	✓
IMPACT OF CONSTRUCTION	<ul style="list-style-type: none"> • Minimal impact on existing clinical services during construction. E.g. noise, dust, decanting and temporary facilities, parallel running • Minimal impact on, or disruption to access and car parking 	✓	✓

13.3 *Benefits Realisation Plan*

13.3.1 The Benefits Realisation Plan for the scheme is provided in Appendix 13. This details the individuals responsible for the delivery of the benefits and the associated timescales for their realisation. The Board will monitor achievement of these benefits through the project's organisational structure as provided Appendix 12.03 and as part of the Transitional Plan provided as Appendix 12.05.

14.0 Risk Management Strategy

14.1 Examination of Risks

14.1.1 The risk register for the project details where the project may be sensitive to external factors that would impact adversely on the construction, contractual or financial structure of the PPP project.

14.1.2 The Board have, through the Project Agreement, passed to the Consortia the relevant elements of project risk. There remains an element of Board and shared risk to be managed throughout the project and this will be addressed through the Board monitoring structure involving in-house managers and external financial, technical and legal advisers.

14.2 Key Risk Categories

14.2.1 The key risk categories have been summarised in Section 9.0 which details the risks retained by the public sector and those risks transferred to the private sector. These risks are both financial and non-financial in nature. The financial risks of the preferred option were quantified during the development of the Public Sector Comparator.

14.3 Risks Retained by the Board

14.3.1 The table below summarises the key risks that are to be retained by the Board and their strategy for the management of these risks.

ID	Risk Title	Probability	Impact	%	Mitigation strategy
	Risk that site conditions require additional work to be undertaken prior to or during construction				The sites have been subjected to a significant degree of investigations by the Consortia and these have identified and quantified the cost profiles associated with ground conditions. The findings were that ground conditions were poorer than the initial investigations undertaken with levels of contaminated land greater than anticipated. The level of costs have been defined to remedy

					these situations and post FC the ongoing risk lies with the Contractor. Japanese Knotweed has been discovered in significant quantity at Stobhill Hospital and a treatment regime commenced for its eradication. There will be a shared risk over the duration of the contract for any recurrence of this problem.
	Construction and commissioning are delayed so accommodation is not available when expected in line with the timetable issued at the Bidders Conference.				The project is behind the original construction programme reflecting difficulties in developing the sites to a level that Planning Approval is granted and the on-going detailed design for departments generally. This has a knock on to Glasgow's ASR programme. Post Financial close the PA addresses time delay in the standard manner and outwith the agreed timescale parameters risk of cost overrun lies with the Consortia. Experience on other PPP projects suggests that the Consortia will seek to minimize programme overruns.
	Onsite Security and safety				Site security and safety feature strongly in the Board's Construction Requirements. The interactive nature of the Stobhill project with the existing site services raises the risk of impacts on existing services.
	Poor PM causing delays and increased costs				The Project management structure has been defined and involves close liaison between the contractor, Board representatives and the independent Technical Adviser. This will ensure that emerging issues will be highlighted early and addressed in a positive manner to minimize any adverse impact on the project timetable and costs.
	Supply chain performance causing delay to project				Constant review of the supply chain will be reported to the Board by the contractor. The consortia have engaged reputable companies for the project and the tenders received have been reviewed by the Boards technical advisers.
	Risk that site conditions require additional work to be undertaken post financial close				See previous comments
	Latent defects – Enabling works not complete in advance of				The Board have implemented the enabling works programme and progress is such that no access

	New build construction causing site access restrictions leading to project delays				delays are anticipated.
	Risk that insurance process has to be finalised				PA will be fully agreed pre FC
	Equipment Infrastructure				An equipping schedule will form part of the PA and the Board has in place a funding package to provide the equipment required to deliver the services within the project.
	Failure to design to brief				No change however £7.2m risk value requires to be checked – (EY)
	Change to client specification causing delay and increased costs				A design freeze has been implemented. The risk remains in light of continuously changing clinical practices but the Board will seek to minimize the impact on programme and to utilize the inbuilt flexibility of the premises.
	Interest rate movement prior to contract finalisation				The interests rate market cannot be dictated by the Board.
	Risk that new legislation requires further works to the building / changes in operational management (non-discriminatory & discriminatory)				A review of legislation will be undertaken and the cost profile of the project is anticipated to include all foreseeable changes during the project lifespan. Inevitably there may be changes.
	Life cycle costs are greater than forecast				The PPP finishes schedule is being reviewed by the Board and agreement reached that the LCC reflects the programme. In the event that it is greater than planned this risk flows to the consortia
	New legislation regulatory requirements - NHS Specific				Remains a significant risk but all foreseeable changes have been accounted for.
	New legislation / regulatory requirements - non NHS Specific				See 8a
	Non approval of Annan St road closure				Annan St Closure Order has been publicized and returned unopposed. GCC will approve closure order in June. New road provided to replace the existing road minimizing any reopening of the issue.
	IT Obsolescence				No change

Risks Retained by the Board	Risk Management Strategy
Board changes to either design, construction or services specification and re-configuration of accommodation or equipment at the Board's request.	The Project Agreement provides a change mechanism for adjusting the unitary charge for such changes. Changes will be authorised by the Board Chief Executive or his designated deputy.
Not achieving planning permission	The Board obtained Outline Planning Consent and has held discussions with Glasgow City Council Planning Authority
Regulatory changes in NHS directives or standards and discriminatory change in law and health sector regulations.	The Board will bear the financial effect of regulatory changes in NHS directives via adjustments to the unitary charge. It is not yet possible to quantify the effect of such changes, but the Board will prioritise continuity of the contract so that funding of increases to the unitary charge would be met from other areas of the Board's budget.
Force Majeure	Force Majeure has been narrowly defined so minimising likelihood of FM event. This is a shared risk. The Board recognises that there are only limited opportunities to manage this risk. The compensation payable to Project Co would be restricted to the level of outstanding senior lenders liabilities at the time of the Force Majeure event. This amount would need to be met by the SE.
Inflation	The unitary charge is adjusted by a proportion in each year.
Labour disputes	The Board will retain responsibility for dispute, national and local, involving Board staff.
Land acquisition	The land has been purchased by the Board.
Interest rates	This risk which can be quantified by running interest rate sensitivities is borne by the Board only up until contract signature.
Changes in quality standards, Board requirements and activity/occupancy levels	These risks have been mitigated through the procurement process from the identification of suitable output specifications. Any required changes will be priced via an adjustment to the unitary charge.

14.4 Principles in dealing with risks remaining with the public sector

In general, the Board intends to approach the risks remaining with the public sector according to the following principles:

- commence with the current risk register and evaluation
- explore actions to mitigate the likelihood of risk occurring or their impact should they occur
- allocate responsibility for risks and contingencies
- establish monitoring procedures (as part of the construction project and service performance monitoring systems)
- at regular 6 monthly intervals (6 or 12 months) review remaining risks and review remaining contingency

14.5 *Monitoring and Reporting Procedures*

14.5.1 Procedures will need to be established which identify instances where risks have occurred and where action is required. This may involve monitoring and reporting procedures to be introduced by the Board. Such procedures will need to include agreed actions which can be implemented when events occur, including for example reference to and including of the contract conditions.

14.6 *Output from Management Procedures*

14.6.1 The output from these management procedures will feed into the post project evaluation.

15.0 Information Management & Technology Strategy

15.1 New Board IM&T Structure

15.1.1 The Board has recognised the importance of IM&T in supporting the modernisation of its services and has created a Board Director of IM&T post in its management structure.

15.1.2 The IM&T function consists of:

- Electronic Patient Records
- Information Services
- Information Technology including IT Help Desk
- Medical Records
- Telecommunications infrastructure

15.2 The Board's Strategy

15.2.1 It is worth stressing that the systems required to support the ACAHs are the same systems to support the whole of the NHS GG&C. The need to support the ACAHs has provided a programme by which the required systems must be in place.

15.2.2 The Board's ICT Strategy recognises the need to support the work of the ACAHs with major, concurrent investment in Information Management and Technology (IM&T) to ensure that service delivery is patient-centred, and focused on that patient's whole care pathway. Such an approach, and the underpinning technology to integrate and share data captured along the care pathway, is key to the ambitions set out in the Pan-Glasgow ICT Strategy, 2002-2004, and ICT Strategy 2004-2007.

15.2.3 Key components of the Board's IM&T Strategies include:

- Picture Archiving and Communications System (PACS)
- Partial Booking of outpatient appointments
- Enterprise-wide access to the Electronic Care Record via the Clinical Portal

15.2.4 Delivering the IM&T requirements for the Hospitals will, therefore, provide the template for supporting all service departments. As such, the major investment envisaged will have been developed ahead of the ACAD Project procurement, over the period of the Hospitals' construction.

- The key driver for the Board is to provide improved access to easy to use, more fully “joined up” patient information through the creation of an electronic, integrated care record, available wherever and whenever required.

15.2.5 The ICT Strategy envisages the Hospitals as both the flagship implementation sites for its strategy and the ultimate test of the Board’s ICT vision in operation.

15.3 *The Project Strategy*

15.3.1 The Hospitals will have included in their infrastructure, network communications cabling which will be incorporated into the Glasgow wide network.

15.3.2 This will allow the Board to implement the Clinical Portal solution over the chosen Patient Administration/Hospital Information System.

15.3.3 The delivery of patient based and management information will be enhanced through the implementation of the Board’s data warehouse giving access to patient information on a service wide basis. This information will be based on all SMR schemes processed by the Board.

15.3.4 All access to information provided through these channels will be subject to established Board confidentiality and data access requirements which in turn is based upon NHSIS security guidance requirements.

15.4 *Board IT Equipment*

15.4.1 The procurement of IT equipment i.e. computer terminals etc for the Hospitals will be a Board function as it has been excluded from the PFI requirements.

16.0 Approach to Equipment Provision

16.1.1 Schedules of equipment have been developed for the Project by the full room data sheet exercise. The schedules, through group classification, identify the responsibilities for the various aspects of the works in relation to the funding, provision, maintenance and replacement of the equipment required for the Hospitals.

16.2 Group 1 Equipment

16.2.1 The items identified as Group 1 will be supplied and installed by the Consortium.

16.3 Group 2 Equipment

16.3.1 The items identified as Group 2 will be supplied by the Board for installation by the Consortium. The supply of this equipment to the Consortium will be in accordance with a detailed programme to enable the Consortium to satisfy its obligations in respect of programme under the Project Agreement.

16.4 Groups 3 and 4 Equipment

16.4.1 The items identified as Groups 3 and 4 will be supplied and installed by the Board in accordance with the User Commissioning Programme.

16.5 Funding of Equipment

The cost of Group 1 and fixing of Group 2 has been agreed with the The Consortium.

16.5.1 The Board will fund the Groups 2, 3 and 4 equipment through a combination of new provision through the annual Capital Programme or by transferring suitable equipment from 'transferred' departments. The Groups 2, 3 and 4 equipment has been costed and based on equipment allowances or current prices where available.

16.5.2 An allowance of 15% of the budget has been made to cover the purchase of 80% new equipment. The remaining 20% of equipment will transfer from existing departments.

- 16.5.3** An equipment strategy has been developed in line with the Equipping of Construction Schemes in the Management of Construction Projects of the Scottish Capital Investment Manual. The equipment budget also includes allowances for the 'non-works' cost of equipping, staff, storage and any transfer costs not provided for in the Project Agreement.
- 16.5.4** The equipment strategy will be monitored against a fully detailed User Commissioning Programme. Equipment lists for all groups are provided in Schedule 13 of the Project Agreement.

17.0 Personnel Issues

17.1 Consultation/Staff Involvement

17.1.1 The Board will, in accordance with its “Policy on Managing Workforce Change”, consult with the Trade Unions/Staff Organisations in all matters relating to staff issues.

17.1.2 The Board continues to develop its commitment to an open and transparent approach to service development recognising that those affected by service change need to be involved in the decision making process.

17.1.3 A Board Partnership Agreement is being developed with staff and their representatives to ensure staff affected by change will be properly involved and allowed to influence the reshaping of services. This will build upon the work that has already been undertaken to involve staff and their representatives in the process of change and as a minimum will contain:

- communication and consultation arrangement
- access to information and Board meetings
- organisational change policies.

17.1.4 Staff Side representatives of affected professional and staff groupings have been involved in the development of the Acute Strategy, the Invitation to Negotiate and the development of the successful in-house Soft FM bid. This involvement will continue throughout the post financial close and operational phase of the project at a local implementation of change level and through the Area Partnership Forum of the Board.

17.2 Staff Transfers

17.2.1 The Board have identified the personnel resources required to operate each service within the new facilities and cross-matched these with the service provisions/resources as they are presently configured.

17.2.2 The H.R. Plan will take full account of the STUC Staff Protocol and SEHD guidance.

- 17.2.3** All clinical, clinical support, administrative and soft FM services will be provided by the Board through directly employed staff who will transfer from existing sites and posts to the new location.
- 17.2.4** The only services to be outsourced will be Hard FM and the Board have taken a position that no member of its existing Estates Staff Hard FM staff will be required to transfer to the new facilities or a new employer. They will be absorbed into the present staff establishment of the Board. Should a member of staff choose to move across to a new employer the TUPE regulations and STUC Protocol will be applied in full.
- 17.2.5** The current expectation is that no staff will be transferring from the Board to the Contractor and so no arrangements have been made to gain Admitted Body Status for pension provisions.
- 17.2.6** In the event that staff do in fact transfer from the Board to the Contractor, the Contractor will be obliged through the Project Agreement to give such employees access to a pension scheme that has been certified by the Government Actuary's Department as broadly comparable to the NHS Pension Scheme
- 17.2.7** Clause 30.32 of the Project Agreement obliges the Contractor to ensure that all individuals that it employs from time to time are engaged on terms and conditions that are "no less favourable overall" than those applying to any transferring Board employees. Clause 30.32 contains the standard form provisions relating to the Staffing Protocol issues.

18.0 Conclusion

18.1 *The Case for Investment*

18.1.1 Since the OBC was approved in January 2003, the Case for Investment has been continuously reviewed and updated in light of:

- emerging strategic changes under the single system structure of Greater Glasgow Health Board and subsequently the merger with part of the former Argyll and Clyde to form Greater Glasgow and Clyde Health Board in April 2006.
- shifting activity assumptions for the common health economy in light of the SE targets;
- developments in the implementation of models of care.

18.1.2 These reviews have resulted in changes to the PSC and the development of a fully designed facility, costed as a PSC and a PFI option.

18.1.3 Value for money and affordability calculations have been undertaken with full capital, revenue, income and savings calculations.

18.2 *The Preferred Option*

18.2.1 This business case presents a strong and coherent rationale for the Project that has been developed. The Project for which approval is sought comprises the building of a two new Ambulatory Care and Diagnostic Hospitals on the Stobhill Hospital site and adjacent to the Victoria Infirmary.

18.2.2 In addition to the design and build of the facilities the PFI scheme also includes a facilities management contract for Hard FM.

18.2.3 The scheme is affordable and represents good value for money to the public purse. It also builds substantially on the OBC.

18.2.4 The hospitals will each provide:

- Outpatient clinics for all specialties. Many of these clinics will be one-stop or rapid access;
- Ambulatory surgery theatres for ambulatory surgery case operations

- Day Care Endoscopy/GI unit
- Ambulatory infusion therapy (e.g. Chemotherapy – Victoria only)
- Cancer Services (treatments)
- Breast services (screening and examination/consultations)
- Access for therapy services
- Fast track diagnostic facilities (x-rays and scans)
- Pharmacy and Phlebotomy
- Patient and Staff Resource Centres (education and academic)

18.2.5 The 1:200 scale drawings which demonstrate the size and content of the scheme can be seen at Appendix 7.

18.3 *Approval of FBC*

18.3.1 The Board requests that the SEHD approves the Full Business Case and so authorises the Board's partnership with The Consortium to progress the proposal to Financial Close.

Appendix 1 Letters of Support:

Appendix 1.01 Letter from Board Chief Executive confirming commitment



Dalian House
PO Box 15329
350 St. Vincent Street
GLASGOW
G3 8YZ
Tel. 0141 201 4642
Fax. 0141 201 4601
Textphone: 0141 201 4479
www.show.scot.nhs.uk/ggnhsb

Dr Kevin Woods
Chief Executive
Scottish Executive Health Department
St Andrew's House
Regent Road
Edinburgh

Date 6th June, 2006.
Your Ref
Our Ref TAD\FEB

Enquiries to Miss Florence Blackburn
Direct Line 0141 201 4642
E-mail florence.blackburn@gghb.scot.nhs.uk

Dear Kevin

AMBULATORY CARE FOR GREATER GLASGOW

I am delighted to confirm the Board's commitment to the development of the two new Ambulatory Care Hospitals at the Victoria and Stobhill sites that represent the first stage of delivery of the Greater Glasgow Acute Services Strategy. We believe that ambulatory care represents an opportunity to deliver healthcare that more truly reflects the needs of users within Glasgow and beyond and reflects the spirit of the White Papers "Designed to Care" and "Towards a Healthier Scotland" and the principles promoted by "Our National Health: A Plan for Action, a Plan for Change".

I would reiterate, on behalf of NHS Greater Glasgow and Clyde, that the Board is satisfied with the case as submitted and is confident that the financial implications of construction, commissioning and running are within its financial affordability envelope.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'T.A. Divers'.

T.A. Divers
Chief Executive

Greater Glasgow NHS Board is the common name of Greater Glasgow Health Board

Appendix 1.02 Letter from Acute Medical Director affirming clinical support

Acute Services Division

Division Headquarters

Southern General Hospital
1345 Govan Road
Glasgow G51 4TF
Telephone 0141-201-1100
Fax 0141-201-2999



Medical Director

Our Ref: BNC/EMF
Your Ref:

9th June 2006

Dr Kevin Woods
Chief Executive
Scottish Executive Health Department
St Andrew's House
Regent Road
Edinburgh

Direct Line: 0141 201 1311
E-mail: Brian.Cowan@sgh.scot.nhs.uk
Enquiries to: Evelyn Forrest

Dear Kevin

I'm writing to indicate my support for the new Ambulatory Hospital developments in Glasgow and to indicate the degree of enthusiasm for this development among clinical staff.

These new hospitals will provide superb facilities for patients and ensure we maintain local access for over 80% of the visits that patients previously made to our more traditional hospitals.

In addition, they are already a focus for service redesign which will continue beyond the commissioning of the buildings well into the next decade.

The genuine participation of clinical staff at every stage in the specification and the design of the buildings will assist us greatly with the commissioning process and further redesign.

The developments have also been enthusiastically supported by the Medical Faculty at Glasgow University who have recognised for some time that we need to move the focus of medical student training away from a traditional bed-centred approach to the areas where modern medicine is increasingly practised in both outpatient clinics and procedure rooms associated with the ambulatory setting.

These new hospitals are the key which has enabled Glasgow to move away from its traditional inpatient, bed-centred focus and has allowed it to plan to reduce the number of inpatient sites, while still retaining local access for the vast majority of care.

Kind regards

Yours sincerely

A handwritten signature in black ink, appearing to read 'Brian Cowan', written over a light blue wavy graphic element.

Dr B N Cowan
Medical Director NHS Greater Glasgow & Clyde and
Medical Director Acute Services Division

Delivering better health

www.nhsggc.org.uk

40390

Appendix 2 Acute Services Review:

Appendix 2.01 Minutes of Greater Glasgow NHS Board Meeting held on 29 January 2002 - extract

CONCLUDING THE DECISIONS ON GREATER GLASGOW'S ACUTE SERVICES REVIEW

A report of the Chief Executive [Board Paper No 02/02] was submitted.

The Chief Executive described a growing frustration among a number of key stakeholders that no definitive decisions about the future of acute services had yet been taken. The opportunity existed now, therefore, for the NHS Board to conclude decisions about this strategy and thus give a clarity which would allow the detailed plans to be developed and implemented which would transform, within the next decade or so, the delivery of acute care within Greater Glasgow.

He described a number of pressures which were impacting on the provision of acute services in Glasgow and the main problems associated with delivering Glasgow's acute services which were:

- Outdated buildings
- Inpatient sites unable to provide one stop/rapid diagnosis and treatment
- Fragmentation of care
- Unsuitable diagnostic and imaging facilities
- Increasing sub-specialisation in medicine
- Glasgow's role in teaching and research : links to the Universities and need to attract and retain high calibre staff
- Too many inpatient sites requiring emergency on call rotas
- Changes in doctors' training
- Restrictions on the hours doctors can work
- The policy imperatives - waiting list guarantees, reductions in waiting times, services designed around the patient

Since 1 October 2001, when the new NHS Board was put in place, the Directors had spent a number of

development sessions on key strategic issues, including the strategy for acute services. The NHS Board wanted to approach its decision making as a Board of Governance. In addition to these working sessions within the NHS Board, the Chairman, the Chief Executive and Members of the Executive Team had undertaken seventeen briefing sessions on acute services during the past seven weeks with a broad range of stakeholder interests. The NHS Board had received feedback from these discussions which had further helped to shape how it would consider this strategy.

In order to discharge this governance role, the NHS Board wished to consider its decisions at three levels. Firstly, as a new NHS Board it wished to be satisfied that the processes which led to the series of decisions taken in December 2000, including the arrangements for public consultation and involvement, were appropriate.

Secondly, the NHS Board wished to be satisfied that the further work flowing from the Health Board's December 2000 decisions had advanced to a point which allowed strategic decisions to be taken now, recognising the need for more detailed ongoing work as part of the development of Outline and Full Business Cases. Thirdly, the NHS Board Members wanted to have the opportunity of hearing first hand about new or different perspectives arising from the briefing meetings with stakeholders described above, with the facility given to specific interest groups to make presentations to the NHS Board meeting, supported by short written submissions. To reflect these arrangements, the agenda papers and meeting had been structured accordingly.

The paper included as Appendix I summarised the consultation processes undertaken during 2000/2001. It demonstrated that a substantial programme of consultation events and publications was worked through during a period of nine months. There was ample opportunity created for any individual or organisation interested in commenting on the Health Board's proposals to participate in the consultation process over that period of time.

In response to a question from a Member, the Head of Board Administration confirmed that the Board's proposals on acute services had been available in three different ethnic languages as well as on audio tape.

Mr W Goudie asked that the Board agree, at a future date,

a process for future public involvement and consultation to ensure a consistent approach with all future consultation documents. This would be submitted to the Board in the context of the recommendations contained in the recently issued National guidance on Patient Focus and Public Involvement and the forthcoming guidelines on consultations..

The Chief Executive briefly outlined the form which would be adopted for the presentations, under the following six headings:

(i) Testing the Validity of the Preferred December 2000 Decision on the Disposition of Acute Services (Three Inpatient Sites and Two Stand-alone Ambulatory Care Hospitals)

(ii) The Provision of Accident and Emergency, Trauma and Emergency Receiving Arrangements

(iii) Bed Modelling and Distribution of Clinical Specialties

(iv) Assessing the Options Carried Forward from the December 2000 Health Board Strategy Against the Board's Adopted Clinical Strategy

(v) The Affordability of the Clinical Strategy and of Individual Options : And a Potential Implementation Plan

(vi) Transport Implications

Each was taken in turn.

The Chief Executive invited Dr B N Cowan, Medical Director, South Glasgow University Hospitals NHS Trust and Dr W G Anderson, Medical Director, North Glasgow University Hospitals NHS Trust to present on the aspect of the Board's clinical strategy for three sustainable inpatient units.

(i) Testing the Validity of the Preferred December 2000 Decision on the Disposition of Acute Services (Three Inpatient Sites and Two Stand-alone Ambulatory Care Hospitals)

Dr B N Cowan, Medical Director, South Glasgow University Hospital NHS Trust

Dr Cowan presented the need to support expertise through three adult inpatient sites. The relentless

move in health care world-wide was towards the creation of expert teams and the inescapable conclusion of this move was that better health care required more of these teams but that they would need to work on fewer sites. If Glasgow patients were to benefit from increasing expertise in acute care, hospitals needed to develop highly expert teams focussed on complex clinical problems.

If patients were to have access to such expertise at any time, the clinicians would have to work in teams which allowed them appropriate on-call arrangements. If these teams were to treat sufficient patients to allow them to develop and maintain clinical expertise, there would need to be a concentration on fewer sites. For most services, spreading patients across five units (as was the current situation in Glasgow) did not allow adequate concentration of clinical resource to permit the full benefits of specialisation to be delivered.

He emphasised, in particular, three major issues which impacted on the future ability of senior medical staff in hospitals to deliver current levels of services. These issues were:

- Changes to the Consultants' working contract.
- Changes to junior doctors' hours of working and the New Deal.
- The implications for senior hospital medical staff arising from the European Working Time Directive.

Dr Cowan stressed that the impact of these changes would mean it was highly unlikely that the current level of inpatient services could be delivered beyond the medium term on five major hospital sites.

Dr W G Anderson, Medical Director, North Glasgow University Hospitals NHS Trust

Dr Anderson commented that Glasgow's hospitals were designed and built before CT scanning, bone marrow transplants, joint replacements and

cardiac surgery; cancer care was part of general services and specialist oncology was unknown. The complexity of modern technology demanded highly specialised teams of professionals working together to deliver modern means of treatment. For many conditions it was no longer acceptable to be treated by a generalist. Clinicians agreed that specialisation, with the development of fully staffed and resourced teams on fewer sites, was the way forward for Glasgow. Decisions on the future disposition of hospital services were overdue. Concentration of services on the sites chosen was essential if patients with complex clinical problems were to receive the highest standards of care. The proposed changes offered significant opportunities to introduce new IT systems that deliver greater linkages between primary and acute services.

The Chief Executive thanked Dr Cowan and Dr Anderson for their presentations.

The Chief Executive welcomed Mr David Simpson, Consultant ENT Surgeon, Stobhill Hospital, to present on the extensive arrangements for care to be delivered from Ambulatory Care Hospitals.

Mr David Simpson, Consultant ENT Surgeon, Stobhill Hospital

Mr Simpson described the nature of an Ambulatory Care Hospital - locally delivered care with a one stop service with patients not requiring an overnight stay. He commented that a state of the art building would enable staff to respond to the demands of changing health care whilst retaining a patient focus. Activity within an Ambulatory Care Hospital would include the following:

- Consulting
- Investigation (such as, blood tests, X-ray, CT, MRI, ECG, Endoscopy)
- Diagnoses
- Treatment (such as minor procedures, day surgery and chemotherapy)

- Eliminating unnecessary visits and ensuring that

they were seen by the right person.

- Improved environment - one stop service.
- Reduced travel distances between services and improved communication.
- Many benefits to primary care services including direct access to test results through improved communication and fuller integration between general and specialist practice. Similarly, there were many benefits to staff with more training and development opportunities and improved inter-departmental interactions and working environments.

Mr Simpson highlighted all those involved in the success of an Ambulatory Care Hospital including nurses, ambulance services, medical staff, primary care, patients and their advocates, social work, ethnic minorities, disability rights organisations and voluntary organisations.

In response to a question from the Chairman of the Hospital Subcommittee, Mr Simpson confirmed that work was being carried out to address staffing issues to ensure cover for three adult acute inpatient hospitals and two stand-alone Ambulatory Care Hospitals across the city. It was paramount to organise clinical staff's working week by looking at job plans to address split site working.

Dr John Nugent (Chair, Local Health Care Co-operative Committee) saw the concept of Ambulatory Care Hospitals as an exciting overlap with current primary care services providing well thought out re-engineering of services that would be offered in a multi-disciplinary setting.

The Chief Executive thanked Mr Simpson for his presentation.

The Chief Executive invited Mr Peter Hamilton, Convener, Greater Glasgow Health Council to present on the perspective from the Health Council.

Mr Peter Hamilton, Convener, Greater Glasgow Health Council

Greater Glasgow Health Council had responded to the two consultation documents on the acute services review issued in September and December 2000. As a result of the Board's consultation papers and many meetings with various bodies including attendance by Health Council staff and Members at public meetings, Mr Hamilton highlighted the Health Council's key comments as follows:

- Supported the need for change.
- Recognised the need for rationalisation.
- Supported one acute hospital, south side, centrally located.
- Supported one trauma centre, south side, centrally located.
- Concerned about one trauma centre, north side.
- Supported development of ambulatory care with necessary protocols.
- Supported proposals for west of the city, particularly prioritising the Beatson programme.
- North and east of the city - more information was required on the distribution of specialist in patient services.
- Future of child and maternity health services - awaited option appraisal outcome.
- Concern over the uncertainty of bed numbers.

The Board's proposal to set up two reference groups to oversee the ongoing process and ensure

involvement and openness was welcomed. The setting up of steering groups to examine further and provide more detailed information on proposed bed numbers, A & E/Trauma proposals and child and maternal health services was also welcomed.

Mr Hamilton asked that if decisions were made and as a result of these decisions interim changes to services and their location were required, the Health Council would wish to be part of any consultation process that looked at the transitional arrangements to ensure adequate services were provided to patients at all times.

The Chief Executive thanked Mr Hamilton for his presentation.

The Chief Executive welcomed Mr Ken McIntosh, MSP, (Eastwood) to present views on the Board's proposals for Glasgow's acute services.

Mr Ken McIntosh MSP (Eastwood)

Mr McIntosh expressed his appreciation of the opportunity to present views direct to the Board on acute services for South Glasgow. He expressed his disappointment at the length of time it had taken the Board to come to conclusions on Glasgow's acute services.

He was critical on the consultation undertaken; the Board had issued information, had not listened to the views received and the proposals had not altered as a result of consultation. The Board's proposals seemed to be clinically led and not patient led.

He made reference to the South-East Health Forum and Friends of the Victoria who were united in their opposition that the Victoria Infirmary should have no inpatient services, particularly no Accident and Emergency Services. He was of the view that this was not in the best interest of Greater Glasgow strategically or of patients in the south-side, in particular.

He recognised the need for the centralisation of some specialties and was of the view that this should be undertaken on a case by case basis - concentrating resources in these instances. He

sought clarity about the cost implications of reducing from five acute inpatient sites to three and encouraged the Board to reject the proposals and take one month to reflect upon patient concerns and seek new information on design and cost of alternative proposals to those being considered.

Councillor McCafferty asked if one month was adequate time to work up alternative proposals for the South side.

The Chief Executive advised that justice could not be done in that time frame to work up proposals with external design teams, consider comparative costs and affordability and have this validated by external auditors. The current proposals had taken three and half months to get to the level of detail now in front of Board Members.

The Chief Executive, Greater Glasgow Primary Care NHS Trust highlighted that the Board had to determine expenditure across primary and secondary care services. The more money allocated to acute services the less was available to primary care, mental health services, addictions and other important services; neither could, therefore, be considered in isolation.

Dr Marshall expressed concern about the misleading term "closing the Victoria Infirmary" - over 85% of patients would still attend the Victoria Infirmary site albeit that services would be provided from a state of the art Ambulatory Care Hospital. This was not a cost-saving exercise but an attempt at balancing difficult decisions and choices between primary and secondary care services. She reflected back on comments made by Dr Brian Cowan during his presentation and reiterated that job plans and rotas would be in place to ensure that split-site working would not exist on a daily basis for staff.

The Director of Public Health defined the choices highlighted by Mr McIntosh as that of:

- One large hospital on the south-side (site yet to be decided) plus one Ambulatory Care Hospital;

or

- Two smaller hospitals on the south-side.

In relation to running two smaller hospitals, the Director of Public Health emphasised the difficulties in running two sets of rotas, two medical receiving units, two surgical receiving units and regardless of costs, providing trained and qualified staff.

The Chief Executive of South Glasgow University Hospitals NHS Trust recognised Mr McIntosh's points on location and access but advised that of the 350,000 patient contacts per annum currently at the Victoria Infirmary, 32,000 patient contacts would be affected - the vast majority of south-east residents would still present at the Victoria Infirmary site to a new purpose built Ambulatory Care Hospital. The choices were not, therefore, related to capital issues but in trying to provide the best quality care for Glasgow residents.

The Chief Executive thanked Mr McIntosh for his presentation.

The Chief Executive welcomed Mr J Smith, Consultant Surgeon, Dr F G Dunn, Consultant Physician and Mr A McMahan, Consultant Surgeon to present a perspective from the Medical Staff Association, Stobhill Hospital. Dr Dunn introduced his colleagues and explained that they would present from two perspectives; Mr McMahan would consider what was required to sustain high quality inpatient medical and surgical care during the interim years if the Board decided to concentrate inpatient services for North Glasgow at Glasgow Royal Infirmary and Gartnavel General Hospital. Mr Smith would outline a longer term role for Stobhill as a full general hospital including inpatient provision.

Mr J Smith, Dr F G Dunn and Mr A McMahan

Mr McMahan opened his presentation by referring to the pressures for a single inpatient site for North-east Glasgow. These were due to increasing specialisation, the reduction in junior doctors' hours and the implications of the European Working Time Directive for Senior Hospital Medical Staff. The main reason given for using the Glasgow Royal Infirmary site seemed to be the

investment already made at that facility.

Mr McMahon outline some concerns regarding the Glasgow Royal Infirmary site. These concerns included the limited land space leading to vertical design; restricted access; inadequate parking facilities; the size of what would be a 1,000 bed hospital and concerns regarding the number of emergencies which would be seen in a single north A & E Department. Clinicians at Stobhill would not wish to see inpatient services removed from their hospital site until accommodation fit for the purpose was provided for Stobhill's patients at Glasgow Royal Infirmary. The clinicians at Stobhill were also concerned regarding the future of the Accident and Emergency services in North-east Glasgow. Assurances had been sought from the North Glasgow University Hospitals NHS Trust that previously stated concerns regarding additional workload at Glasgow Royal Infirmary were being satisfactorily addressed by management with a view to finding agreed solutions with the Accident and Emergency staff and other clinicians involved. There was a lack of confidence that these assurances could be given.

Mr Smith described the possibility of continuing to use Stobhill General Hospital as an inpatient site beyond the medium term. There was a belief that the volume and complexity of Stobhill's activity had been seriously underestimated by colleagues within the Royal Infirmary. In respect to the proposed Ambulatory Care Hospital, clarity was required on both its funding and the catchment population. It was also recognised that there would have to be a significant increase in spending on information technology.

Mr Smith also referred to the need to maintain an inpatient service at Stobhill in the six to ten year interim period. It would be vitally important to avoid a sudden collapse of the Stobhill service and therefore, short and medium term investment would be required. A firm timescale of plans was also required.

Clinicians at Stobhill were also concerned to maintain acute medical, surgical and the other necessary clinical support services, and to avoid a split of emergency and elective surgery as had

been the case over recent years between the Western/Gartnavel General. There was also a need to build bridges in order to integrate Glasgow Royal Infirmary and Stobhill staff to their new working arrangements.

In conclusion, Dr Dunn pointed out that the Stobhill site had a number of clear advantages which he believed had not been seriously considered by the Board. These included the enormous size of the site and its potential for expansion; its easy access and large car parks; a local population who wished to maintain their local hospital and had confidence in it; and local General Practitioners who wished to continue their association with the hospital.

The Chief Executive confirmed that the capital spend associated with the Ambulatory Care Hospital at Stobhill was £60M. He also proposed that a Joint Planning Group would be set up with the North Acute Trust and Consultants at Stobhill to agree how core medical and surgical services would be sustained at Stobhill if it was agreed to centralise inpatient services at the Royal Infirmary and Gartnavel General. The Director of Public Health would be a Member of that Group.

The Chief Executive thanked Mr Smith, Dr Dunn and Mr McMahon for their presentations.

The Chief Executive welcomed Mrs M Hinds, Professor D McGregor and Mr E Canning from the South-East Health Forum to present on the Forum's proposals in respect of South Glasgow.

Mrs M Hinds, Professor D McGregor and Mr E Canning

Mrs Hinds began by stating that the NHS Board planned to build three very large hospitals in the city, including the largest hospital in Britain on the Southern General Hospital site or, less probably, the Cowglen site. If fulfilled, those plans would saddle the south-side with a costly, inefficient hospital against the wishes of the electorate of South-east Glasgow. Informed expert opinion was moving away from the grandiose concept of very large hospitals in favour of dispersed "virtual" hospitals with close organisational links.

Plans for a very large south-side hospital should be replaced by planning for two south-side hospitals of moderate size to serve South-east and South-west Glasgow, linked by a common management and staff combining the benefits of scale with accessibility to their catchment areas. The last five years had been a time of increasing uncertainty, confusion and demoralisation for staff working in Glasgow's hospital services. Reversing this process with a more rational approach to forward planning and the provision of sufficient capital to replace the city's run down infrastructure was the most important task facing the Scottish NHS Executive and the NHS Board's new Chief Executive.

She referred to a technical group report on alternative proposals for a new build Glasgow South Hospital which had concluded that the Board's proposals stemmed from developments and conceptions in the 1980s and 1990s. The needs of the community must form the basis of the hospital design and service brief as an urban hospital must be accessible to the population it served and must be an integral part of that community. Both the Southern General and the Victoria Infirmary were recognised by their respective communities and the concept of a "super hospital", whether at Cowglen or not seemed to be a fundamentally flawed concept. The Forum proposed two hospitals for the South-side with some inpatient specialties based at the new Victoria and different specialties based at the Southern General.

Professor McGregor focussed his presentation on the key issue of transport and access to hospital services in the south-side. He considered that one of the key principles was to move the minimum number of patients the minimum distance without the inconvenience of various modes of transport (bus/train/taxi). He commented that, despite the Board's intention to create the largest hospitals in Britain, the enthusiasm of NHS managers and the medical profession for building very large NHS hospitals serving catchment populations of 300,000 to 500,000 was waning. The realisation that organisational networks which integrated clinical services across a range of hospitals could combine a wide range of specialist expertise with

local accessibility was driving this re-appraisal.

Mr Canning commented that the Board's primary reason for closing Stobhill Hospital and the Victoria Infirmary was that changes in doctors' hours dictated by the European Union Working Time Directive made it difficult to staff surgical and anaesthetic teams to cover five hospitals. Staffing issues may lead to the closure of two viable hospitals. In the case of the Victoria Infirmary, removal of orthopaedic and surgical services on staffing grounds may lead to the transfer of a much larger number of medical and geriatric assessment admissions which accounted for 63% of all admissions to the hospital in 2000/2001.

The Chief Executive of South Glasgow University Hospitals NHS Trust confirmed that the Southern General Hospital currently had 1,000 operational beds (including mental health). He highlighted a range of new build hospitals constructed or being planned in England which had capital costs estimated in a range between £210M and £620M.

Professor Dickson sought two points of clarity from the South-East Forum presenters and in response, Mrs Hinds confirmed that it was the Forum's view to have two hospitals in the south-side (Southern General Hospital site and the Queen's Park Recreation site, adjacent to the Victoria Infirmary) with an A & E service at both. Specialities should be assigned to one of the two sites - a stand-alone Ambulatory Care Hospital was not acceptable neither was the concept of split-site working. Accordingly, as not all clinical specialties would be on both south-side hospitals, some patients would have to make the journey to wherever the specialty was being provided.

In response to a question from a Member, Mrs Hinds confirmed that over 57,000 people had accepted the South-East Forum's campaign with over 200,000 people supporting their views.

The Chief Executive thanked Mrs Hinds, Professor McGregor and Mr Canning for their presentations.

The Chief Executive welcomed Dr K Harden, General Practitioner and Mr J Crossan, Consultant

Orthopaedic Surgeon, West Glasgow to present on the case for retaining A & E and Orthopaedic services in West Glasgow (therefore, three fully resourced A & E/Trauma Units).

(ii) The Provision of Accident and Emergency Trauma and Emergency Receiving Arrangements

Dr K Harden and Mr J Crossan

Dr Harden began by confirming that there was general agreement that the continuation of five inpatient sites was not sustainable in the long run but it was not without significance that the present medical establishment was indeed managing to provide a service on five sites. There was overwhelming evidence and unanimous agreement by the Area Medical Committee that the Board should be moving as soon as practicable to three major inpatient hospitals, namely the Royal Infirmary, Gartnavel General and a South-side hospital.

If the proposals to have only two A & E Departments and two Orthopaedic Departments were to be implemented, there would be a complete range of receiving and A & E Consultant services at the Royal Infirmary and the South-side hospital. There would, however, be a deficit of both Orthopaedics and also A & E Consultants at the West. Although it was possible to have acute medical receiving without an A & E Department, the majority view would be that this was less than optimal. It would certainly lead to an inequity where two of the major receiving hospitals had a full service and one had a less than optimal service.

A system with only two A & E Departments would involve very major increases in these two departments. This major increase must carry with it significant hazards to patient care and one third of the city in the North-west and one major hospital would be deprived of both an Accident and Emergency and an Orthopaedic service. This could not be regarded as being equitable. On the other hand, a move to three major inpatient sites providing the totality of secondary care in each, including three A & E Departments and three

Orthopaedic Departments, would have the potential for a high quality, safe, viable and equitable system.

Mr Crossan commented on the universal acceptance that split-site working was costly, inefficient of manpower and resulted in poorer delivery of care to patients. High standards of trauma care were delivered to patients by Orthopaedic Surgeons who undertook trauma and elective Orthopaedics and trauma centres gave an added dimension to that care. A trauma centre was staffed by Orthopaedic Surgeons who had given up their elective practice and who became Trauma Surgeons. They were backed up by a multi-disciplinary team of Chest and Heart Surgeons, Vascular Surgeons, Neuro Surgeons, Intensive Care Specialists and Interventional Radiologists. Glasgow was unable to establish such a centre because no Orthopaedic Surgeon was prepared to give up elective surgery and the North Glasgow Trust was unable to deliver all of the back up services on one site. Transfer of the West Glasgow Orthopaedic Unit to the Glasgow Royal Infirmary would simply deliver two large Orthopaedic Units onto one site. This transfer would not create a Trauma Centre. He highlighted also some of the key clinical linkages between Orthopaedic Surgery and other specialties within West Glasgow, and most notably Clinical Oncology.

In response to a question from Councillor McCafferty, both Dr Harden and Mr Crossan confirmed that even if economic factors were taken out of the equation, they would both opt for three A & E and Orthopaedic sites across the city to provide a safe quality service to patients.

The Chief Executive thanked Dr Harden and Mr Crossan for their presentations.

The Chief Executive welcomed Dr T J Parke, Clinical Director, A & E Services South Glasgow University Hospitals NHS Trust, Dr W Tullet, Clinical Director, A & E Services, North Glasgow University Hospitals NHS Trust, Mr S McCreath, Clinical Director, Orthopaedic Services, South Glasgow University Hospitals NHS Trust and Mr I Stother, Clinical Director, Orthopaedic Services, North Glasgow University Hospitals NHS Trust to

present on the benefits of two fully resourced A & E/Trauma Units, with emergency receiving undertaken in West Glasgow.

Dr T J Parke, Dr W Tullet, Mr S McCreath and Mr Stother

Dr Parke began by confirming that it was his view that one South-side A & E Department would provide South-side patients with efficiency and quality of care. He stated that this could be best achieved by merging the services currently provided at the Victoria and Southern General Hospitals.

He summarised his views on future service provision in the South-side as being the following:

- One Accident and Emergency and Trauma Centre.
- Two minor injuries units - provided on the main South-site hospital and the Victoria Infirmary Hospital site.

Dr Tullet commented that having just two Accident and Emergency Units in Glasgow would increase average ambulance service times to and from the two A & E Units. The crucial measure of effective health care response, however, was the time taken for the ambulance to reach the patient in the first place (the response time) not the subsequent running time in the ambulance. In order to ensure that response times were not compromised, it would be necessary to invest in additional emergency ambulances. This was achievable within the timescale in which the changes were envisaged to be made (ie the middle of the decade) and would be based on detailed modelling to be undertaken with the Ambulance Service during the next stages of planning.

It was his belief that, in the long run, there should be a move to one Accident and Emergency Department in the North of the city. Emergency receiving would be provided at Gartnavel General and this could be supplemented with the presence of an A & E Consultant on an extended hours basis in order to give a resuscitation capability there.

The A & E Planning Group's work on delivering detailed proposals on each element of the service model, including implementations, was still ongoing. There was some concern about the impact of moving to two A & E Departments on the workload in the Royal Infirmary. The A & E Planning Group had requested further time to consider the full implications of the strategy.

Mr McCreath commented that Glasgow could be the premier Orthopaedic Unit in Scotland if skills and resources were concentrated in the most cost effective way. He highlighted current challenges and the fact that five units wastefully duplicated services, resulting in unachievable activity targets and staff morale being at rock bottom.

In providing an Orthopaedic Centre of Excellence within Greater Glasgow, the way forward was to have two acute inpatient units with outpatient clinics and day surgery available locally. This would attract quality personnel in all disciplines and build the capacity needed to deal with future challenges. This would meet the main aims of accessibility, affordability, quality of care and, in particular, the need to enhance research and training.

Mr Stother drew comparisons between the scale and workloads of the two proposed Orthopaedic Units and other comparable, major orthopaedic centres within Scotland and the UK.

In the ensuing discussion, Mr Murray sought clarification of the new proposal to have an A & E Consultant presence at the Emergency Receiving Unit at Gartnavel General. This was an issue raised at the A & E Planning Group and would be worked through further before a definitive model of service was proposed.

The Vice Chair of the Area Medical Committee referred to the Committee's submission to the Board in December 2000 when it considered that Consultant led Accident and Emergency Services should be developed on two sites, these being the Southern General Hospital and Glasgow Royal Infirmary with acute medical and surgical receiving continuing at Gartnavel General Hospital.

It was, nevertheless, in the best interest of patients that no service be transferred until new facilities were fully in place; these new facilities must be at least as good as those which existed at present. Additionally, where changes were proposed in services it was paramount that all involve clinicians should participate in the planning from the earliest stages.

In response to a question from Councillor McCafferty, in turn Dr Parke and Dr Tullet confirmed that even if economic factors were taken out of the equation they would opt for two A & E and Orthopaedic sites across the city to provide a safe quality service to patients. Mr McCreath confirmed this view for Orthopaedics.

The Chairman commented that it was important to receive the completed work of the A & E Planning Group before concluding a view on the future shape of a & E and Orthopaedic Services.

(iii) Bed Modelling and Distribution of Clinical Specialties (Appendix 9)

The Chief Executive explained that bed modelling calculations for Glasgow's future inpatient requirement should be regarded as work in progress. The model had been 'frozen' in order to provide a 'snapshot' estimate of the bed capacity on which the costs of the various options still under consideration could be based. The number of beds would be an important part of the capital planning and procurement period.

The report on bed modelling and capacity was noted, and recognition given to the fact that bed modelling and planning capacity will continue as a dynamic part of the development of the detailed business case for the provision of new hospital facilities. The Board would receive an annual report on bed modelling, and the Bed Modelling Group would discharge an overall governance role in this matter.

(iv) Assessing the Options Carried Forward From the December 2000 Health Board Strategy Against the Board's Adopted Clinical Strategy

The Board considered which of the options which

were carried forward from the December 2000 Board meeting were compatible with the Clinical Strategy.

There were four options for North-East Glasgow; three of which involved maintaining inpatient services at both Glasgow Royal Infirmary and Stobhill Hospital; in accordance with the clinical strategy only one option remained, namely

Option 1 "In North Glasgow the Clinical Strategy determined that Glasgow Royal Infirmary be the in-patient hospital, with ambulatory care facilities and Minor Injuries Unit at Stobhill Hospital. The Western Infirmary would close (as agreed by the then Secretary of State in 1996) and Gartnavel General Hospital would become the in-patient site with both core and specialist services and would include a Minor Injuries Unit, with the outcome of the A & E Steering Group recommendations determining the nature and pattern of Emergency Receiving services."

This option would be carried forward for further consideration under the affordability considerations of the Strategy."

In South Glasgow, the Southern General Hospital and 'Cowglen' options were consistent with the Clinical Strategy and would be carried forward for consideration under the affordability work.

(v) The Affordability of the Clinical Strategy and of Individual Options : and a Potential Implementation Plan (Appendix 10)

The Chief Executive acknowledged that there were two critical factors in coming to decisions about the pattern of acute hospital services in the future. The first involved the overall affordability of the Acute Services Strategy, viewed in the wider context of the Board's responsibilities across all programmes of care. The second related to the respective costs of the options for redeveloping the Cowglen and Southern General sites.

In terms of overall affordability, the Chief Executive pointed out that a number stakeholder interests had made the point to him that they would be opposed to any decision which would

increase the proportion of the NHS Board's spend on acute services to the detriment of the other major care programmes. The Director of Finance's assessment was based therefore on maintaining the current programme 'shares' determined by Greater Glasgow Health Board.

The Director of Finance commented that, in practice, interpreting affordability required a judgement to be made about the reasonableness of the underpinning assumptions made about that same future time period. Reality was having to make an assessment of the balance of risks associated with the likelihood of any changes to those assumptions and the subsequent impact on the overall project. She set out in summary the relevant calculations of income and expenditure. She clarified the estimated available income, running costs and affordability and confirmed that with the implementation phased as proposed, there was an affordable combination of North and South options. The year on year analysis suggested that some prior planning would be required to cash manage the deficit in year five, that was, 2006/2007. As the overall total could be funded from within the acute programme share by 2013/2014, however, it should be possible to adjust other budgets in the intervening years to accommodate the phasing requirements.

The Chief Executive of North Glasgow University Hospitals NHS Trust described the capital cost implications of the proposals facing the North Glasgow Trust.

The Chief Executive of South Glasgow University Hospitals NHS Trust explained the financial background to both the Cowglen and Southern General Hospital proposed development sites. The capital costs of building a new hospital at Cowglen exceeded those of redeveloping the Southern General Hospital by £130M.

Following brief discussion of the presentations, the Chairman proposed that the affordability framework and working assumptions should be further discussed with Members and submitted to a future Board meeting for consideration.

(vi) Transport Implications (Appendix 11)

The Chief Executive suggested that this be discussed further in detail at a future Board meeting. The transport implications will be better understood when the final shape of the Clinical Strategy had been determined..

(vii) Deliberations

The Chairman thanked all who had lead the presentations, the MSPs and members of the public who had listened intently to the lengthy debate and to all those who had participated in the discussions. It had been useful for the Board to hear direct from those with differing opinions on the future shape of acute services for Greater Glasgow.

The Chairman read out extracts from a letter dated 28 January 2002 from Mr P Martin MSP.

"... We welcome the additional funding of £60M being made available in respect of the ACAD; however we require further clarification on exactly what services will be provided within this facility".

"I would reiterate my call for Board Members to consider our proposal to carry out an independent review after the five year period expires to determine whether Glasgow Royal Infirmary is in a position to deal with an increase in acute services that are presently provided at Stobhill".

The Board deliberated on the documentation and presentations delivered. The Director of Public Health confirmed that in supporting the two main priorities, clinical safety and clinical quality, it was not possible to staff five acute inpatient sites. The arguments had been very clear in that there was a great deal of support for reducing inpatient sites to three. He commended the concept of Ambulatory Care hospitals and highlighted, in particular, the difference this would make to such a high number of patients as they could potentially be seen and diagnosed within seven days.

In relation to the position of Accident and

Emergency Services, Councillor McCafferty was of the view that in having three adult inpatient acute hospitals, there should follow three Accident and Emergency Services. This was also the view of Greater Glasgow Health Council.

Councillor McCafferty was concerned at the possible loss of Accident and Emergency from the west of the city and the impact that could have for the residents of Clydebank. This concern had been further highlighted by the storm the previous day and the impact it had had on transport for the city and difficulty in crossing the River Clyde and also the increased number of hazardous incidents, which only through good fortune had not resulted in anyone from the Clydebank area requiring to go to hospital. He commented that this was not the time to make decisions on Accident and Emergency services.

The Chairman read out a letter from the Chairman, Medical Staff Association, Victoria Infirmary stating the opinions of the senior medical staff that:

- (i) that status quo could not continue in the long term;
- (ii) a new build hospital on a greenfield site (the Cowglen option) was the opinion strongly supported by the overwhelming majority.

After detailed discussion on each of the specific decisions the Board had been asked to consider it was -

DECIDED:

1. A clinical Strategy based on retaining adult acute services on five sites with three adult inpatient hospitals (at Glasgow Royal Infirmary, Gartnavel General Hospital and South Glasgow, either at Southern General or Cowglen site), supported by two ambulatory care hospitals (located at Stobhill Hospital and the Victoria Infirmary) be approved.

Chief Executive

2. Approved the setting up of a Joint Planning Team with the North Glasgow Trust and the Consultants at Stobhill to agree how core medical and surgical services can be sustained at Stobhill during the period prior to centralisation at

Chief Executive

Glasgow Royal Infirmary and Gartnavel General Hospital. The Director of Public Health will be a member of that group.

3. Maintained the working hypothesis that the provision of Accident and Emergency (A & E) and Trauma Care from two fully resourced A & E centres located in the north-east and south Glasgow, working with an Emergency Receiving Unit in west Glasgow is the appropriate basis for the future delivery of A & E care, subject to further work to be completed under the auspices of the A & E Steering Group which will be reported back to the NHS Board for consideration.

**Director
of Public
Health**

4. That the status report on the bed modelling be noted and that the model be 'frozen' to allow the detailed costing of options to be completed.

The Bed Modelling Steering Group continue to develop an agreed planning framework for forecasting future bed numbers as part of the Business Cases for the provision of new Hospital facilities and report back to the Board on an annual basis on its work.

**Chief
Executive**

The outcome of the next meeting of the Bed Modelling Steering Group be reported back to the Board for consideration.

**Chief
Executive**

5. That a detailed paper be brought back to the Board in March 2002 setting out proposals for the proposed distribution of clinical specialities for North/East Glasgow and this be the subject of public consultation.

**Chief
Executive/**

**Chief
Executive,
North
Acute
Trust**

That Board officers describe the public consultation proposals for this issue in light of the recent national guidance on Public Involvement for discussion and approval of the Board.

**Chief
Executive**

6. In North Glasgow the Clinical Strategy determined that Glasgow Royal Infirmary be the in-patient hospital, with ambulatory care facilities and Minor Injuries Unit at Stobhill Hospital. The Western Infirmary would close (as agreed by the then Secretary of State in 1996) and Gartnavel General Hospital would become the in-patient site

with both core and specialist services and would include a Minor Injuries Unit, with the outcome of the A & E Steering Group recommendations determining the nature and pattern of Emergency Receiving services. This option would be carried forward for further consideration under the affordability considerations of the Strategy.

**Chief
Executive**

7. A single inpatient site for acute services met the Clinical Strategy and that both the Southern General Hospital and the "Cowglen" options were compatible with that Strategy and would be carried forward for consideration under the affordability work to be completed and reported back to the Board.

**Chief
Executive**

8. That the options highlighted in Decisions 6 and 7 be carried forward to be considered in the more detailed option appraisal, as part of the Outline Business case.

**Chief
Executive**

9. A full report be further submitted to the Board on the affordability framework and working assumptions for the Acute Services Strategy for members consideration and approval. There was support within the financial parameters outlined in the Director of Finance's paper (Annex A - table 1), that the first three major Capital Schemes taken forward to implement the Strategy should comprise the Ambulatory Care Hospitals at Stobhill Hospital and the Victoria Infirmary (at a capital cost of £60M each) and Phase II development of the Beatson Oncology Centre to be funded from public capital.

**Chief
Executive**

10. That the outcome of the Board's deliberations (and previous papers) be submitted to the Scottish Executive Health Department for approval to the overall direction of the Acute Services strategy.

**Chief
Executive**

Appendix 2.02 Minutes of Greater Glasgow NHS Board Meeting held on 18 March 2002 - extract

ACUTE SERVICES STRATEGY AFFORDABILITY ISSUES - INCLUDING LOCATION OF SINGLE INPATIENT HOSPITAL IN SOUTH GLASGOW

A report of the Chief Executive of Greater Glasgow NHS Board, Chief Executive of South Glasgow University Hospitals NHS Trust and the Director of Finance, Greater Glasgow NHS Board [Board Paper No 02/18] was submitted asking the Board to approve the outline assessment of affordability summarised in Annex C, Table 3 (page 93 of the Board papers). This would be the basis of the submission to the Scottish Executive Health Department and the Board was asked to approve options North 1 and South 1 as the only combination of options which was affordable at the point of full implementation. Additionally, the Board was asked to authorise the Chief Executive to submit the overall assessment of affordability and the Board's decision on the location of the Southside inpatient hospital to the Scottish Executive Health Department.

The Chairman referred to over three hundred and ten letters received from members of the public following a meeting organised by the South-east Forum. Each letter was being answered by the Board addressing the issues raised but in particular clarifying that it was not the case that no acute services would be provided from the Victoria Infirmary site - in fact, a new Ambulatory Care Hospital would be built on that site.

The Chairman tabled a letter dated 18 March 2002 signed by six MSPs (Bill Aitken, Robert Brown, Kenneth Gibson, Janis Hughes, Kenneth Macintosh and Mike Watson). The MSPs were writing to express their concern at the likelihood of NHS Greater Glasgow deciding at the Board meeting to locate all acute hospital services on the South of the city at the Southern General. The Chairman read out extracts of the letter and highlighted the MSPs' main points. They felt that such a decision may be a grave mistake and would not be in the best interests of patients living on the South-side and it would be regretted for years to come. The MSPs were alarmed that, despite clear evidence that a purpose built hospital on a centrally located green field site would attract the support of clinicians and patients alike as being the best choice in the circumstances, the Board was going to opt for the Southern General on grounds of cost. Cost must always be a factor in decisions affecting the Health Service and there was a onus on the Board to make the use of the resources available. However, it should only be one factor and should never be the most important.

Councillor Collins asked if an analysis had been carried out on the three hundred and ten letters received from members of the public in terms of issues raised and on geographic location. The Head of Board Administration confirmed that no

new points of concern had been raised in these letters that had not been raised in previous consultations and correspondence and that a demographic analysis had not been undertaken but could be if required.

Mr Divers reminded the Board that, at its meeting held on 29 January 2002, it decided to adopt a clinical strategy which would see acute services delivered from five hospital sites; inpatient services would be delivered from three sites, with ambulatory care hospitals developed close to the Victoria Infirmary and on the Stobhill Hospital site in new £60M capital developments.

In North Glasgow, inpatient services would be provided from the redeveloped Glasgow Royal Infirmary and Gartnavel General Hospital sites; this option alone met the criteria by which the clinical strategy was set. In South Glasgow, two options - a single inpatient unit located in a completely new build hospital at Cowglen and a substantially rebuilt Southern General Hospital with over 800 new beds - were compatible with the clinical strategy. The NHS Board carried forward a decision about the overall affordability of the strategy and the location of the South-side inpatient centre; the Board Chief Executive and the Chief Executive of South Glasgow University Hospitals NHS Trust were asked to reconvene the South-side Reference Group and to work through with that Group the details of the two South-side inpatient options.

A detailed overview of the assessment of affordability was presented by the Director of Finance at the Board meeting on 29 January 2002. Mr Divers summarised the estimated revenue costs of the strategic options. North 1 (inpatients at Glasgow Royal Infirmary and Gartnavel General Hospital; ambulatory care hospital at Stobhill) and South 1 (inpatients at Southern General Hospital; ambulatory care hospital adjacent to the Victoria Infirmary) would cost £68M additionally per annum at the point of full implementation. The combination of options North 1 and South 2 (inpatients at Cowglen and ambulatory care hospital adjacent to the Victoria Infirmary) would total £78.2M additionally - £10.1M per annum higher.

Mr Calderwood introduced Mr McIntyre, Divisional General Manager, Support Service, South Glasgow University Hospitals NHS Trust, Mr Carrie, Director, Keppie Design, Mr Hackett, Senior Cost Accountant, Currie & Brown, Chartered Quantity Surveyors and Mr Stanger, James Barr & Son.

The design team outlined their design brief:

- On the basis of the Trust brief to develop two inpatient options at Cowglen and Southern General Hospital that were compatible in terms of clinical content.
- To develop for each site the design, costs and property issues.

Mr McIntyre described the square metres required of both sites in relation to the number of beds. The Cowglen site would require 105,000m² to provide 1,171

beds and the Southern General would require 71,000m² to provide 809 beds. He compared this to the Edinburgh Royal Infirmary site which provided 120,000m² and Norfolk and Norwich Hospital at 96,000m². The team had provided designs and layout in accordance with current themes and ideals for specialist centres for care and had used departmental cost allowances as the basis of building the costs of the respective options.

Both sites were described in terms of scale, landscape, goods and supplies, psychiatric village, main entrance and car parking. The Cowglen site had marginally worse site conditions around flooding issues from the River Cart. Both sites had public transport issues to overcome.

The design team went on to highlight the pros and cons of each site as follows:

Southern General

Cowglen Site

Pros

Pros

- Town Planning designation
- Phased implementation
- Phased construction possible
- Existing refurbished estate
- Less commissioning/decanting

- 100% new build
- Optimised departmental adjacencies
- Distribution economies
- Landscape setting

Cons

Cons

- Adjacent industrial areas
- Site dictates phased development

- Site purchase
- Green belt planning issues
- Marginally poorer site conditions

On ownership of land, the Southern General Hospital site was owned by the

NHS. The Cowglen site involved four key players namely, Cowglen Hospital, Retail Property Holdings, National Savings and Pollock and Corrou. Accordingly, the cost of acquisition for the Southern General was nil and the cost of acquisition for Cowglen were estimated as follows:

- National Savings - 6.5 acres - circa £3.25M
- Retail Property Holdings - 14.83 acres - circa £7.5M
- Pollock and Corrou - 36.5 acres - circa £3.65M

In terms of land use and planning, both sites had strengths and constraints. These were highlighted as follows:

Southern General

Cowglen Site

Strengths

Strengths

- | | |
|---|--|
| <ul style="list-style-type: none"> • Established inner urban site • Continuation of existing hospital use supported • Major infrastructure in place • Accessibility and choice of transport | <ul style="list-style-type: none"> • Continuation of hospital use supported • Adjacent development/ commercial sites • Accessible location : M77 and Kennishead Station • Mature landscape enclosure |
|---|--|

Constraints

Constraints

- | | |
|---|---|
| <ul style="list-style-type: none"> • Surrounding industrial areas • 'B' Listed buildings • Tree Preservation Order | <ul style="list-style-type: none"> • Local development pressure - Pollock Town Centre Regeneration • Green belt restrictions to site expansion • Pollock Park conservation area and designed landscape • Ground instability |
|---|---|

- Land ownership constraints

Costs for both sites were summarised as follows:

<u>Costs (£M)</u>	<u>Cowglen Site</u>	<u>Southern General</u>
Construction	238	151
Professional Fees	30	19
Equipment Costs	37	23
Planning Contingency	14	8
VAT	50	32
Total	369	233

Mr Calderwood explained that the bed numbers used were those "frozen" by the Board to allow costing and comparison of the options. He explained the difference in the Cowglen and Southern General new build bed numbers (Cowglen - 1171, Southern General Hospital - 809). Irrespective of the decision about the location of the inpatient facilities, 204 beds would be retained at the Langlands Unit (the recently built PPP project for elderly care patients) within the Southern General Hospital site. Mr Calderwood advised that both sites could be developed within the same timeframe.

In response to a question from Councillor Collins, Mr Calderwood advised that West of Scotland Water had indicated that they may be reviewing Glasgow's sewage works provision including the service provided from the Shieldhall Sewage Works. The proposed building works at the Southern General did not impinge upon neighbouring lands.

In response to a question from Mrs Kuenssberg, Mr Calderwood advised that the additional time taken to acquire the land at the Cowglen site was likely to be offset by the phased building stages at the Southern General Hospital site and there would be little difference in the date of occupation.

Professor Farthing asked about the probability of obtaining all the land necessary at the Cowglen site. It was recognised that there could be real difficulties in trying to acquire all the land necessary from three different owners. Mr Calderwood confirmed that the Trust had taken advice from the Scottish Health Service Central Legal Office regarding ownership issues. A Compulsory Purchase Order was unlikely to be granted for land at the Cowglen site unless the Board could demonstrate that it did not already own land in Glasgow for these purposes. Land acquisition would not be a short process, particularly allowing for appeal stages.

Mr Davison referred to the strategic choice to be made and that the NHS Board had a responsibility, given that the Cowglen site would cost £10M recurring every year, to consider the impact of this "opportunity" cost on other services

particularly when there was the credible option of the Southern General Hospital site. He pointed out that £10M translated into the salaries of 350 - 400 direct care staff.

The Convener of Greater Glasgow Health Council referred to the additional information made available following the Design Team's presentation and asked for an opportunity to share this with other Health Council Members before a final decision was taken. The Chairman was of the view that it was paramount not to defer this decision any longer.

Mrs Smith commended the staff at both the Victoria Infirmary and Southern General Hospital for their commitment and patience throughout the consultation period. She recognised the frustration and uncertainty that had been incumbent upon staff since 1998 and conveyed her appreciation for their patience.

Mr Divers summarised the overall affordability as presented to the NHS Board which showed that, at best, the more cost competitive combination of North/South options could only be affordable by year 12; and that, in broad terms, the additional cost of the Cowglen option could not be met within the overall financial "envelope" at that point; and that the Cowglen option would bring an additional cost premium of about £10M per annum at the point of implementation. Two further points were worth recording:

1. Any decision to commit the additional revenue associated with the Cowglen investment would inevitably involve committing £10M of recurring investment in servicing capital investment and not in improving direct patient care.
2. The financial calculations thus far about "affordability" had been based solely - but appropriately at this stage - on Treasury funding of the major capital investment required to modernise the acute services facilities across Greater Glasgow. The inevitable use of PPP recruitment would produce a further challenge to the overview of affordability presented to the NHS Board.

DECIDED:

- That the outline assessment of affordability summarised in Annex C, Table 3 (page 93 of the Board papers) as a basis of the submission to the Scottish Executive Health Department be approved. **Chief Executive**
- That Options North 1 and South 1 as the only combination of options which was affordable at the point of full implementation be approved. **Chief Executive**
- That the Chief Executive be authorised to submit the overall assessment of affordability and the Board's decision on the location of the South-side inpatient hospital to the Scottish Executive Health Department. **Chief Executive**

Appendix 2.03 Health Minister's Letter

11/02 2005 16:26 FAX 0141 201 2999

MANAGEMENT RECEPTION

002



SCOTTISH EXECUTIVE

Minister for Health & Community Care
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10 August 2002

Yes Gordon

GREATER GLASGOW ACUTE SERVICES STRATEGY APPROVAL

After careful consideration and close scrutiny of all the information I have before me, and after consulting my Ministerial colleagues, I hereby give approval to the proposals flowing from NHS Greater Glasgow's Acute Services Strategy as follows:

That a Clinical Strategy based on three adult in-patient sites, supported by two ambulatory care and diagnostic units (ACADs) on the Stobhill site and on a site adjacent to the Victoria Infirmary site is the appropriate pattern for future years.

In North Glasgow acute in-patient services will be provided from the re-developed Glasgow Royal Infirmary and Gartnavel General Hospital.

In South Glasgow acute in-patient services will be provided from a major new development at the Southern General hospital.

That full A&E services will be provided from two sites located at Glasgow Royal Infirmary (GRI) and the Southern General hospital (SGH) and that;

- acute receiving services will be provided from three inpatient sites GRI, Gartnavel and SGH.
- trauma and orthopaedic in-patient services will be provided from the two full A&E sites. Orthopaedic out-patient and day case services to be provided from all five adult sites;
- minor Injury Units will be provided from all five adult sites (Gartnavel, Stobhill, GRI, Victoria and SGH); and
- paediatric A&E and emergency services will be provided from the Royal Hospital for Sick Children at Yorkhill.

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I welcome Greater Glasgow NHS Board's proposal that Audit Scotland undertake a 'governance' role in respect of the implementation of the acute services plan and understand that a remit is currently being finalised between the two organisations. I would ask that the NHS Board shares that remit with my Department as soon as it has been agreed.

I now look to NHS Greater Glasgow to turn these far-reaching proposals into reality for the benefit of all the people of Glasgow and beyond, and would ask that it closely liaises with my Department in setting and achieving milestones in implementing its plans without further delay.

A Press Announcement advising of my decision and the reasoning behind it will issue from my Department's Press Office on Monday 12 August.

*Yours sincerely
Malcolm Chisholm*

MALCOLM CHISHOLM

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Appendix 3.01 Minute of Greater Glasgow NHS Board Meeting 18 March 2003 – extract

EMBARGOED UNTIL MEETING
BOARD 18 MARCH 2003

34. IMPLEMENTING THE ACUTE SERVICES STRATEGY – PROCUREMENT PROCESS FOR THE AMBULATORY CARE HOSPITALS AT STOBHILL AND THE VICTORIA

A report of the Chief Executive [Board Paper No 03/17] asked the Board to approve:

- that, in terms of the Public Procurement Regulations, the procurement of the Ambulatory Care Hospitals at Stobhill and the Victoria Infirmary should proceed as a Services Contract and that the Services Regulations should apply to the procurement of the project;
- that, in terms of the Services Regulations, the negotiated procedure should be the choice of tendering procedure adopted.

Sir John welcomed Ms Sharon Fitzgerald, Legal Adviser from Bevin Ashford and Shepherd Wedderburn who had been appointed to assist the Board with the procurement process. **ACTION BY**

Ms Fitzgerald advised that in considering which set of Public Procurement Regulations should apply to the Project, it was recognised that the Project would constitute a “mixed” contract involving a combination of both works and services. In determining whether to apply the Public Works Contracts Regulations 1991 (as amended) or the Public Services Contracts Regulations 1993 (as amended) (the “Services Regulations”), the Board had to apply the “main object/primary purpose” test and the “relative value” test to determine the correct Regulations for the Project.

In applying the main object/primary purpose test, the Board acknowledged that it would identify the scope of the Project in terms of the service outputs required rather than focusing on the form of delivery of the Project. Given that the Board was looking for the delivery of a “serviced” accommodation over a 30 year contract period, the Board had concluded that the main object of the Project was the delivery of a service rather than the provision of works.

The test of “relative value” involved a comparison of the works/construction costs of the Project with the cost of the services elements. As part of the preparation of the Outline Business Case for the project, these costs were assessed over a contract term of thirty years. The assessment showed that the services element outweighed the works element over the thirty year life assumed for the Project.

On the basis of the outcome of the “main object/primary purpose” test and the “relative value” test, the Board had concluded that the Project was a services contract and that the Services Regulations should apply to the procurement of the Project.

The Board’s Executive Directors involved in taking this project forward concluded that it would not be appropriate to select the open or restricted tendering procedure for use on this Project. It was proposed that the Board should choose the negotiated procedure for the following reasons:

EMBARGOED UNTIL MEETING
BOARD 18 MARCH 2003

- The nature of the services or the associated risks did not permit prior overall pricing.

- The nature of the services was such that specifications could not be drawn up with sufficient precision to permit the award of the contract using the open and restricted procedures.

The decision to follow the negotiated procedure under the Services Regulations followed the advice of the Board's Legal Advisers and was in line with Treasury Guidance.

The Board's Legal Advisers had prepared the Official Journal of the European Community (OJEC) Notice for the Project on the basis that the Service Regulations applied and on the basis that the negotiated procedure would be utilised. The Board's formal agreement to the recommendations would see the procurement advert appear shortly, ahead of an Open Day on 1 April 2003 which had been arranged for developers potentially interested in the project.

In response to a question from Dr Nugent, Ms Fitzgerald clarified the term "mixed" contract and "negotiated" procedure. The negotiated procedure was more interactive and allowed more flexibility particularly as the price was decided before the Project started and the Board would retain contractual control.

In response to a question from Professor Farthing, Ms Fitzgerald confirmed that the Legal Advisers had already identified a number of potential bidders who would attend the Open Day on 1 April 2003 – as such they could only assume that the Project was attractive to bidders and that they could deliver on time.

ACTION BY

Mr Calderwood clarified for Councillor Handibode the difference between soft FM and hard FM services. The procurement route recommended gave the NHS Board the most flexibility in determining the final shape of the contract and he did not anticipate any current staff suffering any detriment to their employment conditions. The OJEC advert at this stage included soft FM services. Mr Goudie and Councillor McCafferty indicated the concerns that they would have if soft FM services were included in the contract. Mr Divers briefly outlined the National policy framework which directed their inclusion.

Ms Fitzgerald confirmed that there were vigorous evaluation criteria which would be structured specifically to take account of all concerns raised.

DECIDED:

- That, in terms of the Public Procurement Regulations, the procurement of the Ambulatory Care Hospitals at Stobhill and the Victoria Infirmary should proceed as a services contract and that the Services Regulations should apply to the procurement of the Project.

**Chief
Executive**

- That, in terms of the Services Regulations, the negotiated procedure should be the choice of tendering procedure adopted.

**Chief
Executive**

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Reference : 21160-2004
 Document Type : Invitation to Tender Notice - Open Procedure
 Published By : GREATER GLASGOW HEALTH BOARD, (Body Governed By Public Law)
 Country : United Kingdom
 Published on : 04 Feb 2004

Title : UK-Glasgow: project management and design services
 Deadline : 23 Mar 2004
 Recd on : 04 Feb 2004

Regulations : This document is regulated by the European Services Directive
 92/50/EEC

 This is a service contract.
 You are required to make a global bid.
 The contract will be awarded on the basis of the most economic bid.

CONTRACT NOTICE

Services

This contract is covered by the Government Procurement Agreement (GPA):
 Yes.

SECTION I: CONTRACTING AUTHORITY

I.1) Official name and address of the contracting authority: Greater
 Glasgow Health Board, Att: John Hamilton, Dalian House, UK-Glasgow G3
 8YZ. Tel.: 0141 201 4608. Fax: 0141 201 4601. E-mail:
 john.hamilton@gghb.scot.nhs.uk.

I.2) Address from which further information can be obtained: As in I.1.

I.3) Address from which documentation may be obtained: As in I.1.

I.4) Address to which tenders/requests to participate must be sent: As
 in I.1.

I.5) Type of contracting authority: Body governed by public law.

SECTION II: OBJECT OF THE CONTRACT

II.1) Description

II.1.3) Type of service contract Service category: 12.

II.1.4) Framework agreement: No.

II.1.5) Title attributed to the contract by the contracting authority:
 UK-Glasgow: project management and design services.

II.1.6) Description/object of the contract: Greater Glasgow Health Board
 is seeking to appoint a single project management and design consultancy
 leading a team of technical advisors across a range of services
 including; project management, architectural, M&E engineering, quantity
 surveying, facilities management, healthcare planning, to support Greater
 Glasgow Health Board in the procurement of a PFI project for the supply
 of two Ambulatory Care and Diagnostic (ACAD) hospitals in the Greater
 Glasgow area.

Project management consultancy services. Construction project management
 services. Architectural design services. Quantity surveying services for
 civil engineering works. Engineering design services for mechanical and
 electrical installations for buildings. Building and facilities
 management services. The estimated value of the ACAD PFI project is 150
 000 000 GBP. Greater Glasgow Health Board are looking to make a single
 appointment in respect of the services. The appointment will not be
 divisible into lots and responses in respect of individual services will
 not be considered.

II.1.7) Site or location of works, place of delivery or performance: The
 construction sites will be at an area adjacent to the Victoria Infirmary
 in South Glasgow and at Stobhill Hospital site in North Glasgow. The
 services will be provided to NHS Glasgow at the address in 1 or at any
 nominated offices for the project in Glasgow. Strathclyd.

NUTS code: UKA22.

II.1.8) Nomenclature

II.1.8.1) Common Procurement Vocabulary (CPV): 72224000, 74264100,
 74222000, 74232210, 74232100, 74873000.

II.1.9) Division into lots: No.

II.1.10) Will variants be accepted: No.

II.3) Duration of the contract or time limit for completion: 36 months
 from the award of the contract.

SECTION III: LEGAL, ECONOMIC, FINANCIAL AND TECHNICAL INFORMATION

Page 1

III.1) Conditions relating to the contract

III.1.1) Deposits and guarantees required: No initial deposits are requested but the awarding authority reserves the right to require such guarantees or warranties and indemnities as it seems appropriate prior to award of contract.

III.1.3) Legal form to be taken by the grouping of suppliers, contractors or service providers to whom the contract is awarded: Joint and several liability.

III.2) Conditions for participation

III.2.1) Information concerning the personal situation of the contractor, supplier or service provider and information and formalities necessary for the evaluation of the minimum economic, financial and technical capacity required: Any supplier may be disqualified who:

(a) is bankrupt or is being wound up, whose affairs are being administered by the court, who has entered into an arrangement with creditors or who is in any analogous situation arising from a similar procedure under national laws and regulations;

(b) is the subject of proceedings for a declaration of bankruptcy, for an order for compulsory winding-up or administration by the court or for an arrangement with creditors or is the subject of any other similar proceedings under national laws or regulations;

(c) has been convicted of an offence concerning his professional conduct by a judgement which has the force of res judicata;

(d) has been guilty of grave professional misconduct proven by any means which the contracting authorities can justify;

(g) is guilty of serious misrepresentation in supplying the information required under the provisions of the Directive on the criteria for qualitative selection;

(e) has not fulfilled obligations relating to the payment of social security contributions in accordance with the legal provisions of the country in which he is established or those of the country of the contracting authority;

(f) has not fulfilled obligations relating to the payment of taxes in accordance with the legal provisions of the country in which he is established or those of the country of the contracting authority.

III.2.1.2) Economic and financial capacity - means of proof required:

(c) A statement of the firm's overall turnover and its turnover in respect of the goods to which the contract relates for the previous three financial years.

III.2.1.3) Technical capacity - means of proof required: (a) A list of the principal deliveries effected in the past three years, with the sums, dates and recipients, public or private, involved: in the case of public contracting authorities, evidence to be in the form of certificates issued or countersigned by the competent authority; in the case of private purchasers, delivery to be certified by the purchaser or, failing this, simply declared by the supplier to have been effected.

The team leader and lead consultant must provide references for themselves and all members of the team that clearly demonstrates previous involvement and experience in healthcare and PFI projects valued at over 50 000 000 GBP.

III.3) Conditions specific to services contracts

III.3.1) Provision of the service is reserved to a specific profession: Yes.

Team members will be required to be able to provide evidence of the registration of their senior consultants with the appropriate professional bodies for the areas of expertise they propose to provide.

III.3.2) Legal entities required to state the names and professional qualifications of the personnel responsible for execution of the contract: Yes.

SECTION IV: PROCEDURE

IV.1) Type of procedure: Open.

IV.2) Award criteria: The most economically advantageous tender in terms of:

Criteria as stated in contract documents.

IV.3) Administrative information

IV.3.1) Reference number attributed to the file by the contracting authority: ACAD Project Technical Advisors.

IV.3.2) Conditions for obtaining contract document and additional

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documents: Obtainable until: 12.3.2004.

IV.3.3) Time-limit for receipt of tenders or requests to participate:
23.3.2004. Time: 12:00.

IV.3.5) Language or languages in which tenders or requests to
participate can be drawn up: English.

IV.3.6) Minimum time frame during which the tenderer must maintain its
tender: 90 days from the deadline stated for receipt of tenders.

IV.3.7) Conditions for opening tenders

IV.3.7.1) Persons authorised to be present at the opening of tenders:
Senior officers of the awarding authority and appointed legal advisor.

IV.3.7.2) Date, time and place: 23.3.2004-12:30.

Address as at 1.

SECTION VI: OTHER INFORMATION

VI.3) The contract relates to a project/programme financed by EU funds:
No.

VI.4) Additional information: The awarding authority seeks to appoint a
team of advisors to provide the services listed with the option to
require the team leader to appoint any additional specialist advisor
found to be needed during the period of the contract. There is no
profession specified to be the team leader but it is expected that this
would be a project management consultant.

The PFI project is a combined project for the 2 ACAD sites. Previously
the projects had their own advisory teams. The awarding Authority now
wishes to have a single advisory team and will require the contractor
appointed to undertake to take forward work already done on these
projects by the initial advisors. The awarding authority anticipates
issuing the invitation to negotiate for the ACAD project at the end of
February.

Tenderers are advised that as part of the evaluation process the awarding
authority may request them to make a presentation of their tender
proposal and answer questions on it. It is unlikely that more than 3
teams will be requested to make presentations.

Teams will be requested as part of their tender submission (due for
23/3/2004) to advise on their ability to make an early start date (April
2004) for the provision of their services.

GO reference: GO 04013035/01.

VI.5) Date of dispatch of this notice: 30.1.2004.

For further information go to : <http://ted.publications.eu.int>

Appendix 4 Single Bidder Process:

Appendix 4.01 Strategy for Proceeding with a Single Bidder



SHEPHERD+ WEDDERBURN

NHS Glasgow

ACAD Procurement: Bid Development Process

Revised Draft: 6 October 2003

Introduction

On 22 August 2003, Ernst & Young produced a paper "Strategy for proceeding with a single bid" setting out the key risks in proceeding with a single bid and an outline strategy for managing the risks of proceeding with the ACAD procurement on the basis of a single bidder. That paper identified the key elements of the process, a number of recommendations as regards stakeholder buy-in and sought to identify the differences between the standard PFI procurement process and the engagement strategy for a single bidder process.

The primary aims of the engagement strategy were identified as:

1. delivering a technically and clinically robust solution that meets NHS Glasgow's requirements and allows the implementation of the Acute Services Review to continue;

2. procuring ACADs that represent better value for money than traditional procurement;
3. procuring an affordable scheme;
4. procuring a scheme that is commercially acceptable and within the risk allocation assumed by the standard form documentation used within the NHS in the United Kingdom;
5. to enhance, as far as possible, VFM so that it is comparable to that available through competition;
6. to ensure that all assessments and decisions are capable of surviving scrutiny by the relevant public bodies; and
7. managing the risks of pursuing the procurement on a single bidder basis.

The next step of the process is to prepare a detailed engagement strategy and evaluation methodology to support the bid process. Given the high level of scrutiny to which this procurement will be subjected, it has been necessary to focus clearly on desired outputs at each stage of the process. It will be necessary to secure the support of the Scottish Executive, Audit Scotland, NHS Glasgow's external auditor and the bidder to the process. The process has also sought to maximise the use of cooperative working between the bidder and the Project Team and identify a series of continuous deliverables across the period to preferred bidder.

Annexed to this paper is a framework, which sets out the expected bid development process. This process is intended to create a robust assessment framework to support the engagement and bid development process with the bidder. This should be read alongside the Ernst & Young paper, which contains the outline strategy and detailed consideration of issues.

The key features of the bid development process are:

1. the initial development of a PSC and Shadow Bid Model by the public sector. This facilitates the gathering of information, input benchmarks, project costs in order to provide a robust information with which to make informed decisions during the negotiation process;
2. a clear focus on desired outputs and decision points in the process; and

3. identified milestones and definite commitments for the bidder to sign up to as the bid development process continues.

The paper identifies an expected timeframe for each activity, outlines the activity or level of commitment and seeks to identify the purpose of the relevant steps together with identifying the additional checks and balances which are in-built to the process to ensure that at the end of the process NHS Glasgow can demonstrate value for money in procuring the ACAD project.

NHS Glasgow
ACAD Procurement: Bid Development Process
Expected ITN issue date: mid January 2004

Timescale	Requirement	Purpose and Additionality	Process
Pre ITN	<p>PSC and Shadow Bid Model</p> <p>Prior to the issue of ITN, NHS Glasgow will:</p> <ul style="list-style-type: none"> • prepare exemplar designs which have been assessed against the AEDET toolkit; • undertake value for money analysis; • develop a PSC based on the schedules of accommodation; • determine the affordability parameters for the ACAD; and • prepare a Shadow Bid Model based on the standard risk allocation for the PPP projects in the NHS, benchmark costs drawn from the market information available to the NHS and the exemplar design. 	<p>In a multiple bid situation a PSC would be developed to assist in the determination of affordability and value for money parameters.</p> <p>In the single bid process, a substantial amount of additional work will be undertaken to demonstrate that the shadow bid model is robust and realistic. This additional work is outlined below.</p> <p>A value for money analysis will be undertaken to assess the project by comparing the risk adjusted PSC against the Shadow Bid Model. This analysis will give comfort that the project is on track to deliver value for money.</p>	<p>On the basis of information available to the NHS, in-house information, Departmental Cost Guides, current market detailed analysis, benchmarks will be established for the following –</p> <ul style="list-style-type: none"> • capital costs including areas of risk adjustment and site specific issues; • hard FM including reactive costs, planned preventative maintenance, life cycles and costs; and • soft FM – costs for the provision of, cleaning, catering.

Timescale	Requirement	Purpose and Additionality	Process
		<p>In a single bid process, a substantial amount of additional work will be undertaken to ensure that the PSC is robust and realistic. It will provide the key VFM test against which the single bid will be compared. The level of detail will be greater than would normally be achieved in a PSC. In addition, the Shadow Bid Model will be more detailed. It will incorporate benchmark costs for each input item where achievable. These benchmark costs will be developed from a variety of sources including current cost data available to the NHS, published cost/benchmark information and market information from suppliers and providers. The Shadow Bid Model will effectively turn the technical solution developed for the PSC into a realistic shadow bid and therefore act as a surrogate for competition. This process would not be undertaken for a multi-bid process.</p>	<p>Subject to the available information, C & B will also be able to develop a Live Options model for the shadow bid.</p> <p>Greater detail in arriving at cost assumptions including:</p> <ul style="list-style-type: none"> • Comparison of future operating costs with current actual costs • More detailed capital cost assumptions; and • Detailed assessment of risk, in particular comparison with normal levels of risks identified at this stage <p>Comparison of PSC and shadow bid to ensure that the board can properly demonstrate that capital and operating cost estimates are reasonable.</p>

Timescale	Requirement	Purpose and Additionality	Process
		<p>Subsequently, the Shadow Bid Model can be used as a negotiating tool and can be updated to reflect the best available information. This process is not often replicated in a multiple bid situation.</p>	<p>Use of shadow bid modelling to establish pricing parameters over and above its normal use as check for reasonableness.</p>
		<p>An exemplar design will be prepared and scored against the NHS AEDET toolkit. The shadow bid model design will demonstrate that it represents an acceptable solution in terms of function, operation and match to clinical need.</p> <p>The exemplar design (but not the costings derived from that) will be made available to the bidder.</p>	<p>Completion of the review of exemplar designs using the AEDET toolkit. This process is also a peer review with the North Glasgow team reviewing the South Glasgow's design and vice versa.</p>

Timescale	Requirement	Purpose and Additionality	Process
<p>ITN minus 8 weeks.</p> <p>Letter to bidder asap with potential meeting to clarify process if required and written response by 17 October 2003</p>	<p>Pre-ITN Bidder Commitment</p> <p>Bidder to commit to:</p> <ul style="list-style-type: none"> • broad scope of project including inpatient beds at Victoria; • standard risk allocation for NHS PPP procurement; • use of Standard Form Project Agreement (based on DoH Version 3 as adjusted to reflect the requirements of the Scottish Executive Health Department); • use of Standard Form Payment Mechanism as adjusted to reflect project requirements and calibration; • the proposed timetable and single bid process as set out in Sections 4 and 5 of the EY paper of 22 August 2003 "Strategy for proceeding with a single bid" (including user group meetings, statutory approvals etc) to close; • agreement to open book accounting arrangements for bid submission; 	<p>The purpose of the initial bidder commitment is to secure a degree of buy in from the bidder as to the scope and nature of the process. In particular the initial commitment will allow the bidder to plan resources and have an understanding of the process - including the additional checks and balances required to demonstrate value for money.</p> <p>This level of commitment would not usually be sought from bidders in a multiple bid process. By securing an initial commitment, NHS Glasgow can proceed to finalise the ITN documentation and single bid process in the knowledge that the bidder is committed to the process.</p>	<p>The bidder will be asked to confirm in writing their acceptance of the criteria established.</p> <p>A more detailed calibration of the payment mechanism based on service specifications and room weightings used in the exemplar design to demonstrate that the standard mechanism does not cause unacceptable penalties to arise whilst offering a strong incentive for provider performance.</p> <p>Establishment of a robust affordability envelope that allows the Board to meet its project specific and wider affordability targets while incentivise the bidder.</p>

Timescale	Requirement	Purpose and Additionality	Process
	<ul style="list-style-type: none"> • supply chain management proposal identifying those elements of the supply chain to be competitively tendered and the process for securing best value in procurement; • the use of benchmarks to establish value for money; • usual PPP exposure to bid costs in accordance with existing DoH guidance; and • use of the NHS AEDET Toolkit to ensure that the design solution proposed by the bidder is suitable in terms of function, operation and match to clinical need. 		

Timescale	Requirement	Purpose and Additionality	Process
ITN plus 8 weeks	<p>Bid Development Commitment: Level 1</p> <p>Bidder to present bid development work to Project Team. This will include a commitment to the following:</p> <ul style="list-style-type: none"> • delivering the project within the affordability envelope; • acceptance of the response times and service requirements set out in the non-clinical service specifications; • confirmation that the payment mechanism structure and calibration set out in the ITN document are acceptable; 	<p>This commitment is designed to ensure that the bidders level of commitment and certainty increases as the bid development proceeds and that if required NHS Glasgow has a clear exit point in the bid development process. The bidder will be expected to develop its bid from the issue of the ITN and at agreed points demonstrate that progress towards an acceptable solution is being made. NHS Glasgow will have visibility of and an opportunity to test bid development assumptions. If any of the commitments cannot be demonstrated NHS Glasgow will have an option to reconsider its procurement options.</p> <p>To ensure that all bidder representations can be tested and verified for their financial impact and that any variations from standards are fully justified and documented.</p> <p>The commitments have been selected to reflect the usual process of bid development at the 8 week stage.</p>	<p>The technical team will review and test the bidders pre-proposed exception list in respect of design development, timetable and programme assumptions.</p> <p>Comparison of bidder assumptions with those contained in shadow model. Detailed analysis of variations.</p> <p>Assessment of potential variations on unitary charge, affordability and risk management.</p> <p>User group meetings with the relevant stakeholder groups will be undertaken to aid the bidders interpretation of:</p>

Timescale	Requirement	Purpose and Additionality	Process
			<ul style="list-style-type: none"> • the design and construction requirements; and • the FM requirements.
			<p>Clarification meetings with the legal and financial teams will be undertaken. Given the single bid structure these meetings will be interactive with a view to ensuring that the bidder can deliver the Level 1 commitments.</p>

Timescale	Requirement	Purpose and Additionality	Process
	<ul style="list-style-type: none"> • confirmation that the Project Agreement set out within the ITN is acceptable and agreement with NHS Glasgow all project specific amendments required by the bidder; • initial assumptions used to structure and cost project finance requirements; • the design principles set out in the ITN incorporating an exception list and details of project specific requirements including CDM, development control, fire, planning, building services, DDA, clinical relationships and buildability requirements; and • proposed build programme, expected phasing and commissioning timetable. 	<p>In a PPP process with multiple bidders the public sector would not have such detailed visibility of bid development process and would restrict involvement to response to clarifications from bidders.</p>	<p>One of the advantages of the single bid route is the ability to utilise at an early stage the skills and experience of the bidder to establish the likely construction timescales and costs, and the key interfaces to equipment, IT procurement and changes to service delivery.</p> <p>The Advisor team will seek to review in detail the bidders proposed procurement process to ensure the competitive methods adopted maximises competition. This would include a review of the skills and resources of the proposed supply chain partners and degree of competition in the supply chain. This will be tested against the assumptions and methodology used in the preparation of the shadow bid model.</p>

Timescale	Requirement	Purpose and Additionality	Process
ITN plus 12 weeks	<p>Bid Development Commitment Level 2</p> <p>Bidder to present bid development work to Project Team. This will include a commitment to the following:</p> <ul style="list-style-type: none"> • the matters covered at Level 1 have not altered without NHS Glasgow agreement; • terms sheets for preferred finance structure and evidence that funding costs are competitive in the market; • a defined allocation of risk within the SPV and its subcontractors; • heads of terms for key subcontracts e.g. construction and principal FM; • funders' support of the Project Agreement contained within the ITN and the payment mechanism structure and calibration. 	<p>The purpose of the Level 2 Commitment is to confirm with the bidder its continuing commitment and again give NHS Glasgow the opportunity to review bid development and a clear exit point if any of the commitments cannot be delivered.</p> <p>NHS Glasgow will have visibility of and an opportunity to test bid development assumptions. If any of the commitments cannot be demonstrated, NHS Glasgow will have an option to reconsider its procurement options.</p> <p>The Level 2 commitments have been selected to reflect the usual process of bid development at the 12 week stage.</p> <p>As with the Level 1 Commitment, this requirement is additional to the normal process with multiple bidders.</p>	<p>Extension of work carried out at previous stage to incorporate more detailed information now available.</p> <p>As above the legal, financial and technical teams would meet with the bidder as necessary to ensure that the bidder can meet the Level 2 commitments.</p> <p>The team would review the bidders commitment including risk allocation, subconsultant and subcontract conditions to ensure consistency with the principles of the Project Agreement.</p> <p>Technical and clinical reviews will continue as the design proposals are developed.</p>

Timescale	Requirement	Purpose and Additionality	Process
ITN plus 16 weeks	<p>Bid Return</p> <p>The bidder will be required to submit a complete bid in accordance with the ITN requirements.</p>	<p>This stage mirrors the process used in multiple bids. To allow NHS Glasgow the opportunity to fully test the bid assumptions and consider the affordability and value for money implications of the bid, a full bid submission is required. However, on receipt of the bids the NHS Glasgow team will have a much greater familiarity with the bid content and knowledge of the bid development process.</p>	
ITN plus 22 weeks	<p>Bid Evaluation Process</p> <p>The Project Team will evaluate the bid in accordance with the agreed bid evaluation process. The PSC will be utilised to test value for money and the ability of the bidder to deliver an enhanced solution.</p>	<p>In a multiple bidder process evaluation would be undertaken against the PSC and affordability targets. Other than that the evaluation is undertaken on a comparative basis. With the bid assumptions of all bidders being reviewed against each other with a view to identifying the most economically advantageous solution.</p>	<p>It is important at this stage to fully understand the detailed mechanisms underlying the bidders proposal, and to assess the financial impact of variations. This will be particularly important if service enhancements are offered, in which case the vfm characteristics should be fully considered in light of the PSC and affordability.</p>

Timescale	Requirement	Purpose and Additionality	Process
	<p>The Shadow Bid Model will be used to benchmark bid costs and assumptions based on market information. This benchmarking process will cover the entire cost base of the bid, supply chain, finance structure and terms, model optimisation, commercial and contractual terms and conditions.</p>	<p>In the single bid process where competition is not available to provide market comparators an alternative must be developed.</p>	<p>The bidders return in terms of capital cost and risk allowance, supply chain, hard and soft FM will be evaluated against the PSC and the shadow bid model.</p> <p>A full evaluation of the bid response will be undertaken in accordance with the process set out in the ITN.</p>
	<p>The costs of the bid will be assessed against the affordability constraints of NHS Glasgow.</p>	<p>The PSC and Shadow Bid Model will be used to provide detailed cost comparators drawn from current market information. The benchmarks against which the bid will be judged will be the PSC and the Shadow Bid Model (at pre-bid submission stage). The comparison with the Shadow Bid Model is particular to the single bid process and would not be used in a multi-bid situation. This analysis is intended to act as a substitute to having a competition. The NAO Report on the "Airwaves" project, which proceeded on a single bid basis, endorsed this approach.</p>	

Timescale	Requirement	Purpose and Additionality	Process
	<p>As part of the bid evaluation, the VFM analysis will be updated. This will be of critical importance in assessing the value for money of the process.</p> <p>The technical solution will be evaluated in accordance with the NHS AEDET toolkit and compared against the PSC exemplar design.</p>	<p>The bidder will also have been required to competitively compete its own supply chain in line with the commitment agreed at pre-ITN stage.</p> <p>The Project Team will closely track the development of the commercial terms and conditions to ensure that the commercial position tracks market norms. The shadow bid model will be updated over the period of the bid development process to ensure it mirrors current market conditions.</p>	
	<p>The commercial and legal submission will be benchmarked against market norms. NHS Glasgow will draw on the experience of the NHS market in Scotland to provide comparators and benchmarks.</p>	<p>NHS Glasgow will have an opportunity, following the completion of the bid evaluation process to review the position and a clear exit point if the bid submission is not going to meet the parameters of affordability and VFM.</p>	

Timescale	Requirement	Purpose and Additionality	Process
ITN plus 28 weeks	<p>Appointment of Preferred Bidder</p> <p>Prior to the appointment of preferred bidder, NHS Glasgow will require to be satisfied that the process has delivered a solution which meets the technical requirements of the ITN, is commercially acceptable and meets the tests of affordability, deliverability and demonstrates value for money.</p> <p>The FBC will require to have been approved by the Scottish Executive and the NHS Glasgow's auditor must be satisfied that the process has produced a value for money option.</p> <p>The preferred bidder will be required to enter into a preferred bidder letter in accordance with OGC guidance and which will include:</p>	<p>This process mirrors that assumed in a multiple bidder project. It is anticipated that the approvals process may take longer than would usually be anticipated given the expected level of scrutiny.</p>	<p>It is likely that the FBC will have to explicitly demonstrate how vfm had been maintained and that the proxy for competition had been effective.</p>

Timescale	Requirement	Purpose and Additionality	Process
	<ul style="list-style-type: none"> • confirmation of the price for the bid solution – to provide an audit trail against which design development and/or any variations can be monitored. • agreement of the technical solution; • agreement of the project scope, output specifications and project agreement; • acceptance of the payment mechanism calibration; • agreement of the non clinical service specifications; 		

Timescale	Requirement	Purpose and Additionality	Process
	<ul style="list-style-type: none"> • identification of any unresolved issues – to prevent new issues being tabled or agreed ones re-opened. • agreement not to introduce a third party equity provider post preferred bidder (who might be expected to re-negotiate terms); • agreement of a timetable of actions (including detailed planning permission) and milestones to financial close; • agreement of the financial model and key financial terms including the unitary charge, tax treatments and tax risk, Swap, RPI and ratios. 		
ITN plus 42 weeks	<p>Financial Close</p> <p>The process to close would mirror that undertaken in a multiple bidder situation.</p> <p>The length of time from preferred bidder to close is drawn primarily by the planning process and the time taken to secure detailed planning permission.</p>	This process mirrors that assumed in a multiple bidder project.	

Appendix 4.02 Minute of Greater Glasgow NHS Board Meeting held on 18 November 2003 – extract

145. ACUTE SERVICES STRATEGY IMPLEMENTATION UPDATE ACAD PROCUREMENT – NEXT STEPS

Mrs Kuenssberg declared an interest in this item and did not take part in any discussion.

A report of the Programme Director (Acute) [Board Paper No 03/69] was submitted asking the Board to:

- Endorse the Performance Review Group's discussions on submitting to the Scottish Executive Health Department proposals to engage with a single bidder on the basis of the "Strategy for Proceeding with a Single Bidder".

5

EMBARGOED UNTIL MEETING
BOARD: 18 NOVEMBER 2003

ACTION BY

- Receive, from the Programme Director (Acute) an update on the progress on the ACAD procurement process.

Mr Calderwood reviewed the chronology of events in taking forward the single bidder process since the July NHS Board meeting and provided recommendations on the next steps. He referred to the external auditor's (PricewaterhouseCoopers) report – letter dated 17 October 2003 which confirmed that they were content with the process, which had resulted in a single bidder, and that the NHS Board had followed the required guidance and rules.

Mr Calderwood reported that he met with representatives of Glasgow City Council in relation to the planning for the two ACADs. He was optimistic that full Business Cases would be completed by July 2004, contractual close by October 2004 and construction commencing before the end of 2004.

It was intended that the arrangements be finalised for a paper on the Final Invitation to Tender and Negotiate to be considered at the 16 December 2003 Board meeting. At the same meeting the outcome of the Tender process for the Beatson Oncology Centre would also be considered. Three design companies had been short-listed and it was anticipated the proposals could be delivered within the financial framework and planned for already.

In response to a question from Councillor Duncan regarding the scope of the Victoria ACAD project to include sixty inpatient beds, Mr Calderwood advised that it was always the intention to replace the Mansionhouse Unit rehabilitation beds as part of the ACAD development. The final configuration at the Stobhill ACAD was similar with 90 rehabilitation beds already developed on that site. The clinical model would, therefore, be the same for both campuses.

DECIDED:

- That the Performance Review Group's discussions on submitting to the Scottish Executive Health Department proposals to engage with a single bidder on the basis of the "Strategy for Proceeding with a Single Bidder" be endorsed.
- That the update on the progress on the ACAD procurement process be noted.
- That the December NHS Board meeting consider the final Invitation to Tender and Negotiate for the two ACADs and the outcome of the tender process for the Beatson Oncology Centre.

**Programme
Director (Acute)**

**Programme
Director (Acute)
Programme
Director (Acute)**

Appendix 4.03

Letter from Scottish Executive supporting single bidder route



SCOTTISH EXECUTIVE

Health Department
Directorate of Performance Management & Finance

Tom Divers
Chief Executive
NHS Greater Glasgow
Dalian House
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Peter Collings
Director of Performance
Management & Finance
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Fax: 0131-244 2042
peter.collings@scotland.gsi.gov.uk
<http://www.scotland.gov.uk>

Your ref: TAD/JMCA
Our ref: ZZKA/008/004/PC/NWK

3 December 2003

Dear Mr Divers

ACUTE SERVICES STRATEGY - ACAD PROCUREMENT

Thank you for your letter of 17 November in which you advise me of the decisions made by Greater Glasgow NHS Board in taking forward the implementation of the first phase of your Acute Services Strategy Implementation Plan.

We have reviewed your proposals to proceed with your procurement with a single partner and on the basis of the information provided are satisfied that your approach provides a reasonable basis to complete the procurement successfully while demonstrating value for money. The process will have to be managed particularly carefully to bring about the desired outcomes, and it will be important to adhere closely to the agreed milestones, resource the process adequately and take account of the views of your external auditors and advisors as you progress. You mentioned in your letter the need to discuss further an appropriate review process. I commend the key stage review used in the local authority sector and undertaken by Partnerships UK as an appropriate monitoring vehicle to give both yourselves and the Department comfort that the process adopted has been robust and that you are ready for the next stage. Further details can be discussed between your team and my colleagues in the Department.

We are very keen to support you in the exercise and I suggest Robert Calderwood now arranges an early meeting with Norman Kinnear and colleagues to discuss how this can best be achieved including agreement on the review process.

I wish you and your team well with the procurement exercise.

Yours sincerely

Peter Collings
Director of Performance Management and Finance



Appendix 5 Key Stage Review Approval:

Appendix 5.01 Minute of Greater Glasgow NHS Board held on Tuesday 20 January 2004 - extract

7. ACUTE SERVICES IMPLEMENTATION : AMBULATORY CARE HOSPITALS PROCUREMENT PROCESS

Mrs Kuenssberg declared an interest in this item and, therefore, left the room for its consideration.

A report of the Programme Director (Acute Services), Chief Executive, Greater Glasgow NHS Board and Director of Finance, Greater Glasgow NHS Board [Board Paper No 04/2] asked the NHS Board to:

- (i) Consider the report on progressing the procurement of the Ambulatory Care Hospitals.
- (ii) Agree that the procurement should now include the provision of a new Day Surgery Theatre and Diagnostics Complex at Stobhill Hospital; and of 60 new-build rehabilitation beds at the Victoria redevelopment.
- (iii) Re-affirm the strategic imperative of progressing this procurement of the Ambulatory Care Hospitals as a crucial step in the NHS Board's plan for modernising adult acute services care; and of ensuring that the forward financial plan supported the affordability of these developments, as an over arching priority, to be commenced in 2007/08, with full year costs to be met in 2008/09.
- (iv) Re-affirm the original funding of £15 million agreed for the provision of the Ambulatory Care Hospitals, updated to 2008/09 prices, together with additional revenue funding of £2.1 million, if required, to meet the additional costs of extending the brief, at (ii) above.
- (v) Amend its previous decision, in respect of the provision of "Soft" FM Services, to allow the development of an "in-house" bid, to be assessed alongside the bidder's submission in order to ensure value for money was secured.
- (vi) Note the agreement for progressing with Glasgow City Council the outline planning and related issues.

- (vii) Receive verbal feedback from PricewaterhouseCoopers concerning key governance aspects relating to this paper.
- (viii) Authorise the Chief Executive and the Programme Director to release the FITN (Final Invitation to Negotiate) documentation to the consortium in February 2004.

Mr Divers outlined the background to the negotiated process with the single bidder based on the development of a robust process which would achieve best value for money with an appropriate set of governance arrangements. The development of these governance arrangements had had a number of strands. Firstly, PricewaterhouseCoopers, as external auditors, carried out a review of the project to the period ended 30 September 2003. This was presented to the NHS Board's Performance Review Group at its meeting on 22 October 2003 and provided additional assurance that appropriate arrangements had been put in place to obtain best value against the context of a single bidder.

The status review by PricewaterhouseCoopers also enabled the NHS Board Chief Executive to write to the Director of Performance and Finance at the Scottish Executive Health Department to ensure that the Health Department was content with the arrangements and that work with the single bidder should continue. A response was received on 3 December 2003 confirming that the Scottish Executive Health Department was content that appropriate governance arrangements were being developed and that work with the single bidder should continue. A further level of review of the project by Partnership UK (PUK), a consultancy which undertook key stage reviews of PPP projects on behalf of the Treasury, was also commended.

As the project was now nearing a point at which the Final Invitation to Negotiate (FITN) would be ready for issue, it was agreed that PricewaterhouseCoopers would undertake a further review of the project up to the current date so that it could offer the NHS Board its view of the robustness of certain of the best value considerations which had been developed further.

The brief for the project had been re-examined to ensure that the content of both Ambulatory Care Hospitals was comparable and provided the best, long-term arrangements for the delivery of care. The preparation of the initial brief for the Stobhill Ambulatory Care Hospital was based on the premise that the existing, 30 year old theatre suite and the adjoining Day Surgery Unit, developed in the early 1990s, would be upgraded and retained as part of the future Ambulatory Care Hospital. In comparing both the level and facility of theatre, investigative and day case provision which this upgraded scheme would offer, in comparison with the modern purpose built facilities specified for the Victoria Infirmary development, the Programme Director (Acute Services) and his Project Team concluded, with strong support from the Professional Advisers, that both developments should include the provision of new, purpose built day case theatres and diagnostic facilities.

The NHS Board's overall plan for the modernisation of Adult Acute Services included the provision of the replacement of elderly care services currently delivered from the Mansionhouse Unit in two settings, within the South-East and South-West of the city. The provision within the South-East comprised 60 beds for rehabilitation which it was proposed to develop alongside the Ambulatory Care Hospital. Initially, it had been planned that the replacement of the Mansionhouse Unit would be carried out in 2009/10. The opportunity was available, therefore, to include the re-provision of these 60 rehabilitation beds in the ambulatory care procurement, thereby allowing the whole campus development plan to be completed in a single phase.

Maintaining momentum in this procurement process was key to the modernisation of acute services care in NHS Greater Glasgow. It both involved the first stage of implementation of the acute services plan and would contribute materially to addressing the service and workforce challenges of the years ahead. Allied to a major programme of Service redesign, the provision of modern, fit-for-purpose facilities, with enhanced day case and diagnostic capacity, would allow increased “one-stop” provision for patients and help to unblock the current bottlenecks in care pathways. There was also an important issue of credibility with the public, NHS Greater Glasgow staff and elected representatives. Given the duration of the public consultation process and the ensuing decision making process, there still remained doubt in a number of quarters whether the promised modernisation of acute services care would be delivered. It was crucial, therefore, to be able to demonstrate to the wide range of interests involved that the NHS Board was now moving definitively to implement these key first stages of the Acute Services Plan.

Mr Divers outlined the two aspects of value for money and affordability which had to be addressed. The first centred on whether the costs now estimated remained in line with the original financial envelope which the NHS Board approved. The second restated whether the NHS Board’s financial plan for the years ahead would meet the revenue required to support this project. The NHS Board, in approving the Acute Services Review in March 2002, identified a recurrent funding requirement of £19.4 million for the first three major projects, that was, the North and South Ambulatory Care Hospitals and the Beatson redevelopment Phase II. As reported in December 2003, the Beatson Phase II additional recurrent costs were in line with the original affordability assessment of £4 million. Since that meeting, each of the Scottish West of Scotland NHS Boards had confirmed their share of the recurrent revenue requirements. Consequently funding available for the two Ambulatory Care Hospitals was reconfirmed at £15 million at 2006/07 prices, uplifted to £15.8 million at 2008/09 price base.

A Public Sector Comparator had been developed which was key to understanding the value for money aspect of the project and this calculation enabled the NHS Board to proceed to issue the FITN. The detail of the Public Sector Comparator calculations had been reviewed by the project’s Financial Advisers, Ernst and Young and by PricewaterhouseCoopers, external auditors. In line with this, work was also ongoing to prepare a detailed shadow bid which drew on reliable average and contract specific benchmarks – this would form a key part of contract negotiations.

The assessment of the overall revenue requirement for the two Ambulatory Care Hospitals included a provision for equipment which would be excluded from the PPP scheme and would, therefore, be financed through the NHS Board’s capital programme. The overall financial assessment of the two schemes assumed that the funding required for soft FM services would be matched by equivalent monies released from existing budgets held by the North and South Trusts.

In summing up, Mr Divers highlighted:

- The inclusion of the Mansionhouse beds and replacement theatres at Stobhill had increased both the capital and the consequent revenue funding requirements by £2.1 million per annum.
- On the basis of a like for like comparison with the initial brief for the Ambulatory Care Hospitals, the updated cost estimate was in line with the financial provision which the NHS Board agreed in March 2002.

- The forward financial plan would support the additional revenue requirement for the Ambulatory Care procurement. The financial envelope which the NHS Board agreed in March 2002 had been updated to reflect the current knowledge about future years' allocations and commitments. The revenue required for the Acute Services Review Phase I, including the additional £2.1 million (if required) for the Ambulatory Care Hospitals, would represent a first call against development monies available in the years preceding the first full year of operation, 2008/09. Since the NHS Board meeting in March 2003, there had been a series of further discussions which had resulted in a range of views on the arrangements for the provision of soft FM Services. The Project Team had explored whether use of a "best value" approach might be feasible but considered that the work involved in this would add three months to the timetable for implementing the project. Given that "value for money" could be delivered through the mechanism of the "variant bid", without extending the timetable, this was the preferred option.

Agreement for the sale to the South Glasgow Trust of the required portion of the Queens Park Recreation Ground was, in principle, in place. Additionally, detailed discussions about the mechanism by which a replacement relief road could be created to compensate for the closure of Annan Street were underway, such that each of the planning issues could be concluded within timescales consistent with the Consortium's development and submission of the final planning application.

Sir John confirmed the capital cost of expenditure of £190 million was broken down as follows:

- Stobhill Ambulatory Care Hospital - £83 million
- Victoria Infirmary Ambulatory Care Hospital - £108 million

Mr Revie, PricewaterhouseCoopers, summarised his findings under four key areas:

- affordability
 - design fit for purpose
 - public sector comparator
 - shadow bid
- (i) Affordability – PricewaterhouseCoopers was satisfied that the reworked model was comparable with what the NHS Board had seen presented in March 2002. The NHS Board's Director of Finance had reworked the additional revenue costs and the external auditors had recognised the challenge regarding achieving an in-year balance but were comforted that the Acute Services Review Phase I would be given the first call on future years' development monies. On that basis, PricewaterhouseCoopers had concluded that the revisions made to Phase I were affordable.
- (ii) Design Fit for Purpose – PricewaterhouseCoopers was satisfied that there was lots of evidence regarding extensive consultation with clinical and user groups, special advisers and NHS colleagues to ensure that Phase I of the Acute Services Review was undertaken in a design fit for purpose.
- (iii) Public Sector Comparator – this would determine whether there would be value for money in the procurement process. Standard modelling techniques would be used to ensure a like for like comparison and PricewaterhouseCoopers were content that the procurement proceed along the current route.

- (iv) Shadow Bid – given that the NHS Board was in a single bid situation, Mr Revie re-iterated that the process had to be much more robust and this should be benchmarked with a commercial build to ensure that a good deal was being provided.

Mr Revie had been satisfied throughout his audit that all dealings had been open and transparent and throughout the process he had found no barriers from members of staff working on the process.

Mr Robertson commended all those involved for taking forward such a complicated process – he took comfort from the open and transparent manner of the information contained with the Board paper. He suggested that the fourth recommendation on the Board paper be changed to reflect that the Programme Director (Acute Services) would be charged with “a rigorous overhaul of the cost structure of the whole project in order to reduce this additional potential figure to the minimal level required”. Mr Divers agreed to this amendment.

Chief Executive

In response to questions from Dr Nugent, Mr Divers confirmed that there was a requirement for additional revenue sums given the enhancement of the services. The figures shown were, however, net figures and would take account of savings that could and would be made from moving away over time from other sites. The importance of the project was such that the additional £2.1m (if required) should indeed be a first call against development monies in the first full year of operation.

Mr Goudie highlighted the arrangements for the provision of soft FM services and the many discussions that had taken place with staff side interests who had accepted the recommendation of the “value for money” approach. Sir John thanked Mr Goudie for his role in assisting this process.

Mr Divers advised that the next step would be for the Programme Director (Acute Services) to issue FITN documentation in February 2004.

DECIDED:

- (i) That the report on progressing the procurement of the Ambulatory Care Hospitals be noted.
- (ii) That the procurement should now include the provision of a new Day Surgery Theatre and Diagnostics Complex at Stobhill Hospital; and of 60 new-build rehabilitation beds at the Victoria redevelopment be agreed.
- (iii) That the strategic imperative of progressing this procurement of the Ambulatory Care Hospitals as a crucial step in the NHS Board’s plan for modernising adult acute services care; and of ensuring that the forward financial plan supported the affordability of these developments, as an over arching priority, to be commenced in 2007/08, with full year costs to be met in 2008/09 be re-affirmed.
- (iv) That the original funding of £15 million agreed for the provision of the Ambulatory Care Hospitals, updated to 2008/09 prices, together with additional revenue funding of £2.1 million, if required, subject to a vigorous overhaul of the cost structure of the whole project in order to reduce this additional potential figure to the minimum level required to meet the additional costs of extending the brief, at (ii) above be re-affirmed.
- (v) That its previous decision, in respect of the provision of “Soft” FM Services, to allow the development of an “in-house” bid, to be assessed alongside the bidder’s submission in order to ensure value for money was secured be amended.

**Programme
Director – Acute
Services**

**Chief Executive
/Programme
Director – Acute
Services**

**Programme
Director – Acute
Services**

**Programme
Director – Acute
Services**

EMBARGOED UNTIL MEETING
BOARD: 20 JANUARY 2004

ACTION BY

- (vi) That the agreement for progressing with Glasgow City Council the outline planning and related issues be noted.
- (vii) That verbal feedback from Pricewaterhouse Coopers concerning key governance aspects be received.
- (viii) That the Chief Executive and the Programme Director (Acute Services) release the FITN documentation to the consortium in February 2004 be authorised.

**Chief Executive
/Programme
Director – Acute
Services**

Mrs Kuenssberg returned to the meeting.

Appendix 5.02 Pre-FITN Key Stage Review Letter

Health Department
Directorate of Performance Management & Finance

St Andrew's House
Regent Road
Edinburgh EH1 3DG

Margaret Smith
North Glasgow University Hospital NHS Trust
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G21 3ER

Telephone: 0131-244 5041
Fax: 0131-244 3993
Michael.Baxter@scotland.gsi.gov.uk
<http://www.scotland.gov.uk>

Your ref:
Our ref:

19 February 2004

Dear Margaret

KEY STAGE REVIEW GGNHSB AMBULATORY CARE AND DIAGNOSTIC PPP

Thank you for your letter dated 12 February regarding the pre-ITN Review conducted by Partnerships UK the above project and the Board's response to the review findings. I am particularly heartened by the positive comments that you made regarding the process itself and how the process had been conducted. I hope that the outcome of the Review, as well as providing reassurance to the Department, as also provided greater insight to the Board/Project Team in terms of the key risks and issues to be addressed prior to the issue of the ITN.

In general terms, the Department is satisfied with the response made by GGNHSB and the work identified to address the planning and other key risks identified in the PUK Report. We are grateful for the action already put in train to address some of these issues.

As you indicated in your response (and in our telephone conversation this morning) the outstanding land and planning issues are the key risks still associated with project. I appreciate fully the endeavours being made by the Board to engage with the City of Glasgow Council to resolve these outstanding issues and to move the process forward.

I am aware however, of the actions that have been taken to date and that there are still a number of significant issues outstanding which represent a real risk to the procurement proceeding on the envisaged timetable. I note in Annex C of your submission, the proposed work planned to address and resolve the outstanding issues on land and planning. This plan would indicate that outline planning and full approval would be sought by 26th

March 2004 in the South and 27th May in the North. Given the current position, I would be grateful if you could clarify whether this was still a realistic timescale, and, whether the planning processes within the City of Glasgow Council will support this timetable should agreement be reached in the near future.

In your submission you indicated that you recognise that the timetable set out is a challenging one and, as we discussed this morning, given the complexity of the outstanding issues I would be grateful for your comments on whether the timetable set out is still achievable or to give a revised timetable for the process going forward.

I note in your submission you seek to address 2 issues within the SEHD Project Agreement v1 (the economic reinstatement test and permitted borrowings). The position on permitted borrowings has not yet been finalised and that it would be the Department's intention to follow in line with the agreed wording established through discussions with HM Treasury. I appreciate we are not yet in a position to do that but the Standard ITN documentation should allow for subsequent amendment to Standard Form Project Agreement during the course of procurement.

With regard to the Economic Reinstatement Test, I note the application the Standard test is based on a single facility and that you will be operating on 2 sites. I note your reference to activity in England were the Economic Reinstatement Test has been removed in a number of cases. I would advise that this has been done on two schemes we are aware of involving the same consortium. The initiative for this change did not come from the NHS and the Department is certainly not promoting this as a general approach. It is basically funder issue for the consortium to address and put proposals to you. I am happy to consider on that basis.

Given the issues raised both in the PUK report and again in this letter, can you please advise of your intentions with regard to the issue of the ITN and the handling of planning issues subsequent to that, should you decide to proceed. I note from our conversation this morning you would wish to engage with the consortium early next week. I would be interested to know their position on this issue.

I look forward to your response on the issues raised and I am happy to discuss.

Yours sincerely

MICHAEL BAXTER
Head of Private Finance & Capital Unit

Appendix 5.03 ACAD Project Pre PB Key Stage Review

Health Department
Directorate of Performance Management & Finance

Robert Calderwood
Chief Executive
South Glasgow University Hospitals Division
Management Centre
Southern General Hospital
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Performance Management Division

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Telephone: 0131-244 5041
Fax: 0131-244 3993
Michael.Baxter@scotland.gsi.gov.uk
<http://www.scotland.gov.uk>

Your ref:
Our ref:

30 June 2005

Dear Robert

GLASGOW ACAD PROJECT PRE PB KEY STAGE REVIEW

Further to receiving the final set of responses from Alex McIntyre and the updated internal risk register I can confirm that I am content to sign off the KSR process. We had already agreed the issue of the PB letter to Canmore and I understand that their response is imminent.

I appreciate the time and commitment that your Project Team have given to the KSR process and sincerely hope that the process has been to our mutual benefit. I welcome the constructive and helpful dialogue in resolving outstanding clarifications/ issues.

Further to our informal discussions with Alex McIntyre I would like to get formal feedback from you on the process itself and your perspective on how this is gone As you are well aware we are keen to learn from the experience of the Key Stage Review and wish to improve and develop the process as necessary in conjunction with Partnership UK.

I would welcome some feedback from you in terms of documentation and the evidence based required, the method of engagement with Partnership UK and the Department, together with any thoughts on room for improvement.

I look forward to hearing from you in due course on this issue and I trust that the response gives you sufficient comfort on which to proceed.

Yours sincerely

A handwritten signature in black ink that reads "Michael Baxter". The signature is written in a cursive style with a large, prominent initial 'M'.

MIKE BAXTER
Head of Private Finance & Capital Unit

Appendix 6 Professional Advisors used by the Board

CATEGORY	COMPANY	ADDRESS	RESPONSIBLE INDIVIDUAL
Legal	Shepherd & Wedderburn/Bevan Ashford	155 St Vincent Street, Glasgow G2 5NR	Rhona Harper
Finance	Ernst & Young	George House, 50 George Square Glasgow G2 1RR	Michael McVeigh
Technical Advice	Currie and Brown	140 West Campbell St Glasgow G2 4TZ	Alastair Stewart
	Atkins	Clifton House Clifton Place Glasgow G3 7yy	Aileen Walker
	Keppie Architects	160 West Regent St Glasgow G2 4RL	Baxter Allan
Transport	Faber Maunsell	297 Bath St. Glasgow G2 4JL	Stuart Livingstone
Planning	Keppie Architects	160 West Regent St Glasgow G2 4RL	Baxter Allan
Insurance	Willis Coroon	160 West George St. Glasgow G2 2HQ	Anne Rock

**Appendix 7 Site Plans, Floor Plans & working
arrangements**

New Victoria Hospital

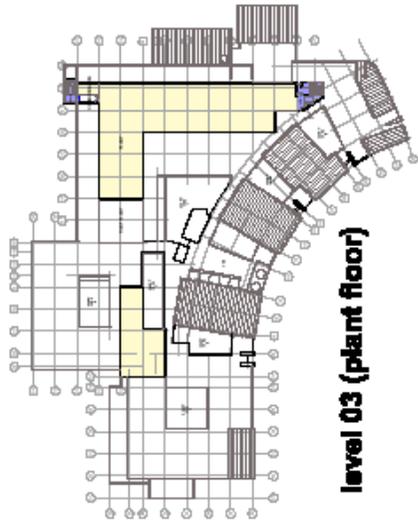


HLM Architects

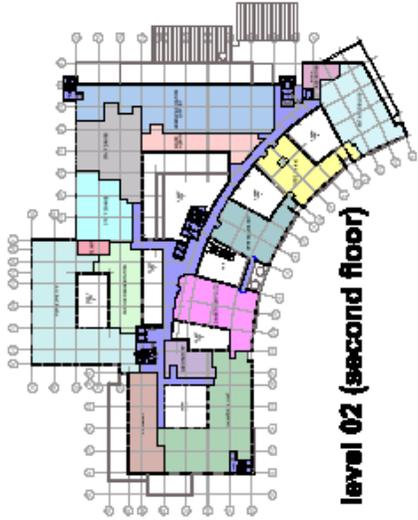
003 (Rev A)



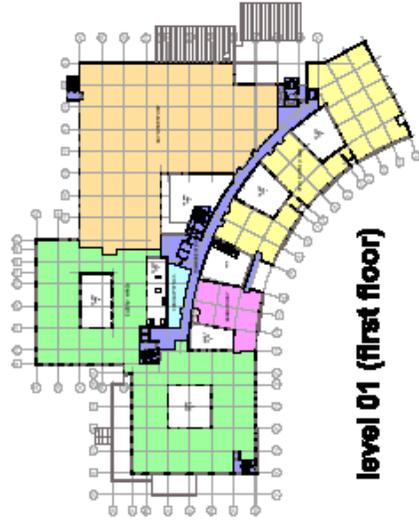
PROPOSED GROUND FLOOR LEVEL SITE PLAN



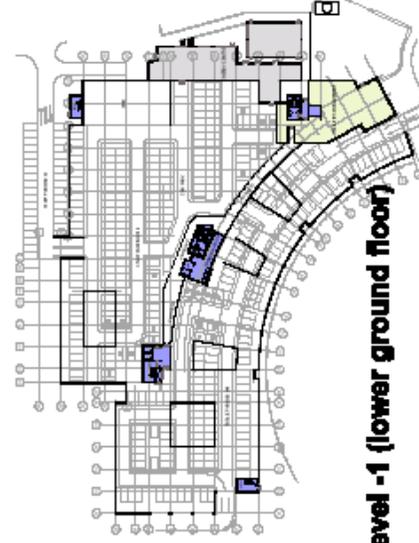
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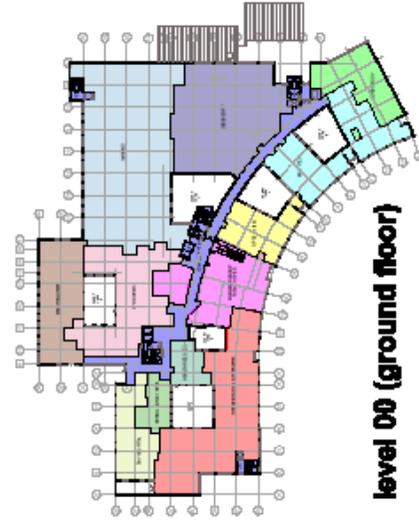
level 02 (second floor)



level 01 (first floor)



level -1 (lower ground floor)



level 00 (ground floor)

Notes

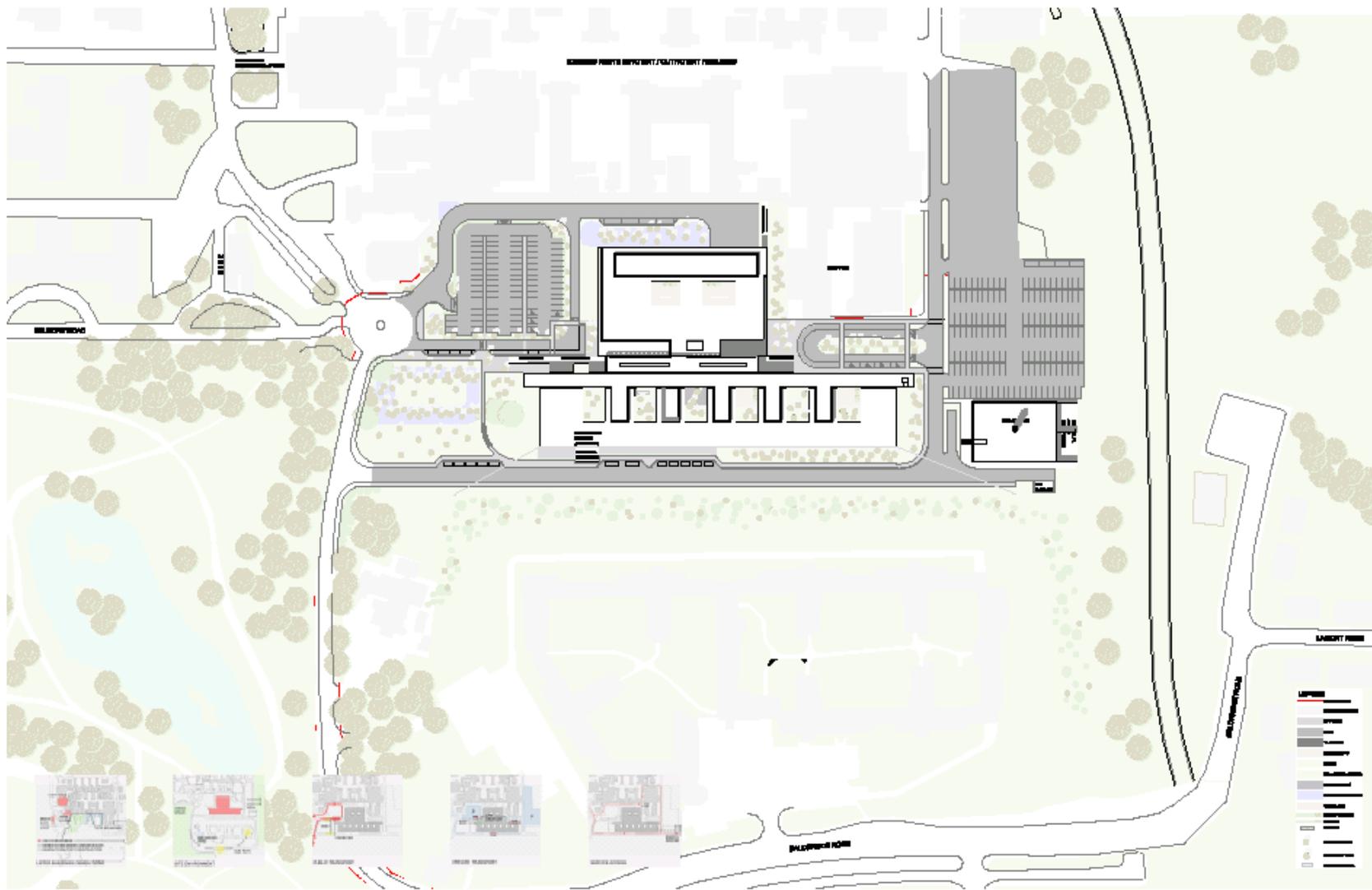
departmental relationships

VICTORIA ACAD

BALFOUR BEATTY

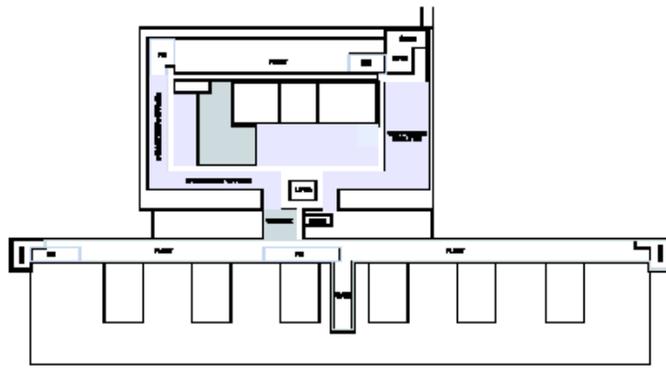
MLM ARCHITECTS

New Stobhill Hospital

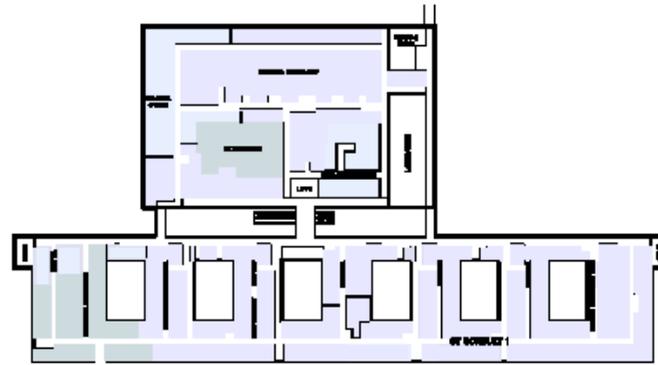


New Stobhill Hospital PPP Site Plan
 October 2006

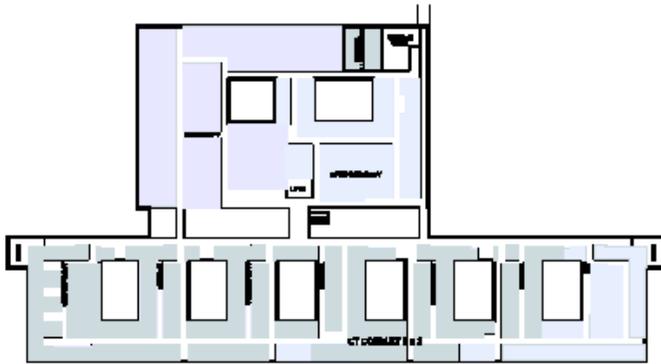
Colin McCann
 Planning
 Release and 19th Amendment
 PLANNING 002



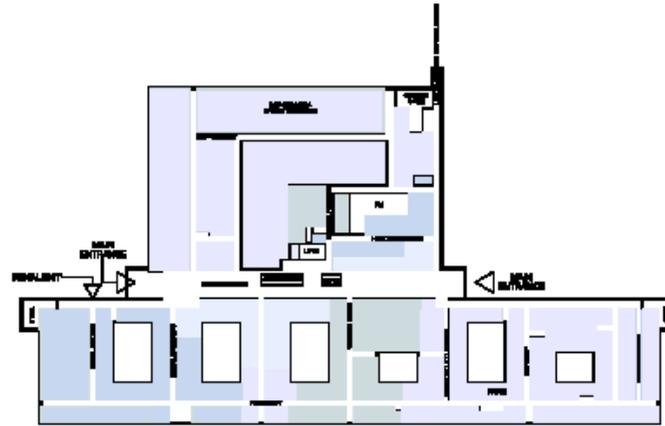
LEVEL 3



LEVEL 1



LEVEL 2



LEVEL 0

REVISIONS
 1. DATE: 11/14/2014
 2. BY: [Signature]

NO.	DESCRIPTION	DATE	BY
1	ISSUED FOR PERMIT	11/14/2014	[Signature]
2	ISSUED FOR PERMIT	11/14/2014	[Signature]
3	ISSUED FOR PERMIT	11/14/2014	[Signature]

REVISIONS
 1. DATE: 11/14/2014
 2. BY: [Signature]
 3. DATE: 11/14/2014
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 8. BY: [Signature]
 9. DATE: 11/14/2014
 10. BY: [Signature]

Appendix 8 GEM Model: PSC & PFI

Excluded – commercial information

Appendix 9 Risk Analysis:

Appendix 9.01 Risk Allocation Matrix

Risk Description	Owner of Risk		
	Board	Private Sector	Shared
Design Risks			
Design requires further amendment during <ul style="list-style-type: none"> • procurement • Construction phases of the contract	✓	✓	
Risk of insurance costs		✓	
Infrastructure is not suitable for equipment		✓	
Failure to design to brief		✓	
Change in design instigated by operator		✓	
Change in client specification	✓		
Areas are redundant due to design parameters being unrealistic	✓		
Construction and Development Risks			
Failure to build to design		✓	
Risk that site conditions require additional work to be undertaken prior to or during construction		✓	
Construction and commissioning are delayed so accommodation is not available when expected in line with the timetable issued at the Bidders Conference.		✓	
Decanting not completed to budget or time	✓		
Commissioning costs are greater than expected		✓	
Onsite security and safety		✓	
Changes in taxation and VAT		✓	
Poor Project Management		✓	
Protester action		✓	
Supply chain performance		✓	
Performance Risks			
Latent defects		✓	
Interface issues with regard to site, inpatient bed and theatres	✓		
Industrial action occurs during the PFI period		✓	
Emergency planning is not sufficient			✓

Risk Description	Owner of Risk		
	Board	Private Sector	Shared
Operating Cost Risks			
Life cycle costs are greater than forecast		✓	
Operational costs are greater than anticipated		✓	
Building available prior to programme completion date		✓	
Double running costs	✓		
Changes in policy effecting the operation of the services provided	✓		
Availability of rooms when required due to closure of certain areas		✓	
Software development (Helpdesk specific)		✓	
FM Failure to adhere to spec		✓	
Technology and Obsolescence Risks			
IT obsolescence		✓	
Financial Risks			
Risk that inflation in construction cost is greater than anticipated		✓	
Group One Equipment costs are greater than expected		✓	
Changes in medical practice are not delivered	✓		
Estimated future levels of activity are different to forecast over the 30 year project and resulting changes required to the ACAD specification	✓		
Economic Inflation is higher than expected		✓	
Interest rate movement prior to contract finalisation	✓		
Failure to generate income from generation schemes		✓	
Other Project Risks			
New legislation regulatory requirements - NHS Specific	✓		
New legislation / regulatory requirements - non NHS Specific		✓	
Risk that site purchase costs are more expensive than budgeted	✓		
Risk of failure to obtain planning approval without incurring additional expenditure up to and following outline planning permission		✓	
Force Majeure			✓

Appendix 9.02 Risk Transfer Calculation & Risk Base Costs

Excluded – commercial information

Appendix 10 Financial Advisor’s Report

Excluded – commercial information

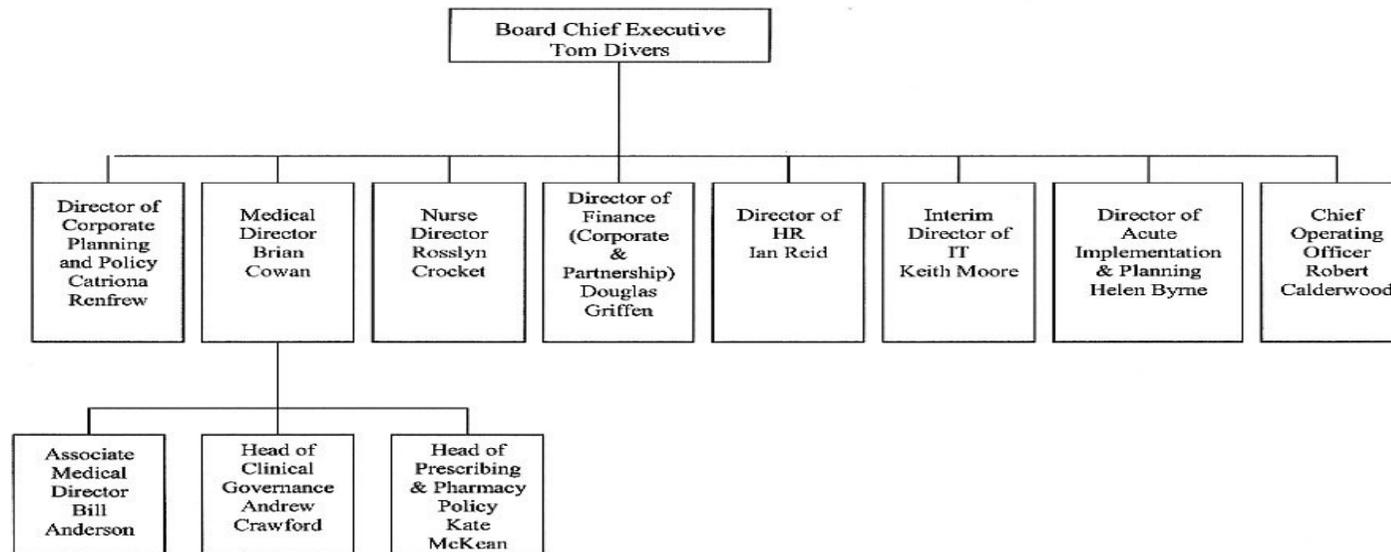
Appendix 11 External Auditor's Report

Excluded – commercial information, however the report concluded:

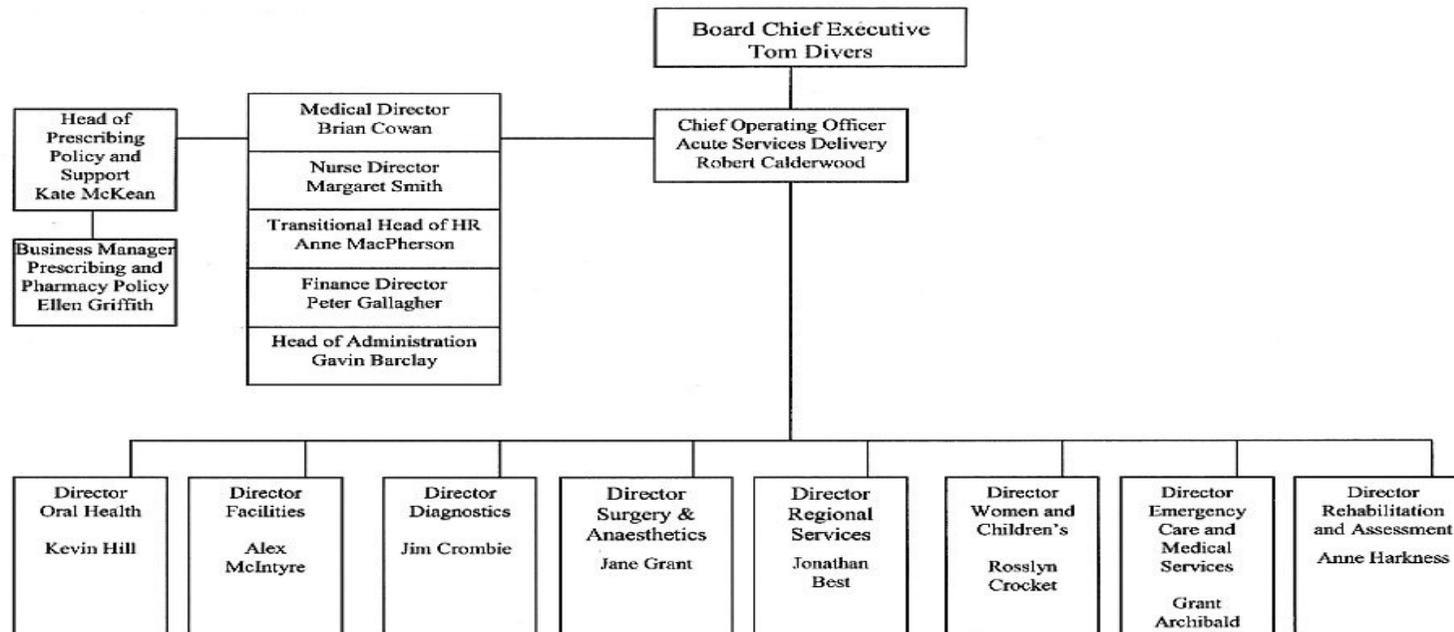
“We are presently not minded to challenge the Board's conclusion that an “off balance sheet” treatment is appropriate.”

Appendix 12 Build Programme and Project Management:

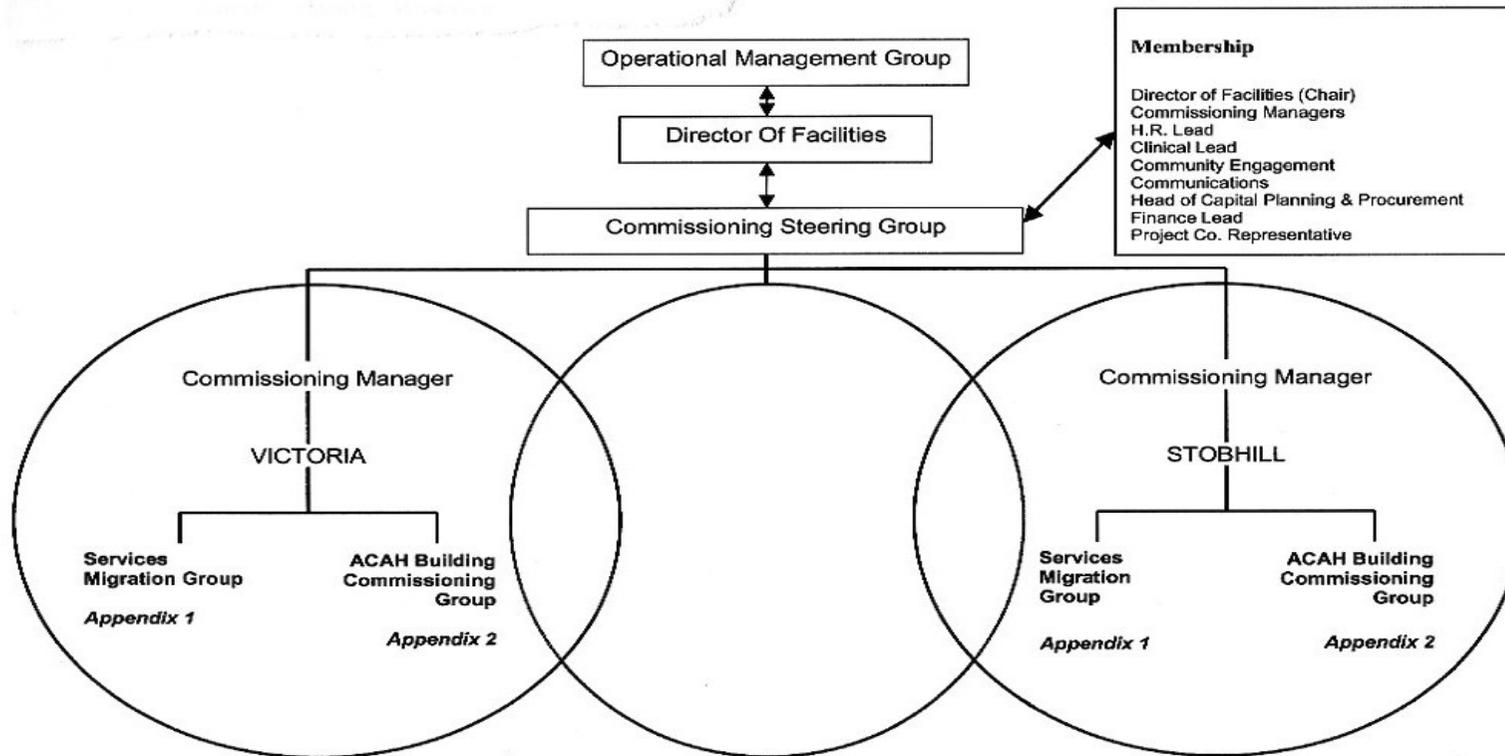
Appendix 12.01 Board Structure

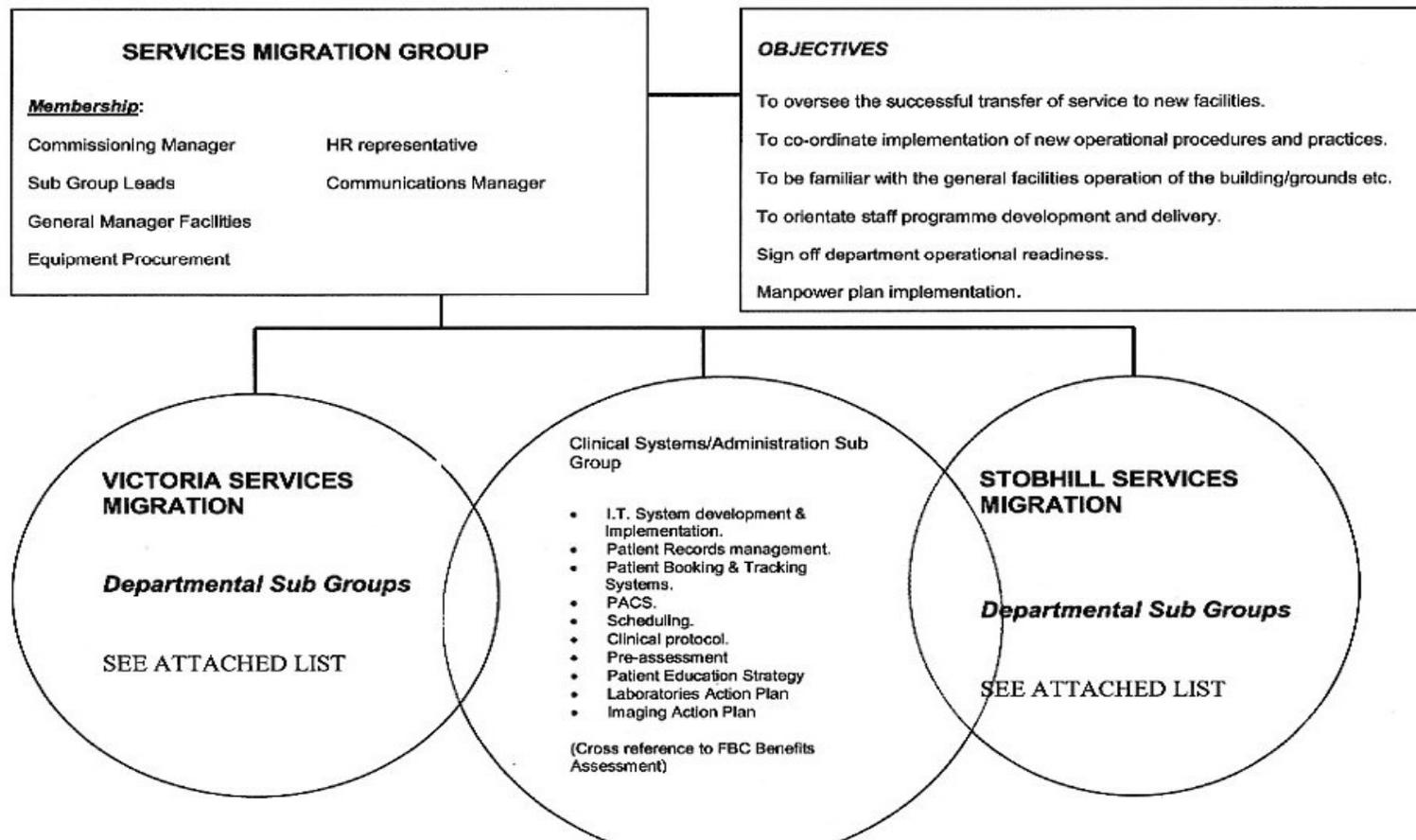


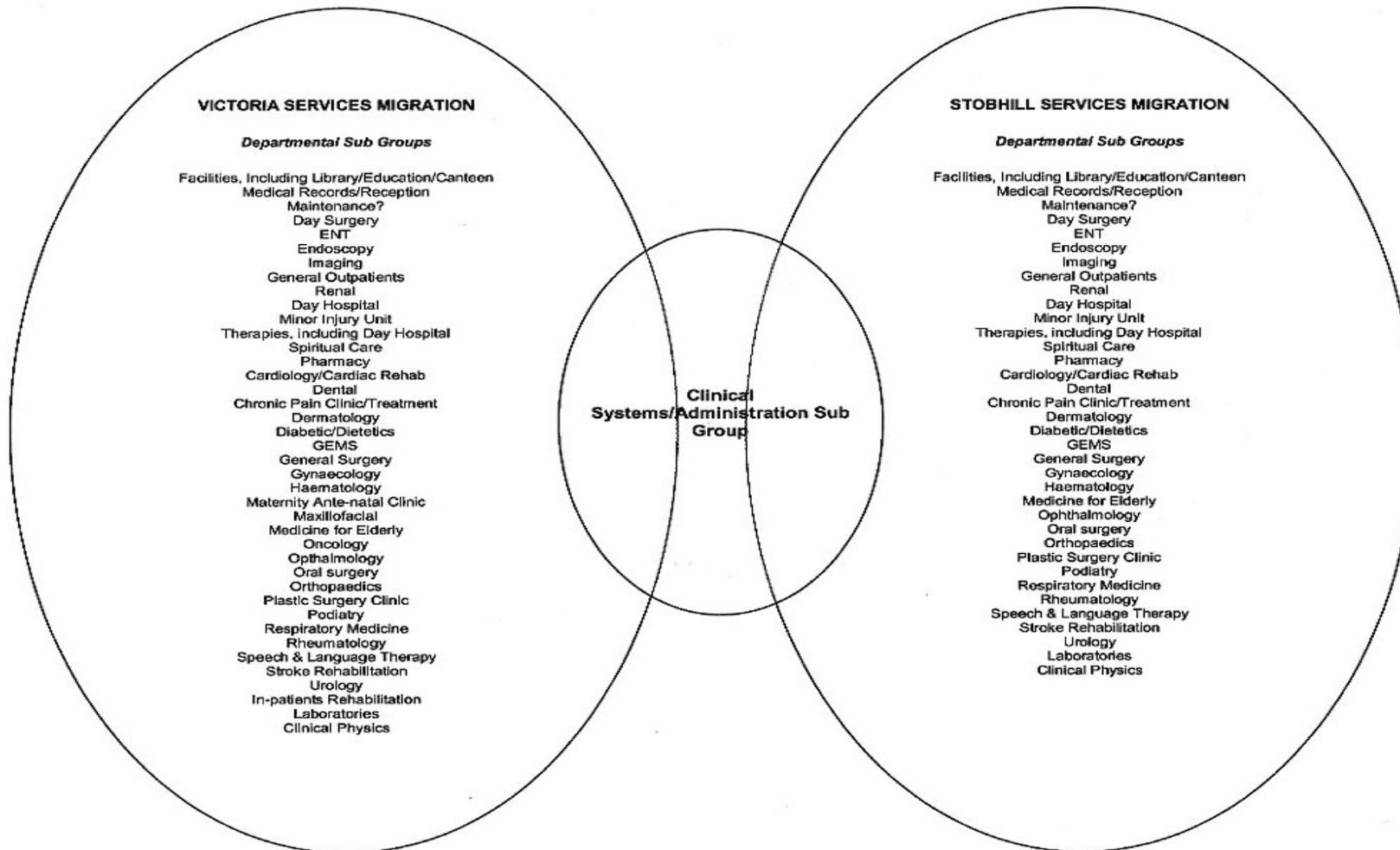
Appendix 12.02 Acute Division Structure



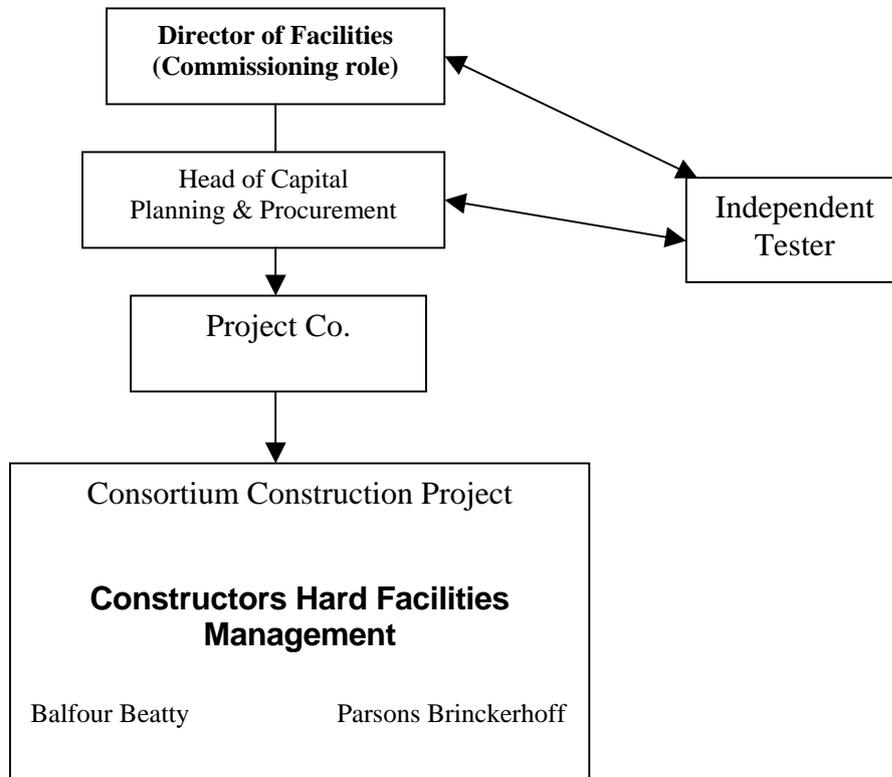
Appendix 12.03 Commissioning Structure







Appendix 12.04 Construction Period Interface



Appendix 12.05 Clinical Transition Programme

	<i>CURRENT PRACTICE</i>	<i>VISION</i>	<i>OUTLINE ACTION</i>
<i>MIGRATION</i>	<ul style="list-style-type: none"> • Most staff have some awareness of ACADs • Few staff know everything about ambulatory care • New management structure pan-Glasgow, ACAD management structure undecided • High level commissioning plan agreed – need clear action plan for transition 	<ul style="list-style-type: none"> • All staff have increased awareness of ACADs • Key staff understand ambulatory care philosophy and changes required to deliver • Clear objectives, and action plan 	<ul style="list-style-type: none"> • Communications and HR Plan • Key staff involved in transition planning • Formal establishment of Clinical Transition Group • Identify leads and ownership • Terms of Reference for Steering Group
<i>SURGERY</i>	<ul style="list-style-type: none"> • Below day surgery target rates • Some day case interspersed with main theatre cases • Named consultant lists • Less than optimum theatre utilisation • Some pre-assessment carried out • Check cancellation rates • Check DNA rates 	<ul style="list-style-type: none"> • Meet day surgery target rates • 100% booked patients • Improve scheduling and utilisation including use of electronic scheduling • Telephone follow-up for every patient 1 day post procedure • Generic pre-assessment for 100% of patient • Move 90% of 1-3 day procedures to daycase/overnight stay 	<ul style="list-style-type: none"> • Action plan by specialty • Scheduling, consultant job plans, patient booking • Clinical protocols – pan-Glasgow approach • Reconfigure acute surgery
	<i>CURRENT PRACTICE</i>	<i>VISION</i>	<i>OUTLINE ACTION</i>
<i>OUTPATIENT CLINICS</i>	<ul style="list-style-type: none"> • Some protocol-based GP referrals • Traditional 	<ul style="list-style-type: none"> • Increase protocol-based referrals including electronic based communication 	<ul style="list-style-type: none"> • ECCI project ongoing – monitor speed of progress • Action plans by

	<p>consultant clinics</p> <ul style="list-style-type: none"> • Partial booking • Many follow-ups 	<ul style="list-style-type: none"> • Scheduling of clinics and resources to support “one-stop” approach • Fully booked clinics • Reduce follow-ups 	<p>specialty</p>
<i>PATIENT EDUCATION</i>	<ul style="list-style-type: none"> • No patient education centre • Uncoordinated patient education 	<ul style="list-style-type: none"> • Dedicated area for patient education 	<ul style="list-style-type: none"> • Develop action plan for patient education
<i>STAFF EDUCATION</i>	<ul style="list-style-type: none"> • Local, ad-hoc staff education 	<ul style="list-style-type: none"> • Access to central facilities for staff E-learning 	<ul style="list-style-type: none"> • Develop action plan for staff education
<i>DIAGNOSTICS</i>	<ul style="list-style-type: none"> • Diagnostic resource impacted by emergency workload • Waiting lists for diagnostics • Diagnostic resource impacted by emergency workload • Mix of wet film processing and digital images, paper reports, mix of digital and hardcopy viewing • Laboratory investigations carried out as part of general workload 	<ul style="list-style-type: none"> • Complete separation of elective and emergency diagnostic work • Scheduled diagnostics, same day diagnostics, increased diagnostic resources • Team Diagnostics • Multiple tests and investigations for one visit • All digital images • PACS electronic reporting and viewing • Hot Lab facility to produce fast track results for standard tests 	<ul style="list-style-type: none"> • Imaging Action Plan • PACS procurement and implementation plan • Laboratories action plan

Appendix 13

Benefits Realisation Plan

BENEFIT	LEAD RESPONSIBILITY	MEASURES	TIMESCALES
QUALITY ENVIRONMENT	Alex McIntyre, Director of Facilities	Board Construction Requirements met Art in Hospital Working Group Objectives Patient and staff feedback	Six months after opening Part of Canmore Partnerships annual review processes
PATIENT SERVICES	Dr. Brian Cowan, Medical Director Margaret Smith, Nursing Director, Acute Division	Waiting times Number of one stop clinics Reduction in follow-up appointments Efficiency of diagnosis and treatment Patient and staff feedback	One year after fully operational; Annual reviews
INFORMATION MANAGEMENT AND TECHNOLOGY	Keith Moore, Acting Director of IM&T,	ICT Strategy Plan Including PACS and Clinical Portal	3 months post completion review As part of Board's ongoing performance review monitoring
STAFF FACILITIES	Alex McIntyre, Director of Facilities Anne McPherson, Director of Human Resources	Staff feedback Recruitment and retention analysis Efficiency of care provision	One year from operational plus annual performance reviews
ENVIRONMENTAL CONSIDERATIONS	Alex McIntyre, Director of Facilities	Board Construction Requirements met Art in Hospital Working Group Objectives Patient and staff feedback FM services monitoring of maintenance regime Condition of building surveys	One year from operational Annual reviews
ACCESSIBILITY	Alex McIntyre, Director of Facilities	Board Construction Requirements met Art in Hospital Working Group Objectives Patient and staff feedback FM services monitoring of maintenance regime Condition of building surveys	3 months post completion review As part of Board's ongoing performance review monitoring Part of Board/Canmore review process
FLEXIBILITY	Alex McIntyre, Director of Facilities	Ease and cost of expansion, refurbishment, redesign Flexibility of clinical use Room utilization	Annual performance reviews
IMPACT OF CONSTRUCTION	Alex McIntyre, Director of Facilities	Impact assessment during construction and commissioning. Patient and Staff feedback	Monitor during construction and joint report with Canmore to be produced 3 months post Completion handover
CLINICAL SERVICES	Dr. Brian Cowan, Medical Director Margaret Smith, Nursing Director, Acute Division	Full Benefits Realisation plan to be developed as part of Clinical Transition to identify specific key performance indicators.	Transition plan developed by end December 2006. Monitored under commissioning programme and as part of Boards ongoing performance review process