

Greater Glasgow NHS Board

Board Meeting

22 February 2004

Board Paper No. 05/9

Chief Executive – Primary Care Division

WEST SECTOR REPROVISION OF MENTAL HEALTH SERVICES – FULL BUSINESS CASE

Recommendation:

Members are asked to:

- (a) Consider the full business case for Mental Health West Sector in-Patient reprovizion; and
- (b) Approve the submission of the full business case to the Scottish Executive.

1 Introduction

- 1.1 The purpose of this paper is to submit a full business case for the reprovizion of the main in-patient services currently located on the Gartnavel Royal Hospital site to a new build facility to be constructed on an agreed footprint designated within the Gartnavel Master Plan. This will allow for replacement of old and unsuitable accommodation currently located on that site.

2 Background

- 2.1 In December 2001, the Scottish Executive approved the Greater Glasgow Primary Care NHS Trust's Outline Business Case submission for the Modernisation of Mental Health Services Acute In-patient Services across the whole Greater Glasgow area. This FBC is concerned with specific requirements of the West Sector developed within the context of the Outline Business Case developed from the Modernising Mental Health Strategic Review (1999).

3 Full Business Case Submission

- 3.1 Scottish Executive capital procurement procedures require all projects in excess of £5M to be submitted to the Scottish Executive for approval. Outline business case approval for the Modernisation of Mental Health Services Acute In-Patient Services was granted in December 2001. The Full Business Case has now been prepared and was approved by the Primary Care Divisional Management Team on 2nd February 2005. It now requires to be presented for the approval of GGNHS Board before being considered for approval by the Scottish Executive.
- 3.2 The Full Business case proposes the provision of an acute mental health hospital by Robertson Group under a PFi funding arrangement. The executive summary which can be found at section 1 of the FBC (attached), provides a brief overview of the project and explains the proposed funding arrangement. It confirms that the reprovizion of mental health services into modern NHS acute in-patient facilities meets NHSGG's requirements, is affordable and demonstrates value for money.

EMBARGOED UNTIL DATE OF MEETING.

- 3.3 At this stage, financial values and contractual terms and conditions are regarded as firm, however are not yet final and will remain subject to change during the period up to financial close and final agreement.
- 3.4 As negotiations with Robertson Group (the preferred bidder) are well advanced and now in their final phase, it is reasonable to assume that any variations to price and/or contract terms and conditions which occur between now and financial close will be minor.
- 3.5 The structure of the proposed financing arrangements for the project, supported by the work carried out to complete the financial appraisal of the project, leads to the conclusion that the transaction will be classed as “off balance sheet”
- 3.6 This, however, remains to be confirmed by NHSGG’s external auditors, PricewaterhouseCoopers, who will provide written confirmation of their opinion on this prior to conclusion of a contract with Robertson Group.
- 3.7 Once approved by GGNHS Board, the full business case will be considered by the Scottish Executive Capital Investment Group on 14th March 2005. Assuming that this timetable is achieved and detailed planning consent obtained, it is anticipated that construction will commence in July 2005 and will be completed by June 2007 with the service transferring thereafter. In the interim, marketing plans will be taken forward for the old East and West Houses at Gartnavel and areas of adjacent land not required for NHS purposes.
- 3.8 The full business case is presented in the standard format required by the Scottish Executive.

4 Conclusion

- 4.1 Approval of the full business case by the GGNHS Board is required so that it can be submitted to the Scottish Executive for the final stages of funding approval.

NHS Greater Glasgow Primary Care Division

**West Sector Reprovision of Mental Health
Services**

**Full Business Case Submission to Scottish
Executive Health Department**

February 2005

**Greater Glasgow NHS Board
Primary Care Division**

**West Sector Mental Health Reprovision of Services
FULL BUSINESS CASE (FBC) SUBMISSION**

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**GREATER GLASGOW NHS BOARD
PRIMARY CARE DIVISION**

**WEST SECTOR - REPROVISION OF MENTAL HEALTH SERVICES
FULL BUSINESS CASE SUBMISSION**

SECTION 1: EXECUTIVE SUMMARY

Section No 1	Executive Summary <u>Required Content = A self standing statement of:-</u> 1.1 <i>The background and objectives of the project</i> 1.2 <i>A description of the preferred option</i> 1.3 <i>A summary of the economic and financial (i.e. affordability) appraisals of the project</i> 1.4 <i>The key milestones and timetable to financial close and delivery of services</i> 1.5 <i>For PPP/PFI only, the key points to the PPP/PFI deal</i>
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1.1 Background and objectives of the project

1.1.1 The purpose of this full business case submission is to secure approval for the provision of modern NHS acute in-patient facilities within the West Sector of Greater Glasgow Mental Health Services for the resident population, replacing old and unsuitable institutionalised accommodation. It aims to reprovide the main in-patient services currently located on the Gartnavel Royal Hospital site in accordance with the Mental Health Strategy approved in 1999.

1.1.2 Mental Health remains a national priority and Greater Glasgow's Local Health Plan confirms that the reprovion of an in-patient accommodation in modern, custom built buildings is a high priority, within an overall programme aimed at the modernisation of mental health services for the Greater Glasgow area.

1.1.3 NHS Greater Glasgow's approach to modernising these services is:

- to replace old and unsuitable institutionalised accommodation with modern, purpose built buildings;
- to provide a wider range of therapeutic interventions in in-patient settings;
- to move toward an integrated service, ensuring continuity of care between in-patient and community based services and between health and social care services; and
- to provide care in setting appropriate to patient needs, moving away from an institutional to community based setting.

1.1.4 The project, which is the subject of this full business case (FBC), relates specifically to services provided within the West Sector of the Greater Glasgow area. An Outline Business Case for the Modernisation of Mental Health Services Acute In-patient Services across the whole Greater Glasgow area was approved by the Scottish Executive on 3rd December 2001. This FBC is concerned with specific requirements of the West Sector developed within the context of the wider Outline Business Case developed from the Modernising Mental Health Strategic Review (1999). It is intended that FBCs will follow for each of the East and South Sectors in due course, when implementation of Acute Services plans release suitable sites at Stobhill Hospital and the Southern General Hospital.

1.2 Description of the preferred option

1.2.1 The preferred option is to provide a total new build on the Gartnavel site for the re-provision of mental health services in the West Sector of Greater Glasgow. The construction of a 117 place, single-bedded en suite, acute psychiatric care facility on the Gartnavel Royal Hospital site is proposed. The facility will contain 12 places for patients requiring IPCU care, 60 places for acute adult admissions, 45 places for acute elderly admissions. These are all at ground floor level with day areas and therapy rooms. A hub facility accommodates the reception, hotel services, therapy, on-call, pharmacy and administrative functions of the hospital.

1.2.2 The preferred solution is for the new building to be provided by Robertson Group under a PFI contract. Key features of the building design include:-

- a safe environment for patients, staff and public with supervised access to the building;
- compliance with patient charter standards; in addition to security measures, rooms and open spaces allow for audio and visual privacy where appropriate; and
- good use of light, colour and space enhance the patient experience during therapy.

1.2.3 The proposed construction site sits within the area designated for a new acute mental health hospital at Gartnavel in the site Masterplan which has been approved by Glasgow City Council. It is adjacent to the site occupied by Gartnavel General Hospital.

1.3 Summary of the economic and Financial (i.e. affordability) appraisals of the project

1.3.1 An analysis of the cash flows of the Public Sector Option and the Private Option has been carried out allowing net present values to be compared. This comparison has required adjustment for:-

- risks retained by the NHS in both options;
- optimism bias in the calculation of the public sector capital expenditure sum; and
- tax adjustment to reflect the different tax receipts that the Treasury derive from adoption of the two options

1.3.2 The results of the analysis are :

	Net Present Value over 30 Years	
	PSC (£'000)	PFI (£'000)
NPV of cash flows	33,714	38,579
NPV of retained risks	12,573	7,006
Risk-adjusted NPV	46,287	45,585

The analysis shows that the PFI option has the lower NPV and is therefore the best value for money over the contract period.

1.3.3 In both cases, it is assumed that building have a 60 year life-span. The contract has a period of 30 years duration from date of signing and it is over this period that the comparison is made.

1.3.4 The preferred option is better value for money because of a lower economic cost. It includes provision of the facility and removal from the Division of significant risk elements, the principal risk element being excess cost of capital construction. Exploration of risk shows that under the PFI model:-

- the Division is protected from potential extra cost of capital cost overrun;
- it is less likely to suffer from construction time overrun, with consequences for service provision and associated costs; and
- the standard of maintenance is explicit and enforceable, to the benefit of the environment and service

1.3.5 The funding streams required to pay for the operation of this unit are incorporated within NHSGG's financial plan for Mental Health Services and are fully approved by the NHS Board. The main funding source will be existing service budgets which will be released as existing ward accommodation is closed. The project is thus containable within existing revenue resources.

1.4 **Key milestones and timetable to financial close and delivery of services**

Primary Care Division FBC approval	3rd February 2005
NHS Greater Glasgow Board approval of FBC	22nd February 2005
Scottish Executive approval of FBC	14th March 2005
Financial close	31st March 2005
Commence construction	July 2005
Complete construction	June 2007
Service commencement	August 2007

1.5 **For PPP/PFI only, the key points to the PPP/PFI deal**

1.5.1 The Division, through the Board, is entering into a single contract for the provision of services. These services are :

- design and construction of a building suitable for carrying out the services specified;
- maintenance of this building; and
- energy and utilities management associated with the building.

1.5.2

The building is to be provided under a contract term of 30 years. The project has used the Scottish Standard Form Project Agreement Version 3. The standard form Project Agreement forms the backbone of the framework and it is accompanied by ancillary agreements allowing for the lease of land, direct agreement with the funders, and collateral warranties between the NHS Board, the ProjectCo and Subcontractors.

GREATER GLASGOW NHS BOARD
PRIMARY CARE DIVISION

WEST SECTOR - REPROVISION OF MENTAL HEALTH SERVICES
FULL BUSINESS CASE SUBMISSION

SECTION 2: STRATEGIC CONTEXT

Section No 2	<p><i>Strategic Context</i></p> <p><u>Required Content:-</u></p> <p><i>2.1 Description of the, NHS Board or Special Health Board and a statement of the objectives of the NHS Body and the project.</i></p> <p><i>2.2 Description of the strategic context of the project.</i></p> <p><i>2.3 Review of key assumptions underlying the strategic analysis and effects of any changes since the OBC was approved.</i></p> <p><i>2.4 Description of present catchment population and present level of service activity.</i></p> <p><i>2.5 Description of the size and scope of the project.</i></p> <p><i>2.6 Justification of the assessment of future delivery of services, projected catchment population and other factors influencing the demand for services.</i></p>
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2.1 Description of Board and Statement of Objectives

Greater Glasgow NHS Board serves the population of the Greater Glasgow area, approximately 922,000 people. The Board is currently supported by four Operating Divisions, of which the Primary Care Division is one. The Primary Care Division, formerly known as Greater Glasgow Primary Care NHS Trust, is the largest primary care service provider in Scotland, made up of approximately 6,000 staff and 2,500 independent contractors (family doctors (GPs), dentists, opticians and community pharmacists). The Division is responsible for the provision of mental health, community and primary care services to the residents of Greater Glasgow. The revenue spending of the Division for 2003/04 was £514.3M. Capital spending was £14.5M

A Framework for Mental Health Services in Scotland, produced in September 1997 by the Scottish Office, set out a requirement for Health Boards, in partnership with local authorities, to undertake a strategic review of mental health services and produce a six year plan for change. Mental health was confirmed as being, and remains, a national priority¹. The document set out a systematic framework to develop a shared approach between health, social work and other organisations to arrive at an integrated and effective mental health service.

¹ HDL(2003)56 – National Priorities

At a Board meeting in May 1999, the Board approved a Joint Mental Health Strategy which set out the future direction for mental health services in Greater Glasgow. It committed the Board, working with the then Greater Glasgow Primary Care NHS Trust, and local authorities, to undertake a major review of mental health in-patient services with the objective of modernising services.

A 'Modernising Mental Health Services' Public Consultation document was produced outlining proposals to reshape significantly adult and elderly mental health across Greater Glasgow over a five year period. Proposals were based on a whole system approach to mental health services between health and social care.

Greater Glasgow is characterised by high levels of deprivation. This is reflected in hospital admission rates and in increased prevalence of mental health problems linked to substance misuse. Greater Glasgow NHS Board's Local Health Plan confirms that the re-provision of in-patient accommodation in modern, custom built buildings is a high priority, within an overall programme aimed at the modernisation of mental health services for the Greater Glasgow area.

The project, which is the subject of this full business case (FBC), relates specifically to services provided within the West Sector of the Greater Glasgow area. An Outline Business Case for the Modernisation of Mental Health Services Acute In-patient Services across the whole Greater Glasgow area was approved by the Scottish Executive on 3rd December 2001. This FBC is concerned with specific requirements of the West Sector developed within the context of the wider Outline Business Case developed from the Modernising Mental Health Strategic Review (1999). It is intended that FBCs will follow for each of the East and South Sectors in due course, when implementation of Acute Services plans release suitable sites at Stobhill Hospital and the Southern General Hospital.

2.2 Description of the Strategic Context of the Project

This project aims to provide modern NHS acute in-patient facilities within the West Sector for the resident population of Greater Glasgow, replacing old and unsuitable institutionalised accommodation. In particular, it aims to re-provide those in-patient services currently located on the Gartnavel Royal Hospital site.

The re-provision of in-patient accommodation is a key component of GGNHSB's strategy for modernising Greater Glasgow's mental health services. The Division's aim is to provide a fully integrated mental health service, focusing on:

- community care;
- reducing institutional provision; and
- developing specialised services, such as drug and alcohol, to meet identified gaps.

In doing so, we aim to:

- provide acute admission services in modern purpose built accommodation;
- provide a wider range of therapeutic interventions in in-patient settings;
- ensure continuity of care between in-patient and community based services and between health and social care services; and
- facilitate a shift in the balance of care away from an institutional to community based setting, with care being provided in settings appropriate to patient needs.

2.3 Review of key assumptions underlying the strategic analysis and effects of any changes since the OBC was approved.

There have been no significant changes since the OBC was approved. There has been some minor adjustment to bed numbers linked to review of the catchment area for the West of the City and the plan to provide increased flexibility in bed utilisation for rehabilitation services.

2.4 Description of present catchment population and present level of service activity

The Outline Business Case reflected a situation where:-

The Greater Glasgow area is characterised by high levels of deprivation. Of a population of 922,000, 77% live in areas with deprivation categories 6 and 7. Patients from very deprived areas are three times more likely to be admitted to hospital than those in very affluent areas². There has been little change in these trends between 1999 and 2004. Of a total population of circa 922,000, approximately 200,000 live within the West Sector.

Admissions to acute adult psychiatric hospital units increased by 15.3% between 1994 and 1999², while occupancy levels rose from 93% to 95%. During this same time period, average length of stay dropped from 34 days to 28 days. This can be attributed to the development of community mental health services, in particular Community Mental Health Teams.

Admissions to acute elderly psychiatric hospitals decreased by 25% from 1994 to 1999², as did occupancy levels (90% to 85%) and length of stay. Again this can be attributed to the development of community infrastructures. In older people, depression is the most common of all mental health problems dealt with by services.

Hospital admissions to acute medical units for self poisoning have continued to rise since 1989, from approximately 1000 admissions per annum to approximately 1400 admissions per annum in 1995. Of these, approximately 1% result in suicides on an annual basis³. Suicide rates particularly in unemployed young men are rising, 85% of suicides relate to people from deprivation categories 6 and 7.

Rates of hospital admission for alcohol misuse are 10 times higher for people living in the most deprived parts of Greater Glasgow than the most affluent², and 33 times higher for problems associated with drug misuse.

Approximately 1800 people in Greater Glasgow have a severe and enduring mental illness with complex needs⁴.

² Mental Health and Mental Health Illness in Greater Glasgow – Drs L Gruer and D Morrison: Department of Public Health, GGHB March 1999.

³ Suicides and other causes of death following attempted suicide – Hawton, K et al: BMJ - 1998

⁴ Keys to engagement – The Sainsbury Centre

2.5 Description of size and scope of the project

A facility is required that contributes to the delivery of effective therapeutic services to psychiatric patients, allowing for flexibility of use between male and female patients. The environment needs to allow for the dignity and privacy of individuals, providing a living environment which is non-institutional in nature.

The construction of a 117 place, single-bedded en suite, acute psychiatric care facility on the Gartnavel Royal Hospital site is proposed. The facility will contain 12 places for patients requiring IPCU care, 60 places for acute adult admissions, 45 places for acute elderly admissions, and other accommodation necessary for the provision of clinical care and the provision of associated non-clinical services. The estimated capital value (including equipment, VAT and fees) is £19.9M and is to be taken forward as a PFI project which is the subject of this Full Business Case. A separate work stream associated with the development of the adjacent Gartnavel General site sees expenditure on site preparation works outwith this Full Business Case.

Current plans see retention within the Gartnavel Royal site of 1 x 15 bed addiction ward as an interim facility pending provision of suitable accommodation in the South of the City. In addition, a rehabilitation unit will be established within vacated refurbished ward accommodation on the site. This will operate in conjunction with the proposed new in-patient hospital. Provision of these facilities is planned in parallel with the provision of the new acute hospital facility and is outwith the scope of the project and this full business case.

In parallel with the re-provision of acute existing in-patient facilities, the Division will also provide suitable alternative office premises, within refurbished ward accommodation, to house:

- (a) non clinical staff directly associated with the provision of mental health services in the West Sector; and
- (b) the relocation of existing Division wide non clinical staff, e.g. Human Resources, Estates, Workshops, Research and Development, who are required to vacate existing accommodation to enable a suitable site for this project.

The aforementioned re-provision of office accommodation is outwith the scope of the project which is the subject of this FBC.

The re-provision of in-patient facilities will result in two substantial listed buildings and land on the site becoming surplus to NHS requirements. The Division wishes to maximise the value to be derived from the disposal of surplus buildings and adjacent land on the Gartnavel Royal Hospital site, and will seek proposals from property developers for residential development in line with the anticipated outline planning consent for the part of the site not required for health care purposes.

2.6 Justification of the assessment of future delivery of services, projected catchment population and other factors influencing the demand for services

Current ward environments do not provide sufficient space to allow clinicians to work with patients in an individual basis. This is attributable to their original design that was focused on simply providing ward based accommodation rather than an environment to facilitate individual treatment and rehabilitation. With the development of community based services, the focus of acute in-patient services has moved to patients with more complex needs, and dependencies. This has accentuated the need for individual living space for patients and for small rooms to facilitate group work with small groups of patients with similar needs. The

current configuration of accommodation, mainly consisting of 30 bedded wards, acts as a barrier to the provision of appropriate packages of care, by affording little opportunity for privacy and for the protection of dignity.

Acute adult and elderly in-patient services require to cater for the needs of a wide range of acutely ill patients with different conditions. Lengths of stay in mental health wards will typically be significantly longer relative to the average for surgical or medical admissions on account of the nature of these conditions, highlighting the need for single room accommodation. Current ward accommodation does not meet this need. It is unable to provide individual rooms for each patient, or small rooms to enable group work involving small groups, or adequate open space (either internally or externally) for general/social interactive activities. Most accommodation does not meet mixed gender accommodation standards for fully segregated facilities within mixed gender wards.

Evidence suggests that current acute average length of stay figures are higher than they need to be with a significant number of admissions inappropriately cared for in in-patient settings. There is scope to improve this by developing:

- links between in-patient and the 'community' services
- intermediate and community services
- expanding the range of therapeutic interventions provided within an inpatient setting.

The enhancement of these services in the way described will allow more patients to be cared for in settings appropriate to their needs. The provision of new custom built in-patient accommodation allied to additional staff with strengthened skill mix will enable the service to focus on the provision of therapeutic treatment regimes; allowing patients to move more rapidly through the level of care most appropriate to their needs.

In recent years there has been a significant development of community based mental health services in Greater Glasgow. These have been based on the development of a mental health team network that is both multi disciplinary and multi agency in nature and have clear links to primary care. Linked to this shift in the balance of care has been a reduction in in-patient bed numbers and a reduction in patient's length of stay within acute in-patient units.

The further development of community based services envisaged within Greater Glasgow Health Board's programme for modernising mental health services has implications for the future provision of in-patient services, as additional services are set up within the community to address a range of needs which were formerly met within an in-patient environment.

In addition, an increase in the volume and mix of staffing has allowed an expansion of the range of therapeutic interventions provided within the in-patient setting. This forecast is expected to impact on bed requirements bringing about a reduction in the length of stay for a subset of the total number of in-patient episodes of care.

In determining the appropriate number and configuration of in-patient beds, the high level of deprivation experienced within the Greater Glasgow area needs to be taken into account in deciding the appropriate number of beds.

The above factors have been taken into account in arriving at the recommended level of acute in-patient service provision for Greater Glasgow's population of circa 922,000 as follows (including the recommended level of provision for West Glasgow). The population size of West Glasgow is forecast to remain relatively stable for the duration of the project.

	Population	Adult Acute		IPCU		Elderly Acute		Drug & Alcohol	
		Proposed	Current	Proposed	Current	Proposed	Current	Proposed	Current
North East	363,000	120	126	12	11	55	73	15	14
North West	200,000	60	80	12	12	45	60		8
South	359,000	100	120	12	12	60	70	15	
TOTAL	922,000	280	326	36	35	160	203	30	22

Greater Glasgow Health Board's programme for modernising mental health services also envisages the transfer of a significant number of elderly continuing care patients from NHS hospitals to alternative packages of care which are more appropriate to their needs, including the NHS partnership beds, community based residential accommodation and supported accommodation. This has now been largely achieved.

**GREATER GLASGOW NHS BOARD
PRIMARY CARE DIVISION**

**WEST SECTOR - REPROVISION OF MENTAL HEALTH SERVICES
FULL BUSINESS CASE SUBMISSION**

SECTION 3: OUTLINE BUSINESS CASE

Section No 3	<p><u>Required Content:-</u></p> <p><i>3.1 A short summary of the OBC including a description of the long list of options</i></p> <p><i>3.2 Description of short list of options considered including results of the economic appraisal, benefits analysis, financial appraisal and sensitivity analysis.</i></p> <p><i>3.3 Review of assumptions underlying the OBC to demonstrate how any changes have affected the ranking of options, including any changes to the assessed benefits of the scheme.</i></p>
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- 3.1 Summary of the Outline Business Case including a description of the long list of options**
- 3.1.1 The outline business case set out the Division's plans to modernise mental health acute in-patient services throughout Glasgow. The outline business case was approved by the Scottish Executive on 3rd December 2001. The project, to which this business case relates, concentrates on services to be provided within the West of the City only.
- 3.1.2 It described the need to modernise acute in-patient facilities for the resident population of Greater Glasgow, in line with Greater Glasgow NHS Board's Joint Mental Health Strategy, replacing old and unsuitable institutionalised accommodation with modern custom built buildings. It was agreed, wherever possible, that planned accommodation would be collocated with acute general hospital services.
- 3.1.3 Alternative models of care were considered for both adult and elderly acute services. Options were derived by varying the level of service provision in different sectors within the spectrum of patient care. The preferred model of care took into account the planned expansion of community based services, allowing for the high level of deprivation experienced in Glasgow, coupled with high levels of alcohol and drug misuse, in determining the appropriate level of in-patient beds re-provision.
- 3.1.4 A sectoral approach was adopted to ensure equitable access to appropriate in-patient services across Greater Glasgow.
- 3.1.5 The Division identified a number of options for the re-provision of acute in-patient services within the West Sector. Options ranged from the status quo through to a combination of existing and new-build and complete new-build. Based on 60 Adult Acute, 40 Elderly Acute (now 45) and 12 IPCU beds, the options identified, along with reasons for their rejection or shortlist, were as follows:

Option		Description	Reject / Shortlist
i.	Do nothing.	Remain in existing accommodation at Gartnavel. Combination of large Victorian buildings and single storey wards built in the 1970s and upgraded in the 1980s.	REJECT – The majority of the beds are in the Victorian buildings, with unsuitable ward configuration and high estate costs. Option would reduce the potential for site disposal proceeds.
ii.	Modify existing accommodation. (1)	Remain in existing accommodation, with modifications and refurbishment.	REJECT – Victorian buildings do not allow for reconfiguration into single rooms and flexible day space. High cost of modification of both building types and ongoing maintenance liabilities. Option would reduce the potential for site disposal proceeds.
iii.	Do minimum. Modify existing accommodation. (2)	Vacate West House and remain in existing accommodation on the rest of the site.	REJECT – High cost of modification of existing buildings. Would mean a service which had limited clinical functionality and effectiveness due to the inability to link these ward areas.
iv.	Combination of existing and new build on non-NHS site.	Remain in 1970s wards with new build for the balance on non-NHS site.	REJECT – Would create a disjointed service, with part of the service not on a DGH site. High cost of modification. High cost and availability of land acquisition. Option would reduce the potential for site disposal proceeds.
v.	Combination of existing and new build on Gartnavel site.	Remain in 1970s wards with new build for the balance on Gartnavel site.	REJECT – Existing accommodation would not satisfy the clinical model of single rooms with adequate day space. Would create a two-tier service. Option would reduce the potential for site disposal proceeds.
vi.	Modify existing and new build on Gartnavel site.	Modify McNiven ward as 2 x 20 bed Elderly acute wards with the new build (60 adults and IPCU) on Gartnavel site.	SHORTLIST – This option would allow the consolidation of adult and elderly services. New-build would be co-located with McNiven wards. However, this would not give complete integration of services to enhance clinical effectiveness.

Option		Description	Reject / Shortlist
vii.	Total new build on non-NHS site.	Re-provision of the in-patient beds on a non-NHS site.	SHORTLIST – Whilst not satisfying the clinical model for service to be located on a DGH site, it would provide a consolidated service, sustaining the clinical preference for an integrated service. However the high cost and availability of land may make this difficult to achieve.
viii.	Total new-build on Gartnavel site.	Re-provision of the in-patient beds on Gartnavel site.	SHORTLIST – This would provide a consolidated service, sustaining the clinical preference for an integrated service. In addition, it would meet the clinical requirement to locate the service on a DGH site.

Three were short-listed from the above list of options, for further consideration.

3.2 Description of short list of options considered including results of the economic appraisal, benefits analysis, financial appraisal and sensitivity analysis

3.2.1 A summary was provided in the Outline Business Case which detailed the short-listed options for the West of the City.

3.2.2 Option vi – Modify existing accommodation and new-build

This would not be consistent with the preferred clinical model, with a combination of new-build adult acute beds, and refurbishment of the existing 60 bed McNiven wards to create two 20 bed elderly acute wards. The model would not provide a fully integrated clinical model, with maximum clinical effectiveness, however, the accommodation would be sufficiently closely collocated to allow partial achievement of an integrated service model.

3.2.3 Option vii – Total new-build on non-NHS site

This option would not meet the requirement for collocation with DGH services. However, it would deliver the key clinical preference for a consolidated service to enhance the clinical effectiveness. Also, the very high land values in the Sector, and the shortage of suitable land may make this option difficult to achieve.

3.2.4 Option viii – Re-provision of the in-patient beds on the Gartnavel site by new-build

This provides the preferred clinical model, with single rooms, wards no greater than 20 beds, flexible day/open space and the ability to design the interior and external environment to meet contemporary clinical and estates standards. The option meets the clinical preference for the in-patient services to be located on a DGH site. It also allows the release of McNiven wards for alternative use as accommodation for non-clinical staff thus freeing up listed buildings and adjacent surplus land for development

consistent with the property strategy. This will generate significant receipts for healthcare reprovion.

3.3 Review of assumptions underlying the OBC to demonstrate how any changes have affected the ranking of options, including any changes to the assessed benefits of the scheme

3.3.1 There have been no significant factors influencing the selected option since the Outline Business Case approval.

**GREATER GLASGOW NHS BOARD
PRIMARY CARE DIVISION**

**WEST SECTOR - REPROVISION OF MENTAL HEALTH SERVICES
FULL BUSINESS CASE SUBMISSION**

SECTION 4: THE PREFERRED SOLUTION

Section No 4	<p><u>Required Content:-</u></p> <p><i>4.1 Description of the consortium and its members, including an evaluation of their strength and qualities. This may include reports by a rating agency.</i></p> <p><i>4.2 Description of the PPP/PFI solution.</i></p> <p><i>4.3 Timetable for securing outstanding planning permission and details of what happens if planning permission is not achieved.</i></p> <p><i>4.4 Timetable from FBC to financial close and delivery of services.</i></p> <p><i>4.5 Details of when the price quoted in the PPP/PFI bid is firm until.</i></p> <p><i>4.6 Details of the assumed interest rate on which the price of the scheme is based, including the interest rate buffer.</i></p> <p><i>4.7 Sensitivity analysis of the effect on price of an increase or decrease in interest rates.</i></p>
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4.1 Description of the consortium and its members, including an evaluation of their strengths and qualities.

The consortium comprises :

Lead member	Robertson Capital Projects
Builder	Robertson Construction
Banker	Bank of Scotland
Financial Advisor	Quayle Munro
Cost Consultancy	E C Harris
Legal Advisor	Mclay Murray & Spens
Architect	Macmon
Facilities	Robertson Facilities Management

The Robertson Group have had experience in a number of PFI schemes, in particular, New Craigs Mental Health Hospital Inverness, Chester-le-Street Community Hospital and Forfar Community Resource Centre. They have reflected in their written submissions and in face-to-face dialogue an understanding of mental health service requirements, both technical and day-to-day service issues. New Craigs, is a 230 bed mental health and learning disability hospital which opened in 2000.

4.2 Description of the PFI solution

4.2a The design consists of 117 single bedrooms with ensuite facilities arranged as :

- 3 x 20 bed Adult Acute Care wards
- 1 x 20 bed and 1 x 25 bed Elderly Acute Care wards
- 1 x 12 bed Intensive Psychiatric Care ward

These are all at ground floor level, with day areas and therapy rooms. A hub facility accommodates the reception, hotel services, therapy, on-call, pharmacy and administrative functions of the hospital.

Key features of the building design include:-

- provision of a safe environment for patients, staff and public with supervised access to the building;
- compliance with patient charter standards; in addition to security measures, rooms and open spaces allow for audio and visual privacy where appropriate; and
- designed for therapy making good use of light, colour and space to enhance the patient experience.

4.2b The proposed construction site sits within the area designated for a new acute mental health hospital at Gartnavel in the site Masterplan which has been approved by Glasgow City Council. It is adjacent to the site occupied by Gartnavel General Hospital.

4.2c The contract term is 30 years.

4.3 Timetable for securing outstanding planning permission and details of what happens if planning permission is not achieved.

Outline planning permission has been received with a masterplan for the whole site agreed with Glasgow City Council.

Detailed planning permission is required. It is anticipated that this will be granted in July 2005. In the event of permission not being granted, the Primary Care Division will work with the **ProjectCo** and Glasgow City Council, where appropriate, to address any outstanding planning considerations.

4.4 Timetable from FBC to financial close and delivery of service.

The timetable is :

Primary Care Division FBC approval	3rd February 2005
NHS Greater Glasgow Board approval of FBC	22nd February 2005
Scottish Executive approval of FBC	14 th March 2005
Financial Close	31 st March 2005
Commence Construction	July 2005
Complete construction	June 2007
Service commencement	August 2007

4.5 Details of when the price quoted in the PFI bid is firm until.

A base date of 31st October 2004 is the date adopted for the price quoted in the PFI bid.

The construction price, upon which the unitary charge is mainly based, will be held firm for 5 months following 31st October 2004 until 31st March 2005.

4.6 Details of the assumed interest rate on which the price of the scheme is based, including the interest rate buffer.

The assumed interest rate on which the price of the scheme is based is :

Senior Debt	5.25%
Margin	1.00%
MLA	0.02%
Credit Spread	0.15%
Total	6.42%

Interest rates may fluctuate between time of writing and date of financial close. The Primary Care Division recognises the need to take account of any change in costs associated with change in the rate of interest in its financial plan to meet the cost of operating the unit.

At time of writing, long term interest rates are lower than the senior debt rate of 5.25%, by a factor of more than 0.25%, and so there is a possibility that there will be a reduction in the rate of interest.

4.7 Sensitivity analysis of the effect on the price of an increase or decrease in interest rates.

The sensitivity of Unitary Charge to interest change is :

Standard Charge (before rates and energy supply)	£'000
at interest rates stated above	1767
Increase in rates by 0.25%	1792
Increase in rates by 0.5%	1817
Decrease in rates by 0.25%	1742
Decrease in rates by 0.5%	1717

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SECTION 5: THE PUBLIC SECTOR COMPARATOR

Section No 5	<p><u>Required Content:-</u></p> <p>5.1 Description of how the PSC has been derived and updated from the preferred option in the OBC.</p> <p>5.2 Explanation of any updates that have been made in order to place the PSC on the same basis as the PPP/PFI option.</p>
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5.1 Description of how the PSC has been derived and updated from the preferred option in the OBC

5.1.1 The PSC is derived from the OBC preferred option. The preferred option was for the provision of a facility of 117 places located on the Gartnavel site. Costing of the preferred option was carried out on the basis of :

Cost of Element	Basis of Cost
Salaries – Clinical and Administration	Current Manpower Plan
Building cleaning and maintenance	Experience of existing acute facilities in Mental Health
Building Cost and pre-planned maintenance	Build cost guidelines, indexed to current value Technical advice on building infrastructure cost
Heat, light, power rates	Current guidance on heating, rates costs as normally applied, scaled to building
Other costs (e.g Catering)	Support services estimates based on current experience
Land	The land is within the ownership of NHS Greater Glasgow and will be licensed for occupation by the ProjectCo

5.1.2 The PSC has been updated to reflect build and other cost inflation to take account of elapsed time since issue of the Outline Business Case :

	OBC Preferred Option Costings	Present PSC Costings
Year	2000/2001 £k	2004/2005 £k
Capital Build Cost	15310	19940
Revenue Costs (capital charges, maintenance, rates, heat/light/power)	1820 p.a	2220 p.a

5.2 **Explanation of any updates that have been made in order to place the PSC on the same basis as the PFI option.**

5.2.1 When the OBC was prepared, a facility of 129 beds was envisaged including 17 beds for rehabilitation in-patient services. Rehabilitation services will now be provided from within an existing ward facility which will become vacant when the new hospital is built. The vacant ward will be refurbished to provide a rehabilitation facility for West Glasgow. Accordingly there is no longer a requirement to seek the provision of a rehabilitation facility as part of this proposal. An additional 5 acute elderly beds are required to take account of a change to patient catchment areas between West and East Glasgow. When the FBC for East Glasgow is submitted, there will be a corresponding reduction in the number of places required.

5.2.2 There have been no significant changes identified during the process of exploring the PFI option which would require adjustment to the PSC.

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SECTION 6: PPP / PFI PROCUREMENT PROCESS

Section No 6	<p><u>Required Content:-</u></p> <p><i>6.1 Description of the procurement methodology undertaken.</i></p> <p><i>6.2 Details of advisers used by the Trust.</i></p> <p><i>6.3 Description of the pre-qualification process indicating the route by which the Trust arrived at the short list.</i></p> <p><i>6.4 Brief summary of the Invitation to Negotiate document including the evaluation process and criteria described for selecting a preferred bidder.</i></p> <p><i>6.5 Explanation of the choice of preferred private sector partner.</i></p> <p><i>6.6 A copy of the original OJEC advertisement should be annexed to the business case.</i></p>
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6.1 Description of the procurement methodology undertaken

The Primary Care Division used the PPP/PFI procurement process based on European Procurement Regulations Negotiated Procedure.

6.2 Details of the advisers used by the Division

Legal : McClure Naismith, Queen Street, Edinburgh

Finance : Tribal Consulting, Queensway, Birmingham

Technical : Young & Gault, Speirs Wharf, Glasgow

Project Management : Currie & Brown, West Campbell Street, Glasgow

Insurance : Willis Ltd, West George Street, Glasgow

6.3 Description of the pre-qualification process indicating the route by which the Primary Care Division arrived at the short list

6.3.1 The Division placed a notice in the Official Journal of the European Community (OJEC) on 22 May 2002 inviting interest in the design, construction, finance and hard facilities operation of the hospital. The negotiated procedure would be applied.

6.3.2 Pre-qualification questionnaires were sent to 16 interested parties of which 5 were interviewed to assess their breadth of experience and depth of interest. 3 consortia were selected for invitation to negotiate :

Canmore Partnership
Robertson Group
Jarvis Projects

Jarvis Projects withdrew their interest due to commitments elsewhere. The two remaining parties, Canmore and Robertson, were selected for invitation to negotiate.

Invitations to Negotiate were issued on 9 October 2003.

6.4 Brief Summary of the Invitation to Negotiate document including the evaluation process and criteria described for selecting a preferred bidder

6.4.1 The Invitation to Negotiate included :

Volume 1 The Division's approach to the invitation process and the requirements from bidders for submission of proposals.

Volume 2 Draft Project Agreement describing the legal framework by which the Division would enter into contract with a private sector partner.

Volume 3 Output Specification detailing output requirements of the building and performance standards required by the Division.

Operational Policies describing how the Division would operate services in the new unit.

6.4.2 The evaluation process was based upon :

- evaluation of the design carried out under a disciplined process of questions and answers on proposed designs, contributions to this process given by clinicians, managers and technical advisors
- legal assessment carried out by the Legal Advisors
- financial assessment carried out by the Financial Advisors
- integrity assessment carried out by Legal Advisors
- technical assessment carried out by Technical Advisors

6.5 Explanation of the choice of preferred private sector partner

6.5.1 The Evaluation panel comprised Divisional representatives (Mental Health Services, Estates, Support Services and Finance) and Advisors who examined the bids and scored them in accordance with agreed criteria.

6.5.2 Both bidders submitted proposals which complied with design outcome requirements Robertson Group had a preferable design. Robertson Group also scored higher in all evaluation categories, in particular in offering a significantly more affordable bid, and were chosen as preferred bidder :

Scoring results	Canmore/Balfour Beatty	Robertson
Legal response	4.80	10.60
Financial response	6.45	10.99
Approach to design and construction	21.90	26.40
Approach to facilities management	15.48	17.24
Project management approach	2.84	3.25
Total	51.47	68.48

6.6 Copy of the original OJEC advertisement

A copy of the original OJEC advertisement is attached as Section 6 Annex A

ANNEX A

COPY OF ORIGINAL OJEC NOTICE

1. Awarding Authority : Greater Glasgow Primary Care NHS Trust, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH, U.K.
Tel. 0141 211 3722 Fax : 0141 211 3971

2a. Award Procedure : Negotiated

2b. Category of service and description, CPC reference number, quantity, options : CPV : 85111500

The services will include the design, construction, equipping and maintenance of a 112 place, single bedded en suite, acute psychiatric care facility on a site at Gartnavel Royal Hospital. The facility will contain 12 places for patients requiring IPCU care, 60 places for acute adult admissions, 40 places for acute elderly admissions, and other accommodation necessary for the provision of clinical care and the provision of associated non-clinical services.

Estimated capital value (including equipment, VAT and fees) : 13,000,000 GBP

In parallel with the provision of a new in-patient facility, the Trust requires suitable alternative office premises to accommodate 200 NHS administration and management staff who are currently based on the site.

It is anticipated that the provision of a new in-patient facility will result in buildings and land on the site becoming surplus to NHS requirements. The Trust wishes to maximise the value to be derived from the disposal of surplus buildings and land on the Gartnavel Royal site, and may seek proposals from the service provider for residential development in line with the anticipated outline planning consent for the part of the site not required for health care, around 17 net acres.

3 Site : Gartnavel Royal Hospital, Glasgow, UK

4a Reserved for a particular profession : No

4b Law, regulation or administrative provision : No

4c Obligation to mention the names and qualification of personnel : No

5. Division into lots : The Trust's current intention is to award 1 contract for all the services in line with the UK Government's Private Finance Initiative

6. Number of service providers which will be invited to tender : 3-4

7. Variants : Variant bids will be permissible, provided that the Trust agrees that the core requirements will be met and subject to restrictions appearing in the invitation to negotiate.

8. Time limits for completion or duration of the contract, and for starting to provide the service : It is anticipated that the construction will be completed on or prior to July 2006 and that services will be provided for an estimated 30 years thereafter. Varying service lengths will be explored for value for money and affordability.

9. Legal form in case of group bidders : The Trust reserves the right to require particular legal form in the case of group bidders. Where the contract is to be performed by more than 1 party, joint and several liability will apply.

10a Justification for the use of shorter time limits : Not applicable

- 10b Deadline for receipt of applications : 21 6.2002 (12.00)
- 10c Language : English
- 11 Deposits and guarantees required : A performance bond or a parent company guarantee may be required to ensure appropriate security for all contractual obligations.
- 12 Qualifications : Potential bidders will (at a later date) be requested to provide information to allow evaluation of their financial and technical status. Information may include :
 details of financial standing;
 company accounts for past 3 years;
 company structures and controls;
 technical information – experience sheets;
 track record in PFI;
 clinical support to design process;
 sub-contractor’s details;
 professional indemnity/public indemnity insurances
 CVs.
13. Service providers already selected : None
14. Other information : This requirement is considered suitable for the application of the Private Finance Initiative (PFI) or an alternative Public Private Partnership (PPP). Service providers who respond to this requirement will ultimately be required to make firm proposals for funding the project in accordance with this application. The Trust reserves the right not to award a contract or to award a contract in a different form, or for only part of the service.
 The Trust reserves the right to exclude the disposal of surplus buildings and land on the site from the contract in order to comply with MEL 55.
 The Trust reserves the right to exclude any request to participate received outside the stipulated time frame.
 An information memorandum/questionnaire will be issued, following the expiry of the final date for requests to participate.
 Bidders will need to demonstrate clearly that they will be able to satisfy Treasury requirements on the transfer of risk and value for money.
 The contract shall be considered as a contract made in Scotland and in accordance with Scots law.
15. Date of dispatch of notice : 10.5.2002
16. Date of previous publications in the Official Journal : Not applicable
17. Procurement covered by the GPA : No

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SECTION 7: APPRAISAL PROCESS

Section No 7	<p><u>Required Content:-</u></p> <p>7a Financial Appraisal (Affordability Analysis)</p> <p>7a.1 <i>Quantification of the revenue implications of the scheme for the PSC, and the PPP/PFI option</i></p> <p>7a.2 <i>Analysis of the impact of the proposals on the NHS Body's operating cost statement, balance sheet and cash flow. This should highlight any peaks or troughs in individual years during the primary contact period</i></p> <p>7a.3 <i>Description of assumptions made for the financial appraisal, including an explanation of the methodology used to project both income and expenditure</i></p> <p>7a.4 <i>Description of the NHS Body's income from other sources, e.g. ACTR</i></p> <p>7a.5 <i>Position on VAT treatment of the project, including details of clearance from C&E</i></p> <p>7a.6 <i>Description of how land and buildings included in the PPP/PFI deal have been treated, and what assumptions have been made</i></p> <p>7a.7 <i>Details and justification for the writing off of any of the NHS Body's debt and/or assets from existing use value to open market value and (where appropriate) from open market value to nil</i></p> <p>7a.8 <i>For building projects, FB1 1-4 forms detailing capital costs must be included</i></p>
	<p>7b Economic Appraisal (Value for Money Analysis)</p> <p>7b.1 <i>Net present value (NPV) comparison of the PSC, and the PPP/PFI option. If the different options have different life spans then the equivalent annual cost (EAC) of the options should be shown. The risk adjusted NPVs or EACs should also be shown separately. It may also be appropriate to include details of the dominant option from the OBC for comparative purposes</i></p> <p>7b.2 <i>An explanation of the reasoning why the preferred option is better value for money.</i></p>

	7b.3	<i>Description of assumptions made for the economic appraisal</i>
	7b.4	<i>Details of how the PSC was calculated, including updated information from the OBC on how the capital expenditure schedules, lifecycle costs and other operating costs were calculated. Consideration should also be given to environmental factors such as emissions, clinical waste volumes, as applicable</i>
	7b.5	<i>Description of the quantification of costs and benefits included in the appraisal</i>
	7b.6	<i>Description of the non-quantified costs over benefits in the scheme, including a weighting and scoring analysis where appropriate</i>
	7b.7	<i>Sensitivity analysis, and scenario modelling of the key assumptions behind the economic appraisal</i>

	7c Risk Analysis	
	7c.1	<i>A risk allocation matrix showing which party is responsible for managing which risk. The risk matrix should reconcile back to the relevant photographs of the project agreement</i>
	7c.2	<i>A list of the key individual risks including an explanation of what each one means, and how the values and probabilities of those risks occurring were determined</i>
	7c.3	<i>An NPV analysis of the risks retained by the public sector under each of the options considered. This should be based on a probability analysis of the quantifiable risks.</i>
	7c.4	<i>An assessment of the total risks associated with the project including those risks which are non-quantifiable in the form of a weighting and scoring matrix</i>
	7c.5	<i>Sensitivity analysis of the key assumptions underlying the risk analysis</i>
	7c.6	<i>Sensitivity analysis on the impact of other purchasers altering purchasing behaviour</i>

7a Financial Appraisal (Affordability Analysis)

7a.1 Quantification of the revenue implications of the scheme for the PSC, and the PFI option.

Costs have been quantified based on work carried out in preparation of the Public Sector Comparator and the financial models supplied by Robertson. Minor changes may take place between the information now presented and the time of financial close and these will be described in the FBC – PPP/PFI Addendum to be submitted following financial close. The revenue implications are :

Costs base at April 2005	Services within scope of PFI	PSC as provided under PFI
	£'000	£'000
Capital Charges	1370	-
Maintenance	370	-
Heat, Light and Power	110	110
Rates	370	370
Unitary Charge (Base Position)	-	1767
Total	2220	2247

This table shows a minor additional cost related to the PFI option. This additional cost is capable of being absorbed within the contract of the MH services' operational budget.

It is possible that the cost of the PFI option may reduce as a result of a fall in long term interest rates compared with that used in the PFI financial model. Based on November 2004 swap rates, the unitary charge would be expected to reduce by approximately £50,000 per annum, which would bridge the small affordability gap referred to above.

7a.2 Analysis of the impact of the proposals on the Primary Care Division's I & E A/c, Balance Sheet and cash flow

The Division's projected financial position is now incorporated within NHS Greater Glasgow's financial projections, and as part of a unified NHS financial plan. The funding streams required to pay for the operation of this unit are incorporated within NHSGG's financial plan for Mental Health Services and are fully approved by the NHS Board. The main funding source will be existing service budgets which will be released as existing ward accommodation is closed.

7a.3 Description of assumptions made for the financial appraisal, including an explanation of the methodology used to project both income and expenditure.

7a.3a Key assumptions :

- Patient service activity is consistent with occupancy assumptions within section 4 of the OBC which have been allocated to sectors based on relative population catchments.
- Staffing - The level of staffing is based on the preferred model of care, with staff transferring from existing acute inpatient facilities to the new facility.
- Indexation assumptions are robust - It is assumed that funding indexation will match cost inflation and will be 2.5%. The economic analysis has been undertaken at an April 2005 price base with no adjustments for indexation/inflation of the cash flows.
- The unitary payment is £1767k p.a. is on an April 2005 price base and will be indexed annually to the RPI value. It will not fluctuate beyond this without explicit agreement of the Board and in accordance with the project agreement.

- Lifecycle costs are borne by the ProjectCo for the duration of the agreement.
- The interest rate used as a discount factor in assessment is 3.5% p.a., as advised for economic assessments, based on HM Treasury Green Book Guidance.
- Delivery of the PFI service commences in the timescale planned, August 2007
- VAT is excluded from the assessment, being assumed as reclaimable, where charged by the ProjectCo.
- Capital charges are omitted from the PFI solution assessment. An off-balance sheet treatment is assumed.
- Land continues in NHS ownership, for which a small capital charge is liable by the Board. It is excluded from the assessment.

No further service development beyond the establishment of the new unit is assumed. However, it is recognised that unforeseen changes will arise. A general assumption is made that these will be matched, as required, with additional revenue funding or realignment of resources.

7a.3b

PFI financial model assumptions :

- Concession period 30 years
- Debt : Equity ratio 90 : 10
- Senior debt £16.8M
- Base position unitary charge £1,767,000 (@ 2005/06 base)
- Overall interest rate 6.42% at time of drafting

7a.3c

Rate of Return

Green Book guidance revised the rate of return from 6% to 3.5% from 1st April 2003. The rate of 3.5% was used in the assessment of bids and the public sector comparator.

7a.3d

Residual Interest

Facilities may revert to NHS ownership at the end of the contract at no charge. Therefore, part of the unitary charge would represent a payment to acquire the facility at the contract end. In these circumstances, a residual interest value would accumulate within the NHS's fixed assets and attract a 3.5% rate of return. Plans will be put in place to allow for this so that the cost consequences can be accommodated.

7a.4

Description of income from other sources

No income is assumed from other sources in this case

7a.5

Position on VAT treatment of the project, including details of clearance from C & E

In accordance with Regulations published by the Treasury, the Board may claim and be refunded tax charged on supply of services and leased accommodation relating to health care facilities. The present scheme falls under this direction.

7a.6 Description of how land and buildings have been included in the deal

NHS land will be used for construction of the facility and there will be a head lease of the land to the ProjectCo, together with an under lease of the land by the ProjectCo to the Board. This arrangement terminates on termination of the deal or ending of the agreement period.

No current buildings are included in the deal, however, the building constructed within the deal may revert to the NHS at the end of the contract period and details of the financial treatment are stated in 7a3d above.

7a.7 Details of writing off of any NHS assets

No writing off of any NHS assets will occur in this deal.

7a.8 For building projects, forms FB 1 – 4 detailing capital costs.

Forms for the building costs of the PSC option are included as Section 7 **Appendix A**.

7b Economic Appraisal (Value for Money Analysis)

7b.1 Net present value (NPV) comparison of the PSC and the PFI option.

An analysis of the cash flows of the Public Sector Option and the Private Option has been carried out allowing net present values to be compared. This comparison has been adjusted to take account of:-

- risks retained by the NHS in both options
- optimism bias in the calculation of the public sector capital expenditure sum
- tax adjustment to reflect the different tax receipts that the Treasury derive from adoption of the two options

Appendix B1 quantifies the risks arising in this project, showing where these risks are retained by the public sector and where they are transferred to the private sector in the case of adoption of the PFI option. The full value of these risks, £11,123,000, is attached to the public sector option. In addition, the value of tax differential, shown on the lower part of **Appendix B2** £1,450,000, is attached to the public sector option to bring it to a comparability with the private sector option. The total value of these two adjustments is £12,573,000.

In the case of the private sector option, it is assessed that it bears risk to a value of £4,117,000, as shown on **Appendix B1**, and it is responsible for all tax receipts for the Treasury. On adoption of the private sector option, comparability with the public sector option requires retention of risk of £7,006,000 in the public sector, only.

In the course of analysis of cash flows, the capital expenditure of the public sector option has been adjusted for optimism bias. This adjustment is required to counteract the tendency in public schemes to underestimate capital costs and work duration. The value added to the estimate of public sector capital expenditure is £3,196,000 and is arrived at taking into account factors shown on **Appendix B2**.

The application of this adjustment follows HM Treasury Green Book guidance on the appraisal and evaluation of projects and circular HDL(2003)13 on the subject.

The results of the analysis are :

	Net Present Value over 30 Years	
	PSC (£'000)	PFI (£'000)
NPV of cash flows	33,714	38,579
NPV of retained risks	12,573	7,006
Risk-adjusted NPV	46,287	45,585

The analysis shows that the PFI option has the lower NPV and is therefore the best value for money over the contract period.

In both cases, it is assumed that the building has a 60 year life-span. The contract has a period of 30 years duration from date of signing and it is over this period that the comparison is made.

7b.2 An explanation of the reasoning why the preferred option is better value for money

The preferred option is better value for money because of a lower economic cost. It includes provision of the facility and removal from the Board of significant risk elements, the principal risk element being excess cost of capital construction. This is shown in an exploration of risk in section 7c below. The chief outcomes are :

- the Division is protected from potential extra cost of capital cost overrun;
- it is less likely to suffer from construction time overrun, with consequences for service provision and associated costs; and
- the standard of maintenance is explicit and enforceable, to the benefit of the environment and service.

7b.3 Description of assumptions made for the economic appraisal

Key assumptions are:

- Prices are based at April 2005.
- Tax and optimism bias adjustments to the public sector comparator are soundly based.
- Risk assessments.
- PSC capital, lifecycle and FM costs have been estimated using a combination of existing experience, current guidance on NHS building costs appropriately indexed to the common cost base date, and using advice of technical advisors on validity of build costs.
- Capital cost indexing estimates are reliable. A BCIS build cost index of 213 is used to forecast the PSC capital cost.
- A discount rate of 3.5% has been used in assessments.
- VAT is excluded from assessments.

7b.4 **Details of how the PSC was calculated, including updated information from the OBC on how the capital expenditure schedules, lifecycle costs and other operating costs were calculated. Consideration should be given to environmental factors.**

Details of the PSC calculation and how it was updated are shown in Section 5.1.

With respect to environmental factors, the project's works output specification draws attention to sustainability and environmental issues, in particular seeking installation of a building management system (BMS) which ensures optimum usage of energy resources. This is incorporated within the PSC design and is also specified in direction to the ProjectCo.

Clinical waste does not feature as an issue in this project.

7b.5 **Description of the quantification of costs and benefits included in the appraisal**

The costs and benefits in the appraisal include the relevant cash flows for the project and money valuation of the risks assessed for the project. VAT and capital charges are excluded from the appraisal, representing cash transfers from one government department to another.

Quantification of PSC costs is outlined in Section 5.1 and quantification of risks is outlined in Section 7c.

7b.6 **Description of the non-quantified costs or benefits in the scheme**

Patient benefits are declared in the OBC and are similar for both options. Non-quantified costs or benefits do not feature in this appraisal.

Section 11 gives detailed descriptions of non-quantified benefits and Section 12 describes the risk management approach where non-quantified costs will arise. These are similar for the PSC solution or the PFI solution.

7b.7 **Sensitivity analysis, and scenario modelling of the key assumptions behind the economic appraisal.**

7b.7.1

The key assumption used in economic appraisal is the interest rate applying to senior debt in the PFI financial model.

Sensitivity outcome :

NPV over 30 year life -

	Senior debt	NPV	UC year 1
	% interest rate	£'000	£'000
Present Model	5.25	45585	1767
Reduce Rate 0.25% to	5.00	45186	1742
Reduce rate 0.50% to	4.75	44727	1717
Increase rate 0.25% to	5.50	46014	1792
Increase rate 0.50% to	5.75	46443	1817

The sensitivity outcome is that the VFM of the PFI option would improve by NPV £429,000 for each 0.25% fall in interest rate on the senior debt and would rise by NPV £429,000 for each 0.25% rise in interest rate.

The interest rate would require to rise by more than 0.4% before the PFI option became economically questionable :

At time of writing, the interest rate is less than that used in the present model and so the possibility of an increase in interest rates beyond the assumed rate is regarded as unlikely.

7b.7.2

Further testing of assumptions is illustrated below:

(i) PSC capital cost over-estimated by 3.3%:

	PSC NPV £k	PFI NPV £k
Original (risk adjusted)	46287	45585
PSC capital cost -3.3%	45551	45568

The PSC capital cost would require to be over-estimated by 3.3% or more to bring the PSC NPV to the value of the PFI NPV or less. This is considered unlikely, the PSC capital cost being within 1.4% of the PFI build cost.

(ii) Maintenance costs over-estimated

	PSC NPV £k	PFI NPV £k
Original	46287	45585
Maintenance costs -12.5%	45551	45567

Maintenance costs would require to be over-estimated by a factor of 12.5% or more to bring the PSC NPV to a value similar or better than the PFI NPV. This is unlikely, the PSC maintenance costs being estimated at less than the PFI maintenance costs.

As a result of this sensitivity analysis, it is considered that the outcome of the economic appraisal is robust and may be relied upon.

7c

Risk Analysis

7c.1

Risk allocation matrix showing which party is responsible for managing which risk

The risk allocation matrix is attached at **Appendix B** and groups risks into :-

- Design risks
- Construction and development risks
- Performance risks
- Operating cost risks
- Variability of revenue risks
- Termination Risks
- Technology and obsolescence risks
- Control Risks
- Residual Value Risks
- Other project Risks

7c.2

A list of the key individual risks including an explanation of what each one means and how the values and probabilities of those risks occurring were determined.

The key individual risks are those substantial risks which transfer to the ProjectCo under the agreement, being in a position to handle them. The key risks to be transferred and their quantification within the PSC are based on :

- **Design** - risk that the design is insufficiently specified or agreed and changes are required after planned sign off stage. Quantified using Divisional experience on smaller scale projects completed to date and escalating to scale of the present project. The technical advisors support such a view. On a project of this scale, it is anticipated that the cost of risks of design changes could exceed £1,000,000. The probability of this is shown on the **Appendix B1**. Under the PFI option, the majority of these costs are transferred.
- **Construction and Development** - risk that costs overrun. The Division's experience is that construction costs do escalate and it is normally addressed by revising specifications. In the PFI option, most of the costs of these risks are transferred.
- **Performance** - risk that defects or other causes make the building unsuitable or unavailable for use. Specification and supervision of construction are rigorous processes designed to eliminate this risk. However, it is acknowledged that unforeseen circumstances can arise which impact the efficient running of the building, if not extending to place part of it out of use. A prudent allowance is made for this risk. The bulk of this risk is transferred, at around £780,000.
- **Operating cost** - risk that cost of maintaining the building is exceeded. The Division has a number of buildings of various ages and is aware that operating costs can escalate beyond those estimated. An allowance is made for this, based on experience. Building operating costs risks are transferred at £580,000.

Risks were initially identified and quantified by Divisional Finance and then amended following review by the Division's Estates function and by the Financial Advisors who were in a position to check for reasonableness by way of comparative studies with other NHS schemes.

7c.3 An NPV analysis of the risks retained by the public sector under each of the options considered.

NPV over 30 years :

Risk Category	Options	
	PSC £'000	PFI £'000
Design	1079	259
Construction and Development	1608	222
Performance	848	62
Operating Cost	5106	4524
Other risks	2482	1939
Total	11123	7006
Risks transferred	-	4117
Total	11123	11123

Details of the risk quantification can be found in the Financial **Appendix B**.

7c.4 **An assessment of the total risks associated with the project including those which are non-quantifiable**

Risks which are quantifiable are described in the above sections.

Risks which are non-quantifiable are described in section 12 : Risk Management

7c.5 **Sensitivity analysis of the key assumptions underlying the risk analysis**

Risks transferred would require to fall by more than £700,000 NPV to make the PSC option better value for money than the PFI option. For this to happen, significant reductions would be required across the key risks e.g. cost of risk of construction costs being exceeded would require to fall by over 50% to reach this position.

7c.6 **Sensitivity analysis on the impact of other purchasers altering purchasing behaviours**

Not applicable

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SECTION 8: SUMMARY OF THE CONTRACT STRUCTURE

Section No 8	<p><u>Required Content:-</u></p> <p>8.1 Description of the contractual framework of the project</p> <p>8.2 A diagram of the legal relationships between the various parties to the deal</p> <p>8.3 Summary of the main provisions of the contract agreement, the position reached on the key issues (detailed further in Annex A) and any points that are outstanding</p>
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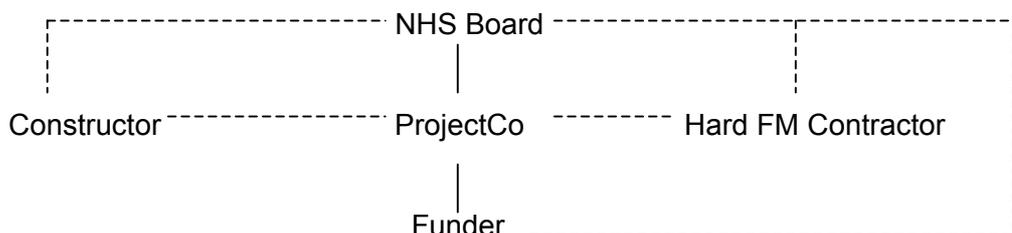
8.1 Description of the contractual framework of the PFI project

A contract has been drawn up for the purpose of setting out the terms and conditions upon which the Project Company will finance, design, construct and maintain services in connection with the operation of a new build mental health hospital.

The project has used the Scottish Standard Form Project Agreement Version 3. Any alterations are confined to project specific areas.

The standard form Project Agreement forms the backbone of the framework and it is accompanied by ancillary agreements allowing for the lease of land, direct agreement with the funders, and collateral warranties between the NHS Board, the ProjectCo and Subcontractors.

8.2 A diagram of the legal relationships between the various parties to the deal



The agreements between the parties are :

- **NHS Board with ProjectCo**

This is the main contract which, in return for a fee, the ProjectCo will finance, design, construct and service a building for 30 years, with which the Division will deliver mental health services. The contract allows the Division to withdraw payment of the fee in a staged manner in the event of failure to deliver on the part of the ProjectCo and allows the Division through the Board

to terminate the contract in the event of complete failure of delivery.

- **NHS Board with Funder**

This agreement allows the Funder and the Division, through the Board, to maintain a funding arrangement in the event that the main contract is terminated.

- **NHS Board with Constructor**

This agreement allows the Division through the Board step-in rights to the ProjectCo/Constructor agreement in the event of default on the ProjectCo's part.

- **NHS Board with Hard FM Contractor**

This agreement allows the Division, through the Board, step-in rights to the ProjectCo/FM Contractor agreement in the event of default on the ProjectCo's part.

- **ProjectCo with Funder, Contractor and Hard FM Contractor**

The ProjectCo will hold agreements with the other three parties fund, design and build, and maintain the facilities.

8.3 Summary of the main provisions of the contract agreement, the position reached on key issues and any points that are outstanding

8.3a The Division, through the Board, is entering into a single contract for the provision of services.

These services are :

- Design and construction of a building suitable for carrying out the services specified
- Maintenance of this building
- Energy and utilities management associated with the building

The building to be provided is described in Section 4.2.

This contract is supported with agreements as outlined in 8.1 above.

8.3b The main provisions conform to the Scottish Standard Form Project Agreement documentation and these include

- Payment mechanism, outlined below in 8.3c
- Step in rights to the Division in the event of avoiding serious disruption to services, e.g. a significant health and safety issue arises
- Termination of agreement in the event of default by the ProjectCo e.g. a material breach of contract is not remedied

- Changes are allowed for in the provision of services that prescribe how they are initiated and which party will pay for them e.g. a change required under law in the housing of mentally ill patients would require to be paid for by the Division.

Further specific issues are contained as follows :

- Energy costs will be passed through to the Division for direct payment, subject to agreed savings targets.
- Rates will be passed through to the Division for direct payment.
- Equipment will be provided by the ProjectCo only in the case of Group 1 equipment where it is installed as part of the building design and construction. The Division will provide all other equipment.
- Hard FM only is to be provided by the ProjectCo and market testing is excluded in view of the scale of service provision.
- Provisions for TUPE and other employment matters are retained although it is not intended that Division employees will transfer in this project.
- The base date for costs is October 2004 and indexing is allowed at RPI on each anniversary of this date.
- The length of the contract is 30 years and there are no break points in this period subject to satisfactory delivery of services by the ProjectCo.
- Composite Trader tax treatment is applied by the Bidder to their financial model, in arriving at the annual unitary charge.

8.3c The payment mechanism conforms to standard guidance providing for deductions in the event of failure in performance or availability. Clear criteria for these matters have been established within the Contract.

The basis of payment is 100% of the fee on availability for use of the whole building at the standards specified in the agreement. Failures on availability or on maintenance standards (which may not impact availability in the short term) will lead to a regime of deductions to this fee on scales explicitly laid out in the agreement, these deductions escalating to complete non-payment in the extreme event of complete unavailability of the premises to the Division.

8.3d There are no outstanding points on this contract which may be material.

8.3e Variations to the Standard Form Project Agreement are currently under discussion but are not considered sufficiently significant to impact the Agreement and contradict the substance of this business case.

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SECTION 9: ACCOUNTING TREATMENT

Section No 9	<p><u>Required Content:-</u></p> <p>9.1 <i>An assessment of the proposed accounting treatment of the project in respect of the NHS Body's balance sheet by the Director of Finance, backed up by appropriate professional advice. It is expected that projects will be likely to be Off-balance sheet. This should include a summary of the rationale and key elements underlying the off-balance sheet accounting opinion. (See Treasury Taskforce Guidance Note No. 'How to Account for PFI Transactions' – or subsequent guidance)</i></p> <p>9.2 <i>There must be written indication from the Trust's external auditors that they have no objection to the proposed accounting treatment of the project. (See Note for Guidance 96/6 published by the Accounts Commission or any subsequent Note for Guidance published by Audit Scotland)</i></p> <p>9.3 <i>SEHD should be notified as soon as possible if it is likely that a scheme will be on balance sheet. The NHS Board will also need to consider how it can cover the on balance sheet project from its capital provision</i></p>
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9.1 An assessment of the proposed accounting treatment

An assessment of the accounting treatment of the scheme has been carried out in accordance with the Treasury Taskforce Technical Note No.1.

In view of the unitary nature of the annual charge, FRS 5 applies and examination of the substance of the transaction leads to a conclusion that it is off balance sheet i.e., it is a revenue item. This is supported by the structure of the payment mechanism, the risks borne by the ProjectCo and the responsibility of the ProjectCo to decide how it builds and operates the building.

9.2 Written indication from the Board's external auditors that they hold no objection to the proposed accounting treatment of the project

The proposed accounting treatment is currently being presented to PricewaterhouseCoopers, external auditors, for review.

- 10.3** The Division's Chief Executive takes full executive responsibility for the project, and for ensuring that it is managed in an appropriate manner. Lead responsibility for achieving the project is delegated to the Director of Finance who has executive responsibility for all Divisional capital projects.
- 10.4** Because of the size and complexity of the project, a Project Board has been established to ensure an appropriate level of ownership of the project within the organisation. This Board comprises
- Director of Finance,
Head of Capital Investment and Property Management,
Director of Nursing (as Lead for Mental Health Services),
Clinical Director (lead Clinician) for the West Sector,
Divisional General Manager for the West Sector,
Nursing Services Manager (West Sector),
Project Manager,
General Manager, Corporate Services,
Communications Manager
- with appropriate input from Finance, Human Resources and Support Services representatives when required. The Project Board is responsible for leading the project including the development of this business case, supported by external consultants as necessary.
- 10.5** The Head of Capital Investment and Property Management will act as Project Manager and will be responsible for driving and managing the project on a day to day basis, coordinating the input of professional advisors across all functions and for the delivery of the project objectives.
- 10.6** A User Panel has been established comprising representatives of each of the relevant clinical and service departments, with delegated authority to confirm user service requirements and agree how these can be met. The User Panel includes representatives of external agencies able to represent patient interests in keeping with current philosophy in the Framework for Mental Health Services in Scotland. The User Panel also includes representatives from Finance, Estates, Human Resources and Support Services.
- 10.7** Throughout the construction phase the Division will continue to ensure the local community around Gartnavel, and other organisations and individuals with an interest in the in-patient facility, are kept updated on the development of the project. Where possible, communication will be developed on a joint basis with the North Glasgow University Hospitals Division to ensure that they reflect activity across the entire Gartnavel site. This work will include the production of a joint Gartnavel briefing update.
- 10.8** The Division also plans to contact local groups and organisations before building work commences to offer to meet with them to provide an overview of the construction timetable, building design and service operation. In relation to user and carer involvement, the West Sector Management Group will develop plans to ensure that, where possible, the views of users and carers are sought.

10.9 Control Arrangements during the Contract

10.9.1 In accordance with “Public Private Partnerships in the National Health: The Private Finance Initiative – Good Practice” and the Project Agreement, the Division has made arrangements to monitor the implementation of the contract following financial close.

10.9.2 The monitoring arrangements will:

- Measure the performance of the Project Co
- Respond to change control requirements throughout the life of the contract
- Provide information for monitoring the value for money of the services provided by the Project Co.

10.10 Independent Certifier

10.10.1 In compliance with the Project Agreement, the Division and the Project Co will jointly appoint a suitably qualified and experienced consultant to act as Independent Certifier.

10.10.2 The role of the Independent Certifier will be to:-

- safeguard the interests of the Division and Project Co for the delivery of the capital works and start up the hard FM facilities management services;
- to manage the change control process up to the operating date of the inpatient facility; and
- to broker the interests of all principal parties to the contract, minimising disputes and lengthy dispute resolution processes.

10.10.3 To comply with the above, the Independent Certifier will undertake the following functions:

- Design Compliance Check
- Procedure Review
- Construction Review
- Reporting and Certification

10.11 Division’s Representative

10.11.1 In accordance with the Project Agreement, the Board has a right to appoint a Division’s Representative who will have a entitlement to unrestricted access at all reasonable times to:-

- view the works on site
- visit any site or workshop where materials, plant or equipment are being manufactured, prepared or stored for use in the works.

- attend monthly progress meetings and site meetings
- monitor compliance with construction programme.

10.11.2 The Division's Representative also has monitoring rights throughout the operational phase of the project, particularly approval of Maintenance Schedules and participation in Review Procedures.

10.11.3 The Division's Representative will report to the Project Manager.

10.12 Control Arrangements during the Operational Phase

10.12.1 The monitoring of the standard of the Service provided by the Project Co will involve a combination of the following:

- Project Co and/or Divisional calls to the Helpdesk
- Project Co self monitoring (in accordance with the Performance Monitoring Procedures)
- User satisfaction surveys (Division, staff, visitors and patients)
- Reviews/reports by statutory bodies
- Divisional audit.

10.12.2 The Project Co will provide the Division with a draft Performance Monitoring Programme that will outline the actions the Project Co intends to undertake to monitor the performance of services provided to the Division in accordance with the Project Agreement and the Services Specification. The Division will agree the Performance Monitoring Programme prior to the delivery of services.

10.13 The Role of External Advisers

10.13.1 Throughout the procurement process for the inpatient facility project, the Division has used the services of a number of external advisers in relation to financial, legal and technical issues.

10.13.2 Following financial close the requirement for external advisers will reduce, however, there will remain the need for their professional input through the construction, commissioning and operational stages up to post project evaluation.

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SECTION 11: BENEFITS ASSESSMENT AND BENEFITS REALISATION PLAN

Section No 11	<p><u>Required Content:-</u></p> <p><i>11.1 Description of the benefits to be delivered under the project, including an indication of differences in the levels of benefits delivered under the PSC and PPP/PFI options.</i></p> <p><i>11.2 A thorough and complete benefits realisation plan.</i></p>
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11.1 Description of the benefits to be delivered under the project, including an indication of differences in the levels of benefits delivered under the PSC and PPP/PFI options.

The project aims to provide modern NHS acute in-patient facilities for the resident population of West Glasgow, replacing old and unsuitable institutionalised accommodation. In particular, it aims to re-provide a significant portion of in-patient services currently located on Gartnavel Royal Hospital site.

The re-provision of in-patient accommodation is a key component of GGHB's strategy for modernising Glasgow's mental health services. This envisages the development of a comprehensive mental health service for Greater Glasgow, based on an integrated service model, which encompasses community, intermediate and in-patient services.

From a service perspective, the objective of the project is to provide modern purpose built in-patient accommodation which will allow the Primary Care Division to address a significant deficit in the quality and range of therapeutic interventions available to patients. By promoting activities which are focussed on rehabilitation rather than observation, it will be possible to return patients more quickly to community based care.

This will be achieved by creating an environment which will provide sufficient space for clinicians to work with patients, both on an individual basis and in small groups. It is envisaged that accommodation will comprise 20 bedded units with individual rooms for each patient, small rooms to enable group-work involving small groups with common mental health problems, open space areas for general/social interactive activities and external space (i.e. garden areas).

A summary of the main benefits to patients will include:

- a care environment which respects the dignity and need for privacy of individuals
- a living environment which is non-institutional and more domestic in nature
- improved care linked to the provision of therapeutic activities, leading to an enhanced ability to cope with illness, earlier rehabilitation and an earlier return to community based care
- reduced stigma.

Benefits to patients

The benefits to patients from the implementation of the project will be as follows:

Benefits to individuals who use our service

- Patients in crisis will be able to access a rapid response that will provide for their needs to be assessed and care to be provided in the most appropriate setting.
- Patients will be able to access services which are geographically local to their own homes.
- When patients are admitted to hospital they will be accommodated in appropriate surroundings that will meet their personal as well as their clinical needs.
- Patients will have greater privacy in these in-patient facilities.
- Patients will be cared for in an environment that is conducive to providing appropriate therapeutic interventions.
- The design and layout of the care environment will minimise the opportunity for self injury by allowing for appropriate levels of observation and intervention by clinical staff.
- Community services will be available to provide the necessary intensive support to patients following discharge.
- Delays for patients moving to the next level of health care will be minimised, as a more appropriate balance of care will allow them to flow more smoothly through the spectrum of inter-agency care.
- Enhanced community services will be able proactively to follow up patients and maintain them in their community where possible, minimising the need for hospital admission.
- A greater emphasis will be placed on locally based community services based on shared care arrangements which are rooted in primary care.
- There will be modern inpatient hospital environments that are fit for purpose
- The development of services which are more responsive to the needs of women and ethnic minority communities.
- There will be the provision of appropriate services for people with dementia.

In assessing patient needs, the Primary Care Division has consulted with service users and carers of persons using mental health services, and incorporated their views within the statement of needs set out above.

Delivery of the above benefits to patients is dependent on all parties (GGHB, the Primary Care Division and 6 Local Authorities) working together to plan and implement the changes required. Developments in health and social care are interdependent and accordingly these will be planned and implemented following a joint approach.

Alternative models of care have been considered for both adult and elderly acute services. Options were derived by varying the level of service provision in different sectors within the spectrum of patient care. The preferred model takes into account the planned expansion of community based services, but allows for the high level of deprivation experienced in Glasgow in determining the appropriate level of in-patient beds re-provision.

A sectoral approach will be adopted in re-providing in-patient services to ensure equitable access to appropriate in-patient services across Greater Glasgow. This will be achieved by the following configuration of in-patient beds.

	Population	Adult Acute		IPCU		Elderly Acute	
		Proposed	Current	Proposed	Current	Proposed	Current
North West	200,000	60	80	12	12	45	60
TOTAL	200,000	60	80	12	12	45	60

The project envisages an overall reduction in the number of acute beds for adult and elderly services. This is planned in conjunction with the further development of community based services, including the introduction of appropriate intermediate services within each geographical sector for the Greater Glasgow area. The relatively larger reduction in the planned number of elderly acute beds takes account of recent trends in occupancy levels for elderly patients.

Benefits Assessment & Benefits Realization Plan

11.2. A plan summarising the benefits and how they will be achieved has been prepared and is presented in the table below:

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Patients will be able to access services which are geographically local to their own homes.	Local accessible service for Glasgow residents and increased retention of patient contact with home, family and friends.	<p>Establish local service and ensure access to accommodation.</p> <p>Bed management protocol in place</p> <p>Admission & discharge protocol.</p> <p>Mental Health Network of care</p>	<p>Director of Estates</p> <p>Adult Services Manager Elderly Services Manager</p> <p>Adult Services Manager Elderly Services Manager</p> <p>Adult Services Manager Elderly Services Manager</p>	<p>Provision of local facility</p> <p>Implementation of bed management protocol</p> <p>Implementation of admission and discharge protocol.</p> <p>Integrated system of mental health care services in place</p>	<p>Director of Estates</p> <p>Sector General Mgr</p> <p>Sector General Mgr</p> <p>Sector General Mgr</p>
When patients are admitted to hospital they will be accommodated in appropriate surroundings that will meet their personal as well as their clinical needs.	Increased opportunities to reduce vulnerability while maintaining dignity, privacy and respect	Patients needs assessed in a therapeutic, non stigmatising, calming environment	<p>Adult Services Manager</p> <p>Elderly Services Manager</p>	Patient satisfaction with care needs assessment process and environment for care delivery	Sector General Mgr

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Provision of single room accommodation and en-suite facility. Patients will have greater privacy in the inpatient facility.	Patients will feel less vulnerable and safe	Single room accommodation	Director of Estates	Ask patients how they feel when they are in the in-patient service	Director of Estates
	Each patient will have their own personal space	Patients will have access to keys to their own rooms where appropriate Protocol for management of keys to be developed and put into place	Ward Manager	Monitor the use of keys by undertaking an audit of the protocol	Lead Nurse – Adult and Elderly
	Promotion of greater trust and respect between patients and staff		Ward Manager		Lead Nurse – Adult and Elderly
Patients will be cared for in an environment that is conducive to providing recovery by appropriate therapeutic interventions.	Recovery period will be optimal and discharge plan will be in place	Development of admission/discharge protocol	Adult Services Manager Elderly Services Manager	Admission/discharge protocol in place	Sector General Mgr
	Therapeutic interventions will be appropriate to need	Robust assessment process which clearly identifies needs Therapeutic plan developed to address identified needs	Adult Services Manager Elderly Services Manager Ward Manager	Needs and therapeutic interventions are identified and a plan of care is in place	Sector General Mgr
	Staff will feel motivated and engage in a more meaningful manner with patients	Staff training and development programme	Ward Manager	Staff are knowledgeable and skilled in providing therapeutic interventions	Lead Nurse

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
The design and layout of the of the care environment will minimise the opportunity for self injurious behaviour by allowing for appropriate levels of observation and intervention by clinical staff	Less opportunity for self harming behaviours	Design will be such that the opportunity for self harming will be minimised	Design Team	Reduction in the opportunities for severe self harm	Sector General Manager
	Improved observation and maximise opportunities to use least restrictive alternative to manage risk	Environment will promote good observation	Sector General Manager Adult Services Manager Elderly Services Manager Sector Nurse	Reduction in the requirement for protracted periods of higher levels of clinical observation for particular patients	
Community services will be available to provide the necessary intensive support to patients following discharge Delays for patients moving to the next level of health care will be minimised, as a more appropriate balance of care will allow them to flow more smoothly through the spectrum of inter-agency care	Patients will spend less time in the most expensive care environment	Named nurse system, multi-disciplinary team care plan	Adult Services Manager Elderly Services Manager	Reduction in number of bed days used per patient Readmission rates	Sector General Mgr
	Improved outcomes for patient with less time spent away from their home	Strengthened liaison arrangements with community teams	Locality Manager	Reduced average length of stay	Adult Services Mgr Elderly Services Mgr
	Potential for relapse minimised	Care support provided by the most appropriate community based service	Locality Manager	Audit of caseload activity of community based services	Adult Services Mgr Elderly Services Mgr
	Most appropriate care delivered in the least intrusive environment	Integrated inter-agency working	Locality Manager	Audit of referrals made to other agencies	Adult Services Mgr Elderly Services Mgr

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Enhanced community services will be able to proactively maintain patients in their community where possible, minimising the need for hospital admission.	<p>Reduction of unnecessary admissions</p> <p>Maintaining people in their own home</p> <p>Reduction of stigma</p> <p>Less disruption to lifestyle</p> <p>Most resource intensive service is used for most needy client group</p>	<p>Ensure a full network of community based services are in place and are effective</p> <p>Providing alternative to in-patient care</p>	Adult Services Manager Elderly Services Manager	<p>Reduction in number of bed days used per patient</p> <p>Readmission rates</p> <p>Reduced average length of stay</p> <p>Audit of caseload activity of community based services</p> <p>Audit of referrals made to other agencies</p>	Sector General Mgr
A greater emphasis will be place on locally based community services delivering shared care arrangements which are rooted in primary care.	<p>Reduction of unnecessary admissions</p> <p>Maintaining people in their own home</p> <p>Reduction of stigma</p> <p>Less disruption to lifestyle</p> <p>Most resource intensive service is used for most needy client group</p> <p>Locally based service provision which is comprehensive and avoids duplication</p>	<p>Meaningful engagement between all care providers to be developed.</p> <p>Shared care protocols and pathways to be developed which contributes to a managed care network</p> <p>Each part of the network be clear about it's role, function and purpose</p>	<p>Locality Manager</p> <p>Locality Manager</p> <p>Locality Manager</p>	<p>Majority of care is provided within local community.</p> <p>Monitoring of admission/discharge protocol</p> <p>Review internal referrals and length of time spent within the service</p> <p>Patient satisfaction survey</p>	<p>Adult Services Mgr Elderly Services Mgr</p>

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
The equality and diversity of services which are more responsive to the needs of women and ethnic minorities.	Increased opportunities to reduce vulnerability while maintaining dignity, privacy and respect for diversity	Patients cultural needs are taken into account in a therapeutic, calming environment	Adult Services Manager Elderly Services Manager	Patient satisfaction with the environment of delivery of care and acknowledgement of cultural and gender requirements	Sector General Mgr
	Women will feel less vulnerable and more safe	Single rooms and single sex seating areas	Adult Services Manager Elderly Services Manager	Ask women how they feel when they are in inpatient service	Sector General Mgr
There will be the provision of appropriate services for people with dementia.	Reduce vulnerability while maintaining privacy, dignity and respect.	Design of services will be such that it will allow individual patients needs to be assessed in a therapeutic non threatening environment	Elderly Services Manager	Stakeholder satisfaction survey	Sector General Mgr
	Maximising of independence through advocacy services	Provision of advocacy services for older people		Analyse the uptake of advocacy services	Sector General Mgr
	Carers needs will be acknowledged	Assessment of carers needs		Carers survey	Sector General Mgr
	Increased opportunities for early diagnosis	Memory clinics		Attendance at memory clinics	Sector General Mgr
	Most resource element of the service is utilised for most needy clients	Ensure all elements of a comprehensive service are in place		Analyse referral patterns to other care facilities from inpatient service Monitor blocked beds	Sector General Mgr Sector General Mgr

The benefits to be delivered under the project are the benefits deriving from the implementation of Primary Care Division plans in partnership with other agencies. The Primary Care Division's services will exist within a wider continuum of care that has been developed and agreed with local partner agencies in accordance with national and local strategy. The proposed pattern of multi-agency services is comprehensive

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SECTION 12: RISK MANAGEMENT

Section No 12	<u>Required Content:-</u> <i>12.1 Details of the plan for managing risks which might arise during the implementation of the project. This will cover all potential risks retained by the public sector.</i>
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12.1 Introduction

12.1.1 The project involves the provision of in-patient care packages by multi-disciplinary teams integrated with community mental health services in a number of different settings, working across inter-agency boundaries. The success of the project depends on the ability of the NHS Greater Glasgow Primary Care Division Mental Health Services, in partnership with other agencies, to operate the model of care which is described in section 12.3.10 in a way which is effective in meeting the needs of the patient groups.

12.1.2 The PCD approach to managing the risks associated with operating its preferred model of care is explained below. This recognises the need to provide the general public with the necessary level of confidence that care is consistently being delivered in settings which provide for an appropriate quality and intensity of care relative to the needs of individual patients.

12.2 Risk Management Strategy

12.2.1 The risk management strategy reflects current national guidelines and is based on a process of risk assessment undertaken by the clinical team, the recommendations of expert practitioners in services, the views of other service providers and the experience associated with the provision specialist mental health services to date.

In addition it is particularly important that the Millan Principles underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003 notably the concept of "least restrictive alternative" are observed.

12.2.2 The strategy is founded on a methodical approach to the identification and analysis of risks. It comprises seven complementary area of activity:

1. **Clinical Risk Management** – the systematic and rigorous application of methods to reduce clinical risks and maximise the clinical benefits to the individual patient.
2. **Active Risk Containment** – the ongoing process of integrating the clinical risk management of individual patients within an environment which is conducive to the balancing of the need for safety with each individual's right to autonomy and right to be treated with dignity and respect.

3. **Contingency Planning** – the development of fall back plans to contain risks arising from circumstances in which the normal function of the service is affected by adverse events.
4. **Safe by Design** – the integration of the service model, the operational management and the care environment.
5. **Physical Capacity** – the ongoing assessment of the demands relative to the capacity of the service.
6. **Service User/Public Communications** – the strategy for communication and engagement with the public, the media, service users and carers.
7. **Residual Public Sector Financial Risk** - the identification and assessment of financial risks associated with resourcing the service.

12.3 Risk Identification and Analysis

12.3.1 There are many identified risks arising from the care of individuals with mental health problems; a client group that presents with a broad spectrum of health and social care needs and an array of problems of varying complexity. The approach to be adopted is described in more detail below.

(i) Clinical Risk Management

12.3.2 Clinical decision making will be supported by the use of an agreed approach, including currently:-

- *Glasgow Risk Screen* – which assesses risk using a set of clinical risk indicators for deliberate self harm, suicide, violence, aggression and self neglect
- *Care Programme Approach* – which is designed to ensure that people with severe and enduring mental illness, and complex health and social care needs receive appropriate packages of care and essential services
- Other evidence based risk assessment tools/rating scales are used to identify risks associated with slips, trips and falls (CANARD), skin integrity, moving and handling of patients, pain management, healthcare associated infection and nutrition screening.

12.3.3 The assessment, design and evaluation of each patient care package will be supported by contributions from all members of the multi-disciplinary team and repeated at regular intervals from admission through to discharge or continuing care as appropriate. Risk assessment will be conducted regularly. At a minimum this will be at point of admission, point of case review(s) and prior to transfer/discharge and more frequently if deemed clinically appropriate based on patients' changing mental state. Actions and interventions aimed at addressing problems and managing risk will be explicitly recorded in the care plan. The named nurse will have responsibility for ensuring that the care plan is delivered appropriately.

12.3.4 Clinical Governance requires the implementation of multiple systems assuring and demonstrating the quality of services to patients and their carers. This is supported by a Clinical Governance Committee which develops and oversees an agreed annual Clinical Governance workplan. The elements of the workplan will be aligned with national and local priorities, and issues arising from complaints and critical incident reviews, and emerging evidence based practice and developments. Aspects of the service which will be particularly influenced by the workplan will

include clinical practice, education and training, user/carer involvement, research and development, clinical audit and clinical effectiveness. This will put in place an additional level of assurance and scrutiny of day to day clinical practice and decision making.

- 12.3.5** Clinical risk management will also be secured through appropriate team building, developing communication networks amongst the clinical team, users/carers and partner agencies and the process of risk management being open to relevant information from any source to ensure a complete clinical picture at all times.

(ii) Active Risk Containment

- 12.3.6** The purpose of Active Risk Containment is to establish the means:

- to rapidly respond to events of unanticipated harm should they occur;
- to mitigate and ameliorate any harm arising;
- to create the opportunity to prevent harm through the collection and analysis of information relating to the causes or potential causes of harm; and
- to manage actively risks that threatens the provision of safe clinical care and the efficient use of clinical resources.

- 12.3.7** Key to this element will be the contribution which suitably trained and skilled staff can make to risk containment through working in a supportive framework in a building designed for purpose.

- 12.3.8** A combination of Clinical Incident Reporting, Critical Incident Review and findings arising from complaints forms a framework of reporting and feedback and maximises opportunities for organisational learning. It is acknowledged that the system will be more effective if the experiences and views of the range of people involved in an incident are captured.

(iii) Contingency Planning

- 12.3.9** Local contingency plans will be underpinned and aligned with the Primary Care Division's contingency policy and will reflect the specific requirements of maintaining the integrity of safety and security systems in the event of service disruption. This will involve the communication of necessary information internally and externally to other agencies and the media.

(iv) Safe by Design

Service Model

- 12.3.10** The philosophy of care will be explicitly user focused and be supported by a robust and systematic approach to clinical governance.

The objective of clinical services will be to provide a range of therapeutic interventions, which are planned, co-ordinated and provided from a multi-disciplinary and user / carer perspective, based on comprehensive ongoing assessment. A key aim will be to provide a platform for social inclusion, not a stepping-stone to exclusion.

Of the individual and group activities available, some will be generic, some

specialised, and some will be onsite and some offsite. Activities will be designed to address a spectrum of health and social care needs which will typically include physical, psychological, recreational, life-skill, cultural, spiritual and social elements.

Each person will be engaged with a programme of activity for each day of their stay, which reflects their needs, wishes and aspirations and recognises their capabilities and self-care deficits. The involvement of patients, and where appropriate their families, will be critical factors. Working towards discharge will be the underpinning objective at all times to prevent inappropriate lengths of stay and promote independence. Effective integrated working and communication with community based health services and other agencies will be a key service element.

Interventions will be evidence-based or based on national consensus good practice and will be under-pinned by national standards and clinical guidelines wherever possible.

The therapeutic milieu will seek to fulfil the following functions: -

- A ward timetable that is consistent and which relates to the organisation of time, space and patient activities
- The involvement of patients as active participants in their care, contributing in a meaningful way to treatment decisions.
- Provision of an environment conducive to the containment and control of potentially dangerous behaviours through consistent staff practices that assist patients to moderate their behaviour and develop internal coping / control skills
- A culture of support in which staff actively promote a sense of well-being and self-esteem in their patients
- The validation and affirmation of each patient's individuality supported by a structure of person-centred care
- Recognise that the therapeutic environment and ambience of the ward is a crucial element in how service users experience their in-patient stay and how they benefit from it and acknowledge that therapeutic interventions, social and recreational activities all play a part in the overall patient experience.
- The therapeutic environment plays an important part in positive treatment outcomes.

(v) Operational Management

12.3.11

The purpose of the inpatient service will be to provide an excellent standard of well co-ordinated treatment and care, in a safe and therapeutic setting to patients who are in the most acute and/or vulnerable stage of their illness. Such patients will typically present with serious and complex health and social care needs which cannot, at that time, be treated and supported safely and appropriately at home or in an alternative, less restrictive, residential environment.

The in-patient service will be provided 365 days per year, 7 days per week, 24 hours per day. The emphasis will be on the provision of a range of interventions and treatment strategies which patients experience as being safe, humane and therapeutic. In this regard the inpatient facility will function as an essential core component of a whole systems approach to mental health care in West Glasgow, thereby complimenting other elements such as Primary Care Mental Health Services, Community Mental Health Teams, and Intermediate Services. It is important that the new buildings and physical environment reflect a positive vision of mental health services as a normal part of health service life and the life of the West Glasgow community they seek to serve.

Operational policies and standards of ward management will be developed in line with the above service philosophy.

(vi) Care Environment

12.3.12

The Royal College of Psychiatrists' Report *'Not Just Bricks and Mortar'* recommends the need for new smaller, more domestic inpatient psychiatric units which must reflect current practice and be of a standard likely to be acceptable to patients and staff well into the middle of the (21st) century. These will be crucial design considerations.

The inpatient service should promote patient safety, dignity comfort, and privacy and provide therapeutic opportunities for recovery and rehabilitation. The design of the internal and external physical environments of the new facility must be sympathetic to these aims.

The care environment should: -

- Create a calm and restful atmosphere and an environment which is non-threatening.
- Maximise therapeutic opportunities and the ability to relieve boredom.
- Afford no undue separation of staff from patients
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design and in the use of natural materials, colours and textures
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light
- Provide opportunities for exercise, leisure and education
- Be sensitive to the needs of physically disabled patients, staff and visitors

Considerations of space and environment will be important, from both the external and internal perspective. Imaginative and creative use of space will be vital, for example the avoidance of long corridors and the creation of attractive easily maintained landscaped gardens.

It is essential for the service to be flexible to the changing needs of individuals and groups, e.g. changes in condition, gender, numbers, cultural needs and so forth. The physical environment will require to be responsive to such changes in demand.

Individual bedrooms with en suite facilities will be required for all patients to maximise opportunities for the maintenance of privacy and dignity. All personal and therapeutic rooms should be designed to enable speech privacy.

Adequate provision of telephone access and information technology infrastructure will be critical to effective communication, education and the provision of evidence-based practice.

Dining arrangements for patients and adequate storage space for equipment and personal belongings will require careful thought, to ensure adequacy and fitness for purpose.

Garden areas should be designed to provide contrasting textures and colours of plants, providing sensory stimulation and promoting a sense of calm and relaxation. There should also be sheltered areas, suntraps and comfortable seating within the overall design.

(vii) Residual Public Sector Financial Risk

- 12.3.13** Section 7C describes financial risk and risk transferred to the Project Company. Some risk remains with the Primary Care Division, described as residual risk, and the risks are outlined in Schedule A attached to this Section.
- 12.3.14** Risks have been considered under four main headings – Design, Construction and Development, Performance and Operating Cost, reflecting the financial dimensions of the project.
- 12.3.15** Significant risks are passed to the Project Company in respect of building construction and maintenance. The Primary Care Division retains financial risk in respect of operation which is described in Schedule A on the following page. The risks described are usual to all the Primary Care Division's services and being substantially operational and unconnected to the business case, they are described only and not evaluated here.

SECTION 12
West Sector Mental Health – Re-provision of Services
RESIDUAL PUBLIC SECTOR FINANCIAL RISK

	MAIN RISKS	RISK ASSESSMENT		KEY ASSUMPTIONS	RISK CONTROL IF UNDER DIVISION'S CONTROL
		Impact	Probability		
1.	<u>Design changes</u> Design Changes	Medium	Low	The Division will continue to be responsive to clinical care developments and to technological changes. Design changes would be effected if required in response to these but it is considered that changes with particular cost consequences to design are unlikely to happen.	The design brief has been based upon the clinicians and other users' specifications and has been signed off by them.
2.	<u>Construction and Development</u>				
2.1	Building cost index exceeds RPI	High	High	Project Co. bears risk	
2.2	Building tenders exceed cost	High	High	Project Co. bears risk.	
3.	<u>Performance</u> Failure of facilities resulting in repairs and unavailability costs	High	Low	Project Co. bears risk	

SCHEDULE A

	MAIN RISKS	RISK ASSESSMENT		KEY ASSUMPTIONS	RISK CONTROL IF UNDER DIVISION'S CONTROL
		Impact	Probability		
4.	<u>Operating cost and variability of revenue</u>				
4.1	Inflation	High	Low	Inflation remains low. NHS funding contains allowance for inflation year by year.	Inflation control does not lie with the Division. In the event that inflation is not low and/or annual funding does not accommodate an allowance for it, the service would be included within the review of all the Division's services by Division Management for prioritising delivery in these circumstances.
4.2	Excess patient demand	Medium	Medium	Patient activity remains within planned activity and design of hospital.	Exercise of agreed protocols. Examination of capacity for flexibility : refer to features set out in Section 13 – Post Project Evaluation. Exercise of normal cost control measures established for a patient services unit. This involves budget setting, monthly cost monitoring and review/discussion/action at a senior level within management and financial functions. Budget responsibility at senior level is identified.

SCHEDULE A

	MAIN RISKS	RISK ASSESSMENT		KEY ASSUMPTIONS	RISK CONTROL IF UNDER DIVISION'S CONTROL
		Impact	Probability		
4.3	Staff Costs	Low	Low	Staff numbers and costs remain within those planned.	Workforce planned within a wide-ranging multi-function context. Staff recruitment control (refer Section 16 Personnel Issues) and cost control measures adopted, as for any other service.
4.4	Energy Costs	Low	Low	Energy costs controlled by Project Co.	Energy targets incorporated in contract with Project Co.
4.5	Maintenance Costs	Medium	Low	Project Co. bears risk.	
4.6	Other non-staff costs	Low	Low	Costs will be similar to those within current experience.	Exercise of normal control measures highlighted in 4.2 above.
4.7	Regulation Changes	Low	Low	No material regulation changes will occur e.g. staffing, safety, causing cost difficulties.	Hospital management will be alert to any proposals in law or regulation which might impact the service, seeking to influence proposals appropriately before adoption. Any resulting impact on cost would require to be followed through in funding discussions or in reprioritising services.
4.8	Litigation Costs	Medium	Low	Standards of care will make these unlikely.	The impact of clinical governance in the Division is to maintain and improve standards of care in addition to changing care regimes. In addition there is a programme of staff training which should lessen likelihood of this risk. Refer also to adoption of clinical and administrative tools in Section 13 Post Project Evaluation.

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SECTION 13: PROJECT EVALUATION PLAN

Section No 13	<p><u>Required Content:-</u></p> <p><i>13.1 A plan for monitoring the progress and completion of the project, and for evaluating the outcome following implementation is essential and should be carefully prepared and implemented.</i></p>
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13.1 The project aims to provide modern NHS acute in-patient facilities for the resident population of West Glasgow, replacing old and unsuitable institutionalised accommodation. In particular, it aims to reprovide those in-patient services currently located on Gartnavel Royal Hospital site.

The main objectives of the project are as follows:

- provision of modern purpose built in-patient accommodation which will allow the delivery of a range of therapeutic interventions for patients;
- the provision of a range of interventions and treatment strategies which patients experience as being safe, humane and therapeutic;
- the interventions will be planned, co-ordinated and provided from a multi-disciplinary and user / carer perspective, based on comprehensive ongoing assessment of patient needs;
- the in-patient facility will function as an essential core component of a whole systems approach to mental health care in West Glasgow, thereby complimenting other elements such as Primary Care Mental Health Services, Community Mental Health Teams, and Intermediate Services;
- the new buildings and physical environment will reflect a positive vision of mental health services as a normal part of health service life and the life of the West Glasgow community they seek to serve;
- the in-patient service will be provided 365 days per year, 7 days per week, 24 hours per day;

The post project evaluation plan describes those measures which will be used to assess whether the clinical services and facilities which will be established by the project are operating in the way described within the full business case submission.

The post project evaluation plan is set out below. This seeks to evaluate the success of the project in achieving its objectives by addressing the following questions:

1. Does the purpose built in-patient accommodation provide an environment for the delivery of a range of therapeutic interventions for patients?

Specifically does the care environment:

- create a calm and restful atmosphere and an environment which is non-threatening;
- maximise therapeutic opportunities and the ability to relieve boredom;
- afford no undue separation of staff from patients;
- be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design and in the use of natural materials, colours and textures;
- create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- provide opportunities for exercise, leisure and education; and
- be sensitive to the needs of physically disabled patients, staff and visitors.

2. When patients are requiring to be admitted to hospital are they accommodated in appropriate surroundings that will meet their personal as well as their clinical needs?

- when patients are admitted will they be able to access a rapid response that will provide for their needs to be assessed and care to be provided in the most appropriate setting;
- will patients be able to access services which are geographically local to their own homes;
- will the provision of single bedroom accommodation provide greater privacy for patients and assist in preserving dignity and respect;
- will patients be cared for in an environment that is conducive to providing appropriate therapeutic interventions; and
- will the design and layout of the care environment minimise the opportunity for self injurious behaviour by allowing for appropriate levels of observation and intervention by clinical staff.

3. Does the new buildings and physical environment reflect a positive vision of mental health services as a normal part of health service life and the life of the West Glasgow community they seek to serve?

- will the inpatient service promote patient safety, dignity comfort, and privacy and provide therapeutic opportunities for recovery and rehabilitation; and
- will the design of the internal and external physical environments of the new facility be sympathetic to these aims.

4. Does the inpatient facility function as an essential core component of a whole systems approach to mental health care in West Glasgow, thereby complimenting other elements such as Primary Care Mental Health Services, Community Mental Health Teams, and Intermediate Services?

- will community services be available to provide the necessary intensive support to patients following discharge;
- will enhanced community services be able to proactively follow up patients and maintain them in their community where possible, minimising the need for hospital admission;
- will a greater emphasis be placed on locally based community services based on shared care arrangements which are rooted in primary care;
- will there be modern inpatient hospital environments that are fit for purpose;

- will the development of services be more responsive to the needs of women and ethnic minority communities and support the evolving equality and diversity strategy; and
- will there be the provision of appropriate services for people with dementia.

As stated above the post project evaluation plan seeks to evaluate the success of the project in achieving the objectives set. The questions listed above will be incorporated into the West Glasgow Clinical Governance workplan and will be reported on as part of the agreed Governance reporting.

Aspects of the service which will be particularly influenced by the workplan will include clinical practice, education and training, user/carer involvement, research and development, clinical audit and clinical effectiveness. This will put in place an additional level of assurance and scrutiny of day to day clinical practice and decision making.

13.2 All PFI projects are subject to the general guidance on Appraisal and Guidance with a specific requirement being the preparation of a post-project evaluation (PPE) report following construction completion.

The focus of PPE is the evaluation of the procurement process and to review the success of the project against its original objectives in terms of time, cost and quality outcomes.

This Evaluation Process will be carried out in four stages:

Stage 1: plan and cost the scope of the PPE work at the project appraisal stage.

Stage 2: monitor progress and evaluate the project outputs on completion of the facility

Stage 3: initial post-project evaluation of the service outcomes six months after the facility has been commissioned

Stage 4: follow-up post-project evaluation to assess longer-term service outcomes two years after the facility has been commissioned. Beyond this period, outcomes shall continue to be monitored at set intervals.

The benefits will be measured by:

- identifying the reasons for any problems which arise throughout the delivery of the project
- assessing the effectiveness of the remedial action plans prepared as part of the project's implementation planning
- identifying areas of risk, including frequency of occurrence and impact, both operationally and financially

A robust process of post project evaluation will also be implemented to cover the full operating contract for Facilities Management (FM) ensuring the Division's objectives are being met.

The primary responsibility for monitoring the FM Contract will lie with the ProjectCo. Within their submission proposals they have stated how they will carry out this self-monitoring and this forms part of their FM Service in accordance with the Service Output Specifications.

The Division will ensure that self-monitoring is working properly and will monitor the self monitoring regime of ProjectCo i.e. monitor compliance within the Output Specifications including performance parameters and KPI's.

Listed below are the key evaluation areas, timescales and responsibilities:-

Evaluation Areas

Milestone	Measurement	Responsible
Post-financial close	<ul style="list-style-type: none"> Identify overall costs of PFI process Review overall timetable to achieve Financial Close Review against strategic objectives. 	Division
Final design process signoff	On completion of design process: <ul style="list-style-type: none"> Compliance to full Project Brief Analysis of any change controls required during final design phase Establish additional costs 	Project Board
Final handover of building	Compliance with the Project Agreement	Independent Tester
Completion of commissioning	<ul style="list-style-type: none"> Compliance with the Project Agreement Clinical and operational risk management outcomes Identify costs, including delays, change controls, and any unforeseen expenditure. Record overall progress against timetable. 	Independent Tester
Financial audits	<ul style="list-style-type: none"> Outturn against annual cost projections.. Division's finances remain in balance. Achievement of Division's identified savings. 	Division Finance
Risks reviews	<ul style="list-style-type: none"> Analysis of risks identified against occurrence Analysis of unidentified risks against occurrence Costs attributable to any identified and unidentified risks occurring. 	Contract Manager / Division Monitoring Team
Non-financial Benefits reviews	<ul style="list-style-type: none"> Analysis of benefits measurement achievements against targets Identify any unforeseen benefits achieved. Complete Patient satisfaction surveys. Complete Staff satisfaction surveys. 	Contract Manager / Division Monitoring Team
FM service performance reviews	Part of monthly service contract monitoring reviews.	Contract Manager / Division Monitoring Team

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SECTION 14: INFORMATION MANAGEMENT AND TECHNOLOGY STRATEGY

Section No 14	<p><u>Required Content:-</u></p> <p><i>14.1 A description of the IM&T Strategy and how it relates to the project under consideration.</i></p> <p><i>14.2 If a major development does not include a specific IM&T component, an outline of how the IM&T strategy will be delivered including any affordability implications.</i></p> <p><i>14.3 A description of the IM&T Strategy and how it relates to the project under consideration.</i></p> <p><i>14.4 If a major development does not include a specific IM&T component, an outline of how the IM&T strategy will be delivered including any affordability implications.</i></p>
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14.1 A Description of the IM&T Strategy and how it relates to the project under consideration

14.1.1 The Division's IM&T strategy is to establish access to relevant patient information via both manual and computerised systems. Staff will work both individually and in multi-disciplinary teams.

14.1.2 Any relevant information systems in use in the Division will be made available to both clinical and administrative staff in the mental health service to support the delivery of care.

14.1.3 The Division's IM&T strategy recognises the need for information exchange and sharing between individual practitioners involved in the process of patient care. It also recognises the need to ensure where that information is shared or exchanged, both inside its own organisation and externally with other organisations; it remains secure and confidential through use of agreed protocols and systems. The Division will continue to work with partner agencies to ensure that data models are compatible and support the sharing of information between systems. Information sharing processes will use national software and communication solutions where these are appropriate.

14.1.4 Patient identifiable information will be shared between organisations only after appropriate consultation has taken place. Protocols are being developed between the organisations involved to ensure that a formal decision making process is adopted and followed. These involve all the agencies contributing to care and rehabilitation to ensure compliance with current legislation including the Data Protection Act 1998, the Mental Health (Care and Treatment)(Scotland) Act 2003, the Human Rights Act 1998 and Caldicott Principles.

14.1.5 The Division has put in place a communications network infrastructure in accordance with the NHSiS communications strategy. This enables staff to communicate internally and externally, and to access relevant application programs. The NHS Greater Glasgow private network restricts access to internal staff. In addition, the Board has a connection to the NHSnet enabling communication between other NHSiS organisations and out to the Internet via a secure firewall.

14.1.6 The Service is currently examining its IM&T requirements in the context of development of multi-agency working and the imperative to maintain high levels of data security within the service. Included in the principles to be adopted will be:-

- active involvement by clinical staff in the development of systems which facilitate good quality data and through this improved patient care;
- accurate recording of therapeutic interventions and the professional specialties responsible in the context of a co-ordinated package of care;
- full compliance with relevant legislation and clinical governance standards recorded so as to ensure that the needs of the service and external accreditation and monitoring organisations are met; and
- secure messaging within the service and limited external links to preserve the security of patient data.

14.1.7 IT systems and technical support will be provided through a combination of in-house arrangements and external facilities management contracts and will reflect the security considerations of the service.

14.2 If a major redevelopment does not include a specific IM&T component, outline how the IM&T strategy will be delivered including any affordability implications

14.2.1 The scope of the procurement will include the provision of:-

- Internal infrastructure to support connectivity for voice and data services for a minimum of two hundred physical locations at a data speed of at least 100 mpbs.
- Internal network links and inter building network links within the facility will be at minimum speed 1000 mpbs.
- External data network connectivity to the NHS Glasgow network will be at minimum speed 100 mpbs.

All telecommunications will be integrated with the NHS Glasgow network.

14.2.3 The procurement excludes the provision of hubs, routers and other associated communications networking equipment. The procurement also excludes the provision of desktop hardware and software and clinical and non-clinical applications. These items are included within the Division's Strategic IM&T implementation plans. IM&T developments are prioritised by the Divisional IM&T Steering Group and funded through the annual capital and revenue budget IM&T allocations.

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SECTION 15: EQUIPMENT

Section No 15	<p><u>Required Content:-</u></p> <p><i>15.1 An explanation of how equipment will be provided for the project, and what equipment is in the PPP/PFIU contract.</i></p> <p><i>15.2 A summary of how equipment within the PPP/PFI contract is handled.</i></p> <p><i>15.3 Details of how equipment not in the PPP/PFI contract will be provided.</i></p>
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15.1 An explanation of how equipment will be provided for the project, and what equipment is in the PPP/PFI contract.

15.1.1 The Project Company will provide for the purchase, installation and commissioning of all Group 1 equipment. Group 1 equipment is all equipment installed into rooms such as heaters, cookers, fixed lifting equipment.

15.1.2 Room data sheets are provided by the Division specifying the Group 1 equipment required room by room, and specifying the standard expected for the items of equipment.

15.1.3 The model of care for assessment, treatment and rehabilitation is based upon clinician to patient interactions. Equipment requirements are of a minor scale compared with the building quality needed for security, living and care activity.

15.2 A summary of how equipment within a PPP/PFI contract is handled

15.2.1 The Project Company will be responsible for all equipment within the contract and will be responsible for training in its use, in addition to maintenance and replacement.

15.3 Details of how equipment not in the PPP/PFI contract will be provided.

15.3.1 The Division will provide for all Group 2, 3 and 4 equipment, i.e. that which is moveable and not part of a room's installation. Equipment to be procured includes:

- Therapeutic activities – tables, working platforms
- Domestic – kitchen, cleaning
- Living areas – tables, chairs, beds etc.
- Reception / offices – office equipment

New equipment is expected to cost £950,000 in total and will be incorporated in Divisional equipment spending plans for years 2006/07 and 2007/08.

15.3.2 Equipment from interim accommodation will also transfer to the new unit, in

categories Group 2, 3 and 4. Any other surplus equipment in good condition within the Division will also be transferred to the unit.

15.3.3

Agreed revenue funding includes an allowance for equipment repair and renewal in respect of Divisional provided equipment.

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SECTION 16: PERSONNEL ISSUES

Section No 16	<u>Required Content:-</u> <i>16.1 If the project involves any significant changes to the numbers and mix of staff employed, a human resource change management plan should be prepared, including redundancy costs, early retrieval costs etc.</i>
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16.1 Context

16.1.1 As part of NHS Glasgow's Modernising Mental Health Services agenda, the current outdated hospital wards required to be re-provided in a new purpose built which supports the delivery of high quality modern mental health services.

16.2 Developing the Current Service

16.2.1 NHS Greater Glasgow Primary Division recognises that the success of the mental health service is dependent on employing and retaining appropriate numbers of staff with the right skills, working in a multidisciplinary and multi-agency way to engender the correct culture, foster rehabilitation of patients and prevent institutionalisation.

16.2.2 Work has been taking place since 2000 to move to the agreed inpatient staffing profile and to ensure that the overall staff numbers and the ratio of qualified staff to unqualified staff is in line with the wider workforce planning objectives of mental health services city wide.

16.2.3 Since 2000 the local management team, in conjunction with local authority partners, users and carers and the voluntary sector, has been working to develop a model of care that is rooted on the provision of an effective community service supported by and integrated with an appropriate number of inpatient beds. The availability of community based services providing alternative treatment options to hospital admission has an impact on the total beds required and the model of care provided.

16.2.4 It has been possible to reduce the number of hospital beds and ward sizes as agreed in the Modernising Mental Health Services plan in advance of the new hospital facility and develop a range of community based services to support this. Ward based staffing levels have been preserved which has resulted in an increase in the nurse/patient ratio. This is in line with the overall workforce planning strategy. See table at page 75.

	Skill Mix Trained/Untrained	Nurse to patient ratio
Adult Services – 72 Beds		
Admission 60 beds (3 x 20 bed wards)	70/30	1.23
IPCU 12 beds	80/20	2.54
Elderly Services – 45 beds		
Admission 45 beds (1 x 20 bed & 1 x 25 wards)	60/40	1.23
Overall	109.12/50.35 wte	

16.2.5 In addition to the above staffing each of the three adult admission wards have two Patient Activity Co-ordinators. The increase in staff/patient ratio facilitates the delivery of high quality patient focussed services. There is also an increase in the trained/untrained skill mix and this reflects the services that require to be provided.

16.3 Workforce Planning Process

16.3.1 The benefits, as defined in Section 11, will shape the wider workforce profile required for the service in terms of numbers and skills. A multi disciplinary approach, involving all clinical and support services, was taken to agree the workforce profile. In the spirit of partnership working, the trade unions were engaged in this process.

16.3.2 Each staff group working as part of a multi disciplinary team plays a critical role in providing a clinically effective safe, secure and flexible patient focussed service. Although the physical aspects of security and risk management are important, employing sufficiently skilled and competent staff is equally important in working with people with mental health problems. In response to this the local team have developed a West Sector Learning Plan. This plan has the support of all the partners in the West and is subject to regular evaluation and review to ensure its relevance and continued alignment with national and local priorities. Progress reporting takes place at the West Sector Clinical Governance Forum and the Mental Health Services Clinical Training Forum.

16.3.3 Mental Health is perceived to be a challenging area of work. For the recruitment and retention strategy to be effective, the service should be as attractive as possible to prospective and current employees. The provision of educational opportunities for staff is being developed and the Directorate is strengthening links with the educational establishments. A commitment is being made to training and developing the workforce within the context of the National Education, Training and Lifelong Learning Strategy for the NHS in Scotland, leading to a clear programme of staff career development.

16.3.4 Nursing staff are responsible for the day to day care to patients over a 24-hour period, 7 days a week. They represent the biggest element of the workforce. Nurses play a key role in facilitating change within the client group by providing skilled interventions that aid crisis resolution, reduce clinical risks, and promote rehabilitation and recovery. A range of skills and expertise is being developed to provide individualised care to patients. The Tidal Model of mental health nursing will be the framework used to underpin the delivery of care. The range of skills and expertise will include:

- Person centred care planning
- Problem solving therapies
- Understanding the needs of diverse minority groups
- Anxiety management and relaxation
- Psychosocial intervention
- Management of patients with personality disorder
- Management of deliberate self harm
- Gender specific interventions
- Multi-professional working
- Working within the framework / principles of the Mental Health (Care and Treatment) Act
- Promotion of self care and independence
- Wound management
- Palliative care
- Respecting and meeting the needs of carers
- Health promotion
- Meeting nutritional needs
- Infection control

16.4 Therapies

16.4.1 The workforce profile recognises the key role which therapies, such as psychotherapy and particularly occupational therapy, will play in maximising normal life functioning and occupational performance. Allied Health Professionals, in conjunction with the patient's named nurse and nursing Patient Activity Co-ordinators, will ensure each patient is given a specific individual programme of activity, which is directed to the maintenance and improvement of functioning. This will include the analysis of the physical, cognitive, interpersonal, social, behaviour and emotional components of the activity and identify the aspects which are most appropriate for the individual's needs.

16.5 Support Services

16.5.1 An integrated model of support services will provide domestic, catering, portering, security and transport functions and will play an essential role in the overall delivery of the service.

16.5.2 On account of the nature and scale of this development, soft FM Services are excluded from the package of services which bidders have been asked to tender for. This means that from the perspective of fully integrating the services there will be no significant associated TUPE issues or early retiral/redundancy costs associated with the current support services functions.

16.5.3 A Primary Care Division workforce plan is updated annually to both recruit required skills and develop them in existing staff. Identified needs are in the provision of therapeutic interventions to patients for both broad and specific needs. This is supported by a process of appraisal and also clinical supervision. These skills will be developed at a range of levels and competencies and delivered informally in-house as well as through formal accredited training.

Workforce Plan

Ward	Beds	Trained	Untrained	Total	%Trained	%Untrained	Ratio
Cuthbertson	20	14.76	9.84	24.6	0.6	0.4	1.23
Timbury	25	18.45	12.3	30.75	0.6	0.4	1.23
McNiven	20	17.21	7.38	26.51	0.7	0.3	1.23
Rutherford	20	17.21	7.38	26.51	0.7	0.3	1.23
McNair	20	17.21	7.38	26.51	0.7	0.3	1.23
IPCU	12	24.28	6.07	30.48	0.8	0.2	2.54
	117	109.12	50.35	160.23			

GREATER GLASGOW NHS BOARD
PRIMARY CARE DIVISION

WEST SECTOR - REPROVISION OF MENTAL HEALTH SERVICES
FULL BUSINESS CASE SUBMISSION

SECTION 17: CONCLUSION

Section No 17	<u>Required Content:</u> 17.1 <i>A statement of the preferred option in the FBC for which approval is being sought</i>
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- 17.1** Mental Health remains a national and local strategic priority. The re-provision of in-patient accommodation into modern functionally suitable in-patient accommodation is a key component in GGNHSB's strategy for modernising Greater Glasgow's mental health services.
- 17.2** The preferred option meets the clinical preference for the in-patient services to be located on a DGH site. It allows the optimum development of surplus land and buildings consistent with the property strategy and enables significant receipts to be reinvested in the healthcare re-provision.
- 17.3** The solution proposed by Robertson's group will allow NHSGG to establish an operational and affordable, functionally suitable, custom built in-patient facility by August 2007 which compares favourably with the alternative of public sector funding.

FULL BUSINESS CASE FOR PREFERRED OPTION**COST FORM FB1**

BOARD: NHS Greater Glasgow Primary Care Division

SCHEME: Gartnavel Royal Hospital

PHASE: N/A

PROJECT DIRECTOR: Anthony Curran

CAPITAL COSTS SUMMARY

	Cost Exc VAT £	VAT £	Cost Inc. VAT £
1. Department Costs (from Form FB2)	8,611,455	1507,005	10,118,460
2. On-Costs (a) (from Form FB3) (61.4% Department Cost)	5,287,430	925,300	6,212,730
3. Works Cost Total (1+2) atFP/VOP* SPSBTP1 (Tender Price index level 2004 = 213 base)	13,898,885	2,432,305	16,331,190
4. Provisional location adjustment (if applicable) (5 %)	694,945	121,615	816,560
5. Sub Total (3+4):	14,593,830	2,553,920	17,147,750
6. Fees (c) (10 % of sub-total 5)	1,459,350	(d) xxxxxxxxxx	1,459,350
7. Non-Works Costs (from Form FB4) (c)			
L.A. Fees	86,825	xxxxxxxxxx	86,825
OTHER			
8. Equipment Cost (from Form FB2) (9.5 % of Department Cost)	816,072	142,813	958,885
9. Contingencies	246,757	43,183	289,940
10. TOTAL (for approval purposes)	17,202,834	2,739,916	19,942,750
11. Inflation Adjustments (f)			
12. FORECAST OUTTURN TAKEOVER BUSINESS CASE TOTAL	17,202,834	2,739,916	19,942,750

Cash Flow	SOURCE			£
	EFL	OTHER GOVERNMENT	PRIVATE	
Year:				
			Total Cost (as 10 above)	_____
				—
				=====
				=

This form completed and authorised by: Anthony Curran Project Director Date: 11.10.04

Address:

..... Telephone No: 0141 211 3585

FULL BUSINESS CASE FOR PREFERRED OPTION

COST FORM FB2

BOARD: NHS Greater Glasgow Primary Care Division
 SCHEME: Gartnavel Royal Hospital
 PHASE: N/A
 PROJECT DIRECTOR: Anthony Curran

CAPITAL COSTS: DEPARTMENT COSTS AND EQUIPMENT COSTS

Functional Content	Functional Units/ Space Requirement (1)	N/A/C/ (2)	DCG Schedule Date	Equipment Cost
			£	£
Administration		N	935,155	
Reception		N	493,700	
Shared Areas and Recreation Area		N	1,151,955	
Beds	Intensive Care 12 Admission – Adult 60 Admission – Elderly 45 Total 117	N	5,938,750	
Stores		N	30,745	
Boiler Rooms		N	61,150	
				816,072
Less abatement for transferred equipment if applicable (...-----%)				
Department Costs and Equipment Costs to Summary (Form FB1)			£8,611,455	£816,072

BOARD: NHS Greater Glasgow Primary Care Division
 SCHEME: Gartnavel Royal Hospital
 PHASE: N/A

CAPITAL COSTS: ON-COSTS

	Estimated Cost (exc VAT)	Percentage of Departmental Cost %
1. Communications £ a. Space b. Lifts	£ } £ } £ }	61.40
2. 'External' Building Works (1) a. Drainage b. Roads, paths, parking c. Site layout, walls, fencing, gates d. Builders work for engineering services outside buildings		
3. 'External' Engineering Works (1) a. Steam, condensate, heating, hot water and gas supply mains b. Cold water mains and storage c. Electricity mains, sub-stations, stand-by generation plan d. Calorifiers and associated plant e. Miscellaneous services		
4. Auxiliary Buildings		
5. Other on-costs and abnormals (2) a. Building b. Engineering		
	£5,287,430	
Total On-Costs to Summary FB1	£5,287,430	61.40

Notes: Must be based on scheme specific assessments/measurements; attach details to define scope of works as appropriate.

* Delete as appropriate

- (1) 'External' to Departments
- (2) Identify any enabling or preliminary works to prepare the site in advance e.g. demolitions; service diversions; decanting costs; site investigation and other exploratory works.

This form completed by: Anthony Curran
 Telephone No: 0141 211 3585

Date: 11.10.04

