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1. FOREWORD

This document presents the Full Business Case (FBC) for the St Andrews Community Hospital and Health Centre in St Andrews Fife.

The Outline Business Case for the project was approved by the Scottish Executive Health Department in April 2002 and the proposals have been further developed and incorporated in this document.

With the agreement of the Scottish Executive Health department this Full Business Case was submitted to the Scottish Executive Capital Investment Group (CIG) for consideration prior to approval at a board meeting of NHS Fife held on 31 July 2007. The document now has full Board approval and is now submitted for final recommendations by the CIG.
2. EXECUTIVE SUMMARY

2.1 Purpose

2.1.1 The purpose of this Executive Summary is to set out the case for the design, build and operation of the St Andrews Community Hospital and Health Centre (the “Project”).

2.1.2 The Full Business Case (the “FBC”) conforms to the Scottish Capital Investment Manual (SCIM) guidance and the layout is in accordance with the guidance in NHS Circular HDL (2002)87. The content of the FBC is designed to demonstrate to the Scottish Executive Health Department (“SEHD”) that NHS Fife’s proposals are robust, affordable and provide value for money. The contents should also assist NHS Fife’s private sector partner, the Morrison consortium (“the Consortium”) and its funders, Dexia Public Finance Bank, with information for their due diligence work in preparation for Financial Close.

2.2 Background

2.2.1 The Strategic Context of this project is set out in Section 3 of the FBC.

2.2.2 In January 2001, the Board launched its largest ever consultation process in which every Fife resident and member of the Board’s staff was given the opportunity to help shape the future of healthcare delivery through a process called “Right for Fife”. In March 2002, the Board agreed both the overall strategy for key parts of Fife’s health services including the 5-year financial strategy and the ‘preferred option’ for achieving the desired changes and developments in each care group. The Board agreed that the St Andrews proposals were consistent with and fully support the Board’s strategic direction.

2.2.3 In April 2002, the Board approved the Outline Business Case for the development of a new build, integrated community hospital and health centre on a single site. The Outline Business Case was subsequently approved in principle by SEHD subject to an Addendum once the outcome of the site selection process was known. The Addendum to the OBC was approved by the Board in July 2003 and the letter of approval to move to FBC was received from SEHD in September 2003.

2.2.4 The principal objective of the St Andrews Community Hospital and Health Centre proposal is to build a new facility which will bring all existing services from St Andrews Memorial Hospital and St Andrews Health Centre, plus additional services, on to a single site.
2.2.5 The building solution is based on three key principles:

- maximisation of flexibility in the use of the accommodation;
- ability of the accommodation to facilitate breaking down of barriers across all disciplines and agencies involved; and
- ease of access to services by all sections of the community.

2.2.6 The Project has been driven by the desire for real integration of services within a single healthcare facility, providing seamless care for patients, as close to the patient’s home as is practical and affordable, taking advantage of developments in medical and information technology, new treatments and improvements in clinical practice. These principles are in accordance with the recent report “Delivering for Health” which provides a framework on the way services need to change in response to Professor David Kerr’s report “Building a Health Service Fit the Future”

2.2.7 The service to be provided will embody a range of community services provided by the Board, Fife Council Social Work Service and the voluntary sector. Co-location will bring excellent opportunities for all professionals to gain a better understanding of each others roles, to communicate more regularly and effectively and to achieve swifter and more effective outcomes for users and their carers. By combining these services the patient pathway through the system will be shorter and both waiting times and travel requirements will be reduced.

2.2.8 Throughout the development of the project the team has taken steps to ensure a high degree of public involvement. The following are some of the measures taken to ensure effective communication of the process and obtain input from a variety of users:

- Project Newsletter (issued quarterly to staff, stakeholders, public and press)
- Public Exhibition of model, plans and drawings of new facility
- Presentations to local Community Councils, Green Belt Forum, Preservation Trust, Rotary Club, Hospital League of Friends
- Inclusion of two Public Representatives on each of the Project Board and Project Team
Preferred Bidder/ NHS Fife Event (to discuss next steps of process with staff, users, public reference group, public representatives and advisers)

The measures taken throughout the development of the project will continue during the build and commissioning phases of the project. The stakeholder groups which have already been established will continue to be involved once the facility becomes operational.

2.2.9 A Project Board and Project Team have been established and robust governance arrangements have been instituted.

2.3 Overview

2.3.1 The combined capital cost of this FBC is (deleted – commercial in confidence). This investment will be delivered by Public Private Partnership (PPP) procurement.

2.3.2 NHS Fife (“the Board”) has agreed to fund the unitary payment and associated running costs of the new facility.

2.3.3 It is intended that the new hospital and health centre should be fully operational by April 2009.

2.3.4 The Board’s Conventional Procurement Assessment Model (CPAM) approved at OBC has been reviewed throughout the procurement process at each Key Stage milestone ensuring that the cost of the project under conventional procurement has been closely monitored and compared to the cost under PPP, with value for money and affordability being demonstrated at each stage.

2.4 Economic and Financial Summary

2.4.1 Results of Financial Appraisal

The annual unitary charge to be paid by the Board to the Consortium, for full availability of the facility and delivery of all the PPP services to the specified standards is currently projected as (deleted – commercial in confidence) at 1st April 2007 prices (excluding pass through costs). The unitary charge becomes payable from 1st April 2009, when the facility is commissioned in line with the requirements set out in the Project Agreement.

Throughout the procurement process the Board has regularly undertaken detailed assessments of the financial implications of the Project to demonstrate that it is affordable within identified
resources. The actual cost of the Project will depend on the final position on interest and RPI swap rates at financial close, but for the purposes of testing for value for money and demonstrating affordability, the above unitary charge is considered robust.

Overall the Project has been assessed as affordable by the Board. The Board’s Finance and Resources Committee has approved the funding requirements as associated with the Project. The Board’s 10 year projections for revenue expenditure currently incorporate the estimated funding required for St Andrews along with other developments within the Board. The Supplementary Paper to the NHS Fife board meeting of 30 January 2007 is attached at Appendix 5.

In subsequent years the unitary charge will increase in line with inflation. It is also anticipated that the Board's resources will increase annually with inflation (or greater) and therefore the Project should remain within the affordability envelope.

The Project has been assessed by the Board’s financial advisors as an “Off Balance Sheet” transaction and therefore suitable for delivery under a PPP contract arrangement.

2.4.2 Results of the Economic Appraisal

All key elements of the Project (design, build, finance and facilities services delivery) have been subject to rigorous appraisal by the Board and its advisers. This has included an economic evaluation to assess the value for money of the proposed PPP solution against a Conventional Procurement Assessment Model (CPAM). The appraisal has been undertaken in line with HM Treasury and Scottish Executive Health Department guidance.

2.4.3 Qualitative Assessment

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

The CPAM has been reviewed regularly and updated by the Board to ensure it remains in line with the PPP option, but delivered through a Treasury funded solution. The results of the economic analysis are summarised below:

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The economic analysis takes into account adjustments for risks transferred under the Project Agreement and the tax advantages of the PPP solution. At this stage the optimism bias is considered low and potential underestimation of costs is reflected in the risk analysis. The risk analysis process has been developed through a series of workshops involving various members of the Project Team and the Project advisers and is considered robust. As a result the Board considers that value for money has been achieved on risk transfer.

The appraisal demonstrates that the Project represents value for money over the 31.5 year appraisal period, reflecting both the construction and operating periods.

2.5 Procurement Process

2.5.1 The Board placed an advertisement for the Project in the Official Journal of the European Union in January 2006 (the OJEU Contract Notice). The OJEU Contract Notice (attached at Appendix 1) invited, in accordance with the negotiated procedure under the Public Services Contracts Regulations 1993 (as updated), suitably qualified consortia/ companies to express interest in the provision of the Project.

2.5.2 A significant number of expressions of interest were received and a Bidders’ Conference was held on 14 February 2006 for interested parties. At the deadline for submission of the Pre-Qualification Questionnaire (“PQQ”) on 31 March 2006, seven completed PQQs were submitted.

2.5.3 On receipt of the submissions, the make-up of each consortium was examined and a number of conflicts of interest identified. Following a round of correspondence, one consortium withdrew its Bid and another two made the appropriate substitutions to
their consortium make-up.

2.5.4 The six remaining consortia were subjected to a rigorous evaluation by the Board. Section 6 describes in more detail the objective evaluation methodology and criteria used.

2.5.5 Following this evaluation and the approval of the Board, the three consortia with the highest weighted scores were invited to proceed to the next stage of the procurement process. These were:

- BHE;
- Morrison; and
- Saltire Care

An extract from the minutes of the NHS Fife board meeting of 30 January 2007 approving the shortlist of Bidders along with the PQQ report and Bidder Shortlisting paper are attached at Appendix 2.

2.5.6 The Invitation to Negotiate (“ITN”) was issued to the three shortlisted consortia on 23 May 2006 and responses were returned on 29 September 2006. During the period from issue of the ITN to the return date for bids, the Board’s Project Team conducted a series of clarification meetings with the Bidders.

2.5.7 The Board adopted a rigorous and equitable methodology, as set out in the ITN, in evaluating the bids in both financial and non-financial aspects.

2.5.8 The Consortium was selected as Preferred Bidder on the basis that its proposals are the most economically advantageous in terms of the pre-determined evaluation criteria and the decision was made public at the regular board meeting of 27 February 2007.

An extract from the Board Meeting approving the appointment of Morrison as Preferred Bidder is attached at Appendix 2.

2.6 Key Stage Review Process

2.6.1 The SEHD has improved the PPP procurement process through standardisation and the introduction of the Key Stage Review process. The Key Stage Review (“KSR”) is a self assessment tool, reviewed and backed up by an independent report by Partnerships UK (“PUK”) to SEHD at defined key stages in the PPP procurement. Sign-off from SEHD is required at each review before approval is granted to proceed to the next stage of the project. It has already significantly improved the quality of
readiness of schools PPP projects coming to the market, and is now being used in the health, waste and justice sectors.

2.6.2 The Project has been the subject of three satisfactory PUK KSR reviews (Pre-OJEU, Pre-ITN and Pre-Preferred Bidder) and the approvals of these KSRs are attached at Appendices 6, 7 and 8. The KSR process continues post-financial close to support long term management and monitoring of PPP contracts.

2.6.3 The project has not been the subject of the Gateway Review process. The final Gateway 5 (Benefit Evaluation) will be held six months to one year after service commencement and will form part of the Project Evaluation plan. It is anticipated that this process will be repeated at regular intervals throughout the life of the project in order to ensure the ongoing need for the service, continuing value for money and robust management.

2.7 Risk Transfer

2.7.1 A summary of the risk management strategy is shown in Section 15 of this document. The Board has endeavoured to ensure transfer of risk where appropriate from the public sector to the private sector. A copy of the Risk Allocation Matrix is attached at Appendix 9.

2.8 Planning Consent

2.8.1 The Board obtained Outline Planning Consent in September 2005 for the construction of the hospital and health centre.

2.8.2 During negotiations in connection with the site purchase the opportunity was taken to obtain a further area of land and a revised Outline Planning Application was lodged with Fife Council Planning Department in May 2006 and was considered at Committee in August 2006. A revised Outline Planning Consent was granted in December 2006.

2.8.3 Upon the appointment of preferred bidder, the planning process has been undertaken by the Consortium. Discussion has taken place on the format of the Full Planning Application and agreement has been reached with the planning officials that the application can be dealt with as a Reserved Matters Application. As such the application need only cover those matters reserved for further detailed consent by the local authority when Outline Planning Consent was granted.

2.8.4 A Reserved Matters Application for Planning Consent was lodged on 16th April 2007 and it is anticipated that the Reserved Matters application will be heard at the next Fife Council Planning
2.9 Timetable

2.9.1 The Board will endeavour to reach Financial Close by September 2007. A construction period of some 19 months is planned with a view to the new facility being commissioned and operational by April 2009.

2.10 Conclusion

2.10.1 The Board has pursued a rigorous and competitive Bidder selection process and a robust evaluation procedure for the Project which met with the approval of SEHD’s Private Finance and Capital Unit through evaluation by PUK.

2.10.2 The Board recognises that qualitatively, the provision of the hospital and health centre will provide service users with accommodation which will meet the Board's objectives and which has taken into account the views and suggestions from the user and staff group meetings held as part of the procurement process.

2.10.3 The FBC demonstrates that the Consortium’s bid will provide the Board with value for money and that the bid is affordable.

2.10.4 The Board recommends that the SEHD approves the FBC thereby approving the partnership of the Board and the Consortium and thus allowing the Board to proceed to Financial Close and contract execution.
3. STRATEGIC CONTEXT

3.1 Overview

3.1.1 This section of the FBC describes the strategic context and how the development links with NHS Fife’s Service Strategy. It provides the context in which these developments now sit. Section 4 provides detail of the original plans as described in the OBC.

3.1.2 Additional information on the Board’s service plans is provided in the NHS Fife Plan 2007/2008.

3.2 Background

3.2.1 The investment proposal for a new community hospital and health centre for St Andrews and the wider community of North East Fife was a strategic commitment by the Board to modernise and improve local health service provision to its catchment population.

3.2.2 This development is the outcome of a detailed consultation process with the people of Fife about how services should be delivered over the coming decades.

3.2.3 The project is one of the key projects within the Glenrothes and North East Fife Community Health Partnership and will incorporate General Practice, Social Work, the Community Hospital and new services such as renal dialysis.

3.3 Demography and Epidemiology

Over the next ten years it is projected that Fife’s total population will rise from 360,000 in 2007 to 376,000 in 2017. In addition, greater life expectancy, falling birth rate and advances in healthcare will all contribute towards an increase in the proportion of older people in the area. The number of households in Fife is projected to rise and the trend towards smaller households will continue. These demographic changes will significantly affect the demand for health, social care, and education and leisure services.

In addition to changes to the population profile, there are also anticipated changes to the level of health due to the following:

- the increase in non-communicable diseases – cancer, circulatory, gastro-intestinal and metabolic disorders;
- increasing incidence of mental illness;
- the propensity towards sedentary lifestyles and obesity; and
- emerging and resurgent infectious diseases.
3.4 National Strategic Context

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

The Scottish Executive publication “Delivering for Health” which was written in response to the report prepared for the Scottish Executive by Professor David Kerr “Building a Health Service Fit for the Future” provides a framework on how services should be delivered. “Delivering for Health” sets out a range of actions aimed at designing and providing community focused health services which shift the balance of care from an acute setting to a primary and community setting, thereby reducing the need for care in acute hospitals. This strategy supports an expanded role for community hospitals which will provide a wide range diagnostic and treatment services, advice and outreach services.

3.4.2 The Scottish Executive document “Developing Community Hospitals: A Strategy for Scotland” published in 2006 sets out the vision of the Scottish Executive in shifting the balance of care from an acute setting to a primary and community setting and states:

“The new community hospital will act as a local community resource centre and provide a bridge between home and specialist hospital care, through the delivery of both ambulatory and / or inpatient services closer to communities”.

The document also states: “New community hospitals should be local community resource centres in which to provide people with more holistic and integrated services quicker and closer to home”.

3.4.3 The investment proposal for the new St Andrews Community Hospital and Health Centre is consistent with, and indeed fully supports, the strategic direction of the Scottish Executive Health Department.

3.5 Strategy and Objectives of the Board

3.5.1 NHS Fife’s service strategy closely mirrors the findings of the Kerr Report “Building a Health Service Fit for the Future” and in particular the NHS Scotland response “Delivering for Health” which sets out a programme of action for the NHS in Scotland. The strategy also reflects the National Framework for Service Change which addressed the changing needs for healthcare, highlighting the combination of an ageing population and the growth in long term conditions and the Scottish Executive paper “Developing Community Hospitals: A Strategy for Scotland”.
NHS Fife’s strategy therefore includes the following:

- separating planned cases from urgent cases;
- better community-based access to diagnostic services;
- community-based casualty departments to provide the majority of unscheduled care; and
- the concentration of specialised or complex care on fewer sites to secure clinical benefit

3.5.2 The NHS Fife 2007 - 2008 Plan focuses on four areas:

- Health Improvement;
- Efficiency and Governance Improvements;
- Access to Services; and
- Treatment Appropriate to Individuals.

It sets out a number of goals that depend on the availability of primary and community care services with sufficient capacity to deliver excellent outcomes for the communities they serve. The most important of these goals are:

- building a local National Health Service which listens to patients, service users and the people of Fife;
- delivering real health improvement, including tackling health inequalities and building a local NHS, designed and organised around the needs of the population;
- building alliances between community planning partners to deliver joined up services offering integrated care wherever it is needed;
- reducing deaths caused by cancer, heart disease, stroke and respiratory disease which are the major causes of death in Fife;
- extending the range of services available to ensure a comprehensive response to people’s health and social care needs at primary care level;
- focussing on health improvement by having local access to information and services that support people to lead healthy
lives;

- achieving inclusive patient-centred services that are accessible and responsive and reflect clinical urgency;

- delivering a holistic, co-ordinated and joined up approach to service delivery in partnership with other organisations; and

- demonstrating real improvements in such areas as waiting times and key targets

3.5.3 The investments proposed in this FBC will make a significant contribution to the goals of the NHS Fife 2007-2008 Plan by building on the developments in primary and community care already achieved and by augmenting the extent and range of services available locally.

3.6 Glenrothes and North East Fife Community Health Partnership

3.6.1 Glenrothes and North East Fife Community Health Partnership (“CHP”) is one of three CHPs in Fife. Glenrothes and North East Fife CHP serves a population of 127,284 residing in the Glenrothes and North East Fife areas.

3.6.2 The CHP is responsible for delivering local, community-based healthcare by enhancing joint working relationships across the whole care pathway in terms of delivery of care models, building on what is already established to improve health and tackle inequalities in health. Working in partnership with other agencies and the public, it aims to provide a cohesive framework amongst primary care and professional groups and between all other community care groups within the same areas to allow the development of services to the local population.

3.6.3 Glenrothes and North East Fife CHP have the combined resource of four community hospitals:

- Glenrothes Hospital;
- St Andrews Memorial Hospital;
- Adamson Hospital, Cupar; and
- Netherlea Hospital, Newport on Tay.

3.7 The Need for Investment

3.7.1 In order to meet the changing patterns of healthcare and to facilitate partnerships and networking with secondary care, the Board needs to take steps to ensure that services are redesigned appropriately
and that the personnel, facilities, equipment and infrastructure are in place to deliver such change.

3.7.2 Services are currently provided in St Andrews from St Andrews Memorial Hospital and St Andrews Health Centre.

![St Andrews Memorial Hospital](image1.png) ![St Andrews Health Centre](image2.png)

3.7.3 Facilities at St Andrews Memorial Hospital fall well below acceptable standards of operational efficiency and functional suitability. The building constrains the delivery of high quality patient care and is incapable of meeting future service requirements by renovation alone. There is no room for further expansion on the existing site either to the building or to the car-parking facilities.

![Minor Injuries Unit Entrance – Existing Hospital](image3.png)

3.7.4 St Andrews Health Centre is extremely overcrowded. There is no space for expansion and the range and quality of services that can be provided are thus compromised, with no space for any additional services.
3.7.5 The new hospital and health centre will provide the broadest possible range of primary care services, diagnostics, assessment, early intervention, treatment and rehabilitation, and will bring all existing services plus additional services on to a single site. It is believed that by the provision of modern, integrated, technically efficient premises and healthcare teams, the health of the community can be maintained and chronic conditions can be managed effectively. The investment is designed to enable the Board to deliver its clinical services in modern, fit for purpose functionally suitable facilities that accommodate the best design with the optimisation of clinical departmental adjacencies.
4. THE OUTLINE BUSINESS CASE

4.1 Introduction

The Outline Business Case was approved by the Capital Investment Group at SEHD in June 2002 subject to the provision of an Addendum once the outcome of the site selection process was known. The Addendum to the OBC was approved by Fife NHS Board in July 2003 and approval to move to FBC was received from SEHD in September 2003.

4.2 Selection of Investment Options

4.2.1 The OBC identified eight options for the re-provisioning of the facility and these were:

Option 1  Do nothing
Option 2  Do minimum
Option 3  New build Health Centre on new site and retention of St Andrews Memorial Hospital with upgrade to Condition Category B
Option 4  New build Health Centre with expanded Primary Care on new site and retention of St Andrews Memorial Hospital with upgrade to Condition Category B
Option 5  New build Health Centre with expanded Primary Care and new build St Andrews Memorial Hospital on separate sites
Option 6  New build integrated Community Hospital and Health Centre
Option 7  Incremental or phased development on single site
Option 8  Two new builds and retention of St Andrews Health Centre

4.2.2 The long list of options was reduced to an agreed shortlist through a non-financial appraisal which assessed them against predetermined objectives and benefits. Four options were shortlisted as follows:

- Option 2
- Option 5
- Option 6
- Option 7
4.2.3 The best ranked option in terms of the benefits analysis alone was to provide an integrated community hospital and health centre on a new site.

4.2.4 A full financial analysis of the shortlisted options was carried out reviewing the capital and revenue costs, the net present values and equivalent annual costs of options, the financial ranking weighted for the non-financial score and an assessment of risk and sensitivity.

4.2.5 Following systematic analysis of the project costs and benefits it was concluded that Option 6, the development of an integrated community hospital and health centre, was the Preferred Option.

4.3 The Preferred Option

4.3.1 The development of a new integrated community hospital and health centre will allow for the provision of a wide range of primary care services, early intervention, treatment and rehabilitation in modern facilities with new ways of working.

4.3.2 Service developments will include a wider range of out-patient and diagnostic facilities, renal dialysis, NHS dentistry, rehabilitation on a day/ outpatient basis for frail older people, mental health services and patients with dementia, and increased numbers of beds for care of older people and rehabilitation.

4.3.3 The new facility will be built in such a way as to present a user friendly, stress-reducing and health promoting environment and will be designed so that services can be easily accessed by all patients, including those with physical disability, sensory impairment or learning disability.

4.3.4 The integration of services on one site will encourage and underpin the development of community services and provide a focal point for community health education, training and advice.

4.4 Changes from OBC

4.4.1 A number of service changes have been applied since the OBC to enhance the clinical objectives as detailed below.

4.4.2 Renal Dialysis

The case for creating a satellite renal replacement therapy programme has been advanced and the ITN schedule of accommodation showed an eight-station facility. NHS Fife Board approval was received at the NHS Fife Finance and Resources Committee Meeting on 30th August 2005 for inclusion of this space within the schedule of accommodation requirements. The required space was within the estimated total building area as reported in the OBC.
4.4.3 Dentistry

At the time the OBC was developed there was no inclusion of NHS dentistry within the scheme. Following discussion with NHS Fife Community Dentistry department a proposal for a combined Community/ Dental Access Centre has been included in the accommodation, which replaces the current Community and Salaried Dental Services in the St Andrews area. At the time of the ITN issue, it was proposed that five Dental Consulting rooms and support accommodation be provided within the new facility. Since issue of the ITN, the requirement has increased to the provision of six dental rooms. The space has again been accommodated within the OBC footprint. The recurring revenue costs will be funded through the Community Dental Service and Salaried Dental Service which are included as part of NHS Fife’s Financial Plan.

4.4.4 Pharmacy

At the time the OBC was developed, there was no reference to the inclusion of a pharmacy. The incorporation of a pharmacy was proposed by Bidders during the clarification process but did not form part of the Standard Bid. The Consortium submitted a Variant Bid which included a pharmacy which will be included in the Project at the Consortium’s risk.

4.4.5 Sustainable Energy Proposals

Bidders were invited to produce a non-mandatory bid to demonstrate
the possibility of improving the fuel efficiency and the carbon footprint of the building. The Preferred Bidder was invited to attend a series of meetings with an energy consultant appointed by the Carbon Trust under their low carbon building design advice scheme. These consultations resulted in the development of a series of measures to reduce the carbon footprint of the building and improve the energy efficiency. St Andrews Project Board recommended the adoption of these measures and they have been included in the Board’s requirements.

A conventional heating system will generate 740 tonnes of carbon dioxide / annum; the adoption of the proposed sustainable energy measures will have the effect of reducing the carbon footprint of the building by 100 tonnes per annum.
5. CONVENTIONAL PROCUREMENT ASSESSMENT MODEL (CPAM)

5.1 Introduction

5.1.1 This section sets out the main developments and components of the Conventional Procurement Assessment Model (CPAM). The purpose of the CPAM is to allow a comparison to be made with the bids received to ensure that a PPP procurement delivers the best solution in terms of value for money over the life of the contract.

5.1.2 The CPAM was developed from the initial costings set out in the OBC, and includes the following, which are discussed in more detail below:

- Capital costs;
- Lifecycle costs;
- Utilities;
- Insurance;
- Hard FM services; and
- Building Management.

5.1.3 At OBC a price base of 1st April 2001 was used. Since then and throughout the procurement process a price base of 1st April 2007 was used.

5.2 Capital Costs

5.2.1 Prior to the issue of the ITN, detailed capital costings were prepared by the Board’s technical advisers (Currie & Brown). These costings were based on detailed schedules of accommodation developed with the users, which formed part of the ITN, and therefore covered the complete scope of the services requested from the Bidders. The cost / m² used was benchmarked against similar recent projects in the market to ensure it was robust. There was not a significant change in scope (<10%) between the OBC and capital costs at ITN, but due to the lapse in timescale between the preparation of the two documents, there was a fairly significant increase in the cost/m² due to high inflation in construction costs.

The OBC costs were based on construction costs at Q1 2002, and the ITN at Q1 2009. The following table sets out the movement in capital cost between OBC and ITN (all costs exclude land):
5.2.2 During the detailed discussions with the Bidders between the issue of the ITN and the bid submissions, a few minor changes to the scope were necessary which resulted in a slight change in the size of the building (from 10,050 m² to 10,250 m²). In addition, the costs were recalculated based on the latest set of building inflation indices and forecasts, resulting in the following changes:

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It will be noted that the capital cost increase due to the changing scope of the project now slightly exceeds the overall limit of 10% movement from the OBC. The increase can be attributed to changing standards of infection control and an increase in internal circulation space due to the need to provide improved separation of the FM services from that of the CPAM. The planning restrictions also necessitated an increase in the site works in order to maintain the building height within the imposed limits. These measures were required to maintain the clinical functionality and to comply with the planning restrictions. The Board has accepted the necessity of the changes and noted that the figures remain within the established affordability limits.

5.2.3 The Preferred Bidder submitted a variant bid that incorporated the provision of a pharmacy, at no additional cost. In addition, discussions were held with the Carbon Trust to introduce a range of energy efficiency measures. In order to enable a like for like comparison at FBC, the capital costs of the CPAM have been updated to incorporate these changes. The impact of these changes is summarised below:

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5.3 Lifecycle Costs

5.3.1 Life Cycle costs were not included in the OBC costings on the basis that it was envisaged in the OBC that these would be paid using the Board's Capital Programme – this being the accepted approach to be taken at the time the OBC was prepared.

5.4 Utilities

5.4.1 The scope of the procurement included the management and delivery of utilities to the facility. However, in line with standard practice, the NHS will take the risk on the utility price and therefore the Bidders were requested to use NHS utility prices when calculating their utilities costs.

5.4.2 NHS Fife Estates Department calculated the projected consumption levels for the CPAM building design in order to develop a utilities cost. This was regularly reviewed throughout the procurement process, as there was concern that the initial projections had underestimated the costs required. The following table sets out the utilities costs estimated at the various procurement stages:

A reduction was achieved at FBC reflecting the annual reduction in energy costs arising from the sustainability investment.
5.5 **Insurance**

5.5.1 The NHS normally self-insures and therefore does not incur annual insurance costs (and therefore no costs were included in the OBC). However, as the PPP provider is required to insure the building and services that it provides, and take a significant level of risk on the cost impact of potential insurance price rises, it is necessary to take into account this cost in developing a like-for-like comparison. Therefore the Board requested a benchmark quote for the annual insurance cost from their insurance advisers. A risk premium was added to this to take into account the risk that the providers were expected to carry in relation to price increases and a total cost of £96k was included in the CPAM. This has remained unchanged.

5.6 **Hard FM Services**

5.6.1 The Estates Department of NHS Fife estimated the cost of delivering the Hard FM services to the new facility, in line with the Service Specifications issued to the Bidders. As these specifications had not been developed at the OBC stage, the associated service delivery costs were re-estimated at the commencement of the procurement process. As there were no changes made to the specifications during the procurement process, the only changes applied to the costs during that time were to cover the increase in floor area resulting from the minor changes in scope.

5.6.2 The following table sets out the Hard FM costs estimated at the various procurement stages; all exclude pass through costs for water, rates and medical gases – total *(deleted – commercial in confidence)*:

| DELETED – COMMERCIAL IN CONFIDENCE |

5.7 **Building Management**

5.7.1 The Bidders are required to deliver a fully managed service, and therefore to enable a like-for-like comparison to be made of their costs, an estimate of the costs of managing the facility are also included in the CPAM. These costs *(deleted – commercial in confidence)* have remained unchanged throughout the procurement process.
5.8 Summary of Inputs at FBC

5.8.1 The following table sets out a summary of the input costs for the CPAM at FBC:

DELETED – COMMERCIAL IN CONFIDENCE
6. **THE PROCUREMENT PROCESS**

6.1 **The Project Management Structure**

6.1.1 The Board has followed the relevant Scottish Capital Investment Manual guidance ("SCIM Guidance") on procurement as well as all relevant EU procurement directives and UK procurement regulations. The Project Team has worked closely with the Private Finance and Capital Unit (PFCU) team and was guided by them in complying with the guidance and relevant legislation.

6.1.2 A Project Board was set up under the chairmanship of Dennis O’Keeffe, Projects Director. The Project Board comprised the CHP General Manager and Clinical Director, a Non-Executive Member of the board of NHS Fife, the Project Manager and representatives from Finance, HR, Estates and Facilities, Staff Side and the Public. The SEHD PFI Facilitator, although not a member of the Project Board attends Project Board meetings on an advisory basis. The remit of the Project Board is to act as the high level decision-making group which oversees the full project and approves Project Team recommendations prior to submission to the Board for corporate approval.

6.1.3 A Project Team was set up under the chairmanship of the CHP Clinical Director with representation from the GPs, Manager of Clinical Services, Finance, HR, Facilities and Estates, Social Work, Staff Side and the Public. The Project Team is responsible, in liaison with their professional advisers, for project development and delivery and management of the interface between the Board and the Consortium.

6.1.4 The Project Board and Project Team each have two Public Representatives sitting on them:

- **Project Board** – Sue Wilkinson and Sam Taylor
- **Project Team** – Pauline Warsop and Martin Dibley

These Public Representatives were appointed through a formal selection procedure and their appointment is reviewed on an annual basis.

6.1.5 The following Project Advisers were appointed to support the delivery of the project:

- Financial Advisers – Deloitte MCS Ltd
- Legal Advisers – MacRoberts
- Technical Advisers – Currie and Brown
ICT Advisers – Faber Maunsell

In addition, the services of Jones Lang Lasalle were enlisted to provide assistance in the development of the planning application and procurement of the site and the Willis Corroon Group were enlisted to provide expertise in Insurance matters.

Currie and Brown, Technical Advisers enlisted the services of the following;

- Buchan and Associates – Healthcare Planning
- Parr Partnership – Architects
- Elders – Mechanical, Electrical, Civil and Structural Engineering
- Colin Buchanan & Partners – Transportation Engineers

6.2 OJEU and Expressions of Interest

6.2.1 The Board placed an advertisement for the Project in the Official Journal of the European Union in January 2006 (the OJEU Contract Notice) which is included in Appendix 1. The OJEU Contract Notice invited, in accordance with the negotiated procedure under the Public Services Contracts Regulations 1993 (as amended), suitably qualified consortia/ companies to express an interest in the provision of the Project.

6.2.2 A significant number of expressions of interest were received and a Bidders’ Conference was held on 14 February 2006 for interested parties. Over 40 companies attended representing construction, finance, legal and project management sectors.

6.2.3 The OJEU Contract Notice advised those interested that it was anticipated that the contract would be awarded under the UK’s PPP/PFI programme.

6.2.4 The OJEU Contract Notice invited requests to participate to be submitted to The Chief Executive, NHS Fife Board by 28th February 2006. Seven expressions of interest were received and PQQs were issued to these parties requiring responses by 31 March 2006.

6.3 Prequalification Process

6.3.1 Pre-Qualification

Seven completed PQQs were returned by the deadline of 31 March 2006.
The evaluation of the PQQs was carried out in accordance with the Guidance Notes accompanying the standard form of PQQ which the Board was required to use, and in compliance with relevant SEHD guidance.

6.3.2 An Evaluation Panel was established which comprised senior members of staff from the Project Board and Project Team along with the Financial, Legal and Technical Advisers.

6.3.3 On receipt of the submissions, the make up of the consortia was examined and a number of conflicts of interest identified. As a result of the conflicts of interest, following a round of correspondence, Catalyst withdrew their bid, and Morrison and Care in Scotland made appropriate substitutions to their consortium make-up.

6.3.4 A copy of the PQQ and PQQ evaluation methodology was issued to the Evaluation Team in advance of completed PQQ submissions. A Scoring Matrix was issued electronically to panel members and the Evaluation Panel met on 18 April 2006 to review and evaluate the completed PQQ submissions.

6.3.5 Based on the pre-determined PQQ evaluation methodology, the submissions were ranked.

The three consortia named below were judged to be most suitably qualified in accordance with the PQQ evaluation methodology and a recommendation was made to the board of NHS Fife that they be invited to proceed to the next stage in the procurement process (see Appendix 2):

- BHE
- Saltire Care
- Morrison

6.4 Invitation to Negotiate (ITN)

6.4.1 The ITN was issued to the three shortlisted consortia on 28 May 2006 and ITN responses were required to be returned by 29 September 2006. An Interim Bid Submission was also required by 1 August 2006 and an Interim Bid Submission presentation on 8 August 2006.

6.4.2 The ITN comprised the following volumes:

Volume 1: Instructions to Bidders

Volume 2: Project Agreement
6.5 Interim Bid Submission

6.5.1 Bidders were required to prepare and present an Interim Bid Submission (IBS) approximately ¾ of the way through the Bid period. Approximately one week in advance of the IBS presentation Bidders were required to submit a prior submission document. The prior submission documents were circulated to the Review Team and discussed at a structured workshop. Subsequently, the IBS presentations were made to the Review Team and lasted approximately 1.25 hours each followed by a 0.5 hours Question and Answer session.

6.5.2 The Review Team was principally constituted from the Project Team the Project Board and the main User Groups. An inclusive and structured workshop was held so as to allow even those with limited availability or technical knowledge to be included, and to be able to participate meaningfully. The process required the entire Review Team to understand and adopt the approved evaluation methodology. An initial assessment of each of the prior submission documents was made by the team during the facilitated workshop.

6.5.3 On the basis of the Bidder’s IBS presentations the initial scores were then re-assessed and in some cases revised. The Review Team was able to actively question the Bidders to further inform their revised scores and the outputs were provided to Project Team and Project Board. The results of this comprehensive review were used to provide constructive feedback to Bidders during subsequent Bidder clarification meetings.

6.5.4 The rationale for the IBS can be summarised as follows:

- PPP is a complex procurement process. The use of the IBS and AEDET helps familiarise users with the process and sets identifiable yardsticks for evaluation;

- opportunity for panel to gain an understanding and interpretation of the presented design information;

- opportunity for panel to assess the ability of a Bidder’s entire team in meeting the Board’s requirements;
opportunity for the Board to assess the cohesiveness of the consortia and any emerging Bid strategies;

provides an early opportunity for the Board to understand the designs and provides an interactive forum for discussion;

allows design teams to communicate their design visions and ideas directly to the end users;

provides an opportunity for end users to meet and discuss varying requirements and facilitates a better understanding of issues spanning across groups;

meaningful and structured involvement for members of Board and team who may find themselves isolated from the evaluation process;

early feedback to Bidders that their chosen option is exceeding or at least meeting requirements; and

best practice suggests early interaction between users and design teams is particularly important in PPP procurement.

Although the outcome of the review was not taken into account in selecting a preferred bidder, the process was welcomed by all participants. Those Bidders who had been apprehensive of such a distraction during the Bid period agreed that it was a very useful exercise and which, certainly in one case, had saved a great deal of abortive work.

6.6 Final Bid Submission

6.6.1 The final Bid Submissions were made to the Board in accordance with the requirements of the ITN. Both BHE and Morrison submitted a model of their proposals. All Bidders were requested to provide a separate thirty page document describing their proposals in terms of the Achieving Excellence Design Evaluation Toolkit (AEDET) assessment.

6.6.2 Bidders were informed that the bids would be evaluated to determine the most economically advantageous bid in terms of two broad sets of criteria:

- qualitative criteria
- quantitative criteria

6.6.3 The broad qualitative criteria to be used to evaluate the bids are as set out below, together with their relative overall weightings.
6.6.4 The evaluation criteria to be applied by the Board fall into three main categories:

- legal
- financial
- technical

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<th>Ref</th>
<th>Evaluation Category</th>
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<td>Executive Summary</td>
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<td>B</td>
<td>Project Management Approach</td>
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<td>C</td>
<td>Legal Response</td>
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<td>25</td>
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<tr>
<td>G</td>
<td>Insurance Response</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Aggregate maximum Score/ Total Score 100

6.6.5 The evaluation was carried out by two teams, a Main Evaluation Team comprising members of the Project Team, department leads and technical advisers, and an AEDET Evaluation Team of 43 people drawn from the wider body of users and Project Board and Project Team members.

6.6.6 The AEDET scores from the above panel accounted for 5% of the overall score for Design and Construction. The final AEDET scores were as follows:

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6.6.7 The results of both the qualitative and quantitative evaluations were then assessed together and the Preferred Bidder was selected on the basis of which bid offered the most economically advantageous bid to NHS Fife.

6.6.8 As part of NHS Fife’s requirements the bidders were requested to produce a building to a NEAT standard of Excellent. It was not considered that a true evaluation of the relative merits could be carried out using NEAT at bid evaluation stage; however the first objective of NEAT was realised “to raise awareness of environmental issues within NHS facilities and services”.

6.6.9 The AEDET document was distributed to the AEDET Evaluation Team and the main documents were distributed by means of hard
copy and discs to the Main Evaluation Panel. The Main Evaluation Panel then carried out an individual review of the designs and a series of review meetings were held to enable consolidated clarification responses to be sent out to the Bidders.

6.6.10 The Bidders were each required to present their schemes to the Board at a formal presentation lasting two hours which included a Question and Answer session. This gave the wider body of NHS Fife a chance to view the designs and question the Bidders on their proposed solutions.

6.6.11 In addition to the Final Bid Submission, Bidders were also requested to deliver a shorter presentation geared to the AEDET paper to enable the AEDET Evaluation Team to more readily identify the various features to be evaluated. The scores were submitted by the AEDET Evaluation Team a few days following this meeting.

6.6.12 The final scores were collated following the evaluation of the submissions by the technical panel and the reports from the legal and financial members.

6.7 The Evaluation Process

6.7.1 The Board undertook to award a contract on the basis of the most economically advantageous tender received, taking account of quantitative and qualitative aspects of the bids. Three compliant mandatory bids were received. No mandatory variant bids were requested but both Morrison and BHE submitted variant bids as follows:

- Morrison – variant 1 incorporating a pharmacy;
- BHE – variant 1 incorporating a pharmacy; and
- BHE – variant 2 providing a biomass energy solution.

The CPAM is in line with the standard bid and does not include a pharmacy.

6.7.2 The proposals submitted by each consortium were evaluated against the pre-defined evaluation criteria as set out in the ITN. No comparability adjustments were required to enable the bids to be evaluated.

6.7.3 The Board’s planned approach to the evaluation process had been agreed in advance of receiving the tenders. Evaluation Groups consisting of internal senior managers and external advisers were established for:
6.7.4  To ensure that a like for like comparison was achieved, the evaluation process was performed on the Standard Bid. (Options contained in Variant Bids were considered only after the feasibility of the Standard Bid had been assessed).

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

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

6.7.7  The advisers verified the compliance or otherwise of the tenders, and advised the Board in detail of the areas where clarification should be sought. Compliance was measured against the bid requirements identified in the ITN.

6.7.8  The Bid was then assessed against CPAM by the main panel and a report produced. This was presented in the most appropriate format for each area.

6.7.9  The Approach to Design review was carried out using AEDET. This was overseen by the Project Manager and the Board’s professional advisers. The technical and FM disciplines also defined the criteria to be used in the evaluation for their aspects and completed their sections of the evaluation accordingly.

6.7.10 Final reports were then submitted to the Main Evaluation Team which met to consider the reports and undertake the scoring of each submission from a global perspective of the overall solution.

6.7.11 Clarification discussions took place between the Board and the Consortium (and to a lesser extent BHE as reserve Bidder) up to Preferred Bidder appointment. The Board had no further discussion with Saltire Care after Bid evaluation.
6.7.12 The conclusion of the exercise was that the Consortium’s Bid represented an acceptable position for the Board in value for money terms.

6.8 Evaluation Conclusion

After a series of negotiations and clarifications regarding the Consortium’s Bid, the Board concluded that the Consortium’s Bid was the most affordable and provided best value for money. As a result, at a Private Session of Fife NHS Board on 30 January 2007 the Board formally approved the appointment of the Consortium as Preferred Bidder. This decision was made public at the board meeting of NHS Fife held on 27 February 2007.
7. PPP SOLUTION

7.1 Introduction

7.1.1 The PPP solution is for the Consortium to design, build, finance and operate a new hospital and health centre on a greenfield site owned by the Board, situated on Largo Road to the South of St Andrews. The concession will be for a 30-year contract period post-completion of construction/ commissioning excluding the provision of clinical services and Soft FM services which will remain with the Board.

7.1.2 The PPP solution will result in the transfer of a significant proportion of the risks of constructing and operating the facility from the public sector to the private sector. The solution will also meet the affordability requirements of the Board and will provide better value for money than the traditional procurement route.

7.1.3 The assessment of the Bid has been reviewed taking full account of the quantitative and qualitative aspects of the offer received.

7.2 Selection of Preferred Bidder

7.2.1 The selection process leading to the appointment of Preferred Bidder spanned a period of eight months and involved rigorous financial, technical and legal evaluations and a series of user clarification meetings to ensure that the Board’s requirements were fully met.

7.2.2 The Consortium was appointed Preferred Bidder on 14 February 2007 and the announcement of the appointment was made public at the board meeting of NHS Fife in St Andrews on 27 February 2007.

7.3 Preferred Bidder Details

7.3.1 The Consortium will establish a Special Purpose vehicle (“SPV”) to design, build and finance the facility.

7.3.2 The Consortium will comprise Galliford Try Investments Limited and Dexia Public Finance Bank as Funder.

7.3.3 The Consortium will appoint Galliford Try Construction Limited (trading as Morrison Construction) and Morrison Facility Services Ltd as its sub-contractors for the Project.

7.3.4 The SPV will in addition to their in-house teams and external funder utilise the services of the following specialists:
Ryder HKS (Architects)

Environmental Designworks (Landscape Architects)

EC Harris LLP (Healthcare Planners and Equipment Advisers)

Cameron Chisholm Dawson Partnership (Building Services Advisers and ICT Passive Infrastructure Providers)

Waterman Civils (Civil and Structural Advisers)

Pinsent Masons (Legal Advisers)

Royal Bank of Canada (Europe) Ltd (Financial Adviser)

Telford Hart Associates (Quantity Surveyor)

7.4 **Project Description**

7.4.1 The proposed scheme aims to achieve the integration of services, improve the effectiveness of clinical services, and provide a flexible, responsive and efficient facility to meet local and national imperatives.

7.4.2 Drawings and plans of the proposed design are available from the Project Office on request.

7.4.3 The following is a brief description of the proposals submitted by the Morrison Consortium.
The development as proposed will be one building comprising pavilions in a hub and spoke arrangement. The building is to be located on a site at Largo Road and a plan of the site is shown in the illustration below:

Site Plan – Proposed Hospital and Health Centre

7.4.4 The following is a description of the individual facilities comprising the development:

- Main Entrance – all patients, staff and visitors will enter the building via the main entrance. This is clearly visible from the footpath, cycle route and car park. Patients will go to an initial reception desk area to register their arrival. They will be directed to the relevant ward/department/GP Practice each of which is clustered round the central hub of the entrance.
Main Entrance – Proposed Hospital and Health Centre

- **GP Practices** – a central waiting area and reception leads to three wings around courtyards for each of the three GP Practices.

- **Community Services** – adjacent to the main entrance with a separate entrance for out of hours access is the minor injuries unit, treatment rooms, consulting and interview rooms for use by community staff and social work. There are two group activity rooms for health promotion and group work including use by voluntary groups. This area will be utilised by the Primary Care Emergency Service out of hours.

- **Diagnostic and Treatment Centre** – on two floors around a courtyard adjacent to the central hub and main reception this houses out-patients, X-Ray, dental, podiatry, theatre and endoscopy.

- **Renal Dialysis** – sited above one of the GP Practices nearest the main entrance.

- **Physiotherapy** – sited above the central GP Practice.

- **Day-based Assessment and Treatment** – sited above the third GP Practice, this area provides occupational therapy, physiotherapy, and speech and language therapy to in-patients and out-patients. This area will also provide an assessment and treatment service on a sessional basis for mental health services.

- **In-Patients** – located to the south of the site, the in-patient accommodation has 40 beds based in two ward areas. These wards have direct access to secure garden areas and are able to take advantage of the views over the town and bay and will cater for GP medical/ rehabilitation patients.
palliative care patients and continuing care of the elderly patients.

Single Bedroom – Proposed Hospital and Health Centre

- Office Accommodation – on the ground floor beneath one of the wards an open plan area will have community staff, administration staff and social work.

- Facilities – a single storey area at the south of the site, this area provides a base for operational staff from Morrison and NHS Fife. Adjacent to the service yard it houses supplies, linen, Boilerhouse, generator, Red Cross equipment store and all support accommodation. The catering department is adjacent to this area and serves a café on the second floor. Meeting and training rooms and staff changing areas are adjacent to this area.

Café – Proposed Hospital and Health Centre
7.4.5 Key Features of the Design

The key features of the design include:

- robust understanding of the required functionality of the clinical output specification;
- single point of access to all areas;
- the three GP Practices centre around a central arrival point enhancing way-finding and ensuring equitable travel distances for all;
- in-patient accommodation at one level with access to secure gardens and views;
- the pavilion approach to the design has delivered a human scale to the Facilities aiding familiarity and assisting intuitive way-finding;
- landscaping includes integral and secure garden areas; and
- main car park is provided on the lower site, with direct visual link to the main entrance.

7.4.6 Making Best Use of the Site

The site is situated on a north facing slope which rises approximately 8.00m from north to south. There are planning restrictions limiting the building height to two storeys and stating that the overall height must remain below the 50m contour. The buildings are located so as to make best use of this feature. The car park is laid out at the northernmost area of the site which is relatively level. The buildings then step up the hillside which enables the southernmost section (the ward area) to present a single storey to the southern elevation. This enables the patients to have the use of a sun room and a secluded garden.

The steps in height enable the north facing areas to have good views over the town while those east facing areas have the benefit of the morning sunshine and open views over the adjoining countryside.

To the west the site is bounded by Largo road which provides good communications to the south and to the town centre. The site entrance has been laid out to facilitate the access by public transport and dedicated patient transport.

The proposed landscape scheme will offer soft boundaries and provide a welcoming appearance to the buildings which themselves
will provide a link between the rural and urban environments.

7.4.7 Clinical Adjacencies

The departmental relationships and clinical functionality required to be delivered by the brief were met to a large extent at the ITN stage. The internal flows and relationships for the departments are good and acceptable to the clinicians and users.

7.4.8 Flexibility and Future Expansion

The proposed design allows for both internal and external adaptation to meet the changing ways in which care will be delivered in the future. Accommodation has been planned and designed to adapt to change, with a standardised room specification so that rooms can be easily converted to alternative uses, and yet readily tailored to specialist needs. For example, all consulting rooms are standard sizes throughout the building.

7.4.9 Interior Design

The design succeeds in breaking down the scale of the project producing a ‘friendly’ and ‘domestic’ type of environment. A key feature of the design is the central entrance that will do much to assist in way-finding for those entering.

7.4.10 AEDET and NEAT

As part of the bid evaluation process each of the bids were evaluated on the basis of the three main categories:

- legal
- financial
- technical

The technical evaluation was based upon the Department of Health Design Evaluation Toolkit ‘AEDET Evolution’ modified to be project specific for the St Andrews Community Hospital and Health Centre. The Project Board, Project Team, Clinical and Non-Clinical Users together with the Technical Advisers, formed the core members of the Evaluation Team.

The Technical valuation was subsequently divided into 3 sections:

- Approach to Design and Construction
- Approach to Facilities Management
- Approach to Project Management

Within the section ‘Approach to Design and Construction’ each
member of the evaluation panel individually scored the submitted bids focusing on a variety of differing factors including the character and innovation of the building, the form and materials proposed, the design’s internal environment and the effects that it may have on patients and staff alike.

As part of the Board’s requirements bidders were requested to undertake a NEAT assessment so as to review both the Environmental and Social impact of the new facility. The Board had stipulated that an ‘excellent’ rating was required. The NEAT assessment will be further developed and reviewed as the design progresses.

### 7.5 Planning Consent

#### 7.5.1
The Board submitted an outline planning application for the site on 25 November 2004 and approval was finally obtained in 5 October 2005.

#### 7.5.2
As a result of the negotiations to secure the site, it was agreed with the vendor that an additional area of land be included in the transaction and a subsequent outline planning application was made to include this area of land. Due to the sensitive nature of the site, and at a request of Fife Council, the outline applications were submitted in extremely detailed form. This latter application was approved on 7 December 2006 subject to a number of reserved matters.

#### 7.5.3
Alterations are necessary to the existing roundabout at Largo/ John Knox Road to incorporate the access for the hospital and health centre. On 27 February 2007, the Board applied for planning consent for these alterations and this consent is anticipated by the end of May 2007.

#### 7.5.4
On 16 April 2007 the Consortium submitted a detailed planning application in respect of the hospital and health centre plans as approved by the Board. In view of the degree of detail already submitted at outline stage this application is to be treated by Fife Council as a reserved matters application and it is anticipated that approval will be obtained in June 2007.

### 7.6 The Site

#### 7.6.1
The site obtained by the Board is a 2.53 hectare greenfield site situated off Largo Road on the south edge of town. The vendors were Hermiston Securities, a joint venture company between Muir Construction and the University of St Andrews. The company also own land to the eastern boundary of the site and as a condition of the sale imposed restrictions on the development with a view to
reserving a right of access to this land. These restrictions have been incorporated in the current planning application.

7.6.2 The site purchase was concluded on 2 October 2006.

Site

7.6.3 The site as purchased was traversed by gas, electric and telephone services. The Board has arranged to have these diverted prior to site start.

7.6.4 A right of way crosses the site, and as required in the outline planning permission, the Board has applied to have this route varied to the site boundary.

7.6.5 An existing access road crosses the site, serving some dozen dwellings at Pipeland Farm to the South of the site. The site layout as submitted incorporates the amendments to allow for this access to be maintained.

7.6.6 It is a planning condition that the alterations to the existing roundabout will be completed before the main works can commence. The Board has had the roundabout works designed, and these were tendered in April 2007. These works are the subject of a separate planning application to be dealt with under delegated powers. The roundabout alterations are programmed for completion by September 2007.
7.7 **Timetable**

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<td>Preferred Bidder Announced</td>
<td>February 2007</td>
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<tr>
<td>Full Planning Application Submitted</td>
<td>April 2007</td>
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<tr>
<td>FBC Approval</td>
<td>July 2007</td>
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<td>Planning Approval</td>
<td>August 2007</td>
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<td>Financial Close</td>
<td>September 2007</td>
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<tr>
<td>Site Start</td>
<td>October 2007</td>
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<tr>
<td>FBC Addendum</td>
<td>November 2007</td>
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<td>April 2009</td>
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7.8 **Financing the Project**

7.8.1 **Introduction**

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

7.8.2 **Funding Structure**

The Project will be funded via the use of senior debt facilities, combined with equity and subordinate debt funds. This structure is very typical for this size and type of scheme, and entirely appropriate. (The scheme is too small to make the use of other forms of financing such as bond financing viable.) The breakdown of the source of funds is set out below:

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The senior debt will be provided by Dexia, and the subordinated debt and equity by Galliford Try. All of the funders and equity providers have provided letters of support and term sheets in line with their commitments and these are reflected in the financial model. They have also confirmed that they:

- will be bound by the terms of the Preferred Bidder letter;
- have reviewed and accept the Consortium’s funding plan and financial model;
- accept the current NHS Standard Form Project Agreement and associated Schedules as amended through the contract
negotiations; and
- have undertaken the technical, legal and financial due diligence expected for a project of this nature prior to financial close.

7.8.3 Contract Term

The contract covers a construction period of 18 months and an operating period of 30 years, giving a total contract length of 31.5 years, and this is reflected in the financial model.

7.8.4 Lending Terms

As stated, the senior debt will be provided by Dexia. The Consortium (like all the Bidders) undertook a detailed funding competition prior to bid submission and the details of this are included in Section 4.1 of the report “Financial Analysis of the ITN Bid Submissions v2.0” included at Appendix 3. The following table sets out the key lending terms (which have been provided to the Board on a Commercial in Confidence basis).

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In line with the Board's instructions, the Consortium has assumed a LIBOR rate of 5%. At the time of ITN issue, this was based on a current interest rate of 4.5% with a 0.5% buffer.

Recent base rate increases have had an influence on the market, and at 21st May 2007 the market swap rate for the debt profile of this project is 5.117%. The Board’s financial advisers will continue to monitor movements in conjunction with the Preferred Bidder’s advisers.

The Board will take the risk on this rate up to financial close, when it will become fixed via a hedging instrument. The swap rate to be used will be benchmarked at financial close by the Board's financial advisors to ensure it is in line with market.
The following table sets out the potential impact of increases to the interest rate if it rises above 5%, based on the model at FBC.

7.8.5 Bank Cover Ratios

The following table sets out the key ratios that the model is required to meet:

7.8.6 Details of the Financial Model

The table below sets out the key cost inputs to the financial model at FBC (price base 1st April 2007):

(The above excludes the pass through costs for rates, water and medical gases.)

7.8.7 Inflation

The construction costs are quoted on a fixed price basis. All costs have been input based on a 1st April 2007 price base, in line with the Board’s instructions. The annual insurance costs were fixed at preferred Bidder stage and do not require benchmarking prior to Financial Close.
The full unitary charge is indexed annually on the 1st April based on the movement in RPI. For modelling purposes, the RPI has been assumed to be 2.5% per annum in line with the Board’s instructions.

The Consortium has put in place a hedging instrument to protect them against adverse movements in RPI that may impact on their ability to repay their senior debt. This hedging instrument covers 100% of the senior debt service in each semi-annual period and currently assumes a long-term inflation rate of 3%. This will be benchmarked at financial close, and the Board will take the risk on any movement to the rate up to Financial Close.

### 7.8.8 Calculation of the Unitary Charge

The unitary charge is adjusted to the minimum level required to ensure that the project is able to meet all the net operating costs, senior debt service and shareholder return requirements. This is an iterative process in that the quantum of unitary charge will impact upon the funding requirements which in turn impacts upon the unitary charge required to repay the level of funding required. As part of the solving process, the relative levels of debt and equity (gearing) will be allowed to float to enable the balance that achieves the lowest unitary charge to be found.

### 7.8.9 Dividend Policy

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

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

### 7.8.10 Changes since Selection of Preferred Bidder

There have been no significant changes to the financial model since the selection of Preferred Bidder however, the impact of sustainability measures introduced have been factored into the financial model.

### 7.8.11 Price Basis

The PPP solution is based on an assumption that Financial Close will be achieved in September 2007, and the price is fixed for three months beyond the end of this month, i.e. to 30th November 2007.
Should financial close be delayed beyond this point, then the standard approach will be taken to inflating cost inputs beyond this point, in line with published indices (as per the ITN), and this has been set out and agreed in the Preferred Bidder letter. Should Financial Close not be achieved within a year i.e. by 31st August 2008, then this approach will be reviewed.

7.9 Taxation Assumptions

7.9.1 Contract Debtor

In line with the Board’s instructions, the Consortium has assumed that the Project fully qualifies for finance debtor accounting and taxation treatment. The Board is receiving the full benefit of this treatment through a lower unitary charge. The Consortium is taking the full risk of achieving the required clearance from HMRC for this approach.

The financial advisers have reviewed the tax treatment in the model and confirmed that the treatment of the loan fees and interest, operating and maintenance costs and interest income are all in line with generally accepted practice.

7.9.2 Tax Rate and Calculation

The Consortium is assumed to be a large company for corporation tax purposes, and therefore the corporation tax rate assumed in the model is 30% per annum. The corporation tax liability has been calculated in accordance with standard practice.

7.9.3 VAT

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

7.9.4 Model Review

The Board’s financial advisers (Deloitte) have reviewed the model, including the taxation assumptions, as part of the financial evaluation of the bids received prior to selection of the Preferred Bidder and again before submission of this FBC. In addition, the senior debt funder Dexia has commissioned a model audit prior to Financial Close. The Consortium will bear the risk on any errors in the model throughout the life of the contract.
8. FINANCIAL APPRAISAL

8.1 Introduction

Throughout the procurement the Board has been committed to assessing the affordability position of the Project at key milestones. This assessment has been based on the anticipated annual unitary charge payments for the facility as compared to the level of resources available from the Board.

In the initial stages of the Project this affordability level was determined based on the outputs from a shadow bid model, which was populated with benchmarked costings from projects of a similar size and nature, and based on the scope of the Project at that time. Relevant cost inputs were provided by the technical and financial advisers and relevant NHS Fife staff. This established a projected unitary charge (and therefore affordability level) of (deleted – commercial in confidence). This level of affordability was confirmed as acceptable by the Board prior to publication of the OJEU Contract Notice.

During the procurement process, the scope of the Project was extended slightly, and more accurate information became available with regards to construction cost inflation forecasts. Prior to receipt of the Bids submitted the shadow bid model was updated to reflect these cost movements, which demonstrated that a higher level of affordability may be required. This has been monitored at each key stage of the procurement.

However the bid received from the Consortium came in below the original affordability level set by the Board. The Board has therefore maintained the affordability level at that established prior to publication of the OJEU Contract Notice. At present the Consortium’s unitary charge is anticipated to come within this level at Financial Close. Confirmation of the Board’s ongoing commitment to this level of resource is included at Appendix 5.

8.2 Funding includes budget available in the Board’s baseline, with additional funding approved by the Board, and included in the financial plans.

Affordability Position (as at 21/05/07):

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The above analysis assumes an interest rate of 5.117%, the market rate at 21st May 2007. Should rates increase beyond this point prior to Financial Close, further resources will be required from the Board to ensure that the project remains affordable.

**Fife Council Contribution**

It is intended that the local Social Work department occupy part of the new premises. The Head of Social Work has been given authority by Fife Council’s Policy and Resources Committee to enter into a sub-lease or other licence agreement extending to 185 sq m. The potential income to the project has been agreed at a maximum of *(deleted – commercial in confidence)* per annum. Area allocations have been discussed but not finally agreed. The financial contribution has not been taken into account when preparing the affordability calculations. This sum will therefore provide an additional buffer against cost increases. The office area is not large and if not occupied could be utilised by other staff from within the CHP.

### 8.3 Summary

The affordability position has been central to the procurement process. It has been monitored by the Board from the OBC stage through to the preparation of this FBC. Prior to the receipt of Bid submissions the affordability position was monitored through the use of a shadow bid model. Following Bid submissions the Bidder’s financial model was subject to detailed evaluation. In order to meet these unitary charge payments the Board has allocated a sufficient level of resources to meet the full year unitary charge. In subsequent years the unitary charge payments will increase by inflation. The Board has assumed that its level of available resource will also inflate by inflation and accordingly the level of resource will increase at the same rate as the unitary charge payments and the project should remain within the affordability envelope.
9. ECONOMIC APPRAISAL

9.1 Introduction

This section covers the economic appraisal of the value for money implications of the project. The appraisal has been conducted with reference to the relevant HM Treasury and Scottish Executive Health Department Guidance.

The economic appraisal has two main elements, a qualitative and a quantitative element, both of which are set out below.

9.2 Qualitative Analysis

The qualitative analysis covers the non financial benefits of the Project. The main benefit to the scheme is the ability of the PPP process to produce an innovative design to promote the Board's preferred model of patient care. The proposed design offers improvements over those envisaged in the CPAM in terms of patient flows, departmental relationships and communication links. It also offers an improved maintenance and FM regime. The full Qualitative Analysis which was based on HM Treasury guidelines was carried out as part of the KSR process and the benefits remain constant. The main points are summarized below.

9.2.1 Programme Level Considerations

This project is one of two major projects being undertaken by the Board as part of a capital programme designed to improve the provision of health care in the Board area.

- This programme will require effective management of the risk as associated with construction and delivery. The PPP process can offer a means of managing these risks and increasing risk transfer to the private sector.

- The private sector has demonstrated the ability to deliver this type of project and the board has received an excellent response to its PQQ. The level of competition would indicate that good VfM has been achieved from the PPP procurement process.

- The building and the services required can be defined as series of output specifications against which the PPP performance can be assessed.

- The requirements of this project are capable of being costed on a whole life, long term basis.
Although at the lower end of the capital cost range, the procurement costs have been examined by NHS Fife and, having been compared and scaled to the fee bids received for the GH&MS project, are not deemed to be disproportionate.

The proposed accommodation has a requirement for flexibility that should ensure that any changes can readily be made.

The proposed project agreement and payment mechanism are based on SEHD standards and been developed from models in use for some years. These are shown to be capable of ensuring the performance of the private sector.

9.2.2 Project Level Assessment

The assessment followed the recommendations of the Scottish Executive VfM Assessment guidance. The Project level assessment falls under the three headings of Viability, Desirability and Achievability and the main points are set out below.

9.2.3 Viability

Programme Level Objectives

- The Board is satisfied that operable contracts can be constructed for this type of project.

- There is a tested suite of documents describing service output requirements based on past projects which can be tailored to this project.

- The outputs are designed to facilitate monitoring and evaluation of the service provision.

- The needs have been established and the outputs are closely based on these needs.

Operational Flexibility

- The contracts include a mechanism for change and cost control. The specifications call for flexibility in design and service provision.

Equity, Efficiency and Accountability

- There is no reason why the proposed services should not be provided under PPP contract.
There are no regulatory or legal restrictions that require FM services to be provided directly and NHS Fife has made the decision to provide the Soft FM services on an in-house basis.

Overall Viability

Strategic and regulatory issues have been considered by the team and an operable contract with in-built flexibility can be constructed to meet these requirements.

9.2.4 Desirability

Risk Management

➢ There are significant risks of cost and time overrun on projects of this nature. The board considers that these proposals maximize the risk transfer to the private sector.

Innovation

➢ The requirements and output specifications are performance driven and NHS Fife has encouraged Bidders to provide innovative solutions to these requirements. There was provision in the documents for Bidders to submit variant bids, some aspects of which have been incorporated in the proposals.

Service Provision

➢ Soft FM services have been excluded from the PPP contract pre-procurement. This decision was the subject of an appraisal process under the protocols developed by The Scottish Executive and the STUC.

➢ The decision process was carried out in accordance with the recommendations of the Scottish Executive, Value for Money guidance.

➢ The appraisal demonstrated that the continued provision of the Soft FM services in-house would provide the quality, flexibility and sustainability required to meet the needs of the PPP provider and the NHS Fife Board throughout the life of the project and represents good value for money.

➢ The proposal to retain the Soft FM services in-house was approved by the Board on 29 November 2005.
Incentives and Monitoring

- Contracts have been prepared in the past for this type of project and base on established models an unambiguous and measurable contract has been achieved for this project.

- Output specifications and service levels have been developed which fully describe the services required and will enable appropriate standards to be achieved.

- A payment mechanism has been prepared based on tested models which will enhance the incentives to meet the required service levels.

Lifecycle Costs

- The design build and operation of the Building and Hard FM services will be integrated.

- The operations period of the contract is 30 years. This length of contractual arrangement is considered suitable and should be to the projects advantage.

- The successful Bidder has established the balance between type of construction and maintenance requirements. The performance specifications are rigorous enough to minimize the operating costs to be carried by NHS Fife.

Overall Desirability

The ability of PPP to provide strong performance incentives over the life of the Contract and the innovation shown by the Bidder’s proposals provides value for money over traditional procurement methods.

9.2.5 Achievability

Transaction Costs and Client Capacity

- NHS Fife has implemented a dedicated Project Team for the procurement. The monitoring of ongoing performance will be carried out through the NHS quality system.

- Work has been carried out to secure appropriately skilled procurement teams and the teams are operating satisfactorily.
Competition

- Three short listed Bidders were selected and all bids fully met the operational and clinical requirements. Two of the bids were very close financially and the Preferred Bidder has been established through a VfM evaluation.

Overall Achievability

The Board is satisfied that a PPP procurement programme is achievable for this project under the arrangements made by NHS Fife and from the response by the Preferred Bidder.

9.2.6 Conclusion on Qualitative Analysis

Taken overall, the above factors demonstrate that the continued provision of the project through the PPP route will provide the quality, flexibility and sustainability required to meet the needs of both the project and NHS Fife throughout the life of the project, and represents good value for money.

9.3 Quantitative Analysis

The quantitative analysis has been carried out using the revised economic assessment methodology set out in HDL(2003) 13 in accordance with HMT green Book.

The purpose of the economic appraisal is to compare the relative costs of the scheme options by ranking them in terms of their net present value (NPV) appropriately adjusted for the risks inherent to each option.

The NPV calculation adjusts future cash flows for the time value of money by applying an appropriate discount factor. In accordance with the Capital Investment Manual and PPP guidance, a discount rate of 3.5% is applied to all cash flows for the first 30 years and 3.0% thereafter. Where the PPP option has been stated at nominal values, a 2.5% deflator is applied to adjust them to reflect real cash flows.

The NPV evaluation only takes account of the economic consequences of an investment option. Indirect taxes and non-cash transfers, such as capital charges, are excluded from the calculation as these represent circular flows of money within Government. The economic cost of each option comprises the NPV of the projected cash-flows (derived from the total project costs of each option) and the NPV of the expected value of the risks.

Both the PPP and the CPAM have the same life spans, therefore it has not been necessary to supplement the NPV calculation with a calculation of the equivalent annual cost (EAC) to accommodate differences.
The purpose of using the NPV comparison is to allow for fairness and consistency. In using the NPV calculations, the effects of different timing of cash flows can be taken into account. The NPV analysis also consistently incorporates the cost to the public sector of raising funds to pay for the development, and allows this to be simply and fairly factored in to the evaluation.

The two options considered by the Board in this FBC, namely the CPAM and the PPP option put forward by the Consortium, the preferred Bidder, were described in Section 5 and Section 7 respectively.

(The same quantitative economic evaluation was undertaken on receipt of the bid submissions to determine the preferred Bidder, and to ensure that at that stage the preferred Bidder represented value for money when compared to the CPAM. The results of this evaluation are included within the report “Financial Analysis of ITN Bid Submissions v2.0” and the supplementary paper included at Appendices 3 and 4.

9.4 NPV Comparison of the Board Options

The table below summarises the results of the NPV analysis of the two options. It highlights the fact that after evaluation of the level of risk to be transferred to the private sector the PPP option provides the greater value for money.

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The risk retained by NHS Fife was assessed using the standard treasury model for risk assessment and the results are within a similar range to those experienced under other comparable schemes.

9.5 Risk Adjustments

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

Section 10 of this FBC deals fully with the analysis which has been undertaken on the risks inherent in the project and Section 16 deals with how any risks which are to be retained by the public sector can be effectively managed.
9.6 **Tax Adjustment**

In addition, it is necessary to recognise that there are tax benefits to the Treasury that arise from the involvement of the private sector under a PPP solution which are not available under a publicly funded project. The “opportunity cost” of this benefit needs to be added to the CPAM model to enable a like-for-like comparison. The standard Treasury template has been used to calculate this benefit and is attached at Appendix 13.

At this stage of the Project it is considered that there is no longer a requirement for a separate adjustment with regards to optimism bias, but that all remaining related risks are incorporated within the risk evaluation.

9.7 **Sensitivity Analysis**

The following table sets out the results of the sensitivity analysis on the economic appraisal. These demonstrate the movements required in certain parameters such that it would alter the value for money assessment between the CPAM and PPP options:

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9.8 **Summary**

On the basis of the assessment the Board is confident that the Project demonstrates the required characteristics of the qualitative analysis. All options have been appraised in terms of projected revenue and capital costs and it can be demonstrated that the proposed deal, to be financed under the PPP clearly demonstrates best value for money for the Board.
10. RISK ANALYSIS

10.1 Introduction

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

- to ensure that the allocation of risks between the Board and the private sector is clearly established and demonstrated within the contractual structure; and

- to demonstrate value for money.

A risk is defined as an event that may or may not occur, and there are a number of such events that could arise during the design, construction, commissioning and operation of the facilities.

Risks are assessed and valued to ensure the CPAM can be compared with the PPP option on a “like-for-like” basis, ensuring the value of risk retained by the Board under both options is evaluated and understood.

Whether under a traditional design, build and operate format (the CPAM) or under a PPP contract, the Board is exposed to an element of risk (for example with regards to changes in required scope). The CPAM exposes the Board to a greater degree of risk in terms of price variations, poor performance, late delivery etc. since the Board is directly managing the contractors and service delivery. Under PPP, the contractor is managing the process and the Board only pays when satisfactory service is delivered, and therefore is exposed to less risk.

Two core principles govern risk transfer in PPP projects:

- risk should be allocated to whoever is best able to manage and control it; and

- the aim is to secure optimal risk transfer (it should be noted that optimal risk transfer is not the same as maximum risk transfer). These principles have been incorporated into the methodology underpinning the risk analysis for the Project.

10.2 Approach

The Board has performed a risk analysis based on a detailed assessment of the risks at each stage of the process. This section of the FBC:
identifies project specific risks; and

provides an analysis comparing the CPAM and PPP options, demonstrating that they are robust and determining which option delivers best value for money.

To understand the quantification of risk transfer under both the CPAM and PPP procurement options, a detailed risk register has been compiled by the Board. The primary tool used to collect information and opinions for the risk register and to evaluate the various risks was through a number of workshops and subsequent follow-up actions. These workshops were attended variously by the Board’s Project Team and its advisors.

The approach at the workshops was to:

- identify the risks in the Project and to discuss each risk event in turn to determine the risk owner (public or private sector) and to make a decision as to whether the risk was quantifiable or non-quantifiable;

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

- this gave the likely financial impact and value of the risks retained by the Board under each option and NPV cashflow of each risk was added to the base cashflow NPVs of the CPAM and PPP options accordingly.

Although the valuation of risk is subjective, the valuations presented in this FBC are the opinion of the Board supported as appropriate by the legal, technical and financial advisers, and based on extensive discussion. The results of the risk evaluation are summarised below:

<table>
<thead>
<tr>
<th></th>
<th>PPP Option</th>
<th>CPAM Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPV of Risks Retained by the Board</td>
<td>903</td>
<td>5,103</td>
</tr>
</tbody>
</table>

The Board has through the Project Agreement passed to the Consortium the relevant elements of the Project risks. There, however, remains an element of Board and shared risk to be managed throughout the Project. It is proposed that this will be addressed by the Board through the monitoring structure put in place i.e. the Project Steering Group which will be formed and will be responsible for all aspects of the Management and Monitoring of the PPP project (including Risk), during construction works/ commissioning and operations.

The Project Risk Register will be maintained and updated and reviewed regularly throughout the construction works/ commissioning and operational phases so as to ensure that any works necessary to remove or mitigate any
of the risks that remain with the Board are met and achieved in a timely manner.

10.3 **Key Risks**

The risks have been analysed and reviewed under eight categories as set out below:

- Design, construction and development: this covers the period from commercial and financial close through the construction phase of the Project to the point prior to the new facilities becoming operational.

- Performance risks: this covers the risks in the operational period and largely considers those affecting the quality of management and performance of services.

- Operating cost risks: this covers the operational period and relates to incorrect estimates of future costs, inflation etc.

- Variability of revenue risks: this primarily relates to the risks associated with the non availability of facilities and the revenue impact of poor performance.

- Termination risks: this covers the risks associated with early termination of the contract.

- Technology and obsolescence risks: this covers the risks of any potential technological change or the obsolescence of equipment etc.

- Residual value risk: this relates to the risk carried on the residual value of the property at the end of the project term.

- Other project risks: these primarily relate to risks with regards to achieving planning permission.

10.4 **Summary**

The risk analysis has been conducted in line with Scottish Executive guidance.

In summary:

- the Board has identified the likely financial impact of the risks it will retain under each option (PPP and CPAM) and adjusted the NPVs for these options accordingly by adding the expected value of each risk to the base NPV. (The risks transferred to the private sector in the PPP option are already included in the private sector's costs.)
the difference in the value of risks retained by the public sector under each option provides a proxy figure for the value of the risks transferred to and borne by the private sector;

the results indicate that the private sector assumes most of the risks under the PPP option, thereby reducing the Board’s exposure to the risk associated with the design, construction, development and operation of the new facilities; and

the risks retained, in full or part, by the Board are generally those involving changes in requirements by the Board and external changes e.g. demand and specific legislation.

the Project Team are in the process of implementing an Organisational Development programme which will inform staff of the requirements of operating in a PPP environment. The draft Interface Agreement will be produced and agreed as part of the Contractor’s proposals.
11. SUMMARY OF CONTRACT STRUCTURE

This Section of the Full Business Case details the main provisions of the Project Agreement as at May 2007, and the position reached on the key issues.

11.1 Contractual Framework

The Board is developing a contract for the Project based upon the Standard Form. The contract structure recognises the interests of all parties to the Project Agreement, including the funders and the various sub-contractors providing services to the Board.

11.2 Legal Relationships Between the Parties

A Special Purpose Company will be established to deliver the Project. The proposed structure is described by diagram as follows:

- Direct Agreement
- Project Agreement
- Sub-contract agreement (Design and Build)
- Sub-contract agreement (FM)

11.3 Contract Documentation

11.3.1 The current Standard Form has been adopted by the Board, with some provisions having been tailored to the particular requirements of the Project in line with applicable SEHD and other Scottish Executive guidance.

11.3.2 The duration of the Project Agreement will be 30 years. It is intended that the construction of the Facilities will be completed in approximately 19 months.
Extensions of time for construction are provided in line with the Standard Contract.

Design and Construction

11.3.3 The Board has set out its requirements in a series of documents which comprise the Board’s Construction Requirements. Project Co is contractually obliged to design and construct the Facilities in accordance with the Board’s Construction Requirements.

11.3.4 The Board has a monitoring role during the design and construction process but shall not be entitled to interfere with or instruct Project Co directly except by way of the Review Procedure set out in Part 10 of the Schedule to the Project Agreement (“the Review Procedure”) and the Variation Procedure set out in Part 22 of the Schedule to the Project Agreement (“the Variation Procedure”). Project Co will be entitled to an extension of time and additional money if the Board requests a Works Variation.

11.3.5 There are currently no outstanding issues with regard to scope or design. The Board is working closely with the Preferred Bidder to ensure that as much of the detailed design as possible is completed prior to Financial Close. Any areas that do remain outstanding will be dealt with under the Reviewable Design Data and the procedures as set out within schedule 10 of the Project agreement, the Review Procedure.

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

11.3.7 Whilst Soft FM is not part of the PPP, specifications have been provided to the Bidders in respect of NHS Fife’s proposals for catering and hotel services. Provision is increased from current level in terms of floor area and numbers for catering. Fife-wide performance management systems are in place which will apply to this scheme.

Services

11.3.8 Project Co shall provide the Hard Facilities Management Services (“Hard FM Services”) and the Board’s in-house staff will provide the Soft Facilities Management Services. The Board has produced output based specifications in respect of Hard FM Services encompassing general services, estates services,
utilities management, gardens and grounds maintenance, pest control and the provision of a helpdesk (“the Services”).

11.3.9 The Service Level Specifications detail the standard of services required together with performance indicators. Project Co’s right to receive the Service Payment is subject to poor performance or non-performance.

11.3.10 Project Co will provide the Services in accordance with the Method Statements which indicate the manner in which the Services will be provided. Project Co may review and amend the Method Statements by way of the Review Procedure.

Maintenance

11.3.11 Project Co is responsible for maintaining the Facilities, however, the Board may comment on and require the amendment of Project Co’s Schedule of Programmed Maintenance. The financial model for the Project includes capital sums attributable to life cycle replacement of fixtures, fittings and equipment within the Facilities for the duration of the Project.

11.3.12 Deductions will be made from the Service Payment in accordance with the Payment Mechanism for poor maintenance or non-maintenance of the Facilities by Project Co.

11.3.13 The Board will not be responsible for the costs of any additional maintenance and/or corrective measures if the design and/or construction of the Facilities and/or the components within the Facilities do not meet the Board’s Construction Requirements. Where appropriate, deductions will be made from the Service Payment in accordance with the Payment Mechanism.

Equipment

11.3.14 Group 1 items of equipment, which are generally large items of plant or equipment which are permanently wired/installed, will be provided and maintained by Project Co throughout the contract.

Group 2 items of equipment, which are items of equipment which have implications in respect of space/construction/engineering services, will be installed by Project Co, but provided and maintained by the Board.
Monitoring and Performance Measurement

11.3.15 Project Co is obliged to monitor its own performance and maintain records documenting its provision of the Services. The Board may carry out performance monitoring on its own account and may audit Project Co’s performance monitoring procedures.

Direct Agreements and Design Warranties

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

Insurance

11.3.17 Project Co is required to carry the following Insurances: -

**During Construction:**
- Construction All Risks Insurance
- Delay in Start-Up Insurance
- Construction Third Party Liability Insurance

**During the Operational Period:**
- Property Damage Insurance
- Business Interruption Insurance
- Third Party Public and Products Liability insurance

Uninsurable Risks and Unavailability of Terms are dealt with in accordance with the provisions set out in the Standard Form.

Summary of Key Areas of Non-Conformity with the Standard Form

11.3.18 The Board will be seeking approval from PFCU for any derogation from the Standard Form. The Project Agreement and Schedule to the Project Agreement are still under negotiation between the parties. A list of proposed derogations will be submitted for approval.

Summary of Commercial Issues to be Agreed between the Board and Project Co.

11.3.19 **Payment Mechanism**
The Consortium has accepted the calibration of the payment mechanism, however this remains subject to technical due diligence by the Funder.
11.3.20 Site Access/ Service Diversions
The following are a list of the works to be completed by the Board prior to a site start by Morrison:

- it is a condition of planning that works to improve the existing roundabout which will provide access to the site are completed before the main building works can start. The Board is tendering these works and it is expected they will commence in July 2007;

- there are existing gas, electricity and telecoms services crossing the site. The gas service has been diverted and contracts have been placed to enable the remaining services to be prior to site start; and

- there is an existing right of way crossing the site. The Board has negotiated with the adjoining land owners to have this route diverted and is awaiting their agreement to the new route pending lodging a formal application to divert.

11.3.21 Planning

The risk on detailed planning lies with the consortium. Detailed planning permission has not yet been obtained for the Site. The parties are therefore currently in discussions regarding the risk of obtaining detailed planning permission. NHS Fife intends to accept the risk of Judicial Review to enable Financial Close to take place in accordance with the programme. The terms of this agreement are currently being drafted.

11.3.22 Pharmacy

Although the Pharmacy will be included in the Project at the Consortium’s risk, the parties appropriate drafting will require to be agreed between the parties to be inserted in the Project Agreement to reflect the arrangements.

11.4 Payment Mechanism

11.4.1 Payment Mechanism

The Board has adopted the Standard Form Payment Mechanism with project specific amendments to reflect the relative size of the Project and range of Services.

11.4.2 Benchmarking

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

11.4.3 Indexation

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

11.4.4 Invoicing and Payment Terms

The Board shall pay the Service Payment to Project Co on a monthly basis. The Board shall settle sums due to Project Co in respect of each Contract Month by the last Business Day of each Contract Month. Where any payment is in dispute the party disputing the payment shall pay any sums which are not in dispute.

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

11.5 Change of Law and Variations

Project Co has proposed to add a Minor Changes regime to the Standard Form Variations mechanism and this is currently under negotiation.

11.6 Delay Events, Relief Events and Force Majeure

No changes have been made to the Standard Form provisions relating to Delay Events, Relief Events and Force Majeure.

Compensation payable upon termination for Force Majeure is calculated in accordance with Standard Form.

11.7 Corrupt Gifts and Fraud

Corrupt Gifts and Fraud are dealt with in accordance with Standard Form.

Compensation payable upon termination for Corrupt Gifts and Fraud is calculated in accordance with Standard Form.

11.8 Termination and Step-In

11.8.1 Project Co may terminate the Project Agreement in the following circumstances:
material breach by the Board of its obligations in terms of the Licence;
non-payment of any sums due to Project Co totalling the equivalent of one month’s Service Payment (index-linked); or
the passing of an Adverse Law.

11.8.2 Compensation payable following Board Default is calculated in accordance with the Standard Contract.

11.8.3 The Project Agreement contains a mechanism dealing with the hand-back of the Facilities to the Board. On expiry of the Project Agreement the Facilities revert back to the Board.

11.8.4 The Board may terminate the Project Agreement in the following circumstances:
- Project Co insolvency;
- Project Co’s Failure to complete the Facilities within 12 months after the Completion Date;
- material breach of the Project Agreement by Project Co;
- abandonment of the Works;
- failure to provide all or a material part of the Services;
- Health and Safety Conviction during the Operational Term;
- Change in Control or Assignation prohibited by Clause 50 (Assignation, sub-contracting and Changes in Control);
- Project Co being awarded a set number of Service Failure Points in any nine (9) month period; or
- failure to pay any sum over £50,000 following 60 days of demand.

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

11.8.6 Compensation payable following Project Co default is calculated in accordance with the Standard Form.

11.9 **Expiry of the Contract**

11.9.1 **Voluntary Termination by the Board**

The Project Agreement provides a right for the Board to terminate at any time throughout the duration of the Project Agreement upon giving not less than six (6) months' notice. On such termination the Board pays compensation on the same basis as if a Board Default had occurred.

11.9.2 This break option provides the Board with the contractual flexibility to terminate the Project Agreement at any point throughout its duration without having to prove to Project Co that the Board should have that right or that Project Co will not be adversely prejudiced by the exercise of such a right.

11.9.3 **Reversion of the Facilities to the Board upon Expiry**

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

11.9.4 **Hand-back Requirements**

Not less than thirty (30) months or more than thirty six (36) months prior to the Expiry Date an inspection will be carried out to identify the works required to bring the Facilities into line with the Hand-back Requirements which are set out in the Project Agreement.

11.9.5 A Hand-back Programme will be agreed to ensure that all necessary works are carried out by Project Co prior to the expiry of the Project Agreement and a Hand-back Amount will be identified setting out the cost of meeting the Hand-back Requirements.

11.10 **Human Resources/ TUPE**

11.10.1 It is anticipated that due to the nature of the Services no staff will transfer and therefore the alternative Standard Form provisions in relation to employee transfer has been used. Some minor
derogations from the Standard Form have been submitted to SEHD for approval.

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

### 11.11 Land Matters

The Board will procure the grant of a licence from the Scottish Ministers to Project Co in line with the Standard Form position subject to any amendments necessary to include a Pharmacy at the Facilities (subject to SEHD approval).
12. ACCOUNTING TREATMENT OF THE PPP SCHEME

12.1 Introduction

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

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

- availability of accommodation;
- performance of related services;
- residual value of the assets at the end of the concession period;
- the potential demand for the facilities;
- the costs to the project co. of providing accommodation and associated services;
- risks associated with the initial design and construction; and
- any third party income.

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

12.2 Application of Financial Reporting Standard (FRS5)

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

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

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

<table>
<thead>
<tr>
<th>Risk</th>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand</td>
<td>The unitary charge is a fixed payment for specified serviced accommodation. Any activity variations within the specified accommodation which affect input costs will not be reflected in the unitary charge and therefore this is a Board risk.</td>
</tr>
</tbody>
</table>
### Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability and Performance</td>
<td>The whole of the unitary charge will be subject to percentage deduction if part of the accommodation becomes unavailable or falls short of strict performance criteria. Deductions are set at such a level that failure would result in significant loss to the Project Co.</td>
</tr>
<tr>
<td>Third Party Revenue</td>
<td>Any third party revenues will accrue to the operator and therefore the risk of shortfalls in this income are borne by the Project Co.</td>
</tr>
<tr>
<td>Inflation</td>
<td>The risk that actual changes in underlying costs will be different from inflation, which is used to index the unitary charge, lies with the Project Co.</td>
</tr>
<tr>
<td>Operating Cost</td>
<td>There will be no upward adjustment to the unitary charge other than under indexation or to compensate for discriminatory legislation and therefore this risk lies with the Project Co.</td>
</tr>
<tr>
<td>Design</td>
<td>The Board has specified outputs for the new facility and the provision of services. As the responsibility for meeting these requirements lies with the Project Co the design risk lies with them rather than the Board.</td>
</tr>
<tr>
<td>Obsolescence</td>
<td>The risk of the facility being affected by obsolescence lies with the Project Co.</td>
</tr>
<tr>
<td>Residual Value</td>
<td>At the end of the contract period the Board has the option to acquire the facility at zero consideration and therefore the residual value risk lies with the Board.</td>
</tr>
</tbody>
</table>

A full qualitative and quantitative analysis has been carried out and this is included at Appendix 11 Financial Advisers Report. The Board’s auditors, Scott Moncrieff have reviewed this report and their opinion is included at Appendix 12 External Auditors Report.

### 12.3 Accounting for the Transaction

On the balance of the above evidence, it is the Board’s view that it should not recognise an underlying asset. There appears to be sufficient risk transfer to conclude that the operator will be exposed to potential variability in returns. Therefore the transaction will be accounted for by the Board by reporting the Unitary Charge against its Revenue Resource Limit. In addition, part of the annual unitary charge will be used each year to build up the value of the asset that will potentially transfer at the end of the thirty year period.
12.4 Final Judgement Report

The above opinion is based on the position of the project at the Preferred Bidder stage. A final judgement report will be produced immediately prior to financial close based on the final financial model and commercial position.

At this stage it is anticipated that the opinion will remain unchanged as there have been no significant amendments to the contract documentation or financial model that will alter the balance of risks between NHS Fife and Morrison from that established at Preferred Bidder stage.
13. PROJECT MANAGEMENT ARRANGEMENTS

13.1 Introduction

13.1.1 As has been demonstrated within this Full Business Case the project to date has been managed effectively and in a timely way, and as such the Board intends to maintain this level of performance and commitment to delivering the project throughout the next key stage of the project.

13.1.2 Within this Section the Board will set out how it intends to manage the project through implementation to successful opening and post-project evaluation.

13.1.3 This Section will examine:

- process to financial close
- project implementation structure, including membership and terms of reference of all implementation groups;
- how the interface with Morrison will be managed through the Construction Phase;
- how the interface with Morrison Facilities Management will be managed through the Operational Phase; and
- liaison with the external stakeholders.

13.1.4 Project management and control arrangements are to be put in place at two key stages of the Project namely post-financial close through commissioning and during operation.

13.2 Process to Financial Close

13.2.1 A joint NHS Fife/ Morrison high level Steering Group has been established to direct and monitor the process to financial Close and this group meets on a monthly basis. A detailed programme has been prepared and is reviewed and updated at these meetings.

13.2.2 In the period to financial close a Financial Close Protocol will be agreed between the Board and the preferred bidder and its financial advisers and this will clearly document the process to be undertaken at close. These processes will be tested at least twice in the week before close. Proposed RPI and interest rate swaps will be benchmarked by the Board’s financial advisers at close, and again this benchmarking process will be tested prior
to close to establish an expected position to enable variations to be quickly identified. Approval parameters will be agreed with the Board for application on financial close.

13.2.3 All project costs and interest rate movements will be closely monitored between now and financial close. Any variations will be reported to SEHD in an addendum to the FBC post-financial close.

13.3 Project Implementation Structure

13.3.1 The key roles described below have to date been supported by an appropriate project organisation structure.

13.3.2 The Project Director is supported by an internal organisation to deliver the key outputs of the project in a timely way. The existing structure will be subject to further development, however the roles and responsibilities will be as set out below.

13.3.3 There is an ongoing requirement to maintain governance structures for the project post Full Business Case.

13.3.4 The exact structure and their respective roles and responsibilities will be developed over the next few months but will include a Project Board, Project Team and several sub-groups including, but not limited to:

- Commissioning and Equipping Group; and
- Benefits Realisation and Evaluation Group

The Locality General Manager, Finance Manager, Estates, Facilities and Human Resource (HR) are all represented on the Project Team and will continue to play an integral part in delivering the project through the construction and operational phases. The Project Owner has been central to the development of the project to date and it is expected that his input will continue.

13.3.5 It is proposed that a Project Steering Group is formed which will be responsible for all aspects of the management and monitoring of the PPP project during construction works, commissioning and operation.

The Steering Group will consist of the following:
The Steering Group’s terms of reference will include the following:

- Supporting the construction process
- Commissioning the building
- Launching and supporting the service
- Operational policies and procedures
- Board communications/ budgets
- Administration of the Project Agreement

During the construction and operational phases the Steering Group will report directly to NHS Fife and the SPV will interact with the Steering Group through the Board representative. During the construction works, Morrison, as the contractor, will report to the SPV and during operation, Morrison FM, as the Facilities Managers, will report to the SPV.

During construction and commissioning, the Steering Group would hold a monthly Progress Meeting, the focus of which should be to update, chart progress and discuss relevant issues. We propose that sub-groups be set up to review such issues as security, equipment and reviewable design data.

The membership of the Steering Group will be reviewed at each of the construction, commissioning and operational phases to reflect management structures within the CHP.

13.3.6 The installation of Board equipment and commissioning the building are the subject of a Commissioning Programme which is being developed by the Bidder, the User Groups and the Project Team. This programme will clearly identify responsibilities, information requirements and timescales and will be included in the Project Agreement. The Project Manager and Equipment Manager are responsible for the management of this programme for NHS Fife.

13.4 The Project Board

13.4.1 The Project Board will continue to fulfil the following key tasks:

- receive reports of the Project against programme and
consider and approve the recommendations of the Project Team in respect of changes in costs or clinical requirements;

- consideration of final Bid and Financial Close;

- implementation of recommendations from NHS Fife or SEHD;

- consideration of PR and communications strategy;

- consider and approve the project resources;

- with the Project Team manage and mitigate the risks identified in the Risk register; and

- report to NHS Fife Board and to the wider interests within NHS Fife.

### 13.5 The Project Team

**13.5.1** It is anticipated that the Project Team continues to play the leading role in the management of the Project. Membership of the Project Team will include:

- clinical service planning groups;

- finance and commercial lead;

- facilities management lead; and

- commissioning and equipment lead.

**13.5.2** From the Project Team, key individuals will be selected to form the Project Steering Group. This group will undertake the routine management of the Project and from this group individuals will be seconded to attend Liaison Meetings and Project Progress Meetings and other ad hoc teams.

### 13.6 Project Manager

**13.6.1** During implementation, this role will be more focused on the project management aspects of the implementation process.

**13.6.2** The key functions of this role during implementation will be to:

- manage the project budget and take responsibility for the
overall financial control of the project;

- draw up a master delivery programme, working with the Commissioning and Change Teams to ensure an effective framework is in place to deliver the project;
- monitor progress against plan and to report variances with action plans;
- work across all user groups, including Fife Council and the voluntary organisations, to ensure that their work plans are continually congruent with the overall project plan;
- liaise with Morrison FM to ensure that the Board decision-making on issues during construction are delivered in a timely way;
- lead the commissioning process for the new development;
- have senior responsibility to the Project Director for the commissioning master plan; and
- manage the work of the sub-groups within the agreed budgetary limits.

13.7 External Advisers

13.7.1 The Project Team will be supported by a team of external advisers, as set out below:

<table>
<thead>
<tr>
<th>Role</th>
<th>Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Adviser</td>
<td>Deloitte MCS Limited</td>
</tr>
<tr>
<td>Legal Adviser</td>
<td>MacRoberts Solicitors</td>
</tr>
<tr>
<td>Technical Adviser</td>
<td>Currie &amp; Brown UK Ltd</td>
</tr>
<tr>
<td>Architectural &amp; Design Adviser</td>
<td>Parr SMC</td>
</tr>
<tr>
<td>Mechanical &amp; Electrical Advisers</td>
<td>Elders Consulting</td>
</tr>
<tr>
<td>Healthcare Planning Adviser</td>
<td>Buchan &amp; Associates</td>
</tr>
<tr>
<td>Insurance Adviser</td>
<td>Willis</td>
</tr>
</tbody>
</table>

13.7.2 Currently all appointments are due to terminate at financial close, however, negotiations are in hand to establish a framework for legal and financial advisers to continue advice as required on an ad hoc basis to commencement of service. The technical adviser is preparing a fee proposal to cover the range of services required from financial close to commencement of service and the final services to be provided will be agreed prior to financial close.
13.8 **Interface with the PPP Consortium**

13.8.1 It is key to the success of the Project that the Board and Project Co work closely and in partnership throughout the implementation of the project through to construction completion and in to the operational phase and throughout the lifetime of the contract.

13.8.2 It will be important to the culture of delivery within the project that a partnership approach is developed rather than an adversarial culture.

13.8.3 The main interface will therefore be via the Project Team Steering Group and through day to day contact between the respective Project Directors, Project Manager and the wider Project Team.

13.8.4 A Project Liaison Committee will be key to the delivery of the project and will ensure that issues arising from both partners in the project are fully explored and resolved.

13.8.5 The terms of reference of the Project Liaison Committee will be:

- to monitor the implementation of the project;
- to identify areas of variance from plan and agreed actions to rectify;
- to share and resolve key issues raised by other groups; and
- to monitor performance of key aspects of the project.

13.8.6 The checking of monthly invoices and change control will fall within the remit of a group comprising the following:

- Locality General Manager
- Facilities Manager
- Finance Manager
- Estates Manager

This group will meet on a monthly basis.

13.9 **Implementation Processes**

13.9.1 Whilst this Full Business Case relates primarily to the Board
actions necessary to deliver the benefits of implementation of this project, Morrison play a critical part in delivering, through partnership, these benefits to the public sector.

13.9.2 The role of the Project Team will be to disseminate progress on the project and any key issues arising, which would benefit from discussion in a more strategic forum.

13.9.3 NHS Fife currently has two PPP schemes in development, each staffed by separate teams under the direction of the NHS Fife Projects Director. While the projects are quite different in scale and content, there is a mutual exchange of information at all stages in the process. It is anticipated that as increasing common ground emerges during the construction and operational phases then Fife-wide policies will be developed for the direction and administration of the projects.
13.9 **Construction Phase Project Management**

13.9.1 The management and monitoring responsibilities following Financial Close and up to Full Service Commencement will be within the Project Team’s and Project Manager’s remit.

13.9.2 The Project Manager will provide leadership and direction to the scheme for internal and external stakeholders. The role will include:

- providing overall leadership of the project through implementation and into operational use;
- working with NHS Board Directors, and Clinical and Non-Clinical Service Managers to deliver and realise the project’s benefits;
- management and control of change within the project; and
- directing the work of the implementation teams.

13.9.3 Management and liaison during the Construction Phase will be led by the Project Manager assisted by the NHS Fife Estates Team and external Technical Advisers. The following table outlines the tasks and works during the construction phase of the works:

<table>
<thead>
<tr>
<th>Key Construction Phase Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monitoring/ Supporting Construction Process</strong></td>
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<tr>
<td><strong>Commissioning – Technical</strong></td>
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</tbody>
</table>
13.10 **Commissioning Phase Project Management**

13.10.1 Commissioning the new facility shall involve the development of a range of processes to ensure that the planned benefits are achieved in a timely fashion. Having made a significant capital investment, it is important to ensure that the facilities come into operation smoothly.

13.10.2 The Operational Commissioning will require the careful co-ordination of the equipment installation, staff recruitment, training and the implementation of workable operational policies and systems in a completely new environment. Detailed planning and good project management are essential to ensure the new facilities are made operational as soon as practical after handover from Morrison.

13.10.3 The Project Manager, supported by the wider Project Team and external technical advisers shall work together with Morrison so as to ensure the smooth transition from building construction to hand over and operation.
13.10.4 At the same time they will assist in the development of an operational manual, which shall ensure the transfer of operational management to those who will ultimately be responsible for the operation of the facility.

13.11 **Construction to Full Service Commencement**

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

13.11.2 During the construction period the Board lead for the interface with the contractor on construction issues will be the Project Manager, supported by the Head of Capital Planning and Procurement together with the external technical advisers.

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

13.12 **Operational Phase**

13.12.1 At Full Services Commencement the provisions of the Project Agreement in terms of liaison will be implemented. In practical terms this provides for the following liaison/management meetings:

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison Committee</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Dispute Resolution Process</td>
<td>As required</td>
</tr>
<tr>
<td>Site Management Group</td>
<td>Monthly</td>
</tr>
<tr>
<td>Departmental Meetings – FM Review</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

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

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

13.12.4 The Liaison Committee has the following functions:

- joint review of day to day issues relating to the contract;
- joint strategic discussion looking at actual and anticipated changes or for more efficient performance of the contract; and
- amicable resolution of disputes or disagreements

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

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

13.12.7 The Board Project Manager will establish formal means to:

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

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

13.13 Service Contract Monitoring

13.13.1 Each service will have a specification detailing frequencies, tasks and response times. Details of each service specification will be made available to each department within the site. The guidelines for use of the FM Helpdesk will be widely available within departments and each request will have reference number generated and given to the requesting department.
13.13.2 It is anticipated that the monthly Key Performance Indicators monitoring report drawn from the Helpdesk will be shared with Heads of Department.

13.13.3 In the event that there are adjustments/amendments to the monitoring mechanisms these will be communicated to departments through a structure of departmental meetings co-ordinated by the Facilities Manager.

13.13.4 The quarterly departmental service meetings will include service reviews and performance reviews and the meetings will be attended by the FM provider.

13.13.5 Wider stakeholders in the service e.g. patients and visitors will have access to the Board’s Suggestion and Complaints procedure. This identifies an individual manager to which patients and members of the public can be directed to discuss any matters pertinent to the building and its services. The outcome of the initial contact will determine the route taken to resolve the issue raised.

13.14 Management and Monitoring

13.14.1 Throughout the above process it is important that the Board’s teams fully understand the obligations imposed by the contract in respect of management and monitoring of the services. A comprehensive list of the Board’s obligations in this respect has been provided at Appendix 15.
14. BENEFITS ASSESSMENT

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

14.1 Description of Benefits

14.1.1 The benefits of the Project were considered at OBC and have been reviewed for the FBC. The Project, whether publicly or PPP funded, delivers the same benefits because the Clinical Briefs and the Schedule of Accommodation to deliver the service and activity were the basis for both the CPAM and the PPP scheme’s development. This level of design input through the planning development stages ensures that the scheme can deliver the benefits identified at OBC and which are critical to the scheme’s objectives. The differentiating factor is the cost and value for money analysis.

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

14.1.3 PPP procurement will provide construction cost certainty, a quicker construction programme and as such an earlier Services Commencement date.

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

14.2 Strategic Benefits

14.2.1 The investments proposed in this FBC will make a significant contribution to the NHS Fife 2007-2008 Plan by sustaining and building upon the developments in primary and community care already achieved by the CHP. In particular it will deliver the goals by:

- building a local National Health Service which listens to patients, service users and the people of Fife;

- delivering real health improvement, including tackling health inequalities and building a local NHS, designed and organised around the needs of the population;
building alliances between community planning partners to deliver joined up services offering integrated care wherever it is needed;

reducing deaths caused by cancer, heart disease, stroke and respiratory disease which are the major causes of death in Fife;

extending the range of services available to ensure a comprehensive response to people’s health and social care needs at primary care level;

focussing on health improvement by having local access to information and services that support people to lead healthy lives;

achieving inclusive patient-centred services that are accessible and responsive and reflect clinical urgency;

delivering a holistic, co-ordinated and joined up approach to service delivery in partnership with other organisations; and

demonstrating real improvements in such areas as waiting times and key targets

### 14.3 Benefits Table

<table>
<thead>
<tr>
<th>Benefit Criteria</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Services</td>
<td>• Rapid, quality patient services – one-stop, rapid access, integrated diagnosis and treatment</td>
</tr>
<tr>
<td></td>
<td>• An Increase in protocol-based referrals thereby enabling better organisation of appointments for assessments, tests, treatments and clinics.</td>
</tr>
<tr>
<td></td>
<td>• Coherent arrangement of clinical facilities to minimise patient journey</td>
</tr>
<tr>
<td></td>
<td>• Separation of scheduled and unscheduled care</td>
</tr>
<tr>
<td>Access</td>
<td>• Provides local access to appropriate services</td>
</tr>
<tr>
<td></td>
<td>• Easy access on foot, by cycle or by road, including adequate parking, drop-off/pick-up zones, bus stops</td>
</tr>
<tr>
<td></td>
<td>• Adequate number of lifts, corridors wide enough for patients and equipment</td>
</tr>
<tr>
<td>Benefit Criteria</td>
<td>Detail</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Quality Surroundings</td>
<td>• Purpose-designed building will ensure appropriate and clearly indicated access (disabled, parents with children),</td>
</tr>
<tr>
<td></td>
<td>• Way-finding will be intuitive, with clear signage and a logical layout</td>
</tr>
<tr>
<td></td>
<td>• The main entrance will be welcoming and fit for purpose.</td>
</tr>
<tr>
<td></td>
<td>• The building will meet the needs of a diverse community – (age, ethnicity, disability issues, religion)</td>
</tr>
<tr>
<td></td>
<td>• Environment will preserve privacy and dignity</td>
</tr>
<tr>
<td></td>
<td>• Enhanced security will be provided for patients, staff and visitors.</td>
</tr>
<tr>
<td></td>
<td>• The building will be designed to minimise staff and patient journey times</td>
</tr>
<tr>
<td></td>
<td>• Decoration, art works and landscaping will enhance the clinical environment and healing qualities within the building.</td>
</tr>
<tr>
<td>Flexibility</td>
<td>• Capable of adapting to changes in clinical techniques, services and technologies.</td>
</tr>
<tr>
<td></td>
<td>• Capable of physical expansion in key areas to meet increased demand</td>
</tr>
<tr>
<td></td>
<td>• Capable of flexible use to accommodate fluctuating service demands.</td>
</tr>
<tr>
<td></td>
<td>• Increased flexibility of response to changing demand for services</td>
</tr>
<tr>
<td></td>
<td>• Capable of alternative uses to accommodate decreases in demand</td>
</tr>
<tr>
<td></td>
<td>• Designed to support major equipment upgrade/replacement with minimal disruption to overall building</td>
</tr>
<tr>
<td>Staff Facilities</td>
<td>• Contribute positively to staff recruitment and retention through new, purpose-built accommodation and developing services</td>
</tr>
<tr>
<td></td>
<td>• Facilitate multi-disciplinary team working</td>
</tr>
<tr>
<td></td>
<td>• Support effective and efficient clinical staffing arrangements</td>
</tr>
<tr>
<td></td>
<td>• Contribute positively to staff learning and training through seminar/meeting areas, a culture of continuing professional development and links with St Andrews University</td>
</tr>
<tr>
<td>Benefit Criteria</td>
<td>Detail</td>
</tr>
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</tr>
</tbody>
</table>
| Staff Facilities Cont. | • Greater satisfaction associated with the delivery of a high quality service  
• Staffing arrangements that most closely reflect national best practice |
| Environmental Considerations | • Provides a therapeutic and healing environment  
• Pleasant outlook and external surroundings for patient, carers, visitors and staff  
• Well-maintained, purpose-designed facilities.  
• Meets health and safety, control of infection and statutory requirements to provide a safe and secure environment. |
| Environmental Considerations Cont. | • Contributes to ‘Green’ issues such as efficient energy usage, re-cycling possibilities and positive impact on surroundings, environmentally friendly.  
• Enhanced security provision  
• Design issues address requirements of Disability Discrimination Act |
| ICT | • Provides infrastructure to support Board’s IM&T strategy  
• Potential to act as a flagship implementation site for the Board’s IM&T strategy including:  
  - provision of “disease management”  
  - tracking to monitor patients throughout their care pathway  
  - provision of a streamlined interface with GPs  
  - provision of computer equipment, cabling and business continuity arrangements to support the day-to-day operation  
  - integration of IT systems to enable patients to register on arrival at a one stop facility |
| Clinical Services | • Improved clinical efficiency  
• Increased/enhanced facilities – renal/dentistry/dermatology treatments/out patients leading to improved waiting times  
• Increased day surgery - by using new, minimally invasive, techniques and changing anaesthetic techniques and assessment criteria, the range of services which can be offered as day procedures is expected to continue to develop and improve. |
<table>
<thead>
<tr>
<th>Benefit Criteria</th>
<th>Detail</th>
</tr>
</thead>
</table>
| Clinical Services Cont. | • Closer working with secondary care clinicians through increase in protocol-based referrals and improved test result and investigation response communication  
• Inter-related clinical departments located adjacent or in close proximity  
• Necessary clinical support services in close location  
• Well-equipped, appropriate facilities to provide quality of care  
• All relevant specialties available to patients |
| Impact of Construction | • New Site, therefore no impact on existing clinical services during construction. e.g. noise, dust, decanting and temporary facilities, parallel running  
• Minimal impact to adjoining neighbours during construction works |

14.4 Benefits Realisation Plan

14.4.1 The objectives and benefits of the project are set out in Section 4 of the Outline Business Case.

14.4.2 A Benefits Realisation Plan has been developed to reflect changes in the scheme requirements and identifies against each benefit:

- who will have lead responsibility for ensuring the delivery of the benefit;
- action to be taken to ensure the benefit is realised;
- the projected timescale for realisation of the benefit; and
- how the realisation of the benefit will be monitored and measured.

The Benefits Realisation Plan is included as Appendix 18 of this FBC.

14.4.3 Overall responsibility for ensuring that the benefits of the project are achieved lies with the Board, through the Project Board or its successor.
14.4.4 Where relevant, the performance measures identified within the benefits realisation plan will be reviewed as part of the post project evaluation plan.

14.5 Project Evaluation Plan

14.5.1 The purpose of undertaking a post project evaluation is to assess how well the scheme has met its objectives and whether they have been achieved to time, cost and quality. Performance measures already contained in the benefits realisation plan will not be replicated in the post project evaluation plan.

14.5.2 The evaluation will be led by the Project Team supplemented by representatives of the User Groups and other key stakeholders. The Project Board, or its successor, will receive evaluation reports on each element.

14.5.3 In accordance with current guidance and good practice the project will be evaluated in stages:

**Stage 1 – Procurement Process Evaluation**

An evaluation of the procurement process will be undertaken following contract signature, to assess the effectiveness of the procurement process in meeting the project objectives and identify any issues and lessons to be learned. This stage will also enable the project team to review its performance and aid in future development of skills.

**Stage 2 – Monitoring Progress**

During the construction period progress will be monitored to ensure delivery of the project to time, cost and quality, and to identify issues and actions arising. On completion of the construction phase the actual project outputs achieved will be reviewed and assessed against requirements, to ensure these match the project’s intended outputs, and deliver its objectives.

**Stage 3 – Initial Post Project Evaluation of the Service Outcomes**

This will be undertaken 6 to 12 months after the new facilities have been commissioned. The objective is to determine the success of the commissioning phase and the transfer of services into the new facilities, and what lessons may be learnt from the process.
Stage 4 – Follow-up Post Project Evaluation

This will be undertaken two years into the operational phase, by an evaluation team, to assess the longer term service outcomes, and ensure that the project’s objectives continue to be delivered.

In each stage the following issues will be considered:

- to what extent relevant project objectives have been achieved;
- to what extent the project went as planned;
- where the plan was not followed, why this has happened; and
- how plans for the future projects should be adjusted, if appropriate.
15. **RISK MANAGEMENT STRATEGY**

15.1 **Examination of Risks**

15.1.1 The Project Risk Register identifies the areas where the Project may be sensitive to external factors that would impact adversely on the construction, or financial structure of the PPP Project.

15.1.2 The Board has through the Project Agreement passed to the Consortium the relevant elements of the Project risks. There remains an element of Board and shared risk to be managed throughout the Project. This will be addressed by the Board through the monitoring structure incorporating in-house managers and external financial, legal and technical advisers.

15.2 **Key Risk Categories**

15.2.1 The key risk categories have been summarised at Section 10.0 which details those risks to be transferred to the private sector and those which are to be retained by the Board. The risks are both financial and non-financial. The financial risks to be retained were identified during the development of the CPAM.

15.3 **Risks Retained by the Board**

The table below summarises the key risks that are to be retained by the board and the strategy for the management of these risks:

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Title</th>
<th>Risk Management Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Failure by board to complete works to Roundabout or service diversions leading to delayed site start.</td>
<td>Contracts placed. Works must be managed to ensure completion. Contract manager appointed by Board</td>
</tr>
<tr>
<td>02</td>
<td>Not achieving planning permission</td>
<td>The Board and the Consortium are working together with planners to ensure planning consent date achieved</td>
</tr>
<tr>
<td>03</td>
<td>Construction and Commissioning delayed leading to delay in occupation.</td>
<td>Delay by contractor covered in PA. Board must seek to avoid any delays in commissioning or in provision of information.</td>
</tr>
<tr>
<td>ID</td>
<td>Risk Title</td>
<td>Risk Management Strategy</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>04</td>
<td>Poor PM causes delays and increased costs.</td>
<td>Structure to be configured to allow close liaison between Board reps/advisers and contractor and Independent Technical Adviser. Issues arising to be identified and managed to minimize impact on the project.</td>
</tr>
<tr>
<td>05</td>
<td>Delay by supply chain.</td>
<td>Supply chain to be monitored by the Consortium and reviewed by Board. Consortium will seek to minimize delays.</td>
</tr>
<tr>
<td>06</td>
<td>Equipment infrastructure</td>
<td>Equipment schedule and procurement/commissioning schedule will form part of the PA. Board is assembling funding to ensure that all departments are fully equipped to deliver the services.</td>
</tr>
<tr>
<td>07</td>
<td>Failure to design to brief</td>
<td>Board to monitor contractor’s proposals to ensure satisfaction of the Board’s Construction Requirements/Project Co Proposals.</td>
</tr>
<tr>
<td>08</td>
<td>Change to Board design, construction or services specification and re-configuring of accommodation or equipment causing delay to the Project and increased costs.</td>
<td>Design has now been frozen but must still be able to accommodate changes in clinical practices. The in-built flexibility of the building should make these simpler. The PA contains a robust change mechanism.</td>
</tr>
<tr>
<td>09</td>
<td>Interest rate movement prior to FC</td>
<td>This risk, which can be quantified by running interest rate sensitivities, is borne by the Board only up to contract signature.</td>
</tr>
<tr>
<td>10</td>
<td>Regulatory changes in NHS Directives or standards and discriminatory changes in law and health sector regulations</td>
<td>The Board will bear the financial effect of regulatory changes in NHS directives via adjustments to the unitary charge. It is not possible to quantify the effect of such changes but the Board will prioritise continuity of the contract.</td>
</tr>
<tr>
<td>ID</td>
<td>Risk Title</td>
<td>Risk Management Strategy</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>IT developments render installation obsolete.</td>
<td>Updates will be negotiated at life cycle replacement periods.</td>
</tr>
<tr>
<td>12</td>
<td>Changes by the Board to design construction or services specifications post construction.</td>
<td>PA provides a change mechanism which will adjust the unitary charge. Changes authorised by Chief Executive.</td>
</tr>
<tr>
<td>13</td>
<td>Force Majeure</td>
<td>Shared Risk. Limited opportunities to manage this risk.</td>
</tr>
<tr>
<td>14</td>
<td>Inflation</td>
<td>The unitary charge is adjusted for inflation in each year.</td>
</tr>
<tr>
<td>15</td>
<td>Labour disputes</td>
<td>The Board will retain responsibility for national and local disputes involving NHS staff.</td>
</tr>
</tbody>
</table>
16. eHEALTH STRATEGY

16.1 Introduction

16.1.1 eHealth plays a significant and important role in the provision of clinical and non-clinical services in the modern health care environment. There is an increasing reliance on eHealth infrastructure to meet these requirements both in terms of performance and availability.

16.1.2 NHS Fife has recognised this and in addition to the management and project structures where the IT Services department have an active involvement, a specialist eHealth Technical Advisor has been appointed to provide all technical documentation for the project and actively represent the Board through to the opening of the hospital.

16.2 eHealth Strategy

16.2.1 The NHS Fife eHealth Strategy closely mirrors the NHS Scotland eHealth Strategy which details a number of e-health initiatives to provide patient centric services for applications such as:

- Integrated Primary and Community Care System (IPACC)
- Picture Archiving and Communications Services (PACS)
- Electronic Health Records System (EHR)
- Identity Management System (IDM)

16.2.2 The strategy developed for the eHealth provision within the confines of the project is clearly defined within the ITN documentation as a Responsibility Matrix for the various eHealth systems and associated interfaces.

16.2.3 A key concept for this health facility is to bring together a number of separate functions, including three GP Practices, diagnostic treatment centre, dental, care for the elderly, social services, etc and integrate them for the benefit of the patient, community and staff. This is mirrored in the eHealth provision where single integrated systems and services will be provided to meet the varying needs of all.

16.3 eHealth Infrastructure

16.3.1 Project Co will provide the Structured Cabling System, all required containment, including diverse routes to the public network, and the associated dedicated accommodation for the Main IT room and supporting IT node rooms. The structured cabling system provides the physical connectivity for all voice and data applications.
throughout the hospital via both copper and fibre cabling in a resilient design to ensure NHS Fife has a high speed reliable and robust network. The structured cabling system is included within the Life Cycle items for the project and will be replaced once in its entirety between the 15 to 20 year point.

16.3.2 Provision of this physical infrastructure by Project Co will enable NHS Fife to concentrate on delivering the local and national eHealth initiatives.

16.3.3 NHS Fife has deliberately retained ownership and responsibility for the active data network, telephone system, servers, PCs, applications and bedside entertainment systems, as this will facilitate a more direct and cost efficient route to the provision and support of eHealth services.
17. APPROACH TO EQUIPMENT PROVISION

17.1 Introduction

Schedules of equipment have been developed for the Project through the use of the NHS Estates ADB Database. The schedules, through group classification, identify the responsibilities for the various aspects of the works in relation to funding, provision, maintenance and replacement of the equipment required for the hospital.

17.2 Group 1 Equipment

Project Co shall be responsible for the supply, installation, maintenance and replacement of all Group 1 equipment listed within the ITN.

17.3 Group 2 Equipment

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

17.4 Group 3 and 4 Equipment

Group 3 and Group 4 equipment will be supplied and installed by the Board in accordance with the User Commissioning Programme.

17.5 Funding of Equipment

The cost of Group 1 equipment and fixing of Group 2 equipment has been agreed with Project Co.

The Board will fund the Group 2, 3 and 4 equipment through new provision and through the annual Capital Programme and by transferring suitable equipment from existing facilities. The Group 2, 3 and 4 equipment has been costed and the budget is based on equipment allowances and current prices available.
18. HUMAN RESOURCES

18.1 Introduction

18.1.1 NHS Fife employs around 8,500 staff providing a wide range of professional, technical, administrative and facilities services.

18.1.2 Employees have been involved throughout the development of the Project through the well-established partnership arrangements which include Staff Representative members on both the Project Board and Project Team. Staff members have and continue to be involved in the development of the detailed operation of services and facilities.

18.1.3 The Board recognises the need for change including the opportunities it presents to develop new skills and extended roles, and address national workforce issues particularly around Pay Modernisation, Modernising Medical Careers and the European Working Time Directive.

18.1.4 It is the intention to continue to involve employees and their representatives in any potential service change to ensure they are fully informed and engaged. If any employee is affected by the change process the Board is already committed to the principles of the nationally agreed Organisational Change Policy which protects relevant terms and conditions of employment and aims to safeguard employment.

18.2 Workforce Planning

18.2.1 The objective is to support the delivery of NHS priorities locally by ensuring there are sufficient numbers of appropriately trained and motivated staff working in the right locations. The NHS Fife Workforce Modernisation and Development Strategic Plan and Action Plan has been developed within the National Workforce Planning Framework (2005)¹ which put in place a mechanism for National, Regional and Board-level consideration of workforce issues.

18.2.2 As well as considering broader issues the Board must consider the local workforce planning issues that are specific to the new facilities in St Andrews. To achieve this it is essential to align workforce planning with the service and financial planning for the new facilities.

¹ National Workforce Planning Framework (August 2005), Scottish Executive
18.2.3 Community and primary care services are split across two main sites (St Andrews Memorial Hospital and St Andrews Health Centre) with the NHS Fife managed services under the same management structure. All staff and services including the three GP Practices will transfer to the new facility. Some in-patient services are to be repatriated from Adamson Hospital in Cupar and Cameron Hospital in Windygates.

18.2.4 During the period up to service commencement the workforce and its various staff groups will continue to be reviewed with a clear programme for any changes in the numbers of staff, skill mix requirements, and ways of working. This will form part of the programme for ensuring that teams are functional when amalgamated in the new facility, in terms of:

- integration of services;
- clinical practices; and
- administration procedures.

18.3 New Service Models and Change Management

18.3.1 Some of the services will need to undergo changes in the way they are delivered and some new services (day-based assessment and treatment, rehabilitation, dermatology treatments and renal dialysis) are to be delivered in the facilities. These will have an effect on the skill mix of staff employed, the numbers of staff and flexible patterns of working.

18.3.2 The Board is currently developing a detailed organisational development and change management action plan for the services. This will enable the workforce to be supported through the period of organisational change and the introduction of new ways of working.

18.4 Staff Transfers

18.4.1 All clinical, clinical support, administrative and Soft FM services (catering and hotel services) will be provided by the Board through directly employed staff who will transfer from existing sites and posts to the new location.

18.4.2 The Hard FM services associated with building and estates maintenance will be provided by Morrison Facility Services Ltd. No member of NHS Fife Hard FM staff will be required to transfer to the new facilities or a new employer.
18.4.3 There are, therefore, no consequences for the Board under the SE/STUC Protocol or the application of the TUPE regulations.

18.5 Integrated Management Approach

18.5.1 An FM Interface Agreement will be drawn up between the Board and Morrison to ensure that the responsibilities of each in relation to Hard and Soft FM services are clear and unambiguous.

18.5.2 Morrison has confirmed that FM staff will be managed broadly in accordance with Board policies and procedures and that they will observe their obligations in respect of Trade Union recognition.

18.5.3 A Management protocol is being developed in line with the Standard Form Project Agreement. This will ensure that responsibilities are clear and unambiguous. The protocol will detail the specific Board and Morrison structure required in order to manage the contract as well as the responsibilities regarding the application of Board policies.

18.5.4 Morrison will provide monthly reports that will include HR issues as part of the agreed monitoring process. This together with regular meetings to discuss key points will assist in maintaining a partnership approach to day-to-day staffing issues.
19. CONCLUSION

19.1 The Case for Investment

19.1.1 Since the addendum to the OBC was approved in July 2003 the Case for Investment has been continuously reviewed and updated in light of:

- Emerging strategic changes
- Altering assumptions in respect of patient access to services
- Increased range of services
- Developments in the implementation of models of care

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

19.2 The Preferred Option

19.2.1 This is a strong and reasoned business case for the project as now presented. The project will provide a new Community Hospital and Health Centre replacing the existing St Andrews Memorial Hospital and St Andrews Health Centre, and offering an increased range of services which is fully in accordance with current thinking on integrated models of care and local service provision. The new build design on a greenfield site will offer a long term solution to primary care provision and will incorporate the flexibility to accommodate changes in service delivery in a straightforward and economical manner.

19.2.2 In addition to the design and construction of the facilities, the PPP scheme also includes a facilities management contract for Hard FM. The operation of the services is to be provided for a thirty year period. The contract arrangements will be as set out in the Standard Form of Contract for PPP Schemes adjusted for project specific issues. Derogations from the Standard Form have been agreed by SEHD.

19.2.3 The scheme is affordable and will deliver good value for money. The changes from the OBC are well reasoned and fully integrated into the case as now presented. The Board has initiated these changes as part of an ongoing process to provide a model of care to meet both patient expectations and the priorities as set by the Scottish Executive.
19.2.4 Significant risk will transfer from the Board to the Consortium and the asset will not be accounted for on the Board’s balance sheet.

19.3 Project Management

19.3.1 The Board has put in place a robust project management system which is operating closely with the Consortium to ensure the delivery of the project through to service commencement in April 2009 and forward into the operational stage.