MIDLOTHIAN COMMUNITY HOSPITAL

FULL BUSINESS CASE

December 2008
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FOREWORD

This document presents the Full Business Case (FBC) for the Midlothian Community Hospital.

The Outline Business Case (OBC) for the project was approved by the then Scottish Executive Health Department in October 2006 and the proposals have now been further developed and incorporated in this document.

Publication of Information

NHS Lothian is fully committed to the principles of open government and is making this business case publicly available to the extent permitted by law. Certain information within the business case cannot be disclosed due to its commercial sensitivity. Financial information in broad terms is disclosed. However, NHS Lothian is not at liberty to disclose detailed cost proposals submitted by bidders. This information is protected by obligations of confidentiality and premature disclosure could not only prejudice the interests of bidders but could prejudice NHS Lothian's procurement of this Project and its ability to achieve the best value for the public purse. Such information is prohibited from disclosure under the Public Contracts (Scotland) Regulations 2006 and is exempt from disclosure under the Freedom of Information (Scotland) Act 2002.

NHS Lothian will keep this matter under review and will ensure that this Project is managed in a manner that facilitates the involvement of patients, staff and the public generally to the fullest extent permitted.

Where appropriate information has been deleted or withheld due to the commercially sensitive nature as shown below:

= Deleted or Withheld
1 EXECUTIVE SUMMARY

1.1 Purpose

1.2 The purpose of this Executive Summary is to set out the case for the design, build and operation of the Midlothian Community Hospital (“the project”).

1.3 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 Government Health Directorates (“SGHD”) that NHS Lothian’s (“the Board”) proposals are robust, affordable and provide value for money. The contents should also assist the Board’s private sector partner, Robertson Capital Projects (“the Consortium”) and its funders, The Co-operative Bank, with information for their due diligence work in preparation for Financial Close.

1.4 Background

1.5 The Strategic Context of this project is set out in Section 2 of the FBC.

1.6 In September 2006, the Board approved the Outline Business Case (the “OBC”) for the development of a new build community hospital on a single site. The OBC was subsequently approved by the then Scottish Executive Health Department CIG and the letter of approval to move to FBC was received from SGHD on 10th October 2006.

1.7 The principal objective of the Midlothian Community Hospital is to build a facility that will bring all existing services from Rosslynlee and Loanhead Hospitals, plus additional services, on to a single site.

1.8 The building solution is based on three key principles:

- Maximisation of flexibility in the use of 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.

1.9 The project has been driven by the requirement 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 Board’s Improving Care Investing in Change Strategic Programme, which was approved by the Scottish Executive Health Department in January 2006.

1.10 The service to be provided will embody a range of community services provided by the Board, Midlothian Community Health Partnership (“the CHP”) 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.
1.11 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 to staff, stakeholders, public and press);
- Public Exhibition of plans and drawings of new facility at Rosslynlee and Loanhead hospital sites and public libraries;
- Presentation to local Community Groups;
- Inclusion of three Public Partnership Forum Representatives on the Project Board and Project Teams;
- Preferred Bidder / The Board Staff and Public Meetings (to discuss next steps of the process with staff, users, public representatives and advisers).

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

1.13 Overview

1.14 The capital cost of this FBC is XXXXX. This investment will be delivered by Public Private Partnership (PPP) procurement.

1.15 The Board has agreed to fund the unitary payment and associated running costs of the new facility.

1.16 It is intended that the new hospital should be fully operational by Summer 2010.

1.17 The Board’s Conventional Procurement Assessment Model (CPAM), formerly known as the Public Sector Comparator, approved at OBC has been reviewed through 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.

1.18 One of the main features of the new proposal is the ratio of single room inpatient accommodation. This has been planned at 90%. This has been introduced to reflect latest thinking on models of care and infection control as well as addressing patient’s views on privacy and dignity. This will give a significant increase in the number of single rooms from the current total bed complement.

1.19 Economic and Financial Summary

1.20 Results of Financial Appraisal

1.21 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 XXXXX at November 2008 prices (excluding pass through costs). The unitary charge becomes payable 18 months from Financial Close, when the facility is commissioned in line with the requirements set out in the Project Agreement.

1.22 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.

1.23 Overall the Project has been assessed as affordable by the Board. The Board’s Finance and Performance Review Committee has approved the funding requirements as associated with the Project. The Board’s projections for revenue expenditure currently incorporate the estimated funding required for the Midlothian Community Hospital along with other developments within the Board.

1.24 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 and therefore the Project will remain within the affordability envelope.

1.25 Results of the Economic Appraisal

1.26 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 Scottish Government Health Directorates and other Scottish Government guidance.

1.27 Qualitative Assessment

1.28 The main non-financial advantages of the Project relate to the Board’s preferred models of patient care. The design of the Project accommodation provides improved departmental relationships and communications links 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.

1.29 Quantitative Assessment

1.30 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:

1.31 The economic analysis takes into account adjustments for risks transferred under the Project Agreement and the tax advantages of the PPP solution. The risk analysis process has been developed through workshops involving various members of the Project Teams with input from Project Advisers and is considered robust. As a result the Board considers that the risk transfer achieved through a PPP solution contributes to the overall VfM result in favour of this procurement route.

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

1.33 Procurement Process
The Board placed an advertisement for the Project in the Official Journal of the European Union in August 1998 (the OJEU Contract Notice). The OJEU Contract Notice invited, in accordance with the negotiated procedure under the Public Services Contracts Regulations 1993 (as updated), suitable qualified consortia/companies to express interest in the provision of the Project.

Following approval of the short list of bidders, 4 expressions of interest were received. A shortlist of 2 bidders was then approved to go to Best and Final Officer (BAFO) stage.

Subsequently, the Outline Planning Application for the first site met with serious objections and therefore the BAFO stage was halted. A Public Enquiry was then held following the Outline Planning Application for the second site. Outline Planning Permission was approved by the then Scottish Executive in December 2001.

The then Trust reviewed “Best Value” for Soft FM and decided on Exclusion from Bids in June 2002.

Following the review of NHS organisational structures there was a need to re-confirm support of the project by The Board in March 2003.

Consideration of the reviewed OBC in March 2003 was then deferred until the Joint Review of Mental Health and Wellbeing Strategy could be completed and the impact of this on the content of Midlothian Community Hospital could be assessed (April 2003 – February 2005).

During this time, one of the bidders altered its strategic approach to PPP and withdrew from the process, leaving The Board to consider whether it wished to proceed with the remaining bidder or return to the market.

In light of the precedent and experience with the Glasgow ACAD contract, meetings were held with the remaining bidder to discuss how such a negotiation might proceed. Robertson Capital Projects showed a strong willingness to co-operate and enter into a fully open-book approach.

An evaluation was subsequently undertaken by Lothian Health Board’s External Advisers, managed and co-ordinated by the then Project Managers (AKH Associates). The evaluation was designed around a framework of time, cost, quality and deliverability and determined a composite and unanimous outcome to retain Robertson Capital Projects.

Lothian Health Board approved this procurement route with the express provision that Audit Scotland monitor and report on value for money issues at key stages of the procurement process and that there would be strict adherence to Standard Form documents.

Details of the PPP Suitability Matrix and the Conditions Precedent Letter which RCP agreed to sign up to can be obtained in Appendices 6 and 7 respectively of the OBC.

The Final Invitation to Negotiate (“FITN”) was issued to the Remaining Bidder on 29th June 2007 and an Interim Bid Submission was returned on 17th August 2007 and a Full Bid was received on 9th November 2007. During the period from issue of the FITN to the return date for the bid, the Board’s Project Team conducted a series of clarification meetings with the Remaining Bidder.
1.46 The Board adopted a rigorous and equitable methodology, as set out in the FITN, in evaluating the Bid in both financial and non-financial aspects.

1.47 The Consortium was selected as Preferred Bidder on the basis that its proposals continued to show Value for Money and Affordability in terms of the pre-determined evaluation criteria. The Board approved Robertson Capital Projects (RCP) as the Preferred Bidder on 23rd April 2008.

1.48 An extract from the Board meeting approving the appointment of Robertson Capital Projects as Preferred Bidder is attached at Appendix 1.

1.49 **Key Stage Review Process**

1.50 The SGHD 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 SGHD at defined key stages in the PPP procurement. Sign-off from SGHD is required at each review before approval is granted to proceed to the next stage of the project.

1.51 The Project has been the subject of two satisfactory PUK KSR reviews (Pre-FITN and Pre-Preferred Bidder) and the approvals of letters from SGHD for both these KSRs are attached at Appendices 2 and 3 respectively.

1.52 The KSR process will continue post-financial close to support long-term management and monitoring of PPP contracts. In line with SGHD Guidance, the Benefits Evaluation will be held six months to one year after service commencement and forms 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.

1.53 **Risk Transfer**

1.54 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 4.

1.55 **Planning Consent**

1.56 Outline Planning Permission was originally granted in December 2001, following a Public Inquiry by the Scottish Ministers.

1.57 Planning Renewal with regard to an extension to the timescale for approval of served matters by 3 years was then granted on 17th February 2005.

1.58 The Board subsequently obtained a further extension to Outline Planning Consent on 4th February 2008 for the construction of the community hospital.

1.59 The Application for Full Planning Approval was submitted by Robertson Construction Lothian Ltd on 2nd June 2008 with Full Planning Permission granted by Midlothian Council on 28th August 2008.
1.60 Timetable

1.61 The Board will endeavour to reach Financial Close in November 2008 (refer to Table 5 in Section 6 of this FBC). A construction period of some 18 months is planned with a view to the new facility being commissioned and operational by Summer 2010.

1.62 Conclusion

1.63 The Board has pursued a rigorous and robust evaluation procedure for the Project that met with the approval of SGHD’s Private Finance and Capital Unit through evaluation by PUK.

1.64 The Board recognises that qualitatively, the provision of the community hospital 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.

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

1.66 The Board recommends that the SGHD 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.
2 STRATEGIC CONTEXT

2.1 Overview

2.2 This section of the FBC describes the strategic context and how the development links with the Board’s Service Strategy. It provides the context in which this development now sits. Section 4 provides detail of the original plans as described in the OBC.

2.3 The plans for reprovision of hospital services in Midlothian are informed by national policies and the Board’s strategies. Additional information on the Board's strategies is available on the Board’s website, www.nhslothian.scot.nhs.uk.

2.4 Background

2.5 The investment proposal for a new community hospital was a strategic commitment by the Board to modernise and improve local health service provision to its catchment population. This project is part of the Board’s Improving Care Investing in Change Strategic Programme, which was approved by the Scottish Executive Health Department in January 2006.

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

2.7 The project is one of the key projects within the Midlothian Community Health Partnership and will incorporate localised outpatient and diagnostic services.

2.8 Demography and Epidemiology

2.9 Midlothian covers an area of 135 square miles and has a population of circa 85,000, representing an approximate increase of 5,000 since the original Business Case submission in 1998. Current expectations are that the population will continue to increase at a rate of 1,000 per year for the next 10 years.

2.10 Midlothian is a community at the rural-urban boundary of Edinburgh, whose towns and villages are mostly based on a mixture of former mining communities, farming communities and an increasing influx of commuters. Deprivation exists in pockets but is not endemic to the locality. Midlothian’s elderly population is growing much more rapidly than other parts of Lothian, although similar in profile to West Lothian.

2.11 National Strategic Context

2.12 The then 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 that will provide a wide range of diagnostic and treatment services, advice and outreach services.
2.13 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:

2.14 “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.”

2.15 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”.

2.16 Better Health Better Care, the Scottish Government’s Health Action Plan published in 2007 confirms the continued commitment to delivering services as locally as possible, and the need to design services to meet the needs of local communities, in line with the principles of a mutual NHS.

2.17 The investment in the new Midlothian Community Hospital will support care closer to home, local access to diagnostics and integration of primary care and hospital services.

2.18 The investment proposal for the new Midlothian Community Hospital is consistent with, and indeed fully supports, the strategic direction of the Scottish Government Health Directorates.

2.19 Strategy and Objectives of the Board

2.20 The key priority for The Board is “improving health for all” by “reducing health inequalities, delivering safe and accessible health services and involving partners, patients and the public in all that we do.”

2.21 Improving Care Investing in Change (2005) set out the Board’s strategic direction for mental health, older people’s services and acute services. The development of Midlothian Community Hospital is an integral part of the delivery of these strategies.

2.22 The Board is committed to empowering local people to take a much more active part in improving health and health services in their own areas. Furthermore, the Board is committed to rebuilding and modernising local healthcare services giving priority to avoiding delayed discharges, increasing access and reducing waiting times, while maintaining financial equilibrium, partnership working, communication, and staff governance. As part of its modernisation agenda the Board supports the development of the Full Business Case for Midlothian Community Hospital to allow necessary improvements in the facilities for local Health Service delivery.

2.23 Services for Older People and those with Mental Health problems are planned to build on the benefits of effective local community care planning, which has resulted in partnership working between local health services delivered via Midlothian CHP and a wider range of services delivered by Midlothian Council.

2.24 Mental Health & Wellbeing

2.25 A joint Mental Health and Wellbeing Strategy Review was completed and approved by the Board and the four Lothian local authorities in 2005. This strategy, covering the period 2005 – 2010 is
shifting the balance of mental health care and treatment towards care in the community, by providing alternatives to admission, an enhanced range of community services and improved support networks. The strategy envisages that each Community Health Partnership area will have the following service components:

- Comprehensive community based responses, 24 hours 7 days a week;
- Comprehensive Community mental health teams and local service networks;
- Local crisis provision which may have the capacity for overnight stay;
- Community support for people in acute phases of illness;
- Community support for people with more chronic and enduring illnesses;
- A range of specialist therapies and interventions;
- Access to acute and intensive psychiatric inpatient care when needed;
- Access to rehabilitation and continuing care provision, including inpatient care when needed.

2.26 Adult community mental health services are already based within community settings in Midlothian and service development will continue to take place outwith a hospital environment, jointly with social care provision by Midlothian Council and voluntary agencies and primary care as appropriate. Those who require an acute mental health hospital admission will have their care provided for in designated mental health beds at the Royal Edinburgh Hospital, where specialist support including intensive psychiatric care can be provided, and any need for inpatient rehabilitation and continuing care can also be met.

2.27 Services for Older People

2.28 The Board undertook a Pan Lothian Review of Older People’s Services that resulted in plans to rationalise health services for Older People to improve the quality and accessibility of care provided. The review confirmed the role of the planned Midlothian Community Hospital to provide inpatient assessment and rehabilitation and continuing care services for care of the elderly with mental health problems and continuing care services for the frail elderly.

2.29 The Chief Medical Officer’s report “Adding Life to Years” (2001) describes a holistic approach to the journey of care for older people that local health systems, with local authorities and partner agencies, should seek to achieve. Midlothian Community Hospital will provide improved local assessment, diagnostic and treatment facilities for the local population, including the opportunity to undertake multi-disciplinary assessment of older people via the planned Intensive Day Treatment Team. The development is entirely consistent with national priorities of preventing unnecessary admission to hospital, and supporting early discharge.

2.30 The Joint Lothian Strategy for Older People 1995 –2005 envisaged an overall reduction by 50% in NHS continuing care provision over the period. Within Midlothian a reduction in continuing care beds from 105 in 1997 to 64 is planned, linked to the reprovision of Rosslynlee and Loanhead Hospitals. The increased elderly and very elderly population of Midlothian and the occupancy level of the current facilities continue to require this provision to meet known needs. It is intended that the continuing care unit will be developed in line with Care Commission Standards for Older People, both to ensure high quality accommodation meeting patients’ privacy and dignity expectations, and to provide future flexibility should the balance between continuing NHS care and nursing home care required in the locality change over time.

2.31 Better Acute Care in Lothian
2.32 The development of a Community Hospital in Midlothian is consistent with the Lothian acute strategy, which focuses acute hospital services on 3 major hospitals in Lothian. Services including out-patients and diagnostics will be provided locally whenever safe and sensible to do so. Midlothian Community Hospital will support this by:

- providing a focal point for community health services for the population of Midlothian which is currently the only local authority area in Lothian without a local community treatment base to support GPs with outreach clinics and diagnostic services;
- provision of a small local outpatient facility with supporting investigative/diagnostic services;
- development of facilities for the delivery of child community health clinics locally;
- the prevention of avoidable travel to the major acute centres through community assessment, diagnostic and therapy services, including the intensive day treatment team;
- reduced lengths of stay in the major acute centres through early discharge with supporting community services,
- the delivery of the Lothian Unscheduled Care Service and community services operating from suitable premises.

2.33 Midlothian Community Health Partnership

2.34 Midlothian Community Health Partnership (“CHP”) is one of 4 CHPs in Lothian. It serves a population of circa 85,000 and has 12 GP practices, two hospitals, and a number of clinics and community based services, including community nursing and therapy services as well as pharmacists/chemists, dentists and opticians.

2.35 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.

2.36 The key issues for the health and well being of the citizens of Midlothian have been set out in the Midlothian Community Plan developed by the community planning partnership. The development of the Community Hospital is fully supported by the local community and by Midlothian Council.

2.37 The NHS Scotland reforms resulting from Partnerships for Care has resulted in Midlothian being established as a Community Health Partnership (CHP) by the Board from April 2005. The previous LHCC, through the existing Joint Futures Committee, was already working in partnership to deliver services for all client groups in the locality. The proposed re-provisioning of Rosslynlee and Loanhead Hospitals has been discussed and supported within the Midlothian Joint Future Committee and this is seen as a vital component for combined and integrated services for the key community care client groups.
2.38 The Need for Investment

2.39 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 personnel, facilities, equipment and infrastructure are in place to deliver such change.

2.40 Inpatient services are currently provided from Rosslynlee and Loanhead Hospitals.

2.41 For many years the hospitals at Rosslynlee and Loanhead have been considered functionally and technically sub-standard and requiring replacement.

2.42 The Board’s Property & Infrastructure Strategy accepts that the two buildings are 100% non-compliant for continuing NHS use and foresees a significant expenditure to bring these properties closer to the agreed statutory standards. It is anticipated that should these buildings not be replaced, then the required capital expenditure will be XXXXX (as at 2006 costs), to meet current category B standards. However, Rosslynlee Hospital is inaccessible and lack of suitability for modern health care delivery means that even a modernised Rosslynlee would fail to address current needs for improved physical and functional integration of services.

2.43 Rosslynlee Hospital

2.44 The Property & Infrastructure Strategy survey indicated that all of the buildings were considered to be non-compliant. Only 7% of the buildings area complies with statutory standards (10% for fire precautions) and capital expenditure is required to achieve acceptable standards. All of the property is in an unacceptable physical condition requiring expenditure to bring it up to category B condition. In terms of functional suitability 42% is deemed to be below an acceptable standard and 17% is unfit for its present purpose. Some 63% of the space is considered to be overcrowded, 27% underused and 10% empty (as at 2006).

2.45 Loanhead Hospital

2.46 The Property & Infrastructure Strategy survey indicated that the building is considered to be non-compliant. None of the building area complies with statutory standards (including fire precautions). Some 72% of the property is not in an acceptable physical condition. In terms of functional suitability 43% is deemed to be below an acceptable standard and the remaining 57% is unfit for its present purpose. Some 59% of the space is considered to be overcrowded and 41% underused (as at 2006).

2.47 The Board’s current Draft Property & Infrastructure Strategy (2008-2013) confirms that both hospitals are unsatisfactory and intended for closure and disposal following the development of Midlothian Community Hospital.

2.48 The re-provision of Rosslynlee and Loanhead services is a priority and the Board has confirmed the priority to progress the development of a new community Hospital in its 2004/05 Local Health Plan.

2.49 It remains the case that the Board’s overall strategy for health services sets a strategic context that anticipates the development of community services. The existing sites in Midlothian are unsuitable for the development of such services. If they were to be closed without re-provision,
there would be no local access to hospital services and a continued loss of integration, access and equality. Particularly for the elderly, the development of a new Community Hospital will bring a level of modernisation long overdue to meet local health care needs.

2.50 Disposal Strategy

2.51 Background

2.52 The proposed new Midlothian Community Hospital due to open in Summer 2010 will replace the existing Rosslynlee and Loanhead Hospitals.

2.53 On the FBC being agreed & Financial Close being finalised, these properties will then be declared surplus.

2.54 The Scottish Government Property Transaction Guidance governs all disposals of land & property. The guidance states that any property/land disposal must:

- be disposed as soon as possible after being declared surplus and consistent with achieving the best return;
- be disposed with regard to the state of the market and good market practice;
- only be disposed on receipt of professional advice.

2.55 Rydens LLP have been appointed to act as Property Adviser and Marketing agent for the disposal of both hospital properties. The District Valuer will be appointed to act as Independent Adviser on the transactions.

2.56 Current Market Conditions

2.57 From late 2007 the property development market has been adversely affected by the global banking problems. Whilst arguably the Scottish Housing Market has suffered less than the rest of the UK, Scottish based residential developers are not immune to the current situation and this is reflected in a weakness within the market at present, (October 2008).

2.58 The Professional Advisers have provided the following information regarding the marketing of the properties:

- Marketing of Properties;
- The development of a marketing strategy for the properties should commence immediately.

2.59 It is believed that planning consent for Loanhead could take 12 months and for Rosslynlee which is category C listed building planning would take up to 18 months.

2.60 Loanhead Hospital – following submissions to the Midlothian Local Plan Inquiry, the Council agreed to remove the site from the designated Edinburgh Greenbelt. This is significant move forward as greenbelt policy would have provided very limited scope for development of the site. The effect of this will provide scope for conversion of the buildings to residential use and subject to agreement with Midlothian Council. The existing access will require to be upgraded.
2.61 Rosslynlee Hospital – the buildings are category C Listed. The Local Plan Inquiry has been broadly supportive of the principle of a residential development comprising of rationalisation and conversion of the category C(S) listed main hospital building, renovation of existing houses in the grounds, infill and modest new development on the adjacent paddock within the “building line” of the existing development. The scope is for circa 120 houses. This is below the threshold requiring a bus service provision and the access road would therefore remain private and be maintained by a private factor.

2.62 Proposed Use

2.63 Loanhead Hospital – would be used for residential development.

2.64 Rosslynlee Hospital - The scope is for circa 120 houses (mixture of conversion of existing buildings and small development) it may also be suitable for other institutional or possibly hotel use. Use of the site for social housing would raise issues about the distances from services and therefore potential planning problems.

2.65 Market Price

2.66 Loanhead – It should be noted that the cost of upgrading the access road is estimated at [redacted] and assuming the new owner/developer would meet this cost the open market value in region of [redacted].

2.67 Rosslynlee – It is anticipated that it would be possible to achieve 120 units and the open market value would be in the region of [redacted].

2.68 Overage Payments

2.69 The sale for Rosslynlee and Loanhead Hospital would be subject to overage/profit sharing payments.

2.70 Summary

2.71 In summary, the Board’s strategy is:

- Board Approval to declare properties surplus November 2008 (on sign off of FBC);
- Trawl of Scottish Government Bodies (in line with Scottish Government Transaction) – completion January 2009;
- On assumption that no interest declared in properties by other Scottish Government Agencies – the properties will be taken to the market;
- Proposed use will be mainly residential – not suitable for social housing. Rosslynlee may have a potential use for hotel;
- Price – Rosslynlee in the region of [redacted] and Loanhead [redacted];
- Offer will be subject to overage/profit sharing.
3 FUTURE CLINICAL SERVICE REQUIREMENTS

3.1 This section describes:

- The development of new models of care;
- New hospital capacity including comparison to the OBC.

3.2 Principles for New Models of Care

3.3 Re-design identified the need for significant clinical and managerial input from within the service. This was achieved by establishing an Adult Mental Health Care Programme Group that included clinicians, nursing, AHP, management, administration and other specialist groups (eg. Psychology).

3.4 Following on from this, workshops were undertaken and a Re-design Action Plan was established. Actions and implementation of identified work streams were progressed by designated working groups who reported back progress regularly to the Care Programme Group.

3.5 In order to implement the Board’s strategic directions as set out in Improving Care Investing in Change (2005), these groups worked over considerable time to determine the key principles underpinning a new model of care, including transitional arrangements that are the stepping stones to the new hospital.

3.6 The principles outlined included:

- A focus on the patient need;
- Clear pathways of care;
- Minimising hospital admission;
- Maximising ambulatory care;
- Enhancing enabling services;
- Integrated and co-located health and social services;
- Improved IM&T;
- Providing new specialised services for Women and Children;
- Maximising roles of nurses and AHPs;
- Producing a compliant, safe and secure working environment.

3.7 New Hospital Capacity
3.8 The table below sets out the services being delivered in Midlothian at the revised OBC stage in September 2006, against what will be in place when the Hospital is available.

*Table 1: Services*

<table>
<thead>
<tr>
<th>Facility/Service</th>
<th>Services Provided in Midlothian at 2004</th>
<th>Strategy for OBC / FBC (MCH unless otherwise stated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE &amp; REHAB (Mental Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute General Adult</td>
<td>19</td>
<td>8-10 REH</td>
</tr>
<tr>
<td>Rehabilitation Beds</td>
<td>6</td>
<td>REH</td>
</tr>
<tr>
<td>OLDER PEOPLE (Mental Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment (including 2 shared care)</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Continuing Care (including 2 shared care)</td>
<td>57</td>
<td>24</td>
</tr>
<tr>
<td>Day Hospital Places (5 days)</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Community Care of the Elderly Team</td>
<td>Loanhead Bonnyrigg HC</td>
<td></td>
</tr>
<tr>
<td>Primary care Dementia Team</td>
<td>Loanhead Bonnyrigg HC</td>
<td></td>
</tr>
<tr>
<td>OLDER PEOPLE SERVICES (Physical Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.D. Continuing Care (incl. 3 shared care)</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Intensive Day Treatment Team</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>AMBULATORY CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach Clinics</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>Unscheduled Care Services (6pm-12pm, w/ends, including minor injuries)</td>
<td>Bonnyrigg HC</td>
<td>√</td>
</tr>
<tr>
<td>Multi Disciplinary Child Community Health Clinics</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>Dental Service</td>
<td>√</td>
<td>Bonnyrigg Dental Access Centre</td>
</tr>
<tr>
<td>Imaging (plain film X-Ray + ultrasound)</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>ECG (not a dedicated facility)</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>OTHER</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>Peripatetic AHP Base</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>Occupational Therapy Treatment Base (multi-use)</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>Physiotherapy Treatment Base (multi-use)</td>
<td>-</td>
<td>√</td>
</tr>
<tr>
<td>TOTAL BED No</td>
<td>148</td>
<td>88 (MCH only)</td>
</tr>
</tbody>
</table>

3.9 Service changes are already taking place within Rosslynlee and Loanhead Hospitals to support the strategic direction and key principles as identified above. The move of the Adult Admission Unit to the Royal Edinburgh Hospital in Edinburgh and the amalgamation of two continuing care wards into one unit are underpinning the new models of care principles within Rosslynlee Hospital. Whereas at Loanhead Hospital, increased Day Hospital activity and enabling and falls work for the frail elderly are increasing. The current service is now very close to matching the service model that will be provided from the new hospital. In terms of working with staff, the service is embracing new and emerging models of care that are already taking place within the service.
3.10  Also the staffing models within Rosslynlee and Loanhead Hospitals are working towards a change in skill-mix to support the new models of care and key principles. Therefore, when the time comes to move to the new hospital the aim is that the staffing profile will match that required. It is unlikely that this will result in any redeployment issues as the service will simply relocate.

3.11  The service is embracing new and emerging models of care and work continues with staff to implement this through ongoing working groups (eg. Rapid Response Team, Long Term Conditions Group, Adult Mental Health Working Group, etc.) undertaking continual audits and evaluations.

3.12  Key senior charge nurses have been involved in leadership courses such as “Leading into the Future” which incorporates work around the “Senses Framework” which focuses on “relationship centred care”.

3.13  Allied Health Professional Service

3.14  The new hospital is providing superior facilities acknowledging the importance of multi-disciplinary working within assessment and rehabilitation.

3.15  The hospital design lay-out allows for improved departmental relationships with the day hospital in close proximity to the AHP area.
4 THE OUTLINE BUSINESS CASE

4.1 Introduction

4.2 The revised Outline Business Case was approved by the Capital Investment Group at the then SEHD in October 2006.

4.3 Selection of Investment Options

4.4 The 2006 OBC revised three options identified from the original 1998 OBC for the re-provisioning of services and these were:

Table 2: Reprovision Options

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Do minimum, taking into account the outcome of the joint Mental Health and Wellbeing Strategy Review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2</td>
<td>Develop new Community Hospital for Midlothian on the existing Rosslynlee site.</td>
</tr>
<tr>
<td>Option 3</td>
<td>Develop new Community Hospital for Midlothian on a new Greenfield site.</td>
</tr>
</tbody>
</table>

4.5 Dispersal options were not considered as the dispersal of services is clearly deficient in terms of local access and equity of provision and would fail to meet either the Board’s or the CHP’s objectives.

4.6 Option 3 was the best ranked option in terms of the benefits analysis alone, using the following criteria:

Table 3: Benefits Criteria

<table>
<thead>
<tr>
<th>Benefits Criteria</th>
<th>Criteria Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Accessibility</td>
<td>30</td>
</tr>
<tr>
<td>2 Clinical Effectiveness</td>
<td>20</td>
</tr>
<tr>
<td>3 Quality of Physical Environment</td>
<td>15</td>
</tr>
<tr>
<td>4 Acceptability to patients, staff and partner organisations</td>
<td>10</td>
</tr>
<tr>
<td>5 Deliverability</td>
<td>15</td>
</tr>
<tr>
<td>6 Disruption to Services</td>
<td>10</td>
</tr>
</tbody>
</table>

4.7 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.

4.8 Following systematic analysis of the project costs and benefits it was concluded that Option 3, the development of a new Community Hospital for Midlothian on a new Greenfield site was the Preferred Option.

4.9 The Preferred Option
4.10 The development of a new community hospital will allow for the provision of a wide range of primary care services, early intervention, treatment and rehabilitation in modern facilities with new models of care.

4.11 Service developments will include a wider range of outpatient and diagnostic facilities, x-ray, ECG, child and family services, clinical psychology, learning disabilities, physiotherapy, occupational therapy, rehabilitation on a day and outpatient basis for older people with mental health problems, patients with dementia and frail elderly.

4.12 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.

4.13 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.

4.14 Changes from OBC

4.15 Two main service changes have been applied since the OBC to enhance the clinical objectives as stated below.

4.16 Care Home Beds

4.17 Originally, the overall affordability of the project was to be secured by designating 20 beds as nursing home beds that would be purchased by Midlothian Council.

4.18 Whilst the Council have maintained their willingness to purchase these beds, subsequent negotiations with Midlothian Council and the Care Commission identified a series of additional requirements that the Board would be subject to as part of this agreement.

4.19 These included design reconfiguration and building alterations, such as moving the location of the nursing home beds from the first floor to the ground floor, which compromised the working relationships and proximity between NHS clinical departments and facilities.

4.20 In addition, whilst agreeing to purchase beds, Midlothian Council was only prepared to do so on the basis of “cost per case” rather than enter into a block contract for all 20 beds. This latter requirement was felt to compromise the stability of revenue streams by significantly increasing the financial risk to the Board that ultimately impacted upon the affordability of the scheme.

4.21 Consideration of both these factors by the Project Board compelled a re-appraisal of revenue sources, which would underpin the affordability of the project without compromising the design principles.

4.22 A solution was subsequently identified.

4.23 Initially the re-provision of Edenhall Hospital in Musselburgh, East Lothian, included the development of a 60-bedded unit by East Lothian Council that would accommodate 30 of the 44 frail elderly and care of elderly with mental health problems beds in Edenhall. This plan was
subsequently amended as part of the East Lothian Old People’s Capacity Plan and there are no longer any plans to develop the 60 bedded unit. As a result of this, East Lothian Community Health Partnership require to identify an alternative to re-provide the 44 beds.

4.24 It was therefore proposed to transfer the property costs for 20 of these beds to Midlothian Community Hospital.

4.25 This proposal was subject to a number of discussions with Council Officers and members in addition to clinicians and staff. A formal proposal was put to the East Lothian Community Health Partnership Sub-Committee on 15th April 2008 and a formal assurance was sought from East Lothian Council that they support this initiative.

4.26 This solution compensates for the income for the care home beds previously assumed.

4.27 Dentistry

4.28 There have been significant organisational developments within Lothian since the original OBC of 1998 resulting in the re-organisation of Trusts to LHCCs and subsequently CHPs.

4.29 Individual service strategic developments have continued, including the development of a bespoke five chair Dental Service based within the old Bonnyrigg Health Centre providing an enhanced service to cover those with learning disabilities and dental-related phobias who are not able / or willing to register with a mainstream dental practitioner.

4.30 This new bespoke service also covers the developments within infection control and the need to ensure appropriate decontamination facilities are provided in line with Infection Control Guidance.

4.31 Due to the provision of an enhanced service within the locality, this service was removed from the project.
5 THE PROCUREMENT PROCESS

5.1 The Project Management Structure

5.2 The Board has followed the relevant Scottish Capital Investment Manual guidance ("SCIM Guidance") on procurement as well as all 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.

5.3 A Project Board was set up under the chairmanship of Gerry Power, General Manager, Midlothian CHP, Project Sponsor. The Project Board comprised two Consultants, Clinical Nurse Manager, Project Director, Project Manager, the SGHD PPP Facilitator, an Executive Member of the Board and representatives from Finance, HR, Estates, Staff Side and the Public. The remit of the Project Board is to act as the high level decision-making group that oversees the full project and approves Project Team recommendations prior to submission to the Board for corporate approval.

5.4 Various Project Teams were set up with representation from the various clinical and non-clinical services, staff side and the public, including external advisers. The Project Teams were responsible for project development and delivery and management of the interface between the Board and the Consortium.

5.5 Public Representation was organised through the Midlothian Public Partnership Forum. There have been three members appointed to the Project Board: Bill Peacock, Marlene Gill and Alex Philip.

5.6 They have also contributed to Project Teams and wider public involvement has been coordinated and compiled by Catherine Evans, Patient Involvement Worker, Midlothian CHP.

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

- Financial Advisers – Grant Thornton
- Legal Advisers – McClure Naismith
- Technical Advisers – Currie & Brown

5.8 In addition, the services of Ryden were enlisted to provide assistance in the development of the planning application and procurement of the site and Willis were enlisted to provide expertise in insurance matters.

5.9 Currie and Brown, Technical Advisers enlisted the services of the following:

- Macmon Architects – for Architectural and Planning advice;
- Buchan & Associates – for Healthcare Planning advice;
- Hulley & Kirkwood – for Mechanical & Electrical Engineering advice;
- URS – for Civil & Structural Engineering advice.

5.10 OJEU and Expressions of Interest
5.11 The Board placed an advertisement for the Project in the Official Journal of the European Union in August 1998 (the OJEU Contract Notice) and obtained significant interest.

5.12 In 2000, two bidders were shortlisted to provide Best and Final Offers (BAFO) for this project. These bidders were retained while several delays to the project took affect. The passage of time saw one of the bidders alter its strategic approach to PPP and back out from the process leaving the Board to consider whether it wished to proceed with the remaining bidder or return to the market.

5.13 In light of the precedent and experience with the Glasgow ACAD contract, meetings with the remaining bidder were held to discuss how such a negotiation might proceed. Robertson Capital Projects showed a strong willingness to co-operate with us and enter into a fully open-book approach. Scottish Executive support was predicated on the involvement of external audit and their satisfaction with the process to be followed.

5.14 The opportunity was taken to consider retaining Robertson Capital Projects, to BAFO, taking into account the pros and cons and consideration of best value.

5.15 A report was prepared to analyse the options for taking the project forward and this was included in the OBC under Appendix 6.

5.16 The purpose of the report was to undertake an objective evaluation of competition versus retaining Robertson Capital Projects as a “Remaining Bidder” to BAFO and thereafter to determine which procurement route represents best value in the particular circumstances presented in relation to the project.

5.17 The evaluation undertaken and set out within the report brought into play a composite evaluation methodology, drawing on the different skills of the advisory team (comprising McClure Naismith (Legal), Grant Thornton (Financial), Currie and Brown (Technical); with AKH Associates (the then Project Managers) managing and co-ordinating the process and developing the conclusions based on the information presented.

5.18 Designed around a framework of time, cost, quality and deliverability, the evaluation determined a composite and unanimous outcome to retain Robertson Capital Projects.

5.19 The principal reasons for the recommendation were that it was the result of an objective “best value” evaluation process with the following benefits and observations:

- There was the potential to improve timescales for delivery. While these could not be guaranteed there was an opportunity to improve upon the competitive process by several months;
- Returning to the market could increase the inflationary pressure on the capital value and thus Unitary Charge due to delay;
- We could increase the time available to engage with the bidder and obtain a more developed scheme at preferred bidder stage.
- Robertson Capital Projects (RCP) is an experienced and respected provider of PPP Healthcare premises in the UK and continues to succeed in the marketplace against good opposition by virtue of delivering value for money.
- RCP’s agreement to an open book process (expressed in the Conditions Precedent) gave the Board the right to interrogate costs at every stage of the procurement process;
- Value for Money could be strictly monitored by benchmarking MCH against two of RCP’s most current PPP healthcare projects of a similar nature (Gartnavel Royal Hospital and Clackmannanshire Community Hospital), in addition to a non-RCP project such as St Andrews Community Hospital or any other relevant benchmarking data that may be available.

5.20 Following the recommendation, work was undertaken to develop the benchmarking system of key inputs to the financial model that RCP had to conform within if they were to be retained in the process. Key provisions within the Conditions Precedent were that Audit Scotland would monitor and report on value for money issues at key stages of the procurement process and that there would be strict adherence to current standard form documents.

5.21 The Board agreed to proceed with RCP as Remaining Bidder and that this route could be supported as that there would be no immediate, real or tangible benefits in returning to the market. A Conditions Precedent Letter was drawn-up and signed by both parties and this was included in Appendix 7 of the OBC.

5.22 It must be noted that this did not preclude the Board returning to the market in the event of any matter arising out of Audit Scotland’s work or through any failure on behalf of RCP to fulfil its obligations under open book accounting and benchmarking and all other Conditions Precedent to the agreement to resume BAFO negotiations.

5.23 Final Invitation to Negotiate (FITN)

5.24 The FITN was issued to RCP on 19th June 2007 with a response required by 9th November 2007, followed by a presentation on 23rd November 2007 to the Project Board and their external advisers. An Interim Bid Submission was required to be completed by 17th August 2007.

5.25 The FITN comprises the following volumes:

- Volume 1: Instructions to Bidders
- Volume 2: Project Agreement
- Volume 3a: Construction Requirements, Clinical Brief and Equipment Schedules
- Volume 3b: Hard FM Requirements and Soft FM Service Level Specifications

5.26 Interim Bid Submission

5.27 RCP were required to prepare an Interim Bid Submission. Full copies of the Interim Bid were submitted to the Project Manager, the Board’s Advisers and all the other members of the Interim Bid Panel. A full list of the interim evaluation panel is given in Appendix 5.

5.28 During the Bid period a series of clarification and evaluation meetings were arranged with members of the Clinical and Non-Clinical Users, Project Team and the Board’s Advisers to
facilitate the clarification of the client requirements and provide an evaluation of the Interim Bid. The fact that the Interim Bid was issued after only 9 weeks of the 17 weeks bid period was taken into account during the evaluation.

5.29 An Interim Bid Evaluation Paper was presented to the Project Board on 29th August 2007. The interim evaluation process and report took in the following activities and was completed in a period of 7 days:

- Circulation of the bid to all the evaluation panel;
- AEDET evaluation workshop;
- The Project Board’s external adviser report (no legal input was requested at this stage of the bid);
- Project Manager’s report;
- Interim bid evaluation panel meeting.

5.30 The Interim Bid or sections of the bid were issued out to all the members of the evaluation panel. These members were requested to evaluate their specific delegated areas of responsibility and provide any comment or seek any clarification prior to the interim bid adviser evaluation meeting that took place on 23rd August 2007.

5.31 As part of the evaluation process, AEDET was promoted and used to evaluate the submitted design.

5.32 This process allowed a group of the department users to participate in assessing the submitted design. Through reviewing the design drawings and scoring these against a level of agreed standard statements ranged to extract a view of the designs impact, building quality and functionality. A full list of the AEDET participants is given in Appendix 5.

5.33 All the external advisers were instructed to produce independent, headline reports to include a qualitative assessment of the entire bid and these were issued to the Project Manager prior to the interim bid adviser evaluation meeting. The Project Manager also submitted an internal view of the submission along similar lines as the advisers’ reports.

5.34 The qualitative assessment of the entire bid was to be in the form of a score for the submitted bid against a weighted scoring sheet agreed and issued by the Project Manager prior to the return of the Interim Bid.

5.35 Details of the Bid Evaluation Criteria and Weightings for the Qualitative Assessment are outlined in the following table:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Evaluation Category</th>
<th>Potential Weighted Maximum Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Executive Summary</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>Project Management Approach</td>
<td>5</td>
</tr>
<tr>
<td>C</td>
<td>Legal Response</td>
<td>10 *</td>
</tr>
<tr>
<td>D</td>
<td>Financial Response</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 4: Bid Evaluation Criteria & Weighting
5.36 No formal legal response was requested in the Interim Bid. However, the Legal advisers were asked to provide a score on how their discussions with RCP were proceeding.

5.37 Summary of Interim Review

5.38 The above evaluation categories were split into the bid sections and scores out of 100 assigned to each section. The Advisers and Project Manager scores were 57 and 64 respectively indicating an “adequate to good” response to the FITN. The reports provided similar views on the interim bid and these were reviewed and presented at the Interim Review Meeting held on 23rd August 2007.

5.39 Despite the submitted interim bid being returned with unaffordable costs, the Advisers and the Project Manager believed the bid to be compliant and included a high level of detail for such a short period of design.

5.40 The bid submission contained a section on suggestions as to how the bid could be refined and lowered.

5.41 The group concluded that bids were unaffordable and that the minimum cost proposal was too far in excess of the affordable annual Unitary Charge of XXXXXXX.

5.42 The group agreed that the interim bid figures still required to be challenged on the following issues:

- Interrogate the capital costs (inclusive of the elemental and enhanced costs)
- Interrogate the life cycle costs
- Interrogate the FM costs

5.43 It was recognised that further action would still be required to bring in an affordable bid and in general terms the most likely successful action would be to target the capital costs by either addressing the space or technical aspects. This could be achieved while co-operating with RCP to complete their full bid.

5.44 On the recommendation of the group, the Board agreed the following formal feedback to RCP on their Interim Bid at a meeting on 31st August 2007:

- To thank and recognise their effort and detail included in the interim bid;
- Invite them to develop further the ideas in the standard bid 3 to make it affordable against the capital target;
- To co-operate in the interrogation of all the costs (including specific issue listed in the feedback report).

5.45 Final Bid Submission
5.46 The final Bid Submission was made to the Board on 9th November 2007 in accordance with the requirements of the FITN. RCP formally presented their Full Bid to the Board meeting on 23rd November 2007.

5.47 As part of the established bid process the bid was initially reviewed by the appointed Full Bid Team (composed of the internal and external advisors). The Team’s initial conclusions and recommendations were presented in a Full Bid Report (dated 19th November 2007) and this was issued to the Project Board for their consideration at their meeting on 23rd November 2007.

5.48 The completed Full Bid submitted was still unaffordable and RCP quoted an Annual Unitary Charge (AUC) of XXXXXXX per annum. This was XXXXXX per annum over the Shadow Bid that was set at XXXXXXX. RCP indicated that a significant portion of this related to increased Mechanical & Engineering (M&E) costs due to market hyperinflation. Further issues related to increased specification over the agreed benchmark projects and an increase in the schedule of accommodation to meet Care Commission requirements.

5.49 All external advisers and the Bid Team considered the Bid to be a “good bid” and believed there was still some latitude to drive down costs and, to a lesser extent, improve the financial package.

5.50 The conclusion of the Bid Team was that the Bid was very close to being affordable (only a 7% increase to the AUC and therefore warranted further investigation and interrogation. This would focus on clarifying and reducing costs and include the incorporation of the Care Commission change to hopefully develop an affordable deal. If this could not be achieved the team would then create a list of specification reductions with the clinical group’s approval to meet the unaffordable gap.

5.51 On the recommendation of the Bid Team, the Project Board at its meeting on 23rd November 2007 agreed to:

- Approve the continuation of the review bid process;
- Issue a formal instruction to change the design to take account of the Care Commission Change;
- Charge the project team and advisers to complete the clarification and interrogation of the submitted bid and, if required, agree with the clinical team any acceptable specification reductions to fill any remaining affordability gap.

5.52 The Project Board also agreed that the Project Sponsor present a paper to the next Board’s Finance & Performance Review Committee (F&PR) on 12th December 2007 advising of the updated position of the project.

5.53 Final Bid Evaluation

5.54 A series of clarification meetings were arranged with members of the clinical and non-clinical users, project team, and the external advisers to facilitate the clarification and evaluation process.

5.55 During this period the Bidder was invited to respond to the issues raised, revising their Bids where appropriate. The Project Board set the date of 3rd March 2008 as the final cut-off date for the review of the bid and took its findings and recommendations to the Board on 11th March 2008.
5.56 The findings were reported in the Currie & Brown (C&B) Costs report dated 6th March 2008. Copies can be obtained from the Project Manager.

5.57 After considering all the reports and the timescales, the Board approved the following strategy and delegated the Project Sponsor responsibility to negotiate with RCP along the following terms:

- Request RCP to reduce its Capital Expenditure, FM and LCC costs to the levels suggested by C&B above.

- It was agreed the Board would contribute to the affordability through deletion of some savings.

5.58 Change to Business Case

5.59 During the Clarification period the negotiations to secure the business case funding from the Local Council for 20 beds could not be concluded. Although the Council was still willing to purchase beds, it was not prepared to commit to a block contract. Therefore the Project Sponsor developed an alternative solution to address the affordability gap. The solution was to reallocate the property costs for 20 beds from the Edenhall to Midlothian Community Hospital.

5.60 Negotiations

5.61 On 26th March 2008 the Project Sponsor, Project Director, Finance member and Project Manager met with RCP to see if they would broker a deal, on similar terms set by the Project Board. After deliberations the following agreement was struck between both parties:

- RCP agreed to reduce their Capital Expenditure costs by XXXX.

- RCP agreed to a further XXXX reduction on their corporate Unitary Charge.

- FM costs were renegotiated to acceptable benchmarking levels.

- RCP agreed to accept transfer of the LCC of the ceiling hoists to the Board.

- RCP agreed to reduce the provisional sum for capping to a maximum cap XXXX and agreed to return all unused costs to self-harm, capping, lime stabilisation, and gas membrane provisional sums.

- The Board agreed to make XXXX savings.

- The Board agreed to carry risk on provisional sums up to the maximums figures.

- RCP and the Board agreed to investigate a further XXXX savings.

5.62 The above savings were incorporated into a benchmarking review required by the board as part of the agreement to continue negotiations with a remaining bidder (the details of which are included in the Currie & Brown report dated 2 April 2008). This review showed value for money and was audited and approved by Audit Scotland, the Board’s external auditors (see Appendix 6).
5.63 The above was reported to the Board at their meeting on 11th April 2008 with an indication that the deal was just unaffordable by the sum of XXXXX per annum. However a positive situation would be achieved by including the funding from the transfer of Edenhall beds property costs.

5.64 Recommendations

5.65 The Board at its meeting on 11th April 2008 approved the following recommendations and agreed:

- To approve the negotiated position;
- To include the additional stair into the design in line with Care Commission requirements, to provide future flexibility should the balance between continuing NHS care and nursing home care required in the locality change over time;
- To replace the Care beds by the Edenhall beds and inject the Edenhall funding to close the affordability gap;
- To approve the Project Sponsor to take the deal to seek Lothian Health Board’s approval to appoint RCP as the preferred bidder.
6  PPP SOLUTION

6.1  Introduction

6.2  The PPP solution is for the Consortium to design, build, finance and operate a new hospital on a
greenfield site owned by the Board, located on the South West corner of the Eskbank Road
round-about, on the A7 trunk road. The concession will be for a 30-year contract period post
completion. Clinical services and Soft FM services will remain with the Board.

6.3  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
 treasury funded procurement route.

6.4  Consortium Members

6.5  The Consortium will establish a Special Purpose Vehicle ("SPV"), Robertson Healthcare
(Midlothian), to design, build, finance and maintain the facility. The SPV will in turn enter into two
separate sub-contracts, one with Robertson Construction to design and build and the other with
Roberson FM to provide a package of Hard FM services.

6.6  The Consortium will comprise:

•  Robertson Capital Projects;
•  Robertson Construction Lothian Ltd;
•  Robertson Facilities Management;
•  The Co-operative Bank.

6.7  The SPV will in addition to their in-house teams and external funder utilise the services of the
following specialists:

Architects            HLM Design
Healthcare Planning  Atkins
Structural Engineering Woolgar Hunter
Building Services    DSSR
CDM Co-ordinator     Kirk & Marsh
Financial Advisers   Quayle Munro
Legal Advisers       Maclay Murray and Spens
Insurance Advisers   Marsh

6.8  Project Description

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

6.10  A site plan and elevations showing the proposed design are included in Appendix 7.
6.11 Key Features of the Design

6.12 The key features of the design include:

- Good departmental relationships as required by the brief;
- Low rise, two storey development;
- Maximised use of natural light throughout the building;
- Maximised staff observation and ward control by ensuring main base is at the focal point of ward;
- Visual connections and direct access to sheltered and secure external amenity / therapy gardens and terraces;
- Convenient car parking for patients, visitors and staff;
- Energy efficiency and sustainability.

6.13 Making Best Use of the Site

6.14 The site is bounded on the north-west and north-east by the Eskbank Road and the A7 trunk road. To the south west is a neighbouring low rise housing estate and to the south-east there is an elevated public footpath / cycleway which connects Bonnybridge and Eskbank.

6.15 The only opportunity for vehicle access is from Eskbank Road. Pedestrian and cycle routes within the site will connect with the existing pathways along the south-west and north-west boundaries. The inclusion of a turning circle will allow regular bus services to enter the site from this access also.

6.16 The design provides a compact building reflecting the Board’s aspirations and requirements with regard to impact, buildability and functionality. The building form minimises travel distances throughout internal spaces, which benefits all user groups, including patients, visitors and staff. The design responds well to the site challenges and constraints, which have influenced the location and shape of the building footprint. The natural topography of the site has been utilised to minimise overall scale and presence, creating a building with character, yet avoiding the domination of its local landscape.

6.17 Clinical Adjacencies

6.18 The proposals met all the important departmental relationships and clinical functionality required to be delivered by the brief.

6.19 The design minimises travel distances for patients, staff and visitors and facilitates the patient flows and clinical pathways described in the clinical brief. The design also combines non-inpatient areas and co-locates each of the inpatient services.

6.20 The design delivers a clear “front of house” zone where outpatients for the AHP Department, Radiodiagnostics, OPD and Lothian Unscheduled Care Service (LUCS) enter by the main entrance and may then directly access the relevant department without entering the main communication spine of the hospital. Day patients enter directly to the day hospital from outside. By this means the communication spine is kept largely clear for in-patient, staff and service traffic movements, with only ward visitors requiring access to the ward entrances for this corridor.
6.21 Flexibility and Future Expansion

6.22 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.

6.23 It is recognised that internal arrangement and room layouts in the Hospital Building are likely to require to be changed over the course of time, post construction and therefore flexibility has been afforded in the structural design.

6.24 Upper floor ward blocks will typically utilise the external and corridor timber stud walls as the load bearing lines, allowing light-weight internal stud partitions to be relocated if required. The ground floor layout and the upper floor to the entrance block will utilise a steel framed structure, thereby allowing all internal partitions to be non-load bearing and moveable within the structural column grid.

6.25 Non-load bearing walls will be built from the concrete slab and therefore no slab infill will be required in the event of a partition being relocated. Thus the internal partitions are generally non-load bearing and allow maximum flexibility within the external skin.

6.26 In order to accommodate identified possible future expansions to the main hospital building, the areas of the structure (including foundations) adjacent to this will be designed to accommodate the loads from these extensions. Furthermore, the below ground drainage layout has been designed to have sufficient capacity to accommodate the extensions. The proposed location of future possible extensions are suitably remote and yet easily accessible to facilitate construction with an adjacent live hospital environment.

6.27 Interior Design

6.28 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.

6.29 The opportunity to bring natural light into as many spaces as possible will be utilised, as it is recognised that natural light is a key component when creating a therapeutic environment.

6.30 AEDET and NEAT

6.31 As part of the bid evaluation process the bid was evaluated on the basis of the three main categories:

- Legal
- Financial
- Technical

6.32 The technical evaluation was based upon the Department of Health Design Evaluation Toolkit “AEDET Evolution”. Members of the Project Board, Project Teams and PPF were involved in the evaluation and the process was led by the Technical Advisers.
6.33 The Technical valuation used a modified version of the AEDET tool.

6.34 The tool was modified by deleting the following three sections for the stated reasons:

- Performance & Engineering – several issues could not be adequately answered with the information at this point in time and the other questions were considered difficult for some of the client group to answer.

- Construction – several issues were considered not to be applicable to the project and other issues could not be adequately answered with the information at this point in time.

6.35 Subsequently this left 7 sections for review by the large client group:

- Character and Innovation
- Form and Materials
- Staff and Patient Environment
- Urban and Social Integration
- Use of Building
- Access of Building
- Building Space

6.36 Each member was requested individually to score the submitted bid focusing on the above factors prior to a joint meeting. The joint meeting allowed discussion and reflection of individual scores. In general, a consensus of opinion was reached in all the sections. The group jointly awarded an average score of 4.2 and based on the following AEDET scoring system, this indicates that the client group have a fair to strong agreement that design expectations have been achieved.

**AEDET Scoring Scale:**

O Unable to score
1 Virtually no agreement (that expectation met)
2 Hardly any agreement (that expectation met)
3 Little agreement (that expectation met)
4 Fair agreement (that expectation met)
5 Strong agreement (that expectation met)
6 Virtually Full agreement (that expectation met)

6.37 On review of the Full Bid proposals which, addressed most of the registered AEDET concerns in this new submission, the Capital Team and Advisers concluded that a further AEDET would not be necessary.

6.38 As a deliverable at FITN, the Board required RCP to carry out an evaluation of their proposals using the NHS Environment Action Tool (NEAT).

6.39 RCP submitted a score of 78%, which is classified as “Excellent under the tool. The efficient and effective design has led to anticipated energy consumption of 40.4GJ which is well within the government target of 35-55GJ/100m³ for new developments. The consortium has also confirmed
that it will endeavour to improve on this energy target and achieve an environmental accreditation to ISO14001 within 18 months of beginning operations on the site.

6.40 Planning Consent

6.41 RCP obtained an extension for the outline planning application for the site on 4th February 2008. Full Planning Consent was obtained on 28th August 2008, subject to conditions.

6.42 One of the conditions includes a new requirement for the provision of 2 new bus stops with pedestrian links to the existing public footways on the A7 close to the Tesco roundabout. Discussions are continuing with Midlothian Council to try to resolve this onerous planning condition.

6.43 The Board has agreed to meet the cost of the physical works estimated to be, at this time, in the region of XXXXXX. If this onerous planning condition is purified then this expenditure would not be required.

6.44 The Site

6.45 The site acquired by the Board is a 6.2 hectare site (Mayshade) adjacent to the A7 along Eskbank Road.

6.46 The site purchase was settled on 26th February 2007.

6.47 Timetable

Table 5: Project Timetable

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning Approved</td>
<td>28 August 2008</td>
</tr>
<tr>
<td>Appoint RCP</td>
<td>27 August 2008</td>
</tr>
<tr>
<td>FBC F&amp;PR &amp; LHB Approval</td>
<td>13 November 2008</td>
</tr>
<tr>
<td>FBC CIG Approval</td>
<td>27 November 2008</td>
</tr>
<tr>
<td>Financial Close</td>
<td>December 2008</td>
</tr>
<tr>
<td>Start on Site</td>
<td>December 2008</td>
</tr>
<tr>
<td>Transfer and Occupation</td>
<td>Summer 2010</td>
</tr>
<tr>
<td>Post Project Evaluation (initial report)</td>
<td>September 2010</td>
</tr>
<tr>
<td>Post Project Evaluation (final report)</td>
<td>June 2011</td>
</tr>
</tbody>
</table>

6.48 Financing the Project

6.49 Introduction

6.50 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.
6.51 Funding Structure

6.52 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 breakdown of the source of funds is set out below.

6.53 The senior debt will be provided by the Co-operative Bank (“Co-op”) and the subordinated debt and equity by RCP. All of the funders and equity providers have 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.

6.54 Contract Term

6.55 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.

6.56 Lending Terms

6.57 As stated, the senior debt will be provided by the Co-op. The following table sets out the key terms from the bank’s term sheet\(^1\) (which have been provided to the Board on a Commercial in Confidence basis):

\(^1\) *Indicating Bank Term Sheet July 2008 (p4).pdf*

<table>
<thead>
<tr>
<th>Table 6: Key Terms from Co-op’s Term Sheet</th>
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</thead>
<tbody>
<tr>
<td><strong>Margins</strong></td>
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<tr>
<td></td>
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<tr>
<td><strong>Fees</strong></td>
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</tbody>
</table>

6.58 The Board will take the risk of any movement in the interest rate (excluding MLAs and credit spread) currently modelled at XXXXX in the financial model, up to financial close. The effect of any change in the interest swap rate will be passed in full to the Board. The Board’s financial advisers, Grant Thornton, will continue to monitor movements in conjunction with the Preferred Bidder’s advisers.

6.59 The Board will take the risk of any movement in the inflation swap rate (excluding credit spread) currently modelled at XXXXX in the financial model, up to financial close.
6.60 Bank Cover Ratios

6.61 The debt facilities provided to the Consortium are subject to a series of cover ratios imposed by the Co-operative (Co-op) Bank, the Consortium’s sole funder. The following table sets out the key ratios that the model is required to meet, as stipulated in Co-op’s term sheet of July 2008:

Table 7: Key Ratios for Financial Model

<table>
<thead>
<tr>
<th>Ratios</th>
<th>Base Case</th>
<th>Lock-up</th>
<th>Default</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADSCR</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>LLCR</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

6.62 Details of the Financial Model

6.63 The table below sets out the key cost inputs to the financial model at FBC (price base November 2008):

Table 8: Key cost inputs to the financial model at FBC

<table>
<thead>
<tr>
<th>Base Costs</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hard FM</td>
<td></td>
</tr>
<tr>
<td>Life Cycle *</td>
<td></td>
</tr>
<tr>
<td>Energy</td>
<td></td>
</tr>
<tr>
<td>PPP Construction Cost (excluding contingencies and net of VAT)</td>
<td></td>
</tr>
<tr>
<td>Construction Start</td>
<td>December 2008</td>
</tr>
<tr>
<td>Construction End</td>
<td>May 2010</td>
</tr>
<tr>
<td>Construction Period (years)</td>
<td></td>
</tr>
<tr>
<td>Unitary Payment</td>
<td></td>
</tr>
</tbody>
</table>

(This will need to be revised once the updated RCP model is received.)

(* Lifecycle cost is an average per annum – clearly actual lifecycle will fluctuate year-on-year.)

6.64 Inflation

6.65 The construction costs are quoted on a fixed price basis. All costs have been input based on a November 2008 price base, in line with the Board’s instructions.

6.66 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 XXXXX per annum in line with the Board’s instructions.

6.67 Calculation of the Unitary Charge

6.68 The unitary charge is adjusted to the minimum level requirement to ensure that the project is able to meet all the net operating cost, 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 that in turn impacts upon the unitary charge required to repay the level of funding drawn down. As part of the solving process, the relative levels of debt and equity (gearing) are allowed to float to enable the balance that achieves the lowest unitary charge to be found.

6.69 Dividend Policy
6.70 UK Company law stipulates that dividends are only payable on the basis of the lower of:

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

6.71 In addition to this, the term sheet issued by Co-op sets out a series of additional constraints:

- There are no events of default;
- The Debt Service and Maintenance Reserve accounts are fully funded;
- Lock-up ratios are met; and
- There are no unfunded General Change in Law capital funding requirements.

6.72 Changes since Appointment of Preferred Bidder

6.73 There have been no significant changes to the financial model, however, a contingency has been provided within the affordability envelope to allow for potential minor changes in the design that may be necessary at the detailed design stage.

6.74 Price Basis

6.75 The PPP solution is based on the assumption that Financial Close will be achieved on 28th November 2008 and the price is fixed up to 30th November 2008.

6.76 In the event that Financial Close occurs after 30th November 2008, capital costs will be increased in line with movements in the BCIS All-In Tender Price index up to the date of actual date of Financial Close.

6.77 Revenue costs will increase in line with the RPI and will be adjusted by application of the movement in RPI over the period between 30th November 2008 and actual date of Financial Close.

6.78 The Board has a change control mechanism contained within the Preferred Bidder Letter to cover any capital expenditure changes prior to Financial Close.

6.79 Taxation Assumptions

6.80 In line with the Board’s instructions in the FITN, the Consortium has supplied finance debtor accounting and contract debtor taxation treatment. The benefit of these treatments flows through to the Board in the form of a lower Unitary Charge. The Consortium is taking the full risk of achieving clearance from HMRC for the proposed tax treatment.

6.81 The Board’s financial advisers have reviewed the tax treatment in the model and have 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.
6.82 The Consortium is assumed to be a large company for Corporation Tax purposes and has, as a result, applied a Corporation Tax rate of XXXX in the financial model. The Corporation Tax liability has been calculated in accordance with standard practice.

6.83 VAT

6.84 The base unitary charge in the financial model is stated exclusive of VAT.

6.85 Model Review

6.86 The Board’s financial advisers (Grant Thornton) 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 the Co-operative Bank has commissioned a model audit prior to Financial Close. The Consortium will bear the risk of any errors in the model throughout the life of the contract.
7 FINANCIAL APPRAISAL

7.1 Throughout the business case process the Board has been committed to assessing the affordability position of the Project at key milestones by comparing the anticipated annual unitary charge payments for the facility against the level of resources identified.

7.2 In the initial stages of the Project this affordability level was assessed based on the outputs from a shadow bid model. The model was populated with benchmarked costing from projects of a similar size and nature and based on the scope of the Project at that time.

7.3 Latterly, the affordability model has been updated to reflect the actual outputs from the Preferred Bidder’s financial model.

7.4 Funding includes budget available in the Board’s baseline, with additional funding approved by the Board and has been uplifted to the point at which the Unitary Charge becomes payable.

7.5 The affordability position outlined in Table 9 below reflects a projected 28 November 2008 Financial Close.

Table 9: Source and application of funding against annual unitary charge

<table>
<thead>
<tr>
<th>Application:</th>
<th>£m (recurrent full year impact)</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unitary Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency – Design Changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total application of Funds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of Funding:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline budgets identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflation on base budgets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net capital charge and utilities budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHP Additional Funding</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Funding Available</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.6 The above analysis assumes an underlying interest rate swap at XXXX and an RPI swap at XXXX. This represents a change to the assumptions applied at OBC stage (XXXX and XXXX respectively). The key reason for the movement relates to wider trends within the PPP funding market. While this does represent a movement from the OBC assumptions, it is clearly linked to prevailing market trends at the time of drafting this FBC. Indeed live quotes we have received for an interest rate swap for this project have indicated that rates of between XXXX and XXXX may be achievable, inclusive of credit swaps. The rate selected for the bidder to use as a base assumption has therefore been placed at a prudent level of some 25bps – 35 bps above this.

7.7 The bidder’s funder (Co-op) moved margins post-Preferred Bidder announcement in response to deteriorating market conditions. In this context, it is important to ensure that the total cost of funds (which includes underlying swaps) is reflective of the market position and not just the margins. Throughout the procurement process, it has been necessary to estimate likely swap
levels at Financial Close, recognising that there is a degree of imprecision due to the timescales involved.

7.8 As Financial Close is now approaching, it is possible to predict with a great deal more certainty the swap rates that will actually be achievable. The advice from the Board’s Financial Advisers is that interest rate swaps have been subject to a declining trend in recent months, while RPI swaps have risen. The available swap rate effectively reflects the market’s view of the likely trend in these variables.

7.9 In order to align the financial model more closely with the likely position at Financial Close, the bidder was asked to amend swap rates to the levels set out at 7.6 above. Table 9 demonstrates that the resulting Unitary Charge falls within the Board’s affordability envelope.

7.10 Double Running Costs

7.11 At OBC stage, the double running costs and costs of disposing of Rosslynlee and Loanhead were excluded. The associated site disposal costs will be written off against sale receipts from the two hospitals. The double running costs associated with transferring patients from the existing hospitals of Loanhead and Rosslynlee are not considered to be financially material to the business case costs of the preferred new build option. There may, however, be a short commissioning period whilst we pay for the new build and still have patients in the existing sites and a contingency budget of XXXXX will be provided from CHP revenue to cover these costs should they arise.

7.12 Despite the current financial climate, the Board is committed to ensure both hospitals are sold at best value. Based on current advice, the asset sales should occur as previously planned (further details can be found in section 2).

7.13 Summary

7.14 The affordability position has been central to the procurement process. It has been monitored and assessed by the Board and its advisers throughout the whole business case process. Prior to the receipt of the Bid submission, a shadow bid model was used to assess the affordability. Following the Bid submission the Bidder’s financial model was subject to detailed evaluation. In order to meet these unitary charge payments the Board has identified sufficient level of resources to meet the full year unitary charge. In subsequent years the unitary charge payments will increase by inflation. The Board will ensure it remains within the agreed affordability envelope and manage any agreed inflationary increases as part of its financial plan.
8 ECONOMIC APPRAISAL

8.1 Introduction

8.2 An economic appraisal has been carried out in accordance with the relevant Scottish Government Health Directorates guidance, including the latest Scottish Capital Investment Manual.

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

8.4 Qualitative Analysis

8.5 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. The full Qualitative Analysis that was based on Scottish Government guidelines was carried out as part of the KSR process and the benefits remain constant. The main points are summarised below.

8.6 Programme Level Considerations

8.7 This project is one of several 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.

8.8 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.

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

8.10 The requirements of this project are capable of being costed on a whole life, long-term basis.

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

8.12 The proposed project agreement and payment mechanism are based on SGHD 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.

8.13 Project Level Assessment

8.14 The assessment followed the recommendations of the Scottish Government 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.

Viability
8.15 Programme Level Objectives

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

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

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

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

8.20 Operational Flexibility

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

8.22 Equity, Efficiency and Accountability

8.23 There is no reason why the proposed services should not be provided under PPP contract.

8.24 There are no regulatory or legal restrictions that require FM services to be provided directly and the Board has made the decision to provide the Soft FM services on an in-house basis.

8.25 Overall Viability

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

Desirability

8.27 Risk Management

8.28 There are significant risks of cost and time overrun on projects of this nature. The Board considers that the PPP solution maximises the risk transfer to the private sector.

8.29 Innovation

8.30 The requirements and output specifications are performance driven and the Board has encouraged the Bidder to provide innovative solutions to these requirements.

8.31 Service Provision

8.32 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 then Scottish Executive and the STUC.

8.33 The decision process was carried out in accordance with the recommendations of the Scottish Government, Value for Money guidance.
8.34 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 Board throughout the life of the project and represents good value for money.

8.35 The proposal to retain the Soft FM services in-house was approved by the Board in June 2002.

Achievability

8.36 Overall Achievability

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

8.38 Conclusion on Qualitative Analysis

8.39 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 the Board throughout the life of the project and represents good value for money.

8.40 Quantitative Analysis

8.41 The quantitative analysis led by our financial advisers, Grant Thornton, has been carried out using the Scottish Government Health Directorates relevant business case guidance, including the Scottish Capital Investment Manual (SCIM).

8.42 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 options considered at this stage are RCP’s PPP solution and an updated Conventional Procurement Assessment Model (CPAM), discussed in more detail below.

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

8.44 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 project cash-flow (derived from the total project costs of each option) and the NPV of the expected value of the risks. Non-cash costs related to Balance Sheet treatment have specifically been excluded from the VfM assessment as these are not relevant to an economic assessment.

8.45 Both the Consortium’s Bid (PPP option) and the CPAM are measured over the same operational life span, therefore it has not been necessary to supplement the NPV calculation with a calculation of the equivalent annual cost (EAC) to accommodate differences.
9 CONVENTIONAL PROCUREMENT ASSESSMENT MODEL (CPAM)

9.1 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 PPP bid received to ensure that a PPP procurement delivers best value for money over the life of the contract.

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

- Capital Costs;
- Life Cycle Costs;
- Utilities;
- Insurance;
- Hard FM Services (including Building Management).

9.3 Capital Cost

9.4 Prior to the preferred bidder stage (PBS), detailed capital costs were prepared by the Board’s technical advisers (Currie & Brown). These costs were based on detailed schedules of accommodation developed with the users, therefore covered the complete scope of the services requested from the Bidders. The cost / m² used were also benchmarked against similar recent projects in the market at that point in time to ensure it was robust.

9.5 The OBC costs were based on construction costs at Q3 2006 and the PBS at Q3 2009 mid point of the construction phase. The following table sets out the movement in capital cost between OBC and preferred bidder stage (all costs exclude land):

<table>
<thead>
<tr>
<th></th>
<th>At OBC</th>
<th>At PBS</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Footprint</td>
<td>6,714m²</td>
<td>7,001m²</td>
<td>287m²</td>
</tr>
</tbody>
</table>

9.6 It will be noted that the capital cost increase is largely pricing differentials between Q3 2006 and Q3 2009 and increased size of footprint to improve clinical service provision. The increase in the footprint is XXXXX greater than the OBC and is mainly due to increased internal communication space requirements. This enabled the development of a design over two floors that will maximise the operational efficiency of the building. The additional capital cost associated with the footprint change is estimated at XXXXX at Q3 2006 costs. The balance of the cost increase is due to construction cost inflationary pressures that have occurred in the intervening period. The Board has accepted the necessity of the changes and noted that the figures remain within the established affordability limits.

9.7 Life Cycle Costs and Maintenance

9.8 Life Cycle Costs and Hard FM costs were estimated at XXXXX in the OBC based on cost of XXXXX per square metre multiplied by the proposed square metres.
9.9 For illustration purposes, RCP has built in lifecycle costs of XXXXX as part of their unitary charge and a further XXXXX for Hard FM costs.

### Table 11: Lifecycle costs movement

<table>
<thead>
<tr>
<th>Lifecycle costs &amp; Maintenance costs</th>
<th>At OBC</th>
<th>At PBS</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
</tbody>
</table>

9.10 The cost increases associated with increased footprint for the project amounted to XXXXX. The remaining difference can be accounted for as a result of inflationary cost pressures between the period March 05 and the PBS and changes in FM specification. These costs have been benchmarked against similar types of project and are broadly consistent with the costs associated with these projects. The Board has accepted the necessity of the changes and noted that the figures remain within the established affordability limits.

9.11 Utilities

9.12 At OBC stage, the Board’s Estates Department calculated the projected consumption levels and multiplied the proposed footprint by cost per square metre recognised at that point in time.

9.13 Insurance

9.14 The NHS normally self-insures and therefore does not incur annual insurance costs, however, the CPAM includes assumptions about insurance to allow a like for like comparison.

9.15 Under the PPP arrangement, RCP is required to insure the building and services that it provides and accepts the SOPC insurance cost share arrangement.

9.16 NPV Comparison of the Board Options

9.17 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 better value for money.

### Table 12: Net Present Cost comparison between CPAM and PPP option

<table>
<thead>
<tr>
<th></th>
<th>CPAM</th>
<th>PPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted Net Present Cost</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Value for Money Result</td>
<td>XXXXX</td>
<td></td>
</tr>
</tbody>
</table>

9.18 Risk Adjustments

9.19 The net quantified risk of XXXXX retained by the Board was assessed using the standard treasury model for risk assessment. A breakdown of each category risk transfer is shown below:
Table 13: NPC Risk Analysis Summary – Risk Retained by the Board

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>CPAM Expected £m</th>
<th>PPP Retained £m</th>
<th>Risk Transfer £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Construction &amp; Development</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Availability &amp; Performance</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Operating Cost</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Variability of Revenue Risks</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Termination Risks</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Technology &amp; Obsolescence Risks</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Control Risks</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Residual Risks</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td>Other Project Risks</td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>XXXXX</td>
<td>XXXXX</td>
<td>XXXXX</td>
</tr>
</tbody>
</table>

As can be seen from the table above, our risk analysis has considered a range of risks that affect the project. These encompass the full lifecycle of the project, through construction and operations, on to the eventual transfer back to the public sector. The methodology for attaching a value to each of these relies on an assessment of the proportion of risk retained by either the public or private sector in each case. The value of the risk is a function of the Unitary Charge or capital cost of the facility and the risk proportions applied.

An assessment of where each risk lies was carried out as part of the OBC process. It has been reviewed at FBC stage but no adjustment was considered necessary, on the basis that changes to the project that have taken place in the intervening period that would alter where risks sit.

Further details on the management of risk can be found in section 15.

**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 effective tax rate adjustment applied to the financial model is XXX that amounts to XXXXXX.

**Optimism Bias**

Optimism Bias of XXX has been included in the above calculation. Further details on the upper calculation and mitigation can be found in Appendix 8.

**Sensitivity Analysis**

As noted above, the VfM assessment has yielded a result of XXXXX or XXXXX in favour of the PPP solution.
9.29 However, it is important to carry out sensitivity analysis to examine the factors that could erode this VfM assessment in the run-up to Financial Close. It is chiefly the overall cost of funds that could cause the differential between the PPP and CPAM to narrow.

9.30 Given that the Consortium has now confirmed the margins that will apply to its financing solution, the risk is that underlying swap rates at Financial Close are less advantageous than those assumed in this Business Case. The Consortium was therefore required to provide further analysis to assess the impact of any deterioration in the overall cost of funds.

**Table 14: Sensitivity of VfM**

<table>
<thead>
<tr>
<th>Sensitivity</th>
<th>Revised VfM £000</th>
<th>Revised VfM %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Case</td>
<td>XXXXX</td>
<td>5.12</td>
</tr>
<tr>
<td>5% Interest Rate / 3.25% RPI</td>
<td>XXXXX</td>
<td>1.89</td>
</tr>
<tr>
<td>5.25% Interest Rate / 3% RPI</td>
<td>XXXXX</td>
<td>(1.02)</td>
</tr>
</tbody>
</table>

9.31 Summary

9.32 On the basis of the assessment carried out by our financial advisers, the Board is confident that both procurement options for the Project have been robustly appraised. The outcome is that the PPP option demonstrates better value for money in the Business Case scenario.

9.33 Furthermore, sensitivity analysis has demonstrated that a significant deterioration in funding terms would be required to erode the VfM case to the extent that the public sector comparator would demonstrate better VfM.

9.34 Based on market trends in underlying swaps (both interest rates and RPI), the Board's financial advisers do not consider that such a material movement is likely to occur by Financial Close. As a result, the PPP option can be considered to deliver better VfM.
10 ACCOUNTING TREATMENT OF THE PPP SCHEME

10.1 Financial Adviser Assessment

10.2 The Board’s financial adviser Grant Thornton, has provided advice on the accounting treatment to be adopted in the context of reporting under existing UK GAAP. The Board’s External Auditor, Audit Scotland, have reviewed the Grant Thornton advice provided on the accounting treatment to be adopted in the context of reporting under existing UK GAAP and agrees with their conclusion that the facility should not be included in NHS Lothian’s balance sheet. Details are shown appendix 11.

10.3 This advice is set out in full in Appendix 10 to this document and assumes that the Guidance applicable to this scheme is Financial Reporting Standard 5 (“FRS 5”) as required by the current Statement of Recommended Practice (“SORP”) for Local Government, and HM Treasury’s Technical Note No. 1 (Revised) – “How to account for PFI Transactions” (TN1), which itself interprets for the public sector, the Application Note F (AN) to Financial Reporting Standard 5 published by the Accounting Standards Board (ASB).

10.4 A full analysis of the balance of risk under the scheme has been undertaken, using a Monte Carlo statistical simulation. In summary, the view of the financial adviser is that the balance of risk lies with the private sector and hence the scheme would not fall to be accounted for on the Balance Sheet of NHS Lothian. The Unitary Charge payable by NHS Lothian in respect of the Midlothian Community Hospital facility and any services associated with it would therefore be a charge to the Board’s Income and Expenditure account.

10.5 Introduction of IFRS

10.6 The Guidance used in forming any opinion provided at the time of approval will not necessarily govern the accounting treatment to be applied at the time that financial statements are prepared. In this light, attention is particularly drawn to the expected imminent introduction of International Financial Reporting Standards (IFRS) in the form of the IFRS-based Financial Reporting Manual (IFReM). The current version of the IFReM indicates that NHS Boards will be required to adopt IFRS from 1st April 2009. It is therefore expected that the IFReM will be the applicable accounting framework by the time MCH becomes operational.

10.7 The specific relevance of this is that the IFReM will introduce IFRIC 12 in respect Service Concession Arrangements (ie. PPP-type arrangements). Grant Thornton have indicated that under the existing interpretation of IFRIC 12 (as encapsulated in the IFReM), the scheme would fall to be accounted for on the Board’s Balance Sheet.

10.8 In view of the contrasting treatments under the two accounting frameworks, Grant Thornton have recommended including as Appendices to this FBC an accounting opinion under both. The IFRS-based opinion can be found at Appendix 9.

10.9 Assessment of Affordability

10.10 IFRIC 12 is expected to bring many existing and planned schemes onto the public sector Balance Sheet. This will have non-cash implications in terms of capital charges and depreciation. It is important to consider the overall revenue impact of the scheme, both in terms of the Unitary Charge and the non-cash implications of on-Balance Sheet treatment, when evaluating the full
affordability position of the scheme. While the approach to accounting for schemes under IFRIC 12 is still very much under development within the NHS, we have provided an illustration, based on the principles in the IFRS-based FReM, of the potential revenue cost and its affect on the existing affordability envelope.


10.11 As per Grant Thornton’s accounting opinion, reporting under IFRS would require the Board to account for the hospital as a fixed asset, with an equal and opposite finance lease creditor. As a result, the cash Unitary Charge will need to be split, with an element being posted to the Balance Sheet to amortise the finance lease creditor. The rate at which this amortisation occurs depends on the interest rate used (see Accounting Opinion at Appendix 9) for more detail.

10.12 The revenue impact of introducing IFRS has been estimated at XXXXX in year 1 of the operational contract period and the impact for capital resource limit will be XXXXXX. In terms of the financial impact and the affordability position stated within the business case, it has been assumed that any revenue and capital consequences associated with the subsequent implementation of IFRS will be fully supported by Treasury and as such IFRS implementation will be cost neutral to this project.
11 RISK ANALYSIS

11.1 Introduction

11.2 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.

11.3 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.

11.4 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.

11.5 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.

11.6 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 in to the methodology underpinning the risk analysis for the Project.

11.7 Approach

11.8 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.

11.9 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 carried out with pertinent members from the Project Board and the Financial and Technical advisers.

11.10 The approach at the workshop was to:

- Split participants into groups (Clinical, Patients & Staffing, Financial and Project Management) to identify the risks under each section. The groups then discussed 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 groups considered the likely impact and probability of each event on the basis of the available evidence and their experience.

11.11 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.

11.12 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. Full details are given in the Risk Allocation Matrix in Appendix 4.

11.13 Most of the transferred risks and retained risks by the Board are standard for PPP projects.

11.14 The Board has, through the Project Agreement, passed to the Consortium the relevant elements of the Project risks. However, there 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.

### Table 15: NPV of Risks Retained by the Board

<table>
<thead>
<tr>
<th></th>
<th>Public Private Partnership Option</th>
<th>Conventional Procurement Assessment Method Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPV of Risks Retained by the Board</td>
<td>XXXXXXX</td>
<td>XXXXXXX</td>
</tr>
</tbody>
</table>

11.15 The Project Risk Management Strategy explained in section 15 will see the continual development of the Project Risk Register throughout the construction works, commissioning and operational phases so as to remove or mitigate any of the risks that remain with the Board are met and achieved in a timely manner.

### 11.16 Summary

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

11.18 The Board has identified the likely financial impact of the risks it will retain under each option (Public Private Partnership and Convention Procurement Assessment Model) and adjusted the CPAM to reflect the impact of the net risk retained under this option. 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 eg. Demand and specific legislation.

11.19 The Project Teams are in the process of implementing an Organisational Development programme that 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.
12 SUMMARY OF CONTRACT STRUCTURE

12.1 This Section of the Full Business Case details the main provisions of the Project Agreement as at 7th October 2008 and the position reached on the key issues.

12.2 Unless expressly provided otherwise, terms defined in the Project Agreement shall have the same meaning in this section of the FBC.

12.3 Contractual Framework

12.4 The Board is developing a contract (the “Project Agreement”) for the Project based upon the SGHD Standard Form Project Agreement (the “Standard Contract”). The contract structure recognises the interest of all parties to the Project Agreement, including the funders and the sub-contractors providing services to the Board.

12.5 Legal Relationships Between the Parties

12.6 The selected private sector partner (“Preferred Bidder”) is a consortium consisting of Robertson Capital Projects Limited as investor, Robertson Construction Lothians Limited as Construction Contractor, Robertson Facilities Management Limited as FM Contractor and The Co-operative Bank plc as funder. Roberson Health (Midlothian) Limited (“Project Co”) is the special purpose company, established to deliver the Project. The proposed structure is described by diagram as follows:
12.7 Contract Documentation

12.8 As a result of the historic nature of the project, the previous SEHD Standard Form (Version 2.1) (March 2005) has been adopted by the Board. Given the timescale involved, the Project Agreement has nevertheless been developed with the Bidder to reflect current guidance to a large extent. Some provisions are also tailored to the particular requirements of the Project in line with applicable SGHD and other Scottish Government guidance.

12.9 The duration of the Project Agreement will be 30 years. It is intended that the construction of the Facilities will be completed in approximately 18 months.

12.10 Extensions of time and delay and compensation arrangements for construction are provided in line with the Standard Contract.

12.11 Design and Construction

12.12 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.

12.13 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 for 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.

12.14 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, where relevant, be dealt with under the Reviewable Design Data and the procedures as set out within Part 10 of the Schedule to the Project Agreement, the Review Procedure.

12.15 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. This reflects the Standard Contract position.

12.16 Services

12.17 Project Co. shall provide the Hard Facilities Management Services (“Hard FM Services”) pursuant to the contract with Robertson Facilities Management Limited 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 window cleaning services, estates services, utilities management services, gardens and grounds maintenance services, pest control services and the provision of a helpdesk (“the Services”).

12.18 The Service Level Specifications detail the standard of services required together with the performance indicators. Deductions will be made from the Service Payment in accordance with the Payment Mechanism for poor performance or non-performance of the services.
12.19 Project Co. will provide the Services in accordance with the Method Statements and Quality Plans 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.

12.20 Maintenance

12.21 Project Co. is responsible for maintaining the Facilities, however, the Board may comment on and require the amendment of Project Co.’s Schedule of Programme 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.

12.22 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.

12.23 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.

12.24 Equipment

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

12.26 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.

12.27 Monitoring and Performance Measurement

12.28 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.

12.29 Direct Agreements and Design Warranties

12.30 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 sub-contracts in the event of termination of the Project Agreement.

12.31 Insurance

12.32 Project Co. is required to carry the following Insurances:

12.33 During Construction:
  • Construction All risks Insurance
  • Delay in Start-Up Insurance
• Construction third Party Liability Insurance

12.34 During the Operational Period:
• Property Damage Insurance
• Business Interruption Insurance
• Third Party Public and Products Liability Insurance

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

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

12.37 The Board is seeking approval from SGHD for any derogations from the Standard Contract. Full details will be included in the FBC Addendum on the final position reached post Financial Close.

12.38 Payment Mechanism

12.39 The Board has adopted the Standard Contract form of Payment Mechanism with project specific amendments to reflect the relative size of the Project and range of Services. There are still some outstanding areas for discussion between the parties. Any derogations from the Standard Contract have been submitted to SGHD for approval.

12.40 Planning

12.41 Detailed planning permission has been obtained for the Site. The parties are however in discussion regarding purification or otherwise of planning conditions relating to the provision of two bus lay by's on the A7.

12.42 Indexation

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

12.44 Invoicing and Payment Terms

12.45 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 fifth Business Day of the beginning of the Contract Month following the issue of the relevant Service Payment Statement. Where any payment is in dispute the party disputing the payment shall pay any sums which are not in dispute.

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

12.47 Delay Events, Relief Events and Force Majeure

12.48 A minor drafting change has been made to the Standard Contract provisions relating to Force Majeure to reflect the market position. The derogation has been submitted to SGHD for approval.
12.49 Compensation payable upon termination for Force Majeure is calculated in accordance with Standard Form.

**12.50 Corrupt Gifts and Fraud**

12.51 Corrupt Gifts and Fraud are dealt with in accordance with Standard Contract.

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

**12.53 Termination and Step-In**

12.54 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.

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

12.56 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.

12.57 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 set period; or
- Failure to pay any sum over £50,000 following 60 days of demand.

12.58 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 any set 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.

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

12.60 Voluntary Termination by the Board

12.61 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 6 months’ notice. On such termination the Board pays compensation on the same basis as if a Board Default had occurred.

12.62 This break option provides the Board with the contractual flexibility to terminate the Project Agreement at any point throughout its duration.

12.63 Reversion of the Facilities to the Board upon Expiry

12.64 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).

12.65 Hand-back Requirements

12.66 Not less than 2 years 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.

12.67 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.

12.68 Human Resources / TUPE

12.69 It is anticipated that due to the nature of the Services, no staff will transfer and therefore the alternative Standard Contract provisions in relation to employee transfer has been used. Some minor derogation from the Standard Contract have been submitted to SGHD for approval.

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

12.71 Land Matters

12.72 The Board will procure the grant of a licence from the Scottish Ministers to Project Co. in line with the Standard Contract position.
13 PROJECT MANAGEMENT ARRANGEMENTS

13.1 Introduction

13.2 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.

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

13.4 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 RCP will be managed through the Operational Phase; and
- Liaison with the external stakeholders.

13.5 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.

13.6 Process to Financial Close

13.7 A joint Board / RCP 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 regularly at these meetings.

13.8 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.

13.9 All project costs and interest rate movements will be closely monitored between now and Financial Close. Any variations will be reported to SGHD in an addendum to the FBC post-Financial Close.

13.10 Project Implementation Structure

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

13.12 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.
13.13 There is an ongoing requirement to maintain governance structures for the project post Full Business Case.

13.14 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.

13.15 The CHP General Manager, Finance Manager, Estates, Facilities and Human Resources (HR) are all represented on the Project Board 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.

13.16 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.

13.17 The Steering Group will consist of the following:

- The Administrator of the Project Agreement (PA)
- Clinical Representatives
- Estates Representative
- Soft FM (Support Services) Representatives
- Financial Representatives
- Admin. / HR Representatives
- Technical Advisers

13.18 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

13.19 During the construction phase the Steering Group will report directly to the Project Board and these groups will interact with the SPV through the Administrator of the PA. During the operational period only the remaining Steering Group will support the Administrator of the PA.

13.20 During the construction works, Robertson Construction, as the contractor, will report to the SPV and during the operational phase, Robertson Facilities Management, as the Facilities Manager, will report to the SPV.
13.21 During the 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.

13.22 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.

13.23 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 the Board.

13.24 The Project Board

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

- Receive reports of the Project against programme and budget;
- 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 the Board or SGHD;
- Consideration of PR and Communications Strategy;
- Consider and approve the project resources;
- With the Project Teams, manage and mitigate the risks identified in the Risk Register; and
- Report to the Board and to the wider interests within the Board.

13.26 The Project Teams

13.27 It is anticipated that the Project Teams will continue to play a leading role in the management of the Project. Membership of the Project Teams will include:

- Clinical Representation;
- Project Capital Accountant;
- Estates Manager;
- Soft FM Representation; and
- Project Commissioning & Equipment Officer.
13.28 Most of the Project Teams and the following additional individuals will 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.

- The Administrator of the PA;
- Project Director;
- Staff Representative.

13.29 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.

13.30 Project Manager

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

13.32 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 voluntary organisations, to ensure that their work plans are continually congruent with the overall project plan;
- Liaise with Robertson Facilities Management 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.

13.33 External Advisers

13.34 The Project Teams 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>Grant Thornton</td>
</tr>
<tr>
<td>Legal Adviser</td>
<td>McClure Naismith</td>
</tr>
<tr>
<td>Technical Adviser</td>
<td>Currie &amp; Brown</td>
</tr>
</tbody>
</table>
13.35 The project team is currently reviewing all the advisory appointments to ensure appropriate and continued adviser support is made available throughout the construction period and into the early operation stage.

13.36 Interface with the PPP Consortium

13.37 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 into the operational phase and throughout the lifetime of the contract.

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

13.39 The main interface will therefore be via the Project Steering Group and through day-to-day contact between the respective Project Director, Project Manager, Administrator of the PA and the wider project groups.

13.40 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.

13.41 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.

13.42 Implementation Processes

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

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

13.45 The Board currently has no other PPP schemes in development. However, the Board has 3 other PPP projects in operation, including the new Royal Infirmary. The Board also has a large group of other Capital funded projects. All these projects are controlled by full time staff members of the Facilities Directorate. While the projects all vary in scale and content, there is
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 the Board-wide policies will be developed for the direction and administration of the projects.

13.46 Construction Phase Project Management

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

13.48 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 CHP Manager, Project Board, 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.

13.49 Management and liaison during the Construction Phase will be lead by the Project Manager assisted by the Board’s Estates Manager and external Technical Advisers. The following table outlines the tasks and works during the construction phase of the works:

Table 16: Key Construction Phase Activities

<table>
<thead>
<tr>
<th>Key Construction Phase Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring / Supporting Construction Process</td>
</tr>
<tr>
<td>Compliance with Board’s Construction Requirements</td>
</tr>
<tr>
<td>Contractor’s Proposals</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
</tr>
<tr>
<td>Quality Assurance</td>
</tr>
<tr>
<td>Design – Drawings</td>
</tr>
<tr>
<td>Design Specification</td>
</tr>
<tr>
<td>Variations – Contractor’s</td>
</tr>
<tr>
<td>Variations – Board’s</td>
</tr>
<tr>
<td>Project Progress Meetings</td>
</tr>
<tr>
<td>Independent Tester Liaison</td>
</tr>
<tr>
<td>RDD Process</td>
</tr>
<tr>
<td>Commissioning – Technical</td>
</tr>
<tr>
<td>Prepare Handover Documents</td>
</tr>
<tr>
<td>Prepare O&amp;M Manuals</td>
</tr>
<tr>
<td>Defects Rectified</td>
</tr>
<tr>
<td>Facilities Team Trained</td>
</tr>
<tr>
<td>Equipment Labelled</td>
</tr>
<tr>
<td>Programme Established</td>
</tr>
<tr>
<td>Inspection &amp; Testing Certificates</td>
</tr>
</tbody>
</table>
### Building Users Operational Manual

<table>
<thead>
<tr>
<th>Building Handover</th>
<th>Defects Liability / Latent Defects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Snagging List</td>
</tr>
<tr>
<td></td>
<td>Contract Documents</td>
</tr>
<tr>
<td></td>
<td>As Built Drawings</td>
</tr>
<tr>
<td></td>
<td>O&amp;M Manuals</td>
</tr>
<tr>
<td></td>
<td>Health &amp; Safety File</td>
</tr>
<tr>
<td></td>
<td>Commissioning – Records / Certificates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Group 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 2</td>
</tr>
<tr>
<td></td>
<td>Asset Register / Database</td>
</tr>
<tr>
<td></td>
<td>Training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transition</th>
<th>Change Management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Security Process / Procedure</td>
</tr>
<tr>
<td></td>
<td>Fire Strategy</td>
</tr>
<tr>
<td></td>
<td>Building User Guide</td>
</tr>
<tr>
<td></td>
<td>Health &amp; Safety</td>
</tr>
<tr>
<td></td>
<td>Transition Logistics</td>
</tr>
<tr>
<td></td>
<td>Liaison with Police / Fire</td>
</tr>
<tr>
<td></td>
<td>Liaison with FM Co.</td>
</tr>
<tr>
<td></td>
<td>Liaison with SPV</td>
</tr>
</tbody>
</table>

#### 13.50 Commissioning Phase Project Management

13.51 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.

13.52 The Operational Commissioning will require the careful co-ordination of the equipment installation, staff 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 the Project Co.

13.53 The Project Manager, supported by the wider Project Team and external technical advisers shall work together with Project Co. so as to ensure the smooth transition from building construction to hand over and operation.

13.54 At the same time they will assist in the development of a Building Users Operational Manual which shall ensure the transfer of operational management to those who will ultimately be responsible for the operation of the facility.

#### 13.55 Construction to Full Service Commencement

13.56 Clause 12 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.

13.57 During the construction period the Board lead for the interface with the contractor on construction issues will be the Project Manager, supported by the Director of Capital Planning & Premises Development, together with the external technical advisers.

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

13.59 Operational Phase

13.60 At Full Service 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>

13.61 The Project Agreement provides for the Liaison Committee to exist throughout the Project and the Committee will consist of three Board representatives (Administrator of the PA, Soft FM representative and Staff Representative) and three Project Co. representatives. One of the Board representatives will be Chairman of the Liaison Committee. During the beginning of the operational phase, the role of the Administrator of the PA will transfer from the Capital Project Manager to a manager in the Facilities Directorate.

13.62 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.

13.63 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.

13.64 The Liaison Committee makes recommendations to the Steering Group but does not itself have authority to vary the contract or make any decision that is binding on the parties.
13.65 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.

13.66 The Administrator of the PA 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.

13.67 The Administrator of the PA 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.

13.68 Service Contract Monitoring

13.69 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 a reference number generated and given to the requesting department.

13.70 It is anticipated that the monthly Key Performance Indicators monitoring report drawn from the Helpdesk will be shared with Heads of Department.

13.71 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.

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

13.73 Wider stakeholders in the service eg. patients and visitors will have access to the Board’s Suggestions 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.

13.74 Management and Monitoring

13.75 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 12.
14 BENEFITS ASSESSMENT

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

14.2 Description of Benefits

14.3 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.

14.4 The PPP process has allowed for an involvement of clinical staff, management, patients and carers and members of the public 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.

14.5 PPP procurement will provide construction cost certainty, a quicker construction programme and as such an earlier services commencement date.

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

14.7 Strategic Benefits

14.8 The plans for reprovision of hospital services in Midlothian are informed by national policies and the Board’s strategies. Additional information on the Board’s strategies is available on the Board’s website, www.nhslothian.scot.nhs.uk.

14.9 The investment proposal for a new community hospital was a strategic commitment by the Board to modernise and improve local health service provision to its catchment population. This project is part of the Board’s Improving Care Investing in Change Strategic Programme, which was approved by the Scottish Executive Health Department in January 2006.

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

14.11 The project is one of the key projects within the Midlothian Community Health Partnership and will incorporate localised outpatient and diagnostic services.

14.12 The investment proposed in this FBC will make a significant contribution to the Board’s strategic direction by sustaining and building upon the developments in primary and community care, in particular, it will deliver:

- a local NHS which listens to patients, service users and the people of Midlothian;
• real health improvement, including tackling health inequalities and building a local NHS designed and organised around the needs of the population;

• alliances between community planning partners to deliver joined up services offering integrated care wherever it is needed;

• 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.

14.13 Benefits Table

Table 17: Benefits Table

<table>
<thead>
<tr>
<th>Benefits Criteria</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>Maximise number of services available locally thus minimising travel distances patients, staff and visitors; Enables patients to easily access services by foot, by cycle or by public transport with easy drop-off and pick-up zones; Adequate car parking provision; Appropriate number of lifts and corridors wide enough for non-ambulant users and equipment.</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Provides good departmental relationships between services allowing integrated and efficient working practises; Allows for co-location of services; Facilitates new ways of working, including one-stop clinics, nurse-led practise; Well equipped, appropriate services to provide quality of care; Relevant specialties available to patients.</td>
</tr>
<tr>
<td>Quality of Physical Environment</td>
<td>Ensure that services are provided in an environment that is conducive to healthcare delivery and promotes a sense of well being and confidence in patients, staff and visitors; Maximises health and safety of patients, staff and visitors; Promotes good staff morale and improved retention and recruitment; Flexibility for future change;</td>
</tr>
</tbody>
</table>
Recognises that healthcare delivery may change significantly in the future and therefore health buildings/sites need to accommodate such a change with the minimum of expenditure and disruption;
Minimises constraints on both developing existing and new services. Enables specialties to cope with potential increases in workload whilst optimising use of the site, buildings and land;
Contributes to green issues such as efficient energy usage, recycling possibilities and positive impact on surroundings;
Design issues address requirements of Disability Discrimination Act.

<table>
<thead>
<tr>
<th>Acceptability to Patients, Staff, Partners and Public</th>
<th>Meet patients’, staff and partners’ expectations in terms of effectiveness, quality and accessibility of services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliverability</td>
<td>Certainty in securing a site; Planning Consent.</td>
</tr>
<tr>
<td>Disruption to Service</td>
<td>Minimising disruption or need for phasing decanting during construction; Minimises health and safety issues during construction; Shortest timescale to completion.</td>
</tr>
</tbody>
</table>

14.14 Benefits Realisation Plan

14.15 The objectives and benefits of the project are set out in sections 5, 7 and 9 of the OBC.

14.16 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.

14.17 The Benefits Realisation Plan is included as Appendix 13 of this FBC.

14.18 Overall responsibility for ensuring that the benefits of the project are achieved lies with the Board, through the Project Board or its successor.

14.19 Where relevant, the performance measures identified within the Benefits Realisation Plan will be reviewed as part of the Project Evaluation Plan.

14.20 Project Evaluation Plan
14.21 The purpose of undertaking a 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 Project Evaluation Plan.

14.22 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.

14.23 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 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 learned from the process.

- **Stage 4 – Follow-up Project Evaluation**
  
  This will be undertaken 2 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.

14.24 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

15.2 A Project Risk Register was developed with the support of all members of the project teams.

15.3 This register identified, assessed level of risk and assigned ownership to all the possible project risks that could be assigned or shared by the Board. These were then reviewed through a series of workshops to mitigate and / or where possible, eliminate the risk.

15.4 Key Risk Categories

15.5 The Board’s Risk Management Strategy will be to regularly review the risk register to continue to minimise the level of risk and ultimately control the risk through agreed management strategies. These would include co-operating with the SPV to minimise those shared risks. This process will be completed through a monitoring structure incorporating in-house managers and external financial legal and technical advisers.

15.6 Active Risks

15.7 The present project active risks are all mitigated to low consequence and they are listed in Appendix 14.

15.8 The risks have been analysed and reviewed, in line with the Board’s Corporate Risk Register, as set out below:

- **Patient Experience**: identified risks relating to quality of patient experience and clinical outcome;

- **Objectives / Project Risks**: identified risks relating to the delivery of project objectives in the organisation / overall organisational objectives;

- **Injury**: identified risks relating to the potential for physical and / or psychological injury to patients, visitors or staff;

- **Complaints / Claims**: identified risks relating to complaints from patients, visitors or staff and potential negligence claims;

- **Service / Business Interruption**: identified risks relating to the continuous effective delivery of our services and functions;

- **Staffing and Competence Risk**: identified risks relating to the impact on the organisation relating to the levels, capacity and capabilities of employees;

- **Financial (including damage / loss / fraud)**: identified risks relating to financial governance, changes in accounting treatment and the Division’s contribution to the achievement of the Board’s Financial Plan;
• **Inspection / Audit**: identified risks relating to issues that may arise from the regulatory environment / governance arrangements;

• **Adverse Publicity / Reputation**: identified risks relating to issues that may arise from poor publicity for the organisation.
16 eHEALTH STRATEGY

16.1 Introduction

16.2 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.

16.3 The Board has recognised this and has included IT involvement throughout the project process.

16.4 eHealth Strategy

16.5 The Board’s eHealth Strategy closely mirrors the NHS Scotland eHealth Strategy which deals with a number of eHealth initiatives to provide patient centred services for applications such as:

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

16.6 A key concept for this health facility is to bring together a number of separate functions, including Radiodiagnostic, Care of Elderly, Women & Children, Assessment & Rehabilitation, 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.

16.7 eHealth Infrastructure

16.8 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 supporting node rooms and central computer room. 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 the Board has a high speed reliable and robust network.

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

16.10 The Board has deliberately retained ownership and responsibility for the active data network, telephone system, servers, PCs and applications, 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

17.2 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.

17.3 Group 1 Equipment

17.4 Project Co. shall be responsible for the supply, installation, maintenance and replacement of all Group 1 equipment listed within the Project Agreement, Schedule Part 13.

17.5 Group 2 Equipment

17.6 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 and replacement of the Group 2 equipment.

17.7 Group 3 and 4 Equipment

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

17.9 Funding of Equipment

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

17.11 The Board will fund the Group 2, 3 and 4 equipment through new provision and also 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 XXXX budget, exclusive of VAT is based on an estimated transfer target, equipment allowances and current prices available.
18 INVOLVING PATIENTS AND THE PUBLIC

18.1 Introduction

18.2 The Public engagement and involvement process for the project has followed the SEHD guidelines that were in existence at the time that each exercise was carried out.

18.3 The aims were to ensure that patients and the public are encouraged to become involved and informed at the beginning and throughout the process to develop health services or change how they are delivered.

18.4 Public Consultation

18.5 The Community Health Partnership undertook a process of internal and external consultation. The process included wide circulation of the proposals to all key stakeholders and also included a series of meetings and presentations. Following this consultation, the proposed reprovision was supported and subsequently an OBC was submitted the then SEHD for approval.

18.6 The Board is committed to involving the public in the shaping of health services. This will enable the provision of services that are patient-focussed and meet the needs of the population. Midlothian CHP has been committed to involving the people of Midlothian from the outset of this project: the approach that has been taken is based on the model of:

- Informing;
- Engaging and then finally;
- Consultation.

18.7 The involvement / consultation methods adopted included:

- Focus groups;
- Staff workshops;
- Face-to-face presentations;
- Questionnaires;
- Public meetings.

18.8 The debate and consultation was not only about a new hospital, but included options for the future development of community services.

18.9 Outcomes from the Consultation Process

18.10 From a public perspective, it is clear that there is a broad recognition of the need for significant change to the way in which services are delivered in Midlothian CHP.

18.11 Use of Midlothian Community Hospital facilities

18.12 The consultation exercise revealed clear support for a new community hospital to be built on the Greenfield site (Mayshade) adjacent to the A7. This proposal is supported by:

- Midlothian Council;
18.13 There is also general support for the criteria proposed by the Board for deciding on location:

- Accessibility;
- Clinical Effectiveness;
- Quality of Physical Environment;
- Acceptability to patients, staff, partners and public;
- Deliverability;
- Disruption to services.

18.14 Development of Community Based Services

18.15 Whilst the precise scope and extent of community based services was left open to debate and discussion during the consultation, it is clear that local access to as wide a range of services as is clinically safe and practical to provide is supported by the majority of stakeholders and the public generally.

18.16 A Patient Involvement Report (July 2008) was produced by the Community Health Partnership which details findings of the community surveys, meetings and community groups about the new Midlothian Community Hospital.
19 HUMAN RESOURCES

19.1 The Board employs around 29,000 staff providing a wide range of professional, technical, administrative and facilities services.

19.2 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 Teams. Staff members have and continue to be involved in the development of the detailed operation of services and facilities.

19.3 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 and the European Working Time Directive.

19.4 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 and locally agreed Organisational Change Policies which protects relevant terms and conditions of employment and aims to safeguard employment.

19.5 Workforce Planning

19.6 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 Board’s Workforce Modernisation and Development Strategic Plan and Action Plan has been developed within the National Workforce Planning Framework (2005 which put in place a mechanism for National, Regional and Board-level consideration of workforce issues).

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

19.8 All staff and services will transfer to the new facility. Some in-patient services are to be reprovided from Edenhall Hospital and the Lothian Unscheduled Care Service will also transfer from the old Bonnyrigg Health Centre.

19.9 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.

19.10 New Service Models and Change Management

19.11 Some of the services will need to undergo changes in the way they are delivered. These will have an effect on the skill mix of staff employed, the numbers of staff and flexible patterns of working.
19.12 A detailed organisational development and change management action plan for the services is currently being developed. This will enable the workforce to be supported through the period of organisational change and the introduction of new ways of working.

19.13 Staff Transfers

19.14 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.

19.15 The Hard FM services associated with building and estates maintenance will be provided by Robertson Facilities Management (RFM). No member of the Board’s Hard FM staff will be required to transfer to the new facilities or a new employer.

19.16 There are, therefore, no consequences for the Board under the SE / STUC Protocol or the application of the TUPE Regulations.

19.17 Integrated Management Approach

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

19.19 RCP 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.

19.20 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 RCP structure required in order to manage the contract as well as the responsibilities regarding the application of Board policies.

19.21 RFM 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.
20 CONCLUSION

20.1 The Case for Investment

20.2 Since the approval of the OBC in October 2006, 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.

20.3 Value or Money and Affordability calculations have been undertaken with full capital revenue income and savings calculation.

20.4 The Preferred Option

20.5 This is a strong and reasoned business case for the project as now presented. The project will provide a new Community Hospital replacing the existing Rosslynlee and Loanhead hospitals and offering an increased range of services that 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.

20.6 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 30 year period. The contract arrangements will be as set out in the Standard Form of Contract for PPP Scheme adjusted for project specific issues. Derogations from the Standard Form have been agreed by SGHD.

20.7 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 patient expectations and the priorities as set by the Scottish Government.

20.8 Significant risk will transfer from the Board to the Consortium and the asset will not be accounted for on the Board’s balance sheet.

20.9 Project Management

20.10 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 Summer 2010 and forward in the operational stage.
LOTHIAN NHS BOARD

Minutes of the Special Meeting of Lothian NHS Board held at 4.15pm on Wednesday, 23 April 2008 in the White Meldon Room, Barony Castle, Eddleston, by Peebles.

Present: Dr C J Winstanley (Chair); Mr R Y Anderson; Professor J J Barbour; Mr D Belfall; Mr A Boyter; Cllr J Cochrane; Mrs T Douglas; Cllr P Edie; Mr E Egan (Vice-Chair); Mr J T McCaffery; Dr A K McCallum; Dr I McKay; Mr J Matheson; Mrs P Murray; Professor M Prowse; Mr S G Renwick; Mrs J K Sansbury; Professor Sir J Savill; Dr C P Swainson; Dr A Tierney; Professor H Tierney-Moore; Mr G Walker and Cllr I Whyte.

In Attendance: Mr G Power (For Item1); Ms J A Stirton and Mr D Weir.

Apologies for absence were received from Cllr J Aitchison; Ms M Ali, Mr R Burley, Ms L Jamie, Cllr R Knox and Professor Sir John Savill.

Declaration of Financial and Non-Financial Interest

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. There were no declarations of interest.

1. Midlothian Community Hospital

1.1 The Chairman welcomed Mr Power, General Manager, East and Midlothian Community Health Partnership to the meeting, advising he was in attendance to provide any detailed contributions required by the Board in respect of the Midlothian Community Hospital proposal.

1.2 The Board agreed to support the recommendation to approve a preferred bidder for the provision of Midlothian Community Hospital project and that the expected accounting treatment would result in this being an off balance sheet Private Public Partnership (PPP) under current Scottish Government Health Department guidance.

1.3 The Chief Executive commented it was important the Board recognised the huge amount of work that both the Vice-Chair and Mr Power had inherited in respect of the Midlothian Community Hospital. The Board recorded its appreciation for the efforts undertaken by both colleagues to truncate the timescale for the provision of the Midlothian Community Hospital.

Mr Power left the meeting.
Dear Iain

MIDLOTHIAN COMMUNITY HOSPITAL: PRE ITN KEY STAGE REVIEW

Further to receiving the final set of responses from Andrew MacDonald I am pleased to confirm that I am now content to sign off the Pre ITN Key Stage Review.

As the project progresses I will be seeking evidence at the next KSR (Pre Preferred Bidder) that the actions detailed in Andrew MacDonald’s letter of 7th June 2007 have been taken forward and issues addressed. In particular Board sign off of vfm/affordability will be expected and I would suggest that the Internal Risk Register be further developed. On the latter issue I would suggest that the model adopted in NHS Fife would be a good starting point.

I appreciate the time and commitment that your Project Team have given to the KSR process and sincerely hope that the process has been to our mutual benefit. I welcome the constructive and helpful approach in resolving outstanding clarifications/issues.

I would welcome further feedback from you in terms of documentation and the evidence based required, the method of engagement with Partnership UK and the Department, together with any thoughts on room for improvement.

I look forward to hearing from you in due course on this issue and I trust that the response gives you sufficient comfort on which to proceed.

Yours sincerely

Michael Baxter
Head of Private Finance & Capital Unit
Andrew MacDonald  
Senior Project Manager  
NHS Lothian  
Planning Team  
Midmar, Mackinnon House  
Royal Edinburgh Hospital  
Morningside Terrace  
Edinburgh  
EH10 5HF

Issued via e-mail

Your ref:  
Our ref: F1489135  
15 May 2008

Dear Andrew

Midlothian Community Hospital – Pre Preferred Bidder KSR Formal Sign Off

Further to the work undertaken with regard to the above review and the detailed report I have received from Partnerships UK I am delighted to formally acknowledge the sign off of the Pre Preferred Bidder Key Stage Review.

I would wish to thank you and your team for your considerable input to the process and I wish you every success in delivering this important project.

Yours Sincerely

Michael Baxter
Mike Baxter
Head of Private Finance and Capital Unit
Scottish Government Health Directorates
## Appendix 5

### INTERIM BID PANEL MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerry Power</td>
<td>CHP General Manager</td>
</tr>
<tr>
<td>Iain Graham</td>
<td>Head of Capital Planning &amp; Premises Development</td>
</tr>
<tr>
<td>Andrew MacDonald</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Louise Birrell</td>
<td>Project Co-ordinator</td>
</tr>
<tr>
<td>Robert Clement</td>
<td>Clinical Nurse Manager</td>
</tr>
<tr>
<td>David Wright</td>
<td>Finance Manager - Projects &amp; Planning</td>
</tr>
<tr>
<td>Libby Tait</td>
<td>Head of Modernisation</td>
</tr>
<tr>
<td>Sylvia Mack</td>
<td>Employee Relations Manager</td>
</tr>
<tr>
<td>Tracy Waite</td>
<td>Staff Side Representation</td>
</tr>
<tr>
<td>Miriam Anderson</td>
<td>Business Operations Manager</td>
</tr>
<tr>
<td>Iain Robertson</td>
<td>Head of e-Health Operations &amp; Infrastructure</td>
</tr>
<tr>
<td>Kenneth Ngai</td>
<td>Finance Manager</td>
</tr>
<tr>
<td>Dougie Coull</td>
<td>Equipment &amp; Clinical Commissioning Manager</td>
</tr>
<tr>
<td>Tom Davidson</td>
<td>Estates Manager</td>
</tr>
<tr>
<td>Marjory Chirnside</td>
<td>Head of Catering Services</td>
</tr>
<tr>
<td>Brian Robb</td>
<td>Catering &amp; Logistics Manager</td>
</tr>
<tr>
<td>Keith Mackenzie</td>
<td>Domestic Services Manager</td>
</tr>
<tr>
<td>George Curley</td>
<td>Head of Estates Services</td>
</tr>
<tr>
<td>Howard Royston</td>
<td>Head of Patient Environment &amp; Monitoring</td>
</tr>
<tr>
<td>Currie &amp; Brown</td>
<td>Technical Advisers</td>
</tr>
<tr>
<td>Grant Thornton</td>
<td>Financial Advisers</td>
</tr>
<tr>
<td>McClure Naismith</td>
<td>Legal Advisers</td>
</tr>
</tbody>
</table>

### AEDET PARTICIPANTS

<table>
<thead>
<tr>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Gerry Power</td>
<td>CHP General Manager</td>
</tr>
<tr>
<td>Robert Clement</td>
<td>Clinical Nurse Manager</td>
</tr>
<tr>
<td>David Grant</td>
<td>Consultant Geriatrician</td>
</tr>
<tr>
<td>Helen Ogilvie</td>
<td>Charge Nurse</td>
</tr>
<tr>
<td>Linda Ferrier</td>
<td>Charge Nurse</td>
</tr>
<tr>
<td>Susan Prior</td>
<td>Acting Head of Occupational therapy</td>
</tr>
<tr>
<td>Keith Mackenzie</td>
<td>Domestic Services Manager</td>
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<td>Head of Patient Environment &amp; Monitoring</td>
</tr>
<tr>
<td>Various Members</td>
<td>Public Partnership Forum</td>
</tr>
</tbody>
</table>
Drawing No. Scale Revision
SOFT LANDSCAPING
FITNCH05 1:500

Bellfield View
Courtyard 3 Courtyard 1 Courtyard 2 Courtyard 4 Courtyard 5 Courtyard 6 Courtyard 7
Main Entrance
Day Hospital Entrance
Roof Terrace 1 Roof Terrace 2
Fire Tender Turning Head
Bus Turning Circle Bus Stop
Access Road with Cycle Lane each side
Pedestrian footpath
Stormwater Attenuation Basin (See civil engineers drawings)
Service Yard
Mortuary Pick Up Drop Off Zone Drop Off Zone
Car Park (100no. bays) Screening Unit Layby
Disabled Parking Ambulant Disabled Parking Disabled Parking Ambulant Disabled Parking
Cycle Parking
Link to cycle network
Pedestrian access ramps and steps
Native Boundary Screen Planting

Reinforced grass paving to civil engineers specification Edged with BN kerb
Mown grass Seeded with low maintenance amenity grass mix
Rough grass Seeded with rough grass mix
Shrub planting Min 450mm topsoil, 3L pot size at 5 plants per msq
Native screen planting Min 450mm topsoil, 40-60mm transplants at 1 per msq
Proposed tree planting 18-20cm rootballed, short double staked
Proposed tree planting 8-10cm bare root inc. wire mesh tree guard
Proposed beech hedging Double staggered row 80-100 transplants @ 450mm centres
Aluminium standing seam roof
Interlocking concrete tiled roof
Aluminium rainwater gutters & downpipes
Masonry base course
White acrylic resin
Aluminium windows & doors
Polyester powder coated curtain walling
Polyester powder coated louvres
Profiled Metal Cladding

All materials and colours are subject to further discussion with local planning department.
ELEVATIONS

NORTH EAST ELEVATION (FRONT)

SOUTH WEST ELEVATION (REAR)

SOUTH EAST ELEVATION

NORTH WEST ELEVATION

MATERIALS

1. Aluminium standing seam roof
2. Interlocking concrete tiled roof
3. Aluminium rainwater gutters & downpipes
4. Masonry base course
5. White acrylic rain render
6. Coloured acrylic render
7. Polyester powder coated aluminium windows & doors
8. Polyresin powder coated concrete wailing
9. Polyester powder coated fascia
10. Profiled Metal Cladding

All materials and colours are subject to further discussion with local planning department.
### MIDLOTHIAN COMMUNITY HOSPITAL

#### MANAGEMENT AND MONITORING - THE BOARD’S OBLIGATIONS

**GENERAL**

<table>
<thead>
<tr>
<th>LEAD RESPONSIBILITY</th>
<th>OBLIGATIONS UNDER THE PROJECT AGREEMENT</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>McClure Naismith on behalf of and at the direction of the Capital Project Manager (Andrew MacDonald).</td>
<td>Deliver to Project Co the <em>Completion Documents</em> (Clause 2.1.2)</td>
<td>On or prior to the execution of the Project Agreement.</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Designate or appoint an insurance and risk manager and notify the details to Project Co (Clause 36.16)</td>
<td>With effect from the date of the Project Agreement.</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Procure the grant of the Licence from the Scottish Ministers to Project Co/Project Co Parties to exercise the Ancillary rights (if any) and enter upon the site (Clause 14.1)</td>
<td>From the date of issue of the Certificate of Commencement until the Actual Completion Date or (if earlier) the Termination Date.</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Procure the grant of the Licence to Project Co/Project Co Parties of the right to enter upon and to remain upon the Site for the carrying out of the Project Operations, the remedying of Defects and the carrying out of Snagging Matters (Clause 14.2)</td>
<td>After the occurrence of the Actual Completion Date until the Expiry Date or (if earlier) the Termination Date.</td>
</tr>
</tbody>
</table>
**CONSTRUCTION AND OPERATIONAL TERMS**

<table>
<thead>
<tr>
<th>LEAD RESPONSIBILITY</th>
<th>OBLIGATIONS UNDER THE PROJECT AGREEMENT</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Capital Project Manager during the Construction Phase and a dedicated member of the Facilities Directorate during the Operational Phase.</td>
<td>Inform Project Co if it becomes unable to meet any of its financial obligations and keep Project Co informed of any course of action to remedy the situation (Clause 5.3.3)</td>
<td>As soon as reasonably practicable</td>
</tr>
<tr>
<td>The Capital Project Manager during the Construction Phase and a dedicated member of the Facilities Directorate during the Operational Phase.</td>
<td>To the extent permitted by Law, supply to Project Co a copy of the Boards Annual Report and Accounts (Clause 5.3.4)</td>
<td>Within 60 days of the publication of the Board’s Annual Report and Accounts</td>
</tr>
<tr>
<td>The Capital Project Manager during the Construction Phase and a dedicated member of the Facilities Directorate during the Operational Phase.</td>
<td>Liaise with Project Co with a view to ensuring that the requirements of Patient Rights and Responsibilities and any other NHS Requirement are met in respect of the operation of the Facilities (Clause 5.5)</td>
<td></td>
</tr>
<tr>
<td>The Capital Project Manager during the Construction Phase and a dedicated member of the Facilities Directorate during the Operational Phase.</td>
<td>Consult with Project Co in respect of the appointment for any replacement for the Boards Representative (Clause 11.3)</td>
<td>Prior to the appointment of any replacement taking into account the need for liaison and continuity for the Project</td>
</tr>
<tr>
<td>Lothian Health Board failing the Capital Project Manager during the Construction Phase and a dedicated member of the Facilities Directorate during the Operational Phase.</td>
<td>Carry out the functions of the Boards Representative during periods (Clause 11.4)</td>
<td>During any period when no Board Representative has been appointed</td>
</tr>
<tr>
<td>The Capital Project Manager to procure the establishment during the Construction Phase and a dedicated member of the Facilities Directorate to ensure it is maintained during the Operational Phase.</td>
<td>Establish and Maintain a Liaison Committee together with Project Co (Clause 12.1)</td>
<td>Throughout the Project Term. To consist of three representatives of the Board (one of whom shall be appointed Chairman).</td>
</tr>
</tbody>
</table>
### OBLIGATIONS UNDER THE PROJECT AGREEMENT

<table>
<thead>
<tr>
<th>LEAD RESPONSIBILITY</th>
<th>OBLIGATIONS UNDER THE PROJECT AGREEMENT</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Project Manager</td>
<td>Comply with the Disaster Plan and liaise with Project Co in order to periodically review and update the Disaster Plan (Clauses 13.1 &amp; 13.2)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Liaise and consult with the Scottish Ministers as licensor in respect of any matters arising under the said Licence (Clauses 14.1 and 14.2) and/or relating to exercise of the rights granted to Project Co (Clause 14.6)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Review any changes made by Project Co to any of the Quality Plans (Clause 25.7)</td>
<td>Throughout the life of the Contract-Construction and Operational phases</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>May carry out audits of Project Co’s quality management systems including all relevant Quality Plans and any quality manuals and procedures (Clause 25.12)</td>
<td>Approximate intervals of 3 months and may carry out periodic monitoring, spot checks and auditing</td>
</tr>
</tbody>
</table>

### CONSTRUCTION PERIOD

**Capital Project Manager**

- Review the Reviewable Design Data in accordance with the Review Procedure at Part 10 of the Schedule (Clause 17.7)
<table>
<thead>
<tr>
<th>Capital Project Manager</th>
<th>Should the Board’s Representative exercise their right to request Project Co to open up and inspect any part(s) of the Works, the Board’s Representative must notify Project Co of his intention to exercise such right, setting out the detailed reasons (Clauses 18.3 &amp; 18.4).</th>
<th>Any time prior to the Actual Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Project Manager</td>
<td>Monitoring progress of the Works in accordance with the Programme submitted by Project Co (Clause 19.2)</td>
<td>Ongoing during Construction phase</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Comply with and fulfil duties and obligations arising under or in connection with the Independent Tester Contract and co-operate with Project Co in relation to all Independent Tester matters (Clause 20)</td>
<td>Ongoing during Construction phase</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Copy to Project Co all instructions and representations issued or made to the Independent Tester (Clause 20.4)</td>
<td>Ongoing during Construction phase</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Liaise and Co-operate with Project Co in order to appoint a replacement consultant to act as the Independent Tester (Clause 20.5)</td>
<td>As soon as reasonably practicable in the event of the Independent Tester’s appointment being terminated otherwise than for full performance</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Jointly develop with Project Co a draft of the Final Commissioning Programme and provide to Project Co (Clause 22.1)</td>
<td>Not less than 6 months before the Completion Date</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Agree the terms of the Final Commissioning Programme (Clause 22.1)</td>
<td>Within 20 Business Days of receipt by the Board of Project Co’s comments on the draft Final Commissioning Programme</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Co-operate with the Independent Tester to ensure that the Independent Tester is familiar with all necessary aspects of the Project (Clause 22.6)</td>
<td>Ongoing during Construction phase</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Procure together with Project Co that the Independent Tester shall, when satisfied that completion has occurred, issue a Certificate of Practical Completion to that effect stating the date upon which the Actual Completion Date occurred (Clause 22.12)</td>
<td></td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Procure together with Project Co that the Independent Tester shall issue a snagging notice specifying the Snagging Matters and an estimate of the cost of rectifying such Snagging Matters (Clause 22.13)</td>
<td>Within 2 Business Days of the date of issue of the Certificate of Practical Completion</td>
</tr>
<tr>
<td>Capital Project Manager</td>
<td>Board’s Representative shall consult with Project Co to rectify all Snagging Matters (Clause 22.14)</td>
<td>Within 20 Business Days of the issue of the Snagging Notice</td>
</tr>
</tbody>
</table>

**OPERATIONAL TERM**

<table>
<thead>
<tr>
<th>LEAD RESPONSIBILITY</th>
<th>OBLIGATIONS UNDER THE PROJECT AGREEMENT</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Shared responsibility to monitor the actual energy consumption at the Facilities with a view to establishing the Energy Thresholds and ascertaining whether and to what extent the thermal and energy efficiency of the Facilities is in excess of 40.4 Giga Joules/100m³ per year (Clause 17.3)</td>
<td>During the period of 2 years following the Actual Completion Date or up until 5 years following the Actual Completion Date until such time as there has been a period of twenty-four (24) consecutive calendar months the Heating Degree Day figure for such period, when averaged, is neither greater than 103% nor less than 97% of the average year figure.</td>
</tr>
<tr>
<td>Role</td>
<td>Task Description</td>
<td>Timeframe</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>If as a result of monitoring there is an indication that the thermal and energy efficiency of the facilities causes energy use exceeding 40.4 Giga Joules/100m³, shall investigate, together with Project Co, the matter to determine the cause of such failure and whether, and what amount of, compensation is payable to the Board (Clause 17.3)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Confirm or withdraw request to accelerate or defer the Schedule of Programmed Maintenance &amp; shall reimburse Project Co the direct and reasonable costs actually incurred by Project Co as a consequence of such acceleration or deferment up to, but not exceeding, the amount of the Estimated Increased Maintenance Costs (Clause 28.7)</td>
<td>10 Business Days following receipt by the Board of notification of the amount of the Estimated Increases Maintenance Costs</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Notify Project Co of any proposed change to the Board Policies (Clause 32.6)</td>
<td>As soon as practicable from introduction of the change</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Co-operate with any disciplinary proceedings against any employee of Project Co or Sub-Contractor who misconducts himself or is incompetent or negligent (Clause 32.13)</td>
<td>As necessary</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Pay Project Co the Service Payments in respect of each Contract Month (Clause 35.1)</td>
<td>Following the Payment Commencement Date</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Where the amount is not disputed, pay to Project Co the amount set out in the VAT invoice (35.2.2).</td>
<td>Within the first 5 Business Day of the beginning of the Contract Month following the issue of the relevant Service Payment Statement.</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Endeavour to resolve any disputes in connection with all or any part of the Service Payments together with Project Co (Clause 35.4)</td>
<td>Within 15 Business Days of the dispute arising</td>
</tr>
<tr>
<td>Role and Responsibility</td>
<td>Description</td>
<td>Time Frame</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>If a risk usually covered by contractors ‘all risks’ insurance, property damage insurance, third party insurance, delay in start up and business interruption insurance or statutory insurance becomes uninsurable, meet with Project Co to discuss the means by which the risk should be managed or shared (Clause 36.14.1)</td>
<td>As necessary</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Notify Project Co of any circumstance which may give rise to a claim of value equal to or in excess of £50,000 under the Insurances &amp; liaise with Project Co to ensure that the relevant claim is preserved/pursued (Clause 36.17)</td>
<td>Within 5 Business Days of becoming aware of any circumstance that may give rise to such a claim</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Give consent to the release of monies from the Insurance Proceeds Account where reinstatement monies are required to be released (Clause 36.20)</td>
<td>Within 1 Business Day of a request from Project Co</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Operate the signatory requirements of the Joint Insurance Account in order to meet any other reasonable costs and expenses of Project Co for the sole purpose of Reinstatement Works (Clause 36.22.3.2.3)</td>
<td>As necessary</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Meet with Project Co to consult and seek to agree the effect of a Relevant Change in Law (Clause 39.4.2)</td>
<td>Within 15 Business Days of a notice by either party to the occurrence of the Relevant Change in Law</td>
</tr>
<tr>
<td>A dedicated member of the Facilities Directorate</td>
<td>Issue a Variation Enquiry (Clause 39.4.3.2)</td>
<td>Within 15 Business Days of the agreement or determination in respect of a consultation with Project Co to agree the effect of a Relevant Change in Law</td>
</tr>
</tbody>
</table>
Meet to consult in respect of the effect of the Change in Law and any Variation required as a consequence (Clause 39.8.1)

Within 15 Business Days of the notice of the need for the Variation

Issue a Variation Enquiry if a Variation is required in order to comply with a Change in Law (Clause 39.8.2)

Within 15 Business Days of the meeting between the Board and Project Co to consult in respect of the effect of the Change in Law

A dedicated member of the Facilities Directorate

A dedicated member of the Facilities Directorate

A dedicated member of the Facilities Directorate

A dedicated member of the Facilities Directorate

Where the Board is or claims to be affected by a Relief Event:

1. take reasonable steps to mitigate the consequences, resume performance of its obligations and use all endeavours to remedy its failure;
2. serve written notice on Project Co;
3. serve a subsequent written notice;
4. notify Project Co of the Relief Event having ceased and of when performance of its affected obligations can be resumed.

(Clauses 42.4 - 42.7)

1. as soon as practicable;
2. within 5 Business Days of the Board becoming aware of the relevant Relief Event;
3. within a further 5 Business Days of the notice;

A dedicated member of the Facilities Directorate

Where the Board is or claims to be affected by an event of Force Majeure:

1. take reasonable steps to mitigate the consequences, resume performance of its obligations and use all endeavours to remedy its failure;
2. serve written notice on Project Co;

(Clauses 42.4 - 42.7)

1. as soon as practicable;
2. within 5 Business Days of the Board becoming aware of the relevant Force Majeure Event;
3. within a further 5 Business Days of the notice;

A dedicated member of the Facilities Directorate

Where the Board is or claims to be affected by an event of Force Majeure:

1. take reasonable steps to mitigate the consequences, resume performance of its obligations and use all endeavours to remedy its failure;
2. serve written notice on Project Co;

(Clauses 42.4 - 42.7)

1. as soon as practicable;
2. within 5 Business Days of the Board becoming aware of the relevant Force Majeure Event;
3. within a further 5 Business Days of the notice;
<p>| A dedicated member of the Facilities Directorate | Endeavour to agree any modifications to the Agreement which may be equitable having regard to the nature of event(s) of Force Majeure (Clause 43.12) | As necessary |
| A dedicated member of the Facilities Directorate | Where Project Co puts forward a programme for remedying Project Co Event of Default, Board must: 1. notify Project Co if they do not accept the programme; and 2. endeavour to agree any necessary amendments to the programme. (Clause 44.4) | 1. within 20 Business Days from receipt of the programme; 2. within the following 5 Business Days. |
| A dedicated member of the Facilities Directorate | Notify Project Co in writing prior to any intended disclosure of the terms of the Project Agreement, Independent Tester Contract, the Funders’ Direct Agreement and the Collateral Agreements to the Scottish Executive Health Department and/or HM Treasury and shall consult with Project Co with view to agreeing whether or relevant Information can be disclosed (Clause 52.11) | Not less than 10 Business Days prior to any intended disclosure |
| A dedicated member of the Facilities Directorate | Where the Board receives a Request for Information in relation to Information that Project Co is holding on its behalf and which the Board does not hold itself the Board shall refer to Project Co such Request for Information that it receives (Clause 52A.2) | As soon as practicable and in any event within five (5) Business Days of receiving a Request for Information |
| A dedicated member of the Facilities Directorate | Pay to Project Co any VAT properly chargeable on any supply made to it under the Project Agreement (Clause 53.2) | Following receipt from Project Co a valid tax invoice |
| A dedicated member of the Facilities Directorate | Send promptly to the Inland Revenue any vouchers which the Project Co gives to the Board (Clause 53.11.7) |  |</p>
<table>
<thead>
<tr>
<th>Benefit ID/Title</th>
<th>Description of the Benefit</th>
<th>Lead Responsibility</th>
<th>Value</th>
<th>Target</th>
<th>Business Area Impacted</th>
<th>Measures</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility (patient services/site access)</td>
<td>• Maximise number of services available locally thus minimising travel distances for patients, staff and visitors; • Enables patients to easily access services by foot, by cycle or by public transport with easy drop-off and pick-up zones; • Adequate car parking provision; • Appropriate number of lifts and corridors wide enough for non-ambulant users and equipment.</td>
<td>Gerry Power, CHP General Manager (patient services); Iain Graham, Head of Capital Planning &amp; Premises Development (site access – delivery via RCP)</td>
<td>Increase patient activity. Distance from bus stop to front door. Currently non-existent at both Loanhead and Rosslynlee Hospitals. Currently providing services in old Victorian buildings that do not meet with current building requirements; have limited lifts and do not comply with DDA.</td>
<td>Local access to diagnostic services. Bus stop to be immediately adjacent to front door. Turning circle included in design in line with bus company request. Ample car parking provided to ensure access by car. DDA compliance.</td>
<td>Reduce pressure on RIE. Saving in transport costs, as provision currently made by NHS Lothian for staff and public access to Rosslynlee Hospital. Improved efficiency in portering services and accessibility due to DDA compliance. Sustained efficiency. Increased frequency of visitors due to DDA compliant measures.</td>
<td>75% utilisation of out-patient facilities. Achievement of radiology activity targets set out in OBC. Improving Care Investing in Change Strategic Programme. NHS Lothian Local Delivery Plan HEAT Targets. Quality Improvement Team (QIT) standing item to review CHP database of complaints. Board</td>
<td>1 year after fully operational (patient services). Annual reviews (patient services). 3 months post completion review (site access). As part of Board’s ongoing performance review (site access). Part of Consortium review process (site access).</td>
</tr>
</tbody>
</table>
## Clinical Effectiveness

- Provides good departmental relationships between services allowing integrated and efficient working practices;
- Allows for co-location of services;
- Facilitates new ways of working, including one-stop clinics, nurse-led practise;
- Well equipped, appropriate services to provide quality of care;
- Relevant specialties available to patients.

<table>
<thead>
<tr>
<th>Fiona Watson, Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services currently operating on two sites, resulting in difficulties for multi-disciplinary intervention.</td>
</tr>
<tr>
<td>Inpatients require outpatient diagnostic services currently only available at WGH or RIE. Visits are by ambulance with nurse escort.</td>
</tr>
<tr>
<td>Nursing staff often off ward as escorts for inter-site transfers, deflecting patient care by as much as 50%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gerry Power, CHP General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently only 6 single AEDET scoring of interim design showed</td>
</tr>
</tbody>
</table>

- Consolidate clinical services onto a single site.
- Greater access to AHP facilities.
- LUCS (Out-of-Hours) located next to diagnostic facilities will greatly improve efficiency.
- Bring together different clinical services offering opportunity for sharing good clinical practise.
- Creates a degree of flexibility in how to use staff.
- Provides opportunity for additional staff training.
- The range of diagnostic facilities allow patients to be seen more quickly and increases the range of assessment available.

<table>
<thead>
<tr>
<th>Provision of single bedrooms will facilitate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Construction</td>
</tr>
</tbody>
</table>

- Increased efficiency of nursing staff and Ambulance Services as inter-site transfers will be significantly reduced, negating the need for nursing escort. Monitor against current baseline volume of transfers - target 75% reduction.
- Positive impact on patient care as nursing staff remain on wards.
- Improved waiting times.
- Reduction in clinical staff movement.
- Improved focal lay-out on the ward increases staff efficiency in terms of patient contact.

## Quality of Physical

- Ensure that services are provided in an

| Currently only 6 single AEDET scoring of interim design showed |

| Board Construction |

- 1 year after fully operational. Annual Reviews.

<p>| Improving Care Investing in Change Strategic Programme. NHS Lothian Local Delivery Plan HEAT Targets. Staff resource data collection via QIT. Admissions Data from ISD reported to QIT and reviewed monthly by CHP. Lean in Lothian – &quot;Kaizen&quot; Workshops. Right Care, Tight Time, Right Place Campaign. |</p>
<table>
<thead>
<tr>
<th>Environment</th>
<th>Manager.</th>
<th>rooms.</th>
<th>a fair to strong agreement that design expectations have been achieved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• environment that is conducive to healthcare delivery and promotes a sense of well being and confidence in patients, staff and visitors;</td>
<td>George Curley, Head of Estates Services.</td>
<td>Significant number of incidents of aggression.</td>
<td>Provision of 90% single bedroom accommodation.</td>
</tr>
<tr>
<td>• Maximises health and safety of patients, staff and visitors;</td>
<td>Director of Human Resources.</td>
<td>Current inaccessibility to site (Rosslynlee in particular) negatively impacts on workforce in staff turn-over and vacancies.</td>
<td>Provision of shower and changing facilities.</td>
</tr>
<tr>
<td>• Promotes good staff morale and improved retention and recruitment;</td>
<td>Loanhead Hospital has a staff room but no staff dining facility.</td>
<td>Rosslynlee Hospital has a dining facility but no staff room.</td>
<td>Provision of staff room.</td>
</tr>
<tr>
<td>• Flexibility for future change;</td>
<td>Neither hospital has appropriate shower and changing facilities.</td>
<td>Neither hospital has appropriate shower and changing facilities.</td>
<td>Provision of dining and vending facilities.</td>
</tr>
<tr>
<td>• Recognises that healthcare delivery may change significantly in the future and therefore health buildings / sites need to accommodate such a change with the minimum of expenditure and disruption;</td>
<td>Significant new build required to comply with future clinical service models already identified.</td>
<td>Compliance with DDA ensures improved access for main areas of population.</td>
<td>Improvement in retention and recruitment. Monitor against current staff turnover.</td>
</tr>
<tr>
<td>• Minimises constraints on both developing existing and new services. Enables specialties to cope with potential increases in workload whilst optimising use of the site, buildings and land;</td>
<td>Non-compliance with BREEAM.</td>
<td>Separate entrance built into design to allow possible future registration as a Care Home.</td>
<td>Reduce patient/visitor complaints about environment by 75%.</td>
</tr>
<tr>
<td>• Contributes to green issues such as efficient energy usage,</td>
<td></td>
<td>Improvement in energy consumption with efficient design of purpose-built facility.</td>
<td>Requirements met.</td>
</tr>
</tbody>
</table>

Manager.
George Curley,
Head of Estates Services.

- HAI recommendations. Monitor against current HAI rate target 50% reduction;
- Safety, Privacy and Dignity guidance;
- Reduction in recorded incidents. Monitor against current rates- target 25% reduction
- Improvement in retention and recruitment. Monitor against current staff turnover.
- Reduce patient/visitor complaints about environment by 75%.

Manager.
George Curley,
Head of Estates Services.

- Monthly Infection Control report considered by Local Health & Safety Group and also reviewed by QIT.
- Patient and staff feedback.
- FM services monitoring of maintenance regime.
- Condition of Building Surveys.
- Regular reviews through User Meetings with FM Provider (as per Contract Performance Indicators.)
| Acceptability to Patients, Staff, Partners & Public | • Meet patients’, staff and partners' expectations in terms of effectiveness, quality and accessibility of services. | Gerry Power, CHP General Manager. | PPF, Staff Side stakeholders and Project Board processes. | PPF and Staff Side representation on the Project Board and throughout Approvals processes (eg. design sign-off, etc.). | Evidenced by Membership of Project Board and Project Teams, Membership of QIT. | 6 months to 1 year after fully operational. | Regular meetings with Public Partnership Forum. |
| Disruption to Service | • Minimal disruption or need for phasing decanting during construction; • Optimal timescale to completion. • Improved business continuity for clinical services. • Improved availability of clinical facilities. • Contractual and clearly identified hard facilities management service | Iain Graham, Head of Capital Planning & Premises Development (delivery via RCP) | No need for decant. Reduced construction time. Reduced disruption to patients. Fewer cancellations and postponements due to facilities issues. Maintenance carried out on a planned basis. | Operation of existing sites ceased. High level of measured availability. Reduction of disruption to clinical services due to modern and well managed facilities. Performance reported on a monthly basis. | Community hospital services including inpatient daycase and outpatient facilities. Maintenance and hard facilities management. Car Parking Access. | Project Management Arrangements as per contract. | Regular Project Management Meetings / Steering Group / Liaison throughout construction process. |
| • Regular monitoring of facilities, services and availability | with fewer interruption of services. Service Disruptions can be robustly monitored and minimised. |  |  |  |  |
### RISK RATING MATRIX

<table>
<thead>
<tr>
<th>Score</th>
<th>Very High</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>Very Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
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<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
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<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
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<tr>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
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</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**Colour Coding:**
- Green = Low
- Yellow = Medium
- Red = High

**Probability**

<table>
<thead>
<tr>
<th>Score</th>
<th>Very Low</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>5</td>
<td></td>
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</tr>
<tr>
<td>LEVEL</td>
<td>COST IMPACT</td>
<td>TIME IMPACT</td>
<td>REPUTATION IMPACT</td>
<td>Probability Criteria</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
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<td>--------------------------------------------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Show Stopper</td>
<td>Impact of Risk fundamentally threatens the viability of the whole project</td>
<td>Very High</td>
<td>&gt; 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very High</td>
<td>&gt; £7.5m</td>
<td>&gt; 12 weeks</td>
<td>Widespread negative news profile, 3rd party action</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>£3.5m to £7.5m</td>
<td>8 to 12 weeks</td>
<td>High news profile, 3rd party action, public embarrassment</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>£1.5m to £3.5m</td>
<td>4 to 8 weeks</td>
<td>Moderate but limited public embarrassment, moderate news profile</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>£800k to £1.5m</td>
<td>2 to 4 weeks</td>
<td>Low impact, low news profile</td>
<td>Very Low</td>
<td></td>
</tr>
<tr>
<td>Very Low</td>
<td>&lt; £800k</td>
<td>&lt; 1 week</td>
<td>No reputation impact of significance</td>
<td>0 to 5%</td>
<td></td>
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<td>Ref</td>
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<td>Area</td>
<td>NHS Lothian Corporate Risk Register Ref</td>
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<td>--------------</td>
<td>------</td>
<td>-----------------------------------------</td>
<td>------------------</td>
<td>-------</td>
</tr>
<tr>
<td>11</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>OBJECTIVES / PROJECT PROJ</td>
<td>Pull Business Case not acceptable</td>
<td>VL</td>
</tr>
<tr>
<td>25</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>OBJECTIVES / PROJECT PROJ</td>
<td>Clockwork running time causes delays</td>
<td>M</td>
</tr>
<tr>
<td>26</td>
<td>01/07/2006</td>
<td>PATIENT</td>
<td>PATIENT EXPERIENCE</td>
<td>Change in the demand for the service alters model of care and available resources</td>
<td>L</td>
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<tr>
<td>29</td>
<td>01/04/2006</td>
<td>PATIENT</td>
<td>PATIENT EXPERIENCE</td>
<td>Unexpected changes in medical technology</td>
<td>L</td>
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<td>37</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>PATIENT EXPERIENCE</td>
<td>Impact upon patient health due to demand</td>
<td>VL</td>
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<td>47</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>OBJECTIVES / PROJECT PROJ</td>
<td>Time Group</td>
<td>L</td>
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<td>48</td>
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<td>CLINICAL</td>
<td>INJURY</td>
<td>Infection control</td>
<td>L</td>
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<tr>
<td>50</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>INFECTION / AUDIT</td>
<td>Change in Design as a result of internal influences, including legislative and regulatory changes specific to NHS</td>
<td>L</td>
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<tr>
<td>55</td>
<td>01/04/2006</td>
<td>CLINICAL</td>
<td>INJURY</td>
<td>Patient harm</td>
<td>L</td>
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<td>57</td>
<td>01/07/2006</td>
<td>BUSINESS / INTERRUPTION</td>
<td>Unrepresented situation in hospital due to major incident</td>
<td>L</td>
<td>M</td>
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<tr>
<td>59</td>
<td>01/10/2006</td>
<td>CLINICAL</td>
<td>OBJECTIVES / PROJECT PROJ</td>
<td>Risk of imaging not going in building (support for LUGS, future development, GPX, PACS)</td>
<td>VL</td>
</tr>
<tr>
<td>60</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>OBJECTIVES / PROJECT PROJ</td>
<td>Serviceability to affect and sustain OPO workload</td>
<td>L</td>
</tr>
<tr>
<td>64</td>
<td>01/06/2006</td>
<td>CLINICAL</td>
<td>PATIENT EXPERIENCE</td>
<td>Provision of piped oxygen - future proofing for Service Change.</td>
<td>L</td>
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<tr>
<td>66</td>
<td>01/04/2006</td>
<td>CLINICAL</td>
<td>PATIENT EXPERIENCE</td>
<td>Provision of piped oxygen - future proofing for Service Change.</td>
<td>L</td>
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<tr>
<td>68</td>
<td>01/04/2006</td>
<td>PATIENT</td>
<td>PATIENT EXPERIENCE</td>
<td>Miscellaneous non-inclusion in project</td>
<td>L</td>
</tr>
<tr>
<td>73</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>INJURY</td>
<td>Induction Control Risks</td>
<td>L</td>
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<td>78</td>
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<td>INJURY</td>
<td>Omit showers from bathrooms</td>
<td>VL</td>
</tr>
<tr>
<td>81</td>
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<td>CLINICAL</td>
<td>PATIENT EXPERIENCE</td>
<td>Omit showers from bathrooms</td>
<td>L</td>
</tr>
<tr>
<td>84</td>
<td>01/04/2006</td>
<td>CLINICAL</td>
<td>INJURY</td>
<td>Health &amp; safety - ventilation in single bedrooms</td>
<td>VL</td>
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<tr>
<td>85</td>
<td>01/06/2006</td>
<td>CLINICAL</td>
<td>INJURY</td>
<td>Omit showers from bathrooms</td>
<td>L</td>
</tr>
<tr>
<td>86</td>
<td>01/04/2006</td>
<td>CLINICAL</td>
<td>INJURY</td>
<td>Omit showers from bathrooms</td>
<td>L</td>
</tr>
<tr>
<td>89</td>
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<td>PATIENT</td>
<td>PATIENT EXPERIENCE</td>
<td>Provisions not included in project</td>
<td>L</td>
</tr>
<tr>
<td>98</td>
<td>01/07/2006</td>
<td>CLINICAL</td>
<td>PATIENT EXPERIENCE</td>
<td>Miscellaneous non-inclusion in project</td>
<td>L</td>
</tr>
</tbody>
</table>

*Prob* refers to probability, *Impact* refers to impact, and *Management Action* refers to management actions planned to mitigate the risk. The table includes dates, risk ratings, and details of actions to be taken, along with due dates for those actions.
<table>
<thead>
<tr>
<th>Ref.</th>
<th>Date Entered</th>
<th>Area</th>
<th>NHS Lothian Corporate Risk Register Ref.</th>
<th>Risk Description</th>
<th>Prob' Impact</th>
<th>Risk Rating</th>
<th>Management Action</th>
<th>Action Status</th>
<th>Action Owner</th>
<th>Due Date</th>
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<tr>
<td>3</td>
<td>01/07/2008</td>
<td>PATIENT &amp; STAFFING</td>
<td>PATIENT EXPERIENCE</td>
<td>Management of Expectations</td>
<td>Planned facilities do not meet expectations of public, staff, clinicians, NHS and Council strategies, etc. Basic needs are met but quality could be lower than optimal. Could lead to lower staff morale, recruitment &amp; retention difficulties and poor reputation. Possibility of re-design and extra cost in order to satisfy stakeholders. Reputation &amp; Service Delivery Impact</td>
<td>M</td>
<td>M</td>
<td>9</td>
<td>1) Include in Comms Plan to communicate project to other parties (both internal and external (PPF)). 2) Public Involvement Representatives 3) Public Partnership Forum 4) Project Board Meeting notices of meetings made available 5) Notices put up at existing hospitals 6) HR policies and information during recruitment process 7) Workshops throughout building process 8) Local staff meetings 9) Lothian Brief 10) Connections</td>
<td>1) Ongoing 2) End user group meetings setup. 3) Ongoing</td>
</tr>
<tr>
<td>30</td>
<td></td>
<td>PATIENT &amp; STAFFING</td>
<td>SERVICE / BUSINESS INTERRUPTION</td>
<td>Teething problems in new build facilities</td>
<td>H</td>
<td>L</td>
<td>8</td>
<td>1) Include in Comms Plan to communicate project to other parties (both internal and external (PPF)). 2) Public Involvement Representatives 3) Public Partnership Forum 4) Project Board Meeting notices of meetings made available 5) Notices put up at existing hospitals 6) HR policies and information during recruitment process 7) Workshops throughout building process 8) Local staff meetings 9) Lothian Brief 10) Connections</td>
<td>1) Ongoing 2) End user group meetings setup. 3) Ongoing</td>
<td>Project Team 2) RCP</td>
</tr>
<tr>
<td>40</td>
<td>01/07/2008</td>
<td>PATIENT &amp; STAFFING</td>
<td>PATIENT EXPERIENCE</td>
<td>External Communication - Lack of awareness of project</td>
<td>L</td>
<td>H</td>
<td>8</td>
<td>1) Include in Comms Plan to communicate project to other parties (both internal and external (PPF)). 2) Public Involvement Representatives 3) Public Partnership Forum 4) Project Board Meeting notices of meetings made available 5) Notices put up at existing hospitals 6) HR policies and information during recruitment process 7) Workshops throughout building process 8) Local staff meetings 9) Lothian Brief 10) Connections</td>
<td>1) Ongoing 2) End user group meetings setup. 3) Ongoing</td>
<td>Project Team 2) RCP</td>
</tr>
<tr>
<td>46</td>
<td>01/07/2007</td>
<td>PATIENT &amp; STAFFING</td>
<td>STAFFING &amp; COMPETENCE RISK</td>
<td>Staff to deliver re-designed services</td>
<td>M</td>
<td>M</td>
<td>9</td>
<td>1) Include in Comms Plan to communicate project to other parties (both internal and external (PPF)). 2) Public Involvement Representatives 3) Public Partnership Forum 4) Project Board Meeting notices of meetings made available 5) Notices put up at existing hospitals 6) HR policies and information during recruitment process 7) Workshops throughout building process 8) Local staff meetings 9) Lothian Brief 10) Connections</td>
<td>1) Ongoing 2) End user group meetings setup. 3) Ongoing</td>
<td>Project Team 2) RCP</td>
</tr>
<tr>
<td>51</td>
<td>01/07/2008</td>
<td>PATIENT &amp; STAFFING</td>
<td>PATIENT EXPERIENCE</td>
<td>Constraints on capital cost lead to design compromises</td>
<td>M</td>
<td>VL</td>
<td>3</td>
<td>1) A review of clinical spec. and requirements 2) Under development 3) Developing from Clinical outputs 4) Ongoing</td>
<td>1) Project Team 2) SM</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>01/07/2007</td>
<td>PATIENT &amp; STAFFING</td>
<td>COMPANIES / CLAIMS</td>
<td>Inadequate IT systems</td>
<td>VL</td>
<td>L</td>
<td>2</td>
<td>1) A review of clinical spec. and requirements 2) Under development 3) Developing from Clinical outputs 4) Ongoing</td>
<td>1) Project Team 2) SM</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>01/07/2008</td>
<td>PATIENT &amp; STAFFING</td>
<td>INJURY</td>
<td>Patient infection caused by poor Facilities management (10% risk for contractor)</td>
<td>VL</td>
<td>M</td>
<td>3</td>
<td>1) Professional Advisors part of the Project Team 2) Regularly review plans 3) Operational procedures in place</td>
<td>1) Project Team / M 2) CH 3) RFID</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>01/10/2007</td>
<td>PATIENT &amp; STAFFING</td>
<td>INJURY</td>
<td>Patient infection - other</td>
<td>VL</td>
<td>M</td>
<td>3</td>
<td>1) Professional Advisors part of the Project Team 2) Regularly review plans 3) Operational procedures in place</td>
<td>1) Project Team / M 2) CH 3) RFID</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>22/04/2008</td>
<td>PATIENT &amp; STAFFING</td>
<td>PATIENT EXPERIENCE Planning Risk</td>
<td>Approval of reduction of external planting</td>
<td>Non</td>
<td>M</td>
<td>M</td>
<td>9</td>
<td>1) Discuss functionality of courtyards with Nursing 2) Review design</td>
<td>1) Project Team / M 2) CH 3) RFID</td>
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<tr>
<td>66</td>
<td>07/04/2008</td>
<td>PATIENT &amp; STAFFING</td>
<td>REVIEW</td>
<td>Review window size (reduction by 30%)</td>
<td>Non</td>
<td>M</td>
<td>M</td>
<td>9</td>
<td>1) Discuss with clinical / nursing staff 2) Review design</td>
<td>1) Project Team / M 2) CH 3) RFID</td>
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</table>
Midlothian Community Hospital Project Internal Risk Register

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Date Entered / Removed / Amended</th>
<th>Area</th>
<th>NHS Lothian Corporate Risk Register Ref</th>
<th>Risk Description</th>
<th>Prob.</th>
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<th>Action Status</th>
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<tr>
<td>1</td>
<td>22/04/2008</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>Risk Transfer (significant Transfer of Risk to suppliers means that the project will not be completed in time and affects time and cost).</td>
<td>L H</td>
<td>8</td>
<td>1) Include an initial view in TN. 2) During TN, prepare a high level review of risk transfer. 3) Post preferred bidder, confirm accounting treatment for external auditors. 4) Favourable Audit Scotland Report issued 02/04/08.</td>
<td>removed 22/04/08</td>
<td>1) AMD</td>
<td>2) DN</td>
<td>3) Financial Advisors</td>
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<tr>
<td>2</td>
<td>01/09/2007</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>NHS Lothian can no longer afford hospital development projects, or due to sustainability issues, cannot proceed with the project. Show Stopper.</td>
<td>VL</td>
<td>5</td>
<td>1) Project management team to monitor project progress. 2) Re-planning management review of contract.</td>
<td>1) Ongoing</td>
<td>3) 1) AMD</td>
<td>2) Financial Advisors</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>01/09/2007</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>Project Co. is dismissed or goes into commercial failure before building work is complete.</td>
<td>M</td>
<td>6</td>
<td>1) Carry out commercial checks 2) Reclaim VAT 3) Dovetail disposal contract terms 4) Revert to LHB prior contract terms.</td>
<td>1) Ongoing</td>
<td>3) 1) AMD</td>
<td>2) Financial Advisors</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>01/09/2007</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>Costs increase significantly during construction / operational phase.</td>
<td>L L</td>
<td>4</td>
<td>1) Regular reviewing and adjustment of Shadow Bid Key Stage Reviews 2) Management review of contract.</td>
<td>1) Ongoing</td>
<td>2) 1) AMD</td>
<td>2) DN</td>
<td>3) Financial Advisors</td>
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<td>8</td>
<td>01/09/2007</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>Project doesn't meet the VfM test.</td>
<td>M M</td>
<td>9</td>
<td>1) Interim Bid into FITN 2) Project reviews re: specifications 3) Management review of contract.</td>
<td>1) Ongoing</td>
<td>2) 1) Project Board</td>
<td>2) Project Team</td>
<td>3) External Advisors</td>
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<td>10</td>
<td>01/09/2007</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>Revenue funding incorrect.</td>
<td>L H</td>
<td>8</td>
<td>1) Continual monitoring 2) Management review of contract.</td>
<td>1) Ongoing</td>
<td>2) 1) GP</td>
<td>2) MA</td>
<td>3) DN</td>
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<td>12</td>
<td>01/09/2007</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>UHB maintain baths (Group 1)</td>
<td>VL</td>
<td>L</td>
<td>2</td>
<td>1) Review Group 1 equipment with Procurement 2) Agree alternative funding with GP</td>
<td>removed 01/07/2008</td>
<td>1) UB</td>
<td>2) GP</td>
</tr>
<tr>
<td>13</td>
<td>01/07/2008</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>UHB maintain baths (Group 2)</td>
<td>VL</td>
<td>L</td>
<td>2</td>
<td>1) Review Group 1 equipment with Procurement 2) Agree alternative funding with GP</td>
<td>removed 01/07/2008</td>
<td>1) UB</td>
<td>2) GP</td>
</tr>
<tr>
<td>14</td>
<td>16/10/2008</td>
<td>FINANCIAL</td>
<td>FINANCIAL</td>
<td>Treasury fail to provide funding for changes to accounting treatment as a consequence of IFRS 11/09.</td>
<td>L H</td>
<td>8</td>
<td>1) DN to liaise with Scottish Government 2) Management review of contract.</td>
<td>1) Ongoing</td>
<td>2) 1) DN</td>
<td>2) Financial Advisors</td>
<td>3) External Advisors</td>
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<td>8</td>
<td>01/07/2006</td>
<td>01/07/2008</td>
<td>AMD</td>
<td>Management Risk</td>
<td>Bus Companies give the project additional costs</td>
<td>N</td>
<td>N</td>
<td>3</td>
<td>1. Strong Project Management. 2. Monitor Specifications 3. Corporate awareness</td>
<td>OK</td>
<td>AMD</td>
</tr>
</tbody>
</table>

**Midlothian Community Hospital Project Internal Risk Register**
Management Summary
The enclosed organisation diagrams and meeting / reporting structures are indicative of the interface between NHS Lothian and the Contractor Robertson Health Care (Project Co/SPV) during the contract of the PPP Project for the New Midlothian Community Hospital.

The NHS Lothian proposes to appoint a Steering Group which will be responsible for all aspects of the Management and Monitoring of the PPP project, during Construction, Commissioning and Operations phases.

Appendix 15.1 shows the lines of communication during the Construction and Commissioning Phases. The Steering Group will report directly to the Project Board and interact with the Project Co through the Administrator of the Project Agreement (Admin PA). During these phases all the contractors including the main contractor Robertson Construction LLP will report to Project Co.

Appendix 15.2 shows the lines of communication during the Operational Phase. The Project Board will be dissolved and the Steering Group will act as the main NHS Lothian body to monitor and control the PPP contract. The Steering Group will interact with Project Co. through the Administrator of the Project Agreement (Admin PA). During this phase all the FM contractors including the main contractor Robertson FM will report to Project Co.

Appendix 15.3 highlights the proposed external meeting structure during Construction and Commissioning Phases. During these phases, NHS Lothian proposes a Monthly Project Progress Meeting with Project Co. The full Steering Group would attend this meeting which would be the main forum to discuss the contract progress and problems. These meetings will be synchronised and followed by a Project Board meeting, to allow the Project Board to discuss and give direction on unresolved issues, and approve any contract variations.

Other fortnightly Site Review Meetings would be held with Project Co. to deal with day-to-day issues. These meetings would be regularly attended by the Admin PA (Capital Project Manager), Capital Project Team, and any required member of the steering group. Any unresolved issues would be referred to the more formal monthly meetings.

NB The Independent Tester will be expected to attend the monthly meetings and any fortnightly meetings if requested.
Appendix 5 highlights the proposed external meeting structure during the Operational Phase. During this phase NHS Lothian proposes regular Monthly Project Progress Meeting. This meeting would be the main forum to discuss the problems and service issues of the contract (including any referred Liaison Meeting issues) and would be regularly attended by the Admin PA (Facilities Directorate Representative) and the Steering Group.

A separate independent Liaison Committee would also function on a regular and ad hoc basis to help resolve problems and make improvement suggestions. This committee can only make suggestions to the Steering Group.

All other day-to-day issues would be dealt with the Project Co and NHS, site managers.

Appendix 5 summaries terms of reference and issues assigned to the Steering Group.
MIDLOTHIAN COMMUNITY HOSPITAL
CONSTRUCTION / COMMISSIONING PHASE
PROJECT COMMUNICATION PLAN

- NHS Lothian Staff
- Public Partnership Forum
- Project Team
- Public / External Authorities

Lothian Health Board

Project Board

STEERING GROUP

External Advisers

PROJECT CO. SPV

Main Contractor

Sub-Contractor

Members
Administrator of Project Agreement (Capital Project Manager);
Clinical Representatives;
Estates Manager;
Soft FM Representatives;
Financial Representative;
Administration / Human Resources Representative.
MIDLOTHIAN COMMUNITY HOSPITAL
OPERATIONAL PHASE
PROJECT COMMUNICATION PLAN

Lothian Health Board

Facilities Directorate

STEERING GROUP

Members
Administrator of Project Agreement (Facilities Directorate Representative);
Clinical Representatives;
Estates Manager;
Soft FM Representatives;
Financial Representative;
Administration / Human Resources Representatives.

PROJECT CO. SPV

Liaison Committee

Members
Project Co. – 3 members;
LHB – following 3 members:
Administrator of Project Agreement
Soft FM Representative
NHS Staff Representative

Main FM Contractor

Sub-Contractor
MIDLOTHIAN COMMUNITY HOSPITAL
CONSTRUCTION / COMMISSIONING

EXTERNAL MEETING STRUCTURE

CONSTRUCTION / COMMISSIONING

Monthly Project Progress Meeting
- Steering Group Representative
- Project Co.
- Independent Tester
- Funder Representatives
- Facilities Management Representatives
- Construction Representatives

Fortnightly Site Review Meetings
- Steering Group Representatives
- Project Co. Representative
- Construction Representative
Glossary of Terms and Abbreviations

A

ADSCR  Average Debt Service Cover Ratio
AEDET  Achieving Excellence in Design Evaluation Toolkit
AHP    Allied Health Professionals

B

BAFO   Best and Final Offer
“the Board”  NHS Lothian Board
bps    Base Points

C

Capping  The maximum sum chargeable.
CDM    Construction Design and Management Regulations
CHP    Community Health Partnership
CIG    Capital Investment Group
Community Mental Health Team  A group of professionals from a variety of different disciplines (eg. medicine, nursing, social work) who work together to provide a range of mental health services outwith the hospital setting.

Continuing Care  Ongoing hospital-based health care and treatment, in excess of 12 months.
CPAM   Conventional Procurement Assessment Model

D

Day Hospital  A day hospital is a hospital or a specified area within a hospital that provides services on a regular daytime basis for specific patients / client groups, for example, the elderly, mentally ill or learning disability. Services normally provided are assessments, rehabilitation and clinical treatment.

F

FBC    Full Business Case. The document prepared by the Service in accordance with the Scottish Government’s Health Directorates Capital Investment Manual to develop the preferred option
previously identified in the OBC and approved by the Scottish Government, where required. It will form the basis upon which final approval of the scheme is granted.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>FITN</td>
<td>Final Invitation to Negotiate</td>
</tr>
<tr>
<td>FM</td>
<td>Facilities Management</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>Small groups of members of the public and other stakeholders where new ideas are discussed.</td>
</tr>
<tr>
<td>FRS</td>
<td>Financial Reporting Standards</td>
</tr>
<tr>
<td>G</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>Hard FM</td>
<td>Hard Facilities Management. The estates services to be provided by the contractor (e.g. maintenance of the building and its fabric, grounds and gardens, utilities, pest control and a helpdesk service.</td>
</tr>
<tr>
<td>HDL</td>
<td>Health Department Letter</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>Information Management and Technology</td>
</tr>
<tr>
<td>In-house</td>
<td>Pertaining to a separate unit within an entity, as distinct from a third party.</td>
</tr>
<tr>
<td>In-patient</td>
<td>A person who is admitted overnight to hospital for observation, examination or treatment.</td>
</tr>
<tr>
<td>Interest Swap Rate</td>
<td>A binding agreement between counterparties to exchange periodic interest payments on some predetermined principal, which is called the notional principal amount. For example, one party will pay fixed and received variable.</td>
</tr>
<tr>
<td>Key Stage Review</td>
<td>Audit Tool used by the Scottish Government to review capital projects over £5m.</td>
</tr>
<tr>
<td>LHCC</td>
<td>Local Health Care Co-operative</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>---------</td>
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<tr>
<td>Multi-disciplinary</td>
<td>A multi-disciplinary team is a group from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition.</td>
</tr>
<tr>
<td>Negotiated Procedure</td>
<td>Procedure where only chosen suppliers are invited to negotiate contracts.</td>
</tr>
<tr>
<td>NEAT</td>
<td>NHS Environmental Assessment Tool.</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>Notice</td>
<td>General term for advertisement placed in the Official Journal.</td>
</tr>
<tr>
<td>NPC</td>
<td>Net Present Cost</td>
</tr>
<tr>
<td>NPV</td>
<td>Net Present Value. The aggregate value of cashflows over a number of periods discounted to today’s value.</td>
</tr>
<tr>
<td>OBC</td>
<td>Outline Business Case. A document prepared to identify the preferred options and financial analysis for the case for investment for the preferred option for the proposed scheme.</td>
</tr>
<tr>
<td>OJEU</td>
<td>Official Journal of the European Union</td>
</tr>
<tr>
<td>Opportunity Cost</td>
<td>Value of most valuable alternative use (eg. the value of an asset in the next best alternative use to which the asset could be put).</td>
</tr>
<tr>
<td>Output Specification</td>
<td>A statement of the needs to be satisfied by the procurement of external resources.</td>
</tr>
<tr>
<td>PPF</td>
<td>Public Partnership Forum</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>Preferred Option</td>
<td>The option chosen as part of the OBC and that is used as a basis for the CPAM.</td>
</tr>
<tr>
<td>“the Project Board”</td>
<td>A group of various disciplines (eg. management, clinical, nursing, planning, finance, estates, strategic, etc.) that have overall responsibility for decision-making through the development of the scheme.</td>
</tr>
<tr>
<td>Project Teams</td>
<td>Individual groups that take forward the day-to-day details planning</td>
</tr>
</tbody>
</table>
for the project with representation from the various services and the Board’s external advisers, where appropriate, to review specific areas of the project relevant to their experience (e.g. Payment Mechanism, Legal, Finance, Technical, FM, etc.). These groups meet regularly and have responsibility for feeding back information to the Project Board.

**R**

REH Royal Edinburgh Hospital
RPI Retail Price Index

**S**

SCIM Scottish Capital Investment Manual
SEHD Scottish Executive Health Department
SGHD Scottish Government Health Directorates (formerly known as SEHD).

Soft FM Soft Facilities Management. Non-clinical operational services to be provided in-house (e.g. domestic, catering and logistic services).

SPV Special Purpose Vehicle
STUC Scottish Trade Union Congress

**T**

TUPE Transfer of Undertakings (Protection of Employment) Regulations

**V**

VfM Value for Money