NHS Forth Valley Healthcare Strategy - Clackmannanshire Community Health Services Project

Full Business Case (Published Version)

(approved by the Scottish Executive Health Department – March 2007)

NHS Forth Valley Healthcare Strategy & Clackmannanshire Community Health Services Project Full Business Case.

FOREWORD

This document presents the Full Business Case (FBC) for the Clackmannanshire Community Health Services Project in Alloa. The Outline Business Case for the project was approved by the Scottish Executive Health Department in June 2003.

This Full Business Case was subsequently submitted by NHS Forth Valley to the Scottish Executive for approval following consideration at a NHS Forth Valley Board meeting on 30th January 2007. It was subsequently reviewed by the Scottish Executive Health Department's Capital Investment Group (CIG) using expedited procedures. CIG recommended approval to the Chief Executive of the NHS in Scotland. Notification of the approval and the invitation to proceed to Financial Close was received by NHS Forth Valley on 8th March 2007.

Publication of Information

Summary

NHS Forth Valley is committed to being open and honest in the conduct of its operations. To this end NHS Forth Valley will ensure:

- a significant amount of routinely published information about NHSFV is made available to the public as a matter of course
- other information is readily available on request, and such a request is dealt with in a timely manner

The *Freedom of Information (Scotland) Act 2002* ("*The Act*") recognises that as a member of the public you have the right to know how public services such as the NHS are organised and run, how much they cost and how you can make complaints if you need to. You have the right to know which services are being provided, the targets that are being set, the standards of services that are expected and the results achieved. We are committed to openness and transparency in the provision of information to the public.

Further information on the Board's publication policy is available from the website NHS Forth Valley - Publications

In line with the Board's policies on openness and transparency this document is now being made publicly available. However *The Act* allows, at this stage in the procurement process, the Board to withhold information that will become available in the normal course of business when contracts are formally awarded (Section 27). It also permits the withholding of information that is considered commercially sensitive and is likely to prejudice substantially the commercial interests of the parties involved (Section 33).

Applicable Sections of *The Act*

The exemptions that are considered applicable in this instance, and the reasons that NHS Forth Valley consider they apply, are as set out below:

Section 26 – Prohibitions on Disclosure

This exemption states that information is exempt from disclosure if such disclosure is prohibited by or under and enactment. It is an absolute exemption, such that the public interest test need not be applied.

Pursuant to Regulation 43 of the Public Contracts (Scotland) Regulations 2006, NHS Forth Valley may not disclose information forwarded to it by a bidder for the PFI project which the bidder has reasonably designated as confidential. To the extent that the Full Business Case includes such information, it may not be disclosed.

Section 33 – Commercial interests and the economy
The FBC includes information the disclosure of which would prejudice substantially the commercial interests of any person.

Specifically the FBC contains information relating to the preferred bidder's proposals and submissions. Releasing that information prior to the execution of a PFI contract between NHS Forth Valley and the preferred bidder would be likely to prejudice substantially the interests of the preferred bidder. Pursuant to procurement legislation, prior to entering into the PFI contract, NHS Forth Valley must issue formal notices to all the original bidders for the project stating its intention to do so. Were there to be any challenge to the procurement process following the issues of these notices, the existing preferred bidder's interests would be likely to be substantially prejudiced in the event that some or all of the elements of the procurement process had to be re-run.

We consider that the public interest in disclosing such information at this time is outweighed by the public interest in maintaining the section 33 exemption. Specifically, it is in the public interest to ensure that competitive procurement processes followed by public bodies are allowed to run their full course (i.e. up to and including execution of the relevant contracts) without the risk of bidders (or potential bidders) being aware of their competitors' proposals.

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

[Removed] or [redacted] = Deleted or Withheld

For enquiries in relation to this project, please contact

For specific enquiries

Mr Neil McCormick
Director of Strategic Projects and Property

Forth Valley Health Board
Carseview House
Castle Business Park
Stirling FK9 4SW

Tel 01786 463031
Email neil.mccormick@nhs.net

For PPP/PFI enquiries

Mr Mike Baxter
Head of Branch

Private Finance and Capital
Scottish Executive Health Department
St Andrews House
Edinburgh EH1 3DG

Email michael.baxter@scotland.gsi.gov.uk

CONTENTS

TABLES **PAGE NO**

FIGURES **PAGE NO**

APPENDICES

EXECUTIVE SUMMARY

Introduction

The purpose of this Full Business Case (FBC) submission is to secure approval for the provision of a modern NHS community hospital and health centre for the resident population of Clackmannanshire. This new facility will replace unsuitable clinical accommodation and re-provide facilities currently located in Alloa Health Centre, Clackmannan County Hospital and Sauchie Hospital.

The Initial Agreement (IA) for the scheme was approved by the Scottish Executive Health Department (SEHD) Capital Investment Group (CIG) in December 2000.

The Outline Business Case (OBC) was approved by the SEHD CIG in June 2003 and the project was advertised in the Official Journal of the European Union (OJEU) in November 2004.

Four consortia completed the Pre-Qualification Questionnaire (PQQ) process by the due date of 28th January 2005. Following this, and the outcome of the pre ITN Key Stage Review, the Invitation to Negotiate (ITN) was issued to three shortlisted bidders in May 2005. Bid documentation was also issued to the NHS Board's In House Team so that a bid could be submitted for the provision of Soft Facilities Management services.

Technical Bids were received by the NHS Board on 23rd August 2005 and Commercial Bids on the 19th October 2005. The results were evaluated in line with the evaluation methodology agreed by the Project Board, and the bid submitted by Robertson Healthcare consortium was approved by the NHS Board as the Preferred Bidder for the project on 31st January 2006. Following detailed discussion, at its meeting on the 14th February 2006, the NHS Board accepted the recommendation of the Project Board that the provision of Soft Facilities Management for the Clackmannanshire Community Health Services Project be provided by the In House Team.

The only change in the scope of the project since the OBC, relates to the provision of 15 acute mental health admission beds. The possibility of this change was discussed in the OBC and following extensive public consultation in 2004 the Forth Valley NHS Board took the decision to locate all acute mental health admission beds on the new acute hospital in Larbert. Consequently the number of inpatient beds to be provided as part of the new facilities in Clackmannanshire reduced to 45. This change was communicated to the SEHD CIG and it was agreed that the project would continue on this basis.

Strategic Context

The pattern of health services in Forth Valley has been changing dramatically over the last two decades driven by the need to modernise health services, improve the quality of care and create sustainable clinical services.

In recognition of the need for change, the NHS Board has agreed an integrated healthcare strategy with acute hospital services to be provided from one site by 2009, and a redevelopment of community based healthcare to ensure that as much care as possible is delivered closer to home. For this to happen, a more seamless service must be created through greater integration of primary and secondary care, supported by a modern information and communication system. This will allow the skills and competencies of staff in both primary and secondary care, to be used to best effect and to ensure the continuing provision of services that achieve quality, safety, sustainability and accessibility.

Forth Valley Healthcare Strategy has been developed in partnership recognising the interdependence of acute/secondary care, primary care/community services and health/social care. The Minister for Health and Community Care approved the Healthcare Strategy and strategic direction in 2003 following an extensive period of public consultation.

The 'whole systems' integrated service approach is one of the key themes of the recent Scottish White paper. It is against this background of partnership working and the development of more integrated services that the Board seeks to develop and redesign services for a manageable and sustainable future. There are four key strands that the healthcare strategy addresses to make this vision a reality, namely the:

- reconfiguration of inpatient and ambulatory care services;
- development of intermediate care and rehabilitation services;
- development of primary care and community services; and
- development of mental health Services.

The first and second Business Cases (OBC I & II) in support of the Forth Valley Healthcare Strategy begin to address a number of these strands, and work is continuing on those elements of community and primary care services that will complete the delivery of the strategy. The Initial Agreement for the development of community facilities in Stirling and Falkirk has already been approved by the Scottish Executive Health Department.

The Outline Business Case

The original investment objectives were based on the Forth Valley Healthcare Strategy, and reflect the consultation on the provision of community services to the resident population of Clackmannanshire. The objectives, constraints and benefits criteria are set out in Chapter 3.3.

The Project Board involved a number of individuals in the option appraisal exercise including clinicians, staff, service users, GPs and managerial staff in both health and Social Work services.

The Board and its planning partners looked at a number of possible options for delivering the desired service models. The long list was originally developed by looking separately at the options for the provision of primary care services and community hospital services.

The Board, its advisors and partner agencies assessed the long list of options in detail. The result of this assessment identified two options that were the subject of more rigorous appraisal. The short listed options were:

- Option 1: Do minimum; and
- Option 2: Integrated Single Site Option.

The preferred option was agreed as Option 2 with the decision based on the analysis of the benefits, costs and risks associated with each. In particular the two major tests of benefits appraisal and risk adjusted economic appraisal, indicated Option 2 as the preferred option.

The preferred option provided the best fit with the objectives of the investment while demonstrating value for money, achieves the required non-financial benefits and is affordable.

The only change in scope of the Clackmannanshire Community Health Services Project since the OBC was approved in June 2003 relates to the provision of 15 acute mental health admission beds. The possibility of this change was discussed in the OBC.

Following the review of mental health strategy and extensive public consultation in 2004, Forth Valley Health Board took the decision to locate all acute mental health admission beds at the new acute hospital in Larbert. Consequently the number of inpatient beds to be provided as part of the CCHSP was reduced to 45. This change was communicated to the SEHD Capital Investment Group and it was agreed that the project would continue on this basis.

The Conventional Procurement Assessment Model (CPAM)

The CPAM represents a comparator scheme, which would meet the Board's clinical and facility management output specifications. It assumes access to capital funds from government and is the benchmark used to demonstrate whether the PFI proposal offers value for money. The CPAM is the scheme from which the approved affordability figures are calculated.

The CPAM has been developed in sufficient detail to ensure that it provides an adequate benchmark against which the private sector solutions can be measured. It is based on the Preferred Option at the OBC, and has been updated to reflect agreed changes in requirements.

The value for money and affordability of the CPAM and the PFI are compared in Sections 13 and 14, respectively.

The PFI Procurement Process

The project has been procured under the relevant European Union rules, through the negotiated procedure applicable to Service Contracts under the 1993 Public Services Contract Regulations. The Board has followed NHS guidance on the PFI procurement process, issued in December 1999, and would like to acknowledge the efforts, commitment and professionalism shown by all bidders at each stage of the Procurement Process.

Over 50 multi-disciplinary clinical and non-clinical staff, including Clackmannanshire Council staff and GP's, have developed the operational policies and specifications of requirements. They have also worked with each of the short listed bidders, at each stage of the procurement process, in developing the designs.

A notice was placed in the OJEU ("S" series) on 24 November 2004, inviting applications from candidates who could fulfil the requirements of designing, building, financing and operating the facility.

Pre-Qualification Questionnaires (PQQ) were issued to all organisations responding to the OJEU advertisement and were evaluated in accordance with the Evaluation Framework agreed by the Project Board. Three consortia demonstrated that they had the experience and resources to undertake the project and the Project Board agreed that these consortia would progress to the ITN stage. The NHS

Board agreed in July 2004 to test Value for Money (VfM) for the provision of Soft Facilities Management services via the procurement process, and allow for the submission of an In House Bid.

The evaluation of submitted Bids has been fully documented to demonstrate a clear audit trail. There was partnership representation throughout the process with staff representation included on key sub groups, the Main Evaluation Panel and the Project Board. Partnership representation was also included on the In House Bid Team.

Following the very thorough evaluation procedure the Project Board agreed that on the basis of both the qualitative and quantitative evaluations, they should recommend to the NHS Board that Robertson Healthcare be selected as Preferred Bidder. This recommendation was approved at the NHS Board meeting held on 31 January 2006 subject to satisfactory resolution in writing of a number of key outstanding issues, and successful completion of the Key Stage Review.

The NHS Board received a presentation and considered a paper "Clackmannanshire Community Health Services Project ITN Evaluation: Soft Facilities Management" at its meeting on the 14th February 2006. Following detailed discussion the NHS Board accepted the recommendation of the Project Board that the provision of Soft Facilities Management for the Clackmannanshire Community Health Services Project be provided by the In House Team in conjunction with Bidder Cs proposals for the design, build, finance and maintenance (hard facilities management) of the new facilities.

The Preferred Bidder letter was issued by the Board on 31 March 2006 and following further extensive negotiations with Robertson Healthcare, and the issue of a revised Preferred Bidder Letter on 18 July 2006, the Preferred Bidder letter was signed by Robertson Healthcare and their funders on 29 August 2006.

The Preferred PFI Solution

The development as proposed will comprise four buildings in a campus arrangement; Health Centre; Community Mental Health Resource Centre; Inpatient and Day Therapy Unit and Facilities Management Building. These buildings are all to be located on the 'Sauchie Hospital' site with the adjacent former Alloa Mill site being used for parking.

The departmental relationships and clinical functionality required to be delivered by the brief were met to a large extent at the ITN stage. The proposed design allows for both internal and external adaptation to meet the changing ways in which care will be delivered in the future. Good use of the entire site with some specific individual expansion areas identified.

This project benefits from there being a straightforward occupation by the Board. There are limited decant issues that affect the completion of the building with no phased occupation currently being envisaged.

Clackmannanshire Council Regulatory Committee considered an application for full planning and listed building consent on 22 December 2006 and Planning Consent was granted subject to conditions. The Board have obligations in regard to some of the Planning conditions, principally in connection with the off site works, which the Board is currently negotiating with the Council regarding responsibilities and financial liabilities.

Human Resources

Board staff have been involved in the development of the Clackmannanshire Community Health Services Project through the well-established partnership arrangements, and it is recognised that the proposals represent significant organisational change challenges for employees. In general the implication for Board staff, associated with the new development are:

- staff working in clinical services will not be transferred to the private sector as part of the PFI contract;
- the successful In-House Team Bid for Soft FM means there are no staff transfers associated with the provision of Soft FM services; and
- the number of Hard FM staff associated with the existing facilities in Clackmannanshire is relatively small. Therefore the Board has actively reduced, through vacancy management, the number of Hard FM staff employed to a level such that there will be no staff transfers associated with the provision of these services at the new facility.

Therefore, there are no consequences for Board under the SE/STUC Protocol or the application of the TUPE regulations.

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

Information Technology

As part of the development of the new health centre and community hospital facilities in Clackmannanshire, Robertson Healthcare shall design, construct and maintain a comprehensive and robust infrastructure (e.g. containment, cabling and computer rooms) in accordance with the Board's ITN documents.

Robertson Healthcare shall provide systems that are fully compatible with the Board's operational information technology systems. The Board will install hardware (e.g. servers, PCs, printers, scanners), make the final connections (at the application and in computer rooms) and commission the operational system.

The precise lines of demarcation of the scope of the provision, by the Boards and Robertson Healthcare, can be found in:

- Table C8/1: Information Technology Responsibility Matrix; and
- Table C8/2: Communication Responsibility Matrix.

Equipment

The Invitation to Negotiate contained a draft list, detailing who was to provide each item of equipment. Medical equipment and moveable items will be procured separately by NHS Forth Valley or transferred from existing facilities.

Robertsons Healthcare have, as part of their bid, costed for the supply, installation, commissioning, maintenance and replacement of equipment which is integral to the construction and maintenance of the building. This will mainly include:

- Group 1 and some Group 2 equipment items shall be procured by Robertsons Healthcare and were costed as part of the bid submission. The maintenance for these items forms part of the Opex costs.

The Board will retain full responsibility for equipment, other than Group 1 and some Group 2 which will include:

- Group 3 and 4 items that will be purchased or leased by NHS Forth Valley through a traditional procurement route. and

- Soft Facilities Management equipment in the new facility as this is a retained service.

There is an expectation within NHS Forth Valley that a percentage of equipment will transfer from current premises to the new development but a percentage has not been confirmed as this will continue to change as new equipment replaces old during the period up to practical completion and service commencement.

Involving Patients and the Public

The Public Engagement/Involvement/Consultation process for the project has used the Scottish Executive Health Department (SEHD) guidelines that were in existence at the time that each exercise was carried out.

The Board undertook a process of internal and external consultation on the Healthcare Strategy in 2002 and 2004, which included the proposal to centralise acute services on one site, with a complementary network of community hospitals and primary care facilities. This process included wide circulation of the Strategy to all key stakeholders and also included a series of public meetings. Following this consultation the strategy was adopted by the NHS Board and subsequently submitted to SEHD for ministerial approval.

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 Forth Valley. In respect of the proposals to build a new Community Hospital for Clackmannanshire and to co-locate a replacement for Alloa Health Centre on an extended Sauchie Hospital site, there has been strong support for this, from within Clackmannanshire and general support from other areas.

In parallel with these formal processes, the Board has pursued an active internal and external communications process to provide information to staff, visitors and the public about the scheme as it has progressed. In addition, the Patient Public Panel has been actively involved in the evaluation of Bids and there has been consistent Patient Representation on the Project Board.

Financing of the Scheme

The evaluation process up to financial close has incorporated several detailed reviews of Robertsons Healthcare FBC Model, provided by Quayle Munro Limited.

The Service Payment payable by the Board under the preferred financing structure is detailed in Chapter 11 "Financing Assessment of the PFI Solution". Chapter 11 also discusses the make-up of the preferred financing structure, together with the terms being offered, and evidence that the financial solution being offered to the Board is VfM.

The senior fixed rate bank debt funding solution selected by Robertson Healthcare is a well known structure used within the PFI market and the terms offered by the senior debt funder are broadly in line with market norms.

Risk Analysis and Risk Management Strategy

A full risk analysis was undertaken as part of the OBC, and standard practice is to roll this forward and add new risks as they are identified. The transferability of risk under the CPAM and PFI options seeks to optimise rather than maximise the transfer of risk, so that the sharing of risk between the Board and Robertson Healthcare is at its most cost effective (i.e. the risks lie with the party best able to manage them).

Risks are assessed and valued to ensure that the Conventional Procurement Assessment Model (CPAM) can be compared with the Private Finance Initiative (PFI) option on a "like for like" basis, ensuring that the value of risk retained by the Board under both options is quantified and understood.

Under the CPAM, publicly funded option, virtually all risks remain with the Board. Therefore the Board is exposed to a greater degree of risk in terms of price variations, poor performance, late delivery etc. The PFI scheme enables a large proportion of these risks to be transferred to the private sector where they are best able to manage them; with the Board remaining responsible only for those risks it is best able to manage.

Since OBC stage the risk register has been further developed to identify and record the project risks across ten categories, as set out in Section 12 "Risk Analysis and Risk Management Strategy". This has been informed by the NHS standard risk matrix which has developed the risks into more specific and manageable areas for practical management.

The risks retained by the Board are monitored through the Project Team with regular reports to the Project Board to ensure that appropriate and timely action is taken to minimise them through the implementation of appropriate mitigation measures.

Economic Appraisal

The purpose of the economic appraisal is to assess in net present value (cost) terms, which of the Public Sector and Private Finance options provides better value for money. Chapter 13 "Economic Appraisal" illustrates that, although the base cost of a PFI proposal is more expensive than the CPAM, when the value of the retained and transferred risks are included in the appraisal, the PFI option demonstrates value for money.

Value for Money has been assessed by NHS Forth Valley using the English Department of Health's Generic Economic Model (GEM), as permitted by the Scottish Executive Guidance. This compares the NPV of the CPAM against Robertsons Healthcare FBC Model (inclusive of risk adjustments) over a 30 year and 60 year period.

Chapter 13 details the full economic appraisal undertaken for the project and summaries the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) of both the CPAM and the PFI options. The analysis demonstrates that The PFI option provides better value than the CPAM and is therefore the preferred option in value for money terms. Sensitivity analysis confirms that the economic case for the PFI option is robust. This is summarised in the table below.

Table ES/1: Results of VfM Assessment using the GEM

	CPAM £'000	**PFI £'000**
Net Present Value	[redacted]	[redacted]
Ranking	**2**	**1**

Financial Appraisal

The purpose of the Financial Appraisal is to assess in annual revenue terms, the impact of the scheme on the Board's income and expenditure account, and against the annual sum committed to the scheme.

Chapter 14 "Financial Appraisal" sets outs the revised affordability position. The Service costs include the new clinical model of care, together with those non clinical services to be retained by NHS Forth Valley. The Unitary Charge is based on the annual charge from Robertson Healthcare together with the annual cost from the In-House Team for the provision of soft facilities management services. The revised affordability position is summarised in the table below.

Table ES/2: Affordability Position

	£m	**£m**
Service Cost	[redacted]	
Unitary Charge	[redacted]	
Total Cost		[redacted]
Existing Service Funding	[redacted]	
Council/Pharmacy income	[redacted]	
Financial Plan	[redacted]	
Capital Plan (Residual Interest)	[redacted]	
Total Funding		[redacted]
Surplus/(Deficit)		[redacted]

Throughout the procurement process, from the inception of the OBC to the FBC, the affordability position of the project has been closely monitored. The Board has allocated sufficient resources to fund the clinical model of care and the Unitary Charge.

Moving forward, costs will increase by inflation, the Board has assumed that the annual uplift from the SEHD will ensure that the affordability is maintained. The appraisal reflects the accounting requirements for buildings within PFI schemes.

Contract Framework and Payment Mechanism

The Project Agreement is in the standard form for NHS Project Agreements as issued by the Scottish Executive Health Department. The version that has been used for this Project is the version that was issued in September 2003 – Standard Form 3 (SF3) together with subsequent changes to SF3 recently issued in draft form. Any proposed derogations from Standard Form will be covered in an update prior to Financial Close.

Chapter 15 "Contract Framework and Payment Mechanism" describes the basis of the legal or contractual framework, which will underpin the Project and sets out a summary of the key contractual relationships, which will be put in place between the Board, Robertson Healthcare and their sub contractors and the funders of the scheme.

The payment mechanism follows the standard form for PFI projects. It is structured such that the Board will make a single monthly service payment for all of the Services delivered by Robertson Healthcare. Underlying the payment mechanism is the philosophy that if Robertson Healthcare fails to provide any services, they will receive financial deductions and Service Failure Points. The Board will have an ability to monitor performance of services and if the service deteriorates the Board will be entitled to increase its monitoring and if necessary step into a specific service.

Accounting Treatment of the PFI Scheme

The Board has received an opinion on the accounting treatment of the project from its corporate financial advisers, PwC. The Board's external auditors have reviewed PwC's report and concur with the conclusion that an off balance sheet treatment is appropriate.

Project Management Arrangements

Chapter 17 "Project Management Arrangement" demonstrates that the project up to financial close has been managed effectively and in a timely way. The Board intends to maintain this level of performance and commitment to delivering the project throughout the next key stage of the process.

The key roles described in Chapter 17 will be retained supported by an internal organisation to deliver the key outputs of the project in a timely way. The precise structure is still to be finalised, however this will include a group focused on the commission and equipping of the facility and a group reviewing the benefits realisation and post project evaluation.

The proposed timetable for completion of the development is set out in the table below.

Table ES/3: Project Timetable

Detailed Planning Consent	December 2006
Approval of Full Business Case (FBC)	January 2007
Scottish Executive Health Department approval of FBC	March 2007
Commencement of Enabling Works	March 2007
Financial Close	June 2007
Practical Completion	September 2008
Service Commencement	October 2008

Benefits Realisation Plan and Post Project Evaluation Plan

The objectives and benefits of the project are set out in Chapter 3, the Outline Business Case. A benefits realisation plan was developed for the OBC and has been reviewed and updated to reflect changes in scheme requirements.

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

Conclusion

This FBC presents a strong and coherent rationale for the development of a modern NHS community hospital and health centre for the resident population of Clackmannanshire. This new facility will replace unsuitable clinical accommodation and re-provide facilities currently located in Alloa Health Centre, Clackmannan County Hospital and Sauchie Hospital.

Robertson Healthcare will be responsible for the financing, design, build and maintenance of the new facilities over a 30 year period (including construction phase). The contract arrangements will be as set out in the Standard Form of Contract for PFI schemes, adjusted to reflect agreement reached on project specific issues. Derogations from Standard Form have been agreed by SEHD.

The scheme has been demonstrated to be affordable, within the affordability framework agreed by Forth Valley Health Board. The scheme continues to provide robust value for money with significant risk being transferred from the Board to Robertson Healthcare and the asset will not be accounted for on the Board's balance sheet.

1. INTRODUCTION

1.1. Introduction

1.1.1 The purpose of this Full Business Case (FBC) submission is to secure approval for the provision of a modern NHS community hospital and health centre for the resident population of Clackmannanshire. This new facility will replace unsuitable clinical accommodation and re-provide facilities currently located in Alloa Health Centre, Clackmannan County Hospital and Sauchie Hospital.

1.1.2 This is the last key step in a three-stage process. The original Initial Agreement (IA) which addressed the future configuration of community services within Clackmannanshire was submitted to the Scottish Executive Health Department (SEHD) Capital Investment Group (CIG) in December 2000.

1.1.3 The Outline Business Case (OBC), which developed the proposals outlined in the IA, was approved by the CIG in June 2003.

1.1.4 This document now presents the Full Business Case (FBC) for the reconfiguration of community services in Clackmannanshire, within the NHS Forth Valley Health Board Area. It includes proposals for a new:

- health centre for Alloa;
- facility for community adult mental health services;
- base for community nurses and council social work staff; and
- community hospital for Clackmannanshire.

1.1.5 Together these proposals add up to the largest investment in health services in Clackmannanshire for a generation, and the second largest capital project in NHS Forth Valley. This Business Case therefore represents a significant step in developing modern health services designed to meet the healthcare needs of the people of Clackmannanshire both now and in the future.

1.1.6 The OBC for the project, which was developed in partnership with Clackmannanshire Council, was approved by the NHS Board in April 2003.

1.1.7 The local health community were extensively consulted in 2003 about the underlying Healthcare Strategy and reconfirmed their support for the project.

1.1.8 Other developments within NHS Forth Valley include the development of acute services, a Full Business Case for this is also due to be submitted in January 2007. Other key developments in community and primary care services within the Falkirk and Stirling areas will be the subject of a further business case, once a full assessment of need has been undertaken, and will represent the third phase in the implementation of the Forth Valley Healthcare Strategy.

1.2. Summary of Current Healthcare Provision in Forth Valley

1.2.1 NHS Forth Valley provides health services to a population of 279,000 in a geographical area stretching from the Trossachs in the north-west to the outskirts of Edinburgh in the south-east. It consists of the three councils of Clackmannanshire, Falkirk and Stirling and incorporates a mix of urban and rural areas.

1.2.2 The majority of the population of Forth Valley is concentrated in Stirling and Falkirk and the surrounding areas. However, there are significant numbers of people living in the small towns and villages in the rural areas of the region.

1.2.3 Healthcare services for the councils of Clackmannanshire, Falkirk and Stirling are predominantly provided by NHS Forth Valley, although some communities on the outskirts receive general hospital services from neighbouring Health Boards. Given the central position of NHS Forth Valley, specialist health services are provided in both Edinburgh and Glasgow.

1.2.4 In developing it's Healthcare Strategy, NHS Forth Valley has recognised the diverse nature of its population and has sought to meet the differing needs of the urban and rural communities. The views of people from these different communities have helped to inform the development of a multi-faceted strategic direction for healthcare services in Forth Valley.

1.2.5 Currently services within Clackmannanshire are provided from three key facilities. These are:

- Alloa Health Centre, where primary care services are provided to a registered population of about 25,000 (the largest primary care facility in Forth Valley and one of the largest in Scotland);
- Clackmannanshire County Hospital, where hospital and community adult mental health services are based serving the whole of Clackmannanshire; and
- Sauchie Hospital where hospital services for older people in Clackmannanshire are based.

1.3. Drivers for Change

1.3.1 The modernisation and further development of services to improve the health and well being of the Clackmannanshire population is severely hampered by the limitations of the three current facilities. All three facilities have significant problems that constrain both the provision of current services and future service development to respond to changes in need and the way needs are met.

1.3.2 The key drivers for change facing the Board and the local health community are:

- The national policy framework set out in 'Our National Health', 'Towards a Healthier Scotland' and 'Partnership for Care';
- The need to create sustainable clinical services;

- The modernisation of services, focussing on quality and clinical effectiveness;
- Pressures on the clinical workforce;
- The inadequacy and unsuitability of much of the existing facilities; and
- The most efficient and effective utilisation of resources to support service modernisation and development.

1.4. Local Application of National Plans and Priorities

1.4.1 This Business Case has been influenced by a number of national policies and strategies, all of which emphasise the need to modernise health services, providing consistently high quality care in order to meet patient staff and organisational needs. The main policies and strategies that set the national context for this proposal are:

- Framework for Mental Health Services in Scotland, 1997
- Modernising Community Care: An Action Plan, 1998
- The White Paper Towards a Healthier Scotland, 1999
- Our National Health – a plan for action a plan for change, 2000
- Community Care – A Joint Future, 2000
- The White Paper Partnership for Care, 2003
- Building a Health Service Fit for the Future (The Kerr Report), 2005
- Delivering for Health (the response to the Kerr Report), 2005
- Developing Community Hospitals – A Strategy for Scotland, 2006

1.4.2 Further information on the policies and strategies that set the national context can be found in Chapter 2, the Strategic Context chapter of this FBC.

1.4.3 The proposals within this FBC take full account of these policies and are in tune with the main themes in the most recent White Paper 'Partnership for Care'. Many of the key issues contained within the White Paper namely, improved partnership working with local authorities and other agencies, service redesign and improved communication and public involvement are already being actively taken forward by NHS Forth Valley.

2. STRATEGIC CONTEXT

2.1. Introduction

2.1.1 This chapter of the Full Business Case sets out:

- The national policy context including the national priorities and planning framework and the drivers for change which emerge from this;
- Description of NHS Forth Valley, including its local population and the Board's priorities for developing local services for residents;
- Current service provision and project objectives including a description of community services in Clackmannanshire, and a statement of objectives for the project;
- Assessment of future strategic changes in the local health economy; and
- The extent to which the Clackmannanshire Community Health Services Project is relevant in the context of future change.

2.2. National Context

2.2.1 The Healthcare Strategy has been influenced by a number of national policies and strategies, all of which emphasise the need for joint working among agencies to achieve better services, better use of resources and improvements in people's quality of life, these include:

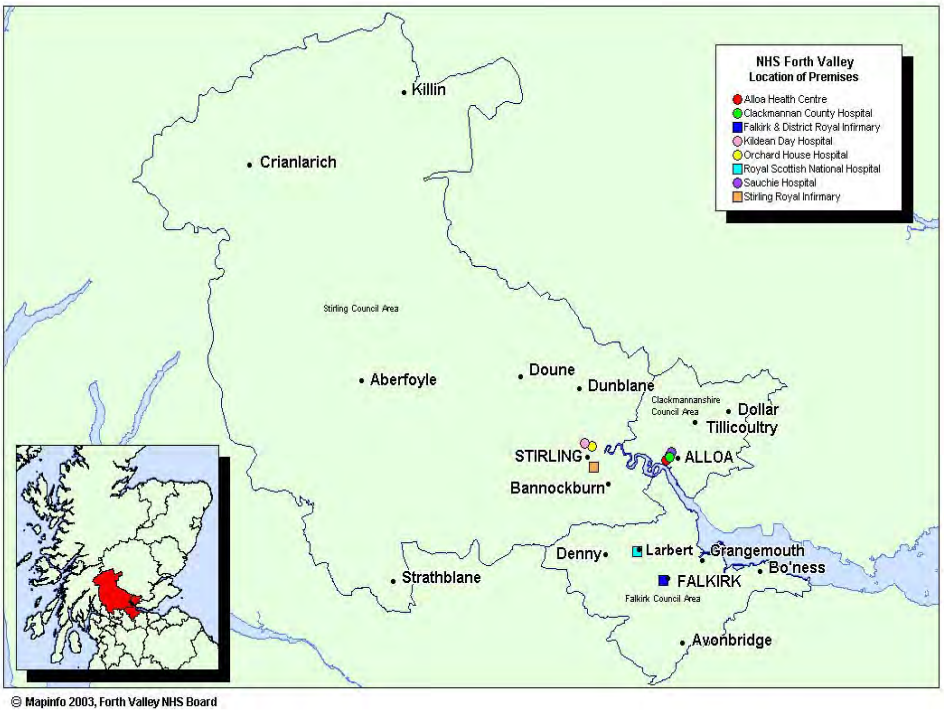
- The recent White Paper "Partnership for Care";
- Framework for Mental Health Services in Scotland, 1997;
- The Acute Services Review report, 1998;
- 'Modernising Community Care: An Action Plan', 1998;
- The White Paper 'Towards a Healthier Scotland', 1999;
- 'Community Care – A Joint Future', 2000;
- 'Our National Health – a plan for action, a plan for change', 2000;
- An Action Plan for Dental Services in Scotland, 2000;
- 'Nursing for Health: a review of the contribution of nurses, midwives and health visitors to improving the public's health', 2001;
- 'Adding Years to Life', 2002;
- 'The Right Medicine: a strategy for pharmaceutical care in Scotland', 2002;
- 'The Health and Well Being of Older People in Scotland', 2002;
- 'Delayed Discharges in Scotland', report to the Minister for Health & Community Care, 2002;
- 'Making the Connections: developing best practice into common practice' report of the Primary Care Modernisation Group, 2002;

- 'Building on Success - future directions for Allied Health professionals in Scotland', 2002;
- 'Future Practice', 2002;
- Developing primary care services;
- Service integration across the care spectrum - community through to acute care;
- Redesigning community based mental health services;
- Responding to the e-health agenda;
- Building a Health Service Fit for the Future, 2005;
- Delivering for Health (2005);
- Delivering for Mental Health (2006);
- National Review of Mental Health Nursing (2006);
- Doing Well by People with Depression – National Evaluation Report, 2006; and
- Developing Community Hospitals – A Strategy for Scotland, 2006.

2.3. Overview

2.3.1 NHS Forth Valley has responsibility for both improving the health of the people of Forth Valley and for providing healthcare services for those in need of clinical care. Figure C2/1 shows a map of the Forth Valley Health Board Area.

Figure C2/1: Forth Valley Health Board Area



2.3.2 The pattern of health services in Forth Valley has been changing dramatically over the last two decades driven by the need to modernise health services, improve the quality of care and create sustainable clinical services.

.

2.3.3 In recognition of the need for change, the NHS Board has agreed an integrated healthcare strategy with acute hospital services to be provided from one site by 2009, and a redevelopment of community-based healthcare to ensure that as much care as possible is delivered closer to home.

2.3.4 For this to happen, a more seamless service must be created through greater integration of primary and secondary care, supported by a modern information and communication system. This will allow the skills and competencies of staff in both primary and secondary care, to be used to best effect and to ensure the continuing provision of services that achieve quality, safety, sustainability and accessibility.

2.3.5 The Minister for Health and Community Care approved the Healthcare Strategy and strategic direction in 2003 following an extensive period of public consultation.

2.3.6 Two business cases have emerged from the Healthcare Strategy, both of which were the subject of Initial Agreements approved by the Scottish Executive at an earlier stage. These were:

- Clackmannanshire Community Health Services (OBC I) approved in June 2003. The Full Business Case is currently in the process of finalisation; and
- Forth Valley Acute Hospital (OBC II) approved December 2003. The subject of this Full Business Case.

2.3.7 In response to the 2002 public consultation further work was undertaken in 2003 to develop more specific proposals for:

- primary care and community services;
- the future model and options for community hospitals;
- adult mental health services; and,
- transitional arrangements for acute hospital services.

2.3.8 A business case was also submitted to SEHD in 2004 on transitional arrangements in acute services.

2.4. Strategic Aims

2.4.1 The Forth Valley Healthcare Strategy is designed to support the delivery of NHS Forth Valley's strategic aims, which remain unchanged from those originally outlined in 2003/04 and reaffirmed by the Local Health Plan 2006/07 to 2008/09. These are to:

- improve Forth Valley's health, and reduce the health gap between rich and poor;

- ensure Forth Valley NHS meets national standards of care to be delivered locally across Scotland;
- improve access to services, reduce waiting and making the patients 'journey of care easier, quicker and safer;
- give patients, public and communities a real voice on the way the Forth Valley NHS is run;
- provide better care for the residents of Forth Valley;
- tackle the 'big three' priorities: heart disease, cancer and mental health;
- improve care and standards in the NHS by valuing and empowering staff and working in partnership with them to work in new, more collaborative, flexible and effective ways; and
- ensure a considered approach to planning and delivery of the whole health agenda.

2.5. Service Specification

2.5.1 Forth Valley Healthcare Strategy has been developed in partnership recognising the interdependence of acute/secondary care, primary care/community services and health/social care.

2.5.2 The 'whole systems' integrated service approach is one of the key themes of the recent Scottish White paper. It is against this background of partnership working and the development of more integrated services that the Board seeks to develop and redesign services for a manageable and sustainable future.

2.5.3 A programme of service design is already being developed to support the whole system changes, building on the knowledge and expertise of the redesign programme. The programme will target the design of service models to enable NHS Forth Valley to deliver the Healthcare Strategy.

2.5.4 There are four key strands that the healthcare strategy addresses to make this vision a reality, namely the:

- reconfiguration of inpatient and ambulatory care services;
- development of intermediate care and rehabilitation services;
- development of primary care and community services; and
- development of mental health Services.

2.5.5 The first and second Business Cases (OBC I & II) in support of the Forth Valley Healthcare Strategy begin to address a number of these strands, and work is continuing on those elements of community and primary care services that will complete the delivery of

the strategy. The Initial Agreement for the development of community facilities in Stirling and Falkirk has already been approved with the timing of the OBC (OBC III) in the 3rd quarter of 2007.

2.6. Inpatient & Ambulatory Care Services

2.6.1 The new acute hospital at Larbert will provide all existing acute services, as summarised in the following table:

Table C2/1: New Acute Hospital Service Profile

- Accident and emergency;
- Acute Inpatient beds, elective and emergency, in the following specialties:
  - Trauma and Orthopaedics
  - General Surgery
  - Vascular Surgery
  - Urology
  - ENT
  - Ophthalmology
  - Oral Surgery
  - Gynaecology
  - Obstetrics
  - Paediatrics & Neonatal Medicine
  - Rehabilitation
  - General Medicine
  - Medicine for the Elderly
  - Cardiology
  - Dermatology
  - Diabetes
  - Rheumatology
  - Respiratory Medicine
  - Haematology
  - Pain Relief
  - Oncology
  - Renal Medicine.
- Critical Care services, including ICU, HDU and CCU
- Services on an Ambulatory Care basis including acute, complex and 'one stop' outpatients; day surgery; and complex day treatments.
- Clinical Support Services including imaging (ultrasound, x-ray, CT, MRI), laboratory and other diagnostic services; allied health professions; and pharmacy.

2.7. Intermediate Care and Rehabilitation Services

2.7.1 Remodelling the delivery of intermediate non-acute care, through a joint development with other health and social care partners, is an important element of the changes proposed within Forth Valley.

2.7.2 The aim of intermediate care and rehabilitation services is to promote functional independence and well-being through joint working with local authorities. As well as bridging high intensity acute secondary care and primary care.

2.7.3 The range of services and facilities that link with intermediate care include services designed to avoid inappropriate admissions, low dependency surgical recovery, non-medically led therapeutic interventions on and off site possibly within a community hospital and services that focus on nurse led units providing step down facilities and rapid response services.

2.8. Primary Care & Community Services

2.8.1 It is recognised within the Healthcare Strategy, in the context of the proposal to locate all acute services on a single site, that there is a need to develop primary and community services to ensure an appropriate pattern of health service provision across the spectrum of care from care provided within peoples' own homes to acute care in a hospital setting.

2.8.2 For this to happen, a more seamless service must be created through greater integration of primary and secondary care, supported by a modern information and communication system. This will allow the skills and competencies of staff in both primary and secondary care, to be used to best effect and to ensure the continuing provision of services that achieve quality, safety, sustainability and accessibility.

2.8.3 The NHS Board's Primary Care Modernisation Programme currently makes provision for significant capital developments in a number of health centre and clinics throughout Forth Valley. One key element of the proposal to enhance primary care and community services across Forth Valley, to support and complement the creation of a single site acute hospital, is the development of community hospitals.

2.8.4 The Primary Care and Community Services Programme was established in 2003 to take forward the primary care and community services aspects of the integrated Forth Valley Healthcare Strategy. This further work, taken forward by a multi agency Programme Board, culminated in the 2004 public consultation referred to above.

2.8.5 Following the outcome of the public consultation the NHS Board took a number of decisions on the future shape and pattern of primary care and community services. To take this programme of work forward a detailed action plan has been developed covering the key service changes are outlined below.

2.9. Primary Care

2.9.1 For most people, their first and perhaps only contact with the NHS is with primary care. In taking decisions about the strategic direction for health services in Forth Valley, the NHS Board recognised that there were several factors also driving change in primary care. For example:

- the changes in population will have a significant effect on primary care services as will changes in health needs and technology;
- there is also a need to modernise services, improving service quality and effectiveness, in order to create sustainable clinical services; and
- many of the existing facilities and premises used to deliver care are inadequate and unsuitable for the future vision of patient care needs.

2.9.2 The NHS Board's vision is to provide healthcare services in a primary care setting when this can be done safely and effectively, so in future, it is envisaged that services will be configured to meet needs at different levels, namely:

- GP Practice level;
- locality or community level;
- area level i.e. North (Stirling and Clackmannanshire) and South (Falkirk); and
- Forth Valley level.

2.10. Community Hospitals

2.10.1 One key element of the proposal to enhance primary care and community services across NHS Forth Valley, and to support the creation of a single site acute hospital, is the development of community hospitals.

2.10.2 It is envisaged that the future role for Community Hospitals would be to provide:

- intermediate care and rehabilitation services;
- continuing care for older people with complex health needs;
- palliative care;
- day hospital services;
- a base for multi-disciplinary and multi-agency rehabilitation teams; and,
- possible future development of inpatient resources for primary care.

2.10.3 Based on projections of future bed requirements, a number of options were developed for future community hospital provision in Forth Valley. In addition to the new Clackmannanshire development, options for both Stirling and Falkirk were the subject of an extensive public consultation exercise in 2004, as a result of which the NHS Board agreed that the preferred location for community hospital and other community services in:

- Falkirk was to retain part of the FDRI site; and
- Stirling was to retain part of the former SRI site.

2.10.4 The estimated cost of the Board's preferred options for community facilities in Stirling and Falkirk will need to be refined once the models of care for each facility are more clearly defined. Revenue costs will need to be affordable within the NHS Board's financial plan. Overall affordability will be evaluated through the Outline Business Case process.

2.10.5 In addition to community hospital services, consideration is being given to including other community services within the scope of these two developments. The Stirling scheme in particular will include a range of ambulatory acute services including acute outpatients and diagnostic services. Further detail on the scope of the new facilities and the models of care will be included in the Outline Business Cases.

2.11. Adult Mental Health Services

2.11.1 At present acute adult mental health admission beds are provided in Falkirk, Stirling and at Clackmannan County Hospital. The business case for the new acute hospital, supported by the Healthcare Strategy, aims to centralises the acute adult admission beds on the new acute hospital site at Larbert.

2.11.2 The main drivers for these changes include the need to ensure quick and easy access to other specialist medical services, the need to ensure the continuation of clinically effective, evidence based care, the changes to working arrangements for junior doctors similar to that affecting general acute services and the requirements of the new Mental Health Act.

2.11.3 The main requirement is to ensure a balance of provision between hospital care for those who are most ill and in need of intensive care and treatment, and community based services that provide care and treatment as close to the patient's home as possible.

2.11.4 The main elements of the proposed new service model are:

- a centralisation of all acute admission beds including psychiatric intensive care beds on the site of the new Acute Hospital at Larbert;
- no mental health admission beds in the new Clackmannanshire Community Hospital;
- continuing residential rehabilitation from facilities at Craigenhall, Falkirk;
- re-provisioning of wards at Bellsdyke Hospital to provide a more dynamic rehabilitative environment;
- rebalancing of inpatient and community resources with around 15 fewer beds and enhanced community provision;
- relocation of Princes Street Day Hospital with other community beds and services in Stirling; and
- relocation of West bank and Dunrowan with other community beds and services in Falkirk.

2.11.5 During the period until 2009 when the new Acute Hospital will be provided, there is a need to gradually work towards the proposed configuration of services. One of the most pressing issues is in relation to working arrangements and hours of work for junior medical staff, which will make it impossible to sustain on-call out of hour's arrangements, covering four sites.

2.11.6 The acute adult mental health and old age psychiatry admission beds were centralised at the end of 2006 on an interim basis on the FDRI site, in conjunction with the intensive psychiatric care unit already located there. The opportunity has also been taken to develop the new community based model of care by utilising the resources released by a reduction of 15 beds.

2.12. Benefits to Patients

2.12.1 Within the context of the overall improvements to healthcare services that will be delivered through the Forth Valley Healthcare Strategy, it is anticipated that the proposals set out in this business case and the business case for the new acute hospital at Larbert, will deliver a range of benefits for patients. The main expected benefits are summarised below.

Table C2/2: Expected Benefits of the Forth Valley Healthcare Strategy

Inpatient & Ambulatory Care Services:

- High-quality clinical care for patients that is timely, accessible and consistently available.
- Sustainable core emergency and elective services.
- Provision of acute medicine and acute surgery on the one site, ensuring co-ordination of care and access to specialist expertise when needed.
- Protection of elective workload from interruption by emergencies, thereby reducing the number of cancellations.
- Closer integration of ambulatory care services, which will improve communication and reduce the movement of patients between departments.
- Computerised booking and scheduling of appointments will manage peaks and troughs in activity to reducing waiting times and improve access to services.
- Modernised services and facilities that will improve the overall patient experience.
- Increased availability of up-to-date high technology equipment and resources, intensive care and high dependency facilities, and clinical support services.
- Enhanced training opportunities for staff that will ensure patients benefit from up to date knowledge and skill.

Intermediate Care & Rehabilitation Services.

- Specialist facilities for those patients that are physiologically stable but who may have other needs that require clinical intervention to support their rehabilitation and overall recovery.
- The delivery of effective intermediate care and rehabilitation in an environment in which staff can provide the right care at the right time to patients.
- Improved access to intermediate care and rehabilitation will ensure that an individual's length of stay is appropriate and beneficial.

Primary Care & Community Services.

- Provision of appropriate services as close as possible to the patient's own home.
- Enhanced model of community hospital provision.

- Improved service integration.

Mental Health Services.

- A clearer vision of the future provision of mental health services in Forth Valley.
- Co-location of acute mental health services with general acute services and access to diagnostics.
- Development of an enhanced community based model.
- A clinically safe and sustainable inpatient service.

2.13. Demographics of the Board's Catchment Area

2.13.1 Key Population Characteristics are:

- Population forecasts issued by the General Registrar Office indicate that, unlike the population in the rest of Scotland, which is forecast to only increase by less than 1%, the Forth Valley area is expected to increase from 281,764 in year 2004 to some 296,377 in 2024 - an increase of approximately 5%. This rate of increase is forecast to continue throughout the planning period.

- The table below demonstrates the growing number of people in the over 65 age groups. It is this cohort that tends to use the greater proportion of the health service and this growth trend will therefore have a significant impact on service provision.

Table C2/3: Forth Valley Population Forecasts

	Population 2004 (mid year estimate)			Population 2024 (mid year estimate)			% Change		
Age Band	Males	Females	Total	Males	Females	Total	Males	Females	Total
0-14	25,938	24,881	50,819	23,690	23,372	47,062	-9%	-6%	-7%
15-24	17,728	16,982	34,710	16,571	17,073	33,644	-7%	1%	-3%
25-44	37,966	41,202	79,168	33,052	37,819	70,871	-13%	-8%	-10%
45-64	35,521	37,168	72,689	37,361	43,153	80,514	5%	16%	11%
65-74	11,493	13,495	24,988	14,861	17,214	32,075	29%	28%	28%
over 75	7,030	12,360	19,390	13,871	18,340	32,211	97%	48%	66%
	135,676	146,088	281,764	139,406	156,971	296,377	3%	7%	5%

Source: General Register Office for Scotland – 2004 based population projections

2.13.2 Clackmannanshire is the smallest mainland Council in Scotland. Future projections for Clackmannanshire to 2016 show a decline in the total population by -3.5% compared to the population of Scotland as a whole which shows a decline over the same period of -2.0% (see table C2/4). By contrast the population of the Forth Valley NHS Board area shows a projected increase over the same period of 3%.

Table C2/4: Population Projections in Clackmannanshire 2001 to 2016.

Total Population					Absolute Change 2000 – 2016	% change 2000- 2016
	2000	2006	2011	2016		
Scotland	5,114,600	5,077,784	5,046,591	5,013,831	-100,769	-1.9%
Forth Valley	278,000	281,318	283,831	286,376	+8,376	+3%
Clackmannanshire	48,460	47,967	47,389	46,745	-1,715	-3.5%

Source: Register General Office (Scotland) 2000 based projections

2.13.3 These figures, however, mask significant changes within the profile of the Clackmannanshire population that will have a marked impact on health and social care services. Between 2006 and 2016 it is projected that the:

- population aged under 14 will reduce by 26%;
- population aged between 30 and 44 will reduce by 32%;
- number of people aged between 60 and 74 will increase by 37%; and,
- number of people aged over 75 will increase by 27%.

2.13.4 These figures suggest that the population of Clackmannanshire will age at a much faster rate than that of Scotland as a whole. This will mean that health and social services will have to be much more sensitive and responsive to the needs of older people than other parts of Scotland (see Table C2/5).

Table C2/5: Population Projections in Clackmannanshire by Age Group 2006-2016

Age bands	2006 % change	2011 % change	2016 % change
0-4	-15.2	-19.9	-12.1
5-14	-7.1	-19.7	-26.6
15-29	-5.1	-0.5	-4.0
30-44	-7.7	-22.4	-32.8
45-59	7.4	9.7	14.9
60-74	12.5	29.9	37.3
75 and over	5.8	14.1	27.4
All ages	-1.0	-2.2	-3.5
Forth Valley	1.2	2.1	3.0
Scotland	-0.7	-1.3	-2.0

Source: Register General Office (Scotland) 2000 based projections

2.13.5 In addition the available information on the health trends and inequalities of the Clackmannanshire population shows some of the greatest need in Forth Valley.

2.14. Financial Position

2.14.1 NHS Forth Valley has an established record of sound financial management and has consistently achieved its financial targets.

2.14.2 The local health plan seeks to achieve recurrent balance by 2008/09. The recurrent gap at 2006/07 is £2.6 million.

2.14.3 Savings programmes have been developed to address this position, although there will continue to be heavy demands on future years' uplifts, e.g. pay modernisation, new consultant contract and new GMS contract, and a number of unavoidable service changes with financial consequences for NHS Forth Valley, e.g. the new Beatson Cancer Centre in Glasgow.

2.14.4 NHS Forth Valley's financial plan to 2010/11 is summarised in Appendix-1. Consideration is currently being given to changing current service levels to help address the recurring financial pressures in NHS Forth Valley.

3. THE OUTLINE BUSINESS CASE (OBC)

3.1. Introduction

3.1.1 The OBC focused on the need to modernise services currently provided from Alloa Health Centre, Clackmannanshire County Hospital, and Sauchie Hospital. This section sets out the case for change, investment objectives and benefit criteria identified within the OBC, along with the long list and shortlist of options that were considered. The OBC was approved by SEHD in June 2003 and copies of the full document, or the Executive Summary, are available, in electronic format, from the Project Office or on the Board's website.

3.1.2 The Chapter will set out a description and summary of the OBC, including:

- the case for change;
- investment objectives;
- investment constraints;
- the long list of options considered;
- the shortlist of options considered;
- the preferred option; and
- changes since the OBC was approved.

3.2. The Case for Change

3.2.1 The modernisation and further development of services to improve the health and well being of the Clackmannanshire population is severely hampered by the limitations and configuration of existing facilities and services.

3.2.2 The key drivers for change facing the Board and the local health community are:

- the national policy framework set out in 'Our National Health', 'Towards a Healthier Scotland' and 'Partnership for Care';
- the need for continued development and modernisation of primary care services in line with recommendations in the report of the Primary Care Modernisation Group;
- the implementation of the Forth Valley Healthcare Services Strategy, and the need to develop community services and provide local access to acute care in partnership with primary care teams;
- a change in the balance of care for older people's services from an institutional model to a more community based model for services for older people, based on a network of integrated local care services and community hospitals with step down/intermediate facilities;

- the healthcare workforce is currently working under considerable pressure. There is an urgent need to develop and expand the workforce to ensure safe and high quality services are maintained - this is not possible whilst existing poor working conditions exist;

- the existing service and site configuration acts as a significant barrier to service integration and the development of new models of care;

- implementation of the national framework for mental health services including the development of the concept of a community mental health resource centre with an integrated team, day hospital, rehabilitation and acute assessment services all with close links to primary care and social services;

- implementation of the Joint Future recommendations and proposals for the joint management and joint resourcing of community care services to ensure closer working and co-operation between health services and social work services to provide a seamless and integrated service for users and carers; and,

- the need to replace outdated and inefficient buildings and estate with modern high quality facilities that support the development of easily accessible patient focused services.

3.3. Investment Objectives

3.3.1 The investment objectives of the Clackmannanshire Community Health Services Project are based on the Board's Strategic Plan, and aim to:

- ensure the Board is able to respond to the needs of the local population in terms of patient activity, efficiency, effectiveness and quality;

- rationalise service provision in NHS Forth Valley to improve patient management and minimise the duplication of services, facilities and resources;

- deliver high quality care in an appropriate environment that respects the patient's need for dignity and privacy, in a manner that is both cost effective and flexible;

- provide sufficient capacity to meet projected demand, with fully integrated support services;

- ensure the provision of a skilled workforce by providing top quality training and education;

- rationalise the Board's estate and reduce dependency on inadequate and ageing buildings; and

- ensure consistency with and to facilitate delivery of the aims of the 'Kerr Report'.

3.3.2 The Board has reviewed these investment objectives and confirm that they remain current.

3.4. Investment Constraints

3.4.1 The OBC identified a number of constraints to the project. These can be summarised as:

- the need for joint delivery and integration of services across all agencies by 2007/08;
- the need for enhanced access to services by optimising the range of health and social services provided locally in one easily accessible location by 2007/08;
- the need to significantly improve the quality of services to meet national clinical and care standards and improve patient outcomes by 2010 as evaluated by NHS Quality Improvement Scotland;
- the immediate need to improve the physical condition of buildings and facilities for primary care, acute outreach, older people's and mental health services to physical condition A by 2007/08;
- need to change clinical models of care to meet the national clinical standards;
- a lack of available sites in suitable locations;
- the preferred option must be affordable with in the overall financial strategy for NHS Forth Valley;
- the proposals must be compatible with the strategic direction for health care services as outlined within the Forth Valley Healthcare Strategy; and
- as the proposals involves many stakeholders, there must be widespread support among staff, clinicians, Clackmannanshire Council and the local community.

3.5. Benefits Criteria

3.5.1 The Project Board involved a number of individuals in the option appraisal exercise including clinicians, staff, service users, GPs and managerial staff in both health and social services. The Project Board proposed the benefits criteria, described in the following table, based on the investment objectives of the business case which it weighted and scored the options against.

Table C3/1: Description of Benefits Criteria.

Benefits Criteria	**Description**
Quality of service provision	***The degree to which the option would be able to provide high quality clinical care.*** This criterion included whether the option allowed compliance with national clinical standards and frameworks such as CSBS, SHAS, mental health, RCGP and other national guidelines, and the ability to support the recruitment and retention of staff.

Quality of environment	***The degree to which the option would be able to provide a high quality environment suited to the needs of patients and staff.*** This criterion included ease of access to other community facilities, whether the option provided a safe environment with space and grounds appropriate for the needs of patients, and whether the option would allow for the provision of facilities to meet best practice in terms of design standards.
Flexibility	***The degree to which the option would facilitate flexibility both in the short and long term.*** This criterion measured the scope for flexibility in the design and configuration of buildings, so that should services need to change to meet future changes in local needs, buildings/facilities could be put to other uses should this be necessary (eg to meet the needs of a different client group) or the buildings/facilities easily adapted or changed.
Strategic fit	***The ability of the option to meet the strategic aims for NHS Forth Valley as set out in the Local Health Plan, local strategies and national policy documents.*** For example the criterion measured the degree to which the option allowed the scope for service integration, and supported implementation of A Joint Future.
Location/ease of access	***The degree to which the option would provide for ease of access for the majority of people who it is planned would use the services outlined in the business case.*** An accessible location was also one that had ample car parking, was close to other services, was accessible by emergency services, allowed for compliance with legislative requirements e.g. Disability Discrimination Act and facilitated access to as many services as possible in one location.

3.5.2 These benefit criteria were chosen to ensure that the Board was able to respond to the needs of the local population in terms of patient activity, efficiency, effectiveness and quality. The Board has reviewed these and confirm that they remain current.

3.6. The Long list of Options Considered

3.6.1 The Board and its planning partners looked at a number of possible options for delivering the desired service models. The long list was originally developed by looking separately at the options for the provision of primary care services and community hospital services.

3.6.2 The long list of options for the New Health Centre/Primary Care Resource Centre included:

- do minimum;
- further development of the existing Health Centre building by for example building an extension or other modifications;
- reconfiguration of services within the Health Centre to make best use of current space, possibly involving moving some services to another location coupled with building an extension as above;
- demolition of the Health Centre and build a new health centre on the current site; and
- a new purpose built Health Centre on a new site.

3.6.3 The long list of options for the New Community Hospital included:

- do minimum;
- reconfigure current mental health and older people's services within existing accommodation on current sites (i.e. Sauchie Hospital and Clackmannan County Hospital);
- reconfigure current mental health and older people's services in existing accommodation on one site - either the Sauchie Hospital site or the Clackmannan County Hospital site;
- re-provide current mental health and older people's services in new build accommodation on both Clackmannan County and Sauchie Hospital sites; and
- re-provide current mental health and older people's services in new build accommodation on one site - the Sauchie Hospital site, or the Clackmannan County Hospital site or on a new site.

3.6.4 The Board and its planning partners, after considering these options, added a further option to the long list that effectively brought the first two strands of the business case together. This would involve:

- re-providing both the new Health Centre/Primary Care Resource Centre and the new Community Hospital services together in new build accommodation on a single site and thus further maximise the opportunities for service redesign and integration.

3.7. The Shortlist of Options Considered

3.7.1 The Board, its advisors and partner agencies assessed the long list of options in detail. The result of this assessment identified two options that were the subject of more rigorous appraisal. The short listed options were:

- Option 1: Do minimum; and
- Option 2 - Integrated option.

3.7.2 The do minimum option is included as a baseline option against which the one site option is appraised. The do minimum option would mean no change in the current configuration of services as described in the OBC and with minimal capital investment to up grade/improve facilities and accommodation in the health centre, Clackmannanshire County Hospital or Sauchie Hospital, as considered appropriate.

3.7.3 In the integrated option the new Health Centre/Primary Care Resource Centre and the new Community Hospital would be provided on the same site, with the result that all the services described in the OBC would be located in new build accommodation on one site thus maximising the opportunities for service integration. This option would also mean the Board would reduce its estate from three sites to one site and thus achieve economies of scale. One site would also allow greater flexibility in the future to respond to changes in needs.

3.7.4 As part of the assessment of option 2 the Board commissioned a detailed feasibility study to assess the potential sites available within the Alloa area. The feasibility study took into account a number of issues, including:

- appraisal of potential sites in terms of existing buildings, topography, location, access points etc;
- the overall space requirements for individual services included within the scheme;
- planning and design issues;
- assessment of engineering services including transportation issues, geotechnical and environmental issues;
- the site's ability to accommodate the footprint of the new facilities;
- the site's ability to accommodate the resultant car parking requirements;
- the potential for further and/or future development, not necessarily NHS services;
- the location of the site in terms of access to services by patients and users; and
- the site's ability to provide amenity space to support the model of care.

3.7.5 Of three sites considered only one, the Sauchie Hospital site, was largely within NHS ownership. The other two sites identified within the Alloa area were both within private ownership. On further investigation one of the sites was discounted on clinical grounds as it did not satisfy the benefits criteria identified in the option appraisal exercise. The other site identified was also discounted as it was considered unlikely to become available for purchase within a reasonable timescale for this scheme, and at a reasonable cost.

3.7.6 The Sauchie Hospital site is already within NHS ownership and with the addition of the adjacent Hall Park Mill site, later purchased by the Board, was considered to be the preferred site option, and satisfied the benefits criteria in the option appraisal.

3.7.7 Following discussion with Clackmannanshire Council and the Boards property advisors, the Board agreed to proceed with the integrated option, located on an enhanced Sauchie Hospital site, as the preferred site option for the scheme.

3.8. The Preferred Option

3.8.1 The case for investment in Clackmannanshire is strong in terms of local health deprivation, clinical quality, capacity and environmental suitability.

3.8.2 The preferred option was Option 2 – Integrated Single Site Option. This decision was based on the analysis of the benefits, costs and risks associated with each option. In particular the two major tests of benefits appraisal and risk adjusted economic appraisal, indicated Option 2 as the preferred option.

3.8.3 The preferred option offers a range of benefits including:

- continued local access to a range of clinical services;
- improved overall accessibility through implementation of new service models, providing a greater level of service on or close to the patient's own home, reducing the need to access the main acute site;
- providing modern purpose-built functional accommodation and provide the best use of the existing estate;
- supporting the implementation of new models of care to improve service effectiveness and cost efficiency, and enhance functional relationships across the health economy; and
- treatment and investigation in facilities that ensure privacy and dignity.

3.8.4 The preferred option provided the best fit with the objectives of the investment while demonstrating value for money, achieves the required non-financial benefits and is affordable.

3.9. Changes Since OBC Approval

3.9.1 The only change in scope of the Clackmannanshire Community Health Services Project since the OBC was approved in June 2003 relates to the provision of 15 acute mental health admission beds.

3.9.2 The possibility of this change was discussed in the OBC. Following the review of mental health strategy and extensive public consultation in 2004, Forth Valley Health Board took the decision to locate all acute mental health admission beds at the new acute hospital in Larbert.

3.9.3 Consequently the number of inpatient beds to be provided as part of the CCHSP was reduced to 45.

3.9.4 This change was communicated to the SEHD Capital Investment Group and it was agreed that the project would continue on this basis.

4. THE CONVENTIONAL PROCUREMENT ASSESSMENT MODEL

4.1. Conventional Procurement Assessment Model

4.1.1 This Chapter deals in further detail with the Conventional Procurement Assessment Model (CPAM) which has been developed by the Board and its advisers.

4.1.2 This Chapter will examine:

- the methodology developed and applied for the preparation of the Conventional Procurement option;
- the OBC Preferred Option and how this has developed into the CPAM or Public Sector Comparator (PSC) as it has been termed in this project;
- a description of the CPAM;
- the **capital cost** of the CPAM;
- the **revenue costs** of the CPAM; and
- a description of the **Key Risks** to the project which are retained if the Conventional Procurement were to be implemented.

4.2. CPAM Design Methodology

4.2.1 The methodology adopted by the Board for the development and preparation of the CPAM design is outlined below. The methodology adopted was developed in conjunction with the Board's technical advisers in the absence of any other general advice being available at the time for development of a CPAM/Public Sector Comparator. The level of detail to which the CPAM is developed as described in the methodology was considered appropriate for a number of reasons including:

- Allowing the Schedule of Accommodation to be tested by practical example;
- Allowing the clinical brief and departmental adjacencies to be tested by practical example;
- Establishing the impact of the development on the site taking into account key constraints;
- Identification of the key areas of weakness of the design through subjecting the CPAM design to AEDET;
- Establishment of the stakeholder environment.

4.2.2 The OBC Preferred Option is outlined in the preceding section. This was used as the basis for the CPAM design. The methodology developed and agreed was in four stages as follows:

- **Stage 1** - Desk study, including consultation with the Planners and site analysis.

- **Stage 2** - Design concept stage involving the production of 1:1250 Development Control Plan (DCP) options and identification of a 'preferred' option. The 'preferred' option would then be further developed to a 1:500 scale with sections and elevations to demonstrate the functionality to stakeholders.

- **Stage 3** - Further consultation with key stakeholders. Development of the 1:500 department layouts supplemented and, if required, with 1:200 drawings of key department layouts. Design workshop with the key stakeholders.

4.3. Description and Functional Content of CPAM

4.3.1 The CPAM represents a comparator scheme, which would meet the Board's clinical and facility management output specifications. It assumes access to capital funds from government and is the benchmark used to demonstrate whether the PFI proposal offers value for money. The CPAM is the scheme from which the approved affordability figures are calculated.

4.3.2 The CPAM has been developed in sufficient detail to ensure that it provides an adequate benchmark against which the private sector solutions can be measured. It is based on the Preferred Option at the OBC, and has been updated to reflect agreed changes in requirements.

4.3.3 The CPAM has been developed in accordance with the methodology outlined above. In terms of the design solution, four possible options for the use of the site and existing buildings were evaluated, mainly around the differing uses of the two sites and whether or not the existing buildings should be retained or partly retained. The conclusion was that all buildings on the existing Sauchie Hospital site should be demolished (with the exception of the Lodge Building).

4.3.4 A further three options were considered regarding how the two sites should be exploited to incorporate the facilities required. The CPAM design is based on a proposal where the Health Centre is located on the lower site and the remainder of the facilities are located on the Sauchie Hospital site. Parking is accommodated on both the upper and lower sites.

4.3.5 The CPAM design is based on an indicated Schedule of Accommodation with rooms sized at the minimum from published health design guidance. For the purposes of the OBC, assumptions were made in regard to the circulation, plant and communication space with an allowance being made at the lower end of the norms. This was done on the basis that bidders would normally be aggressive in design development to keep these areas to a minimum to optimise the floor area.

4.3.6 The facilities comprising the CPAM are made up of a Health Centre and Community Hospital.

4.3.7 The functional content of the Health Centre facilities comprise of:

- Shared Public Space;

- Three GP Practices;
- Pharmacy;
- Older People's Community Mental Health Team;
- Community Patient Services;
- Children's Services;
- Offices and Staff Facilities; and
- Social Services.

4.3.8 The functional content of the Community Hospital facilities comprise of:

- Main Entrance Support;
- Community Mental Health Resource Centre;
- Day Therapy Unit;
- Inpatients – Frail Old People;
- Inpatients – Old Age Psychiatry; and
- Inpatients – Shared Accommodation

4.3.9 In addition to the clinical accommodation facilities are also included to accommodate the Facilities Management functions.

4.4. Capital Cost

4.4.1 The capital cost for the project has been monitored from OBC, through the development of the CPAM that is now compared with the PFI model. The development of these costs is indicated in the table C4/1 below:

Table C4/1: Capital Cost for the CPAM

	OBC	**OBC Update to 4q 2003**[3]	**Current CPAM Cost Plan**
Total Construction cost (excl VAT)			
Fees			
Equipment			
Contingency			
Optimum Bias			
Total at 4q03			
Inflate to 2q07			
Updated Cost to Current Day (2Q07)			
Construction Inflation			
OUTTURN COST (excl VAT)			

Notes:

1 These costs are those included in the OB1 Form in the Outline Business Case.
2 The total construction cost is a 3Q02 base.
3 The "OBC Update" is inflation from 3Q02 (OBC construction price base date) to 4Q03

4.4.2 A reconciliation documenting the shift from the OBC to the current CPAM is described in the following paragraphs.

4.4.3 The original OBC CAPEX was based on an indicative schedule of accommodation. The OBC costs made various assumptions on the clinical areas and the likely level of optimisation that could be achieved in relation to circulation, communication and plant space if the designs were fully developed. These assumptions were adopted at that time but it was recognised that these were aggressive allowances that would be tested by both the CPAM design and Bidders detailed design processes.

4.4.4 In accordance with the agreed methodology, the CPAM design was limited to a high level assessment of design parameters including the site fit, massing, and departmental adjacencies, sufficient to allow planning issues to be developed and make a broad assessment of gross floor area. The clinical areas were based on minimum room sizes contained in health guidance. In terms of the impact on circulation, communication and plant space, the designs were not sufficiently developed to demonstrate optimised design assumptions for these parameters however identified that the assumptions made in the OBC regarding these elements were unlikely to be achieved. This resulted in an increase in the floor area from 6880m2 included in the OBC to 8841m2 which was still considered to represent relatively aggressive targets in relation to circulation, communication and plant space.

4.4.5 The design carried out by the Bidders throughout the bid process confirmed that the layout of the building to meet the clinical requirements of the Board resulted in marginally higher clinical areas than that assumed in the indicative Schedule of Accommodation which was based on minimum room sizes contained in health guidance. In addition, they were unable to match the aggressive targets set in relation to circulation, communication and plant space. This further informed position as a result of the Bidders detailed design process confirmed that it would have been unlikely that the Board could have achieved this under traditional procurement. This resulted in a further increase to 8955m2 which is the floor area upon which the final CPAM is based.

4.4.6 As described further in Section 12.4, the original OBC did not include optimism bias but instead included a contingency allowance in relation to the capital costs. The CPAM has now replaced the original contingency allowance with an optimism bias allowance as set out in Section 12.4.

4.4.7 The increase in floor area throughout the procurement process as described above, along with optimism bias and inflationary changes represents the change in CAPEX from the OBC stage as set out in Table C4/1 above.

4.5. Life Cycle

4.5.1 Life Cycle costs were not included in the OBC costings on the basis that it was envisaged in the OBC that these would be paid for using the Board's Capital Programme – this being the accepted approach to be taken at the time the OBC was prepared. Notwithstanding this a breakdown of potential costs was prepared and included as an appendix to the OBC. The current CPAM life cycle cost allowance is £[redacted] per sq m and this is comparable with the estimates included in the OBC.

4.6. FM Services

4.6.1 The scope of facilities management costed within the OBC and CPAM are as follows:

- FM Management;
- Estates Maintenance;
- Helpdesk;
- Domestic;
- Linen;
- Pest Control;
- Security;
- Energy Costs;
- Water;
- Telephone; and
- Rates.

4.6.2 The CPAM assumes that FM services, with the exception of a small number of traditionally tendered estates functions, will continue to be provided by the Board. The FM cost and the development of this from the OBC to the current position is given below.

4.6.3 The FM cost included in the OBC is £[redacted] per sq m/annum priced at 3q 2004. This cost was based on typical FM costs for this size and nature of facility and was based on benchmark data. The FM cost was refined at the time of preparing the CPAM and the figure increased to £[redacted] per sq m/annum priced at 3q 2004. This increase was a result of having a better understanding of the scope of the FM services to be provided following the drafting of the Facilities Management (FM) output specifications. This figure remains as the FM cost for CPAM but is updated to £[redacted] per sq m/annum priced at 2Q 2006.

4.7. Key Risks if CPAM is Adopted

4.7.1 The project risks are discussed in Section 12. Key risks that would have to be retained by the Board were the CPAM to be adopted include:

- Design;
- Construction Delays;
- Ground conditions and contamination;
- Fitness for purpose;
- Compliance with Planning Requirements;
- Capacity and availability of utilities and infrastructure;
- Commissioning programme and costs;
- Availability of the facilities;
- Quality of management and performance of the services; and
- Incorrect cost estimates.

4.8. Financial Impact of the CPAM

4.8.1 The Board's affordability framework for this project is based on the CPAM and has therefore been updated since the OBC to reflect the changes outlined above.

4.8.2 The CPAM will form the basis of the value for money comparison with the preferred PFI solution. The value for money and affordability of the CPAM and the PFI are compared in Sections 13 and 14, respectively.

5. THE PFI PROCUREMENT PROCESS

5.1. Introduction

5.1.1. This Chapter sets out the process, which the Board has followed in securing a preferred PFI Partner and seeks to demonstrate the robustness and rigour established by the Project Team and the Project Board. The Board, at all times, has followed NHSS guidance contained in the Scottish Capital Investment Manual.

5.1.2. The NHS Board would like to acknowledge the efforts, commitment and professionalism shown by all bidders at each stage of the Procurement Process.

5.1.3. The Chapter will examine the process followed at:

- Official Journal of the European Union (OJEU) Stage;
- Pre-Qualification Stage; and
- Invitation to Negotiate (ITN) Stage.

5.1.4. The project has been procured under the relevant rules of the European Union, through the negotiated procedure applicable to Service Contracts under the 1993 Public Services Contracts Regulations. Copies of all documents issued to Bidders are available, in electronic format, from the Board's Project Office.

5.2. Involvement of Stakeholders

5.2.1. During all stages of the project there has been extensive involvement of stakeholders, both within and out with the Board.

5.2.2. Over 50 multi-disciplinary clinical and non-clinical staff, including Clackmannanshire Council staff and GP's, have developed the operational policies and specifications of requirements. They have also worked with each of the short listed bidders, at each stage of the procurement process, in developing the designs.

5.2.3. The participation of users was led by the Project Board with responsibility for user involvement delegated to the Project Team and nominated service planning leads. Five sub-groups were established to represent individual areas of the facility. These were:

- Services for Older People – Inpatient Services & Day Hospital;
- Community Patient Services & Children's Services;
- General Medical Services;
- Community Mental Health; and
- Clinical support areas such as Main Entrance, Pharmacy, Social Services.

5.2.4. Details of the membership of each group are available from the Project Team on request.

5.2.5. The involvement of so many users has ensured that clinical and non-clinical staff both from within the Board and from other key stakeholders such as Clackmannanshire Council, has ensured that the design has taken account of existing and emerging standards and guidance in relation to healthcare and the local health economy.

5.2.6. Forth Valley Facilities staff were also involved at an early stage, and led the development of the specifications, for both Hard and Soft Facilities Management service.

5.3. Advertising the Project

5.3.1. The Board gave notice of the project through the publication of a Prior Information Notice in the OJEU on 24 August 2004 and this gave details of a Market Awareness Day to be held on 1 October 2004.

5.3.2. The Board held the Market Awareness Day at Dunmar House, Alloa and the event provided an opportunity for NHS Forth Valley staff and other key stakeholders to meet a wide variety of private sector companies who demonstrated great interest in the project.

5.3.3. A notice was placed in the OJEU ("S" series) on 24 November 2004, inviting applications from candidates who could fulfill the requirements of designing, building, financing and operating the facility. A copy of the OJEU notice is included at Appendix 2.

5.4. Pre-Qualification Questionnaire

5.4.1. Pre-Qualification Questionnaires (PQQ) and Memoranda of Information (MOI) were issued to all organisations responding to the OJEU advertisement. The closing date for return of PQQ's was the 28th January 2005.

5.4.2. The purpose of the pre-qualification stage was to evaluate whether consortia interested in the project, and companies within individual consortia, had the relevant experience, capability and capacity to undertake design, build, finance and operate projects of a similar size to the planned project.

5.4.3. The submissions were received in hard copy format and on CD and receipt was recorded in NHS Forth Valley's tender book. The PQQ's were evaluated in accordance with the Evaluation Framework agreed by the Clackmannanshire Community Health Services Project Board on 7 January 2005.

5.4.4. The Board received four PQQ's by the due date of 28 January 2005, from the following consortia:

- Aesculus Clackmannanshire;
- Alloa Hospitals Ltd;
- Robertson Healthcare; and
- Prime plc.

5.4.5. The evaluation process involved:

- The establishment of sub groups to evaluate the legal, financial and technical areas of the submissions;
- Preliminary Reports by Advisers; and
- Detailed Evaluation Reports and scoring of the submissions in accordance with the agreed PQQ Evaluation Framework.

5.4.6. In addition, a number of clarifications were sought from all the consortia that made submissions. Information from these responses was included within the reports of the evaluation sub groups. Details of the clarification questions and responses are kept with each consortium's PQQ in the Project Office.

5.4.7. The Main Evaluation Panel membership included the Chairs of the three sub groups and the Boards Professional Advisors. This ensured a consistent approach to scoring was taken by all sub groups. The Panel reviewed all scores ensuring no obvious errors in scoring, and considered the recommendations from the sub groups before making the final decision on the overall score of each response.

5.4.8. The Main Evaluation Panel met on two occasions to consider the reports from the evaluation sub-groups. The outcome of the first meeting on 23 February 2005 was that further clarification was required before definitive conclusions could be reached on the evaluation. As a result, further clarifications were sought and the Main Evaluation Panel reconvened on 4 March 2005.

5.4.9. At the meeting on 4 March 2005, and in the light of responses from candidates to clarifications, the Main Evaluation Panel agreed the final scores and agreed to recommend to the Project Board that the following candidates be short-listed:

- Aesculus Clackmannanshire (Bidder A);
- Alloa Hospitals Limited (Bidder B); and
- Robertson Healthcare (Bidder C).

5.4.10. These three consortia demonstrated that they had the experience and resources to undertake the project and the Project Board, at its meeting on 11 March 2005 agreed that all three consortia be included for progression to the ITN stage.

5.5. Invitation to Negotiate (ITN) Documentation

5.5.1. The purpose of the ITN documentation was to:

- provide further information in relation to the Project and the supporting healthcare philosophy;
- set out the key assumptions and constraints which Bidders need to understand in

preparing their proposals for the Project;

- require detailed proposals for the design, construction, servicing and financing of the project;
- require fixed priced Bids;
- seek substantive agreement on all contractual issues affecting price and risk allocation, including payment mechanism and performance regime;
- set out the framework, and information requirements within which the responses to the ITN should be made;
- set out the deliverables and the evaluation criteria, which the Board would apply to the responses received; and
- facilitate the evaluation of Bids to enable the Board to select a Preferred Bidder.

5.5.2. The ITN documentation was made up of six parts:

- Volume I – Instructions to Bidders;
- Volume II – The Project Agreement;
- Volume III a – NHS Forth Valley's Construction Requirements;
- Volume III b – Equipment incorporating Room Data Sheets;
- Volume III c – Service Level Specifications; and
- Volume IV – Data Room Catalogue

5.6. Invitation to Negotiate (ITN) Bid Submissions

5.6.1. The NHS Board in July 2004 considered a report on the implications of the Scottish Executive / STUC Staffing Protocol in Public Private Partnership Projects (HDL (2003) 50). The report outlined the options open to the NHS Board in structuring the procurement for Soft Facilities Management services in both the Clackmannanshire Community Health Services Project and the New Acute Hospital Project. The report had been prepared after consultation with the Area Partnership Forum and consideration by the Staff Governance Committee.

5.6.2. The NHS Board agreed in July 2004 to test Value for Money (VfM) for the provision of Soft Facilities Management services via the procurement process for both projects, and allow for the submission of an In House Bid. Accordingly, procurements for both projects were structured to incorporate an In House Bid for Soft Facilities Management services, and external bidders instructed via the ITN, and through meetings during the bid period, that an In House Bid would be submitted.

5.6.3. An In House Bid Team was established, supported by professional advisers (separate to

the NHS Board's advisers), and began work in February 2005 in readiness for the issue of ITN for both projects.

5.6.4. The ITN documentation was issued to the three short listed bidders for the Clackmannanshire Community Health Services Project in May 2005. Prior to the issue of the ITN the NHS Board, at its meeting in April 2005, approved the affordability for the Project and received a report on the pre-ITN Key Stage Review. In addition, the In House Bid Team was invited to submit a bid for the provision of the Soft Facilities Management services.

5.6.5. Each short listed bidder was asked to submit two separate bids:

- A Bid 1 contained detailed proposals for the design, build, finance and maintenance of the new facilities; and
- A Bid 2 that contained detailed proposals for the design, build, finance and maintenance of the new facilities, and also detailed proposals for the provision of Soft Facilities Management services.

5.6.6. At the same time as external bidders were preparing their bids, the In House Bid Team submitted a generic proposal ("Generic Bid") for the delivery of the Soft Facilities Management services. This proposal was based on the data available as part of the Conventional Procurement Assessment Model (CPAM) design carried out by NHS Forth Valley, and information in the ITN.

5.6.7. Once bids had been received from the three external bidders, the In House Bid Team was sent a copy of the Bid 1 designs in order that the In House Team could tailor their generic bid for each bidder's specific design. The In House Team then submitted three specific bids to be evaluated as an integral part of the Bid 1 submissions.

5.6.8. Deadlines for the In House Team were:

- 23 August 2005 for the generic bid;
- 13 September 2005 for the commercial aspects of the generic bid, including the payment mechanism. The commercial bid stage required the In House Team to provide a financial submission in respect of the generic bid detailed above; and
- 19 October 2005 for the three specific bids. The In House Team having received details of the three bidders specific design proposals submitted technical and commercial bids in respect of the specific designs.

5.6.9. The bid period ran from May 2005 to August 2005, with the shortlisted bidders requested to submit technical bids by 23 August 2005. Commercial bids covering legal and financial issues, and the payment mechanism, were submitted on 13 September 2005. Volume 2 of the ITN, containing the draft project agreement and payment mechanism, was not issued by the NHS Board until July 2005 following clarification and approval from SEHD on the use of a new Forth Valley specific payment mechanism.

5.6.10. The Bidders also had access to a "virtual" electronic Data Room, which gave access to documentation and plans to assist them in developing their ITN submissions. A number

of consultation meetings were held with bidders and the In House Team during the bid period, and additional meetings were arranged where appropriate. In addition, each bidder also met with the Clackmannanshire Council planning department. In total 41 consultation meetings were held with bidders and over 100 clarifications were received from bidders.

5.6.11. All the bids submitted were considered against each other for evaluation purposes as detailed below. The In House Bid Team's three specific bids were evaluated as an integral part of Bid 1.

Table C5/1: Bids Submitted at ITN

Consolidated Bid 1		**Bid 2**
Bidder A (Hard FM)	**In house Bid Team Specific Bid for Bidder A**	**Bidder A (Hard and Soft FM)**
Bidder B (Hard FM)	**In House Bid Team Specific Bid for Bidder B**	**Bidder B (Hard and Soft FM)**
Bidder C (Hard FM)	**In House Bid Team Specific Bid for Bidder C**	**Bidder C (Hard and Soft FM)**

5.6.12. The bid requirements and the timescales were all set out in the ITN, together with the evaluation framework so that bidders were aware of the NHS Board's priorities when constructing their bids.

5.7. ITN Evaluation Framework

5.7.1. The evaluation framework was outlined in the ITN. To underpin the evaluation framework a detailed evaluation methodology was also agreed by the Project Board. The methodology was agreed and in place before the submission of bids on 23 August 2005. The purpose of the evaluation methodology was to allow NHS Forth Valley to:

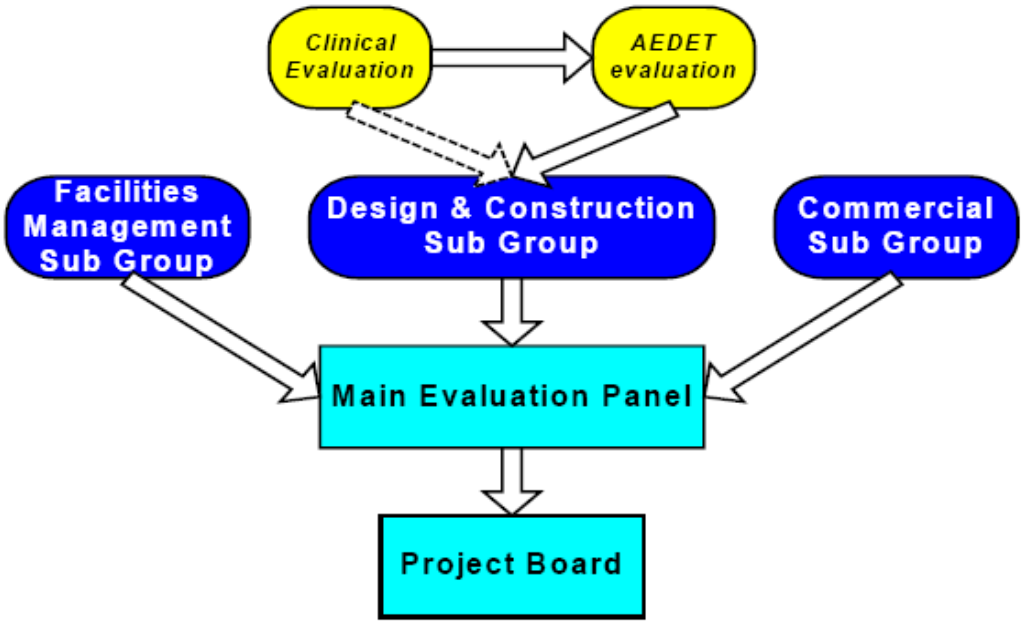
- review the bids with respect to compliance with NHS Forth Valley's requirements and instructions as set out in the ITN documentation;
- satisfy themselves or otherwise that each external bidder and the In House Bid Team had responded adequately to the ITN;
- evaluate in detail the relative merits of each of the bids in order to compare them against each other;
- select the most economically advantageous external bid (the "Preferred Bidder") to design, construct and operate the facilities; and
- decide whether in house or private sector provision of the Soft Facilities Management services offers the most economically advantageous option.

5.7.2. The evaluation has been a coherent and transparent process, and has allowed the Board to assess all aspects of each of the bids, including the submission from the In House Bid Team. The evaluation has also been fully documented to demonstrate a clear audit trail. Full accountability and transparency has been achieved by:

- clearly defining and recording the key features of the process;
- making the evaluation principles known to all bidders including the In House Team; and
- ensuring that judgements were made, not by any individual, but by groups comprising appropriate experienced and competent persons from NHS Forth Valley, the Board's advisers and other stakeholders.

5.7.3. The Board evaluated all bidders on the basis of their ITN responses. The ITN evaluation process is illustrated in the following diagram.

Figure C5/1: ITN Evaluation Structure



5.7.4. The ITN Evaluation was conducted via the following sub groups:

- Design and Construction;
- Facilities Management, and
- Commercial.

5.7.5. A member of the Project Team chaired each group, and membership was drawn from appropriate individuals within NHS Forth Valley, key stakeholders, partnership representatives and professional advisers. Reports from each sub group were presented to

the Main Evaluation Panel. The detailed membership and terms of reference for each group is available from the Project Team on request.

5.7.6. There was partnership representation throughout the process with staff representation included on key sub groups, the Main Evaluation Panel and the Project Board. Partnership representation was also included on the In House Bid Team.

5.7.7. At each stage the evaluation criteria used were weighted to reflect their relative importance to each other. The ITN evaluation criteria and weighting as agreed by the Project Board was as follows:

Table C5/2: Evaluation Criteria Weighting

Evaluation Criteria	Maximum Potential Weighted Score
• Project Management	5%
• Commercial (legal & financial)	20%
• Design & Construction	42%
• Facilities Management	33%
Aggregate Maximum Score/Total Score	**100%**

5.7.8. The design and construction evaluation involved two meetings of the Design and Construction Sub Group preceded by a Clinical Evaluation Workshop, involving key clinicians who attended meetings with the bidders during the bid period, and a full Achieving Excellence in Design Evaluation Toolkit (AEDET) workshop. The design and construction evaluation was mainly concerned with bidders':

- design and construction proposals as evaluated using the AEDET evaluation toolkit;
- NEAT (NHS Environmental Assessment Toolkit) assessment;
- design development;
- compliance with requirements of NHS Forth Valley construction requirements;
- equipment approach;
- construction management approach;
- construction programme;
- commissioning programme; and
- robustness of capital costs.

5.7.9. Design and construction had the highest weighting within the evaluation with 42% out of a potential 100%. Each sub category was also weighted, of which AEDET had the highest weighing of 32%. The rational for this was that it is only within AEDET that clinical functionality is assessed (i.e. how far bidders have met the clinical brief). As

meeting the clinical requirements was the biggest driver in the project overall the Project Board agreed AEDET should have the highest weighting within design and construction.

5.8. Achieving Excellence in Design Evaluation Tool (AEDET)

5.8.1. AEDET is the NHS Estates design evaluation tool that is used to assess a design focusing on a number of key criteria with the following generic headings:

- Uses;
- Access;
- Spaces;
- Character and Innovation;
- Citizen Satisfaction;
- Internal Environment (Patients and Staff);
- Urban and Social Integration;
- Performance;
- Engineering; and
- Construction.

5.8.2. The generic headings above were used to produce detailed evaluation criteria, against which the design submissions at ITN stage of the procurement process were evaluated. The evaluation criteria for the technical and clinical design, and the weightings applied, took into account the priority for clinical functionality, effectiveness and efficiency in line with various recommendations of bodies such as the Royal Institute of British Architects (RIBA) and Commission for Architecture and the Built Environment (CABE).

5.8.3. The AEDET assessment was undertaken in accordance with the evaluation methodology agreed by the Project Board. Firstly a clinical evaluation was undertaken evaluating each bid against the clinical functionality criteria within AEDET. A full AEDET evaluation was then undertaken where the outcome of the clinical evaluation workshop was reported and the bids were evaluated against the remaining AEDET criteria. The outcome of the AEDET evaluation was then reported to the Design and Construction Sub-Group.

5.9. Evaluation of Returned Bids

5.9.1. The ITN evaluation process comprises two separate evaluation exercises, namely the:

- **qualitative evaluation**, where non-financial aspects of the proposals were assessed; and

- **quantitative evaluation**, where the financial aspects of the proposals were evaluated to determine which proposal achieves best value for money and which, at this stage, better meets the Board's affordability constraint.

5.9.2. The structure and methodology approved by the Project Board was used for the qualitative evaluation. The Board's financial advisers, PricewaterhouseCoopers (PwC) undertook the financial (quantitative) evaluation on the price, value for money and funding deliverability of the submissions received from the bidders.

5.9.3. With the exception of the Project Management, each section was the subject of detailed consideration by the relevant ITN evaluation sub group the outcome of which was captured in a comprehensive report. These reports cover in depth the evaluation process undertaken by the relevant sub group, the information considered by the sub group and the outcome of the clarifications issued to bidders. The reports document the rationale for the scoring against each ITN evaluation sub criteria, and the outcome of the sub group's evaluation together with any advice from the NHS Board's professional advisers that was considered should be taken into account when reaching a recommendation.

5.9.4. In the Project Management section of their bids, each bidder was asked to outline their approach to working with NHS Forth Valley to take the Project through its key stages to completion and operation. This section had an overall weighting of 5% out of 100%, and instead of being scored by a sub group, it was agreed in the evaluation framework that the Main Evaluation Panel would evaluate this section. To support the Main Evaluation Panel in evaluating this section, an initial evaluation was undertaken by the Project Team and Mott Macdonald, the NHS Board's technical advisers.

5.9.5. It was the role of the Main Evaluation Panel to bring together the work of each of the three evaluation sub groups, and reach a conclusion on the evaluation overall for presentation to the Project Board. In order to fulfill this task, the Main Evaluation Panel received detailed reports and presentations from each evaluation sub group.

5.9.6. The Main Evaluation Panel reviewed firstly the qualitative evaluation and the scores from each of the three sub groups and the qualitative scores were agreed. From this assessment it was clear that the scores for Bidder A and Bidder C were close ([redacted]%), with Bidder B significantly short of the other bidders ([redacted]%).

5.9.7. It was clear from the quantitative evaluation that the ranking of the bids matched that from the qualitative evaluation. However, there were a number of commercial issues that the Main Evaluation Panel considered required further clarification with Bidders A and C in order for the Panel to be in a position to recommend a Preferred Bidder to the Project Board. These issues included:

- acceptance of the payment mechanism, including the associated Service Level Specifications for both hard and soft facilities management; and
- various technical clarifications associated with bidders' design and technical proposals.

5.9.8. The ITN evaluation framework suggests that in order to make a recommendation on a Preferred Bidder there should be at least a 5% difference in the scores. The Main Evaluation Panel concluded that as a 5% difference was not evident between Bidder A and Bidder C, that a further stage should be initiated with these two bidders. The Main Evaluation Panel also concluded that as Bidder B's scores were significantly lower than Bidders A and C, and that their unitary charge was significantly higher than Bidders A and C, Bidder B would not be asked to participate in this next stage. This further stage should require both bidders to:

- revise their bids, where clarifications were sought;
- accept the payment mechanism and associated Service Level Specifications; and

- confirm the price impact or otherwise as appropriate.

5.9.9. These conclusions from the Main Evaluation Panel were reported to the Project Board on 9 December 2005 and agreed.

5.9.10. The quantitative evaluation, undertaken by the Commercial Evaluation Sub Group, assessed the:

- annual affordability of the ITN bids to the NHS Board; and
- value for money of each bid following HM Treasury guidance.

5.9.11. Annual affordability was assessed by reviewing each bid's proposed unitary charge and value for money was assessed using a Net Present Value calculation of the cost of the bid over the life span of the contract (i.e. 30 years) in accordance with HM Treasury guidance.

5.9.12. In respect of the Soft Facilities Management, the Main Evaluation Panel concluded that, as the payment mechanism and the Service Level Specifications were of equal relevance to the In House Team's bid, the In House Team should also be given the opportunity to revise and confirm their bid on a similar basis to the Bidders' A and C.

5.9.13. The Main Evaluation Panel reported this to the Project Board on 9 December 2005, and this course of action was approved.

5.9.14. The second stage involving Bidders A and C, and the In House Team, was initiated in December 2005, with bidders asked to respond by 30 December and the In House Team asked to respond by 10 January 2006, recognising the timescales for the acute project.

5.9.15. Responses from bidders were assessed in early January and the qualitative scores for Bidders A and C were revised. The Main Evaluation Panel concluded from this second stage that Bidder C's submission was clearly and consistently, throughout the evaluation, the leading bid. However, the Main Evaluation Panel remained sufficiently concerned about several aspects of Bidder C's bid not to proceed with a recommendation to appoint Bidder C as Preferred Bidder until the Panel was satisfied on these outstanding issues. The Main Evaluation Panel also concluded that as these further issues potentially affected the facilities management evaluation, a conclusion could not be reached at this stage on the In House Bid.

5.9.16. The Project Board on 13 January 2006, also agreed that as the evaluation could not be concluded until further discussions had taken place with Bidder C, that consideration of the In House Team's bid should be concluded after the Panel had resolved the outstanding issues with Bidder C.

5.9.17. The Main Evaluation Panel met with Bidder C on 18 January 2006 to discuss the outstanding issues from the evaluation, following which it was considered that a satisfactory position (subject to confirmation in writing) had been reached with Bidder C to recommend that Bidder C (Robertson Healthcare) be appointed as Preferred Bidder.

5.9.18. The Main Evaluation Panel also considered that the facilities management evaluation could now be concluded in order that a recommendation could be made to the Project Board on whether the In House Team or Robertsons Healthcare be appointed to undertake Soft Facilities Management.

5.9.19. The table below summarises the combined weighted qualitative scores for Bidder A and Bidder C.

Table C5/3: Weighted Qualitative Scores for Bidder A and Bidder C

Removed

5.9.20. The outcome of the quantitative evaluation was also that Bidder C 'Robertsons Healthcare reference bid offered lower financial cost to the Board, as measured in Net Present Value (NPV) terms and first full operating year Service Payments.

5.9.21. The outcome of the quantitative evaluation, in terms of the revised annual affordability of Bidders A and C's Bids were assessed as follows:

Table C5/4: Annual Affordability for Bidder A and Bidder C

Removed

5.9.22. The Net Present Value was also assessed as follows:

Table C5/5: NPV for Bidder A and Bidder C

Removed

5.9.23. Following the very thorough evaluation procedure the Main Evaluation Panel agreed that on the basis of both the qualitative and quantitative evaluations, they should recommend to the Project Board that Robertson Healthcare be selected as Preferred Bidder.

5.9.24. The Project Board at its meeting on 13 January 2006 agreed with the Main Evaluation Panels recommendation that Robertson Healthcare be selected as Preferred Bidder. This recommendation was approved at the NHS Board meeting held on 31 January 2006 subject to satisfactory resolution in writing of a number of key outstanding issues, and successful completion of the Key Stage Review.

5.10. Evaluation of Soft Facilities Management

5.10.1. The Project Board reviewed in detail the outcome of the evaluation for Soft Facilities Management services, including both the qualitative evaluation and the quantitative evaluation.

5.10.2. The Facilities Management sub-group agreed that a combined qualitative score for Hard Facilities Management and the relevant Soft Facilities Management score (i.e. either external bidder's or the In House Team's score for the soft facilities management) should be taken as a consolidated score for both Bid 1 and Bid 2, with both the Hard and Soft Facilities Management service provision being weighted at 50%. The rationale for this was that although basic services costs for Soft Facilities Management were greater, approximately a 55/45 split, there were more Hard Facilities Management services than Soft services, and Soft services may be market tested later in the contract period, thus ensuring continued best value to NHS Forth Valley. The Main Evaluation Panel and the Project Board endorsed this approach.

5.10.3. The commercial evaluation of bidder's proposals for Soft Facilities Management services focused on the quantitative aspects. This quantitative evaluation was based on bidders' responses to the ITN, and the Revise & Confirm (R&C) letter issued in December 2005. The In House Team was also invited to revise and confirm their specific Bids for Bidders A and C in the light of the revised payment mechanism and associated specifications. However the following evaluation results focuses on the quantitative evaluation of Bidder C and the In House Team in the light of the NHS Board's decision to select Bidder C as

Preferred Bidder.

5.10.4. Bidder C and the In House Team both submitted strong and affordable bids. The Project Board reviewed the outcome of both the qualitative and quantitative evaluations at its meeting on 2 February 2006. It will be noted that Bidder C achieved [redacted]% on Bid 1 and [redacted]% on Bid 2. In terms of Bid 1 the consolidation of the In House Team's Specific score increases the overall score for Bidder C, with the In House Team's score for Soft Facilities Management exceeding that of Bid 2. In summary, the qualitative evaluation resulted in the following scores:

Table C5/6: Qualitative Facilities Management Scores for Bidder C's Bid 1 and Bid 2

	Bidder C	
	Bid 1	Bid 2
Total Scores	[redacted]	[redacted]
Ranking	1	2

5.10.5. When assessing Value for Money against the Bid Comparator Model (BCM) the figures were also close with Bidder C's Bid 2 i.e. £[redacted]k ([redacted]% over 30 years) better than the Bid 1 submission.

Table C5/7: NPV for Bidder C's Bid 1 and Bid 2

Net Present Value – Bids 1 and 2	£'000
NPV of Combined Bid 1 per R&C submission	[redacted]
NPV of Bid 2 per R&C submission	[redacted]
NPV of the BCM (£'000)	[redacted]
VfM of lowest cost solution per R&C submission	[redacted]%

5.10.6. In reviewing annual affordability, Bid 1 performs better than Bid 2.

Table C5/8: Annual Affordability for Bidder C's Bid 1 and Bid 2

Annual Affordability – Bids 1 and 2	**Bid 1 £'000**	**Bid 2 £'000**
Unitary Charge external Bid 2 Real (as at 1 April 2006)	[redacted]	[redacted]
Annual Operational costs for IHT Specific Bid Real (as at 1 April 2006)	[redacted]	[redacted]
Total cost of Bid Real (as at 1 April 2006)	[redacted]	[redacted]
Ranking	**1**	**2**

5.10.7. In summary the outcome of the Soft Facilities Management evaluation (on the basis that Bidder C was appointed Preferred Bidder) is that:

- the qualitative evaluation indicates a Bid 1 solution;
- NPV indicates a Bid 2 solution; and
- annual affordability indicates a Bid 1 solution.

5.10.8. All three assessments are however; close with no demonstrable gap between the In House Team and Bidder C. The Project Board considered that through a robust and competitive process the In House Team's bids have evaluated well against established external facilities management providers.

5.10.9. The Project Board noted that from both a qualitative and an affordability perspective, the In House Team submission exceeded that of Bidder C. The Project Board also noted that on a Value for Money assessment, using NPV, the difference between the In House Team and Bidder C was marginal ([redacted]% over 30 years).

5.10.10. The Project Board agreed to recommend that the provision of Soft Facilities Management for the Clackmannanshire Community Health Services Project be provided by the In House Team.

5.10.11. The NHS Board received a presentation and considered a paper "Clackmannanshire Community Health Services Project ITN Evaluation: Soft Facilities Management" at its meeting on the 14th February 2006.

5.10.12. It was highlighted that whilst both bid 1 and bid 2 were within the Boards affordability threshold the Project Board's recommendation was that Bid 1, with the higher quality, outweighed the marginally better NPV of bid 2 and therefore provided better value for money for the Board. The NPV difference representing only [redacted]% over 30 years was within the margin of error in the risk adjustment process.

5.10.13. Following detailed discussion the NHS Board accepted the recommendation of the Project Board that the provision of Soft Facilities Management for the Clackmannanshire Community Health Services Project be provided by the In House Team in conjunction with Bidder Cs proposals for the design, build, finance and maintenance (hard facilities management) of the new facilities.

5.10.14. The particular factors which Board members considered weighed in favour of the In House Team were as follows:

- The NPV differential between Bids 1 and 2 was marginal and within the bounds of the risk adjustment made;
- The In House Team service delivery proposals and staffing models were very detailed and service models and method statements were provided to a high level of detail and appeared robust. These were better developed for the operational phase of the project and gave greater comfort of a quality service delivery than the submission made by Bidder C; and
- The In House Team had confirmed that there would be no derogations from the Service Specific Specifications and had accepted the response and rectification times. This demonstrated greater compliance with the Boards requirements than the Robertsons Healthcare proposals.

5.10.15. The Board also noted that although not part of the formal evaluation process the in-house bid would ensure a high level of continuity and integration of the Soft Facilities Management staff and the clinical staff.

5.10.16. The Board noted that the decision would be subject to the approval of SEHD at Key Stage Review, and the conclusion of satisfactory terms with Bidder C on the interface between the In House Team's proposals and Bidder's C's proposals.

5.10.17. Following the Project Board and NHS Boards endorsement of the Preferred Bidder selection and the decision to award Soft Facilities Management to the In House Team, the Preferred Bidder Key Stage Review was submitted to the Scottish Executive on 16 March 2006 and received approval on 27 March 06.

5.10.18. During this period further discussion and negotiations regarding the wording of the Preferred Bidder letter were held with Robertson Capital Projects. The Preferred Bidder letter was issued by the Board on 31 March 2006 and the Board issued a press release on 28 March 2006 announcing the appointment of Robertsons Healthcare as Preferred Bidder.

5.10.19. Following further extensive negotiations with Robertson Capital Projects and the issue of a revised Preferred Bidder Letter on 18 July 2006, the Preferred Bidder letter was signed by Robertson Capital Projects and their funders on 29 August 2006.

5.11. Interaction with the Preferred Bidder

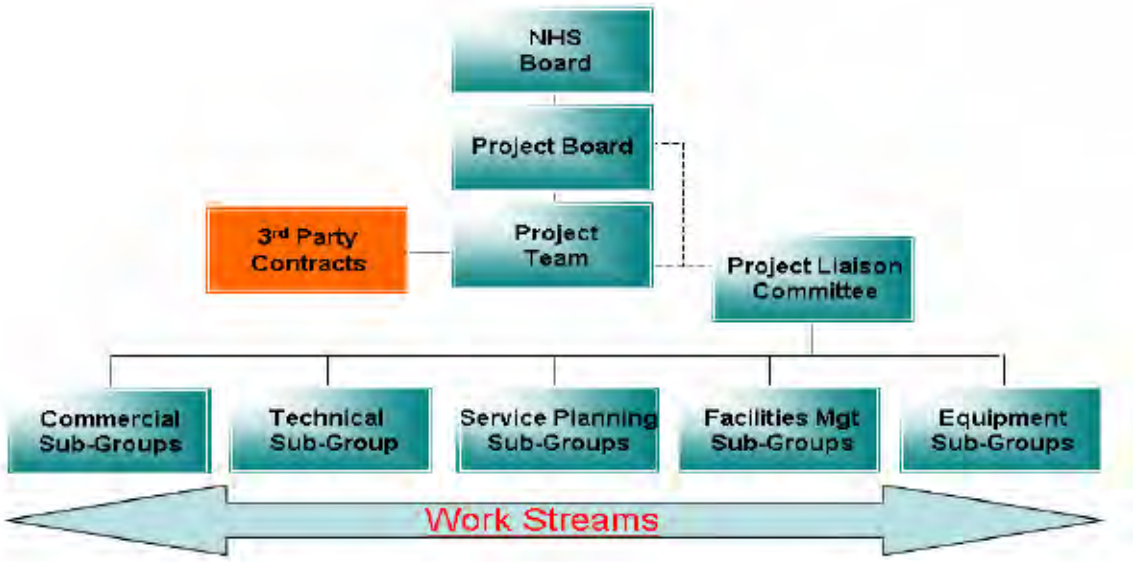
5.11.1. Following the selection of the Preferred Bidder a Project Execution Plan was developed and agreed with Robertson Capital Projects.

5.11.2. The objective of this Project Execution Plan was to produce a planned environment for the contract finalisation process on the Clackmannanshire Community Health Services Project. It establishes the key project management arrangements to be adopted throughout the contract finalisation period including the:

- project organisation structure comprising Board representatives, Board Advisers and Preferred Bidder representatives;
- team roles and responsibilities;
- lines of communication for correspondence and reporting;
- decision making arrangements;
- meetings timetables;
- reporting and recording procedures;
- risk management procedures;
- change control mechanism; and
- programme to financial close.

5.11.3. The Project Execution Plan is a 'live' document that has been be developed and refined as the project progresses to financial close. The Board will be responsible for maintaining and circulating the Project Execution Plan. The Board and Robertsons Healthcare has been responsible for ensuring the plan is implemented. The project organisational structure to Financial Close is as follows:

Figure C5/2: Project Structure to Financial Close



5.11.4. There are five work streams or sub groups in total covering the areas shown in the above diagram. The Board and Robertsons Healthcare joint leads of each Sub-Group have authority for that particular work stream and ensure in conjunction with the Boards Project Team and Robertsons Healthcare that:

- All deliverables are achieved;
- Meetings are scheduled;
- There is appropriate attendance;
- That following meetings minutes are circulated, via the Boards Project Office, to all other Sub-Groups; and
- That progress reports and/or briefing papers are provided to the Boards Project Office for inclusion in a progress report to the Project Liaison Committee.

6. THE PREFERRED PFI SOLUTION

6.1. Introduction

6.1.1 The aim of the Clackmannanshire Community Health Services Project is to bring together on one site primary care and other community based services, including community hospital services, to improve patient access. The new facilities will also support the delivery of new services and allow GPs and other clinicians to improve the quality of services to patients.

6.1.2 The proposed scheme by Robertson Healthcare will deliver a modern environment where current clinical best practice is the starting point for continuous improvement and patients are cared for in clean, safe, high quality surroundings that make best use of the resources.

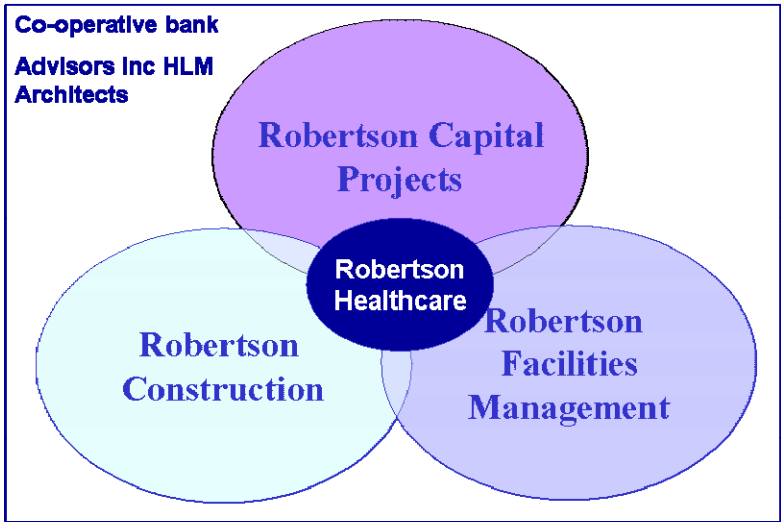
6.1.3 The new facilities will be of a high quality and will provide flexible and adaptable accommodation.

6.1.4 Robertson Healthcare will provide Hard FM services, with the Board retaining the provision of Soft FM services.

6.2. Consortium Members and Project Structure

6.2.1 Robertson Capital Projects is the sole shareholder in Robertson Healthcare with the Co-operative Bank plc providing the senior debt requirements for the project. The other companies within the Robertson Healthcare consortium are shown in the following diagram.

Figure C6/1: Robertson Healthcare Consortium



6.2.2 The experience of the main consortium members in delivering community health services projects and other projects of this size and complexity are available from the Project Team on request.

6.3. Project Description

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

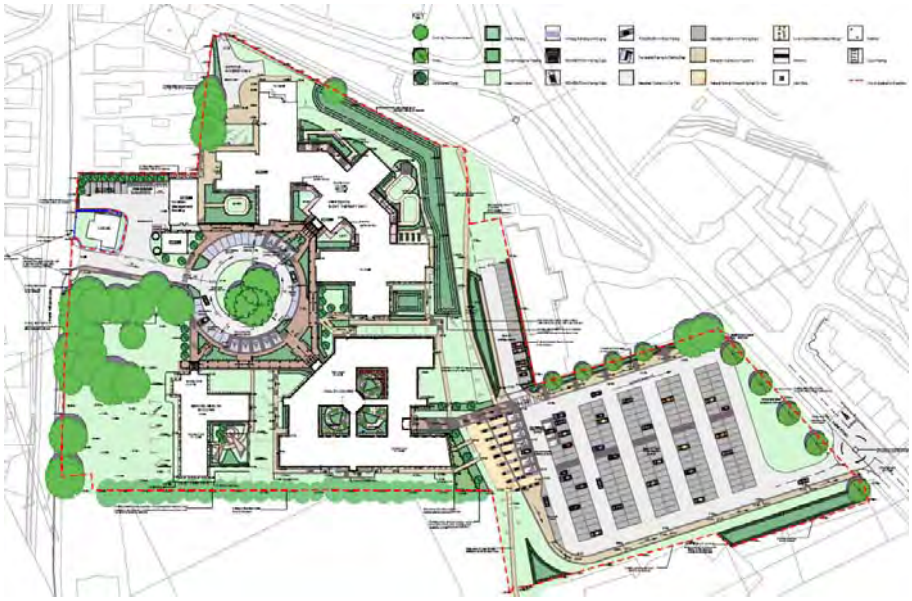
6.3.2 Drawings and plans of the proposed design are available from the Project Team on request. The following is a brief description of the proposals submitted by Robertson Healthcare.

Figure C6/2: Computer Generated Photo Montage Aerial View of PFI Solution.

6.3.3 The development as proposed will comprise four buildings in a campus arrangement; Health Centre; Community Mental Health Resource Centre; Inpatient and Day Therapy Unit and Facilities Management Building. These buildings are all to be located on the 'Sauchie Hospital' site with the Alloa Mill site being used only for parking. (This is a key departure from the CPAM design which envisaged the Health Centre building being located on the Mill site).

6.3.4 The site plan is indicated below:

Figure C6/3: Site Plan.



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

- Health Centre

Figure C6/4: Health Centre – lower site.

health centre level -1 lower site

The Health Centre has been designed as a three-storey courtyard building comprised of four modular quadrants arranged around a central courtyard with a triple height atrium space occupying its North West quadrant. The two upper floors each have one of the quadrants omitted in order to create a stepped built form which responds well to the site topography.

The patient access areas occupy the lower ground and upper ground floor with staff offices and support facilities on the top floor. Patients and staff will enter the building at lower ground level from the main car park with 225 car spaces accessible from Hallpark Road, or from the upper ground floor level if approaching from Parkhead Road where parking is limited to 25 car spaces as advised by Clackmannanshire Council

Planning Authority. Disabled Parking and dedicated key staff parking is available adjacent to both entrances.

Figure C6/5: Health Centre – upper site.

health centre level 00 upper site

The facility includes a pharmacy situated to the North-West quadrant of the Health Centre, diagonally opposite the main entrance. The pharmacy public areas comprising a retail area, waiting space, patient counseling room and dispensary are all accessible from the central atrium space. The upper floors of the Health Centre accommodate the Community Services treatment, consulting and therapy rooms. The top floor has offices for NHS Forth Valley and Clackmannanshire Council Social Services staff.

- Community Mental Health Resource Centre

This building has been given a discrete location within the campus plan closest to the site entrance from Parkhead Road. This is considered to be beneficial to some of the patients attending either the Adult Psychiatric Day Hospital or Adult Psychiatric Outpatients who may experience difficulties in negotiating the busy public main entrance area. The unit will also enjoy a dedicated external entrance, which is linked to the other buildings on the site by a covered pedestrian walkway.

Figure C6/6: Mental Health Resource Centre.

mental health building level 00 upper site

- Inpatient and Day Therapy Unit

The Inpatient Accommodation/Day Therapy Unit will provide a domestic scale environment for patient groups, with the current design arrangement accommodating the Frail Older People and Old Age Psychiatry patient groups in two single storey wings

placed symmetrically around a two storey 'cruciform' element. The inpatient accommodation has been configured in small-scale units of between 6 and 11 beds to give a non-institutional feel. The Frail Older Patients facility has level access to both an outdoor terrace and day garden with the Old Age Psychiatry group benefiting from a similarly accessible terrace and sensory garden.

Figure C6/7: Inpatient Wards and Day Hospital.

inpatients + day hospital level 00 upper site

Shared in-patient accommodation, comprising mainly treatment and rehabilitation spaces, will be located at the centre of the building on the ground floor flanked by the social or day spaces belonging to the two principal patient groups of Frail Older People and Old Age Psychiatric. The multi-disciplinary workstation will be located at the heart of the shared accommodation where it can be readily accessed from both in patient wards and will provide the focal point for patient admissions.

The Elderly Day Therapy Unit occupies the upper floor. External access to this unit will be via Parkhead Road to the central external landscaped courtyard which provides appropriate covered setting down and parking facilities for patients using patient transport services, disabled drivers and those being dropped of by taxi or patient escort. These facilities are linked to the other buildings by a covered pedestrian walkway, which provides level, barrier-free access.

Once inside the building patients will make use of one of two lifts directly inside the front entrance, avoiding the need to pass through any of the inpatient facilities. The location of the Day Hospital at first floor level enables patients to enjoy good views and through the design of a garden area at first floor retain the benefits of access to quality outdoor spaces. Staff changing and showering facilities will be provided on the upper floor of this building along with the multi-faith room, hair dressing and complimentary therapies room.

- Facilities Management Building

The design solution has opted to provide a separate single storey Facilities Management (FM) building, providing an effective base for operational staff. A bespoke building and service yard will be located adjacent to the existing Lodge Building providing FM offices space, laundry and waste accommodation. The building also houses the main electrical incoming supply, the standby generator, main utilities meter and main LV Switchgear for the site.

6.4. Key Features of the Design

6.4.1 The key features of the design include:

- Robust understanding of the required functionality of the clinical output specification;
- Multi-building design sited on the upper site, with level access to all buildings;
- Options for configuring the three GP surgeries around a central arrival point enhancing wayfinding and ensuring equitable travel distances for all;
- Development of a ward 'cluster' model which would allow inpatients to grow outwards from a central shared area without a dependence upon a courtyard design with its inherent privacy difficulties;
- GP surgeries arranged as 'spokes' around circulation 'hub';
- Impatient accommodation at one level and housed in 6/8 bed single storey 'pavilion' clusters;
- A 'campus' style approach of primarily two and three storey buildings located on Sauchie Hospital Site and provides views in two separate directions. Firstly a Health Centre element bordering the cycleway and facing towards Hallpark, and secondly, with a Community Hospital element facing Parkhead Road. The Community Hospital has discreet entrances to Impatient Wards, Day Therapy and the CMHRC.
- The pavilion approach to the design has delivered a human scale to the Facilities aiding familiarity for patients and assisting with intuitive wayfinding;
- Grouping of buildings presents the image of a small well landscaped 'village';
- Range of buildings displaying generally a 'domestic' or residential' character and clad in a traditional approach;
- Landscaping includes integral and secure garden areas; and
- Main car parking is provided on the lower site, with direct visual link to the main entrance, and the health centre.

6.5. Making best use of the site

6.5.1 The challenge of connecting the two sites as a result of the topography is recognised within the design. Robertson Healthcare cut and fill strategy enables the majority of the excavated material to be retained on site, limiting the environmental impacts associated with landfill waste and associated transportation.

6.5.2 The layout of the buildings has been carefully configured to retain almost all of the existing natural features preserving to a large extent the existing natural landscape, mature tree stands and stone walls.

6.5.3 From an urban design point of view the design proposed projects itself well into the surroundings adding a two-storey presence towards Sauchie and Keillarsbrae. Conversely, the inpatient wards and day therapy enjoy good aspect and view towards the Ochil Hills.

6.5.4 Access to the Facility will be straightforward, with clear signposting and dedicated car parks close to the relevant entrances. On the whole, the road network, associated car park and drop off areas, and provision of dedicated entrances where necessary will facilitate good access and egress.

6.6. Clinical adjacencies

6.6.1 The departmental relationships and clinical functionality required to be delivered by the brief were met to a large extent at the ITN stage. It is envisaged that most able bodied patients and staff will access the facilities via the entrance to the Health Centre adjacent to the main car park on the former Alloa Mill site. The main entrance on the upper site acts as the principal point of access and egress to the Health Centre for all other patients and staff. The inpatient and community mental health resource facilities are accessed externally via separate entrances, from the Parkhead Road with each of the buildings linked by a covered walkway.

6.6.2 The departmental relationships have been assessed to be generally good, albeit some involve external routes to access them. On the whole the internal flows for the departments are good and acceptable to the clinicians and users.

6.7. Flexibility and future expansion

6.7.1 The proposed design allows for both internal and external adaptation to meet the changing ways in which care will be delivered in the future. Good use of the entire site has been made for expansion opportunities. The proposed design makes particularly good use of the west side of the site with some specific individual expansion areas identified.

6.7.2 The campus style approach with four buildings allows extension or adaptation works to proceed with limited impact on the others.

6.7.3 Accommodation has been planned and designed to adapt to change, with a standardised room specification so that rooms can be easily converted to alternative uses, and yet readily tailored to specialist needs. For example double bedrooms have been design to be twice the size of the single bedrooms for ease of future conversion.

6.7.4 Internal compartmentalisation is primarily formed using dry walling techniques allowing remodelling work to proceed with minimal disruption in terms of nuisance (noise, vibration and dust).

6.7.5 The structural flexibility proposals are standard and appropriate for a project of this scale. Zones have been dedicated for new build and both vertical and horizontal expansion will be feasible.

6.8. Interior design

6.8.1 The design succeeds in breaking down the scale of the project producing a 'friendly' and 'domestic' type of environment.

6.8.2 A key feature of the Health Centre design is the open courtyard featuring a glazed atrium that will do much to assist in wayfinding for those entering from both the upper and lower entrances.

Figure C6/8: Health Centre Entrance.

6.8.3 The design acknowledges a hierarchy of different types of spaces. The progression through these will be defined by varying approaches to the use of form, light, colours and materials; all helping to assist with the patient's wayfinding.

6.9. Decant

6.9.1 The proposed decant strategy has the following advantages to the Board:

- Overall construction programme completed within 16 months post Contract Date;
- Car parking that provides 250 car parking spaces for Board use and meets local planning requirements throughout the construction period;
- Minimal temporary decants of critical operational areas i.e. clinical staff and patients move once only, and in such a manner that continuous operations will be maintained;

6.10. Impact of the Decant Period on FM Services

6.10.1 This project benefits from there being a straightforward occupation by the Board. There are limited decant issues that affect the completion of the building with no phased occupation currently being envisaged. The introduction of the FM services is therefore comparatively straight forward. The transition of the Soft FM services from other facilities being vacated has no impact on the preferred PFI solution outlined here.

6.11. NEAT - Sustainable Approach to Development

6.11.1 As a deliverable at ITN the Board required the potential partners to carry out an evaluation of their proposals using the NHS Environment Action Tool (NEAT).

6.11.2 Robertson Healthcare submitted a score of [redacted]%, which is classified as "Very Good" under the tool. The building from an engineering perspective has been designed to be flexible and controllable. This efficient and effective design has led to an anticipated energy consumption of [redacted]Gj/100m3, which is within the government target of 35 – 55 Gj/100m3 for new developments. The NEAT assessment has continued to be refined since the ITN stage and Robertson Healthcare have confirmed that based on their most recent assessment a NEAT rating of 'Excellent' is likely to be achieved.

6.12. Planning Permission

6.12.1 The Board prepared a Planning Development Brief for the Project in conjunction with Clackmannanshire Council and this was included in the ITN documentation issued to Bidders. It was agreed with Clackmannanshire Council Planning Department that Outline Planning Permission would not be required given the detail of agreement in the Development Brief. This formed the basis of all future discussions with the Clackmannanshire Council in regard to the development.

6.12.2 In October 2006, Robertson Construction Central Ltd submitted an application for full planning and listed building consent. The latter was required because some of the existing boundary walls are listed. Clackmannanshire Council Regulatory Committee considered the application on 22 December 2006 and Planning Consent was granted subject to conditions.

6.12.3 The Board have obligations in regard to some of the Planning conditions, principally in connection with the off site road works, lighting to the mixed leisure-route (cycle path) and the preparation and publication of a Green Travel Plan. The Board are currently in negotiation with the Council regarding these matters with a view to agreeing responsibilities and financial liabilities. These works require to be completed prior to occupation of the facility.

6.13. Interim Services

6.13.1 Not applicable to this project.

6.14. Timetable

6.14.1 The proposed timetable for completion of the development is.

- Detailed Planning Consent – December 2006;
- Financial Close – June 2007;
- Practical Completion – September 2008
- Service Commencement – October 2008

7. HUMAN RESOURCES

7.1. Introduction

7.1.1 NHS Forth Valley employs around 8,000 staff providing a wide range of professional, technical, administrative and facilities services.

7.1.2 Employees have been involved in the development of the Clackmannanshire Community Health Services Project through the well-established partnership arrangements, and it is recognised that the proposals represent significant organisational change challenges for employees.

7.1.3 The NHS 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.

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

7.2. Workforce Planning

7.2.1 The objective is to support the delivery of NHS priorities locally by ensuring there are sufficient numbers of appropriately trained and motivated staff working in the right locations. The HR strategy for the NHS sets out a managed programme for rapid expansion in the NHS workforce, and the introduction of more flexible ways of working and improving working lives of staff. Delivery of this strategy is absolutely central to the achievement of strategic priorities.

7.2.2 Whilst working towards national targets the Board must also consider the local workforce planning issues that are specific to the new facilities in Clackmannanshire.

7.2.3 Community and primary care services were distributed across three sites (Alloa Health Centre, Clackmannanshire County Hospital, and Sauchie Hospital) although over the last couple of months services on the Sauchie Hospital site have relocated to Clackmannanshire County Hospital.

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

- management structures;
- clinical practices; and
- administrative procedures.

7.3. New Service Models

7.3.1 Many of the services will need to undergo changes in the way they are delivered, with a knock on effect on the shape, size and location of the workforce, including:

- the skill mix of staff employed;
- numbers of staff; and
- flexible patterns of working.

7.4. Change Management

7.4.1 The Board is currently developing a detailed organisational development and change management action plan. This will enable the workforce to be supported through the next two years of organisational change and the introduction of new ways of working.

7.4.2 Given the size of the agenda ahead, and other Boards' experiences of similar levels of change, the Board recognises the need for a systematic approach to the service and workforce redesign. The exact structure and process for this organisational development and change management plan is currently being developed within the Board.

7.5. Staff Transfers

7.5.1 Staff working in clinical services will not be transferred to the private sector as part of the PFI contract.

7.5.2 Facilities Management (FM) services are normally categorised as either "Hard" services or "Soft" services. Hard services are normally those associated with building and estates maintenance, and Soft services are normally considered to be the non-clinical support services such as catering, cleaning, laundry and waste management.

7.5.3 In NHS Forth Valley most FM services are delivered by the "Forth Valley Facilities Unit", with some Soft services delivered on a contractual basis by other external providers' e.g. clinical waste disposal, laundry etc.

7.5.4 The distinction between Hard and Soft services is an important one within the PFI procurement process. Under a traditional PFI model the private sector developer would take responsibility for Hard FM services as it is the developer who is responsible for designing, building and maintaining the new facilities.

7.5.5 The number of Hard FM staff associated with the existing facilities in Clackmannanshire is relatively small. Therefore Forth Valley Facilities has actively reduced, through vacancy management, the number of Hard FM staff employed to a level such that there will be no staff transfers associated with the provision of these services at the new facility. All Hard FM staff will be recruited and employed by Robertson Healthcare prior to service commencement.

7.5.6 The successful Bid for Soft FM, from the Boards In-House Team, means that there is also no staff transfers associated with the provision of Soft FM services at the new facilities. All Soft FM services provision will be retained by the Board with the Forth Valley Facilities Unit supplying the staff necessary to provide the services.

7.5.7 Therefore there are no consequences for Board under the SE/STUC Protocol or the application of the TUPE regulations.

7.6. Integrated Management Approach

7.6.1 The Board and Robertson Healthcare will need to ensure that measures are in place which avoids the creation of a two tier workforce between Hard Facilities Management staff working with NHS Forth Valley. Robertson Healthcare has confirmed that:

- FM staff will be managed broadly in accordance with Board policies and procedures; and
- they will observe their obligations in respect of Trade Union recognition.

7.6.2 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 Robertson Healthcare structure required in order to manage the contract as well as the responsibilities regarding the application of Board policies.

7.6.3 Robertson Healthcare 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.

8. INFORMATION TECHNOLOGY

8.1. Introduction

8.1.1 The Board's ICT strategy will be reviewed over the coming months, however no major changes in strategic direction are anticipated.

8.1.2 The focus of the Board's ICT strategy and that of the national programme is to move towards clinical information systems supporting the move to electronic records rather than paper based systems. The information to support clinicians will be gathered from all the relevant organisations with which the patient has contacts and becomes an integrated care record.

8.1.3 The current methods of communication between clinicians are inefficient and ineffective leading to delays and lack of continuity of care. Goals in this area include remote booking of hospital appointments and electronic handling of immediate discharge documentation.

8.1.4 National programmes to rollout NHS-wide intranet access to General Pharmaceutical, Dental and Ophthalmic Practices will be supported by NHS Forth Valley. The implementation of electronic transmission of prescriptions, e-pharmacy (minor ailments service, acute and chronic medication services), supporting dispensing and reimbursement, will underpin the clinical governance agenda. The supporting of pharmacy prescribing for partially automatic generation of e-referrals and access to the electronic integrated care record will have clear benefits for all primary care professionals.

8.1.5 Information Technology has a key role in the effective provision of out-of-hours services, in conjunction with the introduction of NHS24. The availability of patient information online is an important factor in providing seamless patient care.

8.2. Robertson Healthcare Responsibilities

8.2.1 As part of the development of the new health centre and community hospital facilities in Clackmannanshire, Robertson Healthcare shall design, construct and maintain a comprehensive and robust infrastructure (e.g. containment, cabling and computer rooms) in accordance with the Board's ITN documents.

8.2.2 The services to be supported within information technology include a data network infrastructure capable of supporting as a minimum, but not limited, to the following systems:

- Patient administration system;
- Pharmacy information system including electronic prescribing;
- Electronic patient records;
- Internet, intranet and email services; and

- On-line clinical information systems.

8.2.3 The services to be supported within communications include a voice network infrastructure that is capable of supporting, but not limited to the following systems;

- Voice over internet protocol;
- Conventional voice;
- Modem and fax services;
- Phone to the bed head; and
- Public area pay phone installation.

8.2.4 The Board will install hardware (e.g. servers, PCs, printers, scanners), make the final connections (at the application and in computer rooms) and commission the operational system.

8.2.5 Robertson Healthcare shall install hardware (e.g. incoming switch and handsets but not faxes), make the final connections (at the handset / base station and in switch rooms) and commission the operational system.

8.2.6 Robertson Healthcare shall provide systems that are fully compatible with the Board's operational information technology systems.

8.2.7 Robertson Healthcare shall provide flexible IT and telephone systems ensuring that systems allow for a combined IT and telephone system in the future through the implementation of the National Health Service Information Authority (NHSIA) N3 project. Infrastructure provided by Robertson Healthcare shall be fully compliant with the requirements of the N3 project.

8.2.8 Provision shall be made within the infrastructure for the inclusion of wireless networking.

8.2.9 The structured wiring provided will be able to support both the current and future applications. Clearly it is impossible to predict the network requirements over the full period of the contract but the project includes provision for technology refresh.

8.2.10 The precise lines of demarcation of the scope of the provision, by the Boards and Robertson Healthcare, are summarised in the following tables.

Table C8/1: Information Technology Responsibility Matrix.

Service / Technology	System Design	Construction / Provision	Management	Maintain / Lifecycle Replace
Information Technology (ICT)				
System management	N/A	N/A	Board	Board
System architecture, design	Robertson Healthcare to Board approval	Robertson Healthcare	Board	Robertson Healthcare

Hardware (inc. PCs, printers)	Board	N/A	Board	Board
Hubs, servers / switches	Board	N/A	Board	Board
Computer rooms (see telephony below)	Robertson Healthcare to Board approval	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Containment	Robertson Healthcare to Board approval	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Cabling and faceplates	Robertson Healthcare to Board approval	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Commissioning / labelling / testing	N/A	Robertson Healthcare - with Board in attendance	N/A	Robertson Healthcare
UPS dedicated	Robertson Healthcare (infrastructure only) - Board to provide as a part of hardware	Robertson Healthcare (infrastructure only)	Board	Board
Final connections to hardware, hubs, UPS, external links and other equipment	N/A	N/A	Board	Board
Links to other organisations	Robertson Healthcare (infrastructure only) to Board approval	Robertson Healthcare (infrastructure only)	Board supply all software and hardware and install in commissioned infrastructure	Board (equipment) / Robertson Healthcare (infrastructure)
Video link facilities – external, internal	Robertson Healthcare (infrastructure only), to Board approval	Robertson Healthcare (infrastructure only)	Board to supply and manage	Board (equipment) / Robertson Healthcare (infrastructure)

Table C8/2: Communication Responsibility Matrix.

Service / Technology	System Design	Construction / Provision	Management	Maintain / Lifecycle Replace
Telecommunications				
System management	Robertson Healthcare to Board approval	N/A	Soft FM	N/A
System architecture / design	Robertson Healthcare to Board approval	Robertson Healthcare	Soft FM	Robertson Healthcare

Hand sets	N/A	Robertson Healthcare	Soft FM	Robertson Healthcare
Pagers / staff location system	Robertson Healthcare to Board approval	Robertson Healthcare	Soft FM	Robertson Healthcare
Switch room(s) (see ICT above)	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Containment	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Cabling and faceplates	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Commissioning / labelling	N/A	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Final connections to hardware / hubs	N/A	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare
Dedicated UPS	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare	Robertson Healthcare

9. EQUIPMENT

9.1. Introduction

9.1.1. This chapter of the Full Business Case sets out:

- the categories of equipment used in the ITN documentation;
- an overview of equipment procurement proposals;
- equipment provision within the PFI contract; and
- equipment responsibilities retained by the Board;

9.2. Equipment Requirements

9.2.1. Equipment can be grouped into four main categories. These are:

- **Group 1:** Items that are considered to be part of the building construction and are permanently wired or installed or that will be more effectively included at the building stage. e.g. air-conditioning, power sockets, data points;
- **Group 2:** Equipment that will have an impact on building that may be procured separately and installed as an engineering contract e.g. imaging equipment;
- **Group 3:** Equipment that has an impact on space but will be purchased using capital funds and installed directly by the Division e.g. furniture; and
- **Group 4:** Equipment that has implications for storage but do not have any structural requirements i.e. do not need to be plugged in such as instruments, linen etc.

9.2.2. With the advent of PPP/PFI projects the previously well defined definitions of Group 1- 4 have become blurred, so to ensure absolute clarity Scottish Healthcare Supplies were commissioned by NHS Forth Valley at an early stage in the project (pre-ITN) to develop a Draft Equipment List, detailing who was to provide each item of equipment listed. The list was included as part of the ITN documentation as were indicative Room Data Sheets for every room in the Conventional Procurement Assessment Model.

9.2.3. Major medical equipment and moveable items will be procured separately by NHS Forth Valley or transferred from existing facilities. The assumption made in the Invitation to Negotiate (ITN) was that this would take the form of a traditional capital procurement with management and maintenance of the major medical equipment being undertaken by Board personnel e.g. Health Physics or through specialist sub contractors e.g. dental equipment suppliers.

9.2.4. Robertsons Healthcare have, as part of their bid, costed for the supply, installation, commissioning, maintenance and replacement of equipment which is integral to the construction of the building. This will mainly include Group 1 with some equipment from other Groups as detailed in the Indicative Room Data Sheets.

9.2.5. Some Group 1 and 2 equipment detailed as being for Robertsons Healthcare to procure, install and maintain has input from the Board in terms of specification and tendering, for example suction brackets, as Robertsons Healthcare need to know the type of consumables used by the Board to ensure the correct brackets are purchased.

9.2.6. It is anticipated that Scottish Healthcare Supplies and NHS Forth Valley Supplies Department will support the specification, tendering, procurement and logistical elements of the equipping project for Group 3 and 4 items.

9.2.7. NHS Forth Valley has established an Equipment Procurement Board led by an Equipment Project Manager who is a member of the Clackmannan Hospital Project Team. This Equipment Procurement Board has been established, in line with Prince II Project Management Methodology, with representation from General Managers, Clinical Leads of Healthcare Planning Groups, Finance, IT, Facilities Management and Supplies.

9.2.8. This Board supports the work of the Equipment Project Manager and ensures that procurement of equipment is undertaken and completed in line with Standing Orders and Standing Financial Instructions.

9.3. Funding of Equipment

9.3.1. Equipment within PPP/PFI:

- All Group 1 and some Group 2 equipment items shall be procured by Robertsons Healthcare and were costed as part of the bid submission. The maintenance for these items forms part of the Opex costs.

9.3.2. Equipment not within PPP/PFI:

- Group 3 and 4 items will be purchased or leased by NHS Forth Valley through the traditional procurement route of submission to the Capital Planning Group for approval and prioritisation.

9.3.3. There is an expectation within NHS Forth Valley that a percentage of equipment will transfer from current premises to the new development but a percentage has not been confirmed as this will continue to change as new equipment replaces old during the period up to practical completion and service commencement. An inventory of all medical equipment was undertaken during summer 2006 and the exercise to identify items for transfer will commence during 2007.

9.4. Board Responsibilities

9.4.1. Medical Equipment:

- The Board will retain full responsibility for medical equipment, other than Group 1. There is no provision within the PFI scheme for the procurement of medical equipment; such provision remains within the Board's capital programme.

9.4.2. Non-Medical Equipment:

- The Board will retain full responsibility for Soft Facilities Management equipment in the new facility as this is a retained service. The range and cost of this equipment was identified within the In House Soft Facilities Management Bid. There is no provision for this equipment within the PFI scheme, such provision remains within the Board's capital programme. The provision of all Hard Facilities Management equipment is included within the PFI scheme and shall be for Robertson Healthcare's account.

9.4.3. Transferred Equipment:

- The Board intends that wherever appropriate, existing equipment (including furniture) will be transferred from its current location into the new hospital. This applies to both medical and non-medical equipment. The Board will retain responsibility for existing non-medical equipment that transfers.

10. INVOLVING PATIENTS AND THE PUBLIC

10.1. Introduction

10.1.1 The Public Engagement/Involvement/Consultation process for the project has used the SEHD guidelines that were in existence at the time that each exercise was carried out.

10.1.2 The aims were to ensure that patients and the public are involved and consulted from the very beginning of any process to develop health services or change how they operate.

10.2. Public Consultation

10.2.1 The Board undertook a process of internal and external consultation on the Healthcare Strategy in 2002 and 2004, which included the proposal to centralise acute services on one site, with a complementary network of community hospitals and primary care facilities. This process included wide circulation of the Strategy to all key stakeholders and also included a series of public meetings. Following this consultation the strategy was adopted by the NHS Board and subsequently submitted to SEHD for ministerial approval.

10.2.2 NHS Forth Valley 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. The Board has been committed to involving the people of Forth Valley from the outset of this project: the approach that has been taken is based on the model of:

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

10.2.3 The involvement/consultation methods adopted included:

- Focus groups;
- Staff workshops;
- Face-to-face briefings;
- Consultation documents;
- Questionnaires;
- Consultation fairs; and
- Public meetings.

10.2.4 The debate and consultation included options for a new acute hospital, the development of a new community hospital in Clackmannanshire and the future development of other community services.

10.2.5 In May and June 2003, NHS Forth Valley hosted five workshops, to enable the public, NHS staff and other key stakeholders to debate the future shape of community and primary care services in the area. These workshops considered further integration of acute services with primary care and community services and began to develop, with community involvement, proposals for the future of these services.

10.2.6 This work has informed the planning assumptions for the Stirling development and provided a basis for taking forward discussions with individual communities about the future development of community and primary care services. This is likely to form the basis of a separate business cases to support the implementation of the Healthcare Strategy.

10.2.7 Further details of the public involvement and consultation activities undertaken can be accessed on request from the Project Team.

10.3. Outcomes from the Consultation Process

10.3.1 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 Forth Valley.

10.3.2 In respect of the proposals to build a new Community Hospital for Clackmannanshire and to co-locate a replacement for Alloa Health Centre on an extended Sauchie Hospital site, there has been strong support for this, from within Clackmannanshire and general support from other areas.

10.3.3 Throughout the procurement process the Board has pursued an active internal and external communications process to provide information to staff, visitors and the public about the scheme as it has progressed. In addition, the Patient Public Panel has been actively involved in the evaluation of Bids and there has been consistent Patient Representation on the Project Board.

10.4. Future Development of Community-Based Services

10.4.1 It is clear from responses and the discussion that took place at consultation meetings, that people found it difficult to comment specifically on proposals to further develop community services until the location of the acute hospital was decided upon as this was seen to affect decisions about the scope and extent of provision in local communities.

10.4.2 It was also clear however that retaining 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.

10.4.3 From the detail of responses the Board will require to take a view of the correct balance between access/quality/value for money in deciding on a preferred service model. This will then allow the full engagement of all parties in a discussion of the detail of community services.

10.5. Conclusion – Board Decision

10.5.1 The NHS Board approved the provision of a new Community Hospital for Clackmannanshire, replacing Sauchie and Clackmannan County Hospitals, co-located with a replacement for Alloa Health Centre on an extended Sauchie Hospital site. The OBC relating to this project has been approved by the Scottish Executive.

10.5.2 Further consideration of other primary care and community services will be undertaken with community involvement. This review will include consideration of the future role and number of community hospitals in Forth Valley.

11. FINANCIAL ASSESSMENT OF THE PFI SOLUTION

11.1. Introduction

11.1.1 This chapter considers Robertson Healthcare's proposed funding structure. Who will provide the finance, the terms attaching to the finance and provides commentary and analysis regarding whether the financing solution is Value for Money ("VfM") to the Board. The overall VfM of the project is considered in Chapter 13.

11.1.2 The Chapter will examine:

- the Service Payment payable by the Board under the preferred financing structure;
- the cost make-up of the Service Payment;
- the quantitative and qualitative factors considered in selecting the final funding route;
- the make-up of the preferred financing structure, together with the terms being offered; and
- evidence that the financial solution being offered to the Board is VfM.

11.2. Background

11.2.1 The information contained in this chapter is based on the financial close model entitled "CCHFunding (Bid1EB-Rev Costs) 19.01.07 ([redacted]%+[redacted]% buffer).xls" ("Robertsons Healthcare FBC Model"). The model has been prepared by Quayle Munro Limited and generally follows best modelling practice.

11.2.2 The evaluation process up to financial close has incorporated several detailed reviews of both this and previous models provided by Quayle Munro Limited. Although the financial model has been the subject of detailed analysis by the Board and their financial advisor, PricewaterhouseCoopers (PwC), it has not been audited by the Board or PwC. Under these circumstances neither the Board nor PwC take responsibility for any errors contained therein.

11.3. Service Payment

11.3.1 Service Payment Summary

- The Service Payment payable by the Board will be as follows:

Table C11/1: Service Payment Summary

	Service Payment £'000
First Full Year – real (as at 1 April 2006 prices)[1]	[redacted]
Net Present Value ("NPV")[2]	[redacted]

[1] Real values remove the impact of inflation by stating prices with a common base date, i.e. "in today's money". For the purposes of the financial evaluation, the base date is set at 1 April 2006.

[2] The NPV is calculated at a real (i.e. excluding inflation) discount rate of 3.5% in years 1 to 30 and 3% thereafter to the base date of 1 April 2006.

- The full annual real service payment includes Passthrough Costs comprising water, sewerage and business rates totalling £[redacted]k; and Energy costs totalling £[redacted]k.

11.3.2 Phasing of the Service Payment

- There is no phasing of the service payment by the Board, with 100% becoming payable on practical completion of the Facilities as shown in the table below:

Table C11/2: Phasing of the Service Payment

	Date	Service Payment Step-up %	Service Payment £'000
Construction Start	19 June 2007	N/A	N/A
Practical Completion	26 September 2008	100%	[redacted]
Contract Expiry	18 June 2037	N/A	N/A

- The total concession will run for 30 years from Financial Close. The construction phase is expected to last 16 months with an operating period of 28.7 years.

11.3.3 Inflation Assumptions

- The service payment will vary during the operational period due to the impact of inflation. The indexation will be related to the Retail Price Index. The full service payment will be subject to inflation on the 1 April 2007 and every 1 April thereafter. The financial model assumes that inflation will be 2.5% per annum.

- Post Financial Close, the inflation risk in terms of costs will pass from the Board to Robertson Healthcare with the Service Payment only being subject to inflation by RPI, whatever Robertson's input cost inflation is.

11.4. Analysis of the Financial Cost

11.4.1 Robertson Healthcare's proposals address the Board's scope requirements in terms of design, build and hard facilities management. The NPV of Robertson Healthcare's service payment can be analysed into individual components based on the cash flows in Robertsons Healthcare FBC Model.

Table C11/3: Individual Components of NPV of Service Payment

NPV Analysis	£'000
Total NPV of Unitary Charges	[redacted]
Represented by:	
Capital & development costs	[redacted]
Net interest paid / (received) during construction	
Fees	[redacted]
Lifecycle expenditure	[redacted]
Operation & maintenance costs (including SPC costs)	
Total underlying costs	[redacted]
Equity & Subordinated Debt financing	[redacted]
Senior Debt financing	
Total financing costs	
Corporation Tax	[redacted]
Working capital, cash, interest on cash balances, reserves & other movements	[redacted]
Total NPV at 1 April 2006 (real)	[redacted]

11.5. Taxation

11.5.1 Taxation

- Robertson Healthcare has adopted Composite Trader tax structure in addition to Finance Debtor accounting. Both of these policies result in a significant reduction in tax payable. The tax and accounting treatments assumed by the Bidder remain Robertson's risk.

- The Service Payment is stated exclusive of VAT. VAT at the standard rate of 17.5% will be added to the Service Payment when invoiced. The VAT added to the Service Payment is anticipated to be recoverable by the Board under Contracted Out Services (COS) VAT regulations and therefore the addition of VAT has no net impact on the Board.

11.6. Approach to Financing and Funders

11.6.1 For a PFI project with a funding requirement in the order of £[redacted]m such as this one, commercial bank funding is, in practical terms, the natural choice for senior debt funding requirements. Bond funding is only really considered for projects with a significantly larger funding requirement in excess of at least £[redacted]m and the European Investment

Bank generally invests its funds in larger projects. During the ITN stage, Robertson Healthcare considered both qualitative and quantitative factors in confirming that they would utilise commercial bank funding for the project. They considered several commercial banks and selected the Cooperative bank as their preferred funding partner.

11.6.2 Given the increased competitiveness in the PFI bank debt market funding, Robertson Healthcare has approached the Cooperative Bank and asked them to refresh their terms, which have remained the same since the ITN stage. This negotiation is ongoing currently and could only lead to a reduction in service payment depending on its outcome. The bank terms agreed during the ITN stage and the resulting impact on the Service Payment is discussed throughout the remainder of this chapter.

11.7. Method and Sources of Funding

11.7.1 The total funding as at the end of construction required in the financial model is £[redacted]million. The funding is made up of a combination of senior debt, subordinated debt and ordinary share capital. This funding structure is summarised in Table C11/4 below.

Table C11/4: Proposed Financing Structure

Source	**£000**	**%**
Ordinary Share Capital	[redacted]	[redacted]
Subordinated Debt	[redacted]	[redacted]
Commercial Bank Loan	[redacted]	[redacted]
Total	[redacted]	**100**
Debt /Equity Ratio	**-**	**91.2: 8.8**

11.7.2 The finance plan is typical for a Public Private Partnership (PPP) transaction of this nature, being 91.2:8.8 debt to equity. The terms that have been offered are competitive when compared with the current market. Table C11/5 provides the corresponding names of the providers of each type of finance.

Table C11/5: Finance Providers

Instrument	**Provider**
Ordinary Share Capital	Robertson Capital Projects
Subordinated Debt	Robertson Capital Projects
Fixed Rate Bank Loan	The Cooperative Bank

11.8. Shareholder Funding

11.8.1 The project sponsor, Robertson Capital Projects is providing 100% ordinary share capital and subordinated debt of £[redacted] and £[redacted] respectively. This represents 8.8% of the total funding requirement and therefore complies with the bank's terms and conditions of funding.

11.8.2 The legal entity that will enter into the contract with the Board is a Special Purpose Company ("SPC") which is 100% owned by Robertson Capital Projects, part of the Robertson Group. The subordinated debt subscription [redacted] In addition, the consortium has confirmed that [redacted]

11.8.3 The ordinary share capital will be injected at Financial Close. The subordinated debt is drawn down when the senior debt and facilities have been fully utilised. All terms and conditions are standard for the ordinary share capital and subordinated debt. The coupon on the subordinated debt of [redacted]% over the London Inter-Bank Offer Rate ("LIBOR") is [redacted].

11.9. Senior Debt Funding

11.9.1 Robertson Healthcare has utilised commercial fixed rate bank debt as the principal funding instrument, with the funds coming from the Cooperative Bank.

11.9.2 The Cooperative Bank Fixed Rate Debt Facility

- The Cooperative Bank has provided a [redacted] facility, with a maximum underwritten commitment of £[redacted] million, drawn down [redacted]. The facility will be repaid on [redacted]. A tenor of [redacted] years on a [redacted] years concession is very much in line with current market trends.

- The interest margin over LIBOR is [redacted]% and [redacted]% during the construction and operating periods' respectively.

11.9.3 The funding terms provided by the Cooperative Bank [redacted]. The terms are, [redacted], broadly comparable with the terms offered in the market during the ITN period. As noted in the Value for Money letter, [redacted].

11.10. Reserve Account Requirements

11.10.1 Robertson Healthcare is required by its funders' to set up a Debt Service Reserve Facility to maintain a cash reserve of the following [redacted] months interest and principal due on the senior debt facilities. There is a requirement [redacted].

11.10.2 Robertson Healthcare [redacted].

[redacted].

11.10.3 Robertson Healthcare is also required to establish a Maintenance Reserve Account ("MRA") to ensure that sufficient cash is available for the projected peaks and troughs in lifecycle replacement. The account is to be fully funded by construction completion, on a look forward basis, to ensure a balance in any period equal to:

- [redacted]% of maintenance costs occurring in the following [redacted] months;
- [redacted]% of maintenance costs occurring in months [redacted]; and
- [redacted]% of maintenance costs occurring in months [redacted].

11.11. Interest Rate Risk, Inflation Risk and Hedging Strategy

11.11.1 The cost or benefit of any interest rate changes prior to Financial Close lies with the Board, with the final Service Payment determined at Financial Close being based upon the rates actually achieved that day. Interest rate risks will lie with Robertson Healthcare post-Financial Close until repayment of the senior debt.

11.11.2 The key rate for the Cooperative Bank facility is the underlying LIBOR rate. The Service Payment figures will be based upon the interest rate obtained in the open market at Financial Close together with the funding terms provided by the Cooperative Bank. On the day of Financial Close Robertson's will enter into an interest rate swap with the Cooperative bank which will fix the interest rate for the remainder of the senior debt term. It is the pricing obtained in the market for this "interest rate swap" financial instrument that will determine the Service charge payable. In order to validate the rates secured at Financial Close, the Board's financial advisers will perform a full and transparent benchmarking process for the selection of the LIBOR rate. It should therefore be noted that the Service Payment payable by the Board will not be finally fixed until the day of Financial Close.

11.11.3 Post Financial Close inflation rate risk will also lie with Robertson Healthcare. It is common in PFI projects which are funded by fixed interest rate funding solutions to purchase separate hedging instruments for inflation risk during the operational phase of the project. This requires a proportion of the Service Payment to be swapped to address the risk of the Service Payment from the Board increasing by RPI, whilst the debt repayment element of their costs remained fixed.

11.11.4 Robertson Healthcare [redacted].

11.12. Interest Rate Buffer

11.12.1 Interest rates may move up or down between the date of this FBC and Financial Close. It is important that the financial case for both value for money and affordability made in this document is robust against these potential changes. It is therefore standard practice, and required by Scottish Executive Guidance, to include a "buffer" above current interest rates in the financial model provided by Robertson Healthcare which generates the Service Payment used to assess value for money and affordability throughout this document.

11.12.2 The buffer included at this stage allows for a 25 basis point (0.25%) increase in long term interest rate swap pricing from those available on 19th January 2007 ([redacted]%). Interest rates will be regularly monitored by the Project Team and Financial Advisors in the period up to Financial Close.

11.13. Internal Rate of Return and Cover Ratios

11.13.1 The inherent strength and stability of Robertson Healthcare is evidenced by the rate of return generated on the equity funds and the cash cover ratios in respect of the debt facilities. The blended real equity post tax Internal Rate of Return ("IRR") calculation for Robertson's of [redacted]% is within current market parameters for a project of this nature and as such represents an acceptable return on investor funds.

11.13.2 The cover ratio calculations indicate a minimum/average debt service cover ratio of [redacted] and a minimum/average loan life cover ratio of [redacted] respectively, which are the levels required to meet the requirements of the senior bank funders'. Further details of investor returns are provided in the table below.

Table C11/6: Investor Returns

Investor Returns	**Nominal**	**Real**
Pre-tax Project IRR	[redacted]%	[redacted]%
Blended Equity IRR	[redacted]%	[redacted]%

11.13.3 PwC have expressed their opinion that the funding solution described in this chapter is value for money. A copy of this opinion is annexed at Appendix 3.

11.14. Conclusions

11.14.1 The senior fixed rate bank debt funding solution selected by Robertson Healthcare is a well known structure used within the PFI market.

11.14.2 The terms offered by the senior debt funder are broadly in line with market norms.

11.14.3 It has been demonstrated through comparison of the senior bank funding terms of other health PFI's that the bank funding solution selected is within market norms.

11.14.4 [redacted].

12. RISK ANALYSIS AND RISK MANAGEMENT STRATEGY

12.1. Introduction

12.1.1 The objective of performing risk analysis is to:

- allow the Board to understand the project risks and put in place mitigation measures to manage those risks;
- assess the likely total outturn cost to the public sector of the PFI investment option under consideration;
- ensure that the allocation of risks between the Board and the private sector is clearly established and demonstrated within the contractual structure; and
- demonstrate value for money.

12.1.2 A risk is defined as an event which affects the cost, quality or completion time of the project that may or may not occur. There are a number of such events that could arise during the design, construction, commissioning and operation of the new facilities.

12.1.3 Risks are assessed and valued to ensure that the Conventional Procurement Assessment Model (CPAM) can be compared with the Private Finance Initiative (PFI) option on a "like for like" basis, ensuring that the value of risk retained by the Board under both options is quantified and understood.

12.1.4 Whether under a traditional design, build and operate format (the CPAM) or under a PFI contract, the Board is exposed to risk in project delivery and maintenance.

12.1.5 Under the CPAM, publicly funded option, virtually all risks remain with the Board. Therefore the Board is exposed to a greater degree of risk in terms of price variations, poor performance, late delivery etc. The PFI scheme enables a large proportion of these risks to be transferred to the private sector where they are best able to manage them; with the Board remaining responsible only for those risks it is best able to manage.

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

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

12.1.7 These principles have been incorporated into the methodology underpinning the risk analysis for the project.

12.1.8 A full risk analysis was undertaken, as part of the OBC in order to identify and assess the impact of risks to the scheme during all stages of the project and after it has been completed. This comprised a series of workshops involving Board staff and advisers as well as representatives from Clackmannanshire Council and the local health community.

12.2. Project Risks

12.2.1 Since OBC stage the risk register has been further developed to identify and record the project risks taking into account the specifics of the project. This has been informed by the NHS standard risk matrix and the risk matrix identified at OBC stage. This has developed the risks into more specific and manageable risks for practical management.

12.2.2 The project risks identified used the following risk classifications.

- Planning;
- Design;
- Construction and Development;
- Performance;
- Operating;
- Revenue variability;
- Project Management;
- Market & Commercial;
- Financial; and
- Other.

12.3. Approach to Risk Analysis

12.3.1 The Board has undertaken a robust process in identifying, quantifying and allocating risk in its evaluation process. This has been carried out in order to:

- identify specific risks relating to the project;
- create a risk management process that can be used as a management tool when actually undertaking the project; and
- assist in demonstrating value for money comparing the CPAM and PFI options.

12.3.2 Risk workshops have been carried out frequently throughout the project. These risk workshops have had widespread attendance from the Project Team and Advisors.

12.3.3 The approach adopted by the Board has followed a recognised and proven method of risk evaluation. For each risk identified in the risk register an impact and likelihood (both before and after mitigation) has been agreed to allow a risk contingency to be derived.

12.3.4 Each of these risks are classified as either public (retained by the public sector) or private (transferred to the PFI partner) or shared (shared between the parties).

12.3.5 The output of the quantitative risk evaluation is a percentage risk adjustment that should be applied to the PFI unitary charge to give a best estimate of the likely outturn cost to the Board.

12.4. Optimism Bias

12.4.1 Since completion of the OBC for this project, HM Treasury has introduced a revised methodology for quantifying cost estimating uncertainty to be used in assessing the value for money of PFI projects relative to CPAM comparators[1]. This methodology seeks to quantify an "optimism bias" that has been historically demonstrated in cost estimating for various types of project. The approach of adjusting estimates for "optimism bias" rather than using detailed quantified risk adjustments has been endorsed in the Scottish Executive's Value for Money Practical Application Note.

12.4.2 Optimism Bias has been evaluated for this project using a health sector specific methodology developed by the Department of Health in England. This approach seeks to use high level indicators in the structure of the project to quantify an upper bound for the optimism bias, and then look at project specific factors that have led to mitigation of that bias.

12.4.3 The Project Team has compared the outputs form the optimism bias calculation to the detailed risk quantification undertaken and found them to be similar. This has acted as a cross-check to the project specific applicability of the generic Department of Health optimism bias calculation methodology. Having undertaken this comparison, the quantitative results from the optimism bias approach have been used in the value for money assessment discussed in more detail in Chapter13.

12.4.4 The percentage adjustments applied are shown in table C12/1 below.

Table C12/1: Service Payment Summary

CPAM Cost element	**Optimism Bias percentage**
Capital Costs - optimism bias upper bound - mitigation factor - Optimism Bias	[redacted]
Lifecycle Costs	[redacted]
Operating costs - optimism bias upper bound - mitigation factor - Optimism Bias	[redacted]

12.4.5 The risk adjustment applied to the PFI Service Payment has been assessed to be zero as all quantifiable risks have been passed to the private sector provider. The only risk retained by the Board is the risk of movements in interest rates up to financial close

[1] The Green Book – Appraisal & Evaluation in Central Government, HM Treasury; Supplementary Green Book Guidance – Optimism Bias, HM Treasury; Value Form Money Assessment Guidance, HM Treasury, August 2004.

which is allowed for through the inclusion of the interest rate buffer discussed in Chapter 11. no further adjustment for this risk is therefore required.

12.4.6 Under the PFI procurement model, the Board is undertaking elements of enabling works for grouting and ground stabilisation as capital works prior to the commencement of the PFI contract. This work has been assessed as being analogous in structure and risk allocation to the CPAM, and therefore the CPAM Capital works optimism bias uplift of [redacted]% has been added to this element of the works in the VFM comparator.

12.4.7 The expected value of all risks and the classification between the public, private and shared is a key component in assessing the value for money of the PFI option, as detailed in Chapter 13.

12.5. Risk Management Strategy

12.5.1 The Board will retain or share responsibility for certain risks as set out in the risk register and these risks need to be actively managed by the Board. These risks will be monitored through the Project Team with regular reports to the Project Board to ensure that appropriate and timely action is taken to minimise them through the implementation of appropriate mitigation measures.

12.5.2 The principles supporting the development of the project risk strategy are to:

- identify all retained risks and apply a suitable allocation of risk during the planning phase in accordance with the standard form of contract;
- allocate responsibility to a lead person, identified on the risk register, within the Board who is the designated "risk owner"; and
- ensure that the risk owner identifies and implements the proposed mitigation measures.

12.5.3 Development of the risk management plan is an iterative process and changes as the project develops, and involves constant monitoring and updating as risk exposures change and risk events occur.

12.5.4 Risks that have transferred to Robertson Healthcare are not included within the risk register as the Board is not responsible for their management.

12.5.5 There are a number of risks, such as changes in working practice, which are not specific to this project. These are being managed through other processes within the Board and are not therefore included in this strategy.

13. ECONOMIC APPRAISAL

13.1. Introduction

13.1.1 This chapter covers the economic appraisal of the value for money (VfM) implications of the NHS Forth Valley Clackmannanshire Community Health Services Project. VfM has been appraised with reference to the relevant HM Treasury Guidance and the Scottish Executive PFU Practical Application Note (September 2005) on implementing the Treasury guidance. This involves comparing the bespoke Conventional Procurement Assessment Model (CPAM) against Robertsons Healthcare's model entitled 'Robertsons Healthcare FBC Model', to enable an assessment of whether it remains best value to procure services through the PFI mechanism. This has been achieved by inserting the outputs of each of these models, including risk adjustments applied to Robertsons Healthcare FBC Model into the English Department of Health's Generic Economic Model (GEM), as permitted by the Scottish Executive Guidance.

13.1.2 This chapter will examine the:

- key assumptions of the quantitative analysis;
- quantitative results of the VfM assessment;
- sensitivity analysis which has been undertaken on the quantitative analysis to demonstrate its robustness; and
- qualitative assessment of the project, covering the non-financial benefits of the project.

13.2. Net Present Value Analysis

13.2.1 The guidance referred to above requires that value for money is assessed both quantitatively and qualitatively. It further requires that quantitative assessment of value for money is made using "Net Present Value (NPV)" analysis. The NPV of an option looks at the total life cycle cost of that option over a defined period, recognising the time value of money. The recognition of the time value of money is achieved by using a "discount rate" so that all costs and revenues in the future are discounted by a set percentage to recognise that they are not as valuable to the Board as costs or revenues incurred or received today. The discount factor applied to future costs and revenues is defined centrally by HM Treasury. The effect of inflation is also not included in the analysis as all figures are quoted "Real" – i.e. at a common cost base, in this case 1 April 2006, rather than "nominal" – i.e. inflated to their actual likely cash value at a future pint in time.

13.2.2 The guidance does not allow for VFM analysis to consider any differential in availability of capital or revenue funding to the procuring body, or any annual affordability constraints. It is intended to be a clear "economic" assessment of value. The appraisal therefore also does not include assessment of non-cash elements such as "cost of capital" or "depreciation" which may be different between the procurement routes being compared. For example, the cost of capital that would be incurred by the Board in pursuing a CPAM capital funding procurement route leading to an "on balance sheet" assessment is not included in the analysis.

13.3. Key Assumptions of the Quantitative Assessment

13.3.1 The purpose of the economic appraisal is to compare the relative costs of the project procurement options by ranking them in terms of their net present value (NPV), appropriately adjusted for the risks inherent to each option. The two options considered by the Board are as follows:

- Traditional procurement by the Board itself, which is referred to as the CPAM; or
- Procuring the required services as a Public Private Partnership (PPP), combined with the In House Team delivery of Soft FM services which is referred to as Robertsons Healthcare FBC Model.

13.3.2 Both options are described in Chapters 4 and 5 respectively.

13.3.3 The economic cost of each procurement option comprises the following:

- The NPV of the projected real costs associated with each option over the operating period; and
- The NPV of the risk adjustments applied to each option (see Chapter 12 for details of the approach taken to risk assessment).

13.3.4 The CPAM has been regularly reviewed and updated by the Board and its advisors to ensure a fair comparison between the CPAM and Robertsons Healthcare FBC Model is being undertaken.

13.3.5 Discounting Assumptions

- In accordance with the Capital Investment Manual and PFI Guidance, a discount rate of 3.5% is applied to all cashflows, for both procurement options, for the first 30 years of operations and 3% thereafter. The construction costs for the CPAM have been provided by the Boards technical advisors in nominal terms (inclusive of inflation), therefore a 2.5% deflator is applied to adjust them to reflect the real cashflows (April 2006 prices).

13.3.6 Differential Inflation

- Although all figures in the NPV assessment are Real, it is likely to be the case that some cost elements will not follow standard inflation uplifts – Eg. staff wages have historically run at above RPI inflation reflecting an increase in general standards of living.
- Differential inflation of 1.50% has been applied to reflect the additional wage cost inflation, above a base inflation of 2.5% that will be incurred. This manifests itself as a differential inflation of 1.25% in operating costs as these are a blend of (majority) wage costs assumed to inflate at 1.5% above RPI and non-wage costs assumed to inflate at RPI.

- Differential inflation of 1.5% has been added to life cycle costs as these re principally "construction" related, and building cost inflation continues to run at over RPI. Currently construction inflation (BCIS all-in index) is running at over 6% per annum, so a differential of 1.5% over RPI is a conservative assumption.

13.3.7 PSC Cost Assumptions

- Total base costs for the CPAM have come from the Board's Technical Advisor's spreadsheet entitled 'Clacks v14 cost Plan for FBC' dated 19 January 2007. These are based on a building area of 8,955m^2, with a cost base of 1 April 2006 for life cycle and operating costs, and a nominal cost based on a start on site in June 2007 for the capital costs.
- As insurance costs are not known for the CPAM, the Board's insurance advisors provided benchmark insurance costs recognising that under the CPAM route the NHS effectively self insures for the majority of risks.

- A management overhead assessed by the Board as one full time equivalent post has been added to the CPAM base costs

A breakdown of the cost assumptions is given below:

Table C13/1: Total base costs for the CPAM

	CPAM £'000 Real at April 06	**Source / Assumption**
Construction	[redacted]	[redacted]
Lifecycle	[redacted]	Annual cost of £[redacted]m^2
Operating	[redacted]	Annual cost of £[redacted]m$^{2(1)}$
Insurance Proxy	[redacted]	Annual cost of £[redacted]k advised by Insurance Advisors derived from bid cost
Management Proxy	[redacted]	Annual cost of £[redacted]k advised by Board
Total cost	[redacted]	

(1) – Includes: Domestics, linen, pest control, security, energy, water, telephone, rates, Estates maintenance, FM management, helpdesk

- All the above costs are included within the unitary charge of Robertsons Healthcare FBC Model combined with the soft FM costs of the In House Team.

13.3.8 PFI Cost Assumptions

- The base cost for the PFI is the Service Payment form the Robertsons Healthcare FBC Model.
- The base costs for the In house team soft FM service delivery were taken from the In House Team ITN bid and include start-up capital costs, start-up revenue costs, ongoing operating costs and ongoing life cycle replacement costs.
- A capital cost has been included in the PFI costs for grouting works which are to be undertaken as enabling works outside the PFI contract. Note that a similar cost has not been added to the CPAM as this is felt to be within the range of items covered by the CPAM optimism bias.
- A breakdown of the cost assumptions is given below:

Table C13/2: Total base costs for the PFI

	CPAM £'000 Real at April 06	**Source / Assumption**
PFI Service Payment	[redacted]	Robertsons Financial Model – annual payment of £[redacted] (inc buffer)
Soft FM capital set-up	[redacted]	From In House Team bid
Soft FM operating set-up	[redacted]	From In House Team bid
Soft FM operations	[redacted]	From In House Team bid
Soft FM Lifecycle	[redacted]	From In House Team bid
Grouting Works (capital)	[redacted]	From Robertsons Construction
Total cost	[redacted]	

13.3.9 The following costs have been excluded from the VFM comparison as they are identical between the CPAM and PFI options:

- Off site works for planning conditions;
- Moveable equipment;
- Clinical costs; and
- Catering costs (provided from acute sector).

13.3.10 Risk Adjustments

- Chapter 12 deals with the analysis which has been undertaken to identify and quantify the risks inherent in this project. This work has been undertaken to ensure the economic impact of these risks to the Board under each procurement option is appropriately reflected when comparing the CPAM and Robertsons Healthcare FBC Model for VfM purposes. Percentage risk adjustments made to the CPAM costs are tabulated in Chapter 12.

- A risk adjustment was made to the costs of the In House Team to reflect risks retained by the Board associated with this service delivery model. This resulted in a £[redacted]k NPV risk adjustment.

13.3.11 Taxation Adjustments

- The guidance referred to at the start of this chapter requires VFM to be assessed on the basis of value to the public purse as a whole, and not just to the Board. In making such an assessment, differential tax receipts to HM Treasury under the two different procurement options need to be considered. The guidance includes a flowchart for assessing the level of taxation adjustment to be made to account for lower tax receipts to Treasury under the CPAM route compared to the PFI route. For this project this results in an overall [redacted] adjustment to the CPAM.

13.4. Results of the Quantitative Assessment

13.4.1 The Value for Money comparison has been made by NHS Forth Valley using the GEM and a summary model prepared by the Board's financial advisors. These compare the NPV of the CPAM against Robertsons Healthcare FBC Model (inclusive of risk adjustments) over a 30 year and 60 year period. The reason for this is twofold:

- A contract term of 30 years between the Board and Robertsons Healthcare covers both the construction and operation period; and

- An analysis over a 60 year period considers the typical 55-60 year operational period over which public sector investments, according to Treasury guidance, are based. This period, plus the 1.3 year construction period assists in demonstrating VfM. In this instance the GEM model is populated with Robertsons Healthcare FBC Model inputs for the first 30 years and the CPAM model inputs thereafter to represent the fact that it would be the Board that would take over operations after the contract term expired.

13.4.2 The 60 year appraisal shows no difference in value for money between the options from the 30 year appraisal as both options assume ongoing public sector operation of the facilities from year 30 to 60. For simplicity, only the 30-year assessment has been presented in this FBC.

13.4.3 The result of the VfM assessment using the GEM model is shown in the table below.

Table C13/3: Results of VfM Assessment using the GEM

	£'000
NPV of risk adjusted CPAM	[redacted]
NPV of risk adjusted Robertsons Healthcare FBC Model	[redacted]
Total VFM	[redacted]
Total VFM (%)	[redacted]
Total cost	

13.4.4 The table above shows that Robertson's FBC Model provides better value for money than the CPAM, and is therefore the preferred option based on quantitative VFM assessment.

13.5. VFM Sensitivity Analysis

13.5.1 A sensitivity analysis has been undertaken to demonstrate the percentage movement in key assumptions used in calculating the VfM of the project (based on a comparison between the CPAM and Robertsons Healthcare FBC Model using the GEM model as set out in Section 13.2.1 above) which results in a VfM neutral position. This analysis is intended to test the sensitivity of the VFM outcome to changes in key variables. If a very small change in a certain variable would lead to the VFM between the two options being neutral (i.e. identical NPV) then this variable would need to be investigated further to ensure its accuracy, or range of uncertainty and hence the robustness of the VFM outcome.

13.5.2 The key sensitivities tested are as follows:

- A reduction in CPAM capital costs;
- A reduction in CPAM life cycle costs;
- An reduction in CPAM capital costs and life cycle costs together;
- A reduction in CPAM FM costs;
- An increases in Robertsons Healthcare FBC Model Unitary Payment;
- An increase in the interest rate above the interest rate buffer (calculated outside the model based on data provided by Robertsons)
- An increase in In-House Team operating costs.

13.5.3 The table below summarises the impact of these sensitivities on the NPV's in the above table.

Table C13/4: Economic Appraisal Sensitivity

Scenario	Sensitivity Tested	Change in variable
Base Case	**Not Applicable**	**X% Value for money**
1	A reduction in CPAM capital costs	11% reduction
2	A reduction in CPAM life cycle costs	49% reduction
3	An reduction in CPAM capital costs and life cycle costs together	11% reduction
4	A reduction in CPAM FM costs	12% reduction
5	An increases in Robertsons Healthcare FBC Model Unitary Payment	6% increase
6	An increase in the interest rate above the interest rate buffer	84 basis point interest rate increase
7	An increase in In House Team operating costs	33% increase

13.5.4 The sensitivity analysis confirms that the economic case for the PFI option is robust. A significant change in key variables is required to cause VFM to reduce to zero.

13.6. Qualitative Results

13.6.1 In addition, there are a number of benefits in respect of Robertsons Healthcare FBC Model option, over the CPAM that have not been reflected within the economic appraisal. These are list in Chapter 6 "The Preferred PFI Solution, Section 6.3.

13.6.2 Scottish VFM guidance requires the Project Team to continually update a qualitative assessment of the "viability", "desirability" and "achievability" of undertaking the procurement as a PFI project. This assessment has been made for Key Stage Reviews throughout the procurement process and there have been no changes to the positive assessment of viability, desirability and achievability made at the pre-preferred bidder Key Stage review.

13.7. Summary

13.7.1 The economic appraisal undertaken using the GEM demonstrates that Robertsons Healthcare FBC Model provides [redacted]% better VfM than the CPAM, with NPV's of £[redacted] and £[redacted] respectively.

13.7.2 The sensitivity analysis confirms that the economic case for Robertsons Healthcare FBC Model option is robust.

13.7.3 The Project Team has followed detailed guidance from both HM treasury and the Scottish Executive in its assessment of value for money. A checklist included in the Scottish Executive VFM Practical Application Note is included as Appendix 7 in order to demonstrate adherence to this guidance.

14. FINANCIAL APPRAISAL

14.1. Introduction

14.1.1 The Board throughout the procurement have continually assessed the affordability position of the project, and reported the position at key milestones. Assessments are focussed on the price base at 1st April 2006. The main components of the affordability assessment are detailed below

14.2. Costs

14.2.1 The Service costs include the new clinical model of care, together with those non clinical services to be retained by NHS Forth Valley. The Unitary Charge is based on the annual charge from Robertson Healthcare together with the annual cost from the In-House Team for the provision of soft facilities management services.

14.3. Funding

14.3.1 Funding includes budget available in the Board's baseline, together with additional funding approved by the Board, and included in the financial plan. The facility will be occupied by the Social Work Department of Clackmannanshire Council, together with a Community Pharmacy, estimated levels of income from these partners have been calculated. Capital funding has been identified to fund the residual value of the asset on an annual basis to build up to the expected residual asset value.

14.4. Affordability Position

14.4.1 The revised affordability position is summarised in the table below.

Table C14/1: Affordability Position

	£m	**£m**
Service Cost	[redacted]	
Unitary Charge	[redacted]	
Total Cost		[redacted]
Existing Service Funding	[redacted]	
Council/Pharmacy income	[redacted]	
Financial Plan	[redacted]	
Capital Plan (Residual Interest)	[redacted]	
Total Funding		[redacted]
Surplus/(Deficit)		[redacted]

14.5. Summary

14.5.1 The above table details an affordable project. Throughout the procurement process, from the inception of the OBC to the FBC, the affordability position of the project has been closely monitored. The Board has allocated sufficient resources to fund the clinical model of care and the Unitary Charge. Moving forward, costs will increase by inflation, the Board has assumed that the annual uplift from the SEHD will ensure that the affordability is maintained.

15. CONTRACT FRAMEWORK AND PAYMENT MECHANISM

15.1. Introduction

15.1.1 This Chapter describes the basis of the legal or contractual framework, which will underpin the Project.

15.1.2 It sets out a summary of the key contractual relationships, which will be put in place between the Board, Robertson Healthcare (Project Co), Project Co's sub-contractors and the funders of the scheme.

15.1.3 This Chapter will examine:

- the general provisions of the contract structure;
- the way in which payment will be made to Project Co based on the payment regime agreed;
- details of the payment mechanism which has been agreed to incentivise Project Co to provide the level and quality of service required by the Board;
- how prices will be adjusted during the concession period to ensure continuing value for money for the public; and
- a discussion of other issues, which will relate to termination, direct agreements with the funders etc.

15.2. Contract Framework

15.2.1 The Project is based on a typical PFI structure, with the Board contracting with a Special Purpose Company (a company specially incorporated for the purpose of the project referred to as Project Co in this Chapter), which then subcontracts all its construction and operational obligations, and raising funding [redacted] from a commercial bank.

15.2.2 The Board will be contracting directly with Project Co, a company established by Robertson Capital Projects Limited for the provision of all services related to the PFI Project.

- The total concession will run for 30 years from Financial Close. The construction phase is expected to last 16 months with an operating period of 28.7 years.

15.2.3 The Project Agreement will run for a period of 30 years, including the construction phase. The period will run from the date of the Project Agreement, and is subject to rights of early determination, including in the event of there being poor performance by Project Co of the services.

15.2.4 The Project Agreement is in the standard form for NHS Project Agreements as issued by the Scottish Executive Health Department. The version that has been used for this Project is the version that was issued in September 2003 – Standard Form 3 (SF3) together with

subsequent changes to SF3 recently issued in draft form. Proposed derogations from Standard Form are set out in Appendix 8 of this FBC.

15.3. Land Interests

15.3.1 Project Co will not have a land interest in the hospital, subject to various exceptions that are set out below. Project Co will be given an exclusive licence to carry out the construction works (the Works) in those areas where the construction works will take place.

15.3.2 The Board (acting on the authority of the Scottish Ministers) will also grant to Project Co a non-exclusive licence to perform and manage the FM services in respect of those areas where the services are to be provided. The FM services are to be provided, in part, in advance of the completion of the construction of the new buildings for an interim period and the non-exclusive licence will operate for the relevant areas at the commencement of the provision of the FM services.

15.4. Sub-Contracts

15.4.1 Project Co will sub-contract its obligations to design and construct the Works to Robertson Central Construction Limited and its responsibilities for the provision of FM services to the whole of the site to Robertson Facilities Management Limited.

15.4.2 Robertson Facilities Management Limited intends to provide most services itself but it will be entitled to further sub-contract services to specialist sub-contractors. The facilities management services that are to be provided across the hospital site exclude Soft facilities management, which is retained by the Board, but include:

- Estates services;
- Grounds and gardens;
- Helpdesk;
- Pest control; and
- Utilities.

15.4.3 The provision of these services will be supported by detailed Service Specific Specifications drawn up by the Board and agreed to by Project Co. These Service Specific Specifications are included in Part 14 of the Schedule to the Project Agreement.

15.4.4 Robertson Group Limited, the parent company of both the building sub-contractor and the FM Services sub-contractor will be providing performance guarantees to Project Co (but not the Board).

15.5. Direct Agreement

15.5.1 The Board will enter into a Funder Direct Agreement with Project Co and its funders, the principal purpose of which is to give the funders step-in rights prior to a proposed termination of the Project Agreement by the Board. The draft follows the form set out in Part 6 of the Schedule to the SEHD standard form Project Agreement, and any proposed derogations from that form will be reported in an update prior to financial close.

15.6. Funding Agreements

15.6.1 Co-operative Bank Limited is providing senior [redacted]. Robertson capital Projects Limited is providing a mix of equity, documented in a subscription agreement, and subordinated debt, documented in a loan note instrument.

15.6.2 The Board has not reviewed drafts of these agreements at the date of this report.

15.7. Performance of Services

15.7.1 Project Co will have the primary responsibility for monitoring the performance of the services. The Board will have an ability to monitor performance of services and if the service deteriorates the Board will be entitled to increase its monitoring. Continued poor performance will allow the Board to step into a specific service and ultimately to require Project Co to replace a particular service provider. In the case of extreme poor performance it would be possible for the Board to terminate the Project Agreement entirely, although not individual services.

15.8. Project Specific Issues in respect of the Project Agreement

15.8.1 The following project specific issues are reflected in the Project Agreement.

15.8.2 Although it was known that there were old mine workings on the site, ground investigations after selection of the preferred bidder revealed that the extent of grouting works required to stabilise the site are greater than originally anticipated. The investigation revealed that it is not possible to assess the volume of grout required, and it is therefore not possible to price this risk (None of the bidders provided a fixed price for this risk).

15.8.3 The Board has decided therefore to remove the grouting works from the Project Agreement and enter into a separate contract [redacted].

15.8.4 The Project Agreement will provide that Project Co accepts [redacted]

15.8.5 The grouting works contract will be entered into between the Board and Robertson Central Construction Limited. It will be based on the ICE standard form conditions of

contract on a design and build basis, with re-measurement. The Board accepts the risk of how much grouting is required and how long it will take, and therefore how much it will cost. It is not possible therefore to state a cap to the Board's liability under this contract. The Board will appoint an engineer to monitor the performance of the grouting works to protect its interests, particularly the quantity of grouting required.

15.8.6 Other than the grouting works, the works will be completed in a single phase and payments will commence only upon the commencement of all services.

15.9. Transitional arrangements

15.9.1 There is no requirement for transitional arrangements on the project. Patients are decanted in alternative facilities for the duration of the works.

15.10. Equipment

15.10.1 A list of equipment to be included in the project is being compiled and agreed at the date of this report as part of the review of the 1:50 drawings. Project Co will be responsible for the supply, installation, maintenance and renewal of such equipment throughout the project.

15.10.2 The Board will be responsible for all equipment at the facilities which is not included in the equipment list. This will include IT equipment, certain medical equipment, and also equipment required for providing the soft facilities management services.

15.10.3 Project Co is responsible for the state of equipment included in the project, and when it is handed back at the end of the Project it is to be in a Handback Condition (defined as being of sufficient continuing utility to continue to be used for the purposes of the Board).

15.11. Third Party income generation

15.11.1 No third party income generation is anticipated in the project.

15.12. Other Key Features of the Project Agreement

15.12.1 All key features of the Project Agreement are set out in this Chapter.

15.13. Payment Mechanism

15.13.1 The payment mechanism follows the standard form for PFI Projects issued in consultative form in England. Certain amendments to this document have been agreed.

15.13.2 Negotiations with the preferred bidder on the payment mechanism have not been completed at the date of this report, only project specific items are outstanding and a revised position will be reported in the FBC addendum following financial Close.[1]

[1] This is anticipated shortly, as most principles are agreed.

15.14. Payment Arrangements

15.14.1 Payment of the Service Payment will commence as and when Facilities are fully commissioned in accordance with the Standard Form Contract, i.e. construction/final site works have been completed, equipment installed, facilities provided by Project Co are available and fully operational.

15.14.2 The Board will pay Project Co for services rendered to it on a monthly basis. Charges levied by Project Co will be calculated in accordance with the payment mechanism included within the Project Agreement. There will be a single Service Payment. All payments will be indexed annually in line with annual movements in the retail prices (all items) index.

15.14.3 If services are not provided to an acceptable standard or the service specific specifications are not met in any other way, appropriate deductions will be made from the Service Payment in accordance with formulae set out in the payment mechanism relating to Performance Failures and Unavailability Events. Performance Failures and Unavailability Events also attract a number of Service Failure Points. The level of deductions from the Service Payment and the number of Service Failure Points are dependent on the seriousness of the default and the importance to the Board of the area of the hospital that is affected by poor performance.

15.14.4 As soft services are not included in Project Co's responsibilities, there are no benchmarking and market testing provisions.

15.15. Volume Adjustments

15.15.1 The payment mechanism contains an element of volume adjustment, which is calculated for a contract month and added to the Service Payment for that month. Volume adjustments will apply to Non-Clinical Waste.

15.15.2 Project Co will be responsible for the delivery of energy efficient facilities over the term of the project. The facilities have been designed and will be constructed in order that they meet an agreed maximum limit, which will be based upon a 20-year degree-day average for all space heating loads. This will be subject to independent review on commissioning and throughout the Project Term for the purposes of determining appropriate volume limits. The variations in volumes, which are linked to the deterioration in the energy efficiency of building, will be the responsibility of Project Co. The risk in relation to changes to utility tariffs throughout the concession period will be borne by the Board.

15.15.3 Energy consumption is a shared risk which is subject to a gain share/pain share adjustment with thresholds set at [redacted] which allows the Board to initiate a technical review by an expert to assess where fault lies.

15.15.4 The Board will pay Project Co for the electricity, gas and water consumed at the facilities each month, through the Service Payment, subject to agreed volume limits in any 12 month rolling period.

16. ACCOUNTING TREATMENT

16.1. Introduction

16.1.1 PricewaterhouseCoopers (PwC) are acting as financial advisors to the Project. In particular they are advising on the likely balance sheet treatment of the scheme, i.e. whether the assets delivered through the PFI contract will be "on balance sheet" or "off balance sheet" for the Board. In undertaking this assessment, they have considered the scheme on the basis of Application Note F to FRS 5 – 'Reporting the Substance of Transactions: Private Finance Initiative and Similar Contracts' as interpreted by the Treasury Technical Note 1 (revised) – 'How to Account for PFI Transactions'.

16.1.2 The balance sheet treatment can only be absolutely finalised after the contract has been signed. However, at this stage PwC offer a provisional judgment on their opinion of the likely treatment. This is then considered by the Boards external auditors (Scott Moncreiff), on whose opinion the Board relies.

16.2. Accounting for Land and Buildings

16.2.1 The accounting treatment assumed within the financial and economic analyses for the land and buildings follows the guidance in Land and Buildings in PFI Deals (Version 2) issued in January 2003 and updated June 2003.

16.2.2 The land on which the hospital is built will remain on the balance sheet of the public sector. Its ownership does not pass to Robertson Healthcare (Project Co) who receives a licence to occupy the site for the purposes of the PFI contract.

16.2.3 This Business Case only considers the accounting treatment of the buildings constructed as part of the PFI contract. The accounting treatment of other NHS owned buildings, including buildings to be vacated and or demolished as the PFI project comes into operation are considered separately by the Board.

16.3. Equipment

16.3.1 The PFI scheme excludes medical equipment and other items of equipment as detailed in Chapter 9, not fixed to the building. For this equipment the Board intends to equip the buildings through traditional procurement routes. Board procured equipment will remain on the Board's balance sheet and does not form a part of this accounting treatment analysis.

16.4. Other Accounting Matters – Residual Interests

16.4.1 At the end of the concession period all buildings included within the PPP scheme will pass to the Board for nil consideration (£0). These buildings will have a remaining useful economic life. This residual useful economic life constitutes an asset, which the Board has paid for during the concession period. In accordance with the guidance set out in Land and Buildings in PFI Deals (Version 2) and Treasury Technical Note 1 the residual value (RV) is built up over the concession period on an annuity basis in order to ensure a proper allocation of payments made between the costs of services under the contract. The projected RV at the end of the concession period is necessarily an assumption at this stage, and the Board will continue to monitor the likely value of the buildings through the concession period to ensure that a realistic RV is accounted for. The Board has used a standard spreadsheet methodology developed by HM Treasury to evaluate the split of unitary charge between capital (to build up RV) and revenue funding in its budget projections.

16.5. Accounting Treatment

16.5.1 The following reports are included as appendices to this FBC:

- Appendix 5: Provisional Judgement letter from PwC dated 25th January 2007
- Appendix 6: Quantitative indicator report from PwC dated 25th January 2007

16.5.2 After due consideration of the advice from PwC in these reports, the Director of Finance has concluded that the hospital does not constitute a capital asset during the concession period. The majority of the risks and rewards of property ownership, including lifecycle responsibilities have been transferred to Project Co meaning that the buildings can be treated as "off balance sheet".

16.5.3 The Board's external auditors have considered the opinion of the Director of Finance and they concur with the proposed treatment.

16.5.4 A letters from Scott Moncreiff to this effect is included at Appendix 4.

17. PROJECT MANAGEMENT ARRANGEMENTS

17.1. Introduction

17.1.1 As is demonstrated by this Full Business Case the project up to financial close has been managed effectively and in a timely way.

17.1.2 The Board intends to maintain this level of performance and commitment to delivering the project throughout the next key stage of the process.

17.1.3 This Chapter will set out how the Board intends to manage the project through implementation to successful opening and post-project evaluation.

17.1.4 This Chapter will examine:

- Project implementation structure, including membership and terms of reference of all implementation groups;
- How the interface with Robertson Healthcare will be managed throughout this period;
- Liaison with external stakeholders; and
- How good practice from elsewhere has been included in the Board's thinking.

17.2. Roles and Responsibilities

17.2.1 The following key project roles will be maintained throughout the construction and commissioning phases of the project:

17.2.2 The NHS Board will maintain the overview of the project, receiving regular reports on progress and retaining accountability for the delivery of all aspects of the project.

17.2.3 The Chief Executive, as Accountable Officer and Project Owner, will retain personal accountability for project delivery. The Project Owner receives, and will continue to receive, update reports from the Project Director on key issues and progress.

17.2.4 The Project Director is the key point within the Board for providing 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 all other NHS Board Directors, clinical & non-clinical service managers to deliver and realise the project benefits;
- providing a focal point for external interest in the project;
- managing the relationship between the Board, Robertson Healthcare and its consortium partners;

- managing and control change within the project;
- directing the work of the implementation teams.

17.3. Project Implementation Structure

17.3.1 The key roles described above will be supported by an appropriate project organisation structure.

17.3.2 The Project Director will be supported by an internal organisation to deliver the key outputs of the project in a timely way. The precise structure is still to be finalised, however some of the roles and responsibilities will be as set out below.

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

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

- Commission and equipping group; and
- Benefits Realisation & Evaluation Group.

17.3.5 It is important that the project continues to harness the experience gained throughout the procurement process.

17.3.6 The period post FBC also provides an opportunity to develop individual skills and corporate learning.

17.4. Project Team

17.4.1 It is recommended that the core project team continues. The anticipated roles and responsibilities of the Project Manager are set out below. Membership of the Project Team will also include:

- Clinical service planning group leads;
- Finance and commercial lead;
- Facilities management lead; and
- Commissioning and equipment lead

17.5. Project Manager

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

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

- 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 sub groups to ensure that their work plans are continually congruent with the overall project plan;
- Liaise with Robertson Healthcare to ensure that 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 agreed budgetary limits.

17.6. External Advisers

17.6.1 A team of external advisers, as set out below, will support the Project Team.

Table C17/1: External Advisers to the Project

Role	**Company**
Financial Adviser	PricewaterhouseCoopers LLP
Legal Adviser	Brodies
Lead Technical Advisers	Mott MacDonald
Facilities Management Services Adviser	Mott MacDonald
Architectural Design Adviser (for the CPM)	Mott MacDonald
Quantity Surveyor	Mott MacDonald
Equipment Adviser	Scottish Healthcare Supplies
Healthcare Planning Adviser	Mott MacDonald /Tribal
Insurance Adviser	Willis

17.7. Interface with PFI Consortium

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

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

17.7.3 The key interface will be via the Project Board and through the day to day contact between the respective Project Directors, Project Manager and the wider Project Team.

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

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

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

17.8. Implementation Structures

17.8.1 Although this Full Business Case relates primarily to Board action necessary to deliver the benefits of implementation of this project. Robertson Healthcare plays a critical part in delivering, through partnership, these benefits to the public sector.

17.8.2 The role of the Project Team will be to disseminate progress on the project and any key issues arising, which would benefit from discussion in a more strategic forum. It would also provide the opportunity to review any lessons learnt from elsewhere which might have a bearing on the project.

17.9. Change Management

17.9.1 Management of change during the project is an important aspect of project delivery. The Project Agreement, which is entirely compliant with the NHS Standard Form of Contract, sets out an upper limit for variations, which arise during implementation. In the case of this project, the Project Board shall have the ability to make variations within the affordability limit set by the NHS Board.

17.9.2 The Project Director will ensure that a running total of variations is kept up to date at all times and this will be monitored through the normal performance review mechanisms with the NHS Forth Valley.

17.10. Publication of FBC Post-Financial Close

17.10.1 The Board is aware of its responsibilities under the Scottish Executive's Code of Openness for PFI schemes. Within one month of financial close the Board will ensure that copies of all relevant project documents including the FBC are made publicly available as follows:

- In an accessible place for members of the public at Board Offices at Carseview, Stirling;
- With the local Partnership Forums;

- In the local libraries. This, plus the copy in the NHS Board HQ, will be notified to the public by advertisements in local newspapers;
- Copies will also be sent to the Scottish Executive; and
- On the NHS Forth Valley Board's website.

17.10.2 The documents will be as complete as possible and only areas of genuine commercial sensitivity will be omitted following discussion with Robertson Healthcare.

17.10.3 Foreign language text and the accessibility text can be found on the back page of this FBC.

17.11. Learning from other Projects

17.11.1 Throughout the development of the project, the Project Team has sought to learn lessons from elsewhere and to adopt good practice. During implementation, the team has undertaken visits to other PFI hospital projects which are in, or are close to service commencement, to ensure that lessons are learnt and the potential to avoid any pitfalls is maximised.

17.11.2 The Project Team has also taken the opportunity to review the available good practice and will continue to apply the principles therein to the development of the project.

17.12. Project Timetable

17.12.1 The proposed timetable for completion of the development is set out in table C17/1 below.

Table C17/2: Project Timetable

Detailed Planning Consent	December 2006
Approval of Full Business Case (FBC)	January 2007
Scottish Executive Health Department approval of FBC	March 2007
Commencement of Enabling Works	March 2007
Financial Close	June 2007
Practical Completion	September 2008
Service Commencement	October 2008

18. BENEFITS REALISATION PLAN AND POST PROJECT EVALUATION PLAN

18.1. Benefits Realisation Plan

18.1.1 The objectives and benefits of the project are set out in Chapter 3, the Outline Business Case. A benefits realisation plan was developed for the OBC and has been reviewed and updated to reflect changes in scheme requirements.

18.1.2 The plan when fully developed will identify 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.

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

18.1.4 Where relevant, the performance measures identified within the benefits realisation plan will be reviewed as part of the post project evaluation plan.

18.2. Post Project Evaluation Plan

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

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

18.2.3 In accordance with current guidance and good practice the project will be evaluated in stages. The key stages of the evaluation are described below.

18.2.4 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.

18.2.5 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.

18.2.6 Stage 3 – Initial post Project Evaluation of the Service Outcomes

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

18.2.7 Stage 4 – Follow Up Post Project Evaluation

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

18.2.8 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 happened.

- How plans for the next phase of the project should be adjusted, if appropriate.

19. CONCLUSION

19.1. Summary

19.1.1 This FBC presents a strong and coherent rationale for the development of a modern NHS community hospital and health centre for the resident population of Clackmannanshire.

19.1.2 This new facility will replace unsuitable clinical accommodation and re-provide facilities currently located in Alloa Health Centre, Clackmannan County Hospital and Sauchie Hospital.

19.1.3 Robertson Healthcare will be responsible for the financing, design, build and maintenance of the new facilities over a 30 year period (including construction phase). The contract arrangements will be as set out in the Standard Form of Contract for PFI schemes, adjusted to reflect agreement reached on project specific issues. Derogations from Standard Form have been agreed by SEHD.

19.1.4 The scheme has been demonstrated to be affordable, within the affordability framework agreed by Forth Valley Health Board.

19.1.5 The scheme continues to provide robust value for money.

19.1.6 Significant risk will transfer from the Board to Robertson Healthcare and the asset will not be accounted for on the Board's balance sheet.

19.2. Project Management Arrangements

19.2.1 The Board has in place strong project management arrangements to ensure the project is delivered successfully, in partnership with Robertson Healthcare, through to Service Commencement in October 2008.

19.3. Next Steps

19.3.1 The table below summarises the timetable from approval of the FBC to completion of the construction period and the commencement of clinical services. The dates will only be confirmed when financial close is reached.

Table C19/1: Project Timetable

Detailed Planning Consent	December 2006
Approval of Full Business Case (FBC)	January 2007
Scottish Executive Health Department approval of FBC	March 2007
Commencement of Enabling Works	March 2007
Financial Close	June 2007
Practical Completion	September 2008
Service Commencement	October 2008

Annex C

FINANCIAL PLAN 2006/07 - 2010/11

1.1 This paper outlines the Financial Plan 2006/07 - 2010/11 for consideration and approval.

It covers:-

- funding assumptions
- existing baseline spending
- best value, value for money and savings
- pay, prices and prescribing
- national priorities including Primary Medical Services
- regional planning
- healthcare strategy
- local pressures

A comprehensive risk assessment is also included for consideration.

2.1 Each NHS Board is required to manage within the Resource Limit provided by the Scottish Executive Health Department annually.

Services must be matched to resources available.

2.2 This year, each NHS Board has had to prepare a Local Delivery Plan covering achievement of key targets over a 3-year period. Whilst financial balance is one of the targets, it is essential to ensure that target delivery is achievable and sustainable financially.

2.3 NHS Forth Valley has chosen to continue to prepare and agree a Local Health Plan. This also must be achievable and sustainable financially.

2.4 There has been considerable media interest in the collective and individual financial status of NHS organisations. It is acknowledged that Health and Community Care Services have received unprecedented additional resources over recent years. However, this has been matched by wholesale pay modernisation, increasingly challenging targets to deliver, legislative change such as the Mental Health Act and locally significant service changes as we implement the Healthcare Strategy.

2.5 NHS Systems must demonstrate not only financial balance each year but also that 'recurrent balance' has been achieved. This means that financial balance can be achieved without supplement from 'one-off' funding. For NHS Forth Valley this is essential to ensure implementation of the Healthcare Strategy.

The Financial Plan 2006/06 identified a recurrent gap of £3.889m with plans to achieve recurrent balance by 2008/09 at the latest. This Plan improves the recurrent gap to £2.600m in 2006/07 with achievement of recurrent balance in 2007/08.

2.6 Funding to NHS Boards is calculated using the Arbuthnott formula. NHS Forth Valley is an 'Arbuthnott gainer' meaning that we receive an uplift in excess of the national average. When approving the Healthcare Strategy, the Board agreed that this 'Arbuthnott gain' should be ring-fenced on a 'recurrent' basis for strategy implementation. With the approval of this Plan, £8.223m is 'protected' on this basis.

2.7 The following section will outline the funding NHS Forth Valley expects to receive in 2006/07 onwards and the baseline spending.

3.1 The Scottish Executive Health Department issued the initial Revenue Resource Limit for 2006/07 on 20th February 2006. This confirmed the following:-

	£'m	
Recurring Baseline	**314.943**	
Superannuation transfers to NES/NSD	(0.594)	
Transfers to National Services	(0.495)	
Existing Change & Innovation Fund	0.848	*
Adjusted Recurring Baseline	**314.702**	
Standard 6.75% increase	21.242	
Arbuthnott Parity Adjustment	2.675	
Total 2006/07 Initial Allocation	**338.619**	
Overall % increase	7.60%	

(* The Change & Innovation Fund should be £1.397m, £0.549m will be added to a future letter - - this funding was committed in previous years.)

3.2 Additional points to note are as follows:-

- Any overspend will be carried forward into the subsequent financial year
- Allocation is expected to meet
  - pay pressures including the implementation of Agenda for Change
  - price increases
  - drug bill cost increases
  - health improvement

- Letter indicates that 10% was used as an indicative drugs increase for 2006/07. The actual increase is estimated to be 3-4%, indicating freeing up of approximately 1% of the uplift. This does not necessarily take account of projected spending on New Drugs nor where historically drug increases exceeded estimated increases.

- Deductions still to be made for
  - costs of new national services (£6.8m)
  - support provision of PET (Positron Emission Topography) (£1.0m)
  - national cost of roll-out of colorectal screening programme (£3m)
  - re-distribution of funds for local Ambulance Service developments (£4.8m)
  - pump-priming costs of efficiency projects still to be considered (£16m)

- Funds for CHD/Stroke (£13.5m) and Audiology Services Modernisation (£6m) are still to be distributed - these are already in spending plans and ringfencing will remain in place for a further 2 years.

- Continued delivery of efficiency targets arising from the Efficient Government Initiative. This required 3% cash savings from local schemes to have been achieved by end of 2007/08 by each Board. In addition, further savings are required from national initiatives such as prescribing and procurement.

3.3 Future year increases are based on indications from the Spending Review which ends in 2007/08.

The five year plan assumes the following:-
- 2007/08 increase of 6% (as per allocation letter)
- 2008/09 onwards increase of 4.5% (estimate : no national indication available)

3.4 The majority of NHS resources are already committed before the start of the year for staff, supplies including drugs and buildings. A summary is as follows:-

Funding Available	£'m
Notified General Allocation 2006/07	338.619
Anticipated baseline allocations	5.682
Income from NES	0.595
Total Allocation	**344.896**

Spending	£'m
Acute (Annex 1)	153.666
Primary Care and Community (Annex 1)	146.136
Previous Headquarter Budgets	3.427
Previously approved commitments	16.091
Uplift received	23.917
Prior Years Arbuthnott	5.548
Recurrent deficit	(3.889)
Total Spending	**344.896**

Previously approved commitments include Agenda for Change; Waiting Times: assumed Delayed Discharge Funding and New Drugs.

3.5 With the move to single system and the introduction of Community Health Partnerships the following actions are in progress/completed.

- Single income management
- Split of Primary Care funding between Community Health Partnerships
- Creation of are-wide budgets for Corporate functions.

3.6 The next section outlines the approach to Value for Money and Savings.

4.1 The monthly financial report for 2005/06 has included an assessment of the achievement of savings. This has resulted in £0.720m requiring to be carried forward into 2006/07. This is partially offset by the full year effect of management savings exceeding target by £0.205m.

4.2 NHS Forth Valley must deliver its share of national initiative savings which are as follows:-

	2006/07 £'m	2007/08 £'m
Procurement	0.350	0.500
Prescribing	0.250	0.500
Total	0.600	1.000

These are not allowed to be included in the local savings total of 1% per annum.

4.3 The Allocation letter last year indicated that each Board must deliver 1% cash releasing savings for 3 years i.e. 3% by end of 2007/08.

As part of this target, further savings associated with Transitional Arrangements are required. Savings totalling £3.900m over three years were agreed as part of the agreed Business Case: this target remains in place over 3 years albeit the phasing has been updated annually.

These savings were accounted for on a recurrent basis last financial year with bridging finance provided to phase delivery over three years. For 2006/07 these total £1.380m (£3.900m less £1.110m delivered last year less Bridging Finance of £1.410m).

Further savings of £0.684m are targeted at the reduction in mental health beds by 15. These savings are being reinvested in the implementation of the Intensive Home Treatment Service.

4.4 To complete the delivery of the 3% target, the remaining savings total £1.400m. Detailed plans are currently at very early stages with suggested areas including -

- Document Management / Imaging
- Agency /Bank Staffing Costs
- Cross Boundary Flow
- Telecommunications
- Transport
- Energy
- Clinical Waste

Confirmation of the breakdown of this target will be reported to the next Board meeting.

4.5 The next section covers pay, prices and prescribing.

5.1 The Pay Review Body agreements have yet to be confirmed. An estimate of 2.5% per annum has been used for planning purposes. Initial indications from the Budget on 22nd March 2006 indicate 2.25% but no details are as yet available.

5.2 Further increases in funding are included for both the Consultants Contract and Agenda for Change.

5.3 The Plan also includes an estimate of increased funding required for 'other' doctor grades with a basic uplift of 10% and further increases estimated for on call and backfill for C.P.D. (Continuing Professional Development).

5.4 Price increases have been included at 2.0% with the exception of Resource Transfer (2.68%) and Energy which totals £1.252m.

5.5 Prescribing increases have been reduced reflecting trends in the last year. The overall prescribing uplift for 2006/07 has been calculated from reviewing a range of information with the total including cost and volume changes, new drugs, chemotherapy increases, the impact of the new Pharmacy Contract and the impact of the national Smoking Ban on the requirement for Nicotine Replacement Therapy.

Future years prescribing increases are estimated at 4% per annum plus an additional estimate for new drugs - this will be updated on consideration of updated Horizon Scanning information from the Scottish Medicines Consortium.

5.6 The next section covers the Healthcare Strategy; Primary Medical Services/Out of Hours; Waiting Times; Modernising Medical Careers; Mental Health Act.

6. Significant Initiatives and National Priorities

6.1 The Primary Medical Services allocation was received on 22nd March 2006 and it has not been possible to complete the assessment of its impact for inclusion in this Plan. NHS Forth Valley has already included recurrent funding associated with Superannuation requirements. In respect of Out of Hours further additional resources of £0.596m are planned (including £0.061m from Agenda for Change Funds). However, the Allocation letter indicates that Out of Hours expenditure must be met entirely through the general allocation - this appears to be a change in policy and could have an impact of up to £1.100m for NHS Forth Valley. This has been included on 2006/07 risk schedule at present. If this very initial assessment proves to be correct then further plans will require to be submitted to the Board to address this gap.

6.2 Whilst the Healthcare Strategy implementation does not start in 2006/07, it clearly falls within the five year period. Funding has been provided to cover the following areas:-

Clackmannanshire Healthcare facility.
New Acute Hospital.
Significant Transitional costs associated with these changes.
Updated savings for strategy as per Outline Business Case (to ensure there is no double counting with current savings plans).

6.3 Waiting Times bring one of the most significant cost pressures each year. Significant local and national funding has already been provided but further pressure of approximately £3m has been included in 2006/07. This spend area needs further review to ensure value for money is being achieved.

6.4 The impact of Modernising Medical Careers has been included and totals approximately £3m over 5 years - this is a net estimate as funding is also expected to be transferred from NES (National Education Scotland). This area also requires further assessment.

6.5 The implications of the Mental Health Act are also reflected in the Plan. Funding of over £1.2m is included for the next two years to cover the implementation of the Intensive Home Treatment Service and additional Consultant posts.

6.6 The next section covers specific regional and local pressures.

7.1 The West of Scotland Regional Planning Group has completed a prioritisation exercise with the conclusions to be considered at its meeting on 24th March 2006. The estimated implications for NHS Forth Valley are included in this Plan and cover:-

- Westmarc satellite clinic and wheelchair service
- Electrophysiology

- Haemophilia service
- Open Chest RFA

7.2 Provision has been included for complex care (£0.5m) and for high cost/low volume cross boundary flow (£1.5m). The latter covers increased costs experienced in last couple of years for areas such as bone marrow transplants, drug eluting stents and implantable defibrillators.

7.3 The overall five year financial plan is included at Annex 2.

8.1 The Plan includes a section on Property Related Transactions. This covers:-

- an assessment of the impact of the sale of the Bellsdyke Hospital site
- an assessment of impairment/property sales impact for 2006/07
- accelerated depreciation for Stirling and Falkirk sites
- implications of cessation of capital to revenue funding

9.1 An overarching Risk Assessment is included at Annex 3. This will be updated monthly to reflect known changes.

9.2 This Risk Assessment includes -

- Funding Assumptions
- Healthcare Strategy
- Pay Modernisation
- Savings
- Prescribing
- Modernising Medical Careers

10. Recommendations

The NHS Board is asked to: -

- **Approve the five year financial plan 2006/07 - 2010/11**
- **Note that further information will be provided on local savings targets at a future meeting**
- **Note the significant risks identified at Annex 3**
- **Note the assessment of the impact of the Primary Medical Services Allocation requires to be completed.**

F. Ramsay
Director of Finance
22nd March 2006

Annex 1

Acute Spending : Initial Baseline 2006/07

	£'m
Forth Valley Acute	128.584
Glasgow and Clyde	13.133
Lothian	6.928
Tayside	0.658
Other Scottish Boards	0.491
Cardiac Consortium	1.778
High Cost / Low Volume / Cost per Case	2.094
Total Acute	153.666

Primary Care and Community

			£'m
Forth Valley Primary Care			126.317
Resource Transfer	-	Falkirk	8.667
	-	Stirling	4.203
	-	Clackmannanshire	2.505
	-	Other	0.023
Strathcarron Hospice / Rachel House			1.087
Glasgow and Clyde			0.191
Lothian			0.652
Appliance Centres			1.148
Other including High Cost			0.511
Other Community			0.832
Total Primary Care and Community			146.136

Appendix 1: NHS Forth Valley 2010/110 Financial Plan

FVNHS FINANCIAL PLAN - 2006/07 - 2011/2012
FINAL DRAFT : 21st March 2006

Annex 2

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurren Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurren Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurren Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Scottish Executive Uplift	21242		21242	18882		18882	14161		14161	14161		14161	14161		14161
Arbuthnott		5548	5548	1487	4061	5548		4061	4061	4061		4061	0		0
Updated Arbuthnott		2675	2675		5628	5628	2336	5862	8198	6579	1853	8432	4423		4423
Ring-Fenced Funding	1093	2700	3793	526	2212	2738		1542	1542		1542	1542		1542	1542
Projected Underspend carried forward		400	400		0	0		0	0		0	0		0	0
Waiting Times Funding / CCI funding	3192	1186	4378		139	139									
Anticipated Funding	247	16125	16372	180	12460	12640	157	11837	11994	114	661	775	102	116	218
Existing Funding	1715		1715												
In-Year Slippage to be achieved		2954	2954												
Total Funding Available	**27489**	**31588**	**59077**	**21075**	**24500**	**45574**	**16654**	**23302**	**39956**	**24915**	**4056**	**28972**	**18686**	**1658**	**20344**

Recurrent Deficits (carried forward)

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurren Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurren Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurren Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Recurrent deficit carried forward / Surplus carried forward	-3889		-3889	-2600		-2600	1085		1085	885		885	407		407
Savings Unachieved in previous year	-720		-720												
	-4609	**0**	**-4609**	**-2600**	**0**	**-2600**	**1085**	**0**	**1085**	**885**	**0**	**885**	**407**	**0**	**407**

Savings proposals

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurren Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurren Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurren Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
National Savings - procurement and prescribing	600		600	1000		1000									
Local Savings															
- Management Costs (Full Year Effect of 2005/06)	205		205												
- Mental Health	684		684												
- General Target (see narrative for proposed areas)	1400		1400	604		604					1374	1374	783	717	1500
Healthcare Strategy : PTB/Ancillary/Administrative and Clerical										925		925			
Healthcare Strategy :Womens and Childrens (already achieved)										579		579			
Healthcare Strategy : Bed adjustment										583		583			
Total Savings Required	**2889**	**0**	**2889**	**2004**	**0**	**2004**	**0**	**0**	**0**	**2087**	**1374**	**3461**	**783**	**717**	**1500**
Balance Remaining	**25769**	**31588**	**57357**	**20479**	**24500**	**44978**	**17739**	**23302**	**41041**	**27887**	**5430**	**33318**	**19876**	**2375**	**22251**

FVNHS FINANCIAL PLAN - 2005/06 - 2010/11
FINAL DRAFT : 21st March 2006

Annex 2

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurrent Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurrent Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurrent Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
Pay and Prices	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay Awards (assumes 2.5%)	5589		5589	5589		5589	5589		5589	5589		5589	7146		7146
Capital Charges (indexation)	635		635	600		600	600		600	600		600	700		700
Capital Charges - acute lifecycle costs inflation				100		100	100		100	120		120			
Capital Charges on residual interest : Clackmannanshire				9		9	18		18	27		27	36		36
Capital Charges on residual Interest : Acute										162		162	325		325
Prices (based on 2% uplift)	707		707	707		707	707		707	707		707	707		707
Energy Price Increases	1252		1252												
Total : Pay and Prices	**8183**		**8183**	**7005**		**7005**	**7014**		**7014**	**7206**		**7206**	**8914**		**8914**

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurrent Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurrent Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurrent Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
Pay Modernisation	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Consultants Contract															
Forth Valley Acute Hospitals	371		371												
Forth Valley Primary Care	39		39												
Forth Valley NHS Board	13		13	13		13									
External Trusts and reserves	74		74												
SAS Grade Doctors															
Direct Pay Uplift (10%)	380		380												
On Call / availability (5%)	190		190												
Backfill Costs for CPD	384		384												
Junior Doctors - national appeal		1126	1126		901	901		676	676						
Agenda for Change															
Pays	1001		1001	745		745	489		489	233		233	233		233
Unsocial Hours	187		187												
Pay Modernisation costs - Agenda for Change Team		400	400												
Total	**2639**	**1526**	**4165**	**758**	**901**	**1659**	**489**	**676**	**1165**	**233**	**0**	**233**	**233**	**0**	**233**
Balance Remaining	**14946**	**30062**	**45008**	**12715**	**23599**	**36314**	**10236**	**22626**	**32862**	**20449**	**5430**	**25879**	**10730**	**2375**	**13104**

FVNHS FINANCIAL PLAN - 2005/06 - 2010/11
FINAL DRAFT : 21st March 2006

Annex 2

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurrent Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurrent Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurrent Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
Development Plans - from ring-fenced funding	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Delayed Discharges		1537	1537		1537	1537		1537	1537		1537	1537		1537	1537
New Opportunity Fund Projects - Cancer		17	17												
New Opportunity Fund Projects - Stroke / CHD		106	106	77		77									
New Opportunity Fund Projects - Palliative Care		47	47												
CHD Strategy	309		309												
Stroke Strategy	398		398												
Alcohol Strategy		70	70		70	70									
Tobacco Control Action Plan	106		106	106		106									
Oral Health / dental health	280	34	314	420	34	454									
Sexual Health Strategy		237	237		237	237									
National Drugs Strategy		358	358		40	40									
HAI : Infection Control Manager		40	40		40	40									
Nurse Bank Arrangements		26	26		26	26									
Nursing CPD		78	78		39	39									
Stoma Care (HDL (2006)15)		39	39		39	39	39		39						
Clinical Governance Training		5	5		5	5		5	5		5	5		5	5
Total	**1093**	**2594**	**3687**	**603**	**2067**	**2670**	**39**	**1542**	**1581**	**0**	**1542**	**1542**	**0**	**1542**	**1542**
Balance Remaining	**13853**	**27468**	**41321**	**12112**	**21532**	**33644**	**10197**	**21084.2**	**31281**	**20449**	**3888**	**24337**	**10730**	**832.851**	**11562**

Specific Issues

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurrent Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurrent Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurrent Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Property Related															
RSNH Bridging Finance Phase II		873	873		873	873	185		185						
Implications of no indexation for SRI/FDRI															
Transfer remaining Bellsdyke to non-recurrent plus option	-823	970	147		940	940		902	902		833	833		662	662
Accommodation Review	237		237												
Impairments		795	795												
Profit / Loss on sales		1638	1638												
Implications of cessation of Capital to Revenue Funding	500		500	317	1500	1817	500	1763	2263						
Clackmannanshire Lifecycle costs				183		183									
Acute Lifecycle Costs										510		510			
Total	**-86**	**4276**	**4190**	**500**	**3313**	**3813**	**685**	**2665**	**3350**	**510**	**833**	**1343**	**0**	**662**	**662**
Balance Remaining	**13939**	**23192**	**37131**	**11612**	**18219**	**29831**	**9512**	**18419**	**27931**	**19939**	**3055**	**22994**	**10730**	**171**	**10900**

FVNHS FINANCIAL PLAN - 2005/06 - 2010/11
FINAL DRAFT : 21st March 2006
Commitments

Annex 2

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurrent Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurrent Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurrent Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Acute & Related Services : Balance Acute/Stirling Community										1185		1185	0		0
Clackmannanshire Project (Affordability Paper February'06)				1487		1487									
Acute Hospital															
Buildings Element of Acute Hospital (affordability paper April'05)										6288		6288			
Inflation - 2005/06										440		440			
Inflation - 2006/07										454		454			
Ambulance Services										571		571			
Critical Care										685		685			
Satellite Pharmacy / PITU etc										1028		1028			
Nursing : medical unit										457		457			
Stirling Community Hospital													3541		3541
Acute & Related Services - project support		545	545		545	545		545	545		545	545			
Fees		2000	2000		1000	1000		500	500						
Primary & Community Services-project support		224	224		116	116		116	116		116	116		116	116
Project Support - in-house bid team		124	124												
Prescribing	499		499	2869		2869	2869		2869	2854		2854	2854		2854
New Pharmacy Contract : TBRP and eMAS	2063		2063												
New Drugs	250		250	500		500	500		500	500		500	500		500
Herceptin	600		600												
Nicotine Replacement Therapy	139	100	239												
Tertiary Chemotherapy	708		708												
Tertiary Non Cancer Drugs	347		347												
Introduction of extended Childhood Immunisation programme	100		100												
Pneumococcal Vaccine	18		18												
Service Pressures															
FVAH - Interim Options		-507	-507		-567	-567		-567	-567						
West Lothian-Obstetrics	99		99	60		60									
Lothian Tertiary Services Project	280		280												
Interpreting Service	65		65												
Joint Loan Equipment Service	165		165												
Spiritual Care	60		60	60		60									
Service pressures - future increases				1500	1886	3386	2000	1885	3885	2750	-1000	1750	2000	-1000	1000
Renal	125		125	125		125	125		125	125		125	125		125
Child Health															
Additional Support for Learning		158	158												
Neonatal Transport	8		8												
Sexual Health	46		46	54		54									
Palliative Care															
Hospice - move to 50/50 funding	100		100												
Extended Day Care	7		7												
Rural Home Based Care	17		17												
Robin House				14		14									
Liverpool Care Pathway		4	4												
Cancer															
FV share of new Beatson	595		595	88	112	200									
Potential 4 - 6 local beds as part of Beatson phase 11				250		250	500		500	250		250			
New Opportunity Funded Projects - Imaging services	6		6												
Introduction of Bowel Cancer Screening	159		159	350		350									
Appointment of Clinical Psychologist - Cancer Services	60		60												
Colorectal Cancer nurse specialist - Cancer Services	32		32												
Coronary Heart Disease															
Outreach Palliative Care Specialist Nurse		40	40		40	40		40	40						
Chronic Disease Management															
Pharmacy-led Micro Albuminuria Outpatient Clinic		20	20		20	20									
Immunisation															
Introduction of extended Childhood Immunisation programme	200		200												
	534		534	300		300	300		300	300		300	300		300
Sub-Total	**7282**	**2708**	**9990**	**7657**	**3152**	**10809**	**6294**	**2519**	**8813**	**17887**	**-339**	**17548**	**9320**	**-884**	**8436**

Appendix 1: NHS Forth Valley 2010/110 Financial Plan

FVNHS FINANCIAL PLAN - 2005/06 - 2010/11
FINAL DRAFT : 21st March 2006

Annex 2

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurrent Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurrent Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurrent Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
B/Fwd	**7282**	**2708**	**9990**	**7657**	**3152**	**10809**	**6294**	**2519**	**8813**	**17887.25**	**-339**	**17548.2**	**9320**	**-884**	**8436**
Healthcare Acquired Infection - Action Plan	105	40	145	38	40	78	40		40						
IM & T															
PIMs	93		93												
ECCI Project				93		93									
IM & T - funding sources				-50		-50									
National IT Contract - retendering costs		29	29												
Contingency Reserve	398		398	440		440	500		500	500		500	500		500
Total	**7878**	**2777**	**10655**	**8178**	**3192**	**11370**	**6834**	**2519**	**9353**	**18387**	**-339**	**18048**	**9820**	**-884**	**8936**
Balance Remaining	**6062**	**20415**	**26477**	**3434**	**15027**	**18461**	**2678**	**15900**	**18578**	**1552**	**3394**	**4946**	**909**	**1055**	**1964**

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurrent Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurrent Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurrent Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
National Committed															
Practice Education Facilitators				18		18									
BTS - Effective Use of Blood Project		48	48												
Regional Committed															
Coronary Heart Disease															
Electrophysiology (CRT)	98		98												
RFA (Atricure)	8		8												
Other															
West of Scotland Regional - Workforce Co-rdinator	14		14												
Forensic Learning Disability - Close Supervision Unit				176		176									
West of Scotland Adolescent Inpatient Service				17		17	34		34						
SEAT - Risk sharing agreement															
PET Scanning	200		200	70		70									
Transfer of Oral Maxillo Facial Complex services to Glasgow (estimate)				200		200									
Regional Planning	15		15												
Learning Disability MCN	11		11												
Wheelchair Service	34		34												
Haemophilia Service	8		8												
Total	**388**	**48**	**436**	**481**	**0**	**481**	**34**	**0**	**34**	**0**	**0**	**0**	**0**	**0**	**0**
Balance Remaining	**5674**	**20367**	**26041**	**2953**	**15027**	**17980**	**2644**	**15900**	**18544**	**1552**	**3394**	**4946**	**909**	**1055**	**1964**

FVNHS FINANCIAL PLAN - 2005/06 - 2010/11
FINAL DRAFT : 21st March 2006

Annex 2

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurren Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurren Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurren Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Primary Medical Services															
GMS Superannuation	445		445												
Out of Hours Shortfall	535		535												
GP Premises		-443	-443		-112	-112	293		293	388		388	580		580
Sub-Total including Primary Medical Services	**4694**	**20810**	**25504**	**2953**	**15139**	**18092**	**2351**	**15900**	**18251**	**1164**	**3394**	**4558**	**329**	**1055**	**1384**
Waiting Times															
- Acute submission	2320	4622	6942		2600	2600		1000	1000						
- Cancer Waiting Times Action Plan	600		600												
- Cardiac	36		36												
- Plastics	70		70												
- Cross Boundary Flow	204		204		200	200									
- MRI	200		200												
- Diagnostics	450	172	622												
- CCI Diagnostics and Eye Care					139	139									
- Sleeping Disorders	40		40												
- reduction (e mail 10.3.06)	-400	-150	-550	400		400									
Sub-Total including Waiting Times	**1174**	**16166**	**17340**	**2553**	**12200**	**14753**	**2351**	**14900**	**17251**	**1164**	**3394**	**4558**	**329**	**1055**	**1384**
Mental Health Act															
- IHTT Team and Consultant Appointments	993		993	250		250			0			0			0
Sub-Total including Mental Health Act	**181**	**16166**	**16347**	**2303**	**12200**	**14503**	**2351**	**14900**	**17251**	**1164**	**3394**	**4558**	**329**	**1055**	**1384**
Transitional Arrangements															
- Bridging Finance		1110	1110												
- Organisational Development / Transport in Divisional submission		1270	1270		1400	1400		1400	1400		1400	1400			
- A & E in Divisional submission															
- Additional Request		300	300												
Sub-Total including Transitional Arrangements	**181**	**13486**	**13667**	**2303**	**10800**	**13103**	**2351**	**13500**	**15851**	**1164**	**1994**	**3158**	**329**	**1055**	**1384**
Modernising Medical Careers															
Acute initial assessment (18.11.05 submission)	204		204	791		791	648		648	657		657	329		329
Primary Care - moved to broadly reflect phasing of acute				100		100	100		100	100	-100	0			
Sub-Total including Modernising Medical Careers	**-23**	**13486**	**13463**	**1412**	**10800**	**12212**	**1603**	**13500**	**15103**	**407**	**2094**	**2501**	**0**	**1055**	**1055**

FVNHS FINANCIAL PLAN - 2006/07 - 2011/2012
FINAL DRAFT : 21st March 2006

Annex 2

Narrative	Recurrent Funding 2006/07	Non-Rec Funding 2006/07	Total Funding 2006/07	Recurren Funding 2007/08	Non-Rec Funding 2007/08	Total Funding 2007/08	Recurrent Funding 2008/09	Non-Rec Funding 2008/09	Total Funding 2008/09	Recurren Funding 2009/10	Non-Rec Funding 2009/10	Total Funding 2009/10	Recurren Funding 2010/11	Non-Rec Funding 2010/11	Total Funding 2010/11
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Surplus / (deficit) carried forward	**-23**	**13486**	**13463**	**1412**	**10800**	**12212**	**1603**	**13500**	**15103**	**407**	**2094**	**2501**	**0**	**1055**	**1055**
Healthcare Strategy Implementation															
Transitional Funding (to be reviewed)					1000	1000		3500	3500		2500	2500		1055	1055
Capital Charge funding protected : see affordability paper April'05							688		688						
Timing and updated cost elements of Clacks project to be inserted															
Potential Impairment Cost of Falkirk and Stirling Royal		10636	10636		10636	10636		10636	10636						
Sub-Total including Healthcare Strategy Implementation	**-23**	**2850**	**2827**	**1412**	**-836**	**576**	**915**	**-636**	**279**	**407**	**-406**	**1**	**0**	**0**	**0**
Introduction of Community Health Partnerships	80		80												
Sub-Total including CHPs	**-103**	**2850**	**2747**	**1412**	**-836**	**576**	**915**	**-636**	**279**	**407**	**-406**	**1**	**0**	**0**	**0**
Glasgow Costing Exercise	348		348	308		308									
Sub-Total including Glasgow Costing Exercise	**-451**	**2850**	**2399**	**1104**	**-836**	**268**	**915**	**-636**	**279**	**407**	**-406**	**1**	**0**	**0**	**0**
National Initiatives															
Diabetic Retinopathy	75		75												
Universal Neonatal Hearing Screening	45		45												
Neonatal Transport	8		8												
Balance Remaining	**-579**	**2850**	**2271**	**1104**	**-836**	**268**	**915**	**-636**	**279**	**407**	**-406**	**1**	**0**	**0**	**0**
Acute Services															
Critical Care Development		250	250		250	250		250	250						
Complex Care	500		500												
Cross Boundary Flow	1500		1500												
Bariatric Surgery	20		20	20		20	30		30						
Total	**-2600**	**2600**	**0**	**1085**	**-1085**	**0**	**885**	**-885**	**0**	**407**	**-407**	**0**	**0**	**0**	**0**
Total Surplus/(Deficit)	**-2600**	**2600**	**0**	**1085**	**-1085**	**0**	**885**	**-885**	**0**	**407**	**-407**	**0**	**0**	**0**	**0**

EUROPEAN UNION
Publication of Supplement to the Official Journal of the European Communities
2, rue Mercier, L-2985 Luxembourg
Fax: (+352) 29 29 44 619, (+352) 29 29 44 623, (+352) 29 29 42 670
E-mail: mp-ojs@opoce.cec.eu.int On-line notification: http://simap.eu.int

CONTRACT NOTICE

Works

Supplies

Services **x**

Reserved for the Publication Office

Date of receipt of the notice _____

Identifier _____

Is this contract covered by the Government Procurement Agreement (GPA)? NO YES **x**

SECTION I: CONTRACTING AUTHORITY

I.1) OFFICIAL NAME AND ADDRESS OF THE CONTRACTING AUTHORITY

Organisation **Forth Valley Health Board (known as NHS Forth Valley) as lead contracting authority and Clackmannanshire Council**	For the attention of **Robert G Stewart, Director of Finance, Primary Care Operating Division, NHS Forth Valley**
Address **NHS Forth Valley** **Primary Care Operating Division Headquarters** **Old Denny Road** **(Clackmannanshire Council, Greenfield, Alloa, FK10 2AD)**	Postal code **FK5 4SD**
Town **Larbert**	Country **United Kingdom**
Telephone **01324 404 157**	Fax **01324 562 367**
Electronic mail (e-mail) **liz.hamilton@fvpc.scot.nhs.uk**	Internet address (URL) **www.show.scot.nhs.uk/nhsfv**

I.2) ADDRESS FROM WHICH FURTHER INFORMATION CAN BE OBTAINED

As in I.1 *If different, see Annex A*

I.3) ADDRESS FROM WHICH DOCUMENTATION MAY BE OBTAINED

As in I.1 *If different, see Annex A*

I.4) ADDRESS TO WHICH TENDERS/REQUESTS TO PARTICIPATE MUST BE SENT

As in I.1 **x** *If different, see Annex A*

I.5) TYPE OF CONTRACTING AUTHORITY*

Central level EU institution Other

Regional/local level Body governed by public law **x**

SECTION II: OBJECT OF THE CONTRACT

II.1) DESCRIPTION

II.1.1) Type of works contract *(in case of works contract)*

Execution | Design and execution | Execution, by whatever means of work, corresponding to the requirements specified by the contracting authority

II.1.2) Type of supplies contract *(in case of supplies contract)*

Purchase | Rent | Lease | Hirepurchase | A combination of these

II.1.3) Type of service contract *(in case of service contract)*

Service category 14

II.1.4) Is it a framework agreement? * NO **x** YES

II.1.5) Title attributed to the contract by the contracting authority *

Clackmannanshire Community Health Services PFI/PPP Project _____

II.1.6) Description/object of the contract *(use continuation sheet if necessary)*

The services relate to the design, build, finance and maintenance of a new community hospital facility with circa 45 beds and health centre in Alloa, Scotland, including accommodation for GP practices, AHP Services, acute out-patient services, community mental health services, a day hospital, social work assessment services and potentially pharmacy services. The contract will be awarded under the Government's PPP programme and may include elements of equipment, IM&T and communications provision and maintenance related to the facilities. The contract will also include the opportunity to bid for further support services, including elements of cleaning, domestic, portering and hotelling services.

More details are available in the Project Information Memorandum distributed at the Market Awareness Day held on 1 October 2004, and a copy of which is now available on request from NHS Forth Valley, to the address in Annex A.

II.1.7) Site or location of works, place of delivery or performance

_____

NUTS code * **UKA12** _____

II.1.8) Nomenclature

II.1.8.1) Common Procurement Vocabulary (CPV) *

	Main vocabulary	Supplementary vocabulary *(when applicable)*		
Main object	45.21.51.00-8	-	-	-
Additional objects	74.87.30.00-9	-	-	-
	50.70.00.00-2	-	-	-
	70.33.00.00-3	-	-	-
	74.20.00.00-1	-	-	-
	93.41.12.00-4			
	93.51.00.00-6			

II.1.8.2) Other relevant nomenclature (CPA/NACE/CPC) _____

II.1.9) Division into lots *(for details about lots use Annex B as many times as needed)*

NO **x** YES

Tenders may be submitted for: one lot several lots all lots

II.1.10) Will variants be accepted *(where applicable)*

NO YES **x**

II.2) QUANTITY OR SCOPE OF THE CONTRACT

II.2.1) Total quantity or scope *(including all lots and options, if applicable)*

The estimated capital value of the project, taken from the Outline Business Case, is circa £15m. ___

_____

II.2.2) Options *(if applicable)***. Description and time when they may be exercised** *(if possible)*

The Board reserves the right to award a contract for part only of the services required._____

_____

II.3) DURATION OF THE CONTRACT OR TIME LIMIT FOR COMPLETION

Either: Period in month/s 360 and/or days *(from the award of the contract)*

Or: Starting / / and/or ending / / *(dd/mm/yyyy)*

SECTION III: LEGAL, ECONOMIC, FINANCIAL AND TECHNICAL INFORMATION

III.1) CONDITIONS RELATING TO THE CONTRACT

III.1.1) Deposits and guarantees required *(if applicable)*

Parent company guarantees, warranties and/or deposits may be required – to be specified in tender.

III.1.2) Main terms of financing and payment and/or reference to the relevant provisions *(if applicable)*

To be specified in tender. _____

_____

III.1.3) Legal form to be taken by the grouping of suppliers, contractors or service providers to whom the contract is awarded *(if applicable)*

The Board expects to enter into a contract with a single legal entity, which may be a special purpose vehicle. _____

_____

III.2) CONDITIONS FOR PARTICIPATION

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

All details are contained in the pre-tender questionnaire which interested parties must complete and return to the Board. _____

_____

_____

III.2.1.1) Legal position – means of proof required

All details are contained in the pre-tender questionnaire which interested parties must complete and return to the Board. _____

_____

_____

_____

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

All details are contained in the pre-tender questionnaire which interested parties must complete and return to the Board. _____

_____

_____

III.2.1.3) Technical capacity – means of proof required

All details are contained in the pre-tender questionnaire which interested parties must complete and return to the Board. _____

_____

III.3) CONDITIONS SPECIFIC TO SERVICES CONTRACTS

III.3.1) Is provision of the service reserved to a specific profession?

NO **x** YES

If yes, reference of the relevant law, regulation or administrative provision

_____

_____

III.3.2) Will legal entities be required to state the names and professional qualifications of the personnel responsible for execution of the contract?

NO YES **x**

SECTION IV: PROCEDURE

IV.1) TYPE OF PROCEDURE

Open	Accelerated restricted
Restricted	Accelerated negotiated
Negotiated **x**	

IV.1.1) Have candidates already been selected? *(for negotiated procedure only and if applicable)*

NO **x** YES *If yes, provide details under Other information (section VI)*

IV.1.2) Justification for the choice of accelerated procedure *(if applicable)*

_____

_____

IV.1.3) Previous publication concerning the same contract *(if applicable)*

IV.1.3.1) Prior information notice concerning the same contract *(if applicable)*

Notice number in OJ content list 2004/S 169-145698 of 31 / 08 / 2004 *(dd/mm/yyyy)*

IV.1.3.2) Other previous publications

Notice number in OJ content list /S - of / / *(dd/mm/yyyy)*

IV.1.4) Envisaged number of suppliers which will be invited to tender *(when applicable)*

Number or: minimum **5/6** / maximum

IV.2) AWARD CRITERIA

(A) Lowest price
or
(B) The most economically advantageous tender in terms of: **x**

B1) criteria as stated below *(in descending order of priority where possible)*

1 _____ 4 _____ 7 _____

2 _____ 5 _____ 8 _____

3 _____ 6 _____ 9 _____

In descending order of priority: NO YES
or:

B2) criteria as stated in contract documents **x**

IV.3) ADMINISTRATIVE INFORMATION

IV.3.1) Reference number attributed to the file by the contracting authority * _____

_____

IV.3.2) Conditions for obtaining contract document and additional documents

Obtainable until / / *(dd/mm/yyyy)*

Price *(where applicable)* _____ Currency _____

Terms and method of payment _____

_____

_____

IV.3.3) Time limit for receipt of tenders or requests to participate *(depending whether it is an open, restricted or negotiated procedure)*

/ / *(dd/mm/yyyy)* or days from dispatch of notice

Time *(when applicable):* _____

IV.3.4) Dispatch of invitations to tender to selected candidates *(In restricted and negotiated procedure)*

Estimated date: / / *(dd/mm/yyyy)*

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

ES	DA	DE	EL	EN	FR	IT	NL	PT	FI	SV	Other (s) – third country
				x							_____

IV.3.6) Minimum time frame during which the tenderer must maintain its tender *(in case of an open procedure)*

Until / / *(dd/mm/yyyy)* or months and/or days from the deadline stated for receipt of tenders

IV.3.7) Conditions for opening tenders

IV 3.7.1) Persons authorised to be present at the opening of tenders *(where applicable)*

Authorised Board personnel _____

_____

IV.3.7.2) Date, time and place

Date / / *(dd/mm/yyyy)* Time: _____

Place **NHS Forth Valley Primary Care Operating Division Headquarters, Old Denny Road, Larbert FK5 4SD** _____

SECTION VI: OTHER INFORMATION

VI.1) IS THIS NOTICE A NON-MANDATORY ONE?

NO **x** YES

VI.2) IF APPLICABLE, INDICATE WHETHER THIS PROCUREMENT IS A RECURRENT ONE AND THE ESTIMATED TIMING FOR FURTHER NOTICES TO BE PUBLISHED

_____

_____

VI.3) DOES THE CONTRACT RELATE TO A PROJECT/PROGRAMME FINANCED BY EU FUNDS?*

NO **x** YES

If yes, indicate the project/programme and any useful reference _____

_____

_____

VI.4) ADDITIONAL INFORMATION *(if applicable)*

(A) Interested parties should submit a written request to participate to the postal address, email address or fax number contained in section I.1 and will be sent a pre-tender questionnaire. The questionnaire should be completed and returned to the address referred to in section I.4 by the date specified in IV.3.3.

(B) The right not to award the contract is reserved.

(C) The Board reserves the right to award a contract for only part of the work required.

(D) Suppliers should note that this requirement is considered suitable for the application of the Private Finance Initiative (PFI) or an alternative Public Private Partnership (PPP) and that the successful bidder will be expected to bear a significant proportion of the risks associated with delivery of the project.

VI.5) DATE OF DISPATCH OF THIS NOTICE [ ] /10 / 2004 *(dd/mm/yyyy)*

ANNEX A

1.2) ADDRESS FROM WHICH FURTHER INFORMATION CAN BE OBTAINED

Organisation **Forth Valley Health Board (known as NHS Forth Valley)**	For the attention of **Hamish Battye – Project Manager**
Address **NHS Forth Valley** **Primary Care Operating Division Headquarters** **Old Denny Road**	Postal code **FK5 4SD**
Town **Larbert**	Country **United Kingdom**
Telephone **01324 404 157**	Fax **01324 562 367**
Electronic mail (e-mail) **liz.hamilton@fvpc.scot.nhs.uk**	Internet address (URL) **www.show.scot.nhs.uk/nhsfv**

1.3) ADDRESS FROM WHICH DOCUMENTATION MAY BE OBTAINED

Organisation **As in I.2**	For the attention of
Address	Postal code
Town	Country
Telephone	Fax
Electronic mail (e-mail)	Internet address (URL)

1.4) ADDRESS TO WHICH TENDERS/REQUESTS TO PARTICIPATE MUST BE SENT

Organisation **As in I.1**	For the attention of
Address	Postal code
Town	Country
Telephone	Fax
Electronic mail (e-mail)	Internet address (URL)

ANNEX B: INFORMATION ABOUT LOTS

LOT No

1) Nomenclature

1.1) Common Procurement Vocabulary (CPV) *

	Main vocabulary	Supplementary vocabulary *(when applicable)*
Main object	. . . –	– – –
Additional objects	. . . –	– – –
	. . . –	– – –
	. . . –	– – –
	. . . –	– – –

1.2) Other relevant nomenclature (CPA/NACE/CPC) _____

_____

2) Short description _____

_____

_____

3) Scope or quantity _____

_____

4) Indication about different starting/delivery date *(if applicable)*

Starting / / *(dd/mm/yyyy)* / delivery / / *(dd/mm/yyyy)*

LOT No

1) Nomenclature

1.1) Common Procurement Vocabulary (CPV) *

	Main vocabulary	Supplementary vocabulary *(when applicable)*
Main object	. . . –	– – –
Additional objects	. . . –	– – –
	. . . –	– – –
	. . . –	– – –
	. . . –	– – –

1.2) Other relevant nomenclature (CPA/NACE/CPC) _____

_____

2) Short description _____

_____

_____

3) Scope or quantity _____

_____

4) Indication about different starting/delivery date *(if applicable)*

Starting / / *(dd/mm/yyyy)* / delivery / / *(dd/mm/yyyy)*

..... *(Use present annex as many times as necessary)* .....

[Removed]

[Removed]

[Removed]

[Removed]

Stage Three – Procurement Level Assessment – Refer Section Four of Guidance		
Requirement	**Details Assessed**	**Undertaken / Comments / Action Required**
1. The following is established and firm .	1. the affordability envelope for the project	See FBC Chapter 14. Affordability confirmed
	2. consideration of the extent affordability / costing information that will be shared with bidders	Not applicable at this stage
	3. project specifications (which can be delivered within affordability envelope)	Specification have been proven to be deliverable within affordability envelope
	4. SOPC / SSSC SEHD PA and other relevant standardised documents applied	See FBC Chapter 15 Standard documentation has been used with bespoke payment mechanism endorsed by SE
	5. PPP procurement timetable and forecast OJEU date approved by SE FPU / SEHD PFCU / relevant Centre	SEHD have approved all key project milestone dates
	6. Appropriateness of funding competition / approach to ensuring funding best value reviewed	PwC have offered an opinion on funding VfM and rates continue to be negotiated
	Separate report on the above to be attached to proforma	See FBC test
2. Qualitative Assessment	Confirm that there is no reason to suggest that the project is not: • Viable • Desirable • Achievable Provide supporting report	Viability, Desirability and Achievability has been assessed for Key Stage reviews and remains positive
3. Quantitative Assessment - Bid comparator will be developed.	1. Is a mechanism / process in place to develop risk adjusted Conventional Procurement Assessment Model which will reflect the PPP output specification and timing	See FBC Chapters 4, 12 and 13. Risk adjusted CPAM has been developed
	2. Process to continue to review risk pricing and Optimism Bias of the CPAM and its impact on PPP price tendered	CPAM and optimism bias has been continuously reviewed and updated for each Key stage review
	3. Consideration and application of STUC Staffing protocol undertaken.	STUC protocol has been implemented with in house team wining in competition
	4. Compare PPP bids with CPAM and undertake sensitivity analysis (continue this throughout procurement	See FBC Chapter 13. To be finally updated at financial close

Stage Three – Procurement Level Assessment – Refer Section Four of Guidance		
Requirement	**Details Assessed**	**Undertaken / Comments / Action Required**
	to Financial Close) Report complied by Procuring Authorities, Agency, Department with input from advisers as appropriate.	
4. Other Commercial Areas	1. Confirm that Risk allocation is still best practice, VfM and deliverable. 2. Confirm that a robust bidding and evaluation process has been in place during procurement. Detail in report	See FBC Chapter 12. Risk allocation has been reviewed. Grouting works undertaken outside PFI to optimise risk allocation. Bidding and evaluation process has been subject to SE Key Stage Review
5. Develop strategy to deal with ongoing project issues and elements	1. Process in place to regularly review bidders financial capacity (standard PQQ financial tests at key project stages) 2. Protect for and review for market failure 3. Protect for and review for market abuse 4. Process to review and control and confirm ongoing support for affordability of project 5. Review of Balance Sheet status 6. Bid Evaluation framework 7. Internal Risk Management Register and related Internal Risk Management plan 8. Process to collate and share relevant information with other Procuring Authorities, Departments and Agencies Detail in report to be attached to	Bidder's financial standing has been reviewed and will be re-tested prior to Financial Close Market failure has not been observed – competitive bids received. Market abuse has not been observed – competitive bids received. See FBC Chapter 14. Board has confirmed project affordability. Balance sheet treatment reviewed by PwC and confirmed by external auditors Final Confirmation Outstanding Robust bid evaluation framework was developed and implemented. Demonstrated at Key Stage Review See FBC Chapter 12. Risk registers and management plans have been updated. Clackmannanshire Council and SEHD have been involved through membership of the project Board

Stage Three – Procurement Level Assessment – Refer Section Four of Guidance		
Requirement	**Details Assessed**	**Undertaken / Comments / Action Required**
	proforma	

The above will be reviewed in the Preferred Bidder KSR report (if applicable) and at FBC.

[Removed]

Glossary of Terms and Abbreviations

A

Acute in-patient hospital	A hospital for patients requiring over-night stays including patients with acute mental health needs
ADSCR	Average Debt Service Cover Ratio
AEDET	Achieving Excellence in Design Evaluation Toolkit
A & E	Accident and Emergency
AHP	Allied Health Professionals
ALOS	Average length of stay
Angina	Chest pain
ASB	Accounting Standards Board

B

BAFO	Best and Final Offer
BCM	Bid Comparator Model

C

CADO	Chief Administrative Dental Officer
CABE	Commission for Architecture in the Built Environment. An organisation dedicated public buildings
CCHSP	Clackmannanshire Community Health Services Project
CCU	Critical Care Unit
CDM	Construction Design and Management Regulations
CDS	Community Dental Services
CHD	Coronary Heart Disease Disease, such as angina, coronary thrombosis
CHI	Community Health Index
CHP	Community Health Partnerships
CIG	Capital Investment Group
CMHRT	Community Mental Health Resource Team
Community Mental Health Team	A group of professionals from a variety of different disciplines (e.g. 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

Glossary of Terms and Abbreviations

CPN	Community Psychiatric Nurse
CSBS	Clinical Standards Board Scotland
D	
DCR	Day Case Rate
Day Hospital	A day hospital is a hospital, or a specified area within a hospital, which 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.
DCF	Discounted Cash Flow
DCP	Development Control Plan
Diagnosis	Identification of an illness by means of its signs and symptoms. This involves ruling out other illnesses and casual factors for the symptoms.
DoH	Department of Health
E	
EAC	Equivalent Annual Cost – used to compare the costs of options with a different lift
ECCI	Electronic Clinical Communications Initiative
ENT	Ear, Nose and Throat
EPR	Electronic Patient Record. Computerised patient care information, which will eventually replace hard copy patient notes through the Government's Information for Health initiative.
Elective	Subject to the choice or decision of the patient or physician, applied to procedures that are advantageous to the patient but not urgent and can be planned ahead.
EWTD	European Working Time Directive
F	
FBC	Full Business Case - The document prepared by a trust in accordance with the Capital Investment Manual and 'PFI in the NHS' to develop the preferred option previously identified in the OBC, and approved by the Scottish Executive where required. It will form the basis upon which final approval of the scheme is granted.
FDRI	Falkirk and District Royal Infirmary
FM	Facilities Management. The maintenance of buildings and provision of those non-clinical services essential to the functioning of a clinical facility,
Focus Groups	Small groups of members of the public and other stakeholders where new ideas are discussed.

Glossary of Terms and Abbreviations

FRS	Financial Reporting Standard
G	
GDS	General Dental Services
GEM	Generic Economic Model
GMS	General Medical Services
GP	General Practitioner
GPASS	General Practitioner Administration System for Scotland
H	
HDL	Health Department Letter
HDU	High Dependency Unit
HMCE	Her Majesty's Customs and Excise
HPT	Healthcare Planning Team. The Project Group responsible for determining the specifications for the Project, including leading the service redesign interface with the health community, co-ordinating the development of the clinical, non-clinical and academic services output based specifications.
HR	Human Resources
HSE	Health & Safety Executive
I	
I & E	Income and Expenditure
IA	Initial Agreement
ICE	Institute of Civil Engineers
ICU	Intensive Care Unit
ICT	Information and Communication Technology
IHD	Ischemic Heart Disease
IM	Information Memorandum
IM & T	Information Management and Technology
Indicative Notice	An advance warning of a contract to be awarded at some time in the future
In-house	Pertaining to a separate unit within an entity, as distinct from a third party.
In-patient	A person who is admitted overnight to hospital for observation, examination or treatment.
Intellectual Property Rights	All present or future interests, whether legal or equitable, in patents,

Glossary of Terms and Abbreviations

	registered or unregistered designs, trade marks and service marks (whether registered or not), copyright, design right, and all other intellectual and industrial property rights including those subsisting (in any part of the world) in inventions, designs, drawings, performances, computer programs, semiconductor topographies, plant varieties, confidential information, business names, goodwill and the style of presentation of goods or services and in applications for protection thereof.
Interest Rate Swap	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 receive variable.
Intermediate Care	Range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired.
IPS	Industrial and Provident Societies
IRR	Internal Rate of Return. The rate at which future cash flows, discounted back to today, equal its price.
ISD	Information Services Division
ITN	Invitation To Negotiate

J

Joint Venture	A business venture jointly controlled by two or more independent firms.

L

LHC	Local Health Council
LIBOR	London Inter-Bank Offer Rate
Local Health Care Co-operative	A grouping of general medical practitioners.
Locality	Community services in NHS Forth Valley are split into 10 localities, each of which covers a number of natural communities.
LOS	Length of Stay
LV	Low Voltage

M

Members Organisation	The individual
MCN	Managed Clinical Network
MDT	Multidisciplinary Team
MOI	Memorandum of Information

Glossary of Terms and Abbreviations

Multidisciplinary	A multidisciplinary team is a group from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition.
MRA	Maintenance Reserve Account

N

Negotiated Procedure	Procedure where only chosen suppliers are invited to negotiate contracts.
NBV	Net Book Value
NEAT	NHS Environment Assessment Tool. A Tool, developed by NHS Estat3es, to be used within all NHS capital development schemes, with a view to raising awareness of environmental issues, estimating environmental impact and seeking to establish an environmental improvement programme.
NHS	National Health Service
NHS 24	A new national 24 hour telephone health and information service. If you or someone you look after, are unwell or if you are looking for more information about a health matter or local healthcare services you can call them anytime day or night.
NHS Board	NHS Board replaced the separate board structure of Health Boards and NHS Trusts. The NHS boards cover the same geographical area as the old Health Boards. The overall purpose of th unified NHS Boards is to ensure the efficient, effective and accountable governance of the local NHS system and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes. Membership includes local councillors.
NHSIA	National Health Service Information Authority
NHSis	National Health Service in Scotland
Notice	General term for advertisement placed in the Official Journal.
NPC	Net present cost
NPV	Net Present Value. The aggregate value of cashflows over a number of periods discounted to today's value.

O

OBC	Outline Business Case. A document prepared to identify and develop the preferred option for the proposed scheme.
OBI	Outline Business One
OBS	Output Based Specification
OJEU	Official Journal of the European Union

Glossary of Terms and Abbreviations

OMV	Open Market Value
Open Procedure	Procedure where bidders can apply without prior selection
Opportunity Cost	Value of most valuable alternative use (e.g. the value of an asset in the next best alternative use to which the asset could be put).
Optimism Bias	A tendency to budget or the best possible (often lowest cost) outcome rather than the most likely. This creates a risk that predicted outcomes do not fully replace likely costs.
OT	Occupational Therapy
Out-of-Hours	Between 6pm – 8am Monday to Friday and also weekends and bank holidays.
Out-patients	A patient reviewed in a hospital who does not need to be admitted to the hospital
Output Specification	A statement of the needs to be satisfied by the procurement of external resources.

P

PC	Primary Care. The conventional fist point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively , delivered through general pactices. Primary Care services are the most frequently used of all services provided in NHS Scotland. Primary Care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.
PFI	Private Finance Initiative. A Government initiative seeking private capital funding and operation of serviced hospital accommodation.
PID	Project Initiation Document
PIN	Prior Information Notice
PITN	Preliminary Invitation to Negotiate. A series of documents issued to qualifing candidates in order to invite response. These provide information about the scheme and define the information required in responses from candidates. This stage will be divided into Preliminary Invitation to Negotiate (PITN) and final Invitation to Negotiate (FITN).
PPP	Public Private Partnership
PQQ	Pre Qualification Questionnaire. A questionnaire designed to enable UHL to evaluate the economic and financial standing ability and technical capability of organisations responding to the OJEC notice.
Preferred Option	The option chosen as part of the OBC and which is used as a basis for the Private Sector Comparator.

Glossary of Terms and Abbreviations

Prince	Projects in a controlled environment (standard NHS project management methodology).
PSC	Public Sector Comparator
PwC	Price Waterhouse Coopers

R

R&C	Revise and Confirm
RCGP	Royal College of General Practitioners
RIBA	Royal Institute of British Architects
RPI	Retail Price Index
RV	Residual Value

S

SEHD	Scottish Executive Health Department
SHAS	Scottish Health Advisory Service
SPC	Special Purpose Company
SPV	Special Purpose Vehicle
SRI	Stirling and District Royal Infirmary
STUC	Scottish Trade Union Congress

T

TUPE	Transfer of Undertakings

V

VfM	Value for Money

W

WACC	Weighted Average Cost of Capital

Forth Valley NHS Board

Carseview House
Castle Business Park
STIRLING
FK9 4SW

NHS
Forth Valley

Dr Kevin Woods
Chief Executive
Scottish Executive Health Department
St. Andrew's House
EDINBURGH
EH1 3DG

Date 26 January 2007

Dear Dr Woods,

LETTER FROM NHS FORTH VALLEY'S AREA CLINICAL FORUM

We are writing to confirm the wholehearted support of clinical staff for the new acute hospital and Clackmannanshire hospital Full Business Cases. We are keen to ensure you are fully aware of the enthusiastic commitment of clinical colleagues to the Forth Valley Integrated Healthcare Strategy, which clinicians advocated during the public consultation, and also to the extent of the partnership with clinicians in developing the specifications of both projects. This has involved not only the statutory committees such as Area Professional Advisory Committees and Area Clinical Forum, but also a Clinical Advisory Group, which has provided key clinical leadership and advice.

Clinical colleagues in all health professions in both primary and secondary care have full ownership of, and indeed have helped to drive, the overall Forth Valley Strategy since 2001. They are committed to delivering safer, integrated, sustainable and high quality care both in the acute setting and in settings as close to people's homes as possible. The need for radical service redesign has been recognised and the changes made through Transitional Arrangements in 2005 have already helped separate emergency and planned care. The clinical body have fully embraced principles of patient-focussed care. This includes maximising ambulatory care and anticipating care across sectors and agencies and to further shifting the balance of care, working in partnership. The planned new hospitals will provide facilities which will enable us to deliver our vision of the highest quality care to the people of Forth Valley.

Clinical colleagues have been included in every stage of design and planning, with over 200 individuals intimately involved in a process, which comprised around 50 separate User Groups and a dozen larger groups. The staff have worked closely with the Design Team who have given consideration to all views.

Clinical staff in NHS Forth Valley are justifiably proud of their recent redesign initiatives, which implement the recommendations of the Kerr Report. They are determined to ensure that the planned world-class new facilities in Forth Valley will be matched by the highest standard of patient centred modern practice, which they facilitate.

Yours sincerely

ABridges.

Dr Allan Bridges,
Chair, Area Clinical Forum

If you or someone you know, would like this document to be sent to you in an alternative format, such as audiotape or large print then please either phone free on *0800 456033* or email *yourhealth@fvhb.scot.nhs.uk*

You can obtain the service of an interpreter or have this document translated in your own language by contacting the interpreting services on 0845 130 1170. These services are available free of charge.

ਤੁਸੀਂ, 0845 130 1170 ਤੇ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ (interpreting services) ਨੂੰ ਸੰਪਰਕ ਕਰਕੇ ਇਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਜਾਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਆਪਣੀ ਬੋਲੀ ਵਿਚ ਅਨੁਵਾਦ ਲੈ ਸਕਦੇ ਹੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

آپ 0845 130 1170 پر انٹرپریٹنگ سروس سے رابطہ کرکے کسی مترجم کی خدمات حاصل کرسکتے ہیں یا اس دستاویز کا ترجمہ اپنی زبان میں کرا سکتے ہیں۔ یہ خدمات مفت دستیاب ہے۔

您可以通過撥打翻譯服務熱綫 0845 130 1170 取得翻譯員服務或得到此文件的翻譯版本。 這些服務都是免費的。

Galite prasyti vertejo paslaugu arba gauti sita dokumenta isversta I jusu kalba kreipdamiesi I musu vertimo paslaugu biura skambindami 0845 130 1170. Sitos paslaugos yra nemokamos.

يمكنك الحصول على خدمة الترجمة الفورية أو القيام بترجمة هذه الوثيقة إلى لغتك الأصلية عن طريق الإتصال بخدمات الترجمة الفورية على رقم 0845 130 1170. هذه الخدمات متاحة مجانا بدون أى مقابل مادى.

Dzwoniąc do biura tłumaczeń pod numer 0845 130 1170 możecie Państwo prosić o tłumacza albo otrzymać ten dokument przetłumaczony na wasz język ojczysty. Powyżej wymienione usługi są darmowe.

Carseview House, Castle Business Park, Stirling FK9 4SW
Tel 01786 463031 Fax 01786 451474

www.nhsforthvalley.com

NHS
Forth Valley