Scottish Hospitals Inquiry

Hearing commencing on 24 April 2023

Bundle 10 – Miscellaneous

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NHS LOTHIAN

FINANCE & RESOURCES COMMITTEE

Minutes of a Special Meeting of the Finance & Resources Committee held at 12.30 p.m. on Wednesday 5 March 2014 in the Boardroom, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr G Walker (Chair); Ms K Blair; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Ms M Johnson; Mr B Houston; Professor J Iredale and Mr J Brettell.

In Attendance: Mrs S Allan; Mrs A Mitchell; Dr R Williams; Mrs J McDowell; Mr G Warner; Councillor C Johnstone; Mr A Joyce; Mr A Boyter; Professor A McMahon; Mr B Currie, Mr I Graham; Mr A Orr; Mr R Cantlay; Mr M Pryor; Ms J Mackenzie and Mr P Reith.

An apology for absence was received from Mr P Johnston.

Declaration of Financial and Non-Financial Interest

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

61. Royal Hospital for Sick Children and Department of Clinical Neurosciences, Little France, Project Procurement and Recommendation of Preferred Bidder

61.1 The Committee received a previously circulated report confirming completion of the evaluation of Final Tenders for the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France.

61.2 The Chair reminded members that the information being provided was commercially confidential and counted as "insider information" which could not be communicated to any third party without risking prosecution.

61.3 Mr Currie reminded members of the background to the project and the various steps leading to the recommendations made by the Project Team and endorsed by the Project Steering Board on 28 February 2014.

61.4 The Committee noted that the Scottish Futures Trust required that 60% of the evaluation of Final Tenders had to relate to commercial/cost and that 40% of the evaluation of Final Tenders had to relate to quality. . This comprised 61 criteria divided into 3 sub-sections with a total of 40 marks available to bidders as part of the quality evaluation spread between the bidders' strategic and management approach (5 marks), design and construction approach (23 marks) and Facilities Management approach (12 marks). It was noted in

particular that the quality side of the evaluation was separated from the cost/commercial side of the evaluation.

61.5 Mr Graham commented that the cost/commercial side of the evaluation also included an evaluation of any commercial amendments made by bidders in respect of the legal framework, which consisted of a contract (this being the NPD Project Agreement) agreed in advance with the Scottish Futures Trust.

61.6 Mr Currie advised the Committee that the Project Steering Board now had a preferred bidder and he would be seeking the committee's endorsement of that recommendation.

61.7 Mr Pryor, representing Ernst and Young LLP, as Financial Advisers to the Project, advised that their evaluation had been carried out in accordance with the process set out in the Invitation to Participate in Dialogue and in the Invitation to Submit Final Tender issued on 16 December 2013. He confirmed that it had found that all of the construction costs were below the level of the Scottish Government cap as set at the point of issuing the Invitation to Submit Final Tender. He also confirmed that the life cycle costs had been compared to the amount indicated in the funding letter to the Board and all bidders were below this number. It was noted that the Facilities Management costs had been compared to the sum assumed in the Outline Business Case and that no bidders' cost exceeded this amount and that the provisional preferred bidder had the lowest capital cost and lowest subordinated debt coupon. He was satisfied that the processes had been completed in accordance with the requirements of the Scottish Futures Trust and the Scottish Government.

61.8 Mr Orr, representing MacRoberts LLP, as Legal Advisers to the Project, confirmed to the Committee that following the submissions of the Final Tenders from the three bidders, a legal review had been carried out and a report providing an overview of the legal documents submitted by each bidder in relation to the requirements of the Invitation to Submit Final Tenders had been provided to the Board.

61.9 Mr Orr confirmed that the procurement process followed by the Board had been consistent with other similar projects and the procurement followed by the Board had complied with relevant procurement regulations and best practice. The procurement had also followed the processes and procedures required by the Scottish Futures Trust.

61.10 Mr Cantlay, representing Mott MacDonald, advised the Committee that as technical advisors for the reprovision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France NDP project he believed from a technical perspective that the technical evaluation had been carried out in a manner consistent with the evaluation methodology. From their involvement in this process, the considered scores awarded for the technical evaluation criteria seemed to be correct and it appeared appropriate for the Board to conclude the evaluation process and appoint the bidder identified as having the most economically advantageous tender as the preferred bidder.

61.11 The Chair reminded the Committee that the purpose of the supplemental agreements with Consort were to ensure that whichever bidder was selected there were robust agreements in place to ensure that the enabling works relating to the shared areas between the Royal Infirmary of Edinburgh and the Royal Hospital for Sick Children and Department of Clinical Neurosciences could be completed without delay.

61.12 Mrs Goldsmith confirmed that the main risk implicit in relation to such supplemental agreements relating to the enabling works was in relation to ongoing issues in respect of the clinical enabling works.

61.13 Mr Graham confirmed that each bidder had tendered on the basis of a bidder specific NPD Project Agreement, that all sub-contractors had been required to submit references and visits to sites had been conducted by each bidder.

61.14 Mr Cantlay advised that the price proposed by the preferred bidder was a robust one based on an existing model and the process had been followed to the letter.

61.15 Councillor Johnstone left the meeting.

61.16 Mr Currie confirmed that all three bids had been of an acceptable quality and Mr Orr reassured the Committee that the scheme employed a new standard form contract, this being the NPD Project Agreement published by the Scottish Futures Trust, which ensured that returns to the private sector were capped and any surpluses came back to the public sector. Hard facilities management would be subject to a robust approach and the Payment Mechanism included appropriate penalties which could be used against the bidder in order to incentivise performance. Everything possible had been done to mitigate the risk of poor quality facilities and/or poor services being provided to NHS Lothian.

61.17 Mr Currie confirmed that the project had the potential to expand on the top floor, subject to obtaining town planning consent from The City of Edinburgh Council and the configuration of the ground floor could be altered to a limited degree if additional space was required.

61.18 Mr Currie also confirmed that all details had been clarified in the contract documentation and the Chair reminded the Committee that the Scottish Futures Trust had been members of the Project Board and signed off on all the processes (Key Stage Reviews).

61.19 Mr Orr confirmed that all the required legal processes were in place and documentation required by the Scottish Futures Trust had been used with any changes being made approved by the Scottish Futures Trust.

61.20 Mr Cantlay confirmed that the scores were all appropriate and he was happy with the evaluation and satisfied that the preferred bidder was in full accordance with the requirements.

61.21 Mrs Goldsmith advised that following the decision of the Committee there would be a full debriefing process with the two unsuccessful bidders.

61.22 The Chair sought confirmation that the price in the contract was fixed and Mr Orr confirmed that there would be a fixed price contract in place subject to any variations, agreed increases and other risks which remained with NHS Lothian.

61.23 The Committee agreed to note the outcome of the scored evaluation and the assurance statements provided by Legal, Technical and Financial Advisers along with the completion of the Key Stage Review (Appointment of Preferred Bidder) by the Scottish Futures Trust,

61.24 The Committee agreed unanimously, with no dissent from any members present, to approve the recommendation of the Project Team, as endorsed by the Project Steering Board, to appoint Integrated Health Solutions Lothian as the preferred bidder for the development of the Royal Hospital for Sick Children and Department of Clinical Neurosciences on the site at Little France and to authorise the Project Director to issue the formal Preferred Bidder Letter and the two associated unsuccessful bidder letters in order to formally commence the contract “standstill period” required under the relevant procurement regulations.

62. Date of Next Meeting

62.1 The Chair reminded members that the next full meeting of the Finance & Resources Committee would be held on Wednesday 12 March 2014 at 9:00 a.m. in Meeting Room 7, Waverley Gate, Edinburgh.

23. Full Business Case for the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France.

23.1 Mr Currie introduced the previously circulated Full Business Case for the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France.

23.2 Mr Houston queried the £8m difference between the Outline Business Case and the Full Business Case and Mrs Goldsmith advised that this related to extra works and flood prevention which had been carried out.

23.3 Mrs Blair asked if there was an assurance that the scope of the design was adequate.

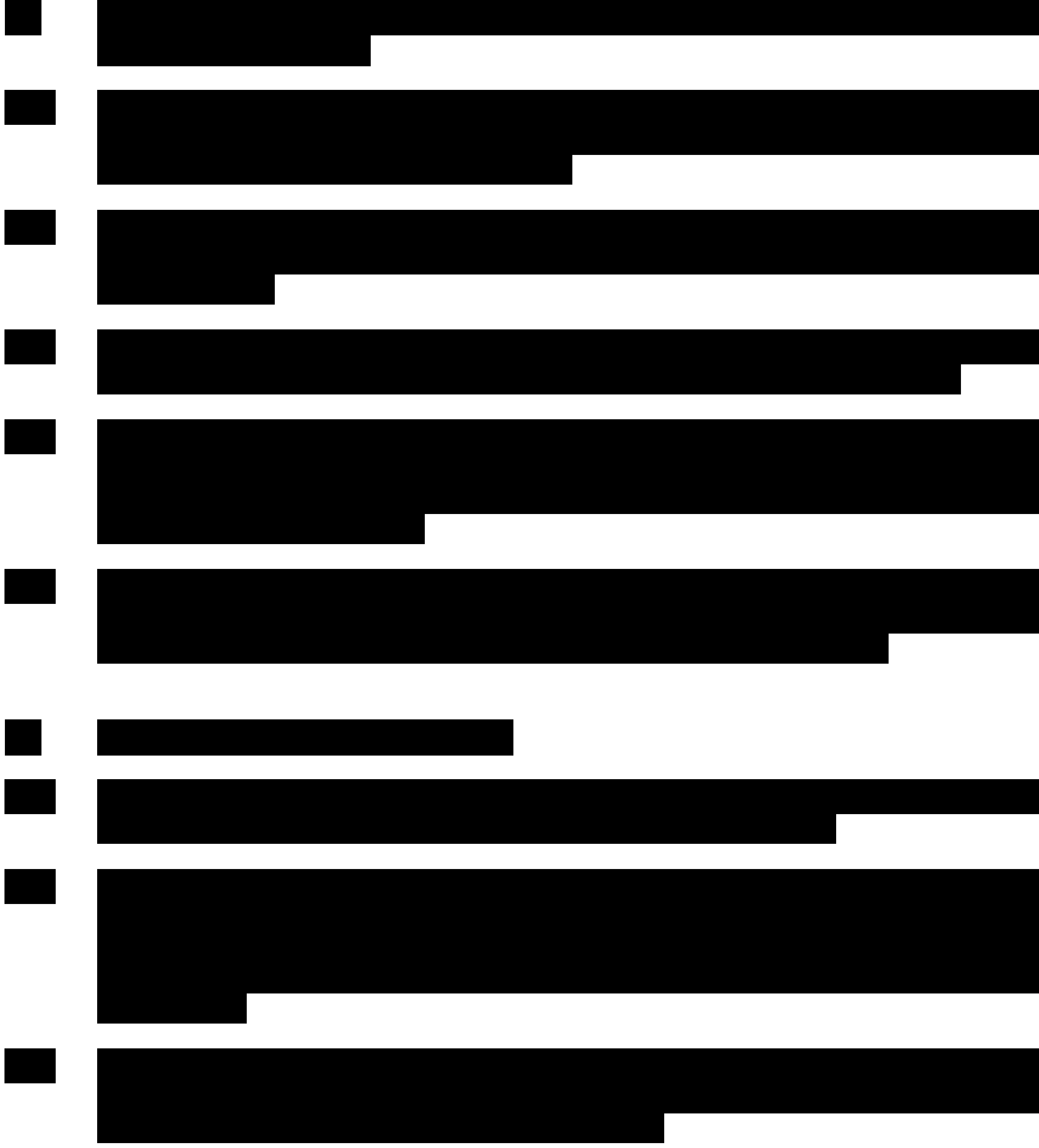
23.4 Mrs Goldsmith explained that the capacity had been based on detailed modelling and the design had been changed to take account of current demand. The design also allowed for the possibility of creating additional space.

23.5 Mrs Goldsmith advised that Mr P Reekie at the Scottish Futures Trust would be asked to take the referendum into account in processing this project and she undertook to invite him to address a future meeting of the Committee. **SG**

23.6 The Committee agreed to approve the submission of the Full Business Case for the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France to Lothian NHS Board with a recommendation that it would proceed to the Scottish Government Health and Social Care Directorates Capital Investment Group.

23.7 The Committee also agreed to recommend to the Board that, subject to the approve of the Full Business Case by the Scottish Government, the approval of the final terms of the non-profiting distributing project agreement and associated contract documentation would be delegated to the Finance and Resources Committee.

23.8 It was also agreed to recommend to the Board that, subject to the approval of the final terms of the project agreement by the Finance and Resources Committee, the signing of the project agreement at the financial close be delegated to the Chief Executive or the Director of Finance for NHS Lothian.



NHS LOTHIAN

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 9:00am on Wednesday 27 August 2014 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr G Walker (Chair); Mrs K Blair; Mr J Brettell; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Mr B Houston; Councillor P Johnson and Dr A McCallum.

In Attendance: Miss L Baird; Mr B Currie (for item 29.1) ; Mr I Graham; Mr P Gabittas; Professor A McMahon; Mr P Reekie ; Mr A Milne (for Item); Mr D A Small and Mr S Wilson.

There were no apologies for absence.

Declaration of Financial and Non-Financial Interest

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

27. Minutes of Previous Meeting

27.1 The previously circulated minutes of the Finance & Resources Committee meeting held 9 July on 2014 were approved as a correct record.

28. Running Action Note

28.1 The Committee received a previously circulated running action note detailing the matters arising from the Finance and Resources Committee meeting held on 9 July 2014, together with the action taken and the outcomes.

29. Matters Arising

29.1 Process to Financial Close and Payment Mechanism for RHSC/DCN Project

29.1.1 Mrs Goldsmith gave a brief verbal overview of the process to financial close and

payment mechanism for the Royal Hospital for Sick Children and the Department of Clinical Neuroscience Project. She highlighted that following IHSL failing to achieve the deadline for the RIE interface documentation Financial Close for this Project would be delayed until November 2014.

29.1.2 Members noted that following the slippage a meeting had been convened with partners and progress would be closely monitored through monthly meetings to ensure that financial close remained on target for November 2014.

Councillor Henderson entered the meeting.

29.1.3 Mr Reekie of Scottish Futures Trust and external member of the RHSC/DCN Project Steering Board gave a brief overview of key contractual provisions and their difference from the RIE project. He firstly reiterated that the services to be delivered by the NPD contractor are significantly less than by the PFI contractor at the RIE. Catering and cleaning for example will remain NHSL responsibilities so that the day-to-day visibility and impact of the contractor on visitors, patients and most staff will be lower. Secondly he discussed the robust payment and contractual terms which are again very different from the RIE contract and allow for meaningful financial deductions to be made for sub-standard performance. Poor performing sub-contractors and ultimately the main NPD contract can also be terminated for persistent poor performance. Finally he explained that whilst making changes to buildings in use is generally an expensive and disruptive activity, the SFT contract has improved rights for the Board and pricing transparency to give better value when changes, whether minor or major, are required as they inevitably will be over the life of the building.

29.1.4 The Committee acknowledged the benefits of the appointment of a Contract Manager to the RHSC / DCN Hospital project, in that one of their key role would be to maintain good lines of communication between NHS Lothian, Consort and key stakeholders.

29.1.5 Members recognized the importance of how lessons learnt could be improved upon for the Royal Edinburgh Hospital Project.

29.1.6 Mrs Goldsmith advised the Committee that a further report would be brought to the committee at the point of close. **SG/PR**

Mr Reekie left the meeting.

29.2 <u>Action Plan for the Corporate Risk: Ensure the Delivery of a Sustainable Financial Framework</u>

29.2.1 Mrs Goldsmith introduced the paper that advised the Committee of the changes to the risk register that mitigate the risk associated with the delivery of a sustainable financial framework.

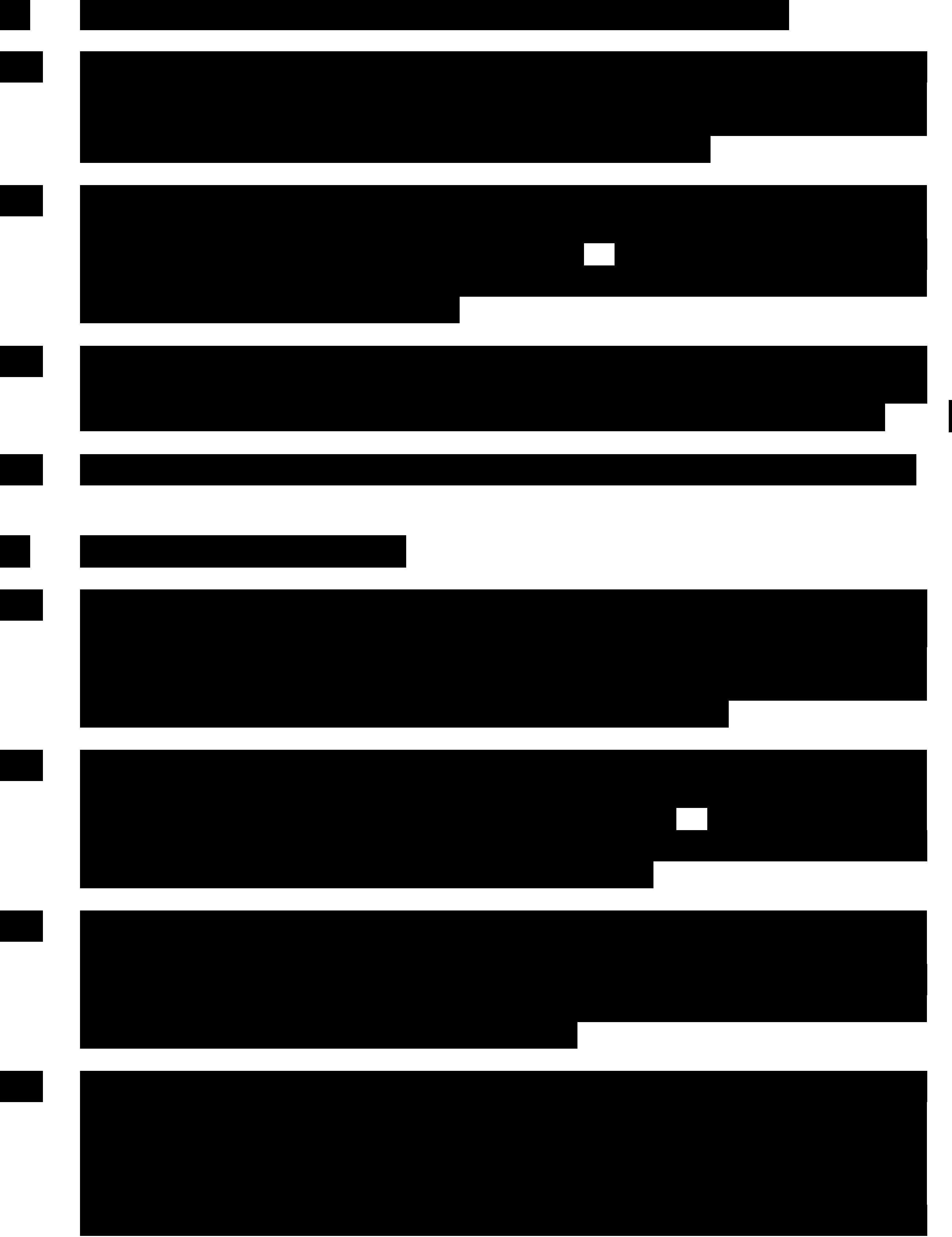
29.2.2 The Committee endorsed the change to Datix corporate risk 3600.

29.3 <u>Royal Hospital for Sick Children & Department of Clinical Neurosciences at Little France – Update</u>

29.3.1 The Committee received the previously circulated report. Members noted the specific requirements and wording for the legalised minute outlined in appendix 1

that supported the contract for delivery.

29.3.2 The Committee agreed to note the wording in appendix 1 and that approval of minor changes required could be delegated the Mr Walker, Chair of the Finance and Resources Committee in the run up to financial close. **GW**



NHS LOTHIAN

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 9.00am on Wednesday 12 November 2014 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

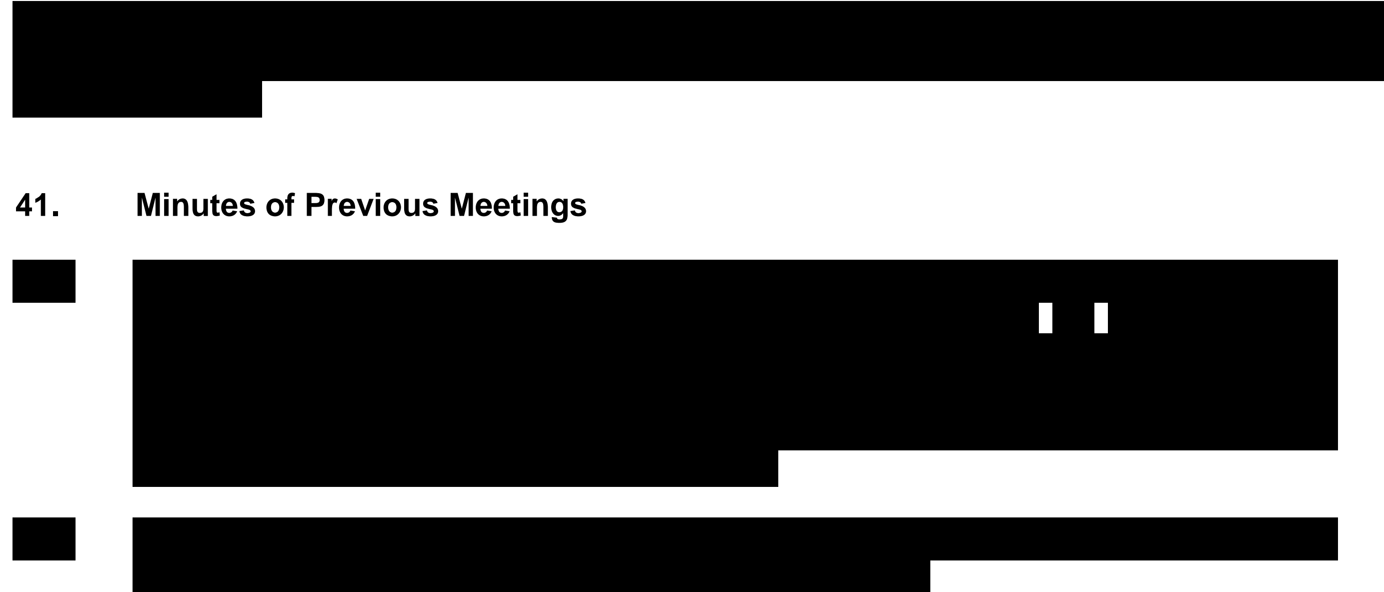
Present: Mr G Walker (Chair); Ms K Blair; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Ms M Johnson and Mr J Brettell.

In Attendance: Mr J Crombie (Director of Scheduled Care); Mr B Currie (Project Director, Royal Hospital for Sick Children / Department of Clinical Neurosciences); Mr I Graham (Director of Capital Planning and Projects); Mr C Kerr (Senior Project Manager); Mr C Marriott (Deputy Director of Finance); Mr P Reith (Secretariat Manager); Mr D A Small (Joint Director of Health & Social Care, East Lothian); Professor A Timoney (Director of Pharmacy) and Mr D White (Assistant General Manager).

Apologies for absence were received from Mr T Davison; Mr B Houston; Professor J Iredale and Mr P Johnston.

Declaration of Financial and Non-Financial Interest

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.



41. Minutes of Previous Meetings

42. Matters Arising

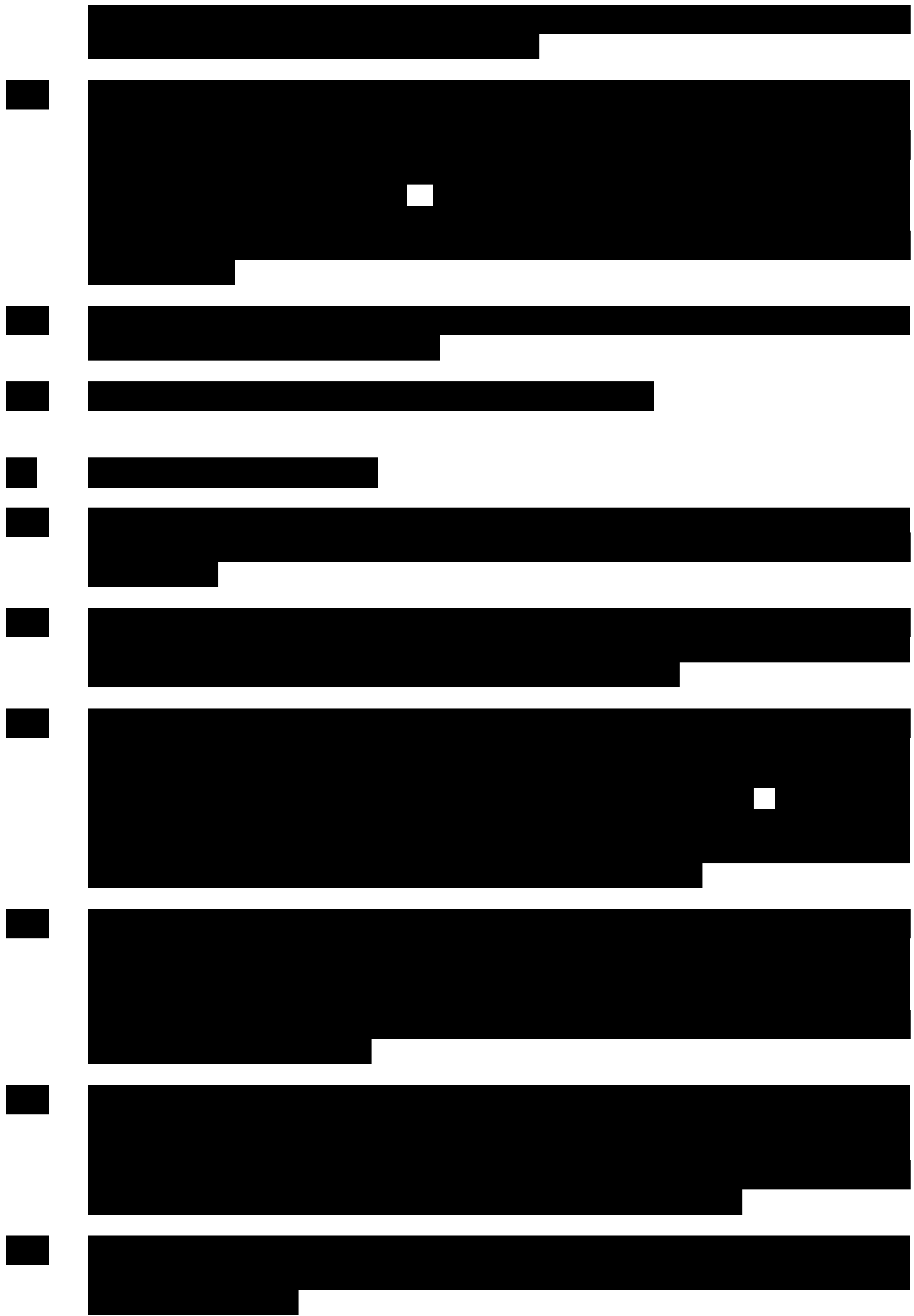
42.1 Western General Hospital Front Door Services Development Project – Ms Johnson advised the Committee that work was in progress to obtain the additional information concerning potential improvement to outcomes, efficiencies, benefits, savings and

MJ

43. Running Action Note

43.1 The Committee received a previously circulated action note detailing outstanding matters arising, together with the action taken and the outcomes.

43.2 Mrs Goldsmith advised the Committee that the Royal Hospital for Sick Children and Department of Clinical Neurosciences financial close was on the agenda and that guidance on due diligence in respect of the integration process was still awaited from the Scottish Government. Both Health Boards and Local Authorities had financial challenges and Lothian had chosen options on managing the finances with flexibility. A report would be brought to the next meeting of the Committee to provide appropriate assurances. Mrs Goldsmith commented that the guidance referred to costs rather than budgets which did not reflect how NHS funding worked. The Committee noted the position.



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47. Royal Hospital for Sick Children / Department of Clinical Neurosciences Programme to Financial Close

47.1 Mrs Goldsmith introduced a previously circulated report giving an update on the probable timeline for achieving financial close and therefore start onsite for the new building at Little France.

47.2 The Committee noted that one of the challenges was that the Scottish Futures Trust required a new partner to produce drawings in much greater depth and to interface with Consort on the project.

47.3 Mr Currie explained that in spite of the slippage of the financial close date due to technical and funder issues, progress had been made with Consort at a technical level although their formal approval had still to be obtained. A January date for financial close might be achievable.

47.4 The Committee expressed disappointment and concern at the delays and noted that the requirements for more detailed technical documentation had been set by the Scottish Futures Trust and had been agreed by the contractor.

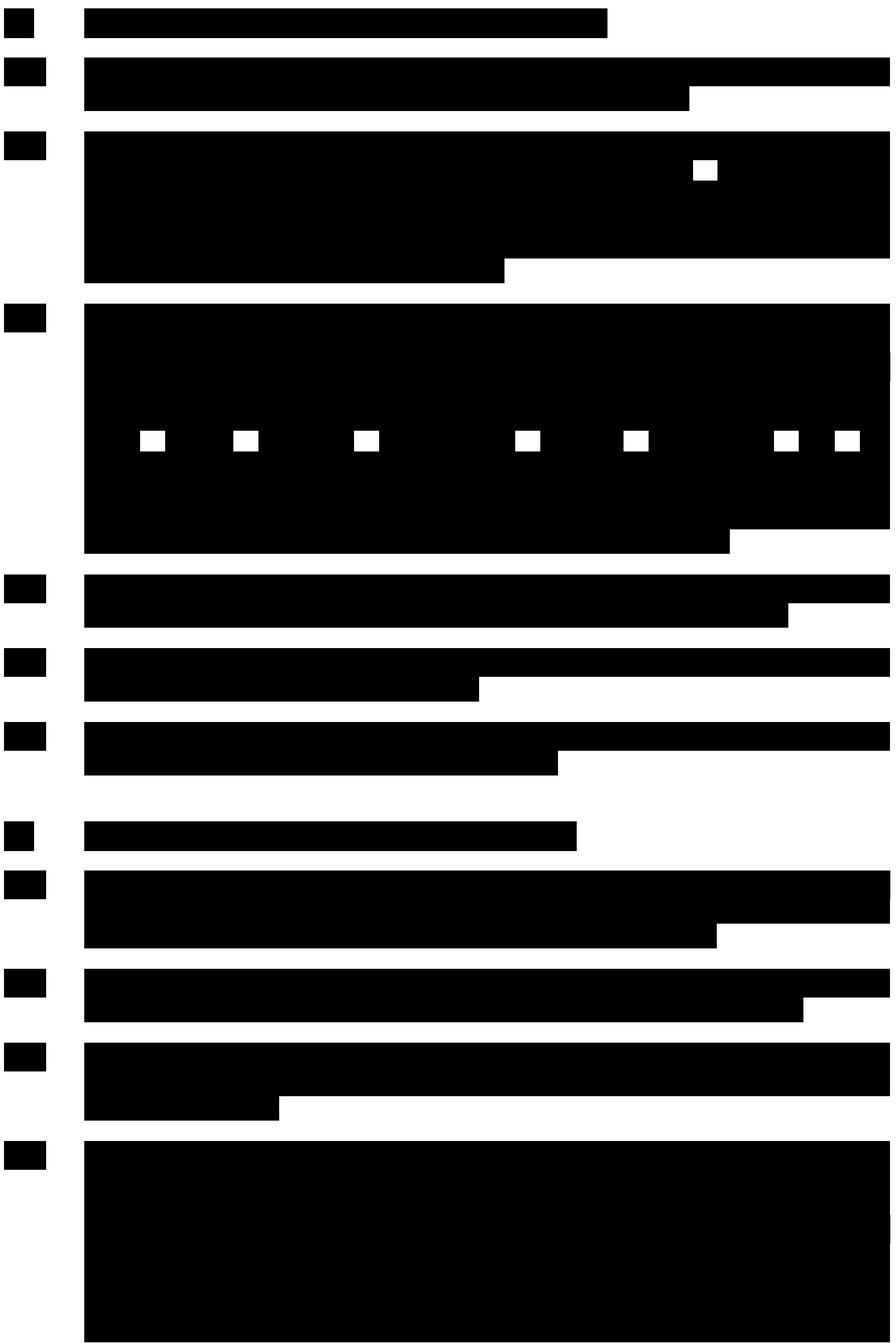
47.5 The Chair commented that the Committee was not reassured by the process and it would be important to demonstrate that risk management was in place before the Committee could be reassured.

47.6 Mr Currie advised that NHS Lothian was managing the project as best as it could but that many of the present issues were outwith NHS Lothian's control. The bidder had signed up to deliver the level of information which was a statutory requirement by the Scottish Futures Trust. NHS Lothian's legal adviser had stated that NHS Lothian was going above and beyond what they were legally required to do in order to expedite the process.

47.7 Mrs Goldsmith commented that the magnitude of the project was such that due diligence could not be achieved in the time originally allocated.

47.8 The Committee noted that there was a financial risk with the "guesstimate" cost being outwith the control of NHS Lothian. Mr Graham advised the Committee that there was an agreed capital cost of the project.

47.9 The Committee agreed to note the financial close programme and the governance in place to support the Board's requirements.



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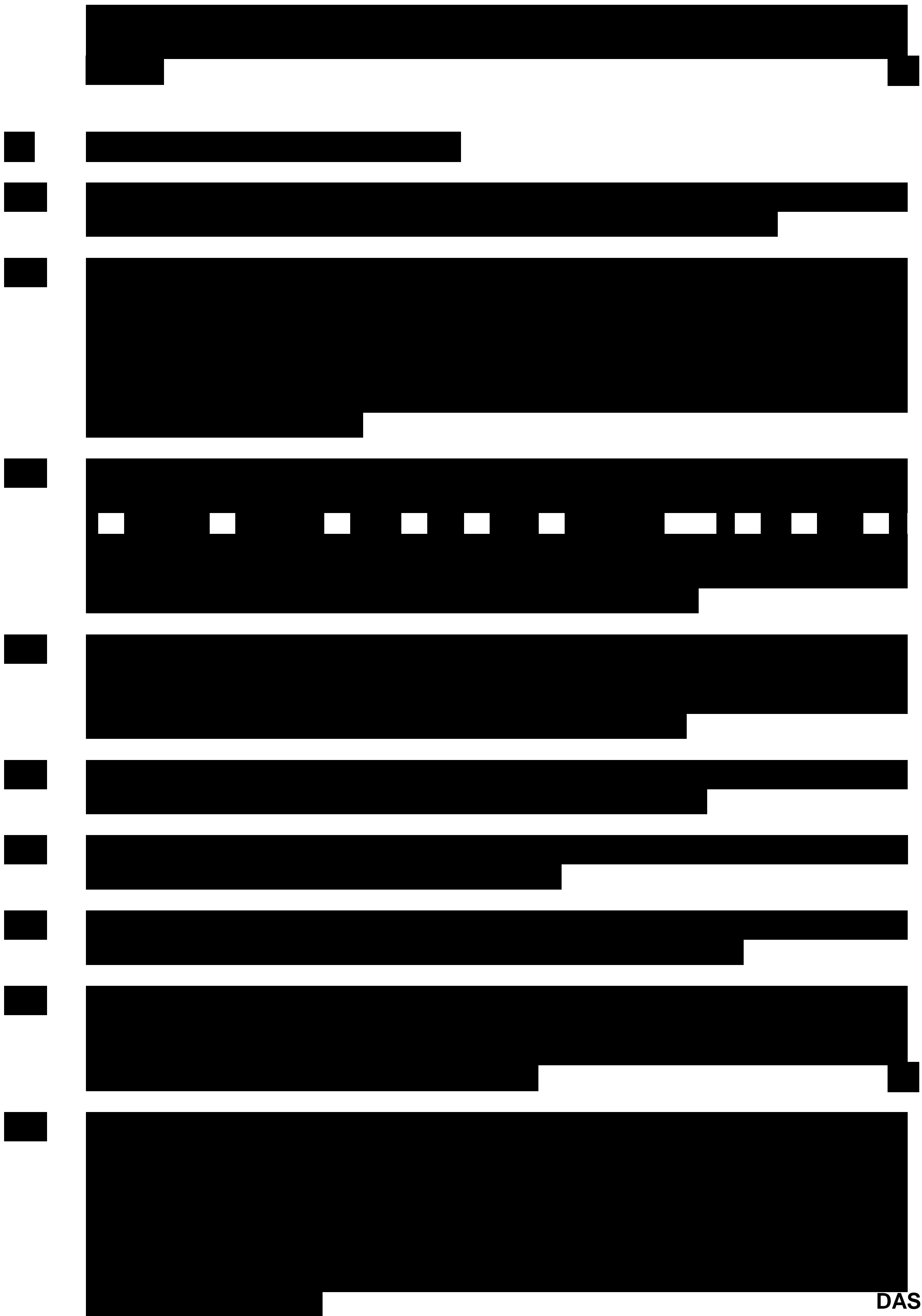

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53. Date of Next Meeting

53.1 It was noted that the next meeting of the Finance & Resources Committee would be held on **Wednesday 21 January 2015 at 9.00am in Meeting Room 7, Waverley Gate, Edinburgh.**

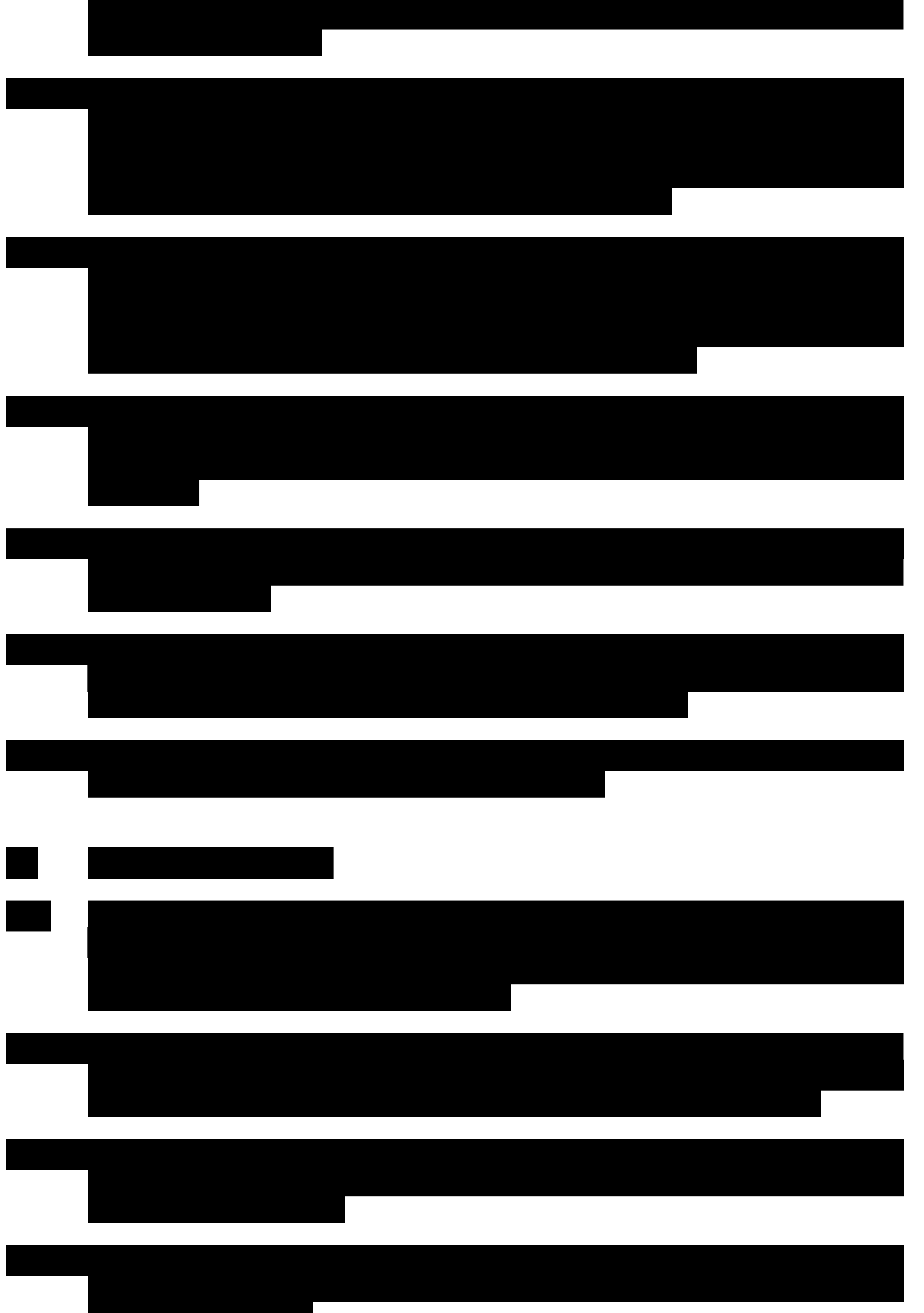
56. Matters Arising

56.1 Royal Hospital for Sick Children / Department of Clinical Neurosciences Programme to Financial Close – Mrs Goldsmith introduced a previously circulated report giving an update on progress towards financial close for the Royal Hospital for Sick Children and Department of Clinical Neurosciences development at Little France.

56.1.2 The Committee noted that following a meeting with the Board Chairman and the preferred Bidder, IHFL, there was only one outstanding issue around the final agreement between the Contractors which was still under discussion in respect of an inflation claim under the terms under the preferred Bidder appointment by the design and build contractor. If this could be resolved it was anticipated that financial close could be achieved within the following two weeks. Any agreed payment would be a one-off capital cost leading to a slight increase in revenue payments.

56.1.3 Mr Brettell sought confirmation on the delegation to approve the final terms of the non-profit distribution project agreement and associated documentation and Mrs Goldsmith confirmed that the circulated paper contained all the requisite details.

56.1.4 After discussion the Finance & Resources Committee agreed to adopt the entire wording laid out in Appendix 1 to this minute, in advance of financial close, which was required as a formal minute of the Committee with authority to complete the financial close of the project delegated to the Chief Executive or the Director of Finance.



SG

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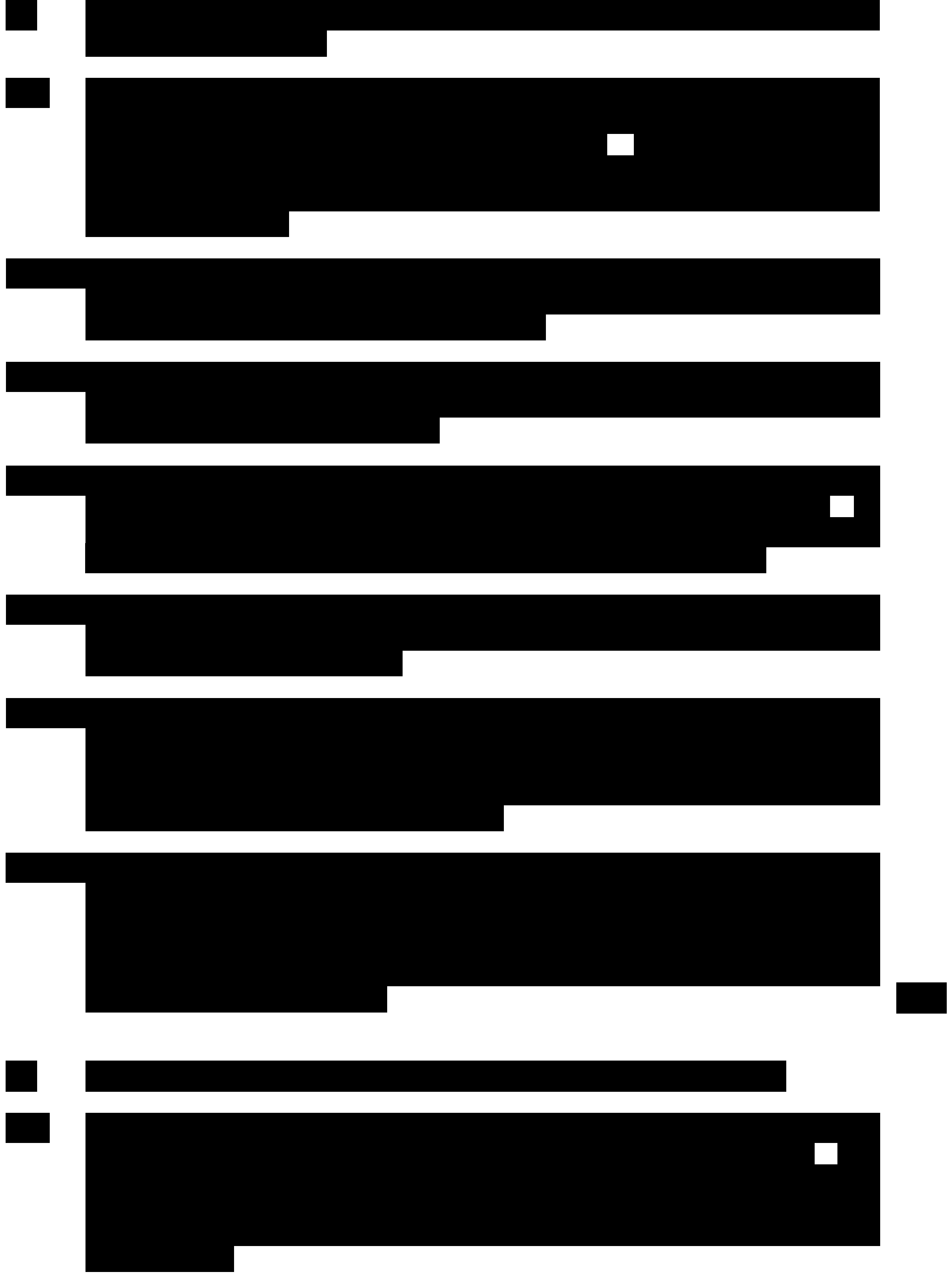
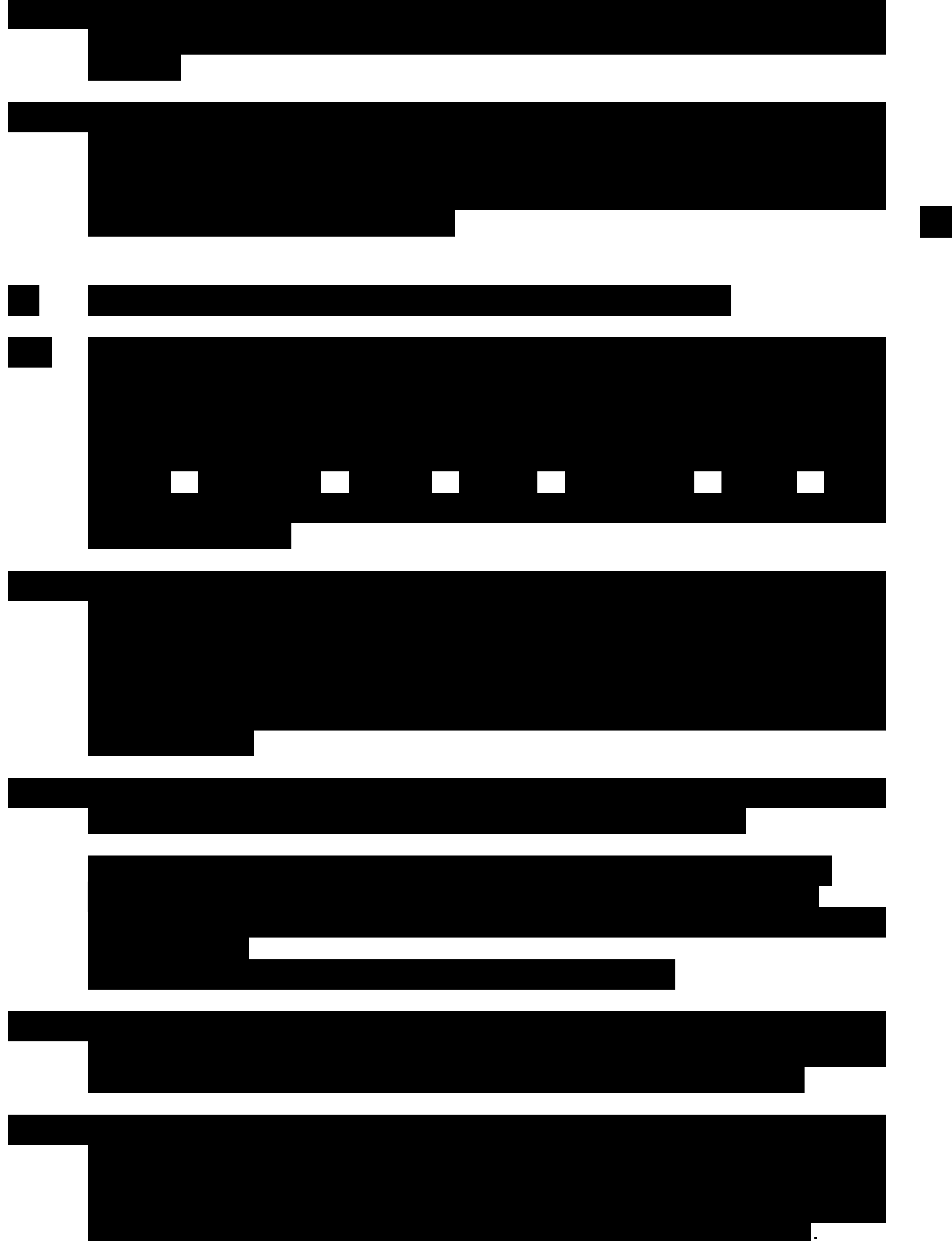
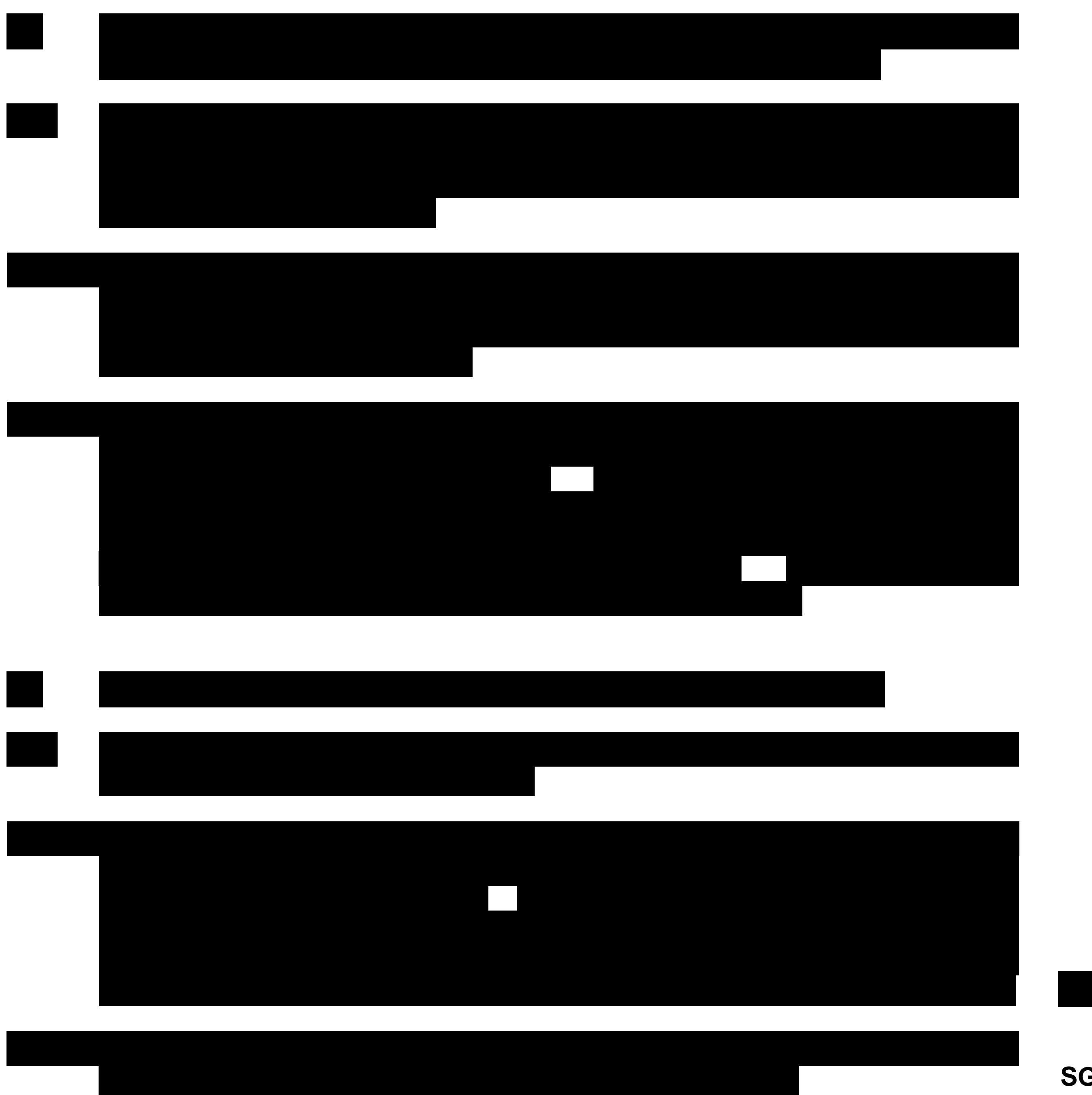
62. Disposal of Royal Hospital for Sick Children and Associated Properties

62.1 Mr Graham introduced a previously circulated report seeking Committee approval to declare the Royal Hospital for Sick Children at Sciences, Edinburgh; 10 Chalmers Crescent; Teviot House and 25 Hatton Place surplus to Lothian Health Board's requirements.

62.1.4 The Committee agreed to approve that the Royal Hospital for Sick Children, 10 Chalmers Crescent; Teviot House and 25 Hatton Place be declared surplus to Lothian Health Board's current requirements immediately upon achieving financial close on the reprovision project for the Royal Hospital for Sick Children and Department of Clinical Neurosciences.







SG

68. Date of Next Meeting

68.1 It was noted that the next meeting of the Finance & Resources Committee would be held on Wednesday 11 March 2015 at 9:00 a.m. in Meeting Room 7, Waverley Gate, Edinburgh.

Re-provision of RHSC and DCN at Little France

ACTION NOTES

Meeting Title: **PROJECT STEERING BOARD**

Date/Time: **Friday 20 June 2014, 13.00-15.00**

Location: **MacKinlay Room, 56 Canaan Lane**

Attendees:

Susan Goldsmith	Director of Finance + Project Sponsor – NHSL (Chair)
Robert Wilson	Non Executive Director – NHSL
Peter Reekie	Director, Finance and Structures – SFT
Brian Currie	Project Director – NHSL
Iain Graham	Director of Capital Planning and Projects – NHSL
Fiona Mitchell	General Manager – Women + Childhood Services - NHSL
Eddie Doyle	Associate Divisional Medical Director – Women, Children and DCN Management Services - NHSL
Janice MacKenzie	Project Clinical Director – NHSL
Tracy Miller	Partnership Representative
Moira Pringle	Head of Strategic Financial Management – NHSL
Margaret di Mascio	Commissioning Manager – NHSL
Sorrel Cosens	Project Manager – NHSL
Carol Harris	Head of Communications – NHSL

Apologies:

George Walker	Non Executive Director – NHSL
Mike Baxter	Deputy Director (Capital + Facilities) – SGHD
Jackie Sansbury	Head of Commissioning – NHSL
Jacquie Campbell	General Manager – Head and Neck
David Farquharson	Medical Director – NHSL
Chris Bowring	Director of Finance – NHS Fife; SEAT representative

1.	**Introductions and apologies**	
	Apologies listed above.	
2.	**Previous Action Notes from 30 May 2014**	
	The notes were approved as an accurate record. BC reported that Jacquie Campbell, General Manager, has agreed to the four medical staff interested in the DCN Clinical Lead post for the project being offered a session each to progress aspects of the project. The theatres and critical care Commissioning Manager post has been advertised as a secondment – no response to date. Paper-lite hospitals paper has been postponed due to conflicting priorities for eHealth, but will hopefully be ready for August.	
3.	**Executive Summary**	
	BC spoke to the circulated summary. <u>Programme</u> The team are over half way through the preferred bidder programme to financial close. BC reported on progress and pressure areas: - Design development with user groups: the second of three rounds completed. Four complex departments will go to a fourth round, and the team are doing	

everything possible to get all design signed off by 31 July. - Drafted interface proposals will be shared with Consort on 27/06/14, later than anticipated. - Technical schedules (Project Co proposals) development is behind programme but now well underway - There has been extensive payment mechanism discussion with Macquarie, Bouygues and lenders technical advisers, to be shared with SFT next week. IHSL are protecting funder, SPV and FM interests in poor performance – NHSL continues to be robust on the tendered position. Discussions need to conclude for funding competition to proceed. BC will report to the July Steering Board on progress and impact on planned financial close at 2 October.	BC
Enabling works Consort anticipate that the emergency department link will be wind and watertight at financial close, although further internal work will be carried out by Consort to complete the package and external access will still be required. All road works could potentially be complete in January 2015. BC confirmed that step 5 of phase 3b of the works would be complete in July, 2014 allowing full and unfettered access to the site for IHSL post Financial Close. BC reported that he had attended a positive meeting with Jim Crombie and Melanie Johnson on managing enabling and clinical enabling works and their impact at the RIE, identifying accountable officers in services there. BC re iterated his concern in relation to the volume and complexity of construction activity at the RIE particularly in 2015 when both MRI + Endoscopy and additional Assessment Beds projects will run in parallel with this project's clinical enabling works and commencement of the main facility build programme.	
Charity contributions The Edinburgh and Lothians Health Foundation have announced £2m for 'added value' projects and the SKFF Trustees meet on 23/06/14 to consider grant applications for further funding. JMacK will report on progress with charitable funds and projects in July. IG reported that the CLO were drafting agreements for charities making donations to / occupying the building to formalise relationships and commitment. Following discussion at the May 2014 meeting, the Project Team are preparing the brief for the retail unit, to be shared with potential charity operators.	JMacK
Flood protection The updated off-site flood protection cost estimate were shared and discussed. As BC has previously explained to the Project Steering Board (meeting of 25th April, 2014), this is a legacy issue from the building of the RIE that the project team now must address as a planning condition. The obligation is on NHSL to provide flood prevention to current statutory standards for hospital infrastructure. RW highlighted that Board members will ask why this legacy issue was not previously identified or known. It was agreed that this should be included in the paper to Finance and Resources Committee (F&RC) and the Board accompanying the FBC. The cost increase is due to a number of factors: more complicated engineering requirements (involving alterations to the existing bridge), later programme dates and hence upturn in tender inflation and increased fees all incurred in response to considerable scrutiny and challenge by local residents and elected representatives, and inclusion of VAT (previously excluded). MP reported that MB has confirmed	BC/SG

SGHSCD will fund these costs, up to a cap. MP is taking advice on the VAT position. BC noted that there had been negative press coverage of the on-site flood piling works, led by local residents and councillors, although Consort are doing this in as considerate a way as possible. The Project Team are working with Communications to respond to the stories and smooth the process; this is likely to continue. BC confirmed that variations to the on-site flood works are required and the value of these is not yet known. This will be managed and reported back to the Steering Board if they exceed the previously agreed costs.	MP BC
<u>Change management</u> The design process is logging any requested changes to the final tender design. IHSL and NHSL then agree whether these can be classified as design development or should be treated as a change. BC hopes that the genuine changes will be small in number and value, to be confirmed after completion of design at the end of July. SG asked PR how the cost of change would be managed in light of SGHSCD funding. PR acknowledged that change would always be a factor at this stage in a project, and that the aim for all parties was to manage this within the cap. JMacK pointed out that the design development included deletions as well as additions to equipment and so the changes were not all an increase in costs. SG noted that the cap in the OBC funding letter (December 2012) was adjusted downwards at the pre-preferred bidder key stage review to reflect IHSL's final tender, and that further discussion on managing the costs would be required at the Steering Board. Requests for change and costs will be scrutinised by the project team and escalated to the Steering Board where guidance is required. SG asked for clarity around the change control process following financial close and BC confirmed that this is formalised in the Project Agreement. SG highlighted that the NHSL scheme of delegation and governance would have to be addressed for any changes to the NPD. This would include the Steering Board until the opening of the hospital in 2017, but increasingly the Clinical Management Teams and Corporate Management Group and the scheme of delegation needed to be developed.	BC/SG
<u>University</u> Professor J Seckl has written to the Chief Executive regarding various concerns about the Little France roadworks. The letter suggests that aspects of works are unsafe and do not cater for the University's needs as a higher education campus. This is strongly disputed by NHSL who can confirm that H+S professionals have been engaged in the planning and execution of the works as have representatives from the University and that local authority planning and highways departments have also approved the proposals implemented. This is managed through the Little France Campus Working Group, at which the University is represented. Any further enhancement of Campus infrastructure more in line with the University's needs has always been seen by NHSL as additional phases with additional funding requirements and has been communicated as such to University many times by the project team. SG will raise the concern with Professor J Iredale to gauge whether this is a concern of the wider University. A reply to Prof Seckl's letter is in preparation.	 SG BC/IG

4.	**Full Business Case**	
	SG reported that the SEAT Regional Planning Group had confirmed on 20/06/14 that all Boards would provide approval of their costs by 27/06/14 if they had not already done so. She noted that the RHSC and DCN was integral to ongoing SEAT discussions around the Little France site as a Trauma Centre, which JKS will attend.	
	MP reported that the increase in non-NPD capital costs since OBC had been discussed with MB, who confirmed on 19/06/14 that the SGHSCD would fund the increase up to a limit. The FBC is to be updated to reflect this agreement before submission to F&RC. NHSL and SGHSCD are to continue discussions re: capital.	MP/MB
	PR suggested the basis of equipment costs be included in the FBC.	MP
	ED noted new guidance on hours for doctors in training would have further workforce planning implications for medical and other clinical staff. JKS will address this with the team responsible for workforce planning, which includes SEAT representatives.	JKS
	PR suggested the FBC articulate the current service pressure, bed modelling process and outcome in more detail. This and other minor comments on the FBC to be reviewed and addressed by SC.	SC
	The Steering Board approved the recommendation that the FBC, with the changes above, be submitted to F&RC and the Board in Private session. SG will discuss the Board meeting with GW, and the proposal that the FBC Executive Summary is taken for the consent agenda.	SG
5.	**Business Case for critical care and renal/transplant HDU**	
	MdM presented the business case for these clinical enabling works, which summarises the costs known at this stage.	
	PR asked why this FBC was being progressed before tender costs were known. SG noted the level of certainty required to underpin the RHSC and DCN FBC and financial close. BC also drew attention to the critical path to complete these works before RHSC and DCN come on site in 2017.	
	MdiM highlighted the challenge of managing the scope and expectations of users, when this work presented a one-off opportunity to make other changes in critical care. The Steering Board felt that it was sensible to do other works at the same time if this did not compromise the critical timescales or the costs attributable to this project. MdiM confirmed that she had developed a log of developments and requested that Consort provide their latest physical condition survey of Wards 115 to 118, to assess the works that are due to be undertake by Consort in 2015-2017. .	
	TM noted that the project could learn from the experience of the project undertaking the stroke works in medicine of the elderly at RIE. FM highlighted similarities with the neonatal unit work also taking place in the critical care infrastructure. The project team will contact these services about lessons to be learned.	MdM
	NHSL has secured derogation from 100% single rooms and will provide 50% in the new renal and transplant unit. Critical Care will be reconfigured in existing clinical areas, there is no opportunity to increase the single room rate.	
	The revenue costs for the critical care and renal/transplant unit are undergoing scrutiny to the same degree as workforce plans in the RHSC and DCN, including the SEAT group.	

	SG noted that this updated internal estimate of costs suggests that the clinical enabling around critical care is viable at a price close to that available. MP confirmed that the prices presented are 2014 costs and will be updated to apply inflation. IG noted that although the works have not been contracted with Consort yet, NHSL's position with regard to securing agreement is far more stable than previously, with competitive tendering to manage costs and less risk of funder support delaying decisions. SG asked that the Steering Board note the progress with this business case and recommended that the covering paper to F&RC for the RHSC and DCN FBC describe this position in relation to clinical enabling works. The Steering Board agreed to this.	MP BC/MP
6.	**Strategic Delivery Programme**	
	BC spoke to the draft programme describing the interdependent workstreams and projects. This is being developed to include detail of - RHSC and DCN workstreams to be delivered by the project team, e.g service redesign, clinical enabling, decommissioning - other projects to be delivered by the project team and Estates + Facilities, e.g. RIE additional beds, MRI/endoscopy - projects to be delivered by other teams in NHSL that the service model is dependent on, e.g. paper-light hospitals and off-site catering. The Steering Board agreed that this, once developed, would be a very useful overview of the context for the project. SG asked that detail of commissioning and double-running was incorporated into the next version. Related to decommissioning and disposals, the Steering Board was informed that opportunities for the preservation of two items of historical / artistic value are being explored – the Phoebe Traquair murals in the RHSC, and the Norman Dott theatres in DCN. IG noted the engagement of SFT in the disposal of the RHSC site. NHSL are to confirm that ELHF support the proposal that endowment properties at Sciennes are to be included in the whole-site disposal for the Sciennes site.	BC/JKS IG
7.	**AOB**	
	MdM requested clarity about when the Pharmacy clinical enabling business case should come to PSB. This will be discussed at the Capital Management Group	SG
8.	**DATE & TIME OF NEXT MEETING**	
	Friday 18 July 2014, 1300 – 1500, Project Offices, 56 Canaan Lane	

MINUTES OF THE CAPITAL INVESTMENT GROUP (CIG) HELD ON TUESDAY 26 AUGUST AT 9:30AM, CONFERENCE ROOMS A AND B ST ANDREW'S HOUSE

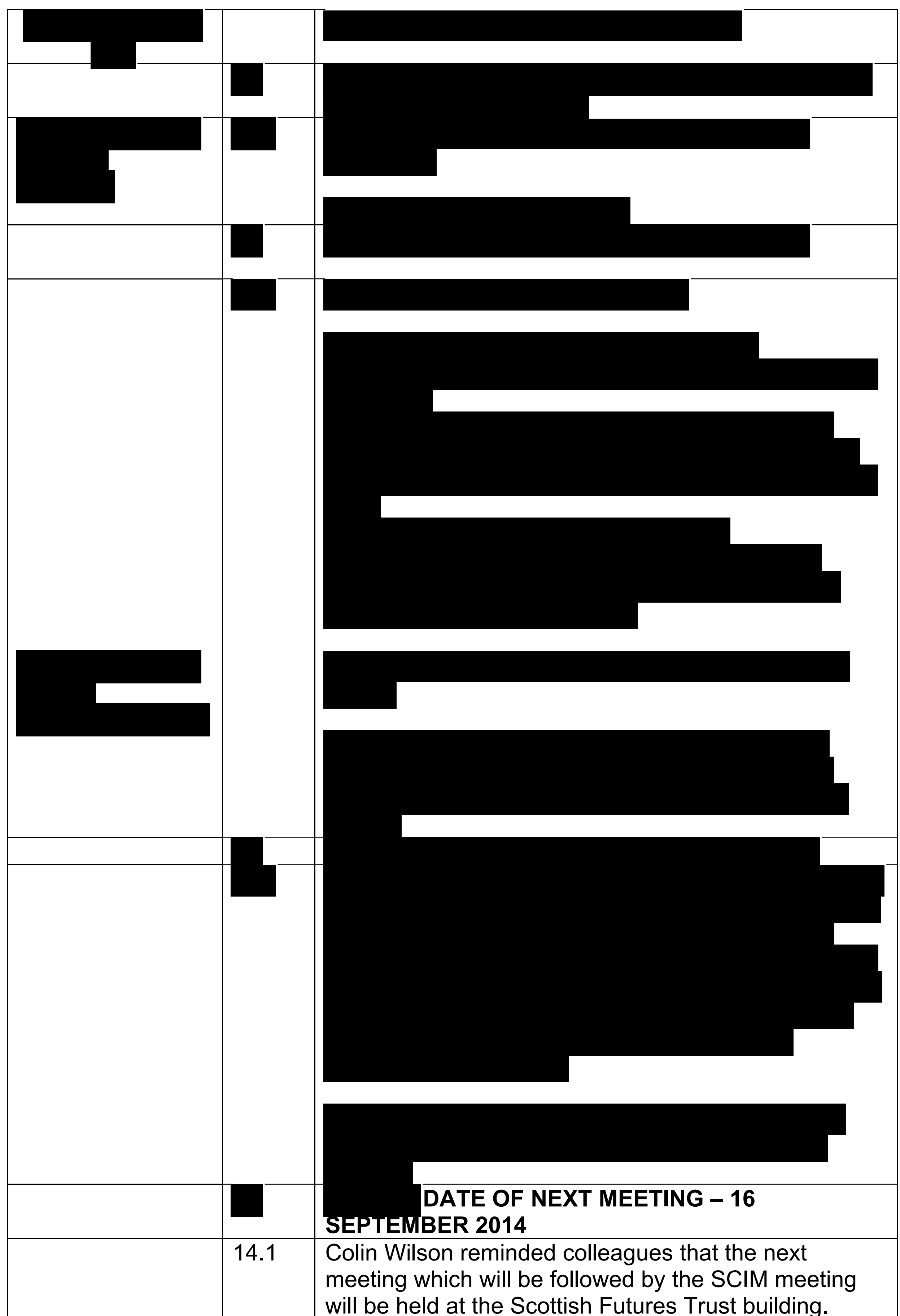
Present: Steven Hanlon
Yvonne Summers
Colin Proctor
Christine McGregor
Lea Mann
Tracy Barschtschyk
Carmel Sheriff
Colin Wilson

Apologies: Mike Baxter
Gillian McCallum
Chris Dodds
Marjorie Marshall

	1.	**APOLOGIES**
	1.1	The Chair, Steven Hanlon (in Mike Baxter's absence) introduced the meeting and apologies were noted.
	2.	**MINUTES FROM THE LAST MEETING – 5 AUGUST 2014**
	2.1	The minutes of the 5 August were taken as an accurate record of the meeting.
	3.	**ACTION POINTS**
	3.1	4.1 – Colleagues noted that the Business Case Timetable had been greatly improved and thanked Colin Wilson for his work on it. It was agreed that colleagues would provide any further comments as they arose to allow the timetable to evolve with the needs of the group. Steven Hanlon provided an update on the status of cases considered at the last meeting:

	4.	
	5.	See item 4 above
	6.	See item 4 above
	7.	**NHS LOTHIAN – ROYAL HOSPITAL FOR SICK CHILDREN & DCN – FULL BUSINESS CASE – PAPER 36/14**
	7.1	Not approved at this meeting due to a number of outstanding comments. Steven Hanlon highlighted the increase in the non-NPD costs compared to the OBC. NHS Lothian had

		been informed that Scottish Government would fund these costs to the FBC level but would not guarantee funding beyond this. Details of the project indicate that there will be initially unutilised space within the paediatric / bio-chemistry units.
ACTION POINT – STEVEN HANLON		*The Group agreed to write to the Board and ask for supporting justification for the shelled areas and timescales for bringing it into service.* Any justification from the Board regarding the unutilised space must be specific about the assumptions that underlie any future plans ie about population projections/future demand/service expansion etc? Formal approval of this project to follow once queries had been resolved.
	8.	



		DATE OF NEXT MEETING – 16 SEPTEMBER 2014
	14.1	Colin Wilson reminded colleagues that the next meeting which will be followed by the SCIM meeting will be held at the Scottish Futures Trust building.

Project title	Royal Hospital of Sick Children
Subject	Ventilation Meeting Minutes – Internal Workshop with HFS + HPS
Location	NHSL Project Office, Clinical Mangement Suite, RHCYP, Edinburgh
Date and time of meeting	04/09/2019 11:30
Recorded by:	RS
Circulation:	Via Email

Attendees

Name	Initials	Company/organisation
Graeme Greer	GG	Mott MacDonald
Brian Currie	BC	National Health Service Lothian (NHSL)
Ross Southwell	RS	Mott MacDonald
Donald Inverarity	DI	Consultant Microbiologist and Infection Control Lead
Lindsay Guthrie	LG	Doctor (NHSL)
Ronnie Henderson	RH	Infection Control Lead Nurse(NHSL)
Janice Mackenzie	JM	National Health Service Lothian (NHSL)
Tracey Gillies	TG	National Health Service Lothian (NHSL)
Sorrel Cosens	SC	National Health Service Lothian (NHSL)
Lisa Ritchie	LR	National Health Service Lothian (NHSL)
Eddie McLaughlin	EM	Health Protection Scotland (HPS)
Ian Storrar	IS	Health Facilities Scotland (HFS)
George Curley	GC	Health Facilities Scotland (HFS)
Jerry Slann	JS	National Health Service Lothain (NHSL)
		Institute of Occupational Medicine (IOM) (By phone)

Apologies

Name	Initials	Company/organisation

Item	Text	Action
1.	**<u>Introduction</u>** TG gave introductions and asked for names around the table, and thanked everyone for attending in such short notice. TG outlined the brief agenda with the goal of focussing on the following main items: - Suite of priority ventilation items, and what progress are we making. - Checking with HFS HPS reports and progress. - Second report from IOM about the general ventilation. TG stated that she believes that there is not yet on a unified position on who is doing what by when, and therefore a clear understanding of the outstanding items. At the same time each main item has varying levels of engagement with IHSL and the contractor (MPX). Underlining that if these are not completed, we will be in the position where we are less confident on how we are progressing. TG added that we need to understand each party's position. If we have the situation where there are any differences, we should identify these now to sort these out. TG mentioned that items which won't be talked about in great detail are Critical Care and Haematology/Oncology as the plans for these are known.	

Critical Care - We understand what we need to understand around critical care. A high value board change has been issued. IS asked what progress had been made. BC stated the Board have issued a standard contract board change. NHSL are meeting IHSL this afternoon to sort out a programme of delivery. The Board High Value Change process has set timelines in the contract progress, but we are trying to shorten these.

Haematology/Oncology – TG stated that we do not need to discuss at this meeting. This was a well known issue. 12 rooms did not meet the standards for neutropaenic patients. The position we have come to is, use the opportunity of the delay, while the building is not open, to progress these rooms.

BC stated it is important to note if the Haematology/Oncology works impact on a DCN move. TG stated before we agree DCN moving requirements, are there any impacts with the planned H/O of critical care in the first instance. Actual timing of the DCN move depends on the AHU being fit for purpose. GG said we should draft the board change. JM confirmed this has been started already. To be picked up after the meeting.

TG identified that it would be helpful in the discussion to attempt to describe for each item :

- what's the problem,
- what's the method of resolution, and
- provide info when item would be completed.

2. **7 Priority Areas**

TG had noted that from her evaluation of the items of concern, the following were key issues which needed to be rectified before the facility can be opened. These were:

- Theatre corridor extract.
- Extract flex duct
- Position of scrub area extract grille
- Isolation backup arrangement – one relates to 5 isolation rooms running off one AHU
- Cabling in AHU
- Motors running over 95% capacity
- AHU pressure controls.

Number of other items with the AHUs where there are multiple issues. BC stated that half a dozen issues that encompass one of these items. TG stated that this is a priority. IOM confirmed at this time the AHUs are non-compliant.

BC noted that at a meeting last Friday, MPX via IHSL will issue an update on AHU's by the end of this week. One of the AHU's will be benchmarked and then a review will be carried out. If all goes well, a programme will be provided with remedials for the other 36 AHUs, beginning with the DCN related AHUs.

TG suggested to go over each issue and to describe what is being done. and address the risk that there is not a shared understanding.

TG has formulated the key items from another source of information. These were the main issues.

1. Issues related to cabling within the AHU.
2. Air tightness and leakage
3. Where they are position within the building
4. Situation of the lights
5. Cleaning of the louvre
6. Filter and grille fit
7. Cable routing
8. Fire dampers

9. Position of the external doors

EM did state that the intake louvres are also included part of AHU issues. BC said that there are other issues HFS have provided separately. TG was going to make this extensive and all issues listed.

TG suggested that we confirm to IHSL/MPX is our understanding of compliance for each item, this is what we are expecting, and this is how we will measure it.

AHU Issues – looked through the Q-nis response excel document.
Please refer to the Q-nis response to the AHU related items (AHU Issues - Qnis Response Email issued 23rd August 2019)

Item 29 – Cabling inside AHU also cable connectors inside AHU
RH stated that this issue has the underlying potential for air to bypass the filters, fire risk and restricts access to the components. RH stated the SHTM clause issued to IHSL/MPX related to materials capable of supporting combustion.
Proposal about trunking: TG's understanding was that one proposal was that cables would be shielded off. GC stated trunking would be provided that it should be contained and sealed.
TG asked what would not be acceptable for HFS colleagues. TG asked if it is a no-go to have cabling inside the AHU. IS agreed and stated Its not practical to seal the trunking consistently. When maintenance is required, there is a risk of contamination.

GC agreed and stated that it reduces the capability to easily maintain the AHU and that a space factor would apply to the trunking installed increasing it's size (18th edition of the IET wiring regulations). RH stated that these are control cables primarily and may not be affected, however still agrees on all issues. JS agrees and recommended that these should be outside the unit.

Additionally, JS stated that the cabling in there can support combustion potentially but what might happen is that there may be fume, smoke, smell which will end up in clinical area causing distress and concern for the surgical team. IOM agrees with HFS and NHS Lothian and recommended that these should be outside the unit.

Item 30 – Filter pleat orientation incorrect on top row of final filters
BC stated this is being actioned by BYES. RH stated this will be included in the activities relating to the AHU.

EM made a point that contractor competence was discussed/raised earlier. EM requested this information but didn't receive adequate response. NHSL/HFS await response from IHSL
TG said this was an action under management and assurance and separate for today. EG asked if HFS are suggesting no actions should be undertaken until this is solved. EM stated No.

Item 31 – Pre filters showing signs of bypass
RH stated that there are gaps allowing air to pass the pre filters. RH added that Q-nis have stated that there is an element of bypass that is allowed. IS believed, from site visits that the current bypass gap is too great. JS stated its absolutely imperative that the minimum or no bypass occurs on the secondary filters and very little on the primary (pre filters). If not, JS stated that there would be a potential propagation of dirt into the AHU. DI stated that this is a compounded risk with other issues. TG question is where do connecting issues fit. DI stated that there should be an appreciation that there is a relationship between these issues as bypass will also be dependent on how wiring is mitigated within the AHU units. RH stated that this may be resolved from inspection and testing of the filters. IS suggested that a smoke test could be done. TG stated we might add additional checks with the model unit. BC says we need to explicitly state how we do these checks. IS/RH to come up with wording to this effect. LG did suggest we could use a format similar to the action plan. Duty is on MPX to demonstrate

	compliance **Item 32 – Magnehelic gauges not marked for clean and dirty limits** To be closed. **Item 40 – Plant labelling incorrect and shows incorrect areas served.** To be closed once RH has checked labels have been provided on site. IS requested that the As-built drawings match the labels. **Item 57 – Inverters** MPX proposal will include that inverters are to be removed from the airstream. **Item 58 – Dampers** Expected to be done in the AHU benchmark unit next week and reviewed. **Item 63 – Thermal wheels** RH stated that Paul (IOM) has provided a report to NHSL for review. IOM recommended that heat exchangers were preferential and not thermal wheels in the critical care/theatres area. GC stated that what we require is that the thermal wheels comply with 8-12 RPM. DI stated that if the thermal wheel exceeds tolerances, what is between that air and a patient? RH stated 1 no. F7 filter (final filter, additional HEPA filters added to critical care areas). DI said he was uncomfortable with this. RH stated that thermal wheels can be turned off to minimise this risk. EM stated that there should be a response to this from IHSL before a long term solution is found. BC stated that in the short term, we could turn them off. DI stated that there would be a selective addressing of which AHU are serving vulnerable patients. There is a wider question to be addressed related to energy saving and if we want thermal wheels to be inside certain AHU's on a risk basis. **Item 64 – Inlet section** Expected to be done in the AHU benchmark unit next week and reviewed. As a general note in the meeting TG stated that we should get a list of what we expect to see in the AHUs. When we review, who is looking at it, how will we confirm it. After this is done, to clarify how this will be addressed in all other AHU. TG asked the members how we will review the units.. Normal evidence is the validation process. TG asked if IS want IOM to come and validate every AHU. IS stated that IOM should validate from NHSL and H&V from MPX. RH stated that NHSL only have to independently validate critical care/theatres and are not required to do all general areas. *Post-meeting note:* Issues raised from the meeting which had not been previous identified are as follows: - GC raised concerns over motors inside the airstream - IS stated that there were issues of general pipe leakage It was agreed by all members that these issues were to be picked up and discussed in the next meeting.	**NHSL** **NHSL** **All**
3.	**<u>HFS Reviews – their priority issues</u>** IS and EM gave a high-level summary of issues that they had noted. These were as follows, - Poorly fitted bypass filters - Penetrations allowing bypass - Thermal wheel speed and control - General AHU Cleanliness - Access to inspection hatches and doors. - Glass traps were noted as dirty.	

	- Light switches at an unsuitable height for access RH stated that MPX are aware of these issues. These are picked up in the Tuesday/Friday meetings and ventilation issues log.	
4.	**Ventilation Issues Log - Review** Before going through the issues log, EM stated angle of the ductwork (External louvres to the intakes - Transitions pieces) being non-compliant. JS did say this has been highlighted. JS to speak to Paul Jameson and IOM to provide a response. TG says to review it, get it on the list and get MPX response.	**IOM**
	Item 3 - Very limited extract in theatre corridors RH stated that MPX are progressing at this time and notified that pen sketches have been provided for review.	**NHSL**
	Item 11 - It is understood that extract grilles in DU are supplied one from each theatre. IOM has provided advice and RH is progressing with MPX.	**NHSL**
	Item 13 - Issues on some theatre light stems, covers missing, not well fitted and cabling exposed BC stated that it was soon to be closed after completion of works by NHSL sub contractor.	
	Item 18 - Excessive flexible ductwork in theatre ceilings HFS asked about the fire rating clarification and that it is the responsibility on MPX to confirm. HFS is content what we have progressed this adequately and all issues have been dealt with.	
	TG stated that a statement should be made along the lines of 'where the Board have indicated any areas of non-compliance, MPX have rectified these. We have requested MPX to undertake a survey and they have declined. The Board will act on any other instance if witnessed. We have other mitigations in place on temp/humidity, for that reason item to be closed at this time.	**NHSL**
	Item 22 - Scrub Extract Grilles RH stated that there is a lack of clarity when comparing installation here with sample layouts in SHTM. The current installation does not fit into any of those samples identified in the SHTM. RH outlined that if the scrub room is adjacent to the operating theatres, it will have its own extract requirements. However, if the scrub is a bay within the operating theatres, the extract grille is to achieve the ACH requirements of the theatre. It was confirmed that the current scrub room bay is open to the theatre. HFS - EM stated that this is a show stopper. Demonstrate that it does what it's supposed to do. Either high level extract 25 ACH or low-level extract as per guidance. No evidence at this time. EM stated that water droplets tend to evaporate more at high level. EM says there needs to be a reasonable approach. If they provide 25ACH for the entire room, then this could be suitable. TG asked if this would be completed? JM did say this will impact DCN. TG confirmed that this should be requested for by next week. EM stated that the remedial actions would be minimal.	**NHSL**
	Item 23 - Anaesthetic Room grilles EM stated it's a clear air path solution and not a dilution solution. EM stated that this is a showstopper. NHSL to ask IHSL to demonstrate by the 13th September that this complies.	**NHSL**
	Item 25 - Several isolation rooms on one AHU EM stated that this would be adequate if successfully demonstrated. However, the users need to be aware of the installation and operational management put in place.	
	Item 27 - Back up arrangements appear to be very complex and as such	

likely to be challenging in future
HFS stated that this was a showstopper.
TG said that this is separated into 2 issues. These being.

- what we need to demonstrate to HFS. IS commented that the contract response times should be a note of concern and reviewed. **NHSL**
- Consequences of one unit not working. (Clinical action) – JM/DI has already started this and are progressing.

In addition, HFS commented;: **NHSL**

- No gas tight dampers in isolation rooms. RH stated that they are in the loop above the lobby. IS didn't believe this was the case. RH to review the report/check lobby.
- Concern about the use of the fire dampers of the duct isolation. Primarily in relation to dual purpose.

IS stated that this is another element for IHSL to prove. RH thinks they are having difficulty achieving this. Potentially a show stopper issue. This needs to be done by demonstration by IHSL. EM/RH work together on pinning down what we need and in what order - in writing. **HFS / NHSL**

Item 28 - Only achieving 3-4 ach/hr vs required 10
Not raised in the meeting

Item 39 - Motorised dampers take a long time to open and close which impacts on the speed of auto-changeover
IOM asked if there was a time delay on the dampers closed. RH said that this is regarding the time between the changeover from duty to standby motor.

IOM

Item 41 - Branch ducts not generally marked up to show areas served
NHSL could not find SHTM compliance clause. IOM to support.

Item 42 - Auto change over arrangements need to be fully tested. Some MD's do not close on plant isolation
Expected to be done in the AHU benchmark unit next week and reviewed.

Item 43 - Some motors running at over 95% speed so there is limited scope for system to overcome dirty filter pressure drop and maintain system performance
RH stated this issue has been reopened. NHSL have asked MPX to provide a report comparing measured values to the maximum designed values. RH thinks this report will be provided by next week.

Item 50 - AHU Pressure Controls **IOM**
RH stated that NHSL has issued pressure trend log to IOM. IOM stated that a suitable evaluation could not be confirmed as pressure does not fully correlate to airflow. IOM to continue review of information.

Item 52 - Plant control temperature Control
RH stated that we are awaiting logs from MPX. We want them by the 13th sept if the valve repairs are carried out.

IOM

Item 53 - Angio procedures room
It does have indicator, but we think it gives all the controls required by the reference. IOM to check compliance information and respond.

IOM

Item 54 - Air change rates below requirement (15ac/h)
RH stated that this will have to be rechecked and awaiting IOM results.

Item 60/61 - Cleaning
IS stated that the plant room has been fouled. HFS picked up in report relating to doors. RH confirmed that this is BYES issue and has been raised on the helpdesk.

	Item 62 - Internals of some units not clean. RH confirmed that this has been passed to BYES. **Item 63 Thermal Wheels (location of thermal wheel)** TG asked what standards this applies to. JS stated this an observation and a question rather than a non-compliance. IS stated that it is not a showstopper. TG asked for 2/3 lines of narrative and if there are any mitigating actions. Note that closed items should be cut to a separate sheet, and narrative added to explain why the item has been closed.	**NHSL**
5.	**<u>IOM Non-Critical areas Report</u>** LG stated 2 issues that she is concerned with. 1. IOM is measuring from the design spec from the environmental matrix. But not clear where the ACH came from and there appears to be discrepancies between rooms with the same functional requirements. LG stated they need to get a better understanding on clinical side and how this relates to ventilation. There is a bit more work to be done to try to articulate what needs to be done. Example - Emergency department information review outlined that there were different values for resus 1 and resus 2 which did not match the design specification. LG stated that she was trying to understand 15ACH and 5ACH from one to another. Need to check so we know what we are delivering. 2. 1.2 correction factor that can be applied but concerned that some areas, the performance that is required, may not be suitable enough. RH stated that this report was from a point in time. MPX are progressing with fixing the issues to get back up to design/commissioning standards. IOM will recheck these once they have been completed. TG commented that we may need to review the Environmental matrix in another way to identify the requirements. RH stated that there is a spreadsheet. GG confirmed that this spreadsheet outlines room types and their associated SHTM/HPN requirements, designed and installed values.	
6.	**<u>AOCB</u>** TG asked HFS regarding Table A1 in SHTM 03-01. What is the parallel guidance for those not identified within this table? IS noted that building regulations and CIBSE, were the appropriate guidance, however he will review and check. Post meeting note – GG queried SHTM 03-01 clause 2.60 and the cross reference to ADB sheets for specific requirements for individual spaces, and whether that should be read in conjunction with building regulations and CIBSE. *Post meeting note:* RH to review all known items from various reviews/audits and collate for ease of review. DI asked JS when we received the theatre reports, noting theatre 32 was not issued at the time. DI asked for the progress. JS to chase.	**HFS** **NHSL** **IOM**
7.	**<u>Date of Next Meeting</u>** Thursday 12th September 2019 @ 12:30 Warlow	

SCOTTISH CAPITAL INVESTMENT MANUAL

Supporting Guidance:

Design Assessment in the Business Case Process

A42675936

DESIGN ASSESSMENT IN THE BUSINESS CASE PROCESS

Introduction

From the 1st July 2010 an assessment of design quality will become part of the business case approval process. This guidance should be viewed as part of the Scottish Capital Investment Manual (SCIM) notified through NHS CEL 19 (2009).

This guidance describes:

- how design standards should be established for projects,
- the Board's role in assessing progress in achieving design standards ,
- the design assessment process,
- submission requirements at each business case stage.

The Scottish Government Health Directorates' purpose in developing and implementing this process is to ensure that the outcomes of development projects meet the Government's objectives and expectations for public investment. Mapping design into the business case is intended to improve the level of design quality achieved across NHSScotland and the outcomes realised through this. The process described aims to promote a culture of continuous improvement by facilitating learning from, and projects that build upon, the best of what has gone before.

Although the full process described below, and the requirement to refer projects to the NHSScotland Design Assessment Process, applies only to projects that are to be considered by Capital Investment Group (CIG), it is intended and expected that Boards will develop 'design statements' and utilise the self assessment methodologies described below on all development projects.

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SECTION 1 - DESIGN ASSESSMENT IN THE BUSINESS CASE PROCESS

There are two complimentary areas of consideration in the design of healthcare buildings. These can broadly be described as healthcare specific design aspects – the areas generally covered by guidance issued by Health Facilities Scotland - and general good practice in design considering the human experience of being in and around buildings, sustainability and the effective and efficient use of resources directed towards achieving whole life value for money. These are brought together in this process, and in the collaboration of HFS and A+DS in the NHSScotland Design Assessment Process, by the means described below.

1.1 Compliance with Healthcare Design Guidance

A Policy on Design Quality for NHSScotland requires that:

"*The SGHD must provide guidance on compliance with those aspects of statutory and mandatory requirements which are particular to the procurement, design and delivery of healthcare buildings and guidance on best practice. This will be effected through the support to be provided by Health Facilities Scotland and Architecture and Design Scotland under the tripartite working partnership with SGHD*."

Accordingly projects submitted to the Capital Investment Group (CIG) for business case approval will be assessed for compliance with current published guidance. To facilitate this, Boards will be requested to submit a comprehensive list of the guidance that they consider to be applicable to the development under consideration (see inset on next page), together with a schedule of derogations that are required for reasons specific to the project's particular circumstances.

Projects submitted for the business case process will be assessed for compliance with the following:

a) Healthcare guidance:

Scottish Health Planning Notes (SHPN)	Health Facilities Scotland
Scottish Health Technical Memoranda (SHTM)	Health Facilities Scotland
Scottish Health Facilities Notes	Health Facilities Scotland
Health Building Notes (HBN)	Dept of Health Estates and Facilities Division
Health Technical Memoranda (HTM)	Dept of Health Estates and Facilities Division
Health Facilities Notes (HFN)	Dept of Health Estates and Facilities Division

Where there is a current SHPN or SHTM relating to a subject then it takes precedence over the equivalent HBN or HTM. Where there is no Scottish version of a document the English document can be used. For further information on the available documents refer to the Scottish Health Planning Guidance: Reference Guide. Scottish guidance can be obtained in the publications section of the HFS web site and English guidance can be obtained by searching the gov.uk/dh website.

Best practice dementia and equality design guidance

b) Statutory requirements
Planning permission
Building Regulations compliance
Disability Discrimination Act compliance
Construction (Design and Management) Regulations compliance

c) Other mandatory requirements
BREEAM Healthcare (BRE Environmental & Sustainability Standard) www.breeam.org
Achieving Excellence Design Evaluation Tool (AEDET):
http://webarchive.nationalarchives.gov.uk/20081022142331/http://design.dh.gov.uk/content/connections/aedet_evolution.asp
Activity Data Base (ADB): www.gov.uk/government/publications/activity-database-2012-software-release

The NHSScotland Design Assessment Process will then make an assessment of the design information available each business case stage for compliance with the guidance. Details of the submission requirements for each stage are included in Appendix A and, the pro-forma* for submission are included in Appendix B. *(*although this is a protected document the proforma has editable regions)*

1.2 Design Statements and their role in assessment of design standards

Purpose of the Design Statement

The development of a Design Statement is intended to assist NHSScotland Boards in using good design to get the most out of their development projects. **These project specific Design Statements should both link into and inform the further development of the Boards Design Action Plan which sets the strategy for all the Board's developments.** The Design Statement is a means of setting out the Board's objectives for an individual project in a series of agreed statements of intent and then defining a benchmark for how the physical result of the project will help deliver those objectives. The benchmarks should not require a pre-determined design outcome, but provide the parameters for what success might look like. The third part of the Design Statement is a plan of action for how the objectives and benchmarks

established for the project will inform key decisions throughout the project including the development and consideration of the business case, and the eventual evaluation of the project's success.

Guidance on the form and content of a 'Design Statement' is included at Appendix C, some help in developing the 'non negotiable is included in Appendix D. Example Design Statements are included at Appendix E as a illustration of the anticipated scope and content of the developed document.

It is proposed that the Design Statement should be the first design control document produced for the project which can, and ideally should, also be used as:

- **a briefing tool**: to describe the design intention, or design vision (perhaps being included in the HLIP), and subsequently be developed into the design brief, supplemented by more detailed briefing materials such as schedules of accommodation, key adjacencies and room data sheets as and when prepared. This area of briefing has been identified as frequently underdeveloped and therefore the introduction of Design Statements is intended to address this.
- **a communication tool**: to communicate the direction of the project to stakeholders and allow some early view of the benefits to assist both in building momentum, obtaining buy-in and in allaying the concerns that often accompany the commissioning of a new facility.
- **a promotional tool**: to stimulate interest in the market in the direction and viability of the project; and to motivate the market to bring its best and most appropriate skills to the table.

The Design Statement in Business Case Approvals Process

The Design Statement, which is to be produced by the Boards for each project prior to the submission of the Initial Agreement (IA), is central to the consideration of design matters within the business case approvals process as it is this document that establishes the design criteria against which the project will be assessed.

The benchmarks set by the Board will also be assessed to ensure that they are in line with the expectations established in national policy. Three Example Design Statements (for different scales and natures of project) are included in Appendix E as guidance on the form and nature of Statements that are expected and to guide boards on the level of benchmarks that will be considered acceptable.

Project teams are advised to discuss, with the NDAP, the draft version of the Design Statement in development where it is likely to differ significantly from one of the example statements, or one approved previously. Assistance may be available from A+DS to help the team develop the statement.

1.3 Referral to the NHSScotland Design Assessment Process

Health Facilities Scotland (HFS) and Architecture and Design Scotland (A+DS) will provide support to Boards in considering design matters in the business case process. Staff from HFS and A+DS, supported as necessary by a broader panel, will have the following roles in relation to all projects that are to be assessed:

- to advise the project team if the standard of benchmarks and self assessment process being established for the project are in line with policy objectives.
- to provide an assessment of the design aspects of the project to support the Board in their consideration of the business case.
- to provide a verification, to the Capital Investment Process (CIG), of the opinion previously given to the Board to support the CIG's consideration of the business case.

The purpose of this resource is to provide support on matters relating to design policy, functionality and healthcare design guidance. The assessment considers the general areas of design being addressed by the project team as a high level verification for the Board and the CIG, as such it should not be seen as a replacement for the project team's in-depth consideration of technical and other standards. Further, the assessment does not provide assurance of the acceptability of the proposals to the Planning or Building Control Authorities. However the opinion given will inform any comment made by A+DS in the planning process (as part of A+DS's Design Review function in the Planning System) and may be used by project teams as evidence of consultation and, where appropriate, in support of their applications.

Referral to NHSScotland Design Assessment Process

Section 2 describes the assessment process and Appendix A gives the submission requirements at each stage of the business case.

Submissions should be made to:

NHSScotland Design Assessment Process
c/o Director, Health Facilities Scotland
3rd Floor, Meridian Court
5 Cadogan Street, Glasgow G2 6QE
Tel: 0141 207 1600 Fax: 0141 221 5122
nss.hfsdesignassessment@nhs.net

It is recognised that different projects and different Boards will require different lead in periods from the point of consultation to the submission to the Capital Investment Group (see CIG timetable on www.pcpd.scot.nhs.uk/Capital/CIG.html). Therefore In order to provide the above services in a timely manner project teams are advised to establish an early dialogue with HFS and keep them informed of the project programme and key dates. Teams are also encouraged to maintain the dialogue, particularly at key design development points, rather than waiting always until the formal reporting points in the business case, to ensure that risks can be identified and addressed timeously.

Support and advice is available from HFS and A+DS staff, contact in the first instance should be with:

Susan Grant, Principal Architect
Property and Capital Planning
Health Facilities Scotland
NHS National Services Scotland
3rd Floor, Meridian Court
5 Cadogan Street
Glasgow G2 6QE
susan.grant7@nhs.net

For support and advice on the development of Design Statements see www.healthierplaces.org and contact A+DS directly:

Healthcare Design Team
Architecture and Design Scotland
Bakehouse Close
146 Canongate
Edinburgh EH8 8DD
T: 0131 556 6699 F: 0131 556 6633
health@ads.org.uk

1.4 Transitional Arrangements

This guidance shall apply to all projects submitted for approval of the Initial Agreement (IA) after 1st July 2010. Projects that have not received approval of their Outline Business Case (OBC) by 1st July 2010 shall be considered for the assessment process on a case by case basis, as part of the initial pilot phase, however the development and demonstrated application of a Design Statement should be considered as good practice for all projects from publication of this guidance.

SECTION 2 - NHSSCOTLAND DESIGN ASSESSMENT PROCESS

General Principles

The NHSScotland Design Assessment Process, for all projects submitted to the Capital Investment Group, sits in an advisory role to decision makers in both the commissioning Board and in the Capital Investment Group within the Scottish Government Health Directorates. The service is provided to Health Boards at no cost to the board.

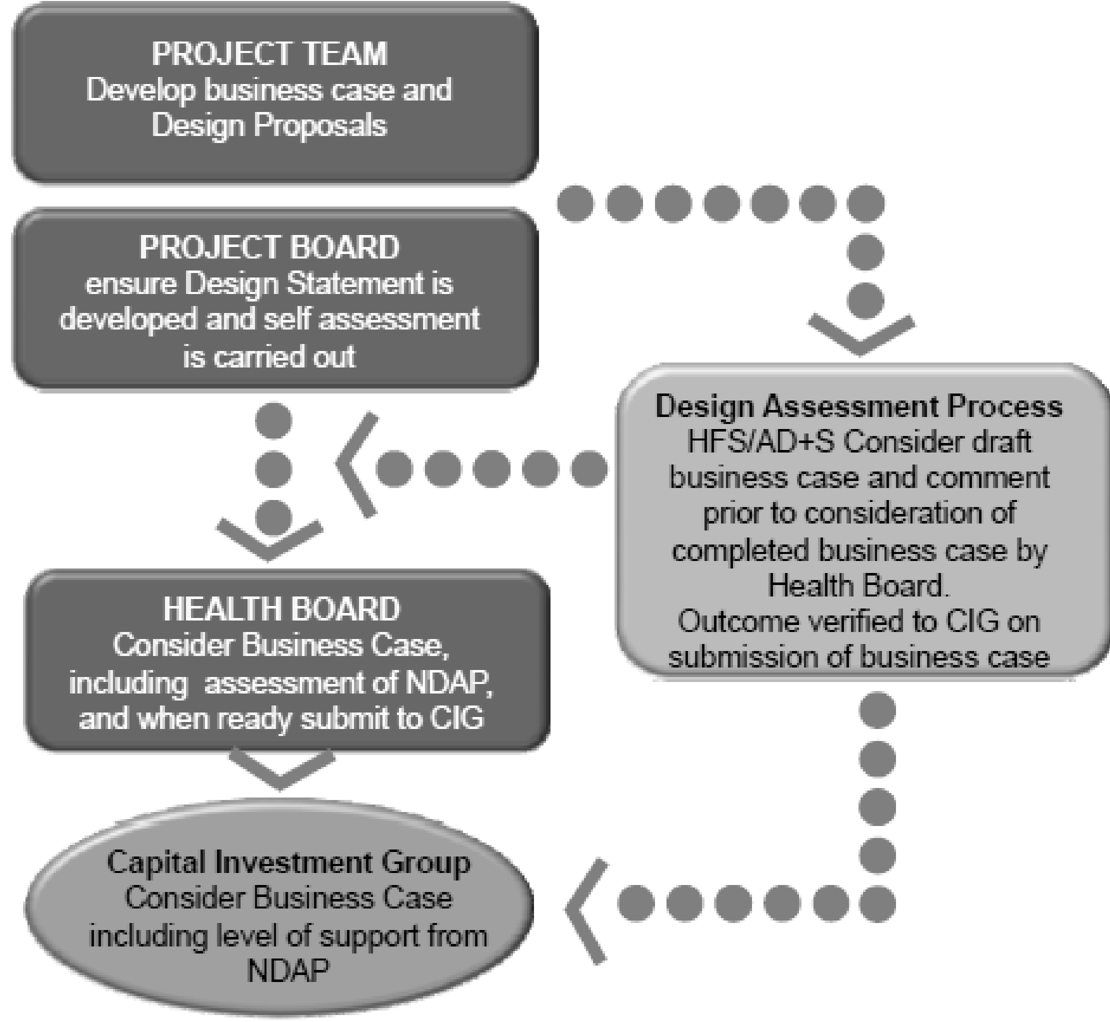

Fig. 1 : Flow diagram showing position of NHSScotland Design Assessment Process consideration in the Business Case Approvals Process ; this diagram applies to IA, OBC and FBC stages.

Types of Assessment and Timescales

There are two methods of assessment in order to provide a response at formal reporting points.

- Desktop assessment by staff at HFS and A+DS based on submitted information, supplemented by conversations with project team to clarify any matters.
- Panel assessment, based on submitted information and supplemented by presentation by, and discussion with, the project team including designers.

All schemes at IA will be viewed as a desktop assessment. Some schemes at OBC and/or FBC stage will be taken to a larger panel. If this is anticipated it will be notified to the Board in the response to the IA or OBC submitted previously. Teams are encouraged to maintain a dialogue between these reporting points to ensure that risks can be identified and addressed timeously.

Notification Period : the notice given by the Board to HFS that a scheme is to be submitted to the NDAP to allow resources to be allocated to allow timeous turn-around.

- desktop assessment: 14 days .
- panel assessment: 28 days. Information must be submitted one week in advance of the panel assessment to allow the panel to digest and prepare.

Period of consideration (from receipt of information to issue of response to Board) **:** This is dependent on the scale of group required to consider the proposals.

- desktop assessment: 14 days unless extended discussions become necessary.
- panel assessment: 21 days from receipt of draft information = circa 14 days from panel discussion.

NB: Faster turn-around may be possible by prior consultation, and a verbal response will be provided at any panel meeting to allow work to progress whilst the paperwork is being done.

Boards should ensure that the consultation is sought in a timeous manner to allow the response to be considered within the board's development of the business case; prior to completion of the business case stage and the subsequent submission to the CIG.
(See CIG timetable www.pcpd.scot.nhs.uk/Capital/CIG.html).

Notification and Submission Process

Notification
Notification using the form included at Appendix B should be sent by e-mail to:

nss.hfsdesignassessment@nhs.net

Submission
The completed submission proforma (see appendix B) and 2 electronic copies (on CDs) of the stage specific information (see appendix A) should be submitted to:

NHSScotland Design Assessment Process
c/o Director, Health Facilities Scotland
3rd Floor, Meridian Court
5 Cadogan Street, Glasgow G2 6QE
Tel: 0141 207 1600 Fax: 0141 221 5122

Response by NHSScotland Design Assessment Process to the Board

The outcome of the assessment will be encapsulated in a brief report to cover the following areas:

Joint Statement of Support (one of following options):

- **Supported :** this may include recommendations as follows:
    - **Essential Recommendations:** those areas requiring amendment or alteration in order to meet either national guidance or established benchmarks but which, in the opinion of the panel, can be amended without significant re-working. The Board will be required to submit agreed evidence to the panel before the 'supported' statement will be verified to the CIG.
    - **Advisory Recommendations:** areas of potential for further improvement for the boards consideration, including notes on aspects which (though not falling short of standards set in the design statement) are potential risks in relation to the development planning process .
    - **Notes of potential to deliver good practice:** where the panel sees that the project is demonstrating the potential to deliver best practice in a particular area of design this will be noted.

- **Unsupported :** this will include a statement of the areas of concern that leads the panel to consider that the project is likely to fall seriously short of either the benchmarks set by the Board, the standards established for healthcare buildings, or the expectations established in national policy (i.e. if the benchmarks established by the board do not address significant areas of policy or are low). Such areas of concern are considered, by the panel, to require significant reworking or reconsideration and are therefore unable to be resolved using the 'essential recommendations' above.

Next Stage Process : the notification required for the next assessment stage and the methodology of assessment that will be applied which will vary depending on the scale and complexity of the project.

Where a project is 'unsupported' it is anticipated that a further dialogue will be established to promote improvement in the areas identified. An amended submission, addressing these areas, would allow the report to be updated and the support status amended prior to progressing the project further through the business case process and prior to any verification to CIG.

Interaction with Capital Investment Process Considerations

HFS will notify the CIG when the process is completed and verify, to the CIG, the recommendation given to the Board. The submission sent, by the Board, to the Capital Investment Process (CIG) should include the information sent previously to the NHSScotland Design Assessment Process (NDAP) and the response received.

In considering the business case the CIG will take the NDAP's response into consideration as follows:

- Supported with no qualifications : CIG can approve.
- Supported with Essential or Advisory Recommendations : Evidence of how the identified issue is being addressed will be required prior to CIG approval.
- Supported with notes of potential to deliver good practice : CIG can approve
- Unsupported : CIG will not approve.

Post Occupancy Evaluations submitted to the CIG should be copied to HFS to inform the assessment process. For projects that have been developed with the use of a 'design statement' the evaluation at POE should include an assessment against the benchmarks in the Design Statement.

Publication of Key Project Information

SGHD requires Boards to publish the outcome of Business Cases within one month of the CIG meeting. After the business case is in the public realm; key information submitted to the Design Assessment Process will be added to the NHSScotland Project Resource (Pulse) on the Healthier Places website www.healthierplaces.org .

The published information will include key project details, selected images and design documents such as the design statement. This is to aid briefing, shared learning between boards and to raise the profile of NHSScotland's developing estate. See Page 20 for further details on the web-based resource.

APPENDIX A - NDAP SUBMISSION REQUIREMENTS

Below are the anticipated submission requirements at the key reporting points. However, teams are encouraged to maintain a dialogue with HFS and A+DS staff through key decision points in the development of the emerging project to ensure that risks can be identified and addressed timeously.

INITIAL AGREEMENT

STAGE : Late in the IA process when a building project appears to be a serious possibility.

Methodology : Desktop assessment based on submitted information, supplemented by conversations with project team to clarify any matters.

Submission requirements

- Completed submission proforma identifying key contacts and dates.
- Design Statement in line with the enclosed guidance, and a note of the persons (name and role) involved in the development of the statement – i.e. those stakeholders represented in the development of both the agreed non-negotiables and the benchmarks.[1]
- Commitment to BREEAM Healthcare

OUTLINE BUSINESS CASE

STAGE : Early in the OBC process an informal consultation on site selection and strategic briefing considering:

- Site Feasibility Studies or Masterplan. Where a project is one of a series being considered for a site, a masterplan will be required to demonstrate the potential interaction of projects.
- analysis of site option(s) in terms of potential for achieving the project's non-negotiables criteria and benchmarks established in the design statement and the inherent design risks (i.e. where the site presents difficulties in achieving the benchmarked standards).
- List of relevant design guidance to be followed – SHPNs, SHTMs, SHFNs, HBNs, HTMs, HFNs, Activity Data Base (see section 1.1).
- Evidence that Activity Data Base (ADB) will be fully utilised during the preparation of the brief and throughout the design and commissioning process

STAGE : Late in the development of the OBC, when the design is becoming formed but is still open to influence – consultation and response to use in Business Case Stage.

[1] Project teams are advised to discuss, with the NDAP, the draft version of the Design Statement in development if it is likely to differ significantly from one of the examples or from one developed and approved previously. Some assistance may be available from A+DS in developing these statements.

Methodology : One of the following – as advised in the response to IA submission.

- Desktop assessment based on submitted information, supplemented by conversations with project team to clarify any matters.
- Panel assessment, based on submitted information and supplemented by presentation by, and discussion with, project team including designers.

Submission requirements

For all projects

- Completed submission proforma identifying key contacts and dates.
- Design Statement , with any updates in benchmarks highlighted.
- Evidence of completion of self assessment on design in line with the procedures set out in the design statement.
- Completed AEDET review at current stage of design development.
- Evidence of consultation with Local Authority Planning Department on their approach to site development and alignment with Local Development Plan.
- Extract from draft OBC detailing benefits and risks analysis (appendix 3 in SCIM).
- Photographs of site showing broader context.
- BREEAM assessment.
- Evidence that DDA compliance will be achieved
- Evidence that Activity Data Base (ADB) is being fully utilised during the preparation of the brief and throughout the design and commissioning process
- Updated list of relevant design guidance to be followed (see section 1.1) and schedule of any derogations in relation to these.

For capital investment schemes and projects likely to go through hub, the following information

- Developed brief.
- Outline design study showing site strategies considered and favoured development option (approaching RIBA Stage C design). Building plans should be rendered to distinguish between main use types (circulation, consult, etc) so that orientation and aspect of areas can be considered.
- 3D sketches of design intent for key spaces identified in Design Statement.

For NPD schemes, the following information

- Developed Conventionally Procured Asset Model in line with guidance.

FULL BUSINESS CASE

STAGE : Late in the development of the FBC, when the design is becoming formed but is still open to influence.

Methodology : One of the following – as advised in the NHSScotland Design Assessment Process's response to the OBC submission:

- Desktop assessment based on submitted information, supplemented by conversations with project team to clarify any matters.
- Panel assessment, based on submitted information and supplemented by presentation by, and discussion with, project team including designers.

Submission requirements

For all projects

- Completed submission pro-forma identifying key contacts and dates.
- Design Statement , with any updates in benchmarks highlighted.
- Evidence of completion of self assessment on design in line with the procedures set out in your design statement.
- Extract from draft FBC detailing benefits and risks analysis (appendix 3 in SCIM).
- Completed AEDET review at current stage of design development.
- 3D sketches of design proposals for key spaces identified in Design Statement.
- Updated list of relevant design guidance to be followed (see section 1.1) and schedule of any derogations in relation to these.
- Evidence that DDA compliance will be achieved
- Evidence that Activity Data Base (ADB) is being fully utilised during the preparation of the brief and throughout the design and commissioning process

For capital investment schemes and projects likely to go through hub, the following information is required to allow the panel to establish that the developed proposals are living up to the promise of the outline proposals at OBC stage and that the technical matters are being addressed.

- Developed design (Stage E) : main drawings only (construction details need not be submitted) including
  - Site layout showing wider context and landscape proposals
  - Plans rendered to distinguish between use types (circulation, consult)
  - Elevations showing design in context
- 3D visualisations of the building in context - perspectives should be constructed from a human eye height (rather than birds eye views).
- Confirmation of Planning Permission and Building Regulation compliance.

For NPD schemes, the following information.

- Design proposals from the Preferred bidder
- Site layout showing wider context and landscape proposals
- Plans rendered to distinguish between use types (circulation, consult)
- Elevations showing design in context
- 3D visualisations of the building in context - perspectives should be constructed from a human eye height (rather than birds eye views).
- Evidence of consultation with Local Authority Planning Department on their approach both to site development and the strategy adopted by the preferred bidder.

APPENDIX B – SUBMISSION PRO-FORMA

NHSSCOTLAND DESIGN ASSESSMENT PROCESS : NOTIFICATION & SUBMISSION PRO-FORMA

PROJECT NAME	
NHSScotland Board	
Other client partners (such as Local Authority)	
Business Case Stage	IA/OBC/FBC
Type of assessment anticipated*	Desktop / panel
Client Contact Person who can respond to queries during consideration period	Name Phone e-mail
Additional Contact Such as the lead designer or design manager (if applicable)	Name Phone e-mail
Procurement route (if known)	
Project Website (if available)	
Key dates	
• Target date for business case to be submitted to own Board	
• Target date for business case to be submitted to CIG	
• Date notification submitted to NDAP	
• anticipated/actual date Information submitted to NDAP	
• (if applicable) pre-agreed date for panel assessment	
• Date response needed from NDAP	
Any other relevant information	

Complete sections highlighted grey (as a minimum) at time of **notification** and send by e-mail to
nss.hfsdesignassessment@nhs.net

Complete all sections when to accompany **submission information** to:
NHSScotland Design Assessment Process, c/o The Director, Health Facilities Scotland
3rd Floor, Meridian Court, 5 Cadogan Street, Glasgow G2 6QE

* IAs will be desktop, thereafter as advised in previous response.

KEY INFORMATION SUBMITTED TO THE DESIGN ASSESSMENT PROCESS WILL, AFTER THE BUSINESS CASE IS MADE PUBLIC, BE USED IN THE NHSSCOTLAND PROJECT RESOURCE : www.healthierplaces.org

APPENDIX C - GUIDANCE ON THE DESIGN STATEMENT

The Design Statement sets out your approach to the project and how it will be delivered. The Design Statement should have three basic elements:

- **The Non-negotiables**[2]
- **The Benchmarks**
- **The Self Assessment Process**

Three example design statements are included at Appendix E.

DESIGN STATEMENT ELEMENTS – THE NON-NEGOTIABLES

As we use buildings, for the most part, to house and support human activity, the Design Statement is built around the needs of the people who the facility will directly impact upon and whole life value for money. It is then expanded to consider the elements needed to deliver on the broader responsibilities of using public money – that of addressing local and national needs – for the public purse to achieve **economies of benefit**[3].

Fig 2 People and Policy Areas for the 'Non-negotiables'

These are incorporated into the Design Statement by establishing, early in the project's development, **agreed** statements that give the core objectives of the project: **non-negotiables** that all key stakeholders can sign up to that derive from and articulate the Investment Objectives. These are the fundamental

[2] Equivalent to Critical Success Factors (SCIM)
[3] Economies of benefit is about getting the most benefit from the money that has to be spent. i.e. if a health and social work centre is to cost £9m, then how can we spend that £9m of public money to do more than build good consulting rooms and a nice waiting space by also to contributing to local regeneration and sustainable economic growth.

aspects that define the success of the scheme - the criteria which, if you cannot achieve them, will seriously call into doubt the viability of the project.

It is anticipated that the non-negotiables will be established and agreed by the Project Board to encapsulate a broad consensus - from a range of points of view, from strategic planners to those with a more intimate and ongoing relationship with the proposed facility - rather than be written by one person. Appendix D suggests a series of questions that might be helpful in debating the non-negotiables with key stakeholders. Once established, these non-negotiables encapsulate an agreed direction and as such can help resist incremental change in the brief due to external pressures or subjective opinions.

DESIGN STATEMENT ELEMENTS – THE BENCHMARKS

One of the strategies that could bring real change, but which the public sector generally under-utilises, is benchmarking developments. The private developer knows that it has to surpass its competitor to obtain market advantage. The advantage to the public sector is less clear as we have yet to fully use the lessons learnt through POE's to understand the impact of a good design on the people and policy factors described previously. However benchmarking against the best and most relevant that NHSScotland and its sister bodies have delivered, and in doing so learning from the work of others, is perhaps the single most helpful tool available to improve both the standard of care environment and the image of the NHS in the community.

Methods of benchmarking

There are three basic ways of benchmarking.

- **Number** - by giving a numerical minima or maxima
  ...the entrance space must be at least 100m^2 in area
- **Relative** - by describing how you want it to be different to something that already exists
  ...the entrance space should be much bigger than the one in the current facility...
- **Comparator** - by pointing to something you want it to be like
  ...the entrance space should be like the one provided elsewhere ...

Each of these has its benefits and pitfalls in terms of the extent of description and even prescription given to the designer and therefore this must be balanced in the methods and skills being employed to assess if this benchmark is being achieved. When setting a benchmark by using a comparator it is important to bear in mind that the purpose of choosing comparators is not to choose a predetermined design solution; it is to provide an example (or better still a range of examples) of 'what success might look like'.

The setting of benchmarks requires an understanding of what has gone before, and this is likely to require the project team to do some research and

carry out site visits to learn from what others have done. As an initial step into this there are a number of web resources that can be used for scoping and as a source of reference projects or criteria. The most likely to be relevant are:

Healthier Places - www.healthierplaces.org

This website has been commissioned by SGHD, HFS and A+DS to house information on good healthcare design to assist boards in brief development and to raise awareness of the good practice being developed and delivered across NHSScotland and elsewhere. In addition to providing guidance on the development of 'design statements', and articles on healthcare design topics, the website holds a project resource (called 'pulse') that can be used in two main ways:

- **Search by project type :** to find out about recent and current developments in NHSScotland, and elsewhere, that are of a similar type to the one being considered by the client team. This will provide basic details on the project, the key team members involved and images where available. Key design documents, such as the 'Design Statement' and Post Occupancy Evaluations will be included once they are in the public realm to allow greater learning from what has gone before. It is envisaged client teams will use this search primarily at the outset of a project to:

    - Establish similar works by colleagues in other boards
    - Facilitate contact to allow shared learning
    - Establish possible visit lists for the client team and key stakeholders to raise awareness and understanding.

- **Search by area :** to find photographs of different areas of the healthcare estate (such as entrance areas and consulting rooms) to raise awareness of what has been achieved elsewhere. It is envisaged client teams will use this search primarily to assist benchmarking within the Design Statement being developed for projects.

This resource will be maintained by A+DS using project information submitted to the NHSScotland Design Assessment Process (once the Business Case is in the public realm), case studies of completed developments, and supplemented by images submitted by users of the site. NHS Boards are encouraged to upload photographs taken during visits to inspirational developments (especially those outwith Scotland) to assist knowledge transfer between project teams.

Macmillan Quality Environment Mark
This self assessment toolkit establishes aims for cancer care environments and views of what success might look like. Though designed particularly with cancer patients in mind may of the objectives have a much wider applicability. Case studies of environments that have been awarded the mark may be added to the site over time.
http://www.macmillan.org.uk/Aboutus/Healthprofessionals/MQEM/MQEM.aspx

Over recent years, some well designed developments have been delivered in Scotland and elsewhere that are supporting care and improving community infrastructure in the areas they serve. The purpose of mapping design into the business case is to extend this higher level of design quality across NHSScotland, and to promote a culture of continuous improvement by facilitating learning from what has gone before. Boards are expected to seek out and choose examples of good practice in design against which to benchmark their projects, such as those given in the example statements attached.

Benchmarks can be refined, as the project develops and more information is understood, or if better benchmarks become available. It is anticipated that the benchmarks set at IA may be revisited in advance of the OBC and FBC to check that they are still the most relevant and useful means of checking that the project is achieving real value. The benchmarks should also be used in the Post Occupancy and Post Project Evaluation processes.

DESIGN STATEMENT ELEMENTS – THE SELF ASSESSMENT PROCESS

This section of the Design Statement should establish the key design milestones for the project; then for each milestone set out the methodology and authority of the assessment, and the information and skills needed to carry it out. There are three areas to cover, when, who and how:

When

The business case process is designed to seek approval at key financial milestones, however these do not always coincide with key design milestones. Therefore the client team must consider and set out the key milestones that are most appropriate to their particular project. These may move relative to each other and relative to the business case milestones, dependant on the procurement route chosen, but are likely to include the following key milestones:

- Site selection
- Completion of Brief (inc. Public Sector Comparator if relevant) or High Level Information Pack (HLIP)
- Selection of Delivery/Design Team
- Approval of early design concept (approx RIBA stage C) from options available
- Approval of design to submit to Planning.
- Approval of design and specification to allow construction.
- Post Project and Post Occupancy Evaluations.

Who

This is likely to be different depending on the milestone reached, the decision being made, and the risk associated with that decision.

The first thing to be decided therefore is the position of the particular assessment within the project governance - i.e. does the assessment sit within the project team (a matter that the project manager handles and reports to the project board on), or is the Project Board looking to undertake this function either itself or by seeking an opinion that is independent from the reporting being given by the project manager and forms part of the Project Board's assurance process.

Thereafter the skills set of the people, process or advisor assessing the options or proposals must be established. It is likely that specific design training and/or expertise would be of value in assessing the information being given and in differentiating between alternatives.

> *For example: A common issue in design team selection is that many people do not feel they have the competence or confidence to differentiate strongly between the ability of different designers to design. This can result in them assessing the 'quality' aspect of the scoring in terms of the clarity and coverage of the written information submitted - their essay writing skill – rather than their potential to design a facility of lasting value.*

How

Firstly, and most importantly, the decision making process for these key points must allow you to ascribe a value to the elements needed to achieve the benchmarks you have set yourself.

Secondly, you should set out how you will approach the assessment. This would include both the tools you might use (such as an AEDET or ASPECT workshop) and the information you will need to inform the decision: i.e. the shortlist of sites for selection are likely to require some level of design feasibility study to provide reliable information on whether the 'Non-negotiables' can be delivered on the site and the implications of doing so.

> *For example, a site that is ideal in terms of transport connections and immediate availability may be very close to a busy road and therefore building on that site will require significant investment in the building envelope (wall and window construction) to attenuate sound, and a more sophisticated building layout and section is likely to be needed to allow the use of natural ventilation to keep the development within the sustainability criteria. This knowledge may either prompt the choice of a different site, where all of these factors are more easily achieved, or if this site is still the preferred option will allow the proper planning and budgeting of a project on this site.*

The information required to make good and informed decisions at these key points needs to be allowed for in the programme and budget of the project and therefore the process of self assessment must be understood early in the project to allow the proper planning of this.

APPENDIX D - WORKSHOP THE 'NON-NEGOTIABLES'

The guidance document includes recommended headline areas (Fig. 2 people and policy) under which to consider and set the objectives of the project, but how these are used or interpreted will be specific to the aims of the project. To assist, the headline areas are expanded upon below by a series of questions and prompts, the responses to which should inform the development of project specific 'non-negotiables'[4].

PEOPLE

PATIENTS ...a welcoming, healing and reassuring place

Converting patient pathways into the patient experience, from leaving their home to returning home.

- Accessibility and approachability - Is this facility to be somewhere that is part of their experience of the community structure; a familiar place they go past when shopping, maybe even pop into for information or coffee, or somewhere that is likely to be a special trip for a significant purpose?
  Therefore how important is location in terms of prominence, links with public transport, parking space etc. Is it something that's an integral part of the built fabric of the community or a place apart from it? What should the initial impression be like? Can we say that drivers (other than those with a particular physical need or urgency) will not be given priority over those arriving by other means - that the facility will not face the world through a sea of car parking?
- Welcome and wayfinding - a place that doesn't stress you out just finding where you have to be.
  A single entrance space from which you can see all secondary reception points has been achieved in a number of primary and acute care buildings - is this a non-negotiable for your project?
- The overall ethos and appearance of the facility.
  A place that gives me confidence that I'll receive good care/treatment, and where I can retain some sense of myself rather than feel subsumed by the system - see also notes above on ethos.
- The patient environment - evidence based design links basic placemaking aspects such as views (positive distractions), control over your environment (noise, heat, ventilation and light etc), and a sense of privacy and human dignity to improved recovery. Can you pick a few key location types (reception/waiting areas, bedroom, and social space) and benchmark these?

- Will there be somewhere nearby I can escape to if there's an opportunity – a breath of fresh air on a difficult day.

[4] Once established these non-negotiables can be a useful tool both in developing the scope and authority of the project team's work, and in counteracting contrary pressures.

PATIENTS ...a place that supports life

- For a children's hospital - a play space I can get to from my bed – an external space I can get to every day if I want - a place my family or friends can be with me....
- For a dementia unit - a place that doesn't add to my confusion, that is reassuring and somehow familiar. A place I can still do some things for myself.
- For many wards - a place I can rest, where I can think, where I can talk in confidence or be comforted in private. A place to get away for a moment to feel I've still some choices and control.
- For outpatient facilities - a place that doesn't depress me / stress me to go to and where those that have to come with me (a carer / a driver / my children) can be kept occupied.

STAFF ...a place that supports the work

- What is the working model that is to be supported by the new/altered facility? Does it transpose current working practices or are new more integrated working methods to be used?
  Can this be embodied in any specifics such as only one reception point (as opposed to one for NHS, one for social work etc) or a commonality of room specification to allow space to be used as a resource rather than a territory?
- Is it a stand-alone facility, or are links to other services/departments/community facilities critical?
  This'll effect both the location and the facilities that'll be needed within the development.
- What do staff need to function effectively in terms of accessibility of the facility, functionality of working space and places to escape. Are there particular spaces you wish to benchmark?
  e.g. deciding early days that there's a particular theatre design that you wish to benchmark (perhaps open plan with windows) will inform very early design approaches to ensure a view that cannot be reciprocated.
- What is the ethos of the facility? What messages is it trying to convey and what behaviours are you looking to engender? The physical nature of the building (imposing or friendly) both embodies and influences the staff/patient relationship and the types, places and modes of communication.
- What level of efficiency are you looking for and how will you approach it? Does 'lean design' mean concentrating solely on staff walking distances (and potentially making the building deep plan and artificially lit/ventilated) or are you really looking at making the briefing and design work harder so that you get more than one benefit from any space (internal and external) that you build?
  eg - Designing areas that have more than one use such as combined circulation/waiting spaces with something such as an atrium that assists with daylighting and ventilation: or, placing accessible external spaces (which may be need as lightwells etc) where they can have

others uses such as formal and informal therapy, play space, additional waiting, respite and contribute to the biodiversity commitment?

- What are the additional benefits you're looking for from the development?
  Are you looking for it to help with staff retention or event to attract new staff - if so which facilities does it have to beat to attract the skilled employees you want?

STAFF ...a place that'll not constrain future work

- How serious are you about future flexibility?
  Will you require all consulting rooms to be the same, and a proportion of such rooms serviceable from more than one sub-reception to allow different users to occupy different areas as needs change? Will you require services to be routed such that walls can be removed/reconfigured more cheaply and the building refurbished on a floor by floor basis? What does flexibility mean in terms of your project?
- Is expansion space an absolute?

VISITORS ...a place to meet and discuss...a place that I can leave loved ones

- Do those accompanying, or visiting patients have a significant impact on the building function and the experience of patients?
  Will they take residents for a walk, or need space to meet and chat with in-patients? Will they be waiting for loved ones to come out of treatment, and need information and reassurance? Will they be there for extended periods and need a breath of fresh air whilst not feeling too out of touch?
- How important are play and even crèche facilities to allow patients to attend and keep accompanying children occupied?
- Are there complimentary facilities or services that'd help meet broader objectives of community perception or accessibility of services / encouraging healthy lifestyles? Are there any other visitors you'd wish to encourage by facilities such as drop-in information point?
  One of the community health facilities in Belfast has a cafe for use by those attending the GP, but it's so nice that it's popular with other locals and helps maintain the vibrancy and 'normality' of the place as it's a familiar part of the community structure rather than a place you go only when unwell.

POLICY

LOCAL NEEDS ... regeneration, community context and development

- **Local Board context**: how does this project link into the board's wider strategic asset management plan? Is it a piece in the onward development of a larger site and therefore must include elements that

deliver on broader site masterplanning and infrastructure elements or set a standard for future developments on the site? What additional benefits does the board want from the project in terms of public perception?

- **Community Context:** The project is undoubtedly a significant investment in the community it serves, how should that be used to support the community structure including local needs for healthier places, regeneration and sustainable growth in the community? e.g. The construction of a facility in a run-down area is a chance to develop local civic pride and a feeling of worth (thereby potentially increasing community ownership and reducing vandalism as well as setting a benchmark for future projects in the area) as opposed to developing something that is simply 'in keeping' with the current dilapidated nature.

- **Planning and Local Development:** In broad terms, the new Planning Act shifts the emphasis of planning to consider and plan "what goes where and why" and therefore local development plans should be supporting the identification and protection of community facilities, such as those for health. This, combined with Single Outcome Agreements, is a real opportunity to plan the location of facilities to support local development rather than in response to it.
  An agreed 'non-negotiable' objective that requires the facility to be placed in a location the supports local regeneration or a planned shift in population, on a project commissioned jointly with the local authority, is likely to be a very powerful tool.

- **Local Board context**: how does this project link into the board's wider strategies such as commitments under the Single Outcome Agreement or local initiatives on health promotion, carer support etc?
  How does the project fit into the board's strategic asset management plan? Is it a piece in the onward development of a larger site and therefore must include elements that deliver on broader site masterplanning and infrastructure elements or set a standard for future developments on the site?
  What additional benefits does the board want from the project in terms of public perception of the board?
  e.g. The location and approachability of the facility can increase or reduce the likelihood of people walking or cycling to the facility and even using it.

NATIONAL NEEDS ... NHSScotland Policies

- **Better Health Better Care** : how does the project support the shift in care patterns and embody the concept of mutuality.
- **Sustainability and Asset Management** : how the project will allow you to improve your reporting on these elements.
- **Design Quality** : This is unlikely to need a specific objective as it should be met in achieving the others.

NATIONAL NEEDS ... Broader Governmental Objectives

- **The 5 Strategic Outcomes and 45 National Indicators :** Health boards, as bodies spending the public purse, are expected to contribute across all of these outcomes.
- **National policies on placemaking and design** : the call for leadership by example in the public sector.

Scotland's Infrastructure Investment Plan 2008 establishes that good design is key to achieving best value from all public sector investment.

"In developing Scotland's infrastructure, the Scottish Government recognises that good building design should be responsive to its social, environmental and physical context. It should add value and reduce whole life costs. Good building design should be flexible, durable, easy to maintain, sustainable, attractive and healthy for users and the public; and it should provide functional efficient adaptable spaces ... Equally important to the design of individual buildings is the design of sustainable places. Well-designed buildings and places can revitalise neighbourhoods and cities; reduce crime, illness and truancy; and help public services perform better".

It is this approach - which is underpinned by national policies on Architecture and on Place Making - that will inform appraisal of all projects.

APPENDIX E - EXAMPLE DESIGN STATEMENTS

The following three example design statements have been worked up based on real NHSScotland projects.

They are included in this guidance both as an illustration of the likely form and content of such statements, but also as a demonstration of the standard of benchmark that is 'deemed to satisfy' policy. Projects submitted to the NDAP that set benchmarks below these standards will be unsupported by the Process.

As stated previously - it is expected that the design statements developed for each project will be the product of cross disciplinary working and represent the core objectives and benchmarks that have been agreed by a broad spectrum of stakeholders including those involved in strategic planning for the board and those with a more intimate link to the particular facility under consideration. A list of those persons involved in the development of the statement should be appended to the initial submission. The self assessment process may more readily be written by the project manager, but must be agreed by the project board.

- **Example Primary Care Design Statement**
- **Example Acute Care Design Statement**
- **Example in-patient Design Statement**

RHSC + DCN

Technical Risks to Close

25/08/14

Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.
Legal / Technical	Schedule Part 31 – Interface Proposals	Delay on programme	High	Interface Proposals issued to Consort 22nd August.	TBC	Board request IHSL progress known missing information, or information that the Board believe to be incorrect.
Technical	Project Co Proposals	Project Co proposals insufficiently developed to required level for FC	High	1. Comments fed back on the PCP structure. 2. Comments fed back on draft 1 of the PCP's. 3. PCP workshop held setting out the Board's expectations. 4. Individual workstreams setting out the Board's expectations.	TBC	Increase the length of the RDD list. Focus on specific design risks. Fast track the legal review
Technical	Project Co Proposals	Lack of review time for the PCP strategy documents	High		TBC	
Technical	Project Co Proposals	Lack of review time for the PCP drawings	High		TBC	
Commercial	Payment Mechanism	Current Position is such that there is a risk that the Funder will hold Board to "ransom" over threshold levels to be set an unrealistically high level as they are attempting to benchmark against large scale Acute facilities in the English market which are not directly comparable. MM and Sweetts are developing a paper to explain this in detail but it may only have a limited impact. Andrew Bruce is aware of the situation as well	High		TBC	
Design	Energy Centre Flue height	Project Co not achieving Planning - Apparently CEC Planning are not accepting the new increased flue height on aesthetic grounds and have communicated this to IHSL. Programme implications	High	Meetings ongoing. Mottmac to explore the viability of a circa 15m flue located where the current VIE is proposed i.e. > 37m from Main Building. Project Co need to have a technical solution available to satisfy this condition immediately on receipt of consent as their funders will have a view on this condition and the risk to FC.	TBC	
Project co risk	Building Warrant	Project Co not achieving Building Warrant on time	High	Meetings being held between Project Co and Board to mitigate risk. Project Co to issue proposed BW programme up to FC.	TBC	Meetings being held between Project Co and Board to mitigate risk. Project Co to issue proposed BW programme up to FC to Board.
Project Co risk	SER Certificate	Delay in achieving FC	High	Project Co yet to confirm SER Certifier to Board. RFI to be raised and issued to Project Co requesting confirmation. Board need to review SER Certifiers work prior to FC.	TBC	Project Co yet to confirm SER Certifier to Board. RFI to be raised and issued to Project Co requesting confirmation. Board need to review SER Certifiers work prior to FC.
Technical	Esso station	Contamination /	High	Esso Station Interpretative Report imminent.	TBC	

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Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.
Design	Acoustics	EFTE atria space (plant noise) – intimating a possible issue but not defined at present	High		TBC	
Design	Acoustics	Light weight roofs (rain noise) – potential derogation that has not been clarified, and IHSL are proposing a retrofit option	High		TBC	
Design	Acoustics	EFTE atria space – still no defined reverberation time and modelling has not yet been undertaken – this is not a direct derogation from the BCR's, but is Good Industry Practice.	High		TBC	
Design	Acoustics	Noise surveys – noise survey now undertaken however no consideration of the naturally ventilated areas, with background noise of between 50/ 60 db;	High		TBC	
Design	Acoustics	No external limit for building services plant – this may be planning issue;	High		TBC	
Technical	Combined Heat and Power Plant Sizing	There is concern about the sizing and arrangement of the CHP. IHSL have not provided detailed assessment to show that the use of one large CHP, without a thermal buffer, will actually provide the optimum operation for the Facilities. IHSL have previously stated that the size of the unit has been dictated by compliance with Building Regulations rather than providing an optimised design and this is of high concern, it may be the CHP operates much less than anticipated.	High	Mott MacDonald and the Board are continually requesting detailed analysis of the CHP sizing from IHSL as part of comments made on the Energy PCP and Energy Strategy CHP. We are awaiting detailed thermal simulation results and analysis from IHSL to mitigate concerns about the sizing and arrangement. Best practice design considerations would include 2 smaller units or incorporation of a buffer vessel, both of which IHSL are currently resisting.	TBC	Continued updates from IHSL on the CHP sizing and it's suitability to the Facilities. Energy model and CHP selection to be part of the RDD.
FM	Equipment replacement	Platform to replace the Intra-operative MRI	High			
Technical	Equipment	Board Specified Group 1 Equipment / update of the provisional sum	High			
Technical	Design	Background information on the revised layout of RHSC entrance	High			
Technical	Design	Natural daylighting in the theatres update	High			
Technical	Design	DCN access to courtyard update	High			
Technical	Design	Quench pipes update and Gauss Lines update	High			
Technical	Design	Agreement on RDS format / content	High			
Technical	Design	Operational Functionality / C sheets meeting taking place	High			
Technical	Reviewable Design Data	Due to the current status of the PCP's, the RDD list could be Extensive.	Medium	Monitor the development of the PCP's in line with the PCP programme.	TBC	Long list of RDD due to further iterations of drawings etc. to be made etc. Board require to both resource the requirements for review and understand the rights of comment they have within the Review Procedure (which is where RDD is reviewed). This should then mitigate risk of Project Co claiming changes
Technical	Design Deliverables List	Project Co miss understanding to Board requirements in terms of the level of detail required in the drawings at FC, potential delay to FC.	Medium	Design Deliverables List was requested at first Design Steering Group meeting. RFI to be issued requesting the information is issued. To be reviewed upon receipt of PCP programme - draft due for issue 24/06/14.	TBC	Awaiting issue of drawings to consider design information.
Technical	Workstream	The equipment list in a state of flux until completion of 1:50 User Group Meetings and group 2B (NHSL supply and IHSL fit) and group 3 (NHSL supply & fit). The provisional sum from Final Tender may change due to ongoing UGMs. The risk is increased cost from provisional sum.	Medium	Yes. Ongoing meetings, Change Control meetings being held, Board accept this will not be finalised until UGM have finished.	TBC	Yes. Ongoing meetings, Change Control meetings being held, Board accept this will not be finalised until UGM have finished.

Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.
Technical	Outline Commissioning Programme	Project Co commissioning programme at FC was reasonably high level.	Medium		TBC	Yes. Mitigation put in place through requirements within the contract detailing inclusions for Final Commissioning Programme. The Board need to ensure a robust plan is in place to develop the Final Commissioning Programme such that it is fully detailed including the requirements within Contract and allows the Board sufficient time to complete there commissioning activities. To be reviewed throughout PB to FC meetings between Board and Project Co.
Design	Sprinkler suppression required to other areas other than the atrium e.g. vulnerable patient areas	Potential cost increase and delay in design	Medium	Proposed sprinkler provision to be agreed with the approval authorities		
Design	Proposed provisions for fire brigade access not accepted by the authorities	Potential significant alterations to the site layout required	Medium	Consultation should be sought from the approval authorities and the fire service to agree fire brigade provisions and access		
Technical	Equipment	The equipment list in a state of flux until completion of 1:50 User Group Meetings and group 2B (Board supply and Project Co fit) and group 3 (Board supply & fit). The provisional sum from Final Tender may change due to ongoing UGMs. The risk is increased cost from provisional sum.	Medium	Yes. Ongoing meetings, Change Control meetings being held, Board accept this will not be finalised until UGM have finished.	TBC	Yes. Ongoing meetings, Change Control meetings being held, Board accept this will not be finalised until UGM have finished.
Technical	Enabling Works	Sign off by the Consort	Medium	Board currently meeting with Consort to mitigate any risks. Board to notify Project Co should any problems/ risk arise.	TBC	Board currently meeting with Consort to mitigate any risks. Board to notify Project Co should any problems/ risk arise.
Technical	European emissions	There is a risk that the designs will need to change due to legislative or regulatory changes specific to the Board.	Medium	Board to establish extent of implication. Project Co currently investigating Board risk.	TBC	
Technical	Board's Construction Requirements	A BREEAM score of "very good" was aspired to in the BCRs. Project Co confirmed the BREEAM assessment results show that a score of 61.43% and a 'Very Good' rating will be targeted for the current proposals	Low	BREEAM meetings have been scheduled during PB - FC stage to ensure this score remains at ' very good'.	TBC	BREEAM meetings have been scheduled during PB - FC stage to ensure this score remains at ' very good'.
Design	Planning requirements.	Project Co not achieving Planning Permission on time	Low	Meetings being held between Project Co and Board to mitigate risk. Planning Submitted for approval on programme.	TBC	Meetings being held between Project Co and Board to mitigate risk. Planning Submitted for approval on programme.
Design	BCR's	Change in design required due to external influences specific to the NHS. There is a risk that the designs will need to change due to legislative or regulatory changes specific to the Board.	Low	Board to review legislative or regular basis throughout PB - FC process advising Project Co where / if any changes in design will occur. To be reviewed and thus mitigated throughout PB- FC process.	TBC	
Design	Cross work stream issues	Cross work stream issues arising during User Group Meetings and/or other work stream meetings not communicated / addressed on time	Low	All the changes to be recorded during the meetings and circulated / distributed to relevant parties for comments / approval. Project Co and Board both responsible for mitigating risk ensuring all work streams are kept in the loop. Work stream meetings/ UGM/ DSG all being held to suit with the view to mitigating risk.	TBC	All the changes to be recorded during the meetings and circulated / distributed to relevant parties for comments / approval. Project Co and Board both responsible for mitigating risk ensuring all work streams are kept in the loop. Work stream meetings/ UGM/ DSG all being held to suit with the view to mitigating risk.
Design	User Group Meetings	Change in requirements of the Board. The Board may require changes to the design during UGM	Closed	Change Control Meetings currently being held throughout PB to FC process, all the changes are being recorded, circulated and distributed between Board and Project Co for comments and sign off prior to FC.		

Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.
Construction	Interface Proposals	Delay in receiving information	Closed	The Board to ensure third parties are informed of required timeframe to return / deliver relevant information		The Board to ensure third parties are informed of required timeframe to return / deliver relevant information
Design	Lack of engagement by Project Co at C&S Work stream Meetings	Delay in achieving FC	Closed	Project Co addressing risk. C&S meeting now due to be held with Board on 16th July 2014. Engagement to be reviewed by Board on a weekly basis.		Project Co addressing risk. C&S meeting now due to be held with Board on **16th July 2014.** Engagement to be reviewed by Board on a weekly basis.
Design	Lack of strong representation from Board at D&C	Estates input required so Project Co delivers most advantageous design to the Board.	Closed	Board to contact estates to try and ensure input is present at the D&C work streams. Board currently reviewing on a weekly basis to mitigate risk.		
Design	User Group Meetings sign off	Delay on programme, also will impact other work streams, i.e. equipment.	Closed	Project Co committed to issuing UGM tracker on 4th July to Board following UGM Rd 2 - confirming progress. Board to review.		Project Co committed to issuing UGM tracker on 4th July to Board following UGM Rd 2 - confirming progress. Board to review.
Design	Progressing the design without noise survey data at the site before FC.	Risk to successful outcome, planning application. Measurement of existing background noise levels prior is generally considered essential in order to quantify impacts of the scheme on nearby sensitive receptors and determine any mitigation of noise impacts which may be required.	Closed	Noise survey to be carried out by IHSL. Inadequate consideration of these risks, in the absence of noise survey data may present risk of delay to the planning application if the local authority are concerned that the assessment of noise impacts is not robust.		
Technical	Enabling Works.	Delay on programme and costs due to unforeseen additional works.	Closed	Meetings being held between Project Co and Board to mitigate risk. Board to update Project Co on any anticipated problems which may have an effect on Project Co programme.		Meetings being held between Project Co and Board to mitigate risk. Board to update Project Co on any anticipated problems which may have an effect on Project Co programme.
Construction	Site Cabins being outside the site boundary.	There is a risk that Consort will not accept the Access Strategy Proposals and therefore IHSL will have no legal right to extend the site boundary in the yellow areas.	Closed	All the submissions made by Project Co to be checked and compared with Final Tender.		All the submissions made by Project Co to be checked and compared with Final Tender.
Design	Helipad	Helipad options update	Closed	To be dealt with as a change post FC.		

Re-provision of RHSC and DCN at Little France

Design Risks to the Board to Financial Close

Risk at 28/01/15

The list below contains the principal high, medium and low design risks, and should be read in conjunction with the detailed feedback that has been provided through each Workstream.

Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.	Person responsible for Risk Closure
M&E	Ventilation		High	The single room with en-suite ventilation design shall comply with the parameters set out in SHTM 03-01. The design solution should not rely in any way with the opening windows as these will be opened or closed by patient choice. The critical factor from SHTM 03-01 for infection control will be the resultant pressure within the room being balanced with or negative to the corridor. Isolation room ventilation shall comply with SHPN 04 Supplement 1.	TBC		
M&E	Incoming water temperature						
Civil / Structural Design / M&E design/ Acoustics	Transfer Beams	IHSL have indicated the transfer beams could impact the operational functionality of clinical areas	High	IHSL to issue summary of the issue to the Board for the Boards consideration. The following comments were raised during the DSG meeting held 24/09/14: 1. Ceiling heights - TBC until drawings are submitted for review highlighting extent of services passing through rooms. In addition, Project Co to confirm ceiling height of 2.7m in Social Work room (GD8001). ~~2. Confirmation that duct work cross sections closed at DSG meeting 24/09/14.~~ ~~3.Confirm that the routing of additional trunking will not alter ambient noise levels in the affected rooms or advise additional measures which will be required to meet the prescribed levels. Response by Wallace Whittle and Acoustic Logic:~~ ~~Air velocities shall be limited to ensure the prescribed noise levels are maintained. Where applicable, cross talk attenuators shall be provided to prevent noise interference between two or more connected spaces.~~ ~~**To be captured within PCP.**~~ ~~4.Confirm frequency of access required for repair and maintenance in the affected areas. Response by Bouygues:~~ ~~Most frequent access for ducts are between quarterly, 6 monthly and yearly, however for this, the equipment need to be accessible and not above desk/beds/tables or not put above rails (bed lifts rails) or medical gases and block the access for cleaning or filters replacement.~~ ~~**To be captured in the PCP and Derogation response.**~~ ~~5.Confirm type of ventilation system which will be used in these areas. Response by Wallace Whittle:~~ ~~General supply and extract ventilation system served via AHU located with Level 04 plant area. Closed at DSG meeting 24/09/14.~~ ~~6.Provide a statement confirming that there will be no adverse effect on sensitive medical equipment in the areas or outline measures which will be introduced to~~	TBC	Will require sign off by CEC Building Control. Closed Closed Closed Closed	BMac/ CMac / JZ/ AM

Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.	Person responsible for Risk Closure
				~~mitigate. Response by Wallace Whittle: The redistribution of ductwork services due to restricted void space is not predicted to cause any adverse effects on medical equipment within occupied rooms.~~ **~~To be included within the PCP, noting it must be an absolute obligation rather than predicted.~~**		Closed	
Technical	European emissions	There is a risk that the designs will need to change due to legislative or regulatory changes specific to the Board.	Low	NHSL / MM reviewed the EUETS thresholds. NHSL to confirm with SEPA the interpretation is correct.	TBC		CMac/AW
Geotechnical	Main Site	Lack of evidence of interpretation of Factual SI – and therefore unknown design concept.	Closed	The Board have requested sight of IHSL's Interpretive Report for the main site.	TBC		ED/AM/BMac
Geotechnical	Petrol Station Site	Satisfactory review of IHSL Interpretative Report and remediation proposals.	Closed	Interpretive Report issued and Board comments issued back to Project Co. Meeting held 23/09/14 to discuss recommendations prior to submission to CEC. IHSL to update interpretive report to Board w/e 3/10/14 with workshop meeting TBA w/c 6/10/14.	TBC	Board to ensure that any remedial actions are undertaken by Project Co to required standards and that where necessary validation documentation is submitted to CEC to allow discharge of planning conditions.	ED/AM
Technical	Board's Construction Requirements	A BREEAM score of "very good" was aspired to in the BCRs. Project Co confirmed the BREEAM assessment results show that a score of 61.43% and a 'Very Good' rating will be targeted for the current proposals	Closed	BREEAM meetings have been scheduled during PB - FC stage to ensure this score remains at ' very good'.	TBC		All
PCP / RDS	Environmental Matrix	Content of Environmental Matrix	Closed	Board reviewing internally on 1st October 2014. Comments to be feedback to IHSL.	TBC		CMac
Board Change	SAS	SAS suggesting changes to the Adult ambulant entrance drop off area.	Closed	Board to check the background to the change. Ongoing internal discussions		Board to confirm changes to Project Co.	BC
Board Change	SAS	Extension to the canopy at the ambulance entrance for the RHSC + DCN	Closed	Board to check the background to the change. Ongoing internal discussions		Board to confirm changes to Project Co.	BC
Fire	Sprinkler suppression required to other areas other than the atrium e.g. vulnerable patient areas	Potential cost increase and delay in design	Closed	Proposed sprinkler provision to be agreed with the approval authorities	TBC	Project Co Risk	JZ
Fire	Proposed provisions for fire brigade access not accepted by the authorities	Potential significant alterations to the site layout required	Closed	Consultation should be sought from the approval authorities and the fire service to agree fire brigade provisions and access	TBC	Project Co Risk	JZ
Fire	Fire Strategy and fire engineered solutions are not approved by the authorities	Delay Construction / Significantly alter the layout and provisions within the building	Closed	Early consultation should be sought with the approval authorities and their comments addressed prior to seeking formal approval IHSL have invited building control to the fire strategy meetings.	TBC	Project Co Risk	JZ
PCP	Vertical Transportation	Lift car sizes - insufficient	Closed	Discussed at DSG due to be held 24/09/14. IHSL to review Board required lift sizes.			DS/ CMac

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Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.	Person responsible for Risk Closure
PCP	Anti-ligature	Lack of definition from IHSL on the Anti-ligature Strategy.	Closed	Board have responded, awaiting IHSL proposals.	TBC		DS
PCP	Acoustics	EFTE atria space – still no defined reverberation time and modelling has not yet been undertaken – this is not a direct derogation from the BCR's, but is Good Industry Practice.	Closed	Still remains a risk following the PCP meeting. Should be 2.5 secs not 3.0 secs as being proposed. **Current mitigation measure - IHSL carrying out basic acoustic modelling, results to be feedback to the Board.**	TBC		AM
M&E	Combined Heat and Power Plant Sizing	There is concern about the sizing and arrangement of the CHP. IHSL have not provided detailed assessment to show that the use of one large CHP, without a thermal buffer, will actually provide the optimum operation for the Facilities. IHSL have previously stated that the size of the unit has been dictated by compliance with Building Regulations rather than providing an optimised design and this is of high concern, it may be the CHP operates much less than anticipated.	Closed	The Board have received the CHP optimisation paper. The Board still have concerns over the CHP design. Board to respond to IHSL paper 01/10/14.	TBC	Continued updates from IHSL on the CHP sizing and it's suitability to the Facilities. Energy model and CHP selection to be part of the RDD.	AW/CMac
FM	Equipment replacement	Platform to replace the Intra-operative MRI	Closed	Route of replacement has been proposed by IHSL, however indemnities from Group 2B contractor for under taking the work to be agreed in Legal workstream by Iain Graham. The responsibility of the removal and replacement of the external cladding panel to be confirmed.	TBC		JKS
Equipment	Equipment	Board Specified Group 1 Equipment / update of the provisional sum	Closed	Specifications have been issued to IHSL. NHSL to confirm all specifications have been issued. Patrick MacAuley working on specs. There is an issue with U of E specs but this is not a high risk as the make and model are known.	TBC		JKS
M&E	MRI Chillers	Location of chillers	Closed	Current location out with recommended distance. IHSL currently reviewing location with possible relocation in courtyards. Info with potential suppliers- due back 06/10/14.	TBC		JKS/ CMac
M&E	Quench pipes design	Quench pipes design update	Closed	IHSL providing quench pipe space for specialist supplier who will install. Board to review drawings to confirm adequate space has been provided. Info with NHSL potential suppliers- due back 06/10/14.	TBC		JKS/CMac
M&E	Quench pipes design	Quench pipes discharge	Closed	IHSL reviewing location of Quench Pipe discharge on roof. Should be 3m clear of obstruction.	TBC		CMac/SD
Technical	Design	Review of RDS content	Closed	RDS have been submitted for Board Review.	TBC		JMac/DS
Technical	Design	RDS omitted by Project Co at FC	Closed	Board reviewing operational design notes to confirm if there are gaps for the omitted RDS.	TBC		JMac/ DS

Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.	Person responsible for Risk Closure
Technical	Specifications	IHSL to confirm supplier 'or equal and approved' for the Doors; Cabinetry; Ironmongery and sanitary fittings.	Closed	IHSL will not confirm supplier or ' equal and approved' until post FC.	TBC		DS
PCP	Communication Area & Corridor Widths	Corridor widths and resting areas have not yet been submitted.	Closed	Board to review IHSL proposals. Workshop meeting TBA.			DS
PCP	Acoustics	EFTE atria space (plant noise) – intimating a possible issue but not defined at present	Closed	It was stated in the PCP meeting by acoustic consultant that this could now be looked at. Feedback awaited.	TBC		AM
PCP	Acoustics	Standing Seam roof Light weight roofs (rain noise) – potential derogation that has not been clarified, and IHSL are proposing a retrofit option	Closed	There is a commitment from Project CO to achieve the rain noise performance under lightweight roofs other than the ETFE roof. However they are still optioneering between membrane in the roof build-up or enhanced ceiling so the issue is not completely bottomed out.	TBC		AM
PCP	Acoustics	Rain noise on EFTE Roof	Closed	With the ETFE roof – our understanding from the PCP meeting is that there is a rain noise solution – in the form of a mesh fitted above the roof and that the working assumption is that this solution will be implemented. This should remain a risk if other factors (e.g. light transmission, maintenance etc) are deemed to take precedence over the rain noise issue. **The Board has rejected the Derogation. Therefore a netting solution is to be proposed by IHSL.**	TBC		AM
M&E	Energy Centre Flue height	Project Co not achieving Planning - Apparently CEC Planning are not accepting the new increased flue height on aesthetic grounds and have communicated this to IHSL. Programme implications	Closed	Revised drawings / information submitted to Planning.	TBC		CMac
Catering	Equipment and costs for catering equipment	IHSL currently reviewing catering equipment options	Closed	IHSL to advise Board ASAP.	TBC		FH/ BC
Geotechnical	Main Site	Lack of evidence of interpretation of Factual SI – it is understood this is a requirement by Building Control.	Closed	The Board have requested sight of IHSL's Interpretive Report for the main site.	TBC		ED/AM
C&S	PCP	General lack of detail in the PCP.	Closed	Information has been requested through relevant Workstream. IHSL to confirm when drawings will be issued for the Boards review. Board to issue comments on C&S drawings	TBC		
Equipment	Gauss Lines	Gauss Lines design update	Closed	Modelling to be undertaken by the Board. Info shared with IHSL on Aconex and discussed at equipment meeting 1/10/14.	TBC		JKS
PCP	Acoustics	Noise surveys – noise survey now undertaken however no consideration of the naturally ventilated areas, with background noise of between 50/ 60 db;	Closed	Not a risk provided that it is confirmed that required minimum ventilation requirements are achieved with windows closed.	TBC		AM

Category	Item	Issue	Risk Impact	Current Mitigation Measures	Final Position	Potential Further Mitigation Required post FC.	Person responsible for Risk Closure
Technical	Design	Agreement on RDS format / content	Closed	RDS content agreed 20 additional rooms TBA prior to FC.	TBC		GG
PCP	Helipad	Helipad Non Clinical Output specification.	Closed		TBC	The Board will rely on the O&M Manuals to define parameters for cleaning operations.	CR / SD
Architectural	Design	Background information on the revised layout of RHSC entrance	Closed	Arrange meeting with IHSL to review the changes	Changes described by IHSL and no further comment from the Board.		
Equipment	Medicine Storage on Hospital In-patient wards	Chief Executive Letter, dated 10/12/13	Closed	Board to ensure Project Co have included the CEL requirements. CEL letter was issued to Project Co.			
Architectural	Design	DCN access to courtyard update	Closed	Board to confirm to Project Co preferred option	TBC	Option to be issued.	JMac/SC
FM	Equipment replacement	Structural Integrity - replacement route of the Intra-operative MRI.	Closed	Route of replacement has been proposed by IHSL, however equipment has not been selected.	TBC		JKS
PCP	Acoustics	No external limit for building services plant – this may be planning issue;	Closed	Still a risk until external limits are proposed and agreed with CEC.	TBC		AM

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Re-provision of RHSC and DCN at Little France

Technical Risks to Financial Close

30/01/15

The list below contains the principal high, medium and low technical risks, and should be read in conjunction with the detailed feedback that has been provided through each Workstream.

Category	Item	Issue	Risk to Project	Mitigation Measures employed upto FC	Position at FC	Required mitigation measures post FC.
Technical	Project Co	Project Co Management of Contract pre FC				
Technical	Project Co	Project Co Management of Contract post FC				
Technical	Health & Safety	Associated H&S issues due to working beside live Hospital campus.	Accident associated with working beside live Hospital campus.	Refer to Schedule Part 31 and 4.3 Construction Methodology PCP.	Ongoing	Board to liaise with Project Co's relevant working groups to follow procedures set out in the PA.
Technical	Health & Safety	Associated H&S issues due to working on site	Accident on site	Project Launch Workshop to be set up to confirm site logistics (27.02.15 TBC).	Ongoing	All staff to be site inducted. All personnel to hold CSCS cards prior to site visit.
Technical	RDD	Despite best efforts of the Board More RDD than was expected by the Board	Less well defined proposals, therefore less certainty by the Board. Lack of design	IHSL pushed very hard to achieve maximum information during PB stage. Further developed RDD schedule for Board.		
Technical	RDD	IHSL have indicated there is going to be a significant quantity of RDD release in the early stages of the construction phase.	Board may not be able to respond in the allocated 15 days. Therefore the RDD item is deemed accepted.	Informal non- contractual design review meetings being held with IHSL. Process confirmed in Part 3 of Section 5 of Schedule Part 6 limiting Project Co's ability to add RDD items with less than 4weeks notice.	Ongoing review.	The Board and Motts to resource RDD appropriately. Manage Project Co's rolling programme in accordance with Part 3 of Section 5 of Schedule Part 6.
Technical	RDD	Significant quantity of RDD release in the early stages of the construction phase will require resourcing and management.	Board may not be able to respond in the allocated 15 days. Therefore the RDD item is deemed accepted.	Internal resourcing / management meetings ongoing.	Ongoing review.	The Board and Motts to resource RDD appropriately and to ensure the review is responded to within the 15 day period.
Technical	Change Control	Change's instigated by the Board.	Increased cost to the Board. Currently 5 Change Controls in process.	Change Control meeting held with IHSL to discuss process.	Ongoing.	Change Control process to be agreed with IHSL post FC.
Technical	Change Control	Change's instigated by Project Co.	Increased cost to the Board	Change Control meeting held with IHSL to discuss process.	Ongoing.	Change Control process to be agreed with IHSL post FC.
Technical	Change Control	Early start work – Redesign of Emergency Dept.	Increased cost and delay to the project.	Principals of change discussed with IHSL at Early Workshop meeting held 30.01.15.	Ongoing.	Change Control process to be agreed with IHSL post FC.
Technical	Planning	Hospital Square works – hard landscaping				
Technical	Interface	Schedule Part 31	Delay to project due to Consort/ Cofely objections. Additional associated costs to the Board.	Position covered in PA by all associated parties.		**[discuss with BC for confirmation of final position]**
Technical	Interface	Enabling Works	Boards enabling works causing delay to IHSL works particularly associated with RIE construction works and redline boundary.	PA states dates in which Board enabling works will be completed. Phasing of works have been set out in Schedule Part 31. Logistics meetings ongoing with Board / Project Co/ Consort.		Monitor and follow works through.

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Category	Item	Issue	Risk to Project	Mitigation Measures employed upto FC	Position at FC	Required mitigation measures post FC.
Technical	Payment Mechanism	Payment Mechanism does not perform the way the Board expects.	Project Co fall short on performance and the Board is unable to make the terminations/ warning notices etc that they expect to	Paymech demonstration meeting held with the Board (12.12.14). Presentation issued to the Board **[insert date]**		None required. Technical advisor advised Board the Paymech operates as expected.
Technical		Petrol Station	Board need to be satisfied remediation works carried out successfully.	The Board has reviewed the Interpretive report.		Onsite monitoring of the remediation proposals and works.
Technical		**Petrol Station works**	**Project Co to obtain relevant planning permissions to undertake remediation works.**			**[discuss with BC for confirmation of final position]**
Technical		Contamination	The Board holds financial and commercial risk for costs out with the Letter of Reliance from Raeburn.	Board and legal team have carefully agreed the drafting around this principal.		Board to monitor and be aware of GI issues with Project Co.
Technical	Equipment	Timing of procurement Early Access for installation Equipment shown on drawings.		Equipment meetings being held with IHSL		
Technical	Equipment	The equipment list in a state of flux until completion of 1:50 User Group Meetings and group 2B (NHSL supply and IHSL fit) and group 3 (NHSL supply & fit). The provisional sum from Final Tender may change due to ongoing UGMs. The risk is increased cost from provisional sum. Risk outstanding re lack for programme for equipment from IHSL.		Risk from provisional sum is low. Our calculation reduces the costs. Equipment list being returned to Project Co 01/10/14 with some updates made, some more to be made by Board and some to be made by Project Co. The list needs a caveat re accuracy and FC as we can't be sure it is accurate and can't sign it off as being so.	TBC	
Technical	Outline Commissioning Programme	Project Co commissioning programme at FC was reasonably high level.			Ongoing	Board to set up early commissioning workshops to develop final commissioning programme.
Design Management	BCR's	Change in design required due to external influences specific to the NHS. There is a risk that the designs will need to change due to legislative or regulatory changes specific to the Board.		Board to review legislative or regular basis throughout PB - FC process advising Project Co where / if any changes in design will occur. To be reviewed and thus mitigated throughout PB- FC process.	Ongoing	
Design		See separate Design risk register				

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Our Ref: LXP/AO/LXP/LOT/7/82 Your Ref:

Private and Confidential
John Ballantyne
Integrated Health Solutions Lothian
c/o New South Glasgow Hospitals
Hardgate Road
Glasgow
G51 4SX

Date 5th March 2014

Dear John

Royal Hospital for Sick Children and Department of Clinical Neurosciences project (the "Project")

Appointment of Integrated Health Solutions Lothian ("IHSL") as preferred bidder ("Preferred Bidder Appointment")

On behalf of and as authorised by the Finance and Resources Committee of Lothian Health Board (the "**Board**") on 5th March 2014, I am pleased to advise you that:

(a) IHSL's Final Tender submitted on 16 January 2014, as clarified and/or amended by the clarification responses set out in Schedule Part 5 *(Clarifications in respect of IHSL's Final Tender)* of this Preferred Bidder Appointment, has been evaluated as the most economically advantageous Final Tender; and

(b) subject to IHSL and each member of its consortium accepting the conditions set out in this Preferred Bidder Appointment including the attached Schedules to this Preferred Bidder Appointment,

the Board has approved the recommendation to appoint IHSL as the Preferred Bidder for this Project on the basis of its Final Tender, the terms of which were set out in the Invitation to Submit Final Tender.

It shall be a condition of IHSL's Preferred Bidder Appointment that if:

(a) IHSL fails to:

(i) comply with the conditions of this Preferred Bidder Appointment, as set out in the Schedules to this Preferred Bidder Appointment; and

(ii) remedy such failures as described in paragraph (a)(i) above within a reasonable period notified by the Board; and/or

(b) any of the executed certificates, including but not limited to Appendix B(iii) *(Due Diligence Certification)*, Appendix H *(Certificate of Non Collusion and Non-Canvassing)*, Appendix H *(Certificate of Acceptance of Contractual Terms)* of the Invitation to Submit Final Tenders, included in IHSL's Final Tender are materially incorrect or no longer valid,

the Board shall be entitled to terminate this Preferred Bidder Appointment and treat IHSL's Final Tender as having been withdrawn.

Execution of Preferred Bidder Appointment

By signing this Preferred Bidder Appointment IHSL and each member of its consortium acknowledge and agree that this Preferred Bidder Appointment does not, and is not intended to, create a contractual obligation on the Board to enter into the Final Tender (Bidder B) NPD Project Agreement or any other contractual arrangement.

Please confirm IHSL's and each member of IHSL's consortium acceptance of this Preferred Bidder Appointment by countersigning and returning a copy of this Preferred Bidder Appointment to me by email not later that 4.00pm on Friday 7th March 2014 and provide the original hard copy Preferred Bidder Appointment by post.

In accordance with the Invitation to Submit Final Tender, the Board reserves the right to abandon the procurement process, including Preferred Bidder discussions, at any time without awarding a contract to IHSL. In particular, the Board may require to do so in the event of a procurement challenge being raised by an unsuccessful bidder between issuance of its standstill letters under Regulation 32 of the Public Contracts (Scotland) Regulations 2012 and Financial Close.

Way Forward

Pending receipt of this signed Preferred Bidder Appointment, the Board looks forward to working with IHSL as Preferred Bidder, starting with an informal planning meeting with the City of Edinburgh Council at 2.00pm on Tuesday 11th March (venue to be confirmed).

The Board hopes that IHSL will be open to discussing the co-location of key individuals in the Project offices in the period up to Financial Close. The Board proposes to launch work with IHSL formally at a Project Team Meeting at 56 Canaan Lane on the morning of Thursday 13th March; please make immediate contact with Sorrel Cosens, on 0131 536 5063 to confirm arrangements for this.

The capitalised terms used within this Preferred Bidder Appointment shall have the same meaning ascribed to them in the Invitation to Submit Final Tender.

Yours sincerely

Brian Currie
Project Director

IN WITNESS WHEREOF these presents typewritten on this and the preceding 2 pages together with the Schedule in 5 Parts are executed on behalf of IHSL and its consortium members that they agree to the terms of this Preferred Bidder Appointment:

For and behalf of Integrated Health Solutions Lothian by [Director/Company Secretary/authorised signatory]

at on

in the presence of:

....	....
Signatory	Witness Signature
	....
	Witness Full Name (print)
....	....
Signatory's Full Name (print)	....
	....
	Witness Address (print)

For and behalf of Macquarie Capital Group Limited by [Director/Company Secretary/authorised signatory]

at on

in the presence of:

....
Signatory

....
Signatory's Full Name (print)

....
Witness Signature

....
Witness Full Name (print)

....

....

....
Witness Address (print)

For and behalf of Brookfield Multiplex Construction Europe Limited by [Director/Company Secretary/authorised signatory]

at on

in the presence of:

....
Signatory

....
Signatory's Full Name (print)

....
Witness Signature

....
Witness Full Name (print)

....

....

....
Witness Address (print)

For and behalf of Bouygues E&S FM UK Limited by [Director/Company Secretary/authorised signatory]

at on

in the presence of:

....

Signatory

....
Signatory's Full Name (print)

....
Witness Signature

....
Witness Full Name (print)

....

....

....
Witness Address (print)

Schedules

Schedule Part 1

Terms of Preferred Bidder Appointment

1.	**Description**	**General Issues**
1.1	Programme	IHSL shall use its best endeavours to diligently progress the Project to Financial Close on 2nd October 2014. IHSL shall further develop and agree the programme set out in Schedule Part 2 of this Preferred Bidder Appointment as a key project management tool in collaboration with the Board. IHSL may amend such programme from time to time subject to the Board's approval, such approval not to be unreasonably withheld or delayed where amendments to such programme are required for reasons out with the control of IHSL or members of its consortium.
1.2	Amendments to Final Tender	IHSL shall not be permitted to make any amendments to its Final Tender except where provided for within this Preferred Bidder Appointment. IHSL acknowledges and accepts that the rules of Competitive Dialogue only permit fine tuning and clarification of IHSL's Final Tender at Preferred Bidder stage as opposed to material amendments which may have a commercial impact in relation to IHSL's Final Tender.
2.		**Legal/Contractual Issues**
2.1	Final Tender (Bidder B) NPD Project Agreement and Final Tender (Bidder B) Payment Mechanism.	IHSL shall work with the Board to develop, agree and finalise the outstanding issues set out in Schedule Part 3 *(IHSL outstanding issues to be addressed in respect of the Project)* and Schedule Part 4 *(IHSL's gaps list in relation to the Final Tender (Bidder B) NPD Project Agreement)* in respect of the Final Tender (Bidder B) NPD Project Agreement and Final Tender (Bidder B) Payment Mechanism.
2.2	Junior finance, shareholder and corporate documentation	IHSL shall use its best endeavours to diligently progress the junior finance documentation, shareholder documentation and other corporate documentation, including the NPD Articles of Association. IHSL shall provide the Board with drafts of such documentation for review in order to permit the Board to carry out the necessary due diligence in respect of such documentation in good time prior to Financial Close.
2.3	Sub-contract documentation	IHSL shall use its best endeavours to diligently progress the Contractor, Service Provider and Key-Sub-contractor sub-contract documentation based upon the final form Final Tender (Bidder B) NPD Project Agreement and heads of terms submitted as part of the Final Tender, together with any relevant interface agreement and professional team appointments. IHSL shall provide the Board with drafts of such documentation for review in order to permit the Board to carry out the necessary due diligence in respect of such documentation in good time

		prior to Financial Close.
2.4	Finance documentation	IHSL shall use its best endeavours to diligently progress the finance documentation with the appointed Funder post funding competition, together with all related Funder conditions precedent. IHSL shall work with the Board to produce or agree drafts of such documentation that will be acceptable to the Board and may be produced or agreed as part of the funding competition. IHSL shall permit the Board to carry out the necessary due diligence in respect of such documentation in good time prior to Financial Close.
2.5	Due diligence reports	IHSL shall use its best endeavours to diligently progress the final due diligence reports on behalf of the Funder's legal adviser, Funder's technical adviser and Funder's insurance adviser. IHSL shall keep the Board appraised of developments in respect of this documentation in order that any issues which may arise may potentially be addressed in good time prior to Financial Close in order that Financial Close is not delayed. Given the extensive Funder due diligence carried out by IHSL during the Dialogue Period, the Board is not expecting (nor is able to address) material amendments to the Final Tender (Bidder B) NPD Project Agreement at Preferred Bidder stage. IHSL shall provide the Board with drafts of such documentation for review in order to permit the Board to carry out the necessary due diligence in respect of such documentation in good time prior to Financial Close.
2.6	Legal opinions	IHSL shall use its best endeavours to diligently progress all relevant legal opinions which may be required as conditions precedent to the finance documents in good time prior to Financial Close. Where relevant, IHSL shall provide the Board with drafts of such documentation for review in order to permit the Board to carry out the necessary due diligence in respect of such documentation in good time prior to Financial Close.
2.7	Independent Tester	IHSL shall use its best endeavours to diligently progress the joint appointment of the Independent Tester, including inviting tenders from a long list of prospective Independent Testers (as agreed with the Board), evaluating all compliant tenders from such long list and preparing a relevant report to the Board. IHSL shall then liaise with the Board in respect of its report in order to jointly conclude the appointment of the Independent Tester. Following appointment of IHSL as Preferred Bidder, IHSL shall develop and agree with the Board a process for identification and appointment of an Independent Tester. The Board would expect IHSL to manage the agreed process, assuming the Board has appropriate approval rights with respect to the identity, cost and terms of the proposed Independent Tester appointee.
3.		**Interface Issues**

3.1	Interface Proposals	IHSL shall use its best endeavours to diligently develop the IHSL's Interface Proposals, these being both its Project Co Proposals and Method Statements addressing the requirements of Appendix A. The Interface Proposals shall be finalised in conjunction with the Board to ensure that both parties are satisfied that the Interface Proposals robustly address the requirements of Appendix A. This shall be a key part of the early stages of the Preferred Bidder period.
3.2	Assistance with Interface Proposals	IHSL shall liaise with the Board and provide all necessary assistance to the Board in progressing the Interface Proposals in order that these can be negotiated and agreed between both the Board and Consort prior to Financial Close.
3.3	Amendment to Interface Proposals	IHSL to amend its Interface Proposals where such amendments are requested by Consort pursuant to the Board's parallel negotiations with Consort in order that a final form of Interface Proposals can be agreed between both Consort and the Board.
3.4	Notices	IHSL to prepare and submit to the Board all necessary notices and or Project Co Proposals/Interface Proposals in accordance with the timescales set out in Appendix A prior to Financial Close in order that construction can commence as soon as possible after Financial Close.
4.		**Design and Construction Issues**
4.1	Schedule Part 3 (IHSL's outstanding issues to be addressed in respect of the Project)	IHSL shall use best endeavours to reach an agreed position with the Board with regard to the specific matters listed in Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project)* and shall comply with any and all requirements of Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project).* For the avoidance of doubt, the matters listed in Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project)* do not represent a complete and exhaustive list of matters to be addressed prior to Financial Close and shall be actioned and completed at no cost to Board.
4.2	Petrol Station Ground Investigation	IHSL shall liaise with the Board and provide all necessary assistance to the Board in progressing Petrol Station ground investigations, particularly in relation to the scope of the ground investigation that will be designed and managed by the Board's environmental consultant, who will produce a "phase 1" and "phase 2" contaminated land risk assessment based on a proposed public open space land use.
4.3	Petrol Station Works	IHSL shall obtain necessary planning permission from The City of Edinburgh Council for the proposed temporary and permanent land uses at the Petrol Station Site e.g. potential construction traffic route during construction and final reinstatement as an area of public open space within the Board's Retained Estate. IHSL shall submit appropriate documentation to obtain such permissions including, but not limited to, risk assessments, a detailed remedial options appraisal and remediation statement which shall be produced in line with Part IIA of the Environmental Protection Act (1990) and follow best practice

		guidelines detailed in CLR11 (2004), BS10175:2011+A1:2013 and PAN 33. Remediation proposals shall be agreed with the Board and its environmental consultant prior to submission to The City of Edinburgh Council and if necessary, SEPA. This shall be a key part of the early stages of the Preferred Bidder period. Any remediation undertaken by Project Co during the Construction Phase shall be independently verified by the Board's environmental consultant and certified in accordance with the City of Edinburgh Council's planning requirements and regulations. IHSL shall use its best endeavours to diligently develop IHSL's remediation and landscaping proposals addressing the requirements of the Board's Construction Requirements. The remediation proposals and landscaping proposals shall be finalised in conjunction with the Board to ensure that both parties are satisfied that the remediation and landscaping proposals robustly address the Boards Construction Requirements. This shall be a key part of the early stages of the Preferred Bidder period. IHSL shall provide the Board with drafts of such documentation for review in order to permit the Board to carry out the necessary due diligence in respect of such documentation in good time prior to Financial Close.
4.4	Technical Schedules	IHSL shall use its best endeavours to diligently develop the following IHSL technical Schedules of the Final Tender (Bidder B) NPD Project Agreement: - Schedule Part 3 *(Key Works Personnel);* - Schedule Part 6 *(Construction Matters),* including Section 1 *(Planning / Consents)*, Section 4 *(Project Co Proposals),* Section 6 *(Room Data Sheets)*, Section 8 *(Quality Plans (Design & Construction);* and - Schedule Part 7 *(The Programme);* IHSL shall use its best endeavours to diligently input to the following Board technical Schedules of the Final Tender (Bidder B) NPD Project Agreement: - Schedule Part 10 *(Outline Commissioning Programme);* and - Schedule Part 11 *(Equipment).* These technical Schedules of the Final Tender (Bidder B) NPD Project Agreement shall be finalised in conjunction with the Board to ensure that both parties are satisfied that these technical Schedules robustly address the Board's Construction Requirements. This shall be a key part of the early stages of the Preferred Bidder period.

4.5	Design Development	IHSL shall further develop their Design included within their Final Tender to the level set out in the Invitation to Submit Final Tender (as a minimum).
4.6	Board's Construction Requirements	The Board's Construction Requirements shall be based upon the version issued by the Board as part of the Invitation to Submit Final Tender.
5.		**FM Issues**
5.1	Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project)*	IHSL shall use best endeavours to reach an agreed position with the Board with regard to the specific matters listed in Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project)* and shall comply with any and all requirements of Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project).* For the avoidance of doubt, the matters listed in Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project*) do not represent a complete and exhaustive list of matters to be addressed prior to Financial Close and shall be actioned and completed at no cost to Board.
5.2	Payment Mechanism and its calibration	IHSL shall commit to working with the Board to ensure that funders and their due diligence advisors fully understand and shall seek acceptance of the Payment Mechanism and its calibration.
5.3	Schedule Part 12 *(Service Level Specification),* Section 2 *(Method Statements)*	IHSL shall use its best endeavours to diligently develop IHSL's Method Statements addressing the requirements of Schedule Part 3 (IHSL's outstanding issues to be addressed in respect of the Project). The Method Statements shall be finalised in conjunction with the Board to ensure that both parties are satisfied that the Method Statements robustly address the requirements of Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project)* and Section 1 *(Service Level Specification)* of Schedule Part 12 *(Service Requirements)* of the Final Tender (Bidder B) NPD Project Agreement. This shall be a key part of the early stages of the Preferred Bidder period. IHSL shall provide the Board with drafts of such documentation for review in order to permit the Board to carry out the necessary due diligence in respect of such documentation in good time prior to Financial Close. IHSL shall liaise with the Board and provide all necessary assistance to the Board in progressing the further development of Schedule 16 *(Change Protocol)* of the Final Tender (Bidder B) NPD Project Agreement) using the rates provided in the submission as a benchmark to produce a more detailed and Board specific costs/rates.
5.4	Schedule Part 12 (Service Level Specification), Energy Strategy	IHSL shall develop IHSL's Energy Strategy which shall contain as a minimum the information contained in the drafting note, in respect of the supply of Utilities to the Facilities and the operation of associated Plant, detailed in Section 1 *(Service Level Specification)* of Schedule Part 12

		(Service Requirements) of the Final Tender (Bidder B) NPD Project Agreement. IHSL shall provide the Board with drafts of such documentation for review in order to permit the Board to carry out the necessary due diligence in respect of such documentation in good time prior to Financial Close
5.5	FM Schedules	IHSL shall use its best endeavours to diligently develop the following IHSL FM Schedules: - Schedule Part 12 *(Service Requirements),* including Section 2 *(Method Statements),* Section 3 *(Service Quality Plan), [*Section 4 *(Energy Strategy)]* (which requires to be added to the Final Tender (Bidder B) NPD Project Agreement); and - Appendices to Schedule Part 16 *(Change Protocol).* These FM Schedules shall be finalised in conjunction with the Board to ensure that both parties are satisfied that the FM Schedules robustly address the Board's Construction Requirements. This shall be a key part of the early stages of the Preferred Bidder period.
5.6	Catering Strategy	IHSL shall liaise with the Board and provide all necessary assistance to the Board in the development of the implications of a revised Catering Strategy which includes the catering production for the whole of Lothian being provided internally by a reduced number of off–site production units within Lothian. The Project's main catering supply will be provided from an off-site production unit with the requirement for storage, regeneration and finishing kitchen(s) on site. There is no increase in footprint and limited impact on services, maintenance and lifecycle anticipated as result of this change.
5.7	Schedule Part 12 *(Service Level Specification)*	The Service Level Specification shall be based upon the version issued by the Board as part of the Invitation to Submit Final Tender.
6.		**Financial Issues**
6.1	Optimisation of the Financial Model	IHSL commits to working collaboratively with the Board and the Scottish Futures Trust to optimise the Financial Model in all relevant areas, including tax and accounting treatment, such that the junior debt coupon does not exceed 9.5% and that the nominal project IRR does not exceed 9.67%.
6.2	Amendment of Financial Model relating to financial security package	IHSL commits to amend the Financial Model in order that the costs of the agreed financial security package are separately identified as an input to the Financial Model.
6.3	Amendment of Financial Model	IHSL agrees that any changes to the Financial Model will be subject to full tracking by IHSL with a clear description and cell reference to

	relating to audit trail	denote each item of change such that it may be reviewed by the Board and its financial advisors. The impact on the Annual Service Payment of each change should be provided, with a clear audit trail in place that demonstrates how such change has been implemented. Any change will be noted in an audit trail worksheet to be included in the Financial Model in as format to be agreed with the Boards' financial advisors.
7.		**Funding Competition Issues**
7.1	Methodology of funding Competition	IHSL commits to undertaking and completing a Preferred Bidder funding competition in accordance with the proposed methodology set out in IHSL's Final Tender response. This commitment includes working collaboratively with the Board, its financial advisors and the Scottish Futures Trust in the selection of a senior debt funding package that is deliverable and which offers value for money to the public sector.
7.2	Update of Financial Model	IHSL undertakes to work with the Board to update the Financial Model as necessary to reflect the senior debt funding structure developed in the period to financial close.
7.3	Equity bridge loan and letter of credit	IHSL undertakes to work with the Board and Scottish Futures Trust during the funding competition process to evaluate the options of using an equity bridge loan and the use of a letter of credit to support junior debt so that the best value for money solution for the public sector can be adopted.
8.		**Planning Issues**
8.1	Planning applications	IHSL shall use its best endeavours to diligently progress any planning applications in respect of the Project as agreed with CEC. IHSL shall keep the Board fully engaged with all progress in respect of all relevant planning developments during the Preferred Bidder stage.
8.2	Reserved matters	IHSL to discharge all relevant reserved matters and planning conditions it shall be responsible for in good time prior to Financial Close.
8.3	Planning conditions	IHSL to discharge all relevant planning conditions it shall be responsible for, as set out in Schedule Part 29 *(Consents and Board Consents)* of the Final Tender (Bidder B) NPD Project Agreement, in good time prior to Financial Close.
9.		**Insurance**
9.1	Insurance inception	IHSL shall use its best endeavours to diligently progress the inception of the insurance programme as required by Clause 53 *(Insurance)* and Sections 1 and 3 Schedule Part 15 *(Insurance Requirements)* of the Final Tender (Bidder B) NPD Project Agreement with its insurance broker. IHSL shall keep both the Board and its insurance adviser Willis appraised of progress in respect of all relevant insurance developments during the Preferred Bidder stage.

9.2	Waiver of subrogation	IHSL to provide assistance to the Board in respect of the Board exploring the waiver of subrogation insurance option in respect of the insurance arrangements for the Facilities and the RIE Facilities as a whole.

Schedule Part 2

Preferred Bidder to Financial Close Programme

Please refer to the separate paper apart which sets out IHSL's Preferred Bidder to Financial Close Programme.

Schedule Part 3

IHSL's outstanding issues to be addressed in respect of the Project

IHSL's outstanding issues to be addressed in respect of the Project		
1.	**Description**	**General Issues**
1.1		N/A
2.		**Legal/Contractual Issues**
2.1	Final Tender (Bidder B) NPD Project Agreement	Please refer to Schedule Part 4 *(IHSL's gaps list in relation to the Final Tender (Bidder B) NPD Project Agreement).*
3.		**Interface Issues**
3.1	Interface Proposals	IHSL shall use its best endeavours to diligently develop the IHSL's Interface Proposals, these being both its Project Co Proposals and Method Statements addressing the requirements of Appendix A. The Interface Proposals shall be finalised in conjunction with the Board to ensure that both parties are satisfied that the Interface Proposals robustly address the requirements of Appendix A. This shall be a key part of the early stages of the Preferred Bidder period.
4.		**Strategic and Management Issues**
4.1	General	IHSL to work with the Board to progress, agree and finalise, as a Method Statement(s) the proposals contained in the Final Tender in respect of performance management and review, surveys and audits, reporting, workshops and meetings in order to capture the proposed strategic and management approach
4.2	B2	IHSL to develop with the Board the proposed set of specific measurable performance mechanisms and agree a review mechanism for these.
4.3	B3	IHSL to work with the Board to develop the proposals for data collection and provision, communication and mobilisation workshops, surveys and audits, and future performance review.
4.4	B4	IHSL to work with the Board to develop a proposed schedule of meetings and work streams. IHSL to provide further details of proposed KPIs for interface.
4.5	B7	IHSL to provide the Board with further detail in respect of the proposed asset tagging of Board direct supply equipment.
4.6	B8	IHSL to work with the Board to develop the proposals for a meeting and reporting structure, including monthly status reports and the proposed liaison committee.

4.7	B10	IHSL to develop with the Board proposals for project information packs, training and knowledge sharing
4.8	B12	IHSL to provide the Board with the draft Health and Safety Management Plan for review. IHSL to agree with the Board the KPIs to measure the implementation of health and safety management.
5.		**Design and Construction Issues**
		The following list of design and construction issues shall be incorporated into IHSL's proposals/Project Co Proposals at Financial Close:
5.1	C1	IHSL to provide to the Board, within 8 weeks of the Preferred Bidder Appointment, further details of the enhanced screening to separate adults from children at the Emergency Department ambulance entrance. IHSL to review with the Board, within 8 weeks of the Preferred Bidder Appointment, the layout of the 4 bedded bay within the children's wards. IHSL to review with the Board, within 8 weeks of the Preferred Bidder Appointment, the design of the linen bays within clinical areas.
5.2	C2	IHSL to provide to the Board, within 8 weeks of the Preferred Bidder Appointment, further details on the economic impact of the heated areas in the gardens.
5.3	C3	The extent of the anti-ligature provision is in accordance with the Board's Construction Requirements, as clarified. The Board confirms that there will be no carpet in clinical areas. The Board wishes to review with the Bidder the location and form of the external staircase at the main entrance. IHSL to provide detailed landscaping proposals for the Petrol Station Site within 8 weeks of the Preferred Bidder Appointment.
5.4	C5	The Board wishes to discuss further the opportunities for expansion of the ground floor.
5.5	C6	IHSL shall provide assurance to the Board that the colours of the proposed signage will provide clarity for the visually impaired. IHSL shall provide assurance to the Board that where it is proposed to use graphics that all issues of copyright have been addressed.
5.6	C8	IHSL shall provide to the Board, within 8 weeks of the Preferred Bidder Appointment, further details on the domestic hot water generation and

		storage capacity based on the occupancies and usage requirements. IHSL shall provide to the Board, within 8 weeks of the Preferred Bidder Appointment, the finalised fire strategy including sprinkler coverage and categorisation. IHSL shall provide to the Board, within 8 weeks of Preferred Bidder Appointment, developed UPS Load assessments for consideration by the Board. IHSL to provide to the Board, within 8 weeks of Preferred Bidder Appointment, developed metering strategy for consideration by the Board. IHSL to provide to the Board, within 4 weeks of Preferred Bidder Appointment, typical installation details of the wiring / containment systems that have been proposed (in particular modular wiring / pre-wired trunking / supertube) for consideration by the Board.
5.7	C9	IHSL to consider, within 4 weeks of Preferred Bidder Appointment, maintenance and infection control issues with their significant use of LED light fittings. IHSL to provide to the Board, within 4 weeks of Preferred Bidder Appointment, confirmation that their lighting design will be in compliance with LG2 for lighting illumination levels and not going up to 10% below minimum stated values. At this time, IHSL also to confirm to the Board that this has no impact on their Energy Targets.
5.8	C10	IHSL to provide to the Board details of CHP optimisation strategy during Preferred Bidder stage with respect to controls, ranking, heat and electrical load matching, heat rejection, efficiencies and number of system start-ups. Proposals shall be provided to the Board for its review and acceptance prior to financial close. IHSL to provide to the Board details of motorised valves on water distribution to toilets during Preferred Bidder stage. IHSL to provide to the Board system description and schematic drawings for its review and acceptance, and confirm proposals comply with SHTM 04-01, with particular emphasis on water supplies to patient bedrooms, prior to Financial Close. IHSL to confirm to the Board prior to Financial Close that "good quality" CHPQA registration and certification will be obtained for the combined heat and power (CHP) installation. IHSL to confirm it will continue to develop a 'bespoke' energy model for the Facilities, in line with Appendix F *(Thermal and Energy Model Parameters)* of the Invitation to Submit Final Tender. IHSL also confirms that it shall work in collaboration with the Board to provide as accurate an estimated energy consumption figure, by fuel type, for the Board's annual Utilities cost forecasting.

		Prior to Financial Close, IHSL shall provide accurate estimates of water consumption and waste water outflows for IHSL's design solution, based on a Good Industry Practice calculation methodology, to inform the Board of annual water consumption costs for the Board's Utilities cost forecasting.
5.9	C12	The Board notes that there are a number of rooms which, whilst meeting the room areas in the Reference Design, do not meet those in the Draft Schedule of Accommodation. The Board would welcome efforts to adjust such rooms to achieve compliance with the Draft Schedule of Accommodation.
5.10	C17	IHSL s required to undertake extensive further development of storm and foul water, and SUDs systems including for the 1:1000 check for flooding. Surface drainage proposal for south east corner of the site are not fully developed. IHSL to further develop the car park detail with particular attention to boundary conditions. IHSL to develop and provide full detail and specification for gas membrane along with any protection required to protect buried pipework. At present IHSL allows for Radon Gas protection only.
5.11	C18	IHSL shall provide to the Board, within 8 weeks of the Preferred Bidder Appointment, the physical location, content and capacity of the new twin-gas governor arrangement. IHSL shall provide to the Board, within 8 weeks of the Preferred Bidder Appointment, further details on the dual water mains supplies. IHSL shall provide to the Board, within 8 weeks of the Preferred Bidder Appointment, the Board are keen to understand the potential to reduce energy consumption as the gas and electrical supply capacities are close to EUETS threshold. IHSL shall provide to the Board, within 8 weeks of the Preferred Bidder Appointment confirmation that his incoming HV Supply design will be in compliance with SHTM06-01 with particular reference to a 5-panel DNO HV switchboard. IHSL shall provide to the Board, within 4 weeks of the Preferred Bidder Appointment, details of the fire routing for consideration by the Board. IHSL shall provide to the Board, within 4 weeks of the Preferred Bidder Appointment details of the telecoms route from Old Dalkeith Road for consideration by the Board. IHSL shall provide to the Board, within 4 weeks of the Preferred Bidder Appointment, further details of the main supply substation and cable routes for consideration by the Board.
5.12	C19	IHSL shall work with the Board to develop and incorporate LZCT solutions and the potential use of grey water to maximise BREEAM

		credits to achieve the required rating of 'Excellent'.
5.13	C21	IHSL to confirm corridor widths that do not meet the NHS Requirements within 4 weeks of the Preferred Bidder Appointment.
5.14	C24	Location, use and restrictions for the temporary footpath from Car Park E to Old Dalkeith Road to the Site to be agreed within 8 weeks of the Preferred Bidder Appointment. IHSL's temporary site office storm drain connection proposed to connect into the county sewer if it is a combined drain. The county sewer is not a combined drain and IHSL will have to provide proposals for appropriate storm drain connection for its temporary site office within 8 weeks of the Preferred Bidder Appointment. IHSL to agree with the Board the environmental sensitive locations in the RIE Facilities within 8 weeks of the Preferred Bidder Appointment. .
5.15	C25	IHSL to conclude before Financial Close the commissioning programme and supporting methodology. IHSL's Commissioning Programme at Task 87 - Fire Alarm runs past the Completion Date. IHSL to conclude the Handover Clean Protocol prior to Financial Close. IHSL to agree with the Board, prior to Financial Close, the access for the Board during the Works including access for equipment installation (Groups 2A, 2B and 3) and the Board's Contractors.
5.16	C27	Confirmation required of 18001 accreditation of principle being used as an umbrella for all parties.
5.17	C28	IHSL to further develop proposals to comply with CDM regulations and in particular its obligation as "client" pursuant to such regulations. Sections 184/185 and 263 to be further developed at Preferred Bidder stage.
5.18	Acoustics	Within 4 weeks of the date of this Preferred Bidder Appointment, the Board requires that IHSL clarifies the construction methodology for dealing with impact sound transmission through floors. The Board requires confirmation that IHSL will take the necessary measures to meet the criteria for gaining BREEAM 2011 Credit Po105 as per the BCRs. Within 4 weeks of the date of this Preferred Bidder Appointment, the Board requires that IHSL clarifies the acoustic strategy for the Department of Audiology.
5.19	Helipad	The Board wishes to discuss with IHSL the configuration of the ramp with a view to reducing the distance between the bottom of the ramp and the "hot" lift core. The Board wishes to discuss with IHSL the implications of designing the

		helipad to take the heavier (15 Ton) Merlin aircraft rather than the (12 Ton) S92.
6.		**FM Issues**
		The following list of facilities management issues shall be incorporated into IHSL's proposals/Method Statements at Financial Close:
6.1	D1	IHSL's Method Statement shall reflect the additional detail required by the Board that all new staff shall be required to have received Occupational Health clearance prior to commencement on the Site.
6.2	D4	IHSL shall develop a Method Statement which shall set out its approach to Environmental Management, Quality Management and Health and Safety to reflect the integrated system proposed by IHSL. The content and scope of the system shall cover the full range of the Services.
6.3	D5	IHSL shall liaise with the Board to further develop its Escalation protocol for major incidents.
6.4	D6	IHSL shall work with the Board to discuss and agree any requirement for development of Departmental SLA's proposed by ISHL in relation to IHSL's approach to interfacing with the Board for undertaking works outside access times.
6.5	D8	IHSL shall liaise with the Board to develop Business Continuity Plans to reflect that the Board needs to be informed immediately of any Business Continuity incidents.
6.6	D10	IHSL shall review and agree with the Board its response to NHS alarms. IHSL shall review and agree with the Board its approach to Helipad lighting maintenance. IHSL shall reflect the information provided within the Reference Bulletin-00151/BULL RES-130 with regard to window and façade cleaning within their Method Statement.
6.7	D12	IHSL shall review and agree responsibilities for legislative compliance for energy and carbon. The Board is concerned that IHSL indicated within its proposal that the responsibility sits mainly with the Board.
6.8	D15	IHSL shall review and agree the process for security clearances for staff with the Board.
7.		**Financial Issues**
7.1		N/A
8.		**Funding Competition Issues**

8.1		N/A
9.		**Planning Issues**
9.1	General	IHSL shall use its best endeavours to diligently develop IHSL's planning issues, both design development including but not restricted to the following areas: - Impression of 'big brother' on approach from the south; - Quality and detailing of 'little brother'; - Hard and soft landscaping proposals across "Hospital Square" and in the immediate environs of the building creating visual complexity, for example, 'The Willows' requiring redesign and simplification; - Arrival experience and pedestrian legibility; and - The quality of internal and external spaces. The planning issues shall be finalised in conjunction with the Board, City of Edinburgh Council and Architecture and Design Scotland to ensure that all parties are satisfied that the Planning Proposals. This shall be a key part of the early stages of the Preferred Bidder period.
10.		**Insurance Issues**
10.1		N/A

Schedule Part 4

IHSL's gaps list in relation to the Final Tender (Bidder B) NPD Project Agreement

Please refer to the separate paper apart which sets out IHSL's gaps list in relation to its Final Tender (Bidder B) NPD Project Agreement.

Schedule Part 5

Clarifications in respect of IHSL's Final Tender

The following table sets out a list of the Clarifications, Bulletins and Bulletin Responses issued by the Board and/or IHSL via Conject during the period after the submission of IHSL's Final Tender. Please note that the Board has deemed that IHSL's Final Tender has been updated and/or amended in respect of all such Clarifications, Bulletins and Bulletin Responses as set out below:

Clarifications in respect of IHSL's Final Tender			
Item	**Description**	**Raised by**	**Reference**
1	Paediatric Bio Lab Costs	Bidder B	Bulletin-00153/BULL RES-134
2	Bidder B C30	Bidder B	Bulletin-00152/BULL RES-133
3	Paediatric Bio Lab Costs	Board	Bulletin-00153
4	Bidder B C30	Board	Bulletin-00152
5	Gas Consumption Clarification - C10	Bidder B	Bulletin-00150/BULL RES-132
6	Gas Consumption Clarification - C10	Bidder B	Bulletin-00150/BULL RES-131
7	Window Cleaning Strategy - Clarification.	Bidder B	Bulletin-00151/BULL RES-130
8	Final Tender Announcement Date	Board	CLAR-00188
9	Window Cleaning Strategy - Clarification.	Board	Bulletin-00151
10	Gas Consumption Clarification - C10	Bidder B	Bulletin-00150/BULL RES-129
11	Gas Consumption Clarification - C10	Board	Bulletin-00150/BULL RES-128
12	Gas Consumption Clarification - C10	Bidder B	Bulletin-00150/BULL RES-127
13	Gas Consumption Clarification - C10	Board	Bulletin-00150
14	Financial Model Clarification	Bidder B	Bulletin-00147/BULL RES-126
15	D14 - MS Word Format	Bidder B	Bulletin-00148/BULL RES-125
16	D14 - MS Word Format	Bidder B	Bulletin-00148/BULL RES-124
17	D14 - MS Word Format	Board	Bulletin-00148
18	Final Tender Heads of Terms	Bidder B	Bulletin-00145/BULL RES-123
19	Funders' Legal Adviser	Bidder B	Bulletin-00146/BULL RES-122
20	Financial Model Clarification	Board	Bulletin-00147
21	Funders' Legal Adviser	Board	Bulletin-00146
22	Final Tender Heads of Terms	Board	Bulletin-00145
23	Final Tender Submission - Executive Summary Video	Bidder B	Bulletin-00144/BULL RES-121
24	Final Tender Submission - Executive Summary Video	Board	Bulletin-00144
25	Final Tender Submission - Executive Summary Video	Board	Bulletin-00143/BULL RES-120
26	Final Tender Submission - Executive Summary Video	Bidder B	Bulletin-00143/BULL RES-119
27	Final Tender Submission - Executive Summary Video	Board	Bulletin-00143
28	Final Tender : C31	Bidder B	Bulletin-00142/BULL RES-118
29	Appendices	Bidder B	Bulletin-00141/BULL RES-117
30	Appendices	Bidder B	Bulletin-00141/BULL RES-116

31	Final Tender : C31	Board	Bulletin-00142
32	Appendices	Board	Bulletin-00141
33	Final Tender : C4	Bidder B	Bulletin-00140/BULL RES-115
34	Final Tender : C4	Board	Bulletin-00140
35	Final Tender Finance Submission	Bidder B	Bulletin-00139/BULL RES-114
36	Final Tender Legal Submission	Bidder B	Bulletin-00138/BULL RES-113
37	Financial Submission	Bidder B	Bulletin-00137/BULL RES-112
38	Financial Submission	Board	Bulletin-00137/BULL RES-111
39	Final Tender Finance Submission	Board	Bulletin-00139
40	Final Tender Legal Submission	Board	Bulletin-00138
41	Financial Submission	Bidder B	Bulletin-00137/BULL RES-110
42	Financial Submission	Board	Bulletin-00137
43	Financial submission	Bidder B	Bulletin-00136/BULL RES-109
44	Financial submission	Board	Bulletin-00136
45	Final Tender Submission Folders	Board	Bulletin-00135

Comments from Colin Proctor SFT 23/1/12

Draft CIG Business Case Checklist – IA, OBC & FBC

Phase	Step	SCIM Checklist – Current Questions*	Questions Added by CIG
1) Scoping (**Initial Agreement)**	Step 1 (Ascertain Strategic Fit)	The SCIM Business Case Guide does not identify checklist issues for this step.	1. Is there a clear case for change and is it 'future proofed' (based on robust future demand projections) and compatible with the principles of Shifting the Balance of Care? 2. Is this a national priority and how might other Health Boards benefit? 3. Is there a clear assessment of how it fits with the Government Economic Strategy and Purpose and Community Plans (CPPs and SOAs)? 4. Is it clear how the case for change fits strategically with other national priorities/programmes/strategies and the local clinical strategy? 5. Is it identified in local development plans (planning), asset management strategies and capital investment plans?
	GATEWAY REVIEW STAGE – GATE 0 – STRATEGIC FIT		
	Step 2 (Strategic Context and Strategic Case)	• Are the investment objectives for the project clear and SMART? • Is there a clear understanding of the existing arrangements and an explanation of "the problem? • Is there a clear exposition of the business needs? • Is there a clear strategy for the consideration of design quality and sustainability and does this take account of policy practice (eg consulting rooms for students in light of extension of GP training capacity)?	1. Is there a clear assessment of how the proposal fits with the 3 Quality Ambitions of the Quality Strategy and Better Health, Better Care? 2. Is there a clear assessment of how the proposal takes account of other public sector interests and opportunities for collaboration? 3. Is there a clear benefits criteria showing the main benefits by key stakeholder groups (stakeholder and gap analyses)? 4. If the project is part of a programme have the

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Phase	Step	SCIM Checklist – Current Questions*	Questions Added by CIG
		• Is there a clear understanding of the potential scope for the project and/or procurement? • Is there a clear statement of the associated benefits, risks, constraints and dependencies for the project?	programme benefits/goals been clearly addressed? 5. Is there an up-to-date masterplan and clear connection to the disposal plan for existing property to show how will the board add value to disposal? **Is there a clear understanding of:** 6. the expected outcomes and expected return on investment? 7. how benefits are to be realised and measured? 8. the patient/service user needs? 9. the existing arrangements and the potential scope for service re-design? 10. the connection to other organisational areas – e.g. Information Systems, IT and Human Resources – and future plans for the organisation? 11. the clinical service/workforce changes required to successfully to deliver the project? 12. the impact on community and environment?
	Step 3 (Economic Case- Part 1)	• Is there a clear understanding of the project's critical success factors? • Is there a long list of 10 to 12 options and have they been subjected to SWOT analysis and do they include geographic , delivery and implementation alternatives, eg outsourcing/partnering with private/public sector? • Is there an emerging way forward? • Is there a shortlist of 3 to 4 options and do they have	1. Does the market analysis cover what already exists locally or in nearby Health Boards and whether there is an opportunity to deliver the service regionally? 2. Is there an assessment of the options using the CSFs to show how well each option meets the investment objectives and benefits critiera? 3. Is there an outline consideration of the clinical and technical case for the project and does the

Insert requirements for steps 4 to 7?

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Phase	Step	SCIM Checklist – Current Questions*	Questions Added by CIG
		indicative costs for full evaluation in the Outline Business Case (including do nothing/minimum option)? • Is there an outline consideration of the financial, commercial and management cases? • Are the project management arrangements clear and evidence provided of capacity and capability of project team?	technical case cover an assessment of: the right location; accessibility; planning and design; community and environment; construction; sustainability; and operation considerations.
	• Has the NDAP's response about the design assessment process been taken into consideration?		
	GATEWAY REVIEW STAGE – GATE 1 – BUSINESS JUSTIFICATION		
	KEY STAGE REVIEW PRE-NPR REVIEW		
2) Planning (Outline Business Case)	Step X (Strategic Case – OBC)	SCIM does not have a step at this point of the OBC	1. Have any relevant updates to the Strategic Case been included? 2. Have investment objectives been ranked in order of priority and made SMART?
	Step 4 (Economic Case – Part 2)	• Is there a revisited and updated Outline Business Case long list? • Is there a revisited and updated Outline Business Case shortlist? • Are there economic appraisals (NPVs) for the shortlisted options, are they risk adjusted (in £s) and do they apply the Optimism Bias? • Are there assessments of both the non-financial risks and benefits? • Is there an assessment of the uncertainties (sensitivity analysis)? • Is there a detailed description of the preferred option (an assessment of a benefit/cost ratio calculated to estimate the VfM and risk)?	1. Is the benefits criteria used to clearly assess the main benefits by key stakeholder groups ranked in order of importance/weight? 2. Is there a reference case (do minimum or do nothing) and, if not, is there an explanation? 3. Is there an assessment of how the project sits with other major investment projects in the Health Board and the potential impacts on costs and timescales? 4. How have opportunities for collaboration with other public bodes been further developed?

Phase	Step	SCIM Checklist – Current Questions*	Questions Added by CIG
	Step 5 (Commercial Case)	**Is there a clear understanding of**: • the procurement strategy, including the proposed procurement methodology and the use of the EC/WTO procurement process? • the scope of the potential deal and required services? • the implementation timescales for the proposed deal? • the supporting payment (or charging) mechanism? • The (recognised) contract being proposed for use and key contractual issues, including TUPE (if applicable) and other personnel implications? • Is there a draft OJEU notice and statement of requirements (to support the above)?	**Is there a clear understanding of**: 1. potential risk allocation and how the risk analysis is used to identify the appropriate, most cost effective procurement strategy? 2. The appropriate form of contract, risk and profit distribution? 3. Potential accountancy treatment? 4. Other similar projects planned by the Health Board, locally or in other Health Boards, and opportunities for bulk purchase, eg materials? 5. The masterplan and outline design?
	Step 6 (Financial Case)	**Is there a clear understanding of:** • The capital and revenue implications of the preferred option and deal? • The impact on the income and expenditure account and the organisation's charges for services (if applicable)? • The impact on the budget, other sources of available funding and any shortfalls? • The impact on the balance sheet? • Is there written evidence of commissioner and stakeholder support?	**Is there a clear understanding of:** 1. Lifecycle costing and evidence that the Health Board can afford lifecycle costs?
	Step 7 (Management Case)	**Is there a clear understanding of:** • The project management arrangements? • Project team capacity and capability? • The change management arrangements?	**Is there a clear understanding of:** 1. Have different funding routes been considered? 2. The Procurement Strategy and the intended method of procurement (including EC/GATT

Phase	Step	SCIM Checklist – Current Questions*	Questions Added by CIG
		• The benefits realisation arrangements, including an attached risk register? • The post project evaluation arrangements?	regulations; evaluation criteria; and selection of preferred bidder)
	• Has the NDAP's response about the design assessment process been taken into consideration?		
	GATEWAY REVIEW STAGE – GATE 2 – PROCUREMENT STRATEGY		
	KEY STAGE REVIEW PRE-STAGE 1 APPROVAL REVIEW		
3) Procurement (**Full Business Case)**	Step 8 (Economic Case)	**Is there a clear understanding of:** • Any alterations to the strategic context and the case for change? • The entire procurement process and service providers' offers? • How the selection of the preferred service provider was made on the basis of an updated CPAM (if applicable) and the investment appraisals, including the SCIM options appraisal guide, generic economic model, optimism bias models which all apply HM Treasury Green Book rules?	**Is there a clear understanding of:** 1. Any major service/design changes? 2. The preferred option and, even if options have changed, an assessment that VfM is still the same and the costs, benefits and risks attributed to the preferred option are still valid? 3. The Value for Money assessment which shows the economic (VfM) and financial (affordability) appraisals separately? 4. The results of the risk/benefits appraisal? 5. The suitability of the methodology indicated in the post project evaluation?
	Step 9 (Commercia l Case)	**Is there a clear understanding of:** • The financial implications of the proposed deal, both in terms of the organisation's contractual obligations and associated spend in support of the required services?	No questions added by CIG
	Step 10 (Manageme nt Case)	**Is there a precise understanding of:** • How the project will be managed? • How change within the organisation will be implemented? • How the benefits will be realised? • How the business and service risks will be mitigated	**Is there a precise understanding of** 1. The scope and services to be provided including timescales for implementation? 2. Key contractual arrangements including timescales? 3. Personnel implications?

Phase	Step	SCIM Checklist – Current Questions*	Questions Added by CIG
		and managed? • How major contract change will be reviewed periodically? • What the contingency plans are in the event of service failure?	4. Accountancy treatment and impact on balance sheet and income and expenditure account? 5. Overall affordability
	• Has the NDAP's response about the design assessment process been taken into consideration?		
	GATEWAY REVIEW STAGE – GATE 3 – INVESTMENT DECISION		
	KEY STAGE REVIEW PRE-CLOSE REVIEW		

* Underlined words and phrases under 'SCIM Checklist – Current Questions' have been suggested by CIG members as additions/revisions

From: Stillie, David
Sent: 06 February 2012 11:49
To: Brady, Thomas; Cantlay, Richard D; McQuarrie, Fraser
Cc: Scott, Andrew G
Subject: RE: RHSC + DCN - Little France | NDAP Review

All

Meeting did take place on 20th January and I spoke to Peter Henderson (architect) at HFS on 23rd
January. No clear way forward came out of the meeting but he did say that everyone present appreciated
that RHSC/DCN project had been reviewed "to death".

I was unable to get a definitive answer from him before the last RDT meeting as he wanted to discuss
further with SFT.

I think it now falls to NHSL, probably Brian, to move this forward with SFT. I imagine he is reluctant to
raise the issue in case it prompts a further round of review meetings.

Regards

David

From: Brady, Thomas [mailto:thomas.brady@davislangdon.com]
Sent: 06 February 2012 11:09
To: Cantlay, Richard D; McQuarrie, Fraser
Cc: Stillie, David
Subject: RHSC + DCN - Little France | NDAP Review
All

The reference design team have been trying to ascertain, for some time now, if we need to complete a
NDAP (NHS Design Assessment Procedure) review of the scheme.

David was advised that a meeting was to be held on 20th Jan between SFT / HfS / A+DS / Scottish
government to discuss if the NDAP review procedure was a requirement for NPD Contracts.

Can either of you raise this with BC to allow the date to be arranged (if required)

Thanks

Tom

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RE-PROVISION OF THE RHSC AND DCN AT LITTLE FRANCE

A project to re-provide the services from the Royal Hospital for Sick Children, Child and Adolescent Mental Health Service and the Department of Clinical Neurosciences in a single building adjoining the Royal Infirmary of Edinburgh at Little France

FULL BUSINESS CASE

Version 2

A42675936

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GLOSSARY

ASP	Annual service payment
BREEAM	Building Research Establishment Environmental Assessment Methodology
CAMHS	Child and Adolescent Mental Health Services
CEL	Chief Executive's Letter, from the Chief Executive of NHS Scotland
CIG	Capital Investment Group
DCN	Department of Clinical Neurosciences
ECCM	East coast costing model
EIB	European Investment Bank
FBC	Full Business Case
FM	Facilities management
HEAT	NHS Scotland targets, under headings of Health, Efficiency, Access, Treatment
HDU	High dependency unit, also known as level 2 critical care
ICT	Information and communications technology
ICU	Intensive care unit, also known as level 3 critical care
IHSL	Integrated Health Solutions Lothian, the preferred bidder appointed as Project Co
ISFT	Invitation to submit final tenders
KSR	Key Stage Review
LDP	Local delivery plan
NPD	Non-profit distributing, the public private partnership model used for this project
NPV	Net present value
OBC	Outline Business Case
OJEU	Official Journal of the European Union
PFI	Private finance initiative, the model for the Royal Infirmary of Edinburgh contract
PICU	Paediatric intensive care unit
Project Co	The name given to the consortium appointed to deliver the NPD project.
PTS	Pneumatic tube system
REH	Royal Edinburgh Hospital
RHSC	Royal Hospital for Sick Children
RIE	Royal Infirmary of Edinburgh, on the Little France campus
SA6	Supplemental Agreement 6 to the RIE Project Agreement
SEAT	South-east and Tayside regional planning for NHS Scotland
SFT	Scottish Futures Trust
SGHSCD	Scottish Government Health and Social Care Directorate
SRO	Senior responsible officer
WGH	Western General Hospital

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1 EXECUTIVE SUMMARY

This Full Business Case (FBC) has been developed following Scottish Capital Investment Manual guidance. It is based on NHS Lothian's Outline Business Case (OBC) for the Royal Hospital for Sick Children (RHSC) and Department of Clinical Neurosciences (DCN) approved by the Scottish Government in September 2012.

1.1 Strategic Context

1.1.1 NHS Lothian has introduced a new Strategic Clinical Framework, in line with the NHSScotland Quality Framework and 2020 Vision, since the OBC was written, however the strategic need for a new RHSC and DCN has not changed. The clinical drivers and policies underpinning the OBC remain relevant, and the need to maintain Waiting Times Standards makes the case even stronger.

1.1.2 While RHSC and DCN successfully provide safe and effective specialist clinical care, the ongoing delivery and development of these services is limited by the challenges posed by geography and by outdated accommodation, with considerable backlog maintenance issues, that cannot be adapted to provide the best service possible.

1.1.3 The investment objectives, or benefits, of the project have not changed. Moving the RHSC, CAMHS and DCN into purpose-built 21st century facilities will improve NHS Lothian's efficiency in using its resources for safe and effective patient care.

1.2 Economic Case

1.2.1 The preferred location for the project has not changed since OBC; co-locating this range of services at Little France will maximise synergies between acute healthcare specialties.

1.2.2 Evaluation in the OBC confirmed that, of the procurement options available to NHS Lothian, a non-profit distributing (NPD) project which brought together children's and neurosciences services in one facility was the most economically advantageous outcome.

1.3 Commercial Case

1.3.1 The FBC is submitted following completion of competitive dialogue with three bidders, the evaluation of final tenders and the appointment of Integrated Health Solutions Lothian (IHSL) as preferred bidder in March 2014.

1.3.2 The FBC outlines the scope of the NPD contract, including risk transferred to the private sector, based on the Scottish Futures Trust (SFT) standard form Project Agreement. Hard facilities management (FM), or estates, is a part of the contract. In line with NHSScotland policy, all other FM services will be delivered by NHS Lothian.

1.3.3 Complex interdependencies with the existing PFI contract for the Royal Infirmary of Edinburgh (RIE) at Little France are recognised in the NPD Project Agreement. The Little France Campus Working Group, chaired by NHS Lothian, has been established to manage relations and operations between all parties on site.

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1.3.4 Commercial arrangements with the existing PFI provider are required for NHS Lothian to:

- Secure vacant possession of the site from Consort, with sufficient enabling works completed for IHSL to start construction in October 2014; and
- Procure works to develop RIE clinical services to support the model and patient pathways for RHSC and DCN. These works require to be contracted through Consort.

1.3.5 The value and scope of charitable donations for the RHSC and DCN is to be determined, and these arrangements will be formalised in accordance with best practice.

1.4 Financial Case

1.4.1 The total capital value of the project is £227m, a marginal decrease from the OBC projection.

1.4.2 A decrease in the NPD capital costs, reflecting the competitive final tender cost, was offset by increased non NPD capital costs, mostly in clinical enabling and offsite flood works.

1.4.3 The SFT cap has now been adjusted downwards to reflect the final tender NPD costs and any increase in the annual service payment due to further design development will be the responsibility of NHS Lothian. SGHSCD have confirmed they will fully fund the revised non NPD capital costs.

1.4.4 The OBC FM costs were estimated on a rate per square metre, and for FBC have now been developed based on the final tender design. The revised costs, after offset by existing budgets, are estimated to be £1m per annum higher than allowed for at OBC.

1.4.5 Additional clinical staffing for the building was explicitly excluded from the OBC, which stated that this required to be addressed through normal financial planning. Since then, detailed work has been carried out by NHSL and partner Boards to identify the staffing required to deliver the agreed service model.

1.4.6 The revenue cost associated with legislation or policy requirements gives rise to a resource gap of £3.6m. Of this, £1.9m relates to the provision of additional capacity for NHS Lothian and will be covered from existing NHS Lothian capacity budgets. The remaining balance will be shared with other systems, including SEAT partners.

1.4.7 It is fully recognised that further work is required, in collaboration with partner Boards, to continue to refine and agree the remaining operational costs to deliver the agreed service model. In particular, costs of £3.9m associated with additional capacity (16 beds to open in 2017 and 3 theatres) and developments totalling £0.9m where there is a choice about phasing, have not been agreed at this point and will require further scrutiny.

1.4.8 The net revenue impact at FBC is £10.8m, £2.5m higher than that projected at OBC.

1.4.9 NHS Lothian confirms that the financial consequences will ultimately be managed as part of their financial planning process.

1.5 Management case

1.5.1 The FBC expands on the project management arrangements described at OBC. This includes responsibilities in the period up to financial close, the construction and commissioning phase, and the 25-year operational term of the contract.

1.6 Approval by other Boards

1.6.1 NHS Borders, Dumfries and Galloway, Fife, Forth Valley and Tayside all confirmed their support in principle for the new RHSC and DCN service model and the NPD project at OBC.

1.6.2 Through the South-east and Tayside (SEAT) group, NHSL have shared, scrutinised and agreed to the running costs of the proposed model with the partner Boards.

1.7 Programme

1.7.1 The approval process and dates for the FBC are based on the programme to reach Financial Close on 2 October 2014, as agreed with Integrated Health Solutions Lothian:

Activity	Timescale
Endorsement of FBC by Project Steering Board	20/06/2014
Approval by NHS Borders, Dumfries & Galloway, Fife and Forth Valley	27/06/2014
Approval of FBC by Finance and Resources Committee	09/07/2014
Approval of FBC by NHS Lothian Board	06/08/2014
Submission of FBC to SGHSCD CIG	29/07/2014
FBC presentation to SGHSCD CIG	05/08/2014
SGHSCD meeting to consider FBC	26/08/2014
Financial close	02/10/2014
Start on site	03/10/2014
Completion / handover	17/02/2017
Project Co FM service commencement	17/02/2017
Hospital Opens	15/05/2017

1.7.2 Approval of the FBC by SGHSCD's Capital Investment Group will allow NHS Lothian to proceed to financial close with the preferred bidder subject to completion of the pre-financial close Key Stage Review (KSR).

1.7.3 Following financial close an FBC Addendum will be prepared to inform NHS Lothian Board and SGHSCD of the final details of the contract.

1.8 Confirmation of status

1.8.1 This FBC was approved by NHS Lothian Board on 6 August 2014 for submission to the SGHSCD Capital Investment Group.

1.8.2 The support from the Scottish Government is outlined in the 2012 funding letter and the March 2014 pre-preferred bidder KSR carried out by SFT.

1.8.3 Contributions from partner NHS Boards have been confirmed, with letters of support attached at Appendix 1.

1.9 Statement of Affordability

1.9.1 NHS Lothian confirms that the financial consequences will be ultimately managed as part of their financial and capital plan process; with support from the Scottish Government NHS Boards and charity partners.

2 THE STRATEGIC CASE

This section describes:

- the national and local context for the project;
- the service model and scope of the project;
- the objectives and benefits of the project; and
- highlights the constraints and dependences.

2.1 Strategic Context

2.1.1 National Strategy

The Scottish Government's vision is for sustainable, quality health care services and works to deliver a healthier future for everyone. The strategic context for this project remains consistent from OBC and the planning for RHSC and DCN has been taken forward in line with all national policy, local strategy and NHS guidance including but not limited to:

- NHS Scotland's Quality Strategy[1] to deliver person-centred, safe, effective, efficient, equitable and timely healthcare, and the implementation plan, 2020 Vision.
- The directive on inpatient accommodation, where all patients will be accommodated in single rooms unless there are clinical reasons for multi-bedded rooms to be available.[2]
- The recommendation that care for children and young people up to age 16, and age 18 for mental health and some complex and chronic conditions, should be provided in age-appropriate facilities.[3]
- Better Health Better Care, with its emphasis on improving quality, addressing excessive variation in practice, and ensuring the highest standards of patient safety.
- The policy to have two Paediatric Intensive Care Units in Scotland, commissioned under NHS National Services;
- Delivering for Health, which describes shifting the balance to community based care with improved partnership working.
- The Kerr Report developed the modernisation and re-design of health services that meet the needs of the local population with local access to services. This includes the provision of integrated health services and improved access to diagnostic and treatment facilities, and specific to this project, the recommendation to deliver adult and paediatric neurosurgery on the same site. [4]
- Modernising Medical Careers, the Consultants' Contract and the European Working Time Regulation all affect workforce planning.
- The requirement that all NHS Boards contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.

The service model that will deliver on these strategies and policies is outlined in section 2.8.

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[1] Scottish Government (2010): *NHSScotland Quality Strategy – putting people at the heart of our NHS*
[2] CEL 27 (2010) on *Provision of Single Room Accommodation and Bed Spacing*
[3] Scottish Government (May 2009): *Hospital Services for Young People*
[4] Kerr (2005): *Building a Health Service 'Fit for the Future'.* Earlier reviews of paediatric surgical services have also made the same recommendations in Kennedy (2001) *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary1984-1995*, and The Society of British Neurological Surgeons (2000) *Safe Neurosurgery.*

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2.2 Organisational overview

2.2.1 NHS Lothian

NHS Lothian provides a comprehensive range of primary, community-based and acute hospital services for the populations of Edinburgh, Midlothian, East Lothian and West Lothian.

NHS Lothian provides services for the second largest residential population in Scotland - circa 800,000 people – and tertiary and national services by contract with other NHS Boards and NHSScotland. NHS Lothian employs approximately 24,000 staff.

2.2.2 Services related to this project

The Royal Hospital for Sick Children provides a comprehensive range of dedicated children's services, including its own accident and emergency department. The RHSC offers acute medical and surgical care, specialist surgical and medical care, haematology and oncology, day care and critical care to Lothian and the South-East and Tayside (SEAT) region. The outpatient department cares for more than 34,000 patients a year.

Child and Adolescent Mental Health Services inpatient and day case facilities are provided for the SEAT region at the Young People's Unit at the Royal Edinburgh Hospital and two satellite units in South Edinburgh.

The Department of Clinical Neurosciences at the Western General Hospital provides acute neurology services for Lothian patients and the tertiary service for the South-East of Scotland and Dumfries and Galloway, and neurosurgery for the same regional population.

2.2.3 NHS Lothian Strategy

NHS Lothian's Strategic Clinical Framework[5] commits to ensuring safe, effective and person-centred care through six strategic aims:

1. Prioritise prevention, reduce inequalities and promote longer healthier lives for all
2. Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
3. Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
4. Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
5. Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
6. Use the resources we have – skilled people, technology, buildings and equipment – efficiently and effectively.

NHS Lothian's Strategic Plan for 2014-2020[6] includes specific proposals to develop services for children, young people and adult neurosciences patients, and cites the delivery of the RHSC and DCN at Little France as a vehicle for these commitments:

a) To implement the NHS Lothian strategy for children and young people 2013–2020,"Improving the Health and Wellbeing of Lothian's Children and Young People";

[5] NHS Lothian (2013): *Our Health, Our Future*: *NHS Lothian's Strategic Clinical Framework for 2013-2020*
[6] NHS Lothian (2014): *Our Health, Our Care, Our Future*: *NHS Lothian's Draft Strategic Plan for 2014-2020*

b) To develop a strategy (including e-strategy) and fully integrated pathways of care for patients with neurological conditions, head injury, sensory impairment, epilepsy, Huntington's and other rare conditions requiring physical and complex care

NHS Boards must meet the NHSScotland National Waiting Times standards.[7] The NHS Lothian Local Access Policy describes how the organisation will meet its treatment time targets and guarantees.

NHS Lothian's Local Delivery Plan describes the organisations objectives, including HEAT targets, setting out how the Board will contribute to Scotland's vision for sustainable, quality health care services.

2.3 Investment Objectives

2.3.1 Benefits criteria, or investment objectives, were developed specifically for this project by stakeholders in RHSC and DCN services. These have been re-validated at each option appraisal and business case stage of the project.

2.3.2 The key investment objectives for this project, and how they relate to the Scottish Capital Investment Manual (SCIM)[8] are listed below:

- To provide an environment that supports **clinical effectiveness**, meeting of national standards and targets and facilitates the implementation of best evidence based practice leading to improved treatment outcomes for patients. (SCIM: clinical effectiveness, meeting standards, evidence based)

- To provide an environment where clinical service arrangements can be delivered to a standard and timeframe that represents best possible outcome for patients, in conjunction with **best value for money**. (SCIM: efficient use of resources and revenue)

- To provide a physical environment the quality of which **promotes the health and well being** of the building's users. (SCIM: a physical environment to promote health and well being)

- To provide a service environment that will easily allow **engagement and involvement with research** and service development opportunities with our partner higher education institutes. To make research, treatments and interventions, and their potential benefits, available to patients. Attracting highly capable staff with progressive research interests will improve patient care and service delivery. (SCIM: research, education and service development.)

- To provide a scheme option that results in the **minimum possible disruption to patients** and allows the continued delivery of clinical services over the duration of the construction, leading to a solution that provides a more efficient and effective clinical service delivery environment. (SCIM: delivered with minimum disruption; delivered to standard and timeframe with value for money)

[7] CEL 33 (2012: *NHSScotland National Waiting Times Guidance*
[8] Scottish Government (2009): *Scottish Capital Investment Manual*

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- To provide services that will be **safely accessible** to patients, visitors and staff by public and private transport. (SCIM: safely accessible services.)

- To optimise the efficient use of energy, water, waste management and in so doing **reduce lifetime recurring revenue costs** whilst also **reducing the carbon footprint** by minimising pollution generation. (SCIM: efficient use of resources and revenue)

- To **future-proof the capacity** of NHS services. (SCIM: efficient use of resources and revenue)

2.4 Existing arrangements

Figure 1: Map of Edinburgh showing locations of existing hospitals relevant to this project

2.4.1 Services for children and young people are currently provided at the RHSC at Sciennes Place. These acute and tertiary services comprise 131 inpatient and day case beds, five operating theatres, outpatient departments, diagnostic, therapies and laboratory services and all administrative functions to support the children's hospital. Clinical specialities include medicine, surgery, neurosciences and oncology for Lothian and the South-east of Scotland, and one of the two paediatric intensive care units in the country.

2.4.2 CAMHS inpatient and day case facilities are provided at the Young People's Unit at the Royal Edinburgh Hospital (REH) and two satellite units in South Edinburgh. These

comprise 12 inpatient beds and a range of supporting day case and outpatient accommodation.

2.4.3 Adult neurology and neurosurgery services are provided in the DCN at the Western General Hospital in 64 inpatient beds, 2 operating theatres, neuroradiology including interventional radiology, day case investigations, outpatients, therapies and supporting office accommodation.

2.4.4 As outlined in the OBC, the strategic need to deliver national policy and NHS Lothian's business drivers point to the project relocating RHSC, CAMHS and DCN to Little France. This site currently comprises the Royal Infirmary of Edinburgh, University of Edinburgh teaching and research buildings, and the BioQuarter research and development park.

2.5 Future Business Needs: The Case for Change

The case for change outlined in the OBC remains valid and is based on the key drivers outlined below.

2.5.1 RHSC – Clinical Drivers

Services in the existing RHSC have been developed to their maximum capacity; they currently take new patients up to their thirteenth birthday and provide ongoing care to existing patients up to age sixteen, which falls short of national policy to provide care for all young people up to age 16 in appropriate facilities[9].

Paediatric neurosurgery is performed in RHSC by surgeons who also work in DCN on a different site four miles away. Resources are allocated to run planned admissions and operations on both sites, however the emergency service is provided by one on-call surgeon across both services. This is possible due to the small number of admissions, but these patients are acutely unwell and the need for medical staff to travel between sites in an emergency is inefficient and, at worst, a compromise to patient safety.

Acutely unwell babies requiring surgery are transferred three miles by road from neonatal critical care alongside maternity services in the RIE to the paediatric theatres at RHSC. The ambulance transfers, physical distance and time delays all pose risk to patient safety.

2.5.2 RHSC – Property Drivers

The 2011-15 NHS Lothian Property and Infrastructure Strategy recognised that the RHSC requires significant improvement and that it would be uneconomic and highly disruptive to adapt the existing site. It also found that overcrowding was a problem at RHSC, and referred to the report by the Scottish Child Health Support Group in 2003, that 'continued investment' (in the RHSC) would be unproductive in the long term and it is clearly no longer fit for purpose'.

The Property Asset Management Strategy (2011-15) gave RHSC the highest possible risk score in terms of the amount of backlog maintenance required, at a total cost of £11.4million. This was considered to be giving rise to poor condition and performance and

[9] Scottish Government (May 2009): *Hospital Services for Young People*

the updated strategy for 2014-21 judges the functional suitability of the RHSC to be not satisfactory / unacceptable.

The age and fabric of the building and the layout of patient facilities, including limited single rooms, makes it difficult to achieve the required infection control standards, to provide adequate isolation or barrier nursing facilities and to maintain standards of cleanliness.

The geographical spread of clinical facilities and poor clinical adjacencies result in inefficient patient and staff flows. Patients often require access to a number of services that are located in separate buildings on the hospital site. Therapies and a range of other services are located in buildings adjacent to the hospital; as there is no covered approach to these buildings patients and families have to go outside to access them in all weather conditions.

2.5.3 CAMHS – Clinical Drivers

NHS Lothian's Joint Mental Health and Wellbeing Strategy[10] includes the aims that more people with mental health problems will have good physical health and that fewer people will experience stigma and discrimination.

In 2006 the ombudsman recommended that NHS Lothian *'should ensure that inpatient mental health services for patients with eating disorders have access to acute in-patient medical services with the specialist knowledge and expertise needed to treat patients with eating disorders.'* [11] Co-locating CAMHS with the hospital for children and young people will provide acute medical as well as mental health services for this vulnerable patient group.

By including mental health in the services provided at the hospital for children and young people, and working to integrate them into the hospital 'family', NHS Lothian will be able to further reduce any stigmatisation of this patient group.

Service redesign work in mental health includes a focus on adolescents and their transition from children's to adult services, which will be on different sites following this move.

2.5.4 DCN – Clinical Drivers

Redesign within the service has resulted in waiting times for inpatients and outpatients reducing to below 12 weeks each, however, there is limited scope within the current facilities to maintain the standard of 18 weeks total wait. There is currently no CEPOD theatre capacity and emergencies in normal working hours impact on planned admissions, thereby causing further waiting times pressures.

Neurology referrals increased by 53% over the period 2006-2009 and neurosurgery by 84% in the same period, with consequent pressure on radiology, theatre and inpatient facilities. Projections from the General Register Office for Scotland show an increase in the population across the DCN catchment area and the incidence of neuroscience conditions, which will put even greater pressure on the resource for secondary and tertiary services provided in DCN.

[10] NHS Lothian (2011): *A Sense of Belonging – Joint Mental Health and Wellbeing Strategy 2011-2016*
[11] Scottish Public Services Ombudsman (June 2006): *Case number 200400447*

A major challenge to effective patient care in the existing model is the distance of the intensive care beds in the WGH from the rest of DCN. A patient journey to and from this area, to access critical care, theatres or radiology in an emergency, can take in excess of twenty minutes and goes through public areas of the hospital. Specialist staff urgently needed in one unit may be engaged in the other, and the distance between the departments does not support efficient management of the workforce.

At present, spinal surgery referrals are made to either neurosurgery in DCN or orthopaedics at the RIE with separate patient pathways for similar conditions and procedures.

This project does not include the provision of longer-term rehabilitation and ongoing care, the service model being underpinned by the assumption this will continue to be provided off-site from the DCN.

2.5.5 DCN – Property Drivers

A key issue for DCN re-provision, identified in the Property and Infrastructure Strategy (2011-15), is that the outdated existing facilities do not meet patient expectations of 'fit for purpose'. Scottish Government directives on single rooms[12] further support the case for new accommodation. At present approximately 20% of DCN beds are in single rooms, none with en-suite facilities, and all are in spaces less than current recommendations of 19m^2 per patient bed.

In the 2011-15 strategy the DCN narrowly achieved a satisfactory rating for health and safety and the physical condition and energy efficiency of the build was judged unsatisfactory. In NHS Lothian's updated 2014-21 Property and Asset Management Strategy, the functional suitability of DCN is classed as not satisfactory / unacceptable. The projected cost of upgrading the existing accommodation to an acceptable standard was over £14million at 2007 costs.

2.6 The Royal Infirmary of Edinburgh

2.6.1 Commercial context

The RIE facility was procured as a PFI contract between the former Royal Infirmary of Edinburgh NHS Trust and Consort Healthcare (ERI) Ltd. The RIE facility was financed, designed and build by Consort Healthcare, and a range of soft and hard facility management services are also provided through the PFI RIE Project Agreement.

The site is leased to Consort Healthcare Ltd for a term of 130 years, thus any site development requires Consort Healthcare approval and changes to the project agreement. The supplemental agreement (SA6) confirming the framework for the land swap and the site enabling works required to deliver the RHSC and DCN project was signed in January 2012.

This project requires enabling work within the RIE to support the clinical model proposed for RHSC and DCN. These separate packages of work to re-model critical care,

[12] Scottish Government; CEL 48 (2008) and CEL 27 (2010) on *Provision of Single Room Accommodation and Bed Spacing*

pharmacy, laboratories and medical photography, and install new pneumatic tube, fire alarm and IT links to the new build, require to be delivered under the terms of NHS Lothian's RIE Project Agreement with Consort.

2.6.2 Clinical enabling – RIE clinical divers

2.6.2.1 A consequence of moving DCN to Little France is the re-modelling of adult critical care in the RIE, giving rise to the need to relocate the current renal and transplant high dependency unit (HDU).

2.6.2.2 General and neurosciences critical care

To ensure the sustainability of critical care on three acute sites across Lothian, and the concentration of expert staff and infrastructure for this patient group, this project will integrate acutely unwell neurosciences patients into the critical care cohort at the RIE. This area comprises HDU beds and intensive therapy unit (ICU) beds, also known as level 2 and level 3 critical care.

At present critical care in the RIE is running at 83% occupancy, above the recommended 75% for an efficient and sustainable service. The unit is restricted in the flexibility it can provide for patients whose conditions fluctuate, and often these patients require to be moved when they are at their most sick, or to accommodate others who have deteriorated.

Bed modelling indicates a need for 42 critical care beds to support the current RIE services *and* neurosciences. This does not include the renal and transplant high dependency beds, to be displaced, which are addressed separately. The current critical care wards require to be re-modelled into a single unit of flexible level 2/3 beds, adding one additional bed space.

2.6.2.3 Renal and transplant HDU

The current renal and transplant HDU beds are over-occupied, with pressure coming from increased incidence of disease and of transplantation activity. In relocating this service for the DCN move, NHS Lothian is able to build a fit-for-purpose and future-proofed HDU with an increase in beds to match regional modelling requirements. The service will be relocated alongside the downstream ward, bringing efficiencies in patient and staff pathways, and an increase in isolation and single room accommodation.

There are currently 11 beds in the unit; demand modelling demonstrates 16 will be required by 2020. 16 bed spaces will be built, with 14 planned to open in 2017.

2.6.2.4 Office accommodation

The space for the new renal and transplant HDU is currently occupied by laboratories, university and IT offices and NHS Lothian need to relocate these 70 clinical support staff to enable the series of moves described above.

2.6.2.5 Spinal surgery services

Accommodation for spinal surgery in DCN will allow a single, equitable patient pathway and provides much-needed capacity for orthopaedics in the RIE theatres and wards.

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2.6.2.6 Helipad and major trauma

The location of the existing helipad on land adjacent to the RIE necessitates the transfer of patients from helicopter to ambulance for transportation to the building itself, with risk to the patient in the delay and double-handling required. The helipad itself no longer meets the standards set out by the Civil Aviation Authority for such facilities, and therefore its hours and conditions of use are limited.

The new facility will include a helipad for the transfer of patients to and from the Little France site by air. 24/7 direct access by air ambulance would contribute to the Scottish Government's stated intention that Edinburgh would have a Major Trauma Centre.

2.6.3 Clinical enabling – accommodation drivers

2.6.3.1 In developing the service model for the RHSC and DCN, clinical support services were considered across the whole Little France site. It was agreed at OBC that the following did not require to be replicated in the new building, and would be enabled from the RIE:

2.6.3.2 Pharmacy

The RIE pharmacy will serve all clinical services in the RIE, RHSC and DCN from 2017. To accommodate the additional activity the department requires increased aseptic accommodation and the installation of robotics for the storage and dispensing of medicines. This necessitates the installation of a pneumatic tube system (PTS) link from the RHSC and DCN build.

2.6.3.3 Laboratory services

The RIE laboratories will support the majority of tests required by the RHSC and DCN from 2017. The addition of specialist paediatric biochemistry laboratory space to the RHSC scope is covered in section 2.7.3.

2.6.3.4 Pneumatic Tube System (PTS)

The use of the RIE pharmacy and laboratories necessitates the extension of the RHSC and DCN PTS network to two stations in the RIE for the delivery of prescriptions and specimens to these departments. This will be a separate network to the PTS in the RIE that the PFI provider there is responsible for.

2.6.3.5 Medical photography

This department, currently used for adults only, requires minor redesign to accommodate the children and young people who will also be seen here from 2017.

2.7 Agreed Scope

2.7.1 This project addresses the re-provision of all acute hospital departments from the RHSC, the CAMHS inpatients and day case services and the DCN to Little France. This includes clinical support provided by laboratories and pharmacy, and facilities management and administrative and management functions.

The RHSC and DCN will be a stand alone facility, managed separately from the existing RIE building and its PFI contract arrangements. Facilities management (FM), access and delivery arrangements, and the procurement and provision of energy and medical gases will be independent of the RIE.

This FBC encompasses the NPD contract for the RHSC and DCN building and the range of related enabling works to be carried out by Consort, the RIE PFI provider.

2.7.2 RHSC and DCN Accommodation

The NPD project encompasses following accommodation requirements:

- inpatient beds: 211
- day case beds: 22
- theatres: 10 suites
- MRI scanners: space for 5 scanners, including one intra-operative in theatres
- CT scanners: 2
- angiography suite: 1
- outpatient departments: 42 clinic rooms
- rehabilitation space for physiotherapy, occupational therapy, speech and language therapy and dietetics
- paediatric emergency department
- helipad
- classrooms for the hospital outreach teaching service
- sanctuary / spiritual care space
- family hotel and family support facilities
- health records library
- office accommodation for administration and clinical support
- staff changing and rest facilities
- kitchen and catering outlets including a restaurant
- retail outlet
- facilities management: domestics, materials management, laundry, waste, portering
- energy centre
- service and delivery yard
- secure accessible garden space
- emergency, disabled and parent and child car parking at entrances
- paediatric biochemistry laboratory

The following accommodation schedule changes have been agreed since OBC:

- Further review of the service model and projected activity in both paediatrics and neurosurgery resulted in a change of scope and the proposed minor procedures room is now a full theatre suite to provide more capacity and flexibility. There are ten operating theatres in the schedule now.

- Where DCN was previously planned to have 100% single rooms, the Chief Medical Officer has since agreed to derogation for eight beds to be provided in two shared 4-bed areas for reasons of clinical safety and observation. [13]

[13] Mike Baxter (16 July 2013): *by email: Justification for derogation from single bed guidance approved*

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- The paediatric biochemistry laboratory has been incorporated into space previously earmarked as shelled accommodation. This service cannot fit into the current RIE labs alongside other RHSC and DCN activity. The NHS Lothian strategy for laboratories may find another solution before May 2017, timescales for this parallel project have not been confirmed, in which case the accommodation would revert to shelled space for future change.

- The accommodation schedule gross internal floor area for the reference design was 49,991m^2. Following the changes above and design development in dialogue, the accommodation schedule for these services is 51,156 m^2.

2.7.3 Facilities management and lifecycle

All soft FM services will be provided by NHS Lothian.

All hard FM and lifecycle will sit with Project Co with the exception of:

- Snow and ice clearing; this is currently done by the RIE PFI provider and for clarity of accountability NHS Lothian intends to extend their contract to include this.
- Pest control; this will be added to NHS Lothian's current outsourcing of this service, which is the approach for the whole of Lothian excluding RIE.

2.7.4 Site boundary

In addition to the site identified in the OBC, the adjacent land that was formerly a petrol filling station has been procured by NHS Lothian for the project. This area shall be included in the landscaping, and is available to Project Co to use for construction access, although not for building upon.

2.7.5 Enabling for the NPD project

Site enabling works to be carried out by the PFI provider of the RIE, to ready the site for vacant possession by Project Co include:

- Sewer and services re-routing
- Relocation of VIE gas plant
- Alterations to roads infrastructure
- RIE Emergency Department link to the new build
- Flood defence works on the Little France site
- Flood defence works not on the Little France site

2.7.6 Site interface

Works on the interface with RIE and the wider Little France site to be carried out by Project Co include:

- Hospital square works: roadworks and landscaping of the area between RIE, RHSC and DCN and the Chancellor's Building
- Specified road works;
- Surface water drainage connections;
- Emergency department and theatres link to the RIE;
- ICT and fire alarm systems interface with the RIE;
- Pneumatic tube delivery system to two specified locations within the RIE.

2.7.7 Clinical enabling in RIE

Clinical enabling works to be carried out by the PFI provider to ready the RIE to support the RHSC and DCN comprise:

- critical care redesign
- creation of a new renal and transplant HDU
- relocation of 70 clinical support staff
- pharmacy works to increase aseptic capacity and install robotics
- medical photography redesign

2.7.8 Exclusions

This project does not include NHS Lothian's Community Child Health service, currently also on Sciennes site, which will be relocated in the same timeframe.

This project does not include NHS Lothian's broader strategic redesign of laboratory services.

2.8 Agreed Service Requirements

2.8.1 Model of Care

The model of care that was signed off at OBC has been reviewed and confirmed as valid. The principle that underpin the service model and accommodation requirements are summarised here.

a) Wherever possible, the provision of outpatient and day case services is shifted to community premises and facilities closer to the patient, including other NHS Board areas.

b) Patient pathways designed to provide rapid assessment and access to diagnostics to speed decision-making and the commencement of treatment.

c) Whenever possible, patients' emergency care needs will be met on an ambulatory basis rather than through admission to hospital.

d) Day case treatment will be the norm for as much planned hospital care as possible.

e) The norm for surgical admissions will be on the day of surgery.

f) Admission and discharge will be safe and timely, with no boarding, unnecessary delays or avoidable re-admission.

g) Care pathways and the physical building will be designed to reduce wasteful activities for patients and staff such as avoidable transfers and travel.

h) Inpatient accommodation will be configured to allow for flexible management of beds to respond to seasonal or other variations in demand.

i) Patients requiring a high dependency of care will be nursed within purpose-built and staffed critical care units.

j) Theatres and radiology facilities will be configured to co-locate equipment and expert staff, and will be shared by adult and paediatric services insofar as this does not impact negatively on the patient experience.

Further planning assumptions for **children and young people's services** include:

k) Incorporating the increased age range from 13-16, for all paediatric services except mental health which extends to 18-years of age.

l) Paediatric acute receiving unit will manage acute medical admissions for up to 72 hours.

m) 59% of inpatient beds, including all adolescent, mental health and oncology beds, will be in single rooms with en-suite.[14]

n) Transitional high dependency area for children with complex needs in a homely environment, for example, preparing patients and family for discharge with home care packages.

o) Adolescent inpatients will have designated single rooms and access to shared facilities specifically for their age group within the RHSC wards.

p) National bed modelling for CAMHS beds[15]

q) 26-room family hotel for carers and relatives, or patients the night before admission

Further planning assumptions for **clinical neurosciences** include:

r) Acute Care area for the receiving and assessment of referrals from other hospitals and care of the least stable patients

s) Time-critical thrombolysis for stroke treatment will take place in DCN

t) Critical care level two (high dependency) and level three (intensive care) patients will be looked after in the RIE.

u) All adult spinal surgery pathways will be through the DCN

v) All inpatient beds in DCN wards and 66% of those in acute care will be in single rooms with en-suite facilities.

2.8.2 Activity modelling

The OBC presented the bed model required to deliver the projected activity for the service model described above. Healthcare planning consultants Civil Eyes and Tribal validated

[14] Approved by the Chief Medical Officer (2008)
[15] SEAT (October 2008) recommendations in response to the Child Health Support Group's 2004 report: *Inpatient Working Group – Psychiatric Inpatient Services for Children and Young People in Scotland: A Way Forward*

these service model assumptions and bed requirements, using benchmarking data from peer hospitals, and Tribal also confirmed the requirements for theatre and radiology facilities.

The bed and activity models are refreshed annually using updated population and activity projections. The most recent, based on 2012/13 information, validates the bed model numbers as detailed in the OBC, achieving upper quartile performance against a peer group. This is summarised in figure 2.

2.8.3 Future-proofing

The building is designed to provide the need for flexibility to support business continuity and variations in activity, for example

- day case beds are located alongside inpatient wards to allow admissions overnight when demand requires it;
- single rooms with en-suite facilities will prevent or contain the spread of infection; and
- isolation rooms will prevent the spread of infection and protect the patients most vulnerable to infection.

Service and bed type		Build	Open 2017	Average bed occupancy
Children and young people	Inpatients, including CAMHS	120	117	74%
	Day cases	22	22	-
	Critical care	24	22	76%
	Total for RHSC	**166**	**161**	**75%**
Clinical neurosciences	Inpatients	67	62	82%
	Day cases	2	2	-
	Subtotal: DCN in the NPD	*69*	*64*	*82%*
	+ Critical care in RIE	11	11	75%
	Total for DCN	**80**	**75**	**81%**

Figure 2: Bed model

The inclusion of expansion capacity in the building specification extends the useful life of the building without major change. The project incorporates capacity to enable future expansion or changes to the service model in a number of ways:

- additional beds beyond those currently required in 2017 will be shelled in RHSC, DCN, and renal & transplant HDU;
- a shelled MRI space for future radiology developments; and
- critical care beds are being built with infrastructure to provide intensive care or high dependency as the patient condition changes, rather than move acutely unwell patients to a different bed space.

2.9 Workforce Planning

2.9.1 Workforce planning principles

The overall vision for the workforce is to ensure the right staff are available in the right place with the right skills and competences to deliver high quality care and services.

The redesign and configuration of services emerging from this development is anticipated to provide the leverage of ensuring long term sustainability of services provided via reviewing roles, responsibilities and skill mix.

There will be the potential for clinical services to further develop new multi-specialty team approaches and roles in advance of commissioning the facility.

The workforce needs to be aligned with both service and financial plans to ensure affordability and sustainability over the long term. To this end, workforce planning has been developed and agreed with partnership colleagues and a working group engaging the five principal NHS Boards that use and pay for services in RHSC and DCN.

The proposed workforce plan takes into account the bed model and the physical specification for the new development (such as single bedrooms, the impact of increased bathrooms and toilets, and the impact of layout on walking distances.)

2.9.2 Workforce planning methodology

Workforce planning has involved multi-disciplinary and management staff from each service working with the project team, human resources colleagues and partnership representatives.

Using the revised Scottish Government Workforce Planning Guidance 6 step methodology (CEL 32, 2011) as a framework methodology an NHS Lothian multi disciplinary Workforce Planning Group was formed to develop an overarching workforce plan. The group considered all non clinical and clinical services in RHSC and DCN, and the impact of the project on critical care in the WGH and RIE. It had at its foundation the planned model of care and the new way services will be provided, as described in the OBC and signed off by NHS Lothian and its partner Boards in 2012.

Accredited and approved workforce tools, where available, were used and triangulated or adapted by those services which currently do not have approved tools available.

Each service was expected to interface their contribution to this workforce plan with that of their own service work plans to ensure synergy, impact analysis and corporate planning for the impact of such a large scale development on a new site, and other services impacted by the relocation of RHSC and DCN.

To develop the models the Workforce Planning Group undertook a series of workshops and analysis meetings cumulating in the development of integrated workforce plans cognisant of the dependencies and interdependencies of services. Comparing these against current staffing profiles resulted in the final workforce plans.

Through SEAT, representation from NHS Borders, Dumfries and Galloway, Fife, Forth Valley and Tayside joined the NHS Lothian project team and service leads to review, challenge and agree the proposed workforce plans.

At these meetings with other Boards the models of care and the specification and design of the hospital were described in detail to ensure a clear understanding of the anticipated benefits the development.

This group has committed to continued working on workforce development and commissioning planning up to the opening of the building.

2.9.3 Workforce plan implementation

A major change programme is required to plan and support the transition of services from their current sites. The impact of this on staff for role development, skill mix changes and shift pattern changes and location of base will be assessed and managed through the NHSScotland Staff Governance Standard and the Organisational Change Policy in partnership with staff side colleagues.

The model of care will be implemented ahead of the move to new premises where practical, which will give the opportunity to regularly refresh the workforce plan as the model is delivered, refined or improved. It is a known risk that the model cannot be fully implemented until the new development opens.

As part of the overall project a commissioning plan is being developed, the transition plan for workforce moving to the new development will be incorporated into this.

2.10 Benefits

2.10.1 Benefits criteria were developed specifically for this project by stakeholders in RHSC and DCN services. These have been reviewed again for the FBC, and the expected benefits are summarised below.

2.10.2 Quality and clinical effectiveness

- Improved clinical outcomes through **reduced waiting times and fewer cancellations**, with hospital capacity built to match anticipated demand.
- Improved clinical outcomes through **redesigned patient pathways, reduced transfer times and reduced length of stay** supported by the co-location of related and inter-dependant services.
- Improved patient safety through **less patient boarding** when hospital capacity, with flexibility, is built to match anticipated variations in demand.
- A **reduction in healthcare associated infection** through modern design, particularly single rooms with en-suite accommodation.

2.10.3 Quality of the environment

- Improved inpatient experience **protecting patient privacy and dignity**, with provision for **control of the personal environment**, including **reduced disturbance,** in single rooms.
- Improved patient experience with **age-appropriate facilities** with hospital capacity built to match anticipated demand.
- Improved staff and patient experience with **standardisation of design** increasing staff efficiency and **releasing time to focus on patient care**.
- Improved patient, family and staff experience with **on-site amenities** including **access to the outside environment**.
- Improved staff experience reflected in **staff recruitment and retention** and a **reduction is sickness-related staff absence.**

2.10.4 Accessible services

- Good user access by **pedestrian routes and all means of transport**.
- Good access to services for users with mobility challenges with **managed proximity parking** for drivers with disabilities, or with disabled and/or small children as passengers.
- Fast **access to emergency services by road and air**.
- A good user experience of following **clear signage and wayfinding** to the departments they need.

2.10.5 Sustainable healthcare services

- Securing the **continued delivery of highly specialist services**, such as paediatric neurosurgery through co-location of RHSC and DCN.
- Sustainable **workforce plans that recruit, develop and retain expert staff**.

2.10.6 Sustainable facilities and communities

- An efficient building that **minimises its impact on the environment and resources** in terms of energy consumption and running costs, and its transport strategy.
- Promoting **local employment and capabilities**, particularly in the construction phase, through training and placement opportunities, engagement with small and medium sized enterprises and social enterprises.

2.10.7 Research and development

- Promoting **collaborative working with higher education, research and development**, in particular the University of Edinburgh through co-location with the Medical School, Research Institute and other developments across the Edinburgh BioQuarter.

2.11 Strategic Risks

The strategic risks to NHS Lothian in delivering this project are:

2.11.1 Service risks

Failure to deliver this project would see NHS Lothian continuing to provide RHSC and DCN in facilities without sufficient capacity for the demand placed upon them. Limits on the available theatre and bed capacity means that meeting waiting times is unsustainable in the long-term. The inclusion of patients aged 13-16 in RHSC emergency department activity would risk their ability to meet the 4-hour unscheduled care target.

Uninterrupted delivery of safe, effective healthcare at the RIE whilst undertaking a project of this scale is a challenge. NHS Lothian is already over one year into the programme of building work at Little France to enable this project, and is closely managing the impact on the RIE. Active risk management, involving working with all parties on the campus, has been set up in advance of the construction of the main NPD project and the clinical enabling works in order to protect operational clinical services.

Risks to the delivery of RHSC, DCN and CAMHS services in their transition to the Little France will be managed through commissioning planning in close partnership with the operational management teams.

2.11.2 Commercial risks

The introduction of an NPD provider into Little France, where there is already an existing PFI, poses commercial risk in relation to both contracts. There is potential for the delivery of the NPD project to impact on availability of the RIE facility in the context of the PFI contract provisions. NHS Lothian has ensured that the new facility is a free-standing development, and that appropriate interface agreements are established in the respective contracts covering both construction and operational phases, with arrangements managed by the Board.

2.11.3 Political and financial risks

The timing of the procurement for the NPD, with the funding competition and financial close programmed either side of the Scottish independence referendum, is unique to this project. There is a risk that the cost of financing could be higher than anticipated, or contractual protection sought by funders before the outcome of the referendum is known. To mitigate this risk, NHS Lothian, SFT and the preferred bidder have engaged and continue to engage with funders during the funding competition. It is also noted that private financiers have funded a number of NPD transactions in Scotland in recent months.

2.11.4 Organisational capacity

NHS Lothian has an ambitious programme of capital and service developments. The Project Team directly responsible for this project has been established and is costed in this FBC. As and when service input is required this is flagged to the departments concerned and support facilitated.

2.12 Constraints

The project constraints from the OBC have been reviewed and updated as follows:

- Delivery within the agreed timescales: the revised Programme, updated following approval of the OBC, is in section 6.2.

- Delivery within the agreed financial envelope: the final tender of the preferred bidder (Project Co) came in under the construction cost cap and progress with other costs is presented in chapter 5.

- Compliance with statutory planning requirements: planning in principle was granted in April 2012, and the submission for Reserved Matters and Local Application went to the City of Edinburgh Council in April 2014. The Planning Authority consultation period has now closed and full planning permission is anticipated by the end of August 2014.

- Architecture and Design Scotland requirements: these were addressed through involving A&DS in the development of the design prior to submission.

- Achievement of a 'good' BREEAM 2011 rating: the final tender design of the appointed preferred bidder achieves as a minimum a 'very good' rating when subjected to a BREEAM 2011 New Construction (SD5073) and BREEAM ENE1 target of 6 credits (excellent) in accordance with the BREEAM Scheme Document for New Construction (SD5073) Section 6.ENE1assessment.

- Management of any disruption to the RIE services and the Chancellors Building during the construction phase will be through the Little France Campus Working Group, including all parties on campus.

2.13 Dependencies

The project dependencies from the OBC have been reviewed and updated as follows:

- The availability and condition of the site; the SA6 agreement with Consort confirms the programme of works will be completed to deliver 'vacant possession' by financial close, with all works due to be completed by June 2015.

- Capacity of RIE clinical and support services to support the new building on site; the programme of clinical enabling works described in the FBC will address this ahead of completion of RHSC and DCN.

- Implementation of an integrated transport strategy for the site; the local authority recently granted planning consent for an updated masterplan for the Edinburgh BioQuarter, which includes the NHS facilities at Little France, and engagement is continuing with stakeholder and government agencies.

3 THE ECONOMIC CASE

This section of the FBC reviews the results from the detailed appraisals previously undertaken at OBC in order to determine if there are any significant changes in the key variables impacting the outcome.

The key variables reviewed at FBC include:

- Capital cost of new build work for RHSC and DCN;
- Capital cost of associated NPD fees and equipment costs;
- Capital cost of associated enabling and clinical enabling work;
- Overall running costs and net revenue impact; and
- Benefits associated with the preferred option.

3.1 OBC Preferred Option

Earlier option appraisals, in 2007 for RHSC and 2009 for DCN, had concluded that the preferred location for both services was the same site as the Royal Infirmary of Edinburgh.

A capital-funded OBC for the RHSC, including CAMHS, to be built at Little France was approved in 2008; however, economic circumstances in 2010 dictated that the project would have to be delivered through a revenue-funded model.

Having confirmed that the benefits criteria used in 2007 and 2009 still reflected the investment objectives for the services, and that the preferred way forward was still to move to Little France, NHS Lothian presented a further assessment of options to the SGHSDC Capital Investment Group in the 2011 Business Case Update. The report from this option appraisal is included at appendix 2.

Option	Net present cost (£000)	Non-financial benefits score	NPV per benefits score (£000)	Ranking
1. NPD RHSC & DCN in a joint build on car park B	**291,415**	**404**	**721.3**	**1**
2. NPD RHSC on car park B **and** PFI RIE extension for DCN	295,092	314	939.8	2

Figure 3: Option appraisal results presented in 2011 Business Case Update

Approval of this update and the preferred option it presented, an NPD joint build for RHSC and DCN, led to NHS Lothian developing the OBC submitted and approved in 2012. The 2012 OBC economic analysis further validated this preferred option.

3.2 Capital cost of the new build

The total projected capital costs at OBC stage were assessed at £230m, with the NPD element estimated at £155m. The capital value of the new build works for the NPD contract has been set by the final tender from the Preferred Bidder at £147m. The Preferred bidder submission is within the terms of the Construction Cost Cap ("the cap"). This covers the construction costs eligible for revenue funding support including the cost of

the building, IT infrastructure, Group 1 (supply and installation) and Group 2A (installation only) equipment and private sector design fees post financial close.

SFT, in setting the cap, took account of progress of the reference design, the invitation to participate in dialogue and the outcome from key stage reviews.

The reduction in the capital value of the NPD new build works for RHSC and DCN between OBC and FBC stages was achieved through the competitive dialogue and tendering process with three bidders.

3.3 Capital cost of associated NPD fees and equipment

The projected capital costs at OBC stage were assessed at £4.5m for specialist Adviser Fees (mainly technical, legal and financial to support the NPD contract).

The updated costs at FBC stage amount to £4.8m for specialist Adviser Fees, which reflects the complexities of the interface of this project with the existing PFI contract both in advance of procurement and during competitive dialogue with bidders. Also, given the nature of this project as the first acute healthcare NPD to commence procurement, many of the deliverables produced by the advisory team have been used for the benefit of the wider NPD programme.

The projected capital costs at OBC stage for equipping the new build development were £36.4m (balance of equipment to transfer from current use or be procured under the Board's normal replacement programme).

Work is ongoing to identify the extent to which equipment will transfer to the new facility and to quantify the cost associated with procuring the balance. The equipment procurement and management will feature as part of the commissioning strategy and implementation phase with the overall programme budget monitoring supporting the mitigation of risk.

3.4 Capital costs of enabling and clinical enabling work

The projected capital costs at OBC stage were assessed at £33.4m. The capital cost of the more detailed plans at FBC stage amounts to £36.2m.

This work is scheduled to be undertaken over the financial years 2014/15 to 2016/17 from traditional public capital funding.

3.5 Annual running costs and net revenue impact

3.5.1 At OBC stage, annual running costs were estimated to increase by £2.0m. This has been reassessed as part of the FBC process and the differential increased to £3.0m.

3.5.2 The OBC explicitly excluded additional clinical staffing for the project, stating that this required to be addressed through normal financial planning. Workforce planning, as described in section 2.9, has now been agreed with partnership and other NHS Boards, with an agreed increase in annual running cost for clinical services at £3.6m per annum.

3.5.3 The split of revenue costs between NHS Lothian and partner NHS boards is detailed in the Financial Case, section 5.4.

3.6 Benefits associated with the preferred option

3.6.1 The key benefits identified in the OBC were developed in consultation with stakeholders. These remain valid and are linked to the benefits realisation plan in appendix 3.

3.6.2 Clinical benefits of integrating these services into one building, supporting the Board and national strategic ambitions, include:

- Efficiency and effectiveness through the ability to deliver paediatric and adult neurosurgery in the same theatre suite, maximising the utilisation of specialist equipment and expert staff, with direct internal access to age-appropriate critical care and wards;
- Joint-working and economies of scale in high-cost specialist clinical areas such as theatres and radiology;
- Proximity of paediatric and adult neurology services for the large adolescent patient group transferring to age-appropriate care;
- The opportunity to improve emergency access to services by incorporating a helipad on the roof of the new build; and
- This option was the least disruptive to adult clinical services and patient pathways at the RIE through the build and commissioning.

3.6.3 Non-clinical benefits of integrating the two services into one building include:

- Economies of scale in sharing support accommodation and facilities such as health records, IT and staff changing;
- Some economy of scale in the provision of public space, whilst preserving the ethos of a hospital for children and young people, segregated from adult services where necessary; and
- Preserving the RIE Facilities expansion zone to accommodate the Board's business needs for future flexibility and growth.

3.6.4 As required by SFT Value for Money Guidance the Board completed a qualitative assessment of value for money at OBC which confirmed that the project was viable, desirable and achievable. Review of the OBC assessment, included at appendix 4, has confirmed that it continues to be valid at FBC.

3.7 Conclusion

3.7.1 Following a robust option appraisal process involving a wide range of stakeholders at OBC stage, the Board determined that its preferred option was Option 1, an NPD joint build for RHSC and DCN.

3.7.2 This decision has been further reinforced by the detailed plans at FBC stage which have identified no significant change in the planned NPD costs or benefits.

3.7.3 The preferred option provides the optimal value for money solution to the Board and public sector of the options available, whilst also addressing key clinical requirements covering both local and national priorities.

3.7.4 Subsequent sections of the FBC provide details on the financial case, the procurement route, risk management and the project plan.

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4 THE COMMERCIAL CASE

This section describes:

- The key commercial details of the NPD contract between NHS Lothian and the Preferred Bidder for the design, build, finance and maintenance of the RHSC and DCN.
- The procurement process for the associated enabling and clinical enabling works on the site and in existing services.

4.1 NPD Deal and Contractual Arrangement

4.1.1 Background

The Scottish Government Draft Budget published in November 2010 advised that the project would be supported through the programme of revenue financed investment through the Non Profit Distributing (NPD) model.

NHS Lothian received confirmation from the Director General for Health and Social Care and Chief Executive of NHS Scotland on 18 September 2012 of the approval of the OBC and to proceed to procurement.

The NPD model was developed and introduced as an alternative to, and has since superseded in Scotland, the traditional private finance initiative (PFI) and Public Private Project (PPP) models and is defined by the broad core principles of:

- Enhanced stakeholder involvement in the management of projects;
- No dividend bearing equity; and
- Capped private sector returns.

The NPD model, in line with traditional PFI and PPP structures, provides for:

- Optimum risk allocation;
- Whole-life costing;
- Maximised design efficiencies;
- Robust programming of lifecycle maintenance and facilities management;
- Performance-based payments to the private sector;
- Single point delivery system, reducing interface risk for the public sector client; and
- Improved service provision.

The standard contract for NPD is designed by SFT to promote maximum value for money through commercially reasonable risk transfer; to simplify as far as possible consistent with a robust commercial structure and fundability and to minimise transaction costs with a standard that should be reasonably acceptable by contractors, investors and funders as well as procuring authorities. It also introduces the following benefits:

- Capped returns ensure that a “normal” level of investment return is made by the private sector and that these returns are transparent;
- Excess profits or surpluses generated by the Project Company are returned to the public sector at the discretion of the Public Interest Director; and

- The public interest is represented in the governance of the NPD structure, which increases transparency and accountability and facilitates a more pro-active and stable partnership between public and private sector parties.

This section outlines the commercial transaction that the Preferred Bidder and NHS Lothian will sign up to and serves to communicate the following:

- Agreed scope of services;
- Agreed risk allocation;
- Agreed payment mechanism;
- Key contractual clauses;
- Personnel implications (TUPE);
- Agreed procurement strategy; and
- Agreed implementation timescales.

4.1.2 Agreed scope of NPD services

The RHSC and DCN shall be a standalone facility in terms of services, management and contract, separate from the existing RIE building and its PFI contract arrangements.

The project will be delivered by a Project Co (a non-recourse special purpose vehicle funded from a combination of senior and subordinated debt underpinned by a 25 year service concession contract, set up specifically to deliver the project).

Project Co will be responsible for providing all aspects of design, construction, ongoing facilities management (hard maintenance services and lifecycle replacement of equipment components) and finance throughout the course of the project term other than a small number of exceptions as set out below.

Project Co shall also carry out the following enabling and interface works to fit with the RIE and wider Little France site:

- Hospital square works;
- Specified road works;
- Surface water drainage connections;
- Emergency department and theatres link to the RIE;
- ICT and fire alarm systems interface with the RIE;
- Pneumatic tube delivery system to two specified locations within the RIE.

NHS Lothian is managing the programme of enabling works, carried out by Consort Healthcare, to deliver vacant possession of the site for Project Co. The commercial arrangements for these works are outlined in section 4.3 below.

In line with national policy, soft facilities management will be provided by NHS Lothian and are therefore excluded from the NPD services. Hard FM comes under the contractor in the Non-Profit Distributing model.

To facilitate joint working arrangements between NHS Lothian and Project Co in relation to the provision of hard FM services, a ‘Responsibility Matrix’ has been agreed between the parties. This matrix articulates responsibility at a practical operational level and shall support the Project Agreement.

An equipment responsibility matrix has been prepared, detailing all equipment by description, group reference, location and responsibility between NHS Lothian and Project Co in terms of supply, installation, maintenance and replacement over the course of the operational term. The matrix shall set out the following details:

- Group 1 items of equipment, which are generally large items of permanently installed plant or equipment, will be supplied, installed, maintained and replaced by Project Co throughout the project term. These are revenue funded, paid for through the NPD annual service payment.
- Group 2A items of equipment will be supplied by NHS Lothian, installed by Project Co, and maintained and replaced by NHS Lothian.
- Groups 2B and 3 items of equipment are supplied, installed, maintained and replaced by NHS Lothian. Groups 2 and 3 equipment are capital costs met by NHS Lothian.

A full description of the services to be included in the RHSC and DCN NPD project, as detailed in the Invitation to Submit Final Tender (ISFT), is available on request.

4.1.3 Agreed NPD risk allocation

This section provides details of how the NPD associated risks have been apportioned between NHS Lothian and Project Co in line with the SFT standard form NPD Project Agreement.

The general principle is to ensure that the responsibility for risks should rest with "the party best able to manage them", subject to value for money.

A key feature of the NPD model is the transfer of inherent construction and operational risk to the private sector that traditionally would be carried by the public sector. Figure 4 outlines ownership of known key risks as per the model for NPD contracts

	Risk Description	**Allocation**		
		NHS Lothian	**Project Co**	**Shared**
1.	Design risk		√	
2.	Construction and development risk		√	
3.	Transitional and implementation risk		√	
4.	Availability and performance risk		√	
5.	Operating risk			√
6.	Variability of revenue risks		√	
7.	Termination risks			√
8.	Technology and obsolescence risks		√	
9.	Residual value risks		√	
10.	Financing risks		√	
11.	Legislative risks			√
12.	Sustainability risks			√

Figure 4: Allocation of key risks in the NPD contract

Project specific risks include the location of the Project, given that the RHSC and DCN shall be constructed within the campus site of an existing PFI project between NHS Lothian and Consort. NHS Lothian shall therefore require to manage its own relationships with Project Co, Consort and the University of Edinburgh, and also relationships between these parties. This risk is mitigated with Project Co preparing interface proposals, which require to be approved, that set out how it intends to construct and thereafter maintain the RHSC and DCN.

1) **Design risk** sits with Project Co, subject to the Project Agreement (Clause 12.5) and agreed derogations identified within the Board’s Construction Requirements.

2) Subject to NHS Lothian securing vacant possession of the site and ensuring that any relevant enabling works have been completed by Consort, the **construction and development risk** for the facilities sits with Project Co, subject to the Project Agreement. For example, a small number of delay and compensation events could entitle Project Co to compensation if the events materialised, such as no access to the site and incomplete enabling works which impact upon the site.

3) **Transition and implementation risk** prior to the actual completion date sits with Project Co in accordance with NHS Lothian’s Construction Requirements and agreed commissioning timetable. After the actual completion date, the transition and implementation risk shall sit with the Board in line with the agreed commissioning timetable.

4) **Availability and performance risk** sits entirely with Project Co subject to the provisions of the Project Agreement.

5) **Operating risk** is a shared risk, subject to NHS Lothian and Project Co’s responsibility under the Project Agreement. For example, Project Co shall be responsible for "hard" services and NHS Lothian shall be responsible for "soft" services.

6) **Variability of revenue risk** is a Project Co risk subject to adjustments of the Annual Service Payment under the Project Agreement. However, NHS Lothian shall be responsible for all pass through utility costs such as energy usage and direct costs such as insurance and local authority business rates, all of which are subject to different factors such as indexation.

7) **Termination risk** is a shared risk under the Project Agreement with both parties being subject to events of default that can trigger termination. In addition NHS Lothian has an additional right of voluntary termination of the Project, subject to the Project Agreement.

8) **Technology and obsolescence risk** predominantly sits with Project Co. However NHS Lothian could be exposed through specification and derogation within the Board’s Construction Requirements, obsolescence through service change during the period of functional operation and relevant or discriminatory changes in law under the Project Agreement.

9) **Residual value risks** sit with Project Co until the end of the Project Term and shall sit with the Board thereafter. In relation to the handback of the facilities by Project Co at the end of the Project Term, Project Co must ensure that the facilities meet certain key standards or shall be required to pay to rectify the facilities in order that it meets certain key standards.

10) **Financing risks** predominantly sit with Project Co subject to the Project Agreement: however relevant changes in law, compensation events that compensate Project Co and changes under the Project Agreement all may give rise to obligation to NHS Lothian to provide additional funding. Board voluntary termination may also bring an element of reverse risk transfer due to aspects of the funding arrangement with the funder.

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11) **Legislative risks** are shared subject to the Project Agreement. Whilst Project Co is responsible to comply with all laws and consents, the occurrence of relevant changes in law as defined in the Project Agreement can give rise to compensation to Project Co.

12) **Sustainability risks** are proportionately shared subject to the Project Agreement. Project Co is obliged to comply with the Board's Construction Requirements in terms of sustainable design and construction, which includes achieving a Building Research Establishment Environmental Assessment Methodology (BREEAM) overall score of 'very good', and an 'excellent' level of performance for the credit pertaining to Reduction in CO_2 Emissions, which sets the Energy Performance Target for the Facilities. Project Co is further obligated to perform tests on completion to demonstrate that its design and construction meets NHS Lothian's energy performance target, and is also required to ensure that these standards are continually upheld by ensuring energy efficient operation of Plant in line with an agreed energy strategy and through maintenance and lifecycle of hard FM components. However, NHS Lothian ultimately carries the operational volume and price risk relating to the actual operating energy and utilities consumption of the facilities.

4.1.4 Agreed payment mechanism

Annual Service Payments (unitary charge) to Project Co will only commence when the development is made operational and will be managed and regulated by means of the payment mechanism that will protect NHS Lothian (by deductions from payment) if there are failures in availability or performance.

The payment mechanism follows standard form drafting, with deductions from the annual service payment for availability and performance failures, such that should the entire facility be unavailable, no payment would be due. The payment mechanism was amended to reflect the acute healthcare nature of the accommodation and includes the application of a gearing mechanism to the deviation of service unit values.

4.1.5 Key contractual clauses

The draft NPD Project Agreement reflects SFT's Standard Form Project Agreement, with additional project specific amendments including amendments relating to interface with the RIE Facilities, lifecycle, TUPE, insurance, community benefits and the payment mechanism. All amendments to the NPD Project Agreement have been agreed by SFT.

During the dialogue period, the Preferred Bidder had the opportunity to discuss and propose further changes to the NPD Project Agreement. As a result of this process, bidder specific amendments to the NPD Project Agreement were agreed to by NHS Lothian and subsequently approved by SFT. Following close of the dialogue period, only fine tuning and clarification issues are able to be considered by NHS Lothian and any issues not raised by the Preferred Bidder during the dialogue period are not able to be considered by NHS Lothian if they involved changes to the basic features of the preferred bidder's final tender submission or the Project which are likely to distort competition or have a discriminatory effect.

4.1.6 Personnel implications

No staff will transfer to Project Co and therefore the alternative standard contract provisions in relation to employee transfer (TUPE) will not come into effect.

Existing staff in RHSC, CAMHS and DCN will move to the new site under NHS Lothian organisational change arrangements.

4.1.7 Agreed procurement strategy

The procurement strategy for the RHSC and DCN project has followed the NPD procurement route.

NHS Lothian made the following key appointments for the provision of adviser support for the Revenue Funded Accommodation Non-Profit Distributing (NPD) project. The following team has advised on the Project during the procurement stages and shall continue to advise NHS Lothian to completion of construction works and commissioning:

- Technical – Mott Macdonald Limited
- Legal – MacRoberts LLP
- Financial – Ernst & Young LLP
- Insurance – Willis

To maximise the value of the development work already undertaken under Frameworks Scotland and to achieve the programme timetable, NHS Lothian maintained its Design Adviser, Technical Adviser and Cost Adviser appointments. These appointments ensured the delivery of the Reference Design and associated costs for the OBC.

4.1.8 NPD implementation timescales

Following CIG approval of the OBC on 18 September 2012, the updated programme for delivery of the project is as follows:

Activity	Timescale
Receipt of funding letter	04/12/2012
Appointment of Preferred Bidder	05/03/2014
FBC formal consideration by NHS Lothian Board	06/08/2014
Funding competition completion	15/08/2014
Targeted town planning committee	27/08/2014
FBC formal consideration by CIG SGHSCD	26/09/2014
Pre-Financial Close KSR approval	30/09/2014
Financial close	02/10/2014
Start on site	03/10/2014
FBC Addendum to NHS F&R Committee	12/11/2014
FBC Addendum to CIG SGHSCD	25/11/2015
Completion / handover	17/02/2017
Project Co FM service commencement	17/02/2017
Hospital Opens	15/05/2017
Post project evaluation	15/05/2018
Project Co FM Service Completion	16/02/2042

Figure 5: Key programme milestones from sign-off of the OBC

4.1.9 Procurement process

In December 2012 NHS Lothian published a contract notice on the Official Journal of the European Union (Ref: 2012/S 235-386758). Pre-qualification questionnaire (PQQ) submissions were received from the following applicants:

- B3 (Balfour Beatty and BAM)
- Integrated Health Solutions Lothian (Macquarie Capital Ltd, Brookfield Multiplex and ETDE)
- Mosaic (Laing O'Rourke, Laing Investments and Serco)

Following a detailed review NHS Lothian confirmed all three applicants qualified to proceed to competitive dialogue and the Invitation to Participate in Dialogue was issued in March 2013.

During the dialogue period the FM provider for Integrated Health Solutions Lothian changed to Bouygues, and the FM provider for B3 changed to Cofely. The PQQ test was updated to reflect these changes and these consortia continued to pass.

The detailed programme of procurement activities to financial close are summarised here:

Activity	Timescale
OJEU notice, PQQ and Information Memorandum issued	05/12/12
Bidders Day	13/12/12
Pre-Qualification Questionnaire submission	21/01/13
Invitation To Participate In Dialogue issued to pre-qualified candidates	18/09/12
3 x Dialogue Meeting 1	w/c 01/04/13
3 x Dialogue Meeting 2	w/c 29/04/13
3 x Dialogue Meeting 3	w/c 27/05/13
3 x Dialogue Meeting 4	w/c 24/06/13
3 x Dialogue Meeting 4A	w/c 17/06/14
3 x Dialogue Meeting 4B	w/c 15/07/14
3 x Dialogue Meeting 4C	w/c 12/08/14
3 x Dialogue Meeting 5	w/c 16/09/13
3 x Dialogue Meeting 5A	w/c 23/09/14
Draft Final Tender submission from 3 bidders	21/10/13
3 x Dialogue Meeting 6	w/c 18/11/13
Close of Dialogue	13/12/14
Invitation to Submit Final Tender issued	16/12/14
Final Tender submission from 3 bidders	13/01/14
Appointment of Preferred Bidder	05/03/14
Funding Competition completion	15/08/2014
Financial Close	02/10/14

Figure 6: Procurement programme

The dialogue process adhered to fair and equitable treatment of bidders to develop proposals in line with the Board's requirements.

The evaluation process adhered to fair and equitable treatment of submissions to identify the most economically advantageous tender.

Following six months of dialogue the bidders' Draft Final Tenders were submitted, reviewed and the subject of the final dialogue meeting.

In December 2013 the European Investment Bank (EIB) confirmed that they would, subject to satisfactory due diligence, provide funding for the project up to a value of £98.81 million.

At the close of dialogue, the Invitation to Submit Final Tenders invited each bidder to submit a Final Tender on 13 January 2014.

4.1.10 Final tender evaluation and appointment of preferred bidder

The three Final Tender legal submissions were evaluated by MacRoberts LLP, who provided a Legal Report to NHS Lothian recommending that the three Bidders 'pass' for the purposes of the Final Tender legal submissions. A copy of MacRoberts' letter to NHS Lothian on conclusion of the Final Tender evaluation is attached at appendix 5.

The technical submissions were evaluated by NHS Lothian expert users and Mott Macdonald technical advisers. Technical proposals were evaluated against quality-based criteria without sight of the financial submissions or knowledge of the outcome of price evaluation.

A copy of Mott Macdonald's letter on conclusion of the technical evaluation is attached at appendix 6.

Financial evaluation was completed by Ernst and Young LLP and their summary report on completion of their Final Tender evaluation is attached at appendix 7.

For each bidder, the mark for the quality evaluation (out of 60) was added to mark for the price evaluation (out of 40) and the bidder with the highest combined mark was deemed to be the most economically advantageous tender.

The evaluation process identified **Integrated Health Solutions Lothian** as the most economically advantageous tender and they were appointed preferred bidder in March 2014. The section of their submission describing the three parties in the Integrated Health Solutions Lothian consortium is included at appendix 8.

4.1.11 Programme to financial close

NHS Lothian and Project Co are now working together towards the conclusion of the NPD procurement with financial close, programmed for 2 October 2014.

During the competitive dialogue period bidders appointed due diligence legal and technical advisers to support the tendered position in respect of the Project Agreement and to engage with potential funders post preferred bidder appointment. A shortlist of preferred funders has been established with the selection managed by Macquarie, sponsor for the Preferred Bidder and monitored by SFT. The competition is due to be completed by 15 August.

4.2 Site Enabling Works

4.2.1 A programme of enabling works is currently underway to de-risk the NPD delivery and ensure the existing facilities at Little France are prepared for new the facilities without ongoing reliance on the infrastructure of the existing PFI.

4.2.2 The agreed scope of works includes:

- Sewer and services re-routing;
- Relocation of VIE gas plant;

- Roads infrastructure;
- RIE emergency department link building to between the RIE Facilities and the Facilities;
- Flood defence works at the Campus Site; and
- Flood defence works not on the Campus Site.

4.2.3 Due to the nature of the existing PFI contract and responsibility for the existing services, these works have been procured using public capital funds through Consort Healthcare and are being delivered by Balfour Beattie Construction. These contracts are let with traditional contract responsibilities but NHS Lothian carries the majority of the risk through indemnity provided to Consort to keep the original PFI Project Agreement 'whole'.

4.2.4 The programme of works is underway and will be completed to the extent that 'vacant possession' of the NPD site is delivered by Financial Close, with all works due to be completed by June 2015.

4.3 Clinical Enabling Works

4.3.1 Further enabling works within the RIE are required to meet the operational and service requirements associated with the co-location of the RHSC and DCN services at Little France. As these works are within the existing footprint of the RIE, they are being procured through Consort Healthcare as capital funded projects.

4.3.2 The scope of the clinical enabling works includes:

- critical care redesign
- creation of a new renal and transplant HDU
- relocation of 70 clinical support staff
- pharmacy works to increase aseptic capacity and install robotics
- medical photography redesign

4.3.3 These contracts will be let with traditional contract responsibilities but NHS Lothian carries the majority of the risk through indemnity provided to Consort to keep the original PFI Project Agreement 'whole'.

4.3.4 As design and tendering for these works are ongoing, separate business cases will be brought forward to NHS Lothian in parallel with this Business Case. The programme of works will be completed by the time of operation of RHSC / DCN.

4.3.5 In addition, the displaced services from RIE are being reprovided in other NHS Lothian facilities, elsewhere in RIE or adjoining Edinburgh BioQuarter.

4.4 Charities

4.4.1 NHS Lothian recognises that there is considerable opportunity to enhance the RHSC and DCN facility through charitable support, and has been working with a number of organisations who are keen to support the project. The proposed contributions cover a range of aspects of the project, for example:

- Family hotel facilities – including equipment and management costs
- Artworks and other enhancements of the base build accommodation
- Hospital radio studio

- Management of the retail outlet as a fundraising venture

4.4.2 It is intended that, following best practice, all charities wishing to donate capital, services or equipment enter into formal agreement within NHS Lothian. This is not intended to deter donation, but to ensure clarity of scope, purpose and costs, to protect obligations and to promote positive long-term relations between all parties. A similar approach will also apply for other third parties, such as university or local authority interests.

4.4.3 All donations will be outside the financial model for the NPD to avoid the need for Project Co to raise debt and NHS Lothian to pay Annual Service Payments against the debt.

4.4.4 Charitable donations and contracts are anticipated between a charity and NHS Lothian only, however, depending on the intended purpose of the donation, back to back arrangements may be needed with

a) Project Co – as NHS Lothian must ensure it fits with the Project Agreement
b) Scottish Government – as NHS Lothian must ensure that if the funds cover the basic build that these are credited against central contributions

4.4.5 NHS Lothian have engaged Central Legal Office to advise on implementing development, facilities or equipment agreements with charities across the wider NHS. MacRoberts LLP, legal advisers to the Board for this project, will ensure that the third party agreements related to RHSC and DCN are in line with the NPD Project Agreement.

5 THE FINANCIAL CASE

The purpose of the financial case is to clearly set out the financial impact of the investment proposals. This section sets out all capital and revenue costs associated with the preferred option, assesses the affordability, and considers the impact on NHS Lothian's financial statements.

In order to make this assessment, an affordability model has been developed which incorporates estimates for:

- Capital costs, both covered by and out with, the non profit distributing (NPD) model ;
- Annual service payment derived from the NPD financial model;
- Revenue costs (pay and non pay) associated with existing services, i.e. baseline costs; and
- Changes to revenue costs associated with service redesign as a direct result of the project.

5.1 Capital Costs

5.1.1 There are two components to the capital element of the scheme: those covered by the NPD model; and those beyond the scope of NPD. Taking these together, the total capital value of the project is £227m as illustrated in figure 7:

	OBC £k	**FBC £k**	**Difference £k**
NPD capital costs	**154,900**	**146,688**	**8,212**
Non NPD capital costs			
Enabling & town planning	22,659	22,174	485
Clinical enabling	10,740	14,121	(3,381)
Offsite flood		4,298	(4,298)
Equipment	36,399	36,399	0
Reference design fees	2,273	2,541	(268)
Petrol station site		550	(550)
Sub total non NPD	**72,071**	**80,083**	**(8,012)**
Total	**226,971**	**226,771**	**200**

Figure 7: Total capital value

The NPD and non NPD elements are discussed in more detail below.

5.1.2 <u>NPD capital costs</u>

The capital cost in the OBC was £154.9m; this is updated to £146.7m at FBC using the final tendered cost from Project Co, the preferred bidder, following competitive dialogue in procurement. This is subject to design development which is ongoing as the project specifications are finalised in conjunction with IHSL. Although this cannot yet be quantified, the project management is minimising any financial impact and there is no expectation that the final position will deviate significantly from the tender price. This

represents the cap set by SFT and therefore any consequent increase in the ASP will be the responsibility of NHS Lothian.

5.1.3 Non NPD capital costs

There are a number of key components to the capital costs which are out with the scope of NPD. The annual impact is illustrated in figure 8 below:

	Pre 2014/15 £k	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	Total £k
Enabling & town planning	10,985	11,064	125			22,174
Clinical enabling		3,415	4,544	6,162		14,121
Offsite flood	381	173	3,744	0		4,298
Equipment	0	1,200	2,161	16,519	16,519	36,399
Reference design fees	2,541					2,541
Petrol station site	433	117				550
Total	**14,339**	**15,970**	**10,574**	**22,681**	**16,519**	**80,083**

Figure 8: Non NPD capital costs

The following assumptions underpin these costs:

- *Enabling and town planning* – based on tendered prices for the 6 supporting projects (on site flood prevention, roads infrastructure, VIE replacement, alterations to RIE building, service and sewer diversions).

- *Clinical enabling* – detailed design has now concluded and a pre tender estimate will be available in early July. In the meantime costs are assumed to be in line with estimates in the OBC.

- *Offsite flood works* - based on a cost plan which reflects the current design, these estimates have been scrutinised by external technical advisors. A pre-tender check will be carried out in September 2014.

- *Equipment* – assumes 20% of existing equipment transfers to the new facility. Beyond this costs are based on an inflation allowance of 8.48% on 2013 prices.

5.2 Sources of Capital Funding

5.2.1 In the OBC funding letter the SGHSCD confirmed the elements of the non NPD capital they would directly fund. Support for the enabling works was capped as follows:

- £17.9m for external enabling works;
- £2.7m for offsite protection works;
- £7.8m for clinical enabling works; and
- £36.4m for equipment.

These figures specifically excluded optimism bias (estimated at £8.1m at the time of the OBC) which is managed centrally by SGHSCD and costs relating to the reference design which were separately funded. Thus funding identified at that point totaled £75.2m. The difference between this and the estimated OBC costs (£0.4m) relates to increases in enabling works identified post OBC and captured in the funding letter.

5.2.2 At £80.1m, the anticipated total cost exceeds the provision in the funding letter (adjusted for optimism bias) by £4.9m. This variance includes flood prevention works which were a condition of planning not known until after the approval of the OBC. This variance has been discussed with representatives from SGHSCD who have agreed to increase the capital support to match the current estimate of £80.1m.

5.2.3 Charities supporting the project include the Edinburgh and Lothian Health Foundation, the Sick Kids Friends Foundation, Ronald McDonald House Charities, Teenage Cancer Trust and Trefoil. No contributions can be assumed until formal commitments have been secured, however it is anticipated that some funding will be provided. Details on these contributions and the extent to which these provide one off capital, or ongoing revenue support will be further developed post FBC.

5.2.4 The University of Edinburgh is a key stakeholder in the project, with $700m^2$ of accommodation (the Department of Child Life and Health) in the schedule. In 2009, for the original RHSC OBC, the cost of university accommodation came to £3m, and the university committed £1m funding with the balance to be funded by the NHS.

5.2.5 The project will release land and buildings at the existing RHSC (and associated) sites. Given the ongoing delivery of other clinical services on the WGH site, there is no assumption that there will be any land release associated with the DCN. This FBC does not include any capital receipt from the sale of the existing RHSC and associated properties as a funding source for the project.

5.2.6 It is therefore assumed that all non NPD capital costs associated with the project, as detailed in figure 8 above, will be funded by an SGHD project specific capital allocation.

5.3 Revenue Costs

5.3.1 To assess the revenue implications of the project, the baseline costs of the current service were established and compared to estimated future costs. To support this, an affordability model was set up with 3 key components:

- Annual service payment (which includes hard FM and lifecycle costs);
- Facilities costs (related to the running the building); and
- Cost of clinical services (workforce in the main).

5.3.2 <u>Annual service payment</u>

Under the rules for revenue funded projects a payment is made to the private sector for the services it provides. This is referred to as an annual service payment (ASP) and has 5 separate components as detailed in figure 9.

Component of ASP	Description
1. Repayment of capital and associated financing costs	Repayment of the original capital cost, interest associated with borrowing and any surpluses
2. Special purpose vehicle (SPV) fees	Administering, insuring, debt monitoring fee and running costs of the SPV
3. Facilities management (hard FM)	Cost of maintaining the building

4. Lifecycle	Replacement cost of major equipment during the life of the project, for example replacing boilers and lifts
5. Surpluses	Represented by excess cash in the model returned to the public sector. Surpluses exist due to the banking cash requirements and the variable nature of the operating cost, for example lifecycle.
6. Other	Including tax and interest on cash

Figure 9: Components of annual service payment

As part of the competitive dialogue process, the preferred bidder supplied a financial model which projected the ASP over the life of the building. For the 25 year period this is estimated at £508m and is analysed by component in figure 10.

	£k
Repayment of capital and associated financing costs	350,967
Special purpose vehicle (SPV) fees	9,652
Facilities management (hard FM)	57,405
Lifecycle	52,345
Surpluses	56,473
Other	(19,142)
Total	**507,699**

Figure 10: Value of annual service payment by component

5.3.3 Scottish Government NPD Revenue Support

The Scottish Government Health and Social Care Directorate provides revenue support for each aspect of an NPD project, defined as follows:

- 100% of the cost of construction and the resulting cost of finance
- 50% of life cycle costs
- 100% of private sector development costs and running costs of the project company

All other costs are to be funded by NHS Lothian and partners.

Figure 11 provides a summary of the charge over a period of years alongside the revenue support from SGHSCD to determine the remaining revenue impact for NHS Lothian and partners.

	Full year impact in 2017/18 **£k**	**Final year impact in 2041/42** **£k**	**Average over 25 years** **£k**
Annual service payment	18,857	22,061	20,308
SGHSCD Total	16,651	17,605	17,120
SGHSCD % share	88.30%	79.80%	84.30%
NHS Total	2,206	4,456	3,188
NHS % share	11.70%	20.20%	15.70%

Figure 11: Annual service payment (base date September 2014)

This shows a disproportionate increase in the element of the ASP payable by NHS Lothian and partners from £2.2m in the first full year of operation to £4.5m in 2041/42, reflecting the differential impact of inflation on the components of the unitary charge. Hard FM (100% funded by NHS Lothian and partners) and lifecycle costs (50% funded by NHS Lothian and partners) are subject to annual indexation, whilst minimal indexation is applied to the financing costs (100% funded by SGHSCD). NHS Lothian and SGHSCD are working towards a joint understanding of the accounting and funding implications, recognising the significant contribution from SGHSCD towards the ASP. The NHS Lothian share of the ASP over the period of operation is shown in figure 12.

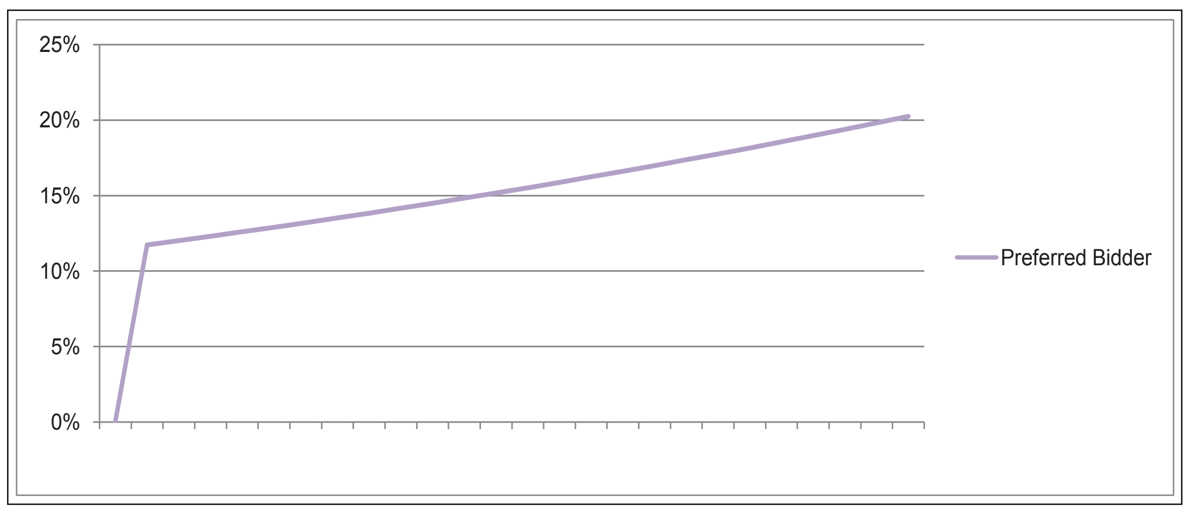

Figure 12: NHS Lothian share of ASP

As required by Scottish Futures Trust Value for Money Guidance, NHS Lothian has completed a qualitative assessment of value for money. This confirmed that the project is considered viable, desirable and achievable.

5.3.4 Facilities Management Services

Elements of ongoing running costs will be covered by the annual service payment, whilst other services such as cleaning and utilities will be provided by NHS Lothian. In the OBC, existing soft FM services within NHS Lothian and other available benchmarks were used to provide indicative costs for the facilities management services to be provided directly by NHS Lothian.

This approach was refined in July 2012 when the facilities management workforce work stream commenced planning the future services workforce needs. This involved:

- establishing the workforce baseline and budget for each facilities management area (domestic, estates, materials management, logistics and catering services);
- identifying the future workforce needs;
- critically examining the rationale for any proposed change;
- estimating overheads associated with the service; and
- exploring opportunities for re-design of service delivery and roles.

Estimated costs, offset by baseline budgets are shown in figure 13.

	OBC £k	FBC £k	Diff £k
Soft FM			
Domestics Services	1,593	2,363	770
Catering Services	493	410	(83)
Logistics	567	1,072	505
Rooftop helipad	0	284	284
Estates	86	224	138
Materials management	51	43	(8)
Sub total soft FM	2,790	4,396	1,606
Energy	1,052	1,300	248
Rates	1,067	1,000	(67)
Other	51	221	170
Sub total costs	**4,961**	**6,917**	**1,956**
Off-setting budgets	(2,934)	(3,936)	(1,002)
Net position	**2,027**	**2,981**	**954**

Figure 13: Facilities management costs

5.3.5 Cost of clinical services

The OBC noted that activity was projected to increase in the run up to the opening of the new facility, with a consequent impact on staffing levels. It further proposed that the inevitable increase in costs would be recognised as a financial planning issue and be considered and managed during the annual planning cycle, between OBC agreement and the new facility being opened.

Since then, detailed work has been carried out to identify the staffing required to deliver to the service model. NHS Lothian has worked together with partner boards to approve the workforce planning principles, review and agree costing methodologies and scrutinise and test the impact on costs.

As part of this work, costs have been categorised as follows:

- *Legislation and policy* – driven by legislation or national policy. The impact on workforce of the significantly increased number of single rooms as prescribed in CEL 27 (2010), Provision of Single Room Accommodation and Bed Spacing being one example. To support the FBC, SEAT partners have agreed in principle to increases in costs of £1.8m in this classification.

- *Additional NHS Lothian capacity* - representing the impact elsewhere in the NHS Lothian system of additional capacity created in the new RHSC/DCN facility. Examples include spinal beds transferring from orthopaedics to DCN. Costs in this category are estimated at £1.9m and will be funded via existing NHS Lothian capacity plans and will not be shared with SEAT and other partners.

- *Additional capacity* – additional 26 beds (16 to open in 2017) and three theatres required to deliver the service model. Further work is required to explore the extent to which the associated activity is already being delivered albeit in different ways,

including through the independent sector or extended working days. The estimated cost associated with this capacity is £3.9m.

- *Capacity which could be phased in* – developments totalling £0.9m where there is a choice about phasing. One example would be the helipad where the start date could be delayed or hours of operation limited, although this decision would have to factor in the impact of the trauma centre. As above, work will continue with our partners to explore the options and associated implications.

SEAT partners have agreed in principle to the requirement for increased clinical service costs where these are driven by legislation or policy requirements. The cross-board group established to review the costs will continue to refine and agree the remaining operational costs to deliver the agreed service model, factoring in the annual review of capacity models and population projections, and related financial planning implications.

5.3.6 Non recurring costs

A high level assessment of transitional/non recurring costs has been undertaken and will be continually developed and refined in the years leading up to the handover of the facility.

5.4 Net revenue impact

5.4.1 Taking all of these items together, the net revenue impact of £10.9m is shown in figure 14.

	OBC £k	**FBC £k**	**Difference £k**
Recurring costs			
Annual service payment	22,381	18,857	(3,524)
Facilities costs	4,961	6,917	1,956
Equipment depreciation and running costs	4,308	4,606	298
Clinical services		3,646	3,646
Total recurring costs	**31,649**	**34,027**	**2,377**
Offsetting funding			
SGHSCD contribution to ASP	(20,029)	(16,651)	3,378
Existing NHS Lothian budgets (facilities & depreciation)	(3,295)	(4,685)	(1,390)
Existing NHS Lothian budgets (capacity)		(1,896)	(1,896)
Affordability gap	**8,325**	**10,795**	**2,469**

Figure 14: Net revenue impact

5.4.2 This compares to an affordability gap of £8.3m at the time of the outline business case and, whilst there have been offsetting movements across a number of headings, the difference relates largely to the further work undertaken to quantify the additional capacity available and the consequent impact on costs of the agreed clinical service model as outlined above.

5.4.3 This will be managed across all NHS partners and will be equitably distributed across each of the Boards using the East Coast Costing Model (ECCM). Figure 15 details the proposed percentages and share of costs.

5.4.4 All NHS partners recognise the financial risks which underpin the revenue position at this stage. NHS Lothian is in dialogue with neighbouring boards to progress any further financial impact of the agreed clinical service model.

	%	**£k**
Lothian	71.6%	7,729
Fife	11.4%	1,231
Forth Valley	4.9%	529
Borders	4.0%	432
Tayside	2.3%	248
Dumfries & Galloway	2.6%	281
Other	3.2%	345
Total	**100.0%**	**10,795**

Figure 15: Share of revenue costs based on ECCM

5.5 Impact on Balance Sheet

5.5.1 The accounting treatment likely to apply to assets created by the project into three categories:

- Assets within the scope of the NPD contract
- Assets delivered by Consort Healthcare
- Assets funded and subsequently owned and/or managed by NHS Lothian

5.5.2 <u>NPD Assets</u>

5.5.2.1 *NHS Lothian's Accounts*

In considering the appropriate accounting treatment for the NPD Project assets, it is first necessary to consider whether the arrangement is regarded as a service concession falling within the scope of HMT Guidance on IFRIC 12.

The project will be delivered using the standard contract for NPD projects issued by SFT. As such, the following features of the contract are indicative that the NPD arrangement is within the scope of IFRIC 12 as it meets all the following requirements under the HMT Guidance:

- NHS Lothian will control or regulate what services the NPD operator must provide with the infrastructure, to whom it must provide them and at what price;
- NHS Lothian controls significant residual interest in the infrastructure asset at the end of the term of the agreement; and
- the infrastructure has been constructed by the NPD operator on land that will be under the control of NHS Lothian.

Accordingly, per the guidance set out in IFRS, NHS Lothian will need to record the infrastructure assets constructed under the project on its balance sheet. Any resultant impairment will be treated as an ODEL impairment and fully funded by SGHSCD.

5.5.2.2 *Governmental accounts*

From 1st April 2009 the accounting and budgetary treatments in relation to PFI and similar transactions diverged. As noted above, accounts for bodies such as NHS boards follow IFRIC 12 and ESA 95 (or ESA2010 as from September 2014). Departmental budgets such as those of the Scottish Government must follow national accounting standards, as set out in the Manual on Government Deficit and Debt (MGDD).

The key issue under MGDD is the classification of the assets involved in the arrangement, either as government assets or as the (NPD) operator's assets. The assets can be considered as non government assets only if there is strong evidence that the operator is bearing most of the risk attached to the specific partnership. In this context the risk assessment focuses on the following three main categories of risk:

- Construction risk: (covering events like late delivery, meeting defined specifications and additional costs);
- Availability risk: (covering volume and quality of output); and
- Demand risk: (covering variability of demand).

The assets should be classified as off balance sheet for government if both of the following conditions are met:

- the operator bears the construction risks, and
- the operator bears at least one of either availability or demand risk.

If these conditions are met, the contract is treated as similar to the treatment of an operating lease in ESA 95/2010, it would be classified as the purchase of services by government. If the conditions are not met then the assets are to be classified as on balance sheet for government.

Based on the proposed NPD contractual arrangements the operator and not NHS Lothian will be exposed to construction and availability risk. Conversely, NHS Lothian will bear the demand risk.

On this basis the analysis under the MGDD would suggest that for national accounts purposes the assets would be off balance sheet.

5.5.3 Consort Healthcare Assets

At present, the assumption made in this business case is that assets to be delivered by Consort Healthcare will be paid for directly by NHS Lothian. Consort Healthcare will carry out the works and recover the cost from NHS Lothian without amendment of the annual service payment. Payments in this category will be accounted for as capital grants in line with the Capital Accounting Manual. As such they will be off balance sheet for both NHS Lothian and the Scottish Government.

5.5.4 Assets funded by Scottish Government/NHS Lothian

Largely equipment, any such assets in this category would be on balance sheet at both NHS Lothian and Scottish Government level.

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5.6 Impact on Income and Expenditure Account

The SGHD budgetary framework with UK Treasury is operated under ESA. This is broadly equivalent to the former method of resource accounting framework under UK Generally Accepted Accounting Principles (UK GAAP). Since 2008 however, Health Boards' accounts and financial targets have been set under International Financial Reporting Standards (IFRS).

Recognising the impact of IFRS accounting treatment, the likely impact of the NPD on both the Board's and Scottish Government's budget is summarised in the figure 16 below.

NPD Cost	Board Budget	Scottish Government Budget	Funding
Capital cost of revenue financed asset	Non-core CRL	Capital ODEL	Fully funded by SG
Annual Service Payments	Core RRL	Resource DEL	SG will fund all components except for 50% Lifecycle and 100% Hard FM
Depreciation of revenue financed assets	Non-core RRL	Resource ODEL	Fully funded by SG
Impairments of revenue-finances assets	Non-core RRL	Resource ODEL	Fully funded by SG

Figure 16: NPD accounting

It is assumed that any write down of the existing RHSC property will be treated as a funded impairment via the AME (Annually Managed Expenditure) process.

5.7 Statement of Affordability

NHS Lothian confirms that the financial consequences will ultimately be managed as part of their financial and capital plan process; with support from the Scottish Government, NHS Boards and other partners.

6 THE MANAGEMENT CASE

This section aims to outline the management arrangements for the NPD under three project phases:

a) completion of procurement, up to financial close;
b) construction and commissioning; and
c) the operational phase for the completed development.

6.1 Governance framework

6.1.1 Figure 16 sets out the governance structure and reporting framework in phases (a) and (b), showing how the Project Steering Board and Project Co fit into this structure.

6.1.2 The Director of Finance for NHS Lothian is the Senior Responsible Officer, chairing the Project Steering Board and reporting to NHS Lothian Finance and Resources Committee, a sub-committee of the NHS Lothian Board.

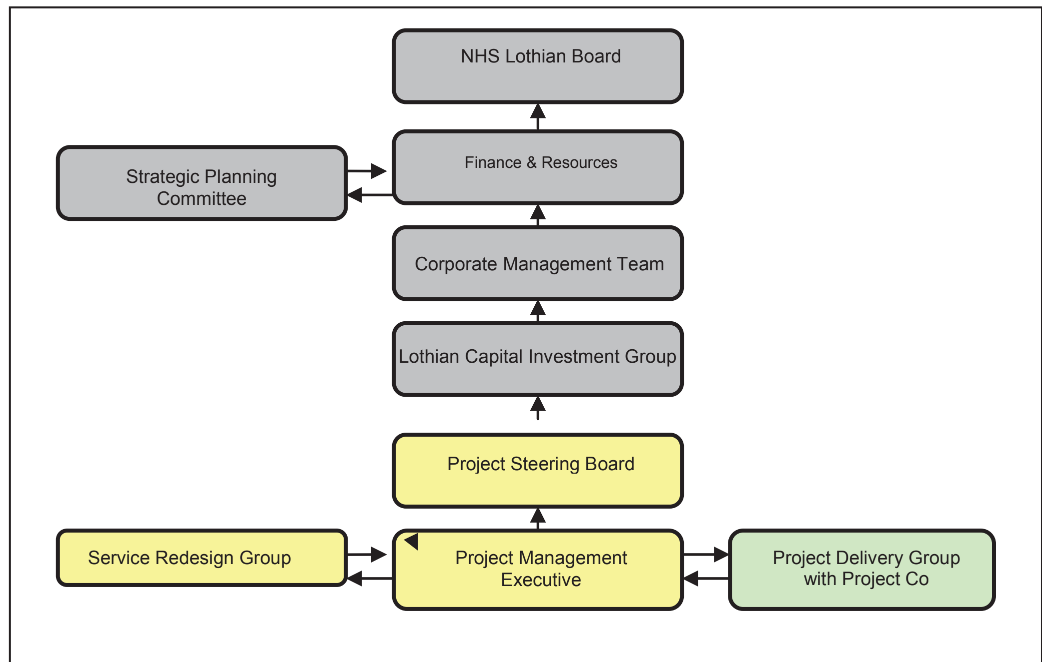


Figure 17: NHS Lothian governance structure with project governance groups in place until the hospital opens

6.1.3 NHS Lothian is committed to working closely with Partnership colleagues, who are represented on the Project Steering Board and the Service Redesign Group.

6.1.4 The project is a substantive agenda item on the SEAT Directors of Finance and Directors of Planning meetings. A representative of this group sits on the Project Steering Board.

6.1.5 As principle stakeholders in the project NHS Borders, Dumfries and Galloway, Fife and Forth Valley, through SEAT, have participated in the development and sign-off of the service model and associated revenue costs.

6.1.6 Figure 18, taken from Project Co's final tender, sets out the governance structure and management structure in the hospital operational period. 'On site' staff are responsible for

day to day management and reporting of the contract; 'off-site' denotes the parties engaged in governance and supporting contract management.

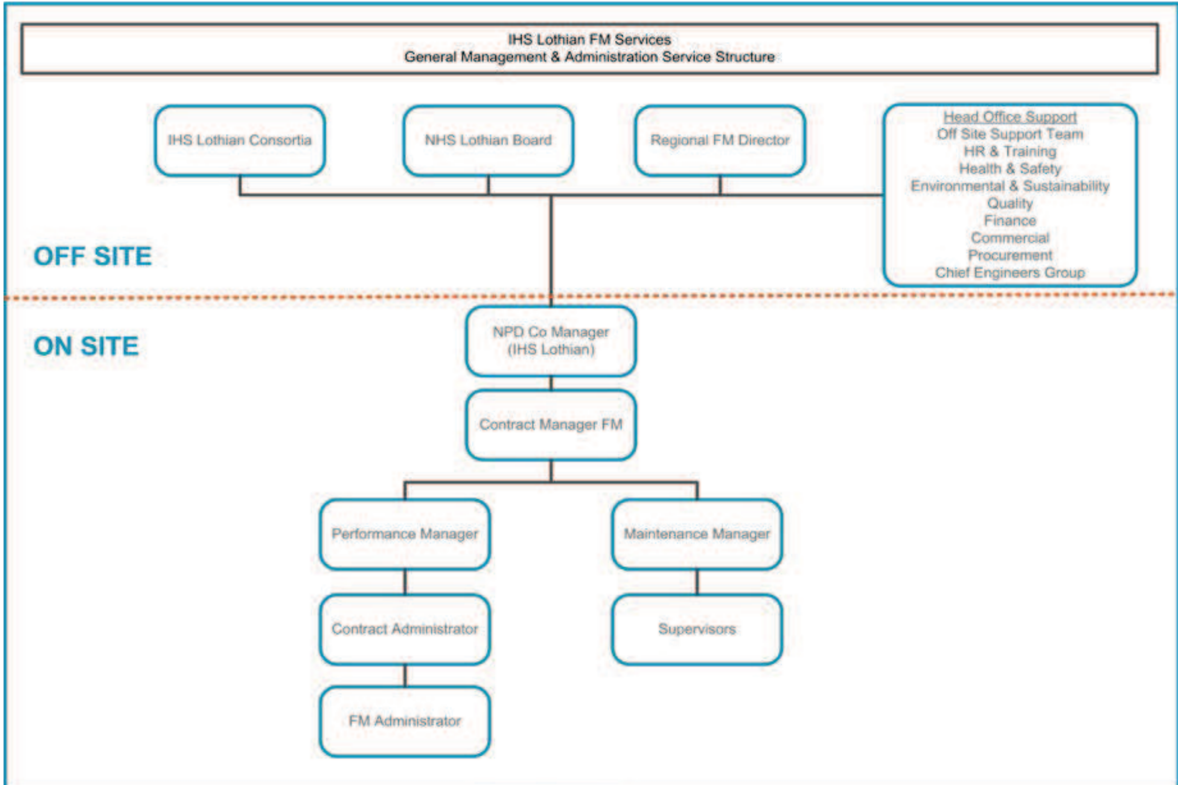


Figure 18: Project Co proposed contract management and governance structure from hospital opening

6.1.7 The responsibilities of the groups in figure 17 are outlined below:

Team or Group	Phase(s)	Responsibilities
NHS Lothian Board	a, b, c	• Investment decision maker • Oversee the project and, once operational, the performance of the facility. • Approve the final contract award • Resolve matters outside the Board's delegated authority
Finance and Resources Committee	a, b, c	• Approve the preferred bidder appointment • Approve the business case • Agree and prioritise the Capital Plan
Strategic Planning Committee	a, b, c	• Advise the Board on the appropriateness of clinical and service strategies to achieve the high level vision and aims of the NHS Lothian Strategic Clinical Framework
Lothian Capital Investment Group	a, b, c	• Oversee the NHS Lothian property and assets management investment programme
Project Steering Board:	a, b	• Establish project organisation • Authorise the allocation of programme funds

Team or Group	Phase(s)	Responsibilities
NHS Lothian and public sector partners		• Monitor project performance against strategic objectives • Resolve strategic issues which need the agreement of senior stakeholders to ensure progress of programme • Maintain commitment to the programme • Manage the governance structure • Produce the FBC document • Prepare for transition to operational phase
Project Management Executive: *NHS Lothian project leads and advisers*	a, b	• Monitor project delivery and make recommendations for approval to the Project Board. • Co-ordinate submission of papers to all governance groups as required
Service Redesign Group: *NHS services only*	a, b	• Deliver the service modernisation programme with the clinical management teams • Maximise the integration of development opportunities across directorates and with external partners
Project Delivery Group: *NHS Lothian Project Management Executive* ***plus Project Co leads***	a, b	• Manage interface between NHS Lothian and Project Co • Agree and monitor the programme, escalating issues for resolution where necessary. • Manage and report on risk • Agree responsibilities for the production of information and documentation. • Develop the content of the Project Agreement and all associated documentation • Receive and agree actions on reports from the User and Project Groups, Adviser Team and other bodies.

Figure 19: Project group responsibilities

In addition to the governance groups described above, the Little France Campus Working Group has been established as a project management interface for all partners on the site to co-operate in establishing arrangement for a safe working environment.

6.1.8 Roles and responsibilities – NHS Lothian

The key roles of those involved in governance for NHS Lothian are, and named individuals at the time of the FBC, are outlined in figure 20.

Role	Group / individual	Summary of Role
Senior Responsible Owner (SRO)	Susan Goldsmith, Director of Finance	Overall responsibility for the project, being directly accountable to the NHS Lothian Board. Provides strategic direction and leadership, and ensures that the business case reflects the views of all stakeholders.
Project Director	Brian Currie	Lead responsibility for delivering the facilities and services agreed in the business case. Provides strategic direction, leadership and ensures that the business case reflects the views of all stakeholders.

Role	Group / individual	Summary of Role
Board Observer	Brian Currie	NHS Lothian representative who will attend and participate (but not vote) at Project Co board meetings after financial close.
Project Clinical Directors	Janice MacKenzie (RHSC) and [Vacancy] (DCN)	Represents clinical services in the project. Works with preferred bidder to financial close to complete design in line with the Board's Construction Requirements within the financial limits. Leads the implementation of the agreed service model in respective clinical services in order to deliver the associated benefits.
Head of Commissioning and Service Redesign	Jackie Sansbury	Ensures that the clinical enabling projects required in the RIE are delivered. Leads the overall service change and workforce planning implementation for the project. Leads planning for and co-ordinate the transition of services into the new facility in conjunction with Project Co.
Commercial lead	Iain Graham	Manages the legal, commercial and financial workstreams for NHS Lothian. Liases with SFT regarding the funding competition. Interface with the RIE PFI contract. Supports the project director in relation to wider Board capital plan requirements.
Head of Property and Asset Management Finance	Moira Pringle	Responsibility for all finance aspects relating to NHS Lothian's capital plan / programme, and lead financial input into the project.
Contracts Manager	Stuart Davidson	Ensures that NHS Lothian expenditure is effective and efficient and that a productive relationship is established and maintained with Project Co. This role is endorsed by SFT and described in SCIM Guidance.[16]

Figure 20: Key NHS Lothian personnel responsible for delivering the project

6.1.9 Roles and responsibilities – external advisers

The NHS Lothian project team is supported by a team of external advisers, as set out in figure 21 below.

Role	Responsibilities
Project Manager – Mott Macdonald	The project manager will be co-ordinate the inputs of the appointed advisers and their interface with NHS Lothian and Project Co.
	Following financial close: • Coordinate due diligence on bidder solutions
Legal Advisers – MacRoberts LLP	The role of the legal adviser is to give appropriate advice in their areas of expertise, including up to financial close: • Evaluating and advising on all legal and contractual solutions;

[16] Scottish Futures Trust (June 2011): *Review of Operational PFI/PPP/NPD Projects*

Role	Responsibilities
	• Developing the contract documentation for the project, using SFT specific standard documentation where appropriate; and • Undertaking legal due diligence on Project Co's solutions.
	Following Financial Close: • Supporting the Commercial Lead in clarification and fine tuning of legal aspects. • Assisting NHS Lothian on implementation of the contract
Financial Advisers - Ernst & Young LLP	The role of the financial adviser is to give appropriate advice in their areas of expertise, including up to financial close: • Supporting the development of financial aspects of the FBC; • Developing the payment mechanism in conjunction with the technical advisers; • Reviewing funding and taxation aspects of the solutions; and • Preparing the accounting opinion for the Director of Finance.
	Following financial close: • Supporting the Commercial Lead in clarification and fine tuning of financial aspects. • Assisting NHS Lothian on implementation of the contract, for instance in the operation of the payment mechanism and reviewing calculation of the annual service payment.
Technical Advisers - Mott MacDonald Limited	The role of the technical adviser is to give appropriate advice in their areas of expertise, including up to financial close: • Supporting the development of technical aspects of the FBC; • Review of Project Co's proposals to ensure they meet NHS Lothian's objectives; • Developing the payment mechanism in conjunction with the financial advisers; • Undertaking technical due diligence and scrutinising costs of Project Co's proposals • Reviewing Project Co's planning submission; • Supporting the Project Director in clarification and fine –tuning of technical issues.
	Following financial close: • Assist with general queries and assist with technical due diligence. • Support the Project Director in the construction and commissioning phase
Insurance Advisers - Willis	The role of the insurance adviser is to give appropriate advice in their areas of expertise in all phases of the project.

Figure 21: External advisers to NHS Lothian

The project team shall continue to review the advisory appointments to ensure appropriate and continued adviser support is made available throughout the construction period and into early operation stage as necessary.

6.1.10 Roles and responsibilities – Scottish Futures Trust

NHS Lothian is being supported by SFT who retain responsibility for managing the NPD programme nationally.

SFT will nominate a Public Interest Director for the Project Company to perform the duties in accordance with the articles of association for that company.

6.2 Project plan

6.2.1 The strategic programme to the RHSC and DCN opening in 2017 is attached at appendix 9. Key milestones are summarised in figure 22.

Activity	Timescale
Appointment of Preferred Bidder	05/03/2014
Preferred Bidder/Authority Project Initiation Workshop	28/04/2014
Town Planning Application	09/05/2014
FBC formal consideration by NHS Lothian Board	06/08/2014
Funding competition completion	15/08/2014
Targeted town planning committee	27/08/2014
FBC formal consideration by CIG SGHSCD	26/09/2014
Pre-Financial Close KSR approval	30/09/2014
Financial close	02/10/2014
Start on site	03/10/2014
FBC Addendum to NHS F&R Committee	12/11/2014
FBC Addendum to CIG SGHSCD	25/11/2015
Completion / handover	17/02/2017
Project Co FM service commencement	17/02/2017
Hospital Opens	15/05/2017
Post project evaluation	15/05/2018
Project Co FM Service Completion	16/02/2042

Figure 22: Programme milestones from Preferred Bidder appointment

6.2.2 The dates detailed in figure 23 highlight the key milestones for FBC governance.

Activity	Timescale
Endorsement of FBC by Project Steering Board	20/06/2014
Approval of FBC costs by NHS Borders, Dumfries & Galloway, Fife and Forth Valley	20/06/2014
Approval of FBC by Finance and Resources Committee	09/07/2014
Approval of FBC by NHS Lothian Board	06/08/2014
Submission of FBC to SGHSCD CIG	29/07/2014
FBC presentation to SGHSCD CIG	05/08/2014
Approval of FBC by SGHSCD CIG	01/10/2014
Financial close	02/10/2014
Start on site	03/10/2014
Submission of FBC Addendum to SGHSCD CIG	22/10/2014
FBC Addendum to NHS F&R Committee	12/11/2014
Approval of FBC Addendum by SGHSCD CIG	25/11/2014

Figure 23: FBC governance programme

6.3 Preferred bidder appointment to financial close – key activities

6.3.1 Development of the final tender design to achieve planning consent and to complete detailed design is managed by IHSL's Design Manager with support from the NHS Lothian project team, including technical advisers, and extensive user engagement in the following:

- 1:200 departmental level sign-off
- 1:50 room design, including equipment and room data sheets sign-off
- Technical design sign-off, e.g. interior design, fire strategy, ICT strategy

6.3.2 Town planning matters are managed by IHSL and their planning advisers, with input from NHS Lothian supported by planning and technical advisers. The consultation period for the town planning submission for Reserved Matters and Local Application closed in June 2014 and full planning permission is anticipated before the end of August 2014.

6.3.3 NHS Lothian have engaged Health Facilities Scotland (HFS) to advise on equipment requirements for the project and to support the procurement, installation and commissioning. HFS are participating in design development, and once the equipment schedule is agreed at completion of design, will progress the equipment procurement and commissioning process.

6.3.4 Development of the Project Agreement and supporting contract schedules will be led by IHSL with input from NHS Lothian and legal, technical, financial and insurance advisers.

6.3.5 IHSL will confirm funding arrangements with the EIB, and conclude the funding competition to secure the remaining finance.

6.3.6 IHSL and NHS Lothian are working together to identify aspects of the project that will attract charity contributions, and to maximise the additional value that this can bring for all users of the facilities.

6.4 Commissioning and equipment – key activities

6.4.1 Commissioning arrangements are outlined in the Project Agreement with IHSL, to ensure all aspects of construction conform to the relevant standards and comply with contractual requirements. This will require appropriate certification, the handover of building operational manuals and a 'builders' clean to remove construction debris. In this phase, control of the site will transfer from the construction contractor to NHS Lothian and the FM service provider.

6.4.2 The operational commissioning programme, detailing the transfer of hospital services from their current sites to the new facility, will dovetail with the commissioning of the building.

6.4.3 NHS Lothian has developed a programme of service redesign, including workforce planning and change management, in preparation for the new model of care.

6.4.4 The NHS Lothian commissioning team structure has been agreed, with the following roles reporting to the Head of Commissioning and Service Redesign:

- A commissioning manager each for RHSC, DCN and RIE has been appointed, with departmental commissioning facilitators within the services to be identified
- NHS Lothian equipment lead – identified

- HFS equipment team - identified
- Theatres and critical care commissioning lead – recruitment underway
- Radiology commissioning lead - identified
- ICT commissioning lead – to be identified
- Building commissioning lead – to be identified
- Facilities management commissioning lead – to be identified

6.4.5 The contractual arrangements for the different groups of equipment is outlined in section 4.1.2. Management of the equipment schedule on completion of the design by IHSL will be handed to NHS Lothian, to be supported by HFS. This will include the specification of equipment in line with user requirements, procurement and programming for installation and commissioning with IHSL. Equipment will require testing, calibrating and tagging as appropriate, and staff will require to be trained. This will also include the identification of equipment items to transfer from existing sites.

6.5 Communication and reporting arrangements

6.5.1 The stakeholders in the project can be summarised as follows:

- NHS Lothian, comprising Lothian Partnership Forum, clinical management teams, facilities management services, corporate services.
- Project-specific groups and workstreams
- Statutory authorities and public bodies such as the Health & Safety Executive, City of Edinburgh planning department, Architecture and Design Scotland (a statutory consultee through the planning process)
- Funders comprising NHS Lothian, other NHS Boards, charities, the University of Edinburgh, the Scottish Government, European Investment Bank and Project Co.
- Patient Focus and Public Involvement (PFPI) groups
- Other Stakeholders comprising National Education Services Scotland (NES), core NHS Lothian sections & others.

Key stakeholders of the project are represented within the appropriate workstreams and, where required, at Project Steering Board level.

6.5.2 A communications plan is in place to ensure communication and consultation with the wider network of stakeholders to the project, including staff, patients and their families, partner organisations and the public.

6.5.3 The project has a community benefits plan with deliverables developed during competitive dialogue stage and forming part of the tender by the Preferred Bidder and will be implemented from mid-August 2014 through the Preferred Bidder's experienced Community Benefits Co-ordinator. The Community Benefits framework follows the SFT standard form and includes key deliverables for training, placements and employment in excess of the Construction Skills Framework upon which it was based. Engagement with small and medium sized enterprises (SMEs) and social enterprises form part of the construction and operations phase deliverables by Project Co.

The deliverables proposed by the Preferred Bidder will be monitored through the contracted Performance Management regime and reinforced by commercial deductions in the event of failing to meet the objectives.

6.5.4 All governance functions are supported by a range of reports, including the Project Progress (dashboard), Risk Register Report, Financial Report and a range of supplementary reports.

6.5.5 In the construction and commissioning phase Project Co are responsible for providing information on their progress against programme.

6.5.6 In the operational phase Project Co reporting will form part of the performance management and payment mechanism arrangements as a part of the Project Agreement, managed through NHS Lothian's Contract Manager.

6.5.7 All reports are commissioned on behalf of the Project Steering Board by the Project Management Executive and submitted for approval. Regular progress reports are submitted to the Lothian Capital Investment Group and the Finance and Resources Committee as part of internal governance requirements.

6.6 Risk management

6.6.1 All risks will be assessed using the same process, summarised below:

- Identifying the risk;
- Assessing the risk;
- Documenting the risk;
- Managing and reporting the risk; and
- Closing the risk.

6.6.2 Once the likelihood and impact of a risk has been rated, each risk will then have a single score which shall be calculated by multiplying the likelihood and impact ratings. This single score determines whether a risk is rated red, amber or green. The table set out below outlines the scores for likelihood and impact, and how these relate to the rating of a risk:

			Likelihood				
			Rare	Unlikely	Possible	Likely	Almost Certain
		Score	1	2	3	4	5
Impact	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Minor	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5

Risk rating	**Combined score**	**Action/Treatment**
HIGH	15 – 25	Poses a serious threat. Requires immediate action to reduce/mitigate the risk.
MEDIUM	9 – 12	Poses a threat and should be pro-actively managed to reduce/mitigate the risk.
LOW	1 – 8	Poses a low threat and should continue to be monitored.

Figure 24: Risk assessment matrix

6.6.3 At the time of writing the FBC the risk register contained 59 live risks. The risks described in figure 25 are red and amber rated.

Risk ref.	Risk description	Risk management	Mitigated risk score
Procurement risk			
8	Programme delay in reaching financial close	User and adviser input to deliver a) town planning b) technical schedules c) contractual documentation d) funding competition	**20**
59	Availability of funding	The programme has the funding competition before the independence referendum and financial close afterwards. There is potential for funders to seek a higher cost of finance or contractual protection due to their perceived risk of the financial covenant or credit rating of a newly independent Scotland.	**10.5**
Enabling risk			
29	Insufficient space in RIE to support RHSC/DCN clinical models	The last remaining displaced staff who require to move for the critical care and renal and transplant model require replacement office accommodation.	**13.5**
10	Vacant possession of site	Agreements are in place with Consort to secure land and deliver enabling and the programme for delivery is being closely managed.	**12**
39	Infection control	Enabling works construction in the RIE will be closely managed with infection prevention and control to minimise this risk to hospital services.	**12**
30	Impact on RIE clinical services productivity	Enabling works in the RIE will be closely monitored with clinical management teams to minimise the impact on service delivery and waiting times.	**10**
31	Infrastructure damage to RIE in construction	Enabling works construction in the RIE will be closely managed with contractors to prevent damage to utilities and consequent impact on hospital services.	**10**
28	Delays in completion of RIE clinical enabling	Programme identifies critical path and monitoring of contractor progress.	
14	RIE construction interface failures	Control plans are being developed with Project Co and Consort, to be finalised by financial close.	**15**
15	RIE interface failures: access routes	Project Co to join working group of all site partners to jointly manage this risk.	**15**
16	Site traffic	Project Co to join working group of all site partners to jointly manage this risk.	**12**
NPD construction risk			
9	Specification changes post Financial Close	Governance is in place for approval of change. Annual review of service model and assumptions.	**10.5**
11	Programme	Site surveys undertaken; Project Co to complete their own	**9**

	delay due to unexpected site conditions	before Financial Close.	
NPD commissioning risk			
21	Equipment transfer and service downtime	Equipment schedule and commissioning programme to be fully developed with Project Co.	**9**
25	Service change	Governance is in place for approval of change. Annual review of service model and assumptions.	**9**
63	Project team resources	Team established to deliver current phase of project; further appointments for commissioning to be made.	**12**
Operational risk			
45	Service change	Degree of flexibility is designed into the accommodation. Governance is in place for approval of change. Annual review of service model and assumptions.	**9**
46	Campus management	Project Co to join working group of all site partners to jointly manage this risk.	**9**
External / governance risk			
49	Campus management	Project Co to join working group of all site partners to jointly manage this risk.	**9**
55	Charities input	It is proposed to formalise charity contributions and terms.	**9**

Figure 25: High and medium risks extracted from the project risk register, as of June 2014

6.7 Key Stage Review

6.7.1 As part of the governance process for NPD projects, there is a requirement to participate in SFT Key Stage Reviews (KSRs) at specific stages up to Financial Close. Completed KSR reviews are detailed below.

Key Stage Review	Completed
Pre-OJEU	04/12/2012
Pre-ITPD	07/03/2013
Pre- Close of Dialogue	13/12/2013
Pre-Preferred Bidder	28/02/2014

Figure 26: Key Stage Reviews to date at submission of the FBC

The KSR Report for the appointment of the Preferred Bidder is available in appendix 10.

6.7.2 Following submission of the FBC to the SGSCHD Capital Investment Group (CIG) a final KSR (Pre- Financial Close) will be required in advance of Financial Close.

6.8 Change Management

6.8.1 Procurement phase pre-financial close

Changes to Project Co's final tender, by Project Co or by NHS Lothian, are being managed through the Project Delivery Group and, if there are costs that will impact on this FBC, escalated to the Project Steering Board for agreement.

6.8.2 Construction and commissioning phase

The change protocol in the Project Agreement governs the management of changes post Financial Close.

6.8.3 Operational phase

The service provided by Project Co is enshrined in the Project Agreement. Day to day matters, performance delivery issues and the management and control of change will be through the NHS Lothian Contract Manager role.

With NHS Lothian having both a PFI and an NPD project on the Little France site, there is benefit in this role co-ordinating with both parties on the management of their contracts.

6.8.4 Organisational level

This project represents a significant change for NHS Lothian. The change to the physical infrastructure is simply an enabler to a more fundamental change in the way that healthcare will be delivered for the population served by NHS Lothian.

The impact of the change to workforce, facilities and the model of care will be considerable, and the service redesign group for the project, linking to the NHS Lothian Strategic Planning Committee, will manage this change agenda.

6.9 Post Project Evaluation

6.10 The purpose of undertaking a project evaluation is to assess how well the scheme has met its objectives and whether they have been achieved to time, cost and quality.

6.11 The evaluation will be led by the project team supplemented by representatives of key stakeholders. The Project Steering Board, or its successor, will receive evaluation reports on each element.

6.12 Evaluation of the procurement process has been carried out at key stages by SFT, with reviews to be completed before proceeding to the next phase.

6.13 Benefits realisation, using the benefits management plan at appendix 3, will be evaluated at the following stages

a) Spring 2015 – recording the baseline in current services
b) Spring 2017 – re-recording the baseline prior to the move
c) Summer 2018 – evaluation of the benefits 12 months after opening

6.14 In the 12-months post-project evaluation, the following issues will be considered:

- To what extent relevant project objectives have been achieved?
- To what extent the project went as planned?
- Where the plan was not followed, why this has happened?
- How plans for the future projects should be adjusted, if appropriate.

APPENDIX 1

Support from partner Boards:

a) **NHS Borders**

b) **NHS Dumfries and Galloway**

c) **NHS Fife**

d) **NHS Forth Valley**

e) **NHS Tayside**

NHS Borders

Chair & Chief Executive's Office

Chair & Chief Executive's Office
NHS Borders
Headquarters
Borders General Hospital
Melrose
Roxburghshire TD6 9BD

Tel : 01896 826000
www.nhsborders.org.uk

Date 3rd June 2014
Your Ref
Our Ref CC/IB

Ms Susan Goldsmith
Director of Finance
NHS Lothian
Waverley Gate
2-4 Waterloo Place
Edinburgh EH1 3EG

Dear Susan

Re-provision of RHS and DCN

Thank you for coming to NHS Borders on Monday 2nd June. We found the meeting and your presentation informative. Please also pass on our thanks to Sorrel.

We have reviewed the RHSC and DCN FBC costs to other Boards document dated 22nd May 2014 and we:

- are content to approve the methodology proposed for the split of Full Business Case costs, based on activity across the NHS Boards
- agree to support our share of the NPD annual service payment
- commit, in principle, to our share of the related operational costs and will in conjunction with colleagues in NHS Lothian continue to review and scrutinise these
- are committed to continue to work with NHS Lothian to agree the implementation of service capacity and changes, and related workforce requirements, to ensure value for money and cost effective provision. This will include working together to agree the most appropriate and timely care pathways.

This is subject to approval at our Board Meeting on the 26th June 2014.

Yours sincerely

Calum Campbell
Chief Executive

A42675936

Dumfries and Galloway NHS Board

Chief Executive's Office

Mid North
Crichton Hall
Bankend Road
Dumfries
DG1 4TG
Tel: 01387 272743
Fax: 01387 252375

Ref: JA/KL/RHS&DCN
Date: 20th June 2014

Ms Susan Goldsmith
Director of Finance
NHS Lothian
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

Dear Susan

Re-provision of RHS and DCN

Thank you for coming to NHS Dumfries and Galloway on Monday 16th June. We found the meeting and your presentation informative. Please also pass on our thanks to Sorrel.

We have reviewed the RHSC and DCN FBC costs to other Boards document dated 22nd May 2014 and we:

- are content to approve the methodology proposed for the split of Full Business Case costs, based on activity across the NHS Dumfries and Galloway;
- agree to support our share of the NPD annual service payment;
- commit, in principle, to our share of the related operational costs and will in conjunction with colleagues in NHS Lothian continue to review and scrutinise these;
- are committed to continue to work with NHS Lothian to agree the implementation of service capacity and changes, and related workforce requirements, to ensure value for money and cost effective provision. This will include working together to agree the most appropriate and timely care pathways.

NHS Dumfries and Galloway Board approved the RHSC and DCN FBC at our meeting on Monday 16th June 2014.

Yours sincerely,

JEFF ACE
Chief Executive

Fife NHS Board

Hayfield House
Hayfield Road
Kirkcaldy
Fife KY2 5AH
Telephone: 01592 643355
Fax: 01592 648142
www.nhsfife.org

Ms Susan Goldsmith
Director of Finance
NHS Lothian
Waverley Gate
2-4 Waterloo Place
EDINBURGH
EH1 3EG

Date 3 July 2014
Your Ref

Dear Susan

Re-provision of RHS and DCN

Thank you for coming to NHS Fife on Tuesday 27th May 2014. We found the meeting and your presentation informative. Please also pass on our thanks to Jackie and Sorrel.

We have reviewed the RHSC and DCN FBC costs to other Boards document dated 22nd May 2014 and we:

- are content to approve the methodology proposed for the split of Full Business Case costs, based on agreed activity across the NHS Boards
- agree to support our appropriate share of the NPD annual service payment as laid out in the Outline Business Case
- commit, in principle, to our appropriate share of the related operational costs and will in conjunction with colleagues in NHS Lothian continue to review and scrutinise these
- are committed to continue to work with NHS Lothian to reach agreement on the implementation of service capacity and changes, and related workforce requirements, to ensure value for money and cost effective provision. This will include working together to agree the most appropriate and timely care pathways.

This was approved at our Board Meeting on the 24th June 2014.

Yours sincerely

John Wilson
Chief Executive

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone: 01786 463031
Fax: 01786 451474

Susan Goldsmith
Director of Finance
NHS Lothian
Waverley Gate
2-4 Waterloo Place
EDINBURGH
EH1 3EG

Date 23rd June 2014

Your Ref:

Dear Susan

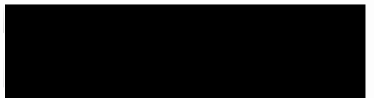
FULL BUSINESS CASE FOR ROYAL HOSPITAL FOR SICK CHILDREN AND DEPARTMENT OF CLINICAL NEUROSCIENCES

NHS Forth Valley considered the summary financial information provided by NHS Lothian at a closed session of the Board on Tuesday 17th June 2014.

The Full Business Case was approved and additional funding supported in principle, subject to continued work with SEAT Boards to minimise the additional costs. Whilst supportive of the development, there is concern about the magnitude of additional costs. There was support to the commitment across the region to pursue potential efficiencies to further reduce costs. This review should include efficiency improvements and clear understanding of costs being incurred through the current costing model.

Our nominated representatives will continue to work with Lothian and other SEAT Board staff to address these issues.

Yours sincerely



Jane Grant
Chief Executive

Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

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Extract Minute

NHS Tayside

TAYSIDE NHS BOARD
FINANCE AND RESOURCES COMMITTEE – RESERVED BUSINESS

Minute of Meeting of Tayside NHS Board Finance and Resources Committee held at 09.30 a.m. on **Thursday 17 April 2014** in the Board Room, King's Cross Conference Suite, Dundee

Present
Dr A Cowie, Non-Executive Member, NHS Tayside
Mr D Cross, Chair, Dundee Community Health Partnership & Non-Executive Member, NHS Tayside
Dr D Dorward, Non-Executive Member and Clinical Director, Dundee CHP, NHS Tayside
Mrs J Golden, Employee Director, NHS Tayside
Mr M Landsburgh, Non-Executive Member, NHS Tayside
Mrs A Rogers, Chair, Angus Community Health Partnership & Non-Executive Member, NHS Tayside

Attending- Executive Directors
Mr I S McDonald, Director of Finance, NHS Tayside
Ms L McLay, Chief Executive, NHS Tayside
Dr A Russell, Medical Director, NHS Tayside

Regular and Other Attendees
Mr L Bedford, Associate Director of Finance – Planning and Operational, NHS Tayside
Mr D Carson, Assistant Director of Finance, Governance and Corporate Finance, NHS Tayside
Mr D Colley, Finance Governance Accountant, NHS Tayside (for items 1 – 16)
Ms K Dapre, Energy and Climate Manager, Health Facilities Scotland (for items 1 – 12)
Mr G Doherty, Director of Human Resources, NHS Tayside
Ms M Dunning, Board Secretary, NHS Tayside (for items 11 - 14)
Mr S Hay, Non-Executive Member, NHS Tayside
Miss D Howey, Head of Committee Administration, NHS Tayside (for items 11 - 14)
Mr S Lyall, Head of Finance – Operational Unit, NHS Tayside
Miss D Robertson, Representative Area Clinical Forum, NHS Tayside

In Attendance
Mrs R Forbes, PA/Office Manager, Directorate of Finance, NHS Tayside

Apologies
Mr M Anderson, Head of Property, NHS Tayside
Mr J Boland, Representative Area Partnership Forum
Councillor D Doogan, Non-Executive Member, NHS Tayside
Mrs L Dunion, Chair, Perth and Kinross CHP and Non-Executive Member, NHS Tayside
Ms C Hastings, Representative Area Clinical Forum, NHS Tayside
Dr M McGuire, Nurse Director, NHS Tayside
Mr S Watson, OBE, DL, *(ex officio)* Chair, NHS Tayside

Dr Dorward in the Chair

ACTION

20. RE-PROVISION OF ROYAL HOSPITAL FOR SICK CHILDREN AND DEPARTMENT OF CLINICAL NEUROSCIENCES, EDINBURGH

Mr Lyall spoke to report FRC 28/2014.

Mr Lyall informed the Committee that Plans to build a replacement for the current Royal Hospital for Sick Children (RHSC), incorporating CAMHS, and Department of Clinical Neurosciences (DCN), Edinburgh, has been in the making for several years. This project would see a combined building constructed next to the Edinburgh Royal Infirmary, bringing paediatric care, specialist neonatal care, neurosciences and adult and children's emergency departments together on one site to create a centre of excellence.

NHS Lothian was now moving towards preparation of the Full Business Case for approval by the Board and the Scottish Government Capital Investment Group. It was announced as part of the Scottish Government's budget for 2011/12 that the re-provision of RHSC and DCN would be funded using the Non Profit Distributing Model. An Outline Business Case was subsequently developed and approved by Scottish Government in September 2012. .

20. RE-PROVISION OF ROYAL HOSPITAL FOR SICK CHILDREN AND DEPARTMENT OF CLINICAL NEUROSCIENCES, EDINBURGH cont'd.

ACTION

Following this, Integrated Health Solutions Lothian were chosen as the preferred bidder in March 2014 to design, build and maintain the new RHSC and DCN and construction work was expected to start in autumn 2014 with the hospital opening in the summer of 2017.

Members noted that the RHSC and DCN were regional facilities and Regional partners, including NHS Tayside, were engaged in the project through the South East and Tayside (SEAT) Regional Planning Group. The re-provision of services would incur additional recurring revenue consequences associated with the move to a new facility but that the additional recurring revenue costs associated with the new building were mostly funded by SGHSCD as it was an NPD scheme. There were other additional recurring revenue costs, mainly due to additional staffing requirements and soft FM costs that are in excess of existing budgets and Boards are asked to contribute an appropriate share of the additional cost.

Mr Lyall highlighted the costs contained within Table 1 of the report. NHS Tayside's share of recurring revenue costs was estimated at £0.4 million (2.3%) which was based on historic activity patterns. It should be noted that figures remain provisional at this stage as NHS Lothian was currently engaging with regional partners in a detailed examination of costs. Progress on any material variation would be reported back to members through future Corporate Finance reports to the Committee.

Members noted that NHS Lothian required all Boards to sign up to their share of costs by June 2014 to allow the Full Business Case to proceed through NHS Lothian and SGHCD governance processes. NHS Tayside would make provision for the additional costs in the next iteration of the Strategic Financial Plan 2015/16 to 2019/20 with provision in 2017/18. The Committee noted that there were no capital implications

Mr Lyall drew member's attention to the slides accompanying the report.

The Chairman thanked Mr Lyall for the report and the Committee noted the status of the project and approved NHS Tayside's share of the additional recurring revenue consequences associated with this project from 2017/18 provisionally estimated at £0.4 million.

The meeting concluded business at 11.15 a.m.

Subject to any amendments recorded in the Minute of the subsequent meeting of the Committee, the foregoing Minute is a correct record of the reserved proceedings of the meeting of NHS Tayside Finance and Resources Committee held on 17 April 2014 and was approved by the Committee at its meeting held on 15 May 2014.

……………………………..................... ……………………….....................................

CHAIRPERSON **DATE**

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APPENDIX 2

Benefits appraisal of the project options (2011)

RHSC & DCN OPTIONS at 2011 – NON-FINANCIAL BENEFITS APPRAISAL

Stakeholders met on 16 December 2010 to review and score the two shortlisted options for the location of the Department of Clinical Neurosciences at Little France.

Options

As this exercise was to score the *non-financial* benefits of the location of DCN, the different procurement routes for Option 1 were not considered, and only two options were scored:

1: Joint build in an independent build with the new RHSC
2: Extension at the south end of the ward arc, plus some existing RIE space

Scoring Participants

Stakeholder Group	Representative
Senior Management Team	Fiona Mitchell, Director of Operations – Women's, Children's and Neurosciences
	Colin Briggs, Head of Service for DCN and Service Manager for RHSC
DCN Clinical Management Team (CMT)	Colin Mumford, Clinical Director
Children's Services CMT	Dr Edward Doyle, Clinical Director
	Janice McKenzie, Chief Nurse
Critical Care CMT	Dr Brian Cook, Clinical Director
Anaesthetics & Theatres CMT	David Hood, Service Manager
General Medicine CMT	Jackie Drummond, Assistant Service Manager
Radiology CMT	Michael Conroy, Radiology Manager
NHS Lothian Staff Partnership	Susan Lloyd, Partnership Redesign
Project Team	Brian Currie, Project Director
NHSL Capital Planning	Iain Graham, Director of Capital Planning and Projects

Benefit Criteria

The group agreed that the following benefit criteria and weighting should be used to score the project options.

Quality of care: clinical effectiveness and meeting national guidance.	Weighting
To provide integrated neuroscience services providing good patient and staff pathways within DCN: Essential: immediate adjacency of DCN Acute Care, neuroradiology and neurosurgical theatres (horizontal or vertical); neuroscience ITU and HDU beds within approximately 5 minutes transfer by trolley from DCN Acute Care, neuroradiology and neurosurgical theatres. Desirable: co-location of outpatient clinics, therapies, neurophysiology and radiology.	35
To provide good patient and staff pathways between DCN and related adult specialities: Essential: immediate adjacency of General ITU (Ward 118) and neurosciences ITU and HDU; Desirable: close proximity between A&E and DCN Acute Care (horizontal or vertical); adjacency with trauma; adjacency with orthopaedic back services in order to support a single spinal surgery service; adjacency with RIE radiology to allow economies in build and revenue costs; proximity to acute stroke unit.	
To provide good patient and staff pathways between DCN and related paediatric specialities: Essential: RHSC access to DCN theatres; PICU beds within approximately 5 minutes transfer by trolley from neuroradiology and neurosurgical theatres. Desirable: co-located with RHSC radiology and neurophysiology to allow economies in build and revenue costs.	
Deliverability – the ability to implement options	
Delivering the operational solution by 2015.	25
Minimising disruption to clinical services during construction and commissioning of services.	
Minimising disruption for the wider site during construction and commissioning of services.	
Quality of the physical environment	
A functional, safe and efficient working environment for the assessment, treatment and care of patients.	15
Sustainability	
The delivery of emergency specialist services 24/7.	15
Maximising potential efficiencies to deliver a sustainable workforce.	
An energy efficient infrastructure and working environment.	
A facility that allows for flexibility and further expansion to meet changing service needs.	
Accessibility (Helicopter access only)	
Ease of access to the Little France hospitals for emergency patients transferred by helicopter.	10

The stakeholder group agreed that the site options to be scored would deliver no significant difference in the remaining criteria used in the initial appraisal, so Research and education was therefore not weighted.

Scores

BENEFIT CRITERIA		Unweighted scores OPTION 1 Joint build with new RHSC	Unweighted scores OPTION 2 New build extension and some existing RIE	AGREED WEIGHT	Weighted scores OPTION 1 Joint build with new RHSC	Weighted scores OPTION 2 New build extension and some existing RIE	Notes on discussion
1	Quality of care	47.3	39.3	35	**138.1**	114.7	Option 1 provided the best pathways for essential links between RHSC and the DCN theatres. Option 1 is more flexible in the internal adjacencies for DCN than the site at the end of the ward arc. Both options have excellent proximity from DCN to ITU.
2	Deliverability	48.0	32.7	25	**100.0**	68.1	Considerable disruption anticipated for RIE to build DCN on the end of the ward arc. Concerns about live construction either side of A&E for option 2. Overall timescale for completion of two separate projects thought likely to be longer.
3	Sustainability	49.7	34.3	15	**62.1**	42.9	Greater energy efficiency demanded of option 1. Less impact on sustainability of RIE services during construction of option 1. Option 2 would utilise last remaining RIE expansion zone.
4	Quality of the physical environment	53.0	39.0	15	**66.3**	48.8	New builds would be 100% single rooms. Proportion of DCN would be in existing RIE wards and therefore not single rooms in option 2. Higher quality of build expected in purpose-designed and -built accommodation complying with latest regulations.
5	Accessibility - Helipad only	45.0	48.0	10	**37.5**	40.0	Noted that this was for a small but critical group of patients.
6	Research and education	0.0	0.0	0	**0.0**	0.0	
	TOTAL	243.0	193.3		**403.9**	314.4	

APPENDIX 3

Benefits realisation plan

RHSC and DCN at Little France - **Benefits Realisation Plan**

The anticipated benefits map to the investment objectives for the RHSC and DCN at Little France project.

The project team lead for each benefit will co-ordinate baseline measurement by the end of 2014/15.

Contents

Benefit:	Page no:
1. Quality and clinical effectiveness	2
2. Quality of environment	6
3. Accessibility	9
4. Sustainability of environment	12
5. Sustainability or services and workforce	14
6. Deliverability	16
7. Research and development	18

1. Quality and clinical effectiveness

Overview

- Improvement in health and reduction in health inequalities by delivering and sustaining high quality care and treatment.
- A hospital that facilitates good clinical pathways and interfaces between specialities, diagnostic and support services.
- The building will allow NHS Lothian to meet quality and treatment targets set out in national and clinical guidance.

Responsibility for delivering the benefit

- Project Director
- General Manger for Children's Services
- General Manger for Clinical Neurosciences

Responsibility for monitoring the benefit

- Service Planning Project Manager
- Associate Medical Director for Children's Services
- Associate Medical Director for Clinical Neurosciences

<table>
<tr>
<td>**S**pecific</td>
<td>

Benefits

Improved access to care and treatment for all at the right time and in the right location. A hospital that facilitates and maximises interfaces between related specialities through co-location on site of:

- adult and paediatric emergency departments
- paediatric and neonatal surgery
- adult and paediatric neurosurgery
- physical and mental health services for children and young people
- acute neuroscience care and the emergency department
- adult spinal surgery in DCN and orthopaedics

A hospital that facilitates good clinical pathways and patient journeys between specialities, diagnostics and support services, e.g.

- reduced patient transfer time from the emergency department to diagnostics, theatres and critical care as required
- reduced patient transfer time for the retrieval of critically ill patients from other hospitals, by road or air
- provision of critical care in specialist HDU and ICU units rather than general wards
- provision of specialist transitional care for children and young people in a dedicated unit
- reduction in time between the admission of emergency patients to initiation of specialist care
- reduction in patients boarded into another speciality ward

A reduction in healthcare associated infection.

Improved patient safety.

Reduced waiting times with improved performance against Treatment Time Guarantees.

Upper quartile performance against peer national services.

Disadvantages

Distance created for neuro-oncology service between DCN at Little France and oncology at WGH requires to be addressed to ensure no negative impact on service quality.

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<tr>
<td>Measurable</td>
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Evidence required

- New service co-located with major acute adult hospital – completion of RHSC and DCN at Little France project
- Evidence of improved pathways & processes, physical adjacencies and best practice
- Evidence of distance and timescales for patient journeys
- Evidence of meeting Treatment Time guarantees
- Reduction in the cancellation of operations and over-run of theatre sessions
- Reduction in / maintain minimal infection rates
- Reduction in clinical incidents
- Benchmarking against peer services, currently done through Civil Eyes Valuing Medical Resources programme.

Examples of how benefits will be monitored

- Monitor LOS prior to introducing new models of care and after transfer to new building - health intelligence data
- Measure pre and post move transfer of patient journey times between key departments e.g. DCN theatres to adult ICU, emergency departments to theatre, SMMP to RHSC theatre.
- Waiting times performance before and after the move
- Monitor comparative levels of HAI – Infection Control Reports and Audits
- Scottish Patient Safety Programme measures, e.g. for HAI, surgical incidents and critical care outcomes.
- Interrogate Datix incident / near miss reports for the services
- The Productive Operating Theatre measures
- Releasing Time to Care measures
- Parent and family satisfaction audits before and after the move.
- Monitor volume of and issues raised in complaints before and after the move

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Achievable	**Actions necessary to realise benefits** ▪ Engagement of staff in developing, signing-off and delivery of the project. ▪ Develop and sign-off a design that delivers the necessary adjacencies and relationships. ▪ Redesign of patient pathways, and associated operational policies, workforce plans and service development plans. ▪ Development of a robust communications plan with staff and public to give understanding of the benefits of the project implementation. ▪ Commissioning Plan
Relevant	**Associated Investment Objective** To provide an environment that supports Clinical Effectiveness, meeting of national standards and targets and facilitates the implementation of best evidence based practice leading to improved treatment outcomes for patients.
Time-bound	**Timeframe for monitoring this benefit** Baseline monitoring: 2014/15 Re-visit the baseline pre-move: 2016/17 Post-project evaluation: 2018/19

2. Quality of environment / acceptability

Overview

- A quality physical environment which promotes the health and wellbeing of the building's users.
- There will be an increase in stakeholders satisfaction in the new 'fit for purpose' environment
- The building will comply with Hospital Building Note (HBN) guidance, the Disability Discrimination Act (DDA) and Design Quality for NHS Scotland 2010.

Responsibility for delivering the benefit

- Project Director
- General Manger for Children's Services
- General Manger for Clinical Neurosciences

Responsibility for monitoring the benefit

- Project Clinical Director
- Associate Medical Director for Children's Services
- Associate Medical Director for Clinical Neurosciences

<table>
<tr><td>Specific</td><td>
Benefits

Patient privacy and dignity in care will be improved with single rooms and fit for purpose design.
Patients will have increased control over their own environment – noise , temperature, light, socialisation – and will experience fewer interruptions to their sleep
Increased patient and public satisfaction in the facilities.
Building users will have access to external amenity space
Age appropriate care
A reduction in healthcare associated infection.
Improved patient safety.
Reduced staff absence – unplanned absence will achieve the target of below 3.5%
Improvement in the recruitment and retention of staff with a reduction in staff turnover

Disadvantages

None identified
</td></tr>
<tr><td>Measurable</td><td>
Examples of how benefits will be monitored

Patient Quality Indicators audit measures
Patient satisfaction / parent and family satisfaction audits before and after the move.
Monitor environmental / facilities complaints before and after the move
Monitor environmental / facilities issues in staff feedback before and after the move
Monitor comparative levels of HAI – Infection Control reports and Audits
Monitor staff absence and turnover – personnel systems

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Achievable	**Actions necessary to realise benefits** ▪ The design and finished environment will be scrutinised through the AEDET process. ▪ The building will be DDA compliant. ▪ The building will conform to the Design Quality for NHSScotland Standards 2010. ▪ Engagement of staff and patient representatives in developing, signing-off and delivering the project. ▪ Develop and sign off a design that delivers the necessary adjacencies and relationships. ▪ Develop and sign off a design that delivers patient safety and operational functionality within each department. ▪ Develop and sign off a design that delivers the internal design required to enable patient control of their environment, and promote user satisfaction and well-being.
Relevant	**Associated Investment Objective** To provide a physical environment, the quality of which, promotes the health and well being of the buildings users.
Time-bound	**Timeframe for monitoring this benefit** Baseline monitoring: 2014/15 Re-visit the baseline pre-move: 2016/17 Post-project evaluation: 2018/19

3. Accessibility

Overview

- Services that will be safely accessible to patients, visitors and staff, by public and private transport.
- The project includes a rooftop helipad to serve all clinical services in RIE, RHSC and DCN
- The project includes provision of car-parking, cycle-parking and public transport drop-off, and the reprovision of car park B at the RIE, which is being taken over for the new RHSC and DCN.

Responsibility for delivering the benefit

- Project Director
- General Manager for Children's Services
- General Manager for Clinical Neurosciences

Responsibility for monitoring the benefit

- Capital Planning Project Manager
- Chief Nurse for Children's Services
- Chief Nurse for Clinical Neurosciences

Specific	**Benefits** ▪ The site location enables easy access on foot or by car, cycle or public transport. ▪ The main entrance to the building is pedestrianised ▪ The site supports rapid and ease of emergency access by land and air ▪ The joining of adult and paediatric emergency departments, allowing families to be treated on the one site ▪ Separation of emergency and routine traffic Patients arriving by emergency ambulance will enter by the A & E entrance Patients arriving for day case or outpatient appointments will enter via the main entrance into hospital ▪ Adequate car parking provision is provided to support the specific needs of patients, frontline staff, essential car users and visitors to the site ▪ A drop off facility for carers adjacent to the main entrance and A&E ▪ Car parking spaces adjacent to the main entrance and A&E for disabled patients / drivers ▪ Car parking for RHSC & DCN patients and visitors will be in the closest public car park on the Little France site ▪ Access to park and ride facilities close to new hospital ▪ Provision is made for cyclists to secure their bikes to bike racks ▪ The signage access and way-finding will be compliant with DDA **Disadvantages** ▪ Limited parking capacity; some staff eligible for a pass at their current place of work will no longer have one – perceived disadvantage.
Measurable	**Examples of how benefits will be monitored** ▪ Monitor transport / access complaints before and after the move ▪ Monitor transport / access issues in staff feedback before and after the move ▪ Usage of flexible parking permits and other parking management information ▪ Access audit ▪ Monitor transfers to acute hospital services by air before and after the move.

<table>
<tr><td>Achievable</td><td>Actions necessary to realise benefits

▪ Good public information including signage and route management to direct public and staff by the planned safe route into the building
▪ Include access management in the commissioning programme
▪ Provide dedicated set down and pick up points clearly identifiable within the site layout plans
▪ Provide car parking arrangements that meet the requirements recommended by the Scottish Government
▪ Provide safe access route into the RHSC and DCN Building and Little France site
▪ Provide good real time travel information at the exits to the hospital
▪ Provide bike racks to allow cyclists to secure their bikes
▪ Shuttle bus and park and ride facilities close to hospital building</td></tr>
<tr><td>Relevant</td><td>Associated Investment Objective

To provide services that will be safely accessible to patients, visitors and staff, by public and private transport.</td></tr>
<tr><td>Time-bound</td><td>Timeframe for monitoring this benefit

Baseline monitoring: 2014/15
Re-visit the baseline pre-move: 2016/17
Post-project evaluation: 2018/19</td></tr>
</table>

4. Sustainability - environmental

Overview

- Efficient use of resources and revenue to deliver services. Scottish Government policy is for all new NHS buildings achieve the standard of BREEAM Healthcare 'Excellent'.

Responsibility for delivering the benefit

- Project Director
- Director of Operations – Facilities

Responsibility for monitoring the benefit

- Capital Planning Project Manager
- Energy and Environment Manager

Specific	**Benefits** • 20% of energy from low carbon technology • BREEAM 'very good' rating, with 'excellent' for energy credits ▪ Reduced utilities consumption and lifecycle costs ▪ Reduced carbon emissions ▪ Reduced waste **Disadvantages** • Costs of achieving BREEAM standard to be determined

<table>
<tr><td>Measurable</td><td>Examples of how benefits will be monitored

ENVIRONMENTAL SUSTAINABILITY from BREEAM 2011 guidance:
▪ Management
▪ Health & Wellbeing
▪ Energy
▪ Transport
▪ Water
▪ Materials
▪ Waste
▪ Land Use & Ecology
▪ Pollution</td></tr>
<tr><td>Achievable</td><td>Actions necessary to realise benefits

• The building design will to be compliant with Edinburgh Standards for Sustainable Buildings
• A strategy for waste reduction during construction will be implemented
• Once operational, recycling will be promoted through the provision of appropriate and accessible storage areas for waste
• What material will be used on the building?
• Off site recycling of waste
• For transport see Accessibility benefit, above</td></tr>
<tr><td>Relevant</td><td>Associated Investment Objective

• Efficient use of resources and revenue to deliver services.</td></tr>
<tr><td>Time-bound</td><td>Timeframe for monitoring this benefit

Baseline monitoring: 2014/15
Re-visit the baseline pre-move: 2016/17
Post-project evaluation: 2018/19</td></tr>
</table>

5. Sustainability – service / workforce

Overview

- Delivery of sustainable clinical services, particularly adult and paediatric critical care, and neurosurgery.

Responsibility for delivering the benefit

- Project Director
- General Manager for Children's Services
- General Manager for Clinical Neurosciences

Responsibility for monitoring the benefit

- Head of Redesign and Commissioning
- Service Manager for Children's Services
- Service Manager for Clinical Neurosciences

Specific	**Benefits** ▪ Secure paediatric neurosurgery and intensive care unit in RHSC ▪ Sustainable delivery of adult ICU on three acute sites in Lothian ▪ Sustainable service and workforce plans for all teams and specialties **Disadvantages** • None identified
Measurable	**Examples of how benefits will be monitored** ▪ Sustainable medical staff rotas; use of agency / locum cover ▪ Sustainable nursing staff rotas; use of agency / locum cover ▪ Performance against Treatment Time Guarantees ▪ % theatre cancellations by NHSL ▪ % outpatient cancellations by NHSL

Achievable	**Actions necessary to realise benefits** ▪ Demand projection and capacity planning • Workforce planning, including implementation of / recruitment to new roles • Treatment Time performance recording
Relevant	**Associated Investment Objective** • Efficient use of resources and revenue to deliver services.
Time-bound	**Timeframe for monitoring this benefit** Baseline monitoring: 2014/15 Re-visit the baseline pre-move: 2016/17 Post-project evaluation: 2018/19

6. Deliverability / Disruption

Overview

- Continuity of RHSC, DCN and RIE services with minimal impact on quality or targets throughout the delivery of the project

Responsibility for delivering the benefit

- Project Director
- General Manager for Children's Services
- General Manager for Clinical Neurosciences

Responsibility for monitoring the benefit

- Head of Redesign and Commissioning
- Service Manager for Children's Services
- Service Manager for Clinical Neurosciences

Specific	**Benefits** • Services in RHSC and DCN will be uninterrupted through construction phase as the new build is off-site. • Services in the RIE will experience minimal disruption as traffic management and construction project management will work to reduce impact and risk. **Disadvantages** • Double-running requires resource – staff, equipment and support services • Staff engagement requires resource – clinical and non-clinical groups, design, equipment, workforce planning, commissioning
Measurable	**Examples of how benefits will be monitored** ▪ Services will maintain waiting times and quality targets before, during and after the commissioning phase , e.g. HEAT targets ▪ 'Loss of facility' registered for the RIE PFI provider

Achievable	**Actions necessary to realise benefits** • Construction programme planning to minimise disruption • Commissioning programme planning to maximise service delivery, including double-running where necessary • Engagement of RIE site PFI providers in traffic management planning for construction and commissioning period
Relevant	**Associated Investment Objective** • To provide a scheme option that results in the minimum possible disruption to patients and allows the continued delivery of clinical services over the duration of the project (activity levels maintained).
Time-bound	**Timeframe for monitoring this benefit** Baseline monitoring: 2014/15 Re-visit the baseline pre-move: 2016/17 Post-project evaluation: 2018/19

7. Research & Development

Overview

- To provide an environment that facilitates engagement and involvement with the University of Edinburgh and other research and development bodies and opportunities.

Responsibility for delivering the benefit

- Project Director
- Associate Medical Director for Children's Services
- Associate Medical Director for Clinical Neurosciences

Responsibility for monitoring the benefit

- Clinical Project Director
- Director of the Edinburgh Clinical Research Facility
- Director of the Centre for Clinical Brain Sciences, University of Edinburgh

Specific

Benefits

- Co-location with the Chancellor's Building, Queen's Medical Research Institute and Edinburgh BioQuarter
- Access to quality training and teaching facilities for staff in RHSC and DCN specialties
- Access to quality training, teaching and personal study facilities for undergraduate and postgraduate study in paediatric and neuroscience disciplines
- High quality research facilities
- Formal partnership arrangements with education and research institutes
- Enhanced research and education portfolio in paediatric and neuroscience disciplines

Disadvantages

- None identified

<table>
<tr><td>Measurable</td><td>Examples of how benefits will be monitored
Research Assessment Exercise rating for hospital-based clinical subjects, psychiatry and neuroscience.
Research portfolio in paediatric and neuroscience disciplines</td></tr>
<tr><td>Achievable</td><td>Actions necessary to realise benefits
Formal partnership arrangements with education
Enhanced research portfolio
Multidisciplinary involvement in the research and education programme</td></tr>
<tr><td>Relevant</td><td>Associated Investment Objective
To provide a service environment that will easily allow engagement and involvement with research and service development opportunities with our partner higher education institutes. To provide a service that will advance treatments and interventions and attract highly capable staff with progressive research interests and who can be more readily retained.</td></tr>
<tr><td>Time-bound</td><td>Timeframe for monitoring this benefit

Baseline monitoring: 2014/15
Re-visit the baseline pre-move: 2016/17
Post-project evaluation: 2018/19</td></tr>
</table>

APPENDIX 4

Value for money assessment from the Outline Business Case (2011)

SGHD Value for Money Assessment Guidance: Capital Programmes and Projects
Appendix C – Checklist and Pro-forma of Required Actions Stage 2

Requirement	Details Assessed	NHS Lothian response
Qualitative Assessment of NPD	1. Review, confirm and complete applicable pro-forma below relating to: • Viability of project • Desirability of project • Achievability of project (in particular market capacity and likely bid competition / market interest to be reviewed) 2. Consider wider VfM factors and generic VfM factors 3. Review proposed Project Timetable 4. Confirm proposed risk allocation (as per standard form NPD/hub DBFM contract, where applicable) 5. Confirm benefit assessment and deliverability 6. Support evaluation and decision with evidence from pervious projects. Report findings should include the results of the assessment of the viability, desirability and achievability of revenue financed procurement. (This should include the pro-forma assessment tables and the results of the workshops which assessed these.)	The remaining sections of this table address each of these points.
Review of Affordability – to determine if the project can continue	Confirm project is affordable / supportable to the procuring authority based upon forecast scope and delivery timescales. The affordability implications (including the affordability envelope under a range of sensitivities) should be signed off required. The affordability assumptions and implications should be detailed within the report.	Refer to section 5.6.
Review of Balance Sheets Status	The accounting implications of the project should be assessed and recorded within the Report.	Refer to section 5.4.

VIABILITY		
Issue	**Questions**	**NHS Lothian Response**

VIABILITY		
Issue	**Questions**	**NHS Lothian Response**
Project level objectives and outputs	Is the Procuring Authority satisfied that a long term, operable contract could be constructed for the project?	Yes. The requirement is for discrete facilities capable of being managed under a specific contract, with clearly definable outputs. The clinical requirement supports long-term strategy within the NHS in Scotland.
	Confirm that the proposed contract describes / will describe service requirements in clear, objective, output-based terms over a long term period in accordance with the standard NPD contract and guidance.	The project will use the standard form NPD contract as drafted by SFT, with no derogation envisaged other than in project-specific areas.
	Confirm that the contract will support assessments of whether the service has been delivered to an agreed standard in accordance with the standard NPD contract and guidance.	As above.
	Confirm that the proposed project outcomes will meet the project objectives and address the need.	The development of the project has ensured that the outcomes to be sought under the procurement are aligned with clinical and strategic objectives and will meet long term clinical needs.
	Will there be significant levels of investment in the new capital assets and related services?	Yes. Refer to section 5.1. The project is a major capital investment for the NHS, with a value of circa £150 million.

VIABILITY		
Issue	**Questions**	**NHS Lothian Response**
	Confirm that any interfaces with other projects or programmes are clear and manageable?	The key areas of interface will be with the ongoing operations of the Royal Infirmary of Edinburgh, managed via a contract between NHS Lothian and Consort. This interface is critical to the success of the project and has been addressed in detail in risk management processes. Ensuring an effective interface is a key aspect of the project management and governance structure.
	Confirm that the services to be provided as part of the project do not require the essential involvement of Procuring Authority personnel? To what extent does any involvement negate the risk transfer that is needed for VfM?	The services to be provided by the contractor are limited to Hard FM. NHS Lothian will have no direct role in the delivery of these services, although the monitoring and management of contractual arrangements will be a key task for NHS Lothian staff.
	Will the private sector have control / ownership of the intellectual property rights associated with the performance / design / development of the assets for the new service? Confirm that the standard form NPD contract provisions relating to intellectual property rights will be adopted.	Arrangements for these issues will be governed by the contract, which will utilise the standard form drafting provided by SFT.

VIABILITY		
Issue	**Questions**	**NHS Lothian Response**
Operational flexibility	Is the Procuring Authority satisfied that operational flexibility is likely to be maintained over the lifetime of the contract at an acceptable cost?	Yes. The contract will contain drafting to deal with the management of change. The specification for the facilities will be derived from detailed design work already undertaken that ensures that long-term clinical needs will be met. As FM services are limited to Hard FM only, the NHS will have control over the delivery of the vast majority of operational services provided within the new facility.
	Is there a practical balance between the degree of operational flexibility that is desired and long term contracting based on up-front capital investment in projects?	See above.
	What is the likelihood of large contract variations being required during the life of a typical contract?	The facility is designed to deliver long-term need as it is currently understood. Any requirement for change will derive from factors and influences that are not yet known. However, major variation is not expected or considered likely.
Equity, efficiency and accountability	Does the scope of the project services allow the contractor to have control of all the relevant functional processes? Do the services have clear boundaries?	These factors will be fully addressed within the contract, which follows SFT standard form.
	Are there regulatory or legal restrictions that require project services to be provided directly?	There are no such restrictions envisaged.

VIABILITY		
Issue	**Questions**	**NHS Lothian Response**
	Will the private sector be able to exploit economies of scale through the provision, operation or maintenance of other similar services to other customers?	The project is located centrally within Scotland's central belt and has good access to communication links. While it is not yet known which private sector parties may decide to take part in the procurement, we can reasonably assume that they will be experienced operators of similar contracts, facilities or services in Scotland or elsewhere in the UK, and so could exploit economies of scale on this basis.
	Does the private sector have greater experience / expertise than the Procuring Authority in delivery of the project services? Are the services in the project non-core to the Procuring Authority?	The services to be provided by the contractor are limited to hard FM services, which cannot be considered core to the NHS. All core NHS services are to be retained by NHS Lothian.
	Is the Project likely to deliver improved value for money to the Procuring Authority as a whole?	Yes. The procurement process will be highly competitive and will drive a value for money outcome. During operations the governance of the NPD vehicle will ensure that the contractor operates efficiently and maximises returns for stakeholders.
OVERALL VIABILITY	**Is the relevant Accountable Officer satisfied that operable contracts with built in flexibility can be constructed across the project, and that strategic and regulatory issues can be overcome?**	Yes, this is confirmed.

DESIRABILITY		
Issues	**Question**	**Response**
Risk management	Does the project involve the purchase of significant capital assets, where the risks of cost and time over-runs are likely to be significant?	The assets to be procured are significant and there are several risks inherent in a project of this nature. However, each of these risks has been identified, as set out in section 6.7, and quantified where possible. Risk mitigation processes have been put in place for each risk. In addition, the affordability analysis takes account of a number of sensitivities that test the implications of delays and cost overruns.
	Is the private sector likely to be able to manage the generic risks associated with the project more effectively than the Procuring Authority? Bearing in mind the relevant risks that need to be managed for the project, what is the ability of the private sector to price and manage these risks? Can envisaged standardised payment mechanisms and contract terms incentivise good risk management within the project, as per the standard form NPD contract?	The risk processes applied have sought to identify all risks and allocate them to the party best place to manage that risk. In particular, the standard NPD contract embodies a risk allocation that is well understood and accepted by the private sector. The project will, therefore, only seek to allocate risks to the private sector that it can manage effectively and price so that value for money is not damaged. NHS Lothian will retain other risks. The use of the NPD standard contract will ensure that good risk management arrangements are put in place.

DESIRABILITY		
Issues	**Question**	**Response**
Innovation	Does a preliminary assessment indicate that there is likely to be scope for innovation on a project basis? Does some degree of flexibility remain in the nature of the technical solutions / services and / or the scope of the project? Can solutions be adequately free from the constraints imposed by the Procuring Authority, legal requirements and / or technical standards?	The approach to be taken in the project is to create a reference design for the facilities that embodies desired clinical adjacencies and functionality that will form a key element of the output specification for the project. Bidders will be able to focus, therefore, on delivering the most effective and innovative solution that delivers these outputs, built on a solid foundation of work already completed by NHS Lothian.
	To what extent will the individual project's scope, specification and operation be pre-set or open to negotiation with the private sector?	The scope of the project and the outputs sought will be set. However, the competitive dialogue process will allow scope for discussion about how the bidders might best deliver this scope in output terms.
	Could the private sector improve the level of utilisation of the assets underpinning the project (e.g. through selling, licensing, commercially developing for third party usage etc)?	There is no specific barrier to bidders coming forward with proposals along these lines during the competitive dialogue subject to the core requirement being delivered and to the constraints of avoidance of direct competition with commercial activities delivered by Consort at the Royal Infirmary.

DESIRABILITY		
Issues	**Question**	**Response**
Service provision	In relation to the project, are there good strategic / service delivery reasons not to retain soft service provision in-house? What are the relative advantages and disadvantages of this approach?	The decision to include only hard FM services in the project was taken at programme level and has been agreed with Scottish Government. There are no specific reasons why Soft FM should be included in the contract alongside Hard FM.
Incentive and monitoring	Confirm that the standard form NPD / hub DBFM contract provisions relating to monitoring and incentivising service delivery will be adopted.	This is confirmed
Lifecycle costs / residual value?	Is it possible to integrate the design, build and operation of the project?	Yes – bidders will be asked to provide an integrated solution that encompasses design and build, with life cycle and hard FM provisions designed to be complementary to the chosen design.
	Is a lengthy contract envisaged? Will long-term contractual relationships be suitable (or advantageous) for the service? Are there constraints on the status of the assets at contract end?	Yes – a contract length as per the NPD standard will be adopted, along with the standard approach of assets reverting to NHS Lothian at nil cost at the end of the concession.
	Are there significant ongoing operating costs and maintenance requirements across the project? Are these likely to be sensitive to the type of construction?	Yes. The contractor will be fully responsible for all hard FM and life cycle aspects of the facility throughout the contract and will be required to cost such services in tandem with design and construction so that the elements are fully integrated.

DESIRABILITY		
Issues	**Question**	**Response**
OVERALL DESIRABILITY	Overall, is the relevant Accountable Officer satisfied that the project and its procurement approach would bring sufficient benefits?	Yes. The chosen approach will ensure that the need is met via a competitive process that will be designed to encourage bidders to add value.

ACHIEVABILITY		
Issue	**Question**	**Response**
Transaction costs and client capacity	Does the Procuring Authority have an appropriate governance and management structure in place for progressing the procurement of the project?	Yes. The project is supported by a well-resourced team of internal and external staff as described in section 6.3.
	Is there sufficient Procuring Authority capability and capacity to manage the procurement process and appraise the ongoing performance against agreed outputs?	Yes, see above.
	Can an appropriately skilled procurement team be assembled in good time?	Yes, this team is already in place as shown in section 6.3.
	Will the project be feasible within the required timescale? Is there sufficient time for resolution of key Procuring Authority issues?	Yes. Considerable work has been put into designing a challenging yet deliverable timetable for the project that has been agreed with SFT and SG.
	Does the size of the project justify the transaction costs?	Yes. Transaction costs have been factored into the financial modelling undertaken on which affordability of the project has been established. These amount to some x% of the overall project cost and are derived from benchmarking against other similar projects.

ACHIEVABILITY		
Competition / Market Interest	Is there evidence that the private sector is capable of delivering the required outcomes for the Project?	Yes. The scope of the project is broadly similar to other DBFO-type projects delivered successfully in the NHS in the UK. Considerable informal market interest has already been demonstrated.
		As above.
	Have any similar projects been tendered to market?	The concept of NPD is now well established in the market, with three completed schools projects and a completed NPD project in the NHS, NHS Tayside's Mental Health Developments Project.
	Is there likely to be sufficient market appetite for the project in the timetable currently anticipated?	The timing of the project is such that there are few other similar projects in progress at this time and that interest from the market, which is very keen to see a clear pipeline of deals emerging, will be considerable.
	Has this been tested robustly? Is there any evidence of market failure for similar projects?	Yes. See above. This has been tested via various market sounding exercises.
	Has the Procuring Authority's commitment to a revenue financed solution for this type of project been demonstrated?	NHS Lothian has demonstrated its commitment to a privately financed approach and has procured several facilities, included the Royal Infirmary of Edinburgh, in this way in the past.

ACHIEVABILITY		
	Do the nature of the investment and / or the strategic importance of the work and / or the prospect for further business suggest that it will be seen by the market as a potentially profitable project?	Yes. This is a large and important project that creates a major opportunity for the market to be involved in a significant long-term partnership that will generate a variety of sub-contracts. NHS Lothian recognise that it is desirable for the private sector to be able to generate a reasonable profit from such a project, bearing in mind that the contract will be let competitively and value for money tested rigorously.
OVERALL ACHIEVABILITY	Overall is the relevant Accountable Officer satisfied that the project is achievable, that the project team is sufficiently resourced and the project is attractive to the market?	Yes. NHS Lothian has invested heavily in this project in order to ensure its success.

APPENDIX 5

Legal adviser letter on completion of final tender evaluation

Commercial – in confidence

APPENDIX 6

Technical adviser letter on completion of final tender evaluation

Commercial – in confidence

APPENDIX 7

Financial adviser letter on completion of final tender evaluation

Commercial – in confidence

APPENDIX 8

Preferred bidder consortium

The IHS Lothian team has unique experience, delivering value for PPP projects in the healthcare market

This IHS Lothian team comprises:

MACQUARIE CAPITAL (MACQUARIE)

A global leader in procuring, developing and managing essential social infrastructure assets, with a significant commitment to the Scottish market. An example includes the successful close of Forth Valley PFI Hospital. Macquarie has extensive global experience as junior debt investor and financial adviser on a wide range of PPP infrastructure projects, with a special focus on healthcare and social infrastructure.

Having been the lead sponsor for the Peterborough PFI Hospital, Royal Adelaide PPP Hospital and a number of other international healthcare PPP projects, Macquarie has a unique knowledge and unrivalled experience in delivering successful healthcare PPPs post the global financial crisis.

It is testament to Macquarie's expertise that it has closed over 60 PPP projects exceeding £10 billion in the last 10 years in the UK and Europe alone.

BROOKFIELD MULTIPLEX (BM)

An international leading construction contractor with a long track record in delivering world-class, quality healthcare projects. Currently building the New South Glasgow General Hospital, BM has a significant local presence and a positive understanding and relationship with the local supply chain. In partnership with Macquarie, BM delivered Peterborough Hospital PFI three months ahead of programme.

Their management team focus and thrive on delivering complex healthcare projects. As an example on the New South Glasgow General Hospital, a new £20 million office block will now be built funded by savings made on the project by BM.

BM has engaged with world class designers to provide a bespoke, state-of-the-art, tailor-made facility to optimise the patient and user experience, for both the children's and neurological centres.

BOUYGUES ENERGIES & SERVICES (BES)

A world leader in delivering sustainable energy efficient solutions, BES brings the real value benefit of combined FM services delivery and lifecycle management. With substantial expertise in the UK including Mid Essex Hospital Services, North Middlesex University Hospital and West Middlesex University Hospital, BES services are tailored to delivering high quality healthcare.

Within the BES team, qualified healthcare professionals, now permanently engaged in FM delivery, bring operational knowledge into the application of the support services adding value beyond a usual FM operator. The IHS Lothian team and BES specifically will work in partnership with the Board to develop the right type of facility and FM approach to service Lothian's needs and the Board's requirements. BES also has an established office in Edinburgh.

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APPENDIX 9

Strategic programme

Re-Provision of RHSC & DCN at Little France

Strategic Programme PB to Hospital Opening

Line	Name	Start	Duration	Finish
1	Key Milestones	10 Mar 14	157w 1d	15 May 17
2	Identify Preferred Bidder	10 Mar 14		10 Mar 14
3	Submit Planning Application	08 May 14		08 May 14
4	Planning Approval	31 Jul 14		31 Jul 14
5	Commercial and Financial Close	02 Oct 14		02 Oct 14
6	Start on Site	03 Oct 14		03 Oct 14
7	Handover Completed Hospital	17 Feb 17		17 Feb 17
8	Hospital Operational First Patient In	15 May 17		15 May 17
9	Preferred Bidder to Financial Close Period	10 Mar 14	29w 2d	02 Oct 14
10	Communication with Stakeholder Meetings	13 Mar 14	4w 2d	13 Apr 14
11	Clinical and Non Clinical Design Review	11 Mar 14	23w 4.5d	27 Aug 14
12	Project Delivery Group Meetings	11 Mar 14	23w 4.5d	27 Aug 14
13	Clinical / User Groups Review	01 Apr 14	17w	30 Jul 14
14	Planning - Reserved Matters Application	01 May 14	16w 4d	27 Aug 14
15	Building Warrant Required by Financial Close	01 Oct 14		01 Oct 14
16	Cost Plan	02 Jun 14	16w	22 Sep 14
17	Design freeze, cost plan capex and its revenue and life cycle fixed	15 Jul 14	6w 4d	01 Sep 14
18	Financial	10 Mar 14	29w 2d	02 Oct 14
19	Schedule Part 12	26 Jun 14	7w 2d	15 Aug 14
20	PCP Section 4	10 Jul 14	6w 3d	26 Aug 14
21	Technical Schedules	28 Jul 14	5w	01 Sep 14
22	Financial Close	02 Oct 14	1d	02 Oct 14
23	Design Programme	09 May 14	82w 2d	12 Jan 16
24	Procurement Programme	27 May 14	111w 3d	26 Aug 16
25	Construction Period	03 Oct 14	116w 1d	17 Feb 17
26	Construction	03 Oct 14	116w 1d	17 Feb 17
27	Site Possession	03 Oct 14		03 Oct 14
28	Mobilisation and Site Establishment	03 Oct 14	20w	05 Mar 15
29	Enabling Works	03 Oct 14	42w 4d	19 Aug 15
30	Interface Works	20 Oct 14	32w 2d	24 Jun 15
31	Main Plant	05 Jan 15	63w 1d	18 Apr 16
32	Piling	12 Nov 14	22w	05 May 15
33	Basement	02 Dec 14	31w 2d	29 Jul 15
34	GF Pile Caps	05 Jan 15	30w 3d	12 Aug 15
35	Cores	27 Jan 15	43w 1d	01 Dec 15
36	Concrete Frame	02 Feb 15	46w 4d	14 Jan 16
37	Structural Steelwork	16 Jul 15	39w	04 May 16
38	Envelope	11 Jun 15	46w 4d	24 May 16
39	Fit Out	11 Jun 15	79w	18 Jan 17
40	Level 1 Fit Out	11 Jun 15	75w 2d	09 Dec 16
41	Level 2 Fit Out	15 Jul 15	71w 3d	16 Dec 16
42	Level 3 Fit Out	22 Jul 15	72w 1d	11 Jan 17
43	Level 4 Fit Out	15 Dec 15	52w 2d	18 Jan 17
44	Level Ground Fit Out	30 Jul 15	68w	07 Dec 16
45	Level Basement Fit Out	07 Dec 15	51w 4d	22 Dec 16
46	Stairs Fit Out	02 Mar 16	17w 2d	07 Jul 16
47	Lifts Installation	08 Dec 15	48w 1d	29 Nov 16
48	M & E Plantroom Fit Out	17 Sep 15	47w 2d	02 Sep 16
49	Energy Centre & FM	03 Feb 15	87w	31 Oct 16
50	External Works	20 Oct 14	112w	03 Feb 17
51	Commissioning	17 Nov 14	110w	17 Feb 17
52	Demobilisation	14 Nov 16	12w	17 Feb 17
53	IHSL Handover Completed Hospital	17 Feb 17		17 Feb 17
54	Board's Pre-Completion and Post Completion Commissioning	21 Oct 16	26w 4d	15 May 17
55	Board's Pre-Completion Commissioning	21 Oct 16	11w 1d	20 Jan 17
56	Board's Post Completion Commissioning	20 Feb 17	11w 3d	15 May 17

Date of Issue: 08/07/2014

Print Date: 08/07/2014 Drawn By: DAB

Comments: Progress to 30th June 2014

Programme No.: IHSL-RHSC&DCN-PB01 Revision: 07B

Revision Date: 08/07/2014

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APPENDIX 10

Key Stage Review report at pre-preferred bidder appointment

SCOTTISH
FUTURES
TRUST

Validation of Revenue Funded Projects:

NPD Programme

Pre-Preferred Bidder Appointment Key Stage Review

28 February 2014

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NPD Programme
Pre-CoD Key Stage Review

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Notes to the Reviewer

1.1. Background

It is a condition of Scottish Government (SG) funding support that all projects in the revenue funded programme are, in addition to any existing project approvals processes, externally validated by SFT. SFT undertakes validation by carrying out Key Stage Reviews (KSRs) of projects at key stages of a procurement. The KSR process is designed to support the successful delivery of revenue funded projects whether delivered through the non-profit distributing (NPD) model or the hub initiative as Design Build Finance and Maintain (DBFM) projects by providing an assessment of the readiness of a project before it moves on to the next stage in the procurement process.

1.2. Timing

This review is required to be completed following evaluation of Final Tenders and in advance of the appointment of a Preferred Bidder.

The review should be carried out by the member of the Scottish Futures Trust team who normally provides support to the relevant project (the Reviewer). The Reviewer must agree the precise timing of the review and submission of SFT's report with the Project Sponsor and/or SG to integrate with the other project approvals processes.

In the run up to each review point, the Reviewer will inform and keep up-to-date the SFT validation team of the estimated timetable for carrying out the KSR. The validation team will arrange for a member of the SFT's senior management team (SMT) to scrutinise the list completed by the Reviewer before it can be submitted to the Project Sponsor and/or SG. The Reviewer should thereafter liaise directly with the allocated SMT member and must return a countersigned copy of the list to the Validation Team upon SMT sign-off. The Reviewer should discuss arrangements with the allocated SMT member and provide a verbal briefing if requested in advance of review so that if required necessary background information can be made available.

1.3. Process

The Reviewer must familiarise him/herself of the requirements of the checklist and consider which elements s/he can answer on the basis of existing knowledge of the project and identify what additional information is required in relation to the project in order to complete the remaining sections. The Reviewer should, at the earliest opportunity, explain to the Procuring Authority / Project Team what additional information s/he will require, in what form and by when in order to complete the review within the agreed timescales.

The review is not intended to be a "stop-start" process and the Reviewer should refer to the list throughout each delivery stage so that all sections of the checklist can be completed without delay to the project. The process involves the Reviewer completing this pro-forma list on the basis of information obtained in his/her day-to-day dealings with the project, considering whether in his or her view the project is ready to proceed to the next stage of procurement and making recommendations as to what actions may be required to achieve appropriate state of readiness. No formal submission, as such, will be required from the Procuring Authority, but the project team will be required to provide the Reviewer with information to allow him/her to complete the list and compile his/her report.

Once completed by the Reviewer, the list and draft report should be submitted to the allocated SMT member for scrutiny before being issued to the relevant Project Sponsor and/or SG and copied to the Procuring Authority. The relevant Project Sponsor and/or SG will thereafter, as part of its overall sign-off process, determine whether and on what basis the project should proceed to the next stage

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taking into consideration any recommendations made in the KSR report. The Reviewer should liaise directly with the Project Sponsor and Procuring Authority as may be required to address any queries arising from the KSR report or recommendations.

1.4. Further information

Please contact the Validation Team for further information on the KSR process. Queries relating to the revenue funded programme requirements should be directed to the SFT Finance Team.

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Pre-CoD Key Stage Review List

SFT Reviewer (Primary Reviewer)	Donna Stevenson
SFT Secondary Reviewer (SMT Member)	Tony Rose

Section 1: Project Outline

Project title	**Royal Hospital for Sick Children and Department of Clinical Neuroscience (RHSC/DCN) Project**
Brief project description	The provision of the Royal Hospital for Sick Children, Edinburgh and the Department of Clinical Neuroscience, currently within the Western General, Edinburgh in a joint new building adjacent to the existing Royal Infirmary of (RIE) at Little France in Edinburgh. The new build will extend to approximately 50,000 square metres with separate energy centre and facilities management yard and basement.
Outline of scope of services in project (please identify the services and who (NPD SPV or Procuring Authority) will provide those services)	The NPD SPV is to provide lifecycle replacement, hard FM service with associated helpdesk facilities including grounds maintenance, utilities procurement and management and window cleaning. NHS Lothian (the Board) is to provide the soft fm services.
Key programme dates: • **Preferred Bidder appointment** • **Financial Close**	The following dates for key elements of the programme: • OJEU: was issued on 5 December 2012 • ITPD : 11 March 2013 • ITFT : to be issued 13 December 2013 • PB appointment: to be made on 10 March 2014 • FC: scheduled for 1 October 2014

Project Contact Details

Project Sponsor /SG Responsible Officer	Scottish Government's Health and Social Care Directorates ("SGHSCD")

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(name & contact details)	Mike Baxter, Deputy Director, St Andrew's House, Waterloo Place, Edinburgh Telephone: [redacted] Email : Mike.Baxter@scotland.gsi.gov.uk
Project Authority Responsible Officer **(name & contact details)**	Susan Goldsmith, Project Sponsor Email: Susan.Goldsmith@nhslothian.scot.nhs.uk
Project Director/Manager (name & contact details)	Brian Currie, Project Director NHS Lothian, 56 Canaan Lane Edinburgh Telephone : [redacted] Email: brian.currie@luht.scot.nhs.uk
Principal legal, technical and financial advisers (firm/company & name of main contact)	Technical : Richard Cantlay, Mott Macdonald Financial : Michael Pryor, Ernst & Young Legal: Andrew Orr, MacRoberts

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Section 2: Project Requirements

The key objective of this section is to confirm that the proposed technical solution has been developed and agreed with the proposed preferred bidder in sufficient detail, minimising the risk of changes in the period up to financial close. Arrangements must be in place for anticipating, identifying and managing any changes to the project scope thereafter.

	Question	Yes/No	Comments
1.	Please outline any changes that been made to the scope of the project since the last KSR and demonstrate that such changes have the required level of approval within the Procuring Authority and from the relevant Project Sponsor and/or SG.		There have been no changes in scope since the Pre COD KSR except that there is a proposal to be considered by the Project Steering Board on 28 February to consider changing the catering strategy from full service kitchen to offsite production and regeneration facilities within the hospital. The Board has advised that the space requirements would remain the same for the kitchen and that there is sufficient room on the wards for the proposed new arrangements. The Board's view is that there is not likely to be a material change in costs for the NPD project, nor should it give rise to any procurement issue. If approved, the Board intends to proceed with a variation post PB. **Recommendation : (1) that the Board advises SFT of the outcome of the consideration of this proposal and of the progress for the change in scope, including the steps to be taken by the board to ensure value for money in relation to the change in costs; and** **(2) that the Board develops the detail of the implementation of its strategy, including interface management, so that catering arrangements will be in place in advance of the operational date, noting that an interim strategy will also require to be developed should the Board's long terms catering strategy not be fully implemented at the proposed facility opening date.**
2.	Is the Procuring Authority satisfied that the proposed	Yes	The position remains as at the Pre COD KSR except for the catering

	preferred bidder's solution will satisfy its operational and functional requirements (including in relation to the matters below) and deliver the project objectives, benefits and outcomes:		proposal noted above.
	- the scope of FM services within the project;		As Pre COD KSR
	- the impact of the project on staff (including potential impact of TUPE legislation);		None anticipated
	- the interface between FM services to be included within the project and those for which the Procuring Authority will retain responsibility;		As Pre COD KSR
	- the interface between design and the delivery of FM services (e.g. cleaning) and risks (e.g. energy consumption, security) retained by the Procuring Authority;		As Pre COD KSR
	- the interface (during both construction and operations) between the works and services within the project and the Procuring Authority's other facilities and services (e.g. impact on use of adjoining facilities during the construction phase) ;		As Pre COD KSR
	- sustainability;		As Pre COD KSR
	- community benefits;		The proposals from the bidders meet the Board's requirements and there are remedy provisions which the Board considers to be appropriate.

	- the inclusion of equipment within the project;		As Pre COD KSR subject to any subsequent changes to the catering arrangements
	- the delivery of the Procuring Authority's IT requirements within the new facilities;		As Pre COD KSR
	- decant from existing facilities and migration to new facilities;		As Pre COD KSR
	- any conditions or recommendations on scope/specification/design identified in the outline business case approval or previous KSRs.		See Question 31 regarding the recommendations which were mead in the Pre COD KSR.
3.	Is the Procuring Authority, and are its advisers, satisfied that any further development of technical information required from the preferred bidder appointment to financial close is achievable within the current project timetable?	Yes	The Board has confirmed that all bidders have provided detailed programmes to cover the activities for the period until FC and that the development of the technical information is at least as advanced as the Board anticipated at this stage. The Board and its advisers are satisfied that any further development of technical information from PB appointment to FC is achievable within the current project timetable. **Recommendation :** **a. The Authority is asked to share the developed version of the draft PB letter to allow SFT the opportunity to comment and to take due account of those comments.** **b. It is understood that the Board's communication strategy is such that the Preferred Bidder will be announced publicly prior to receiving the signed PB letter from the proposed PB. The Board is asked to confirm to SFT that it has considered whether there are any significant issues which would merit obtaining signature to the PB letter prior to a public announcement and that the Board's final**

			communications strategy for the PB announcement has been informed by this process.
4.	Please demonstrate that a control mechanism and an approvals process are in place for identifying and managing changes to scope, costs and timescales during the procurement process.		As Pre COD KSR

Section Three: Affordability

The key objective of this section is to consider and test the overall affordability position of the project for both the Procuring Authority and the Scottish Government, in terms of both revenue and capital funding requirements.

2. Please complete the following project affordability table (with information for the relevant KSR stage)[1]:

[Note : the following commentary was included at the Pre COD KSR stage:

The issues arise in relation to the bidders' financial submissions and the table below:

*2.1. **Construction cap:** the construction cap remains at £137.757m plus inflation to mid point construction of 4Q 2015 (from 3Q 2011) or earlier midpoint if applicable during procurement: the earlier date is not applicable. The inflated construction cap has been fixed at 28 November 2013 on which date the relevant BICS indices were 3Q2011: 220; 4Q2015: 254. This gives an inflation percentage of 15.45% (£21,283,457) and revised, and now fixed, construction cap of £159,040,567.*

*2.2. **SPV average annual operating costs:** The funding letter was based on estimated SPV costs of £387k. Only one Bidder's costs exceed this amount.*

*2.3. **SPV project development costs** The funding letter envisaged an indicative level of 3%, and all of the bids are outside of this estimate. The Board challenged these costs during dialogue and made clear its expectation that they could be reduced. A more detailed analysis of the breakdown and content of these costs will be required at ISFT stage to ensure comparability with the funding letter indicative sum.*

*2.4. **Lifecycle maintenance fund :** lifecycle costs are to be compared to the £27m2 indicated in the funding letter. All Bidders are below this number.*

*2.5. **Hard Fm costs :** these costs are to be compared to the £29m2 assumed in the OBC . The Board challenged the costs of the bidder whose cost exceeds this amount and there may be potential for this to be reduced at the final tender stage.*

*2.6. **Unitary charge:** both the total and SG's share of the first full year's unitary charge (which is to be adjusted per the note below) for all three bidders is below SFT's current affordability assumptions.*

***Note:** as stated in Question 28 (referring to Question 1 of the Pre ITPD KSR) the costs of the specialist paediatric biochemical laboratory **are excluded from SG's funding** and the costs of the petrol filling station works are capped.]*

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[1] It is expected that these costs will be based on internally generated estimates pre-OJEU and pre-ITPD and that cost expectations will be updated to reflect bids as they are submitted during the procurement process.

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In relation to the Provisional Preferred bidder's (PPB) figures:

(a) Construction costs: the construction costs are over £12m below the construction cap of £159,040,567, which was the inflated figure at ISFT of the base construction cap of £137.7m.

(b) SPV average annual operating costs: the funding letter was based on estimated SPV costs of £387k. The PPB's costs are £235k.

(c) SPV project development costs : the funding letter envisaged an indicative level of 3% and the PPB's figure is 3.66%.

(d) Lifecycle maintenance fund : lifecycle costs are to be compared to the £27/m2 indicated in the funding letter. The PPB's figure is £22.89/m2 which inflates at RPI plus 0.5%.

(e) Hard Fm costs : these costs are to be compared to the £29/m2 assumed in the OBC. The PPB's figure is £27.93/m2, which inflates at RPI plus 1%.

(f) Unitary charge: The Board advise that the first year's full annual unitary charge is £18.956m and has calculated NHS Lothian's share of the unitary charge as £2,150m, so that SG's share would on that basis be £16.806m. The Board has advised that no adjustment has yet been made as regards the bio lab nor taking account of the cap on the petrol filling station works but the Board will work with SFT/SG to make the required adjustment according to an agreed process in the post-PB period. The amounts advised by the Board for both the unitary charge and SG's share are within SFT's affordability limits. The Board's advisers have also confirmed that in relation to demonstrating that the indexation of the unitary charge follows the natural hedge, the inflation sensitivities were provided, with the required scenarios being provided by the bidders as a financial proforma, with satisfactory results that show that an appropriate proportion is indexed. The base case position for the preferred bidder is indexation of 20% of the unitary charge.

	Pre-OJEU	Pre-ITPD	Pre-IFT	Pre-PB[2]	Pre-FC
Construction cost (nominal cumulative)	£137.7m plus inflation to mid point construction of 1Q 2016 (from 3Q 2011) or earlier midpoint if applicable during procurement See footnote 3	£137.7m plus inflation to mid point construction of 4Q 2015 (from 3Q 2011) or earlier midpoint if applicable during procurement See footnote 4	£137.7m plus inflation to mid point construction of 4Q 2015 (from 3Q 2011) or earlier midpoint if applicable during procurement	£146.688m [Note: construction cap, including inflation was £159.041m]	
Design fees	See footnote 5	As Pre OJEU	Included in	Figure not	

[2] Provisional Preferred Bidder's numbers have been included

[3] Note : The inflation allowance to be applied to the uninflated amount will be calculated on the basis of the pricing base date of Q3 2011 and a construction midpoint (the revised midpoint) being 1Q 2016 or, if earlier, the construction midpoint which is being proposed through the procurement process. The inflation allowance on the basis of the BCIS index published in October 2012 was £11,271,620 so that the Construction Cost Cap at that date on that basis is £149,027,938.
The movements in the forecast index will be monitored periodically including through the KSR process as it proceeds. In addition there is significant capital requirement both for enabling works and equipment and support is to be provided as set out in the Funding Letter.

[4] Note : The inflation allowance to be applied to the uninflated amount will be calculated on the basis of the pricing base date of Q3 2011 and a construction midpoint (the revised midpoint) being 4Q 2015 or, if earlier, the construction midpoint which is being proposed through the procurement process. The inflation allowance on the basis of the BCIS index published in 18 Feb 2013 was £10,645,000 so that the Construction Cost Cap at that date on that basis is £148,402,000 on the basis of a mid point construction of 4Q 2015.
The movements in the forecast index will be monitored periodically including through the KSR process as it proceeds. In addition there is significant capital requirement both for enabling works and equipment and support is to be provided as set out in the Funding Letter.

[5] TC5B states that there is included an allowance based upon 8.5% of the estimated construction value and this is included in the construction cap figure. The assumption is that the design costs prior to financial closure are carried elsewhere.

(nominal cumulative)		assumption	construction cap	provided separately	
Bid development costs [6] (nominal cumulative)	See footnote 7	As Pre OJEU assumption	See commentary above	£5.365m	
SPV costs (in construction) (nominal cumulative)	See footnote 8	As Pre OJEU assumption	As Pre OJEU assumption	Figure not provided separately	
Hard FM costs (real per annum)	£29/m See footnote 29	As Pre OJEU assumption	See commentary above	£27.93/m2	
Lifecycle costs (real cumulative)	£27/m210	As Pre OJEU assumption	See commentary above	£22.89/m2	

[6] Including success fees

[7] The Board's advisers financial model assumes 5% of capex whereas SFT considers that 3% of capex is more appropriate, taking account of the level of design development pre procurement.

[8] The Board's advisers financial model does not have an entry for SPV costs during construction : development fees are 5%.

[9] The Board's advisers model also includes a risk allowance which significantly increases the overall sum for hard fm. The Atkins Report forming an annex to SFT's Project Review says that the figure of £29/m2 sits within the expected range of benchmarks.

[10] The Atkins Report says that "Based on a range of benchmark information the Life Cycle Cost per square metre per annum of £27/m2, at 3Q 2011 prices, sits within the acceptable range of benchmarks"

SPV costs (in operations) (real per annum)	£387,000 See footnote 11	As Pre OJEU assumption	See commentary above	£235k	
Operational Term (years)	25 years	As Pre OJEU assumption	As Pre OJEU assumption	25 years	
Percentage of unitary charge indexation	22%12	As Pre OJEU assumption	As Pre OJEU assumption	20%	
Swap rate13	4%14	As Pre OJEU assumption	Term sheet assumes LIBOR assumed to be 4.00% and all in rate for EIB as 5.50% p.a.	Term sheet assumes LIBOR assumed to be 4.00% and all in rate for EIB as 5.50% p.a.	
Unitary charge	See footnote	As Pre OJEU	See commentary	£18.956m	

[11] SFT's assumption is £350kpa

[12] Per EY's shadow bid model : SFT's estimate of indexed amount would be lower given lower estimates of lifecycle, hard fm and SPV costs.

[13] Including any buffer

[14] for swap rate plus buffer per EY's shadow bid model : 3.41% (SFT model), but margin 2.25% (EY model), 3% (SFT model) and MLA + swap spread 0.38% (EY model), 0.5% (SFT model) – hence all in senior rate 6.63% (EY model), 6.91% (SFT model). (Also sub debt rate – 13% EY, 11% SFT – hence pro forma WACC 7.27% EY, 7.32% SFT.)

(nominal year 1 of operations)	15	assumption	above	(ye 31 March 2018	
SG funding support (nominal year 1 of operations)	See footnote16	As Pre OJEU assumption	See commentary above	£16.806m, but see note (f) above	

	Question	Yes/No	Comments
5.	Please explain any changes that have been made to the cost and funding assumptions (both revenue and capital) since the last KSR and demonstrate that such changes have the required level of approval within the Procuring Authority and from the relevant Project Sponsor and/or		As Pre COD KSR: se comment above re catering strategy **Recommendation** : The Authority's attention is drawn to the fact that the Construction Cost Cap of £159,041m is no longer relevant for affordability purposes and is replaced by the Preferred Bidders construction proposal. SG anticipates no increase in the revenue

[15] As is made clear in the Funding Conditions (and see email correspondence between SFT and the Board culminating on 7 March 2012), there is discrepancy between the figures calculated by the Board and those by SFT : the relevant figures are : Unitary charge (nominal 1st full yr of ops - 12 months to 31/3/2018) - £22,381k (EY model), £20,970k (SFT model) – both excluding insurance costs. No unitary charge figures are to be provided to bidders.

[16] See footnote 14: the relevant figures SG Funding Support (nominal first full year of ops - 12 months to 31/3/2018) - £19,115k SFT. We cannot find the equivalent figure in the EY financial model but the OBC v3.0 at page 49 says £20,029k

	SG.		funded capital amount, subject to any changes agreed between SG and the Board. In relation to any changes in costs due to any change the catering strategy, which are anticipated by the Board to reduce the costs. The revenue funded amount will be calculated on the basis of the funding letter and SFT's guidance at or near financial close and will take account of the actual financing terms and interest rates which are fixed at financial close.
6.	Please demonstrate that the project remains affordable to the Procuring Authority in terms of enabling capital costs, unitary charge contributions and ongoing operational costs (e.g. utilities, soft FM services).		The Board has confirmed that the project remains affordable of the basis of the tenders which have been submitted. The Board has confirmed that the Costs of the external enabling works are being maintained within the current budget.
7.	Please confirm what sensitivities have been applied in assessing the affordability of the project and demonstrate that an appropriate allowance is in place to absorb reasonable cost movements.		The Board advises that the sensitivity of the financial position, including ASP, clinical cost, cost of enabling works etc will be addressed in detail in the FBC. No specific sensitivities have been carried out on figures within the ASP other than those relating to indexation, as key figures are all comfortably within the thresholds for affordability agreed at OBC stage.
8.	What are the key risks / outstanding issues that may have an impact on the affordability of the project and what		The senior debt funding for the project will be sought during the PB period. The Board will require the PB to run a funding competition. This will be conducted in accordance with the principles set out in the

	strategy is in place to manage these?		ISFT, which the Board has confirmed have been accepted by the Preferred bidder. The Board, its advisors and SFT will have transparency of process and a right for approval of the final funding selected. **Recommendation :** It is recommended that the Board and its advisors continue to liaise with SFT up to and beyond the PB appointment in order to agree funding strategy and plan that is acceptable to all parties.
9.	Please provide details (including amount, proportion of total funding requirement and proposed timing) of any capital contributions that the Procuring Authority intends to make any capital contributions to the SPV during the project and confirm that the size and timing of these has been agreed with the proposed preferred bidder. Please demonstrate that the amount of the capital contribution includes allowance for associated financing fees etc. Please demonstrate that the documentation of this arrangement has been agreed and complies with relevant guidance.		The Board anticipates that there will be no capital contributions
10.	Has the proposed preferred bidder assumed composite trader tax treatment and has the full benefit of this been passed on to the Procuring Authority?	Yes	The Board's financial advisers have also confirmed that the treatment of the taxation of surpluses on the tenders is appropriate consistent with previous discussions with SFT.
11.	Please provide details of how delays to financial close and indexation of input costs are to be treated.		The price will hold for 3 months after the target FC date. After this period BCIS All-in TPI will apply to capital costs and RPI to lifecycle, SPV and FM costs. The proposed PB has accepted this position.

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12.	Please demonstrate how any recommendations / actions / requirements in relation to the affordability of the project, detailed in the outline business case approval and previous KSRs, have been addressed.		See Question 31 regarding the recommendations which were made in the Pre COD KSR.

Section 4: Value for Money

The objective of this section is to ensure that the key drivers of value for money are addressed in the Procuring Authority's approach to development and delivery of the project. Please refer to relevant Value for Money guidance[17].

	Question	Yes/No	Comments
13.	Please demonstrate how the Procuring Authority intends to drive value for money through "Effective Delivery". *[Response required only to the extent that the position has changed since last KSR]*		As Pre COD KSR
14.	Please describe how any changes to scope and procurement options since the last KSR have been assessed and the impact that these have on the delivery of value for money.		On changes to scope see above re the catering strategy: there have been no changes in the procurement options.
15.	Please describe the steps that the Procuring Authority and advisers have taken to assess and benchmark the sufficiency / efficiency/competitiveness of bidders' proposals in relation to the following: - capital cost inputs - SPV average annual operating costs - SPV project development costs		The following comments from Question 33 of the Pre COD KSR are relevant: "(1) The capital costs were evaluated having regard to the Reference Design cost plan which was benchmarked and current benchmarking. The deliverability of capital costs were assessed by the Board's technical advisers. 2) Bidders have been providing key metrics to the Board in relation to key financial aspects of their bids. These have been benchmarked against other projects and market expectations and challenged where inconsistent. The Board's view is that all bidders are currently largely

[17] Value for Money Assessment Guidance: Capital Programmes and Projects (updated October 2011) and SFT's Supplementary Guidance for projects in £2.5bn Revenue Funded Investment Programme (October 2011)

	- lifecycle maintenance fund and profile - tax efficiency - financing terms - subordinated debt return		in line with expectation with regard to SPV costs, sub-debt return and development costs." See also the commentary at the affordability section above relating to performance against benchmarks.

Section 5: Commercial

The key objective of this section is to test that a robust commercial position has been established with the preferred bidder and that a strategy is in place to deal with any outstanding issues in the period up to financial close.

	Question	Yes/No	Comments
16.	Please confirm that a list of derogations from the standard NPD contract documentation (including service specification, payment mechanism, NPD articles of association and accompanying guidance) has been agreed with the preferred bidder and approved by SFT.	Yes	As discussed with SFT at the Pre COD KSR there are some drafting points to be resolved at PB stage.
17.	Are there any outstanding contractual points?	No	
18.	Please explain how the proposed preferred bidder has demonstrated that it has the support of sub-contractors for the technical proposals and commercial positions in their final tender. Have heads of terms been agreed between the proposed preferred bidder and its sub-contractors?		The Board has confirmed that the proposed preferred bidder has submitted agreed signed heads of term from with their construction contractors, service provider and key Subcontractors. The Board has confirmed that on its advisers advice the levels of caps and indemnities are in accordance with market norms.
19.	Has the preferred bidder secured committed senior debt finance for the project? If not, what strategy is in place for securing senior debt financing proposals and has this been agreed with SFT?		An institutional term sheet approach was taken at SFT. The Preferred bidder has therefore not secured committed senior debt and there is to be a post PB funding competition on the basis of the principles proposed by SFT. All Bidders have accepted the SFT principles for a funding competition and have submitted detailed timetables for completion, incorporating

			a funding competition. Refer to recommendation 4 at Q8.
20.	Has the proposed preferred bidder, sub-contractors and funders confirmed their willingness to sign up to a commitment letter that establishes the terms of their appointment?		The funder position remains as described above insofar as bidders have performed their own diligence on a shadow basis to support funder commitment and have support letters to reflect this but that committed funds will not be secured until post PB. With regards to sub-contractors, please see Q18 above.
21.	What, if any, key commercial issues remain outstanding with the proposed preferred bidder and how are the implications for the project programme and affordability position to be managed?		The Board has advised that there are no key commercial issues outstanding, subject to the securing of senior debt following the funding competition, which has been factored into the programme, and any variation for the catering position.
22.	Specifically, has agreement been reached with the preferred bidder in relation to the following matters: - vandalism risk - warning notice and termination triggers - payment mechanism (including levels of deductions, unavailability thresholds etc) - TUPE and pensions - level of cash buffer applied before surplus payments		Yes in each case, as set out in the Pre COD KSR subject to final Funder Direct Agreement terms being subject to discussion and agreement with the selected funder. The cash buffer of the preferred bidder is modelled at £100k which the Board advises is well within the stipulated limits set out in the ISFT and in SFT guidance.

	- funders direct agreement		
23.	Is the Procuring Authority satisfied that the incentives delivered by the service specification and payment mechanism reflect its priorities and desired outputs? Please describe what scenario testing has been applied in calibrating the payment mechanism.	Yes	No change since pre COD KSR
24.	Please confirm the status of the Procuring Authority's title investigations, and whether a list of disclosed title conditions, and the impact of these conditions, has been agreed with the proposed preferred bidder.		As Pre COD KSR
25.	Please demonstrate that a programme has been agreed with the proposed preferred bidder for the various due diligence processes required to reach financial close and that these are realistic and synchronised with the overall procurement timetable.		A programme capturing the processes required from PB to FC formed part of the Final Tender submission. The Board has provided a consolidated programme which sets out the main activities. programme is however currently light on detail for due diligence processes. This will need to be further developed with the Preferred Bidder, and in consideration of the strategy to secure senior debt funding, to ensure this activity is synchronised with the overall procurement timetable. **Recommendation :** It is recommended that provision of a detailed programme and work plan for the project, to include the capture of diligence and agreed funding procurement route is prioritised for agreement at the first meeting with the PB.
26.	Please confirm the period for which the preferred bidder's final tender is open for acceptance.		The prices are held for 3 months after anticipated FC then indexation applies. The Board has advised that there is no specific end date in the tenders.
27.	It is a condition of SG revenue funding support that the project meets the requirements for classification as a	Yes	There has been no change from the pre COD KSR. No further changes to standard form have been proposed. Accordingly the risk allocation

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	non-government asset for national accounts purposes under relevant Eurostat (ESA95) guidance. Please confirm that the contract terms agreed with the proposed preferred bidder transfer availability and construction risk to the private sector.		follows standard form and transfers construction and availability risk.
28.	Please describe any changes that have been made to the risk register and risk management plan since the last KSR, and the impact that any such changes have on the project.		No changes have been made to the Risk Management plan and the risk register has been updated. The three key changes are : Risk 10 – Vacant Possession of Site now AMBER (previously RED) – as discussed this is due to confirmation from Consort on availability of access and status of link building. Risk 29 – Insufficient Space in RIE (Clinical Enabling) now AMBER (previously RED) – displaced staff no longer dependent on labs strategy progress. Risk 6 – Procurement Progress Challenge increased to AMBER (previously GREEN) – reasons given in KSR section 29.
29.	Please describe the risks that the Procuring Authority considers to be most significant to the preferred bidder stage and the strategy for managing these risks.		The key risks in the Updated risk register are as listed in Annex B.
30.	Please describe any changes since the last KSR to the mechanism in place for reviewing and updating the risk		No changes have been made.

	register and risk management plan.		

Section 6: Readiness

The key objective of this section is to determine whether the necessary steps have been taken to enable the project to move forward and to ensure that appropriate project management arrangements, processes, protocols and documentation are in place to support progress to financial close.

	Question	Yes/No	Comments
31.	Please demonstrate how the recommendations / actions / requirements, detailed in the last KSR report, have been addressed (to the extent that these are not dealt with under separate sections of this KSR questionnaire).		The recommendations from the Pre COD KSR are noted with an update and ongoing recommendations in Annex A.
32.	Do any further internal/external processes need to take place before appointment of the preferred bidder?	Yes	The appointment will be considered by the Project Steering Group on 28 February and then by the Board's Finance and Performance Committee on 5 March.
33.	Please explain any changes that have been made to the governance and project management arrangements, resourcing and budgets since the last KSR.		No changes have been made.
34.	Please confirm any changes that have been made to the Procuring Authority's procurement strategy (including timetable) since the last KSR and demonstrate that this remains/is realistic and deliverable.		There have been no changes in the strategy since the Pre COD KSR: there will be a post PB funding competition in line with the process agreed with and involving SFT.
35.	Please demonstrate that a robust and comprehensive project plan is in place and that the project team has a clear understanding of all tasks / work streams (including evaluation, clarifications, and approvals) to manage the project through to financial close.		The Board had provided a composite programme for the NPD project as well as the equivalent programme for the external enabling and clinical enabling works. The Board advises that the underlying programme which were submitted by bidders were elaborate and demonstrated that

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			considerable thought had already gone into the process. As noted at Question 25 above, a more detailed programme and work plan is to be developed, including the detail of the funding competition and finalisation of the funding documentation. Reference is made to the recommendation at Question 25.
36.	Please demonstrate how the project team intends to manage the interface between the preferred bidder and stakeholders (e.g. end users) going forward.		There are meetings which have already been diaried to enable the detailed consultation on the 1:50 drawing with clinicians during the PB stage. User involvement following the appointment of the preferred bidder will be crucial and the NHSL Project Team are committed to delivering this. The NHSL Project Team will manage the stakeholder interface with the Preferred Bidder to ensure this is done in a timely manner and that consultation and engagement is meaningful and effective. This will be taken forward in a number of ways: • Following the announcement of PB there will be 11 Open Sessions for staff and key stakeholders (charities, volunteers and patient PFPI groups) across hospital sites to launch the PB's design and update on the next stage of the project • Service leads have been identified for each department to take forward the detailed design development with the PB Design Team and NHSL Project Team and one of their key responsibilities is to ensure views of staff and patients and relatives are taken account of in the planning of departments. In addition to this a number of charitable organisations will be involved e.g. Sick Kids Friends Foundation, Edinburgh & Lothian's Health Foundation, Ronald MacDonald, and Teenage Cancer Trust

			• The RHSC Family Council, Young People's Advisory Board and DCN Patient Reference Group will continue to be consulted with in relation to the ongoing development of the design of the hospital and also service redesign • Project Stakeholder Board will continue to meet quarterly Recommendation **The Board is asked to monitor engagement with the stakeholders during the PB period recognising the programme and tendered design and price agreed in the final tender process and the risks associated with these elements changing.**
37.	Please demonstrate that the project timetable allows sufficient time for all outstanding staffing issues (if any) to be resolved, including (if applicable) achieving LGPS admitted body status / GAD scheme certification.		It is not anticipated that there will be any TUPE transfers.
38.	Please provide an update on the land/site strategy (e.g. acquisition, title issues, ground conditions, surveys, enabling works) and planning matters and describe what strategy is in place to manage the impact of any outstanding matters on the project timetable and/or affordability position.		Title issues remain as per the Pre COD KSR. On planning: (a) For the on site works for the hospital the preferred bidder will develop detailed proposals to be submitted to the August planning committee; and (b) For the offsite works the application is to be submitted to target the committee in September and this consent is required as part of the S75 requirements. Reference is made to the ongoing recommendation from the Pre COD

			KSR. Site investigations for the petrol filling station site have now been instructed. The external enabling works are ongoing and the Board is now confidant that: (a) although the road works will be not yet be completed by programmed date of financial close, these works will not interfere with the preferred bidders' ability to obtain possession of the site; (b) the link building will be completed to shell and while Consort will still require access, the preferred bidder has confirmed that it will not need access to the affected are until spring 2015. The Board has advised that the development of the clinical enabling works is going well with discussions with Consort ongoing ad Supplementary agreements being drafted.
39.	Please describe what steps the Procuring Authority has taken to verify that the financial and economic standing of the preferred bidder remains unchanged from the pre-qualification stage.		The Board has confirmed that the PQQ tests were rerun at the final tender stage and all were satisfactory.

Is the project ready to proceed to the next stage? (*Delete as applicable)	~~Yes.*~~ Yes , subject to recommendations below* ~~No, due to reasons outlined below.*~~
Reasons / Recommended actions:	To be completed by:
Question 1 : Recommendation : (1) that the Board advises SFT of the outcome of the consideration of this proposal and of the progress for the change in scope, including the steps to be taken by the board to ensure value for money in relation to the change in costs; and (2) that the Board develops the detail of the implementation of its strategy, including interface management, so that catering arrangements will be in place in advance of the operational date, noting that an interim strategy will also require to be developed should the Board's long terms catering strategy not be fully implemented at the proposed facility opening date.	
Question 3 : Recommendation : a.The Authority is asked to share the developed version of the draft PB letter to allow SFT the opportunity to comment and to take due account of	

those comments. b. It is understood that the Board's communication strategy is such that the Preferred Bidder will be announced publicly prior to receiving the signed PB letter from the proposed PB. The Board is asked to confirm to SFT that it has considered whether there are any significant issues which would merit obtaining signature to the PB letter prior to a public announcement and that the Board's final communications strategy for the PB announcement has been informed by this process.	
Question 5: Recommendation : The Authority's attention is drawn to the fact that the Construction Cost Cap of £159,041m is no longer relevant for affordability purposes and is replaced by the Preferred Bidders construction proposal. SG anticipates no increase in the revenue funded capital amount, subject to any changes agreed between SG and the Board in relation to any changes in costs due to any change the catering strategy, which are anticipated by the Board to reduce the costs. The revenue funded amount will be calculated on the basis of the funding letter and SFT's guidance at or near financial close and will take account of the actual financing terms and interest rates which are fixed at financial close.	
Question 8: Recommendation : It is recommended that the Board and its advisors continue to liaise with SFT up to and beyond the PB appointment in order to agree funding strategy and plan that is acceptable to all parties.	
Question 25: Recommendation : It is recommended that provision of a detailed programme and work plan for the project, to include the capture of diligence and agreed funding procurement route is prioritised for	

being extended for that reason. 6. Recommendation : that (1) the Board progresses these planning procedures to obtain planning consent for the offsite works prior to financial close and (2) works with the preferred bidder to ensure that resolution of reserved matters and planning permission of main facility and the works the petrol filling station site are achieved within the timescales required by the overall programme for financial close. 7. Recommendation : that the Board place a focus on the issues which require to be resolved to ensure that the clinical enabling works are developed and completed within the timescale required to enable the new facility to operate properly on completion and to bring forward regular reports on proposals and progress to the Project Steering Board.	
Signature of Primary Reviewer	Signature of Secondary Reviewer
Date: 4 March 2014	Date: 4th March 2014

Procuring Authority Declaration	I confirm that: a) I am not aware of any information that would materially change the assessment and review of the project; and b) the project's details as logged in the Scottish Government's Infrastructure Projects Database (SGIPD) are up-to-date and complete and reflect the current state of the project (including the information on the project's time table and assurance activity).
Name and Position:	Date and Signature:

agreement at the first meeting with the PB.	
Question 36 Recommendation: The Board is asked to monitor engagement with the stakeholders during the PB period recognising the programme and tendered design and price agreed in the final tender process and the risks associated with these elements changing.	
Ongoing recommendations from the Pre COD KSR : see Annex A 1. Recommendation: That the Board keeps SFT advised as to progress in relation to the development of the proposals for the scope and costs in relation to the works on the petrol filling station site during the period until financial close. 2. Recommendation: that the Board operates and monitors the open book mechanism in relation to the cost of the petrol filling station works to maximise value for money. 3. Recommendation : that the Board continue discussions as to potential charitable donations and consider how any such donations will be factored in the project, consistent with the funding letter and the timescale for achieving financial close. 4. Recommendation: That these and any other key risks are closely monitored with mitigations put in place in a timely manner following discussions by the Project Steering Board 5. Recommendation: that the Board continues to monitor closely the Consort works and takes appropriate mitigation measures to ensure that vacant possession can be provided to the NPD contractor at financial close without the timescale for that close	

Annex A : Responses to recommendations from Pre COD KSR

Recommendation	Update and, where applicable, ongoing recommendations
Question 1: **Recommendation** : That the Board keeps SFT advised as to (i) progress in relation to the development of the proposals for the scope and costs in relation to the works on the petrol filling station site during the period until financial close; (ii) the Project Steering Board's decision following consideration of a further paper on the Board's catering	**Update:** **(i) Process ongoing: Site investigation now underway;** **(ii) Paper to be considered by the Project Steering Board on 28 February : see comments above.** **Recommendation:** That the Board keeps SFT advised as to progress in relation to the development of the proposals for the scope and costs in relation to the works on the petrol filling station site during the period until financial close. On the catering strategy, reference is made to the recommendation at Question 1 above.
Question 1: **Recommendation:** that the Board operates and monitors the open book mechanism in relation to the cost of the petrol filling station works to maximise value for money.	**Ongoing recommendation**
Question 2: **Recommendation** : That, prior to close of dialogue, the Board receives and copies to SFT, letters, in the form of the drafts which the Board have earlier provided to SFT, from each of its financial, legal and technical advisers	**Completed**

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confirming that each consider that it is appropriate for the Board to close dialogue.	
Question 24: **Recommendation** : that the Board continue discussions as to potential charitable donations and consider how any such donations will be factored in the project, consistent with the funding letter and the timescale for achieving financial close.	**Ongoing recommendation**
Question 28 (1 from Pre ITPD KSR): **Recommendation :** that the Board monitors and reports to SFT the cost of this change in scope (including inflation, financing, lifecycle and other consequent costs) separately so that the level of revenue support (excluding this change) can be calculated.	To be dealt with post PB stage
Question 28 (19 from Pre ITPD KSR): **Recommendation:** That these and any other key risks are closely monitored with mitigations put in place in a timely manner following discussions by the Project Steering	**Ongoing recommendation**

Board	
Question 28 (19 from Pre ITPD KSR): **Recommendation:** that the Board continues to monitor closely the Consort works and takes appropriate mitigation measures to ensure that vacant possession can be provided to the NPD contractor at financial close without the timescale for that close being extended for that reason.	**Ongoing recommendation**
Question 28 (19 from Pre ITPD KSR): **Recommendation :** that (1) the Board progresses these planning procedures to obtain planning consent for the offsite works prior to financial close and (2) works with the preferred bidder to ensure that resolution of reserved matters and planning permission of main facility and the works the petrol filling station site are achieved within the timescales required by the overall programme for financial close.	**Ongoing recommendation**
Question 34:	

Recommendation : that prior to closing dialogue, (1). the Board is satisfied that all of the NPD documentation, with bidder specific derogations, as agreed with SFT, covers all commercial issues and is complete and reflects the agreement reached with each of the bidders during the dialogue process; and (2) the relevant bidder (in respect of which this point remains outstanding) confirms that it accepts that all of petrol filling works, including landscaping, will be completed at or prior to the same time as the works on the main hospital.	**Completed**
Question 49: **Recommendation** : that the Board place a focus on the issues which require to be resolved to ensure that the clinical enabling works are developed and completed within the timescale required to enable the new facility to operate properly on completion and to bring forward regular reports on proposals and progress to the Project Steering Board.	 **Ongoing recommendation**
Question 56: **Recommendation :** That, prior to close of dialogue, the Board the ISFT updates the ISFT to reflect the petrol filling	**Completed**

station works clarification, including the process for carrying out surveys and fixing the provisional sum prior to financial close.	

Annex B: Key Risks

Number	Risk:	Impact	Mitigation :	**Adequacy of Controls**	**Status**
8	Programme delay in reaching Financial Close	Programme delayed due to protracted or inconclusive closure of dialogue and/or negotiations to reach financial agreement	Use of Standard Form PA, determination to create a 'level playing field' and fully developed suite of ITPD documents all in place prior to commencing competitive dialogue. Programme	**Not satisfactory at present.** The Project Team continue to be sceptical regarding delivery of FC in less than six months from appointment of Preferred Bidder. Third party involvement	Red

			updated July 2013 to address design compliance before close of dialogue. However, this remains the highest risk to project procurement.	in the town planning process or the funding competition are of particular concern. The Project Team note that Glasgow College took 3 months more than anticipated 4 month programme to close, however that construction commenced before FC at the contractor's risk. Review monthly.	
6	Procurement process	Programme is delayed by	Comprehensive procurement	Given anticipated very close	Amber

	challenge	challenge from an unsuccessful bidder or third party. High cost in programme and fees.	documentation to inform the market and ensure level playing field. Feedback through competitive dialogue on bidders' proposals. Transparent evaluation process with robust audit trail. Evaluation completed and standstill letters and feedback to unsuccessful bidders being	final scores following evaluation process the likelihood of a challenge has increased. Satisfactory at present.	
14	RIE interface failures	Planned interface construction (e.g. ED link, PTS) does not deliver operational	NHSL working with Consort to minimise risk until Project Co appointed. Discussions	-	Amber

		functionality.	in competitive dialogue to keep bidders informed of works; control plans to be finalised with preferred bidder by financial close.		
15	RIE interface failures	Construction of areas outside the red line to be handed to Consort are not completed to specification and access to Facility through RIE links is not possible e.g. Hospital Square, ED, theatres links.	Arrangements in place for Preferred Bidder to join LFCWG and interface with all parties on their delivery of these works.	Adequate at present, to be progressed with Project Co on appointment as Preferred Bidder	Amber
29	Insufficient space in	Accommodation	Engagement with	Satisfactory at present.	Amber

	RIE to support RHSC/DCN clinical models	required in RIE to support service models (e.g. adult critical care) is not feasible. This includes accommodation for the downstream works for transplant and renal critical care and the displaced laboratory / eHealth staff.	Consort and their design team to establish the Renal, Transplant HDU and Critical Care is ongoing. In parallel, commercial / supplemental agreement negotiations has commenced to meet RHSC / DCN programme and mitigate risks. Relocation plans for staff displaced from the above changes are underway, with detailed negotiations ongoing	Residual risk remains until all contracts agreed and staff relocated, but all parties now actively pursuing relocations and works to meet the programme, subject to their respective governance processes. Separately, the Laboratories Strategy is being supported for the longer term delivery of their pan NHS Lothian service requirements but this	

			with Scottish Enterprise for space in EBQ Building Nine for office type uses. Parallel engagement with staff and services also underway to ensure clearance of the space in line with RHSC / DCN programme.	is not on the RHSC / DCN critical path.	
10	Vacant possession of site	Programme is delayed as Board unable to provide project site for NPD at Financial Close programme date of October 2014.	SA6 and SA Enabling secured rights to site. Provisional strategic programme has been provided to the Project Steering Board and SFT, with further	Satisfactory at present. Consort have confirmed that access to site at October 2014 will not be restricted or prevented by enabling works	Amber

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			details requested of Consort. Programme to deliver works will be influenced by requirement for vacant	operators, and that only reduced access and hoarded off areas will be required post Oct 2014 by	
59	Availability of funding	Availability of funding, and cost of financing, could both be higher than anticipated with funders concerned over the prospect of Scottish independence and the financial covenant or credit rating of a newly independent Scotland. SFT bear the risk of	Dialogue with bidders suggests that funders are not deterred.	Satisfactory at this stage. Funders may add a premium to their pricing to address their risk. To be reviewed as part of the post -preferred bidder funding competition.	Amber

		any increased premium; NHSL bear the risk of delays to achieving financial close, in terms of indexation if over three months later than programme, and completion and handover of the project.			
9	Specification changes post Financial Close	Programme is delayed due to Board changing service and accommodation requirements.	Governance structures in place to manage approval of change. Governance structures in place to manage approval of change. Project / Clinical	Adequate at present but may change in future dependant upon changes in strategy. Most likely changes are around need to manage increased	Amber

			Management Team would require to make case to Project Steering Board. Activity driven bed model is revisited annually and currently being updated to explicitly consider the implications of the above although it should be noted that this would go against NHS Scotland strategy of local access. Provision of shelled bed space in the design and	activity due to failure of sustainability of local DGH children's services. Some of the potential shelled bed space has been allocated to Specialist Paediatric Biochemistry Laboratory. Review monthly.	

			construction specification as well as flexibility from the location of day beds alongside the inpatient facility. Bed modelling for children's' services has been undertaken, demonstrating sufficient capacity in design with further options for change of purpose at a later date if required. DCN modelling has commenced.		

c

Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE)

HAI SCRIBE

Project: RHSC & DCN Re-Provision Project, Little France
Location:
Date:19th November 2014

Construction Start: **TBC**
Construction End: **TBC**

Project Summary:

A project to re-provide the services from the Royal Hospital for Sick Children, Child and Adolescent Mental Health Service and the Department of Clinical Neurosciences in a single building adjoining the Royal Infirmary of Edinburgh at Little France

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Risk Assessment in accordance with “HAI-SCRIBE June 2007: Development Stage 3, Construction / Redevelopment Phase in accordance with: Scottish Health Facilities Note 30: Version 3”

Section 1

Scope of Works:	
Location of work activity	**RIE Campus – Car Park B**
Commencement date and duration	**TBC**
Description of work activity	**Construction of new facility**
Who will carry out the work	**IHSL**
Estates Department representative name and contact details.	

HAI SCRIBE Assessment			
Construction/ Refurbishment activity type	**Type 4– Major demolition and construction projects**		
	Comment Small amount of demolition required		
Patient Risk Group	**Group 4 – highest risk**		
	Comment		
Risk Classification	**Class I**	Tick	
	Class II		
	Class III		
	Class IV	√	

Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE)

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Section 2 – consultation.			
The undernoted staff have been consulted in the preparation of this Risk Assessment			
Department	**Print**	**Sign**	**Date**
Infection Control	Janette Richards		19:11:2014
Design Manager/IHSL	Liane Edwards-Scott		19:11:2014
Lead Architect/IHSL	Lorraine Robertson		19:11:2014
Technical Advisor	David Stillie		19:11:2014
Technical Advisor	Colin Macrae		19:11:2014
Clinical Director	Janice MacKenzie		19:11:2014
Project Manager	Fiona Halcrow		19:11:2014
Contracts Manager	Stuart Davidson		19:11:2014

Section 3 – contractor acceptance.			
I have read and understood the control measures detailed within this risk assessment and accept responsibility for the implementation and maintenance of those measures. The work activity **must not** commence until the work area has been inspected and approval to proceed has been granted by the responsible Estates Department representative.			
Organisation	Print name	Sign	Date

Section 4 – initial inspection of control measures.			
I have inspected the work area and am satisfied that the necessary control measures are in place.			
Department	Print	Sign	Date
Estates			
Infection Control			

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Proposed Plan

Section 2: Assessment of the Risk of Infection from the Design and Layout of the Facility

	Comments					
	Yes	**X**	**No**		**N/A**	

	Question	Yes		No		N/A	
	healthcare facility inhibit the spread of infection?	With reference to national Guidance SHTMs, HBNs etc Infection Control Drawings have been produced and reviewed throughout the process up until FC.					
2.2	Is the ventilation system design fit for purpose, given the potential for infection spread via ventilation systems?	Yes		No	x	N/A	
		Some concern has been raised in relation to a potential issue with ventilation with regard to negative/balance pressure in single bed rooms. Awaiting drawings and further information to fully understand if there is a risk/issue.					
2.3	Has account been taken of the use of natural ventilation being affected by neighbourhood sources of environmental pollution as discussed in Development Stage 1?	Yes	X	No		N/A	
2.4	Is the interior of the healthcare facility easy to clean and maintain clean? (Surfaces of floors, walls and ceilings should be appropriate to the particular room and the required management of infection risk. Thus, carpeted floors in offices may be appropriate but not appropriate in clinical areas. There should be coving at right angle junctions of walls, floors and ceilings to ease effective cleaning.)	Yes	X	No		N/A	
		Throughout the process interior design has been discussed and meets HAI Scribe 30. No clinical area will have carpets in this building.					
2.5	Does each ward allow sufficient space between beds to comply with the current guidance, thus facilitating the healthcare services to the patient, which in turn may reduce HAI risk?	Yes	X	No		N/A	
		The distance between bed spaces in the multiple bed areas has been assessed throughout the process and meets guidance. Single room accommodation derogation was sought for both RHSC and DCN and approved by the SGHD.					
2.6	Are there facilities to enable high standards of hand hygiene to be maintained? For example, standards specified in: • 'Improving Clinical Care in Scotland Healthcare Associated Infection (HAI); Infection Control' (QIS 2003); • 'Standards Healthcare Associated Infection (HAI) Infection Control' (CSBS 2001).	Yes	X	No		N/A	
		Reviewed thoroughout detailed UGM's (April-July 2014).					
2.7	Where curtain rails and curtains are fitted are they easy to clean and maintain clean?	Yes	X	No		N/A	
		To be further developed through procurement phase.					

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		Yes	X	No		N/A	
2.8	Is the toilet, bath and shower accommodation conveniently sited in relation to the ward and, where possible, is this accommodation en- suite?	Yes	X	No		N/A	
		This has been achieved and all relevant drawings have been signed off as operationally acceptable during the UGMs (Apr-July 2014).					
2.9	Is the toilet, bath and shower accommodation accessible for cleaning purposes and is the accommodation easily cleaned?	Yes	X	No		N/A	
		Will be compliant with SHTM 64.					
2.10	Does the ventilation of the toilet, bath and shower accommodation ensure extraction of air from the room to the outside air?	Yes	X	No		N/A	
		Exceeds guidance (3 to 10 air changes).					
2.11	Are the staff changing facilities suitably sited, have sufficient space, and readily accessible?	Yes	X	No		N/A	
		Various staff changing accommodation within building that meets relevant guidance. Signed off during UGM's (April - July 2014)					
2.12	Are the staff showering facilities suitably sited and readily accessible for use, particularly in the event of contamination incidents?	Yes	X	No		N/A	
		Showering facilities for staff to access in incidents requiring decontamination are sited in relevant departments (e.g. ED/Child Life and Health/Radiology Department /Helipad).					
2.13	Is there satisfactory provision of isolation facilities for infectious and potentially infectious patients?	Yes	X	No		N/A	
		Each ward area has the required number of isolation facilities.					
2.14	Is there separation of dirty areas from clean areas to minimise the risk of HAI contamination?	Yes	X	No		N/A	
		FM drawings illustrate the separation of dirty and clean areas. Drawings accepted at UGM's and FM Group.					
2.15	Is there sufficient storage accommodation provided in each area of the healthcare facility for equipment which is mobile and not in continuous use?	Yes	X	No		N/A	
		Sufficient storage accommodation has been provided in all departments to meet users needs (Mobile Hoists/wheelchairs etc).					
2.16	Are there satisfactory facilities for storage of	Yes	X	No		N/A	

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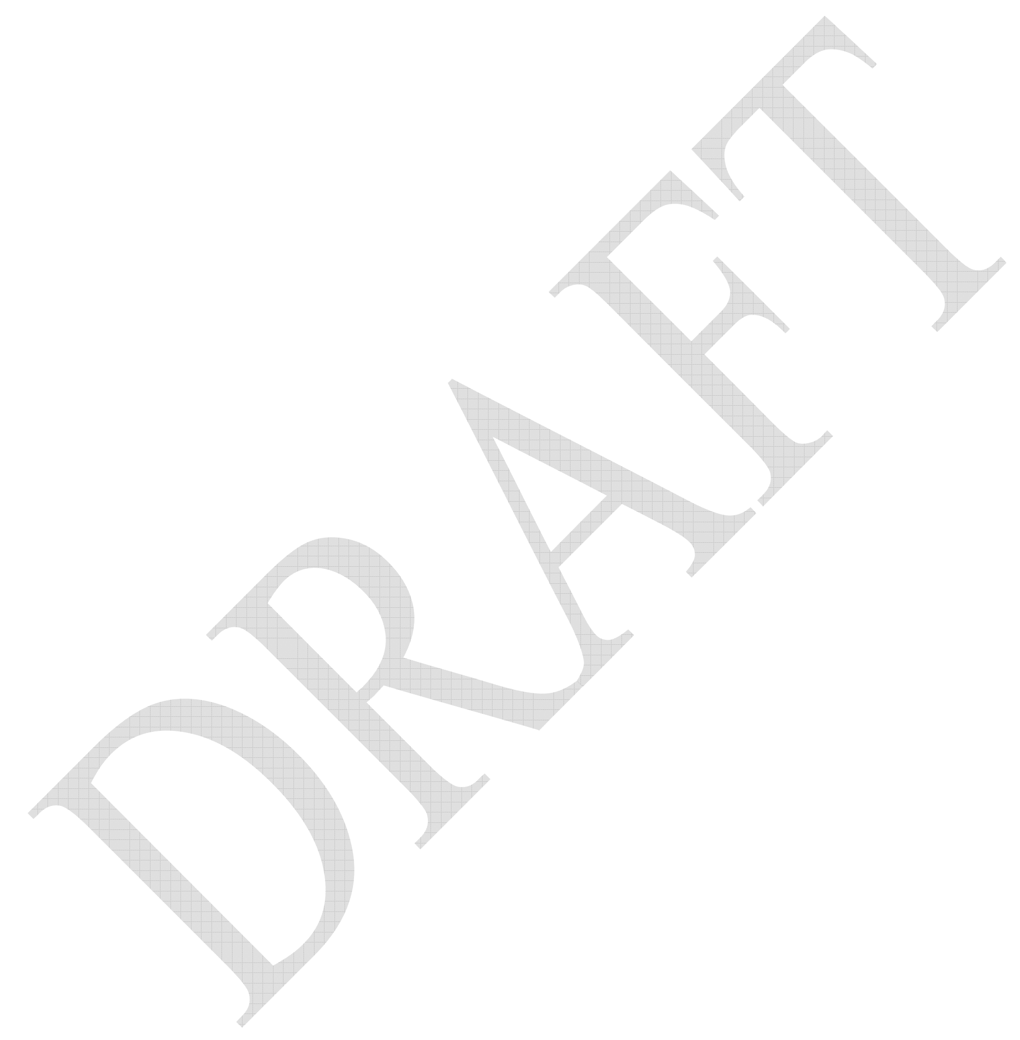
cleaning equipment e.g. Domestic Services room?	DSR facilities provided in department areas that allow for the safe storage of materials.



Question	Yes		No		N/A	
2.17 Is the service ducting for utilities etc. concealed to ease routine cleaning of surfaces?	Yes	X	No		N/A	
	Integrated Plumbing System used to ease access for cleaning and identified on drawings. Bed Head trunking will conceal services.					
2.18 Does the service ducting for utilities provide sufficient access for maintenance and pest control?	Yes	X	No		N/A	
	Drawings show removable panels for access for maintenance and management of pest control. Further detail to be developed.					
2.19 Are there sufficient and conveniently sited facilities provided for the cleaning of common equipment like trolleys, wheelchairs etc?	Yes	X	No		N/A	
	Designated areas in specific departments to aid this process.					
2.20 Are the food preparation areas (including ward kitchens) and distribution systems fit for purpose and complying with current food safety and hygiene standards?	Yes	X	No		N/A	
	Specialist catering advisors involved in process to ensure areas fit for purpose on completion.					
2.21 Are waste management facilities and systems robust and fit for purpose? (This includes local and central storage, systems for movement of waste to central storage, systems for handling and compaction of waste, systems for separation and security of waste, especially healthcare clinical waste.)	Yes	X	No		N/A	
	Segregated waste areas provided and further detail to follow as part of the RDD process.					
2.22 Is the water distribution system designed to discourage bacterial growth and to ensure delivery of hot and cold water to users at the appropriate temperatures?	Yes	X	No		N/A	
	Further detail to follow as part of the RDD process.					
2.23 Is the drainage system design, especially within the healthcare facility building, fit for purpose with access points for maintenance carefully sited to minimise HAI risk?	Yes	X	No		N/A	
	Further detail to be provided through RDD process.					

2.24 Are there satisfactory arrangements for effective management of laundry? (This includes local and central storage, systems for movement of laundry to central storage, systems for handling laundry, systems for separation and security of laundry, especially contaminated laundry.)	**Yes**	X	**No**		**N/A**	
	Areas identified to manage all laundry types.					
2.25 Are there sufficient and suitably sited facilities for bed pan washing/disposal?	**Yes**	X	**No**		**N/A**	
	Each clinical area has a dirty utility room with access to facilities for bed pan washing/disposal where relevant.					

The answers to the above questions should be 'yes'. Where a potential hazard is identified a careful assessment of that hazard must be undertaken.

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PCP 4.32 Derogation Register

IHS LOTHIAN INTEGRATED HEALTH SOLUTIONS

"2.7 Project Co shall comply with Section 3 (Boards Construction Requirements) of Schedule Part 6 (Construction Matters), subject to the agreed derogations as set out in sub-section 32 (derogations) of Section 4 (Project Co's Proposals) of Schedule Part 6 (Construction Matters)."

	Date	Revision	Issued by
IHSL-XX-XX-SH-001	16/01/2015	*Revision K* *Wording included in relation to the PA, see above sub heading.*	LE / IHSL

No.	Reference	Date Issued	Project Co. Signed	NHSL Signed	Revision/Brief Description/ Notes
001	IHSL-ACO-001	15/09/2014	13/11/2014	14/11/2014	03 Drop Seals -REWORDED AS AGREED BY NHSL
002	IHSL-ACO-002	15/09/2014	13/11/2014	14/11/2014	01 Screens in AC rated walls
003	IHSL-FIRE-001	05/09/2014	13/11/2014	14/11/2014	01 Lifts
004	IHSL-FIRE-002	05/09/2014	13/11/2014	10/11/2014	04 Department Adjacencies (Links to C30 - 051 Summary Item)
006	IHSL-FIRE-004	05/09/2014	13/11/2014	10/11/2014	04 Dampers to Ductwork REWORDED
007	IHSL-FIRE-005	05/09/2014	13/11/2014	14/11/2014	01 Adjacencies LINKS TO C30 (Summary 050)
008	IHSL-FIRE-006	05/09/2014	13/11/2014	14/11/2014	05 Atrium REDRAFTED 13/11/14
010	IHSL-FIRE-008	05/09/2014	13/11/2014	14/11/2014	02 Fire Alarm & Detection
011	IHSL-FIRE-009	05/09/2014	13/11/2014	14/11/2014	02 Fire Stopping
012	IHSL-FIRE-010	05/09/2014	13/11/2014	14/11/2014	01Compartmentation
013	IHSL-FIRE-011	05/09/2014	13/11/2014	14/11/2014	04 Escape Routes
014	IHSL-FIRE-012	05/09/2014	13/11/2014	14/11/2014	02 Temporary Waiting Spaces
015	IHSL-FIRE-013	05/09/2014	13/11/2014	14/11/2014	01 Fire Supression
017	IHSL-FIRE-015	05/09/2014	13/11/2014	14/11/2014	01 Fire Hazard Rooms
019	IHSL-MEP-001	05/09/2014	13/11/2014	14/11/2014	02 Fire Suppression REWORDING ACCEPTED
020	IHSL-MEP-002	05/09/2014	13/11/2014	14/11/2014	02 25% Cabling Capacity
021	IHSL-MEP-003	05/09/2014	13/11/2014	14/11/2014	03 Clinical Equipment Alarms-Rewording Accepted
023	IHSL-MEP-005	05/09/2014	13/11/2014	14/11/2014	01 DRAFT Routes through common services
027	IHSL-MEP-009	05/09/2014	13/11/2014	14/11/2014	01 Luminaire Colour/Temperature
028	IHSL-MEP-010	05/09/2014	13/11/2014	14/11/2014	01 Sprinkler Protection
029	IHSL-MEP-011	05/09/2014	13/11/2014	14/11/2014	03 Fibre Optic Cables
033	IHSL-MEP-015	05/09/2014	13/11/2014	14/11/2014	03 Environmental Matrix REWORDED 12.11.14
034	IHSL-MEP-016	05/09/2014	13/11/2014	14/11/2014	02 Sustainability
035	IHSL-MEP-017	05/09/2014	13/11/2014	14/11/2014	02 Mech Vent / Air Con
042	DER/Arch/02	FT	13/11/2014	14/11/2014	**Submitted C30** Single bedroom/ensuite layout HBN 23
044	DER/Arch/04	FT	13/11/2014	14/11/2014	**Submitted C30** Critical care layout HBN 57
046	DER/Arch/07	FT	13/11/2014	14/11/2014	**Submitted C30** Clinical support spaces layout HBN 00-03
048	DER/Arch/09	FT	13/11/2014	14/11/2014	**Submitted C30** Clinical support spaces layout HBN 00-04
051	DER/Arch/12	FT	13/11/2014	14/11/2014	**Submitted C30** Adult in-patient assisted shower rooms HBN 04-01
054	DER/Aco/01	FT	13/11/2014	14/11/2014	**Submitted C30** Ceilings
064	As/Hel/02	FT	13/11/2014	14/11/2014	**REV 01 15/10/14** Helicopter Weights
065	1	FT	13/11/2014	14/11/2014	**Submitted C30** VIE Equipment
067	3	FT	13/11/2014	14/11/2014	03 (Submitted C30) Blinds/Curtain/Shower Curtain Tracks- Clarification
079	18	FT	13/11/2014	14/11/2014	03 (Submitted C30) Planting Maturity REDRAFTED
082	23	FT	13/11/2014	14/11/2014	**Submitted C30** 25% extra capacity
089	33	FT	13/11/2014	14/11/2014	**Submitted C30** FFE to external works
098	IHSL-ARC-001	15/09/2014	13/11/2014	14/11/2014	01 Clinical Output Specifications 1/4
099	IHSL-ARC-002	15/09/2014	13/11/2014	14/11/2014	01 Single Bedroom Arrangement
100	IHSL-ARC-003	15/09/2014	13/11/2014	14/11/2014	01 Multibed Room Bed Spaces
101	IHSL-ARC-004	15/09/2014	13/11/2014	14/11/2014	02 Theatres Size WORDING AMENDED 07/11/14
102	IHSL-ARC-005	15/09/2014	13/11/2014	14/11/2014	01 Sanitary Spaces - Alternative Layout
103	IHSL-ARC-006	15/09/2014	13/11/2014	14/11/2014	01 Sanitary Spaces - Alternative Layout
104	IHSL-ARC-007	15/09/2014	13/11/2014	14/11/2014	01 Consult Exam Room Sizes
105	IHSL-ARC-008	15/09/2014	13/11/2014	14/11/2014	01 Treatment Room areas
106	IHSL-ARC-009	15/09/2014	13/11/2014	14/11/2014	01 Infection Control
107	IHSL-ARC-010	15/09/2014	13/11/2014	14/11/2014	01 100% Single Bedrooms
110	IHSL-ARC-013	16/09/2014	13/11/2014	14/11/2014	03 Assisted Shower toom to multi-bed rooms
111	IHSL-ARC-014	16/09/2014	13/11/2014	14/11/2014	01 Open Linen Bays
112	IHSL-ARC-015	16/09/2014	13/11/2014	14/11/2014	03 4 bed layout
113	IHSL-ARC-016	16/09/2014	13/11/2014	14/11/2014	01 Viewing Zones
114	IHSL-ARC-017	16/09/2014	13/11/2014	14/11/2014	02 Georgian wired glassPco revised confirmation
115	IHSL-ARC-018	16/09/2014	13/11/2014	14/11/2014	01 Georgian Wired Glass
116	IHSL-ARC-019	16/09/2014	13/11/2014	14/11/2014	01 Vision Panels
117	IHSL-ARC-020	16/09/2014	13/11/2014	14/11/2014	03 Georgian wired glass REWORDED 07/11/14
118	IHSL-ARC-021	16/09/2014	13/11/2014	14/11/2014	01 Door widths
119	IHSL-ARC-022	16/09/2014	13/11/2014	14/11/2014	05 Extent of Shielding
120	IHSL-ARC-023	17/09/2014	13/11/2014	14/11/2014	01 Ironmongery
121	IHSL-ARC-024	17/09/2014	13/11/2014	14/11/2014	01 Equipment - Carcasses
122	IHSL-ARC-025	17/09/2014	13/11/2014	14/11/2014	01 Flexible Hoses-CAMHS
123	IHSL-ARC-026	17/09/2014	13/11/2014	14/11/2014	02 Anti- Ligature
124	IHSL-ARC-027	17/09/2014	13/11/2014	14/11/2014	01 Single Rooms - Bed Spacing 02 Proposal wording revised 22/09/14
125	IHSL-ARC-028	17/09/2014	13/11/2014	14/11/2014	04 Bed Spacing REWORDED
126	IHSL-ARC-029	17/09/2014	13/11/2014	14/11/2014	01 Single Room Accommodation
127	IHSL-ARC-030	17/09/2014	13/11/2014	14/11/2014	01 Car Parking
128	IHSL-ARC-031	17/09/2014	13/11/2014	14/11/2014	01 Drop Off
129	IHSL-ARC-032	17/09/2014	13/11/2014	14/11/2014	01 Building Envelope REDRAFTED 30/10/14
130	IHSL-ARC-033	17/09/2014	13/11/2014	14/11/2014	01 Corridor WidthsREDRAFTED 30/10/14
131	IHSL-ARC-034	17/09/2014	13/11/2014	10/11/2014	02 Windows redrafted 10.11.14
132	IHSL-ARC-035	17/09/2014	13/11/2014	14/11/2014	01 Flooring
133	IHSL-ARC-036	17/09/2014	13/11/2014	14/11/2014	02 Gas Cylinder Storage REWORDED
134	IHSL-ARC-037	17/09/2014	13/11/2014	14/11/2014	01 Heated External Spaces
135	IHSL-ARC-038	17/09/2014	13/11/2014	14/11/2014	01 Escalators
136	IHSL-ARC-039	22/09/2014	13/11/2014	14/11/2014	03 Handrails REVISED WORDING
137	IHSL-ARC-040	15/10/2014	13/11/2014	14/11/2014	01 Helipad Ramp Gradient
138	IHSL-MEP-023	04/11/2014	13/11/2014	10/11/2014	Fiscal Metering
139	IHSL-ARC-041	15/10/2014	13/11/2014	14/11/2014	01 Drainage Life Expectancy
140	IHSL-ARC-042	12/11/2014	13/11/2014	14/11/2014	01 Lift Door Widths
141	IHSL-ARC-001 (2)	12/11/2014	13/11/2014	14/11/2014	01 Clinical Output Specifications 2/4
142	IHSL-ARC-001 (3)	12/11/2014	13/11/2014	14/11/2014	01 Clinical Output Specifications 3/4
143	IHSL-ARC-001 (4)	12/11/2014	13/11/2014	14/11/2014	01 Clinical Output Specifications 4/4

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RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	*03 Drop Seals -REWORDED AS AGREED BY NHSL*	IHSL-ACO-001

BCR Clause

[copy text from BCR's / PA, include clause numbers]

In Scottish Health Technical Memorandum 08-01: Specialist services Acoustics (May 2011) it is stated that:

Doors
2.71 Doors are inevitably a weakness in a partition and will reduce the overall acoustic performance of most constructions.
2.72 Reasonable acoustic performance cannot be achieved without seals around the whole door perimeter, including threshold and meeting stiles. It is recognised that there can be significant restrictions on the use of door seals; therefore, doors should be sealed as far as practically possible.
2.73 Possible conflicts with the desired acoustic performance include opening force (including under emergency conditions), infection control, patient safety (for example if double-swing doors are required) and ventilation regimes. Designers should make an informed decision about the provision of door seals when the other restrictions are considered.

Relevant Regulation - HBN, SHTM, Building Regulations etc

[copy text from relevant docts, include clause numbers]

Scottish Health Technical Memorandum 08-01: Specialist services Acoustics (May 2011) - SHTM08-01.

Requirement

[summarise what is being asked for in the docts above]

Table 5 of SHTM08-01 - Matrix showing sound-insulation performance required (dB DnT,w), presents the installed sound-insulation performanced (DnT,w) required for different room types.

Derogation

[why derogation is required]

Due to infection control issues drop seals will only be used in the following rooms:

1. Sleep laboratory
2. Audiology rooms
3. Radio Lolipop Studio
4. Medical Resonance Imaging Rooms
5. Laboratory areas within Specialist Biochemistry Lab and Child Life & Health
6. Single isolation room within Clinical Research Facility
7. Testing rooms within Audiology
8. Plaster Suite within ED + RHSC Outpatients
9. Splinting/Casting Room within RHSC Therapies
10. Orthotics Workshop within RHSC OPD

As stated in 2.72 of SHTM08-01 reasonable acoustic performance cannot be achieved without seals around the whole door perimeter.

In terms of airborne sound insulation between adjacent rooms an indirect airborne transmission path occur through the doors of

both rooms. The magnitude of this indirect airborne transmission path is essentially determined by: i) the performance of the doors, i.e. the magnitude will increase if the performance of the doors decrease (for ex. if seals are not provided around the all door perimeter) and ii) the location of the doors, i.e. the magnitude will increase if doors from both rooms are close to each other or if they are facing each other.

Therefore, derogation of the acoustical requirement regarding airborne sound insulation between rooms is needed (acoustical requirement stated on Table 5 of SHTM08-01) for:

2. All adjacent rooms that due to user requests have their doors close to each other (side by side) or facing each other.

3. All adjacent rooms that have doors, movable walls, gaps or any other system interconnecting each other.

Proposal
It is proposed that in cases where due to user requests adjacent room have their doors close to each other (side by side) or facing each other the requirements stated in Table 5 of SHTM08-01 should be decreased to 6dB. *It is proposed that in cases where due to user requests adjacent rooms are meant to be interconnect to each other by means of doors, movable walls, gaps or any other system, the requirements stated in Table 5 of SHTM08-01 should not be applied.*

Reference Docts - Sketches, drawings, reference material extracts etc
[give all items a full ref code which can be tracked on Aconex]

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Screens in AC rated walls	IHSL-ACO-002

BCR Clause

[copy text from BCR's / PA, include clause numbers]

In Scottish Health Technical Memorandum 08-01: Specialist services Acoustics (May 2011) it is stated that:

2.67 Where observation windows are included between adjacent rooms, partitions (including the glass) should ideally achieve the target ratings given in Tables 4 and 5. However, it can be difficult to fit windows that meet the full acoustic specification into the width of partitions. In this case, as a minimum, the glazing configuration alone should achieve an Rw that is no more than 10 dB below that of the required Rw for the partition alone. This will reduce the sound insulation by an amount that depends on the size of the observation window in relation to the size of the partition.

Relevant Regulation - HBN, SHTM, Building Regulations etc

[copy text from relevant docts, include clause numbers]

Scottish Health Technical Memorandum 08-01: Specialist services Acoustics (May 2011) - SHTM08-01.

Requirement

[summarise what is being asked for in the docts above]

Table 5 of SHTM08-01, Matrix showing sound-insulation performance required (dB DnT,w), presents the installed sound-insulation performanced (DnT,w) required for different room types.

Derogation

[why derogation is required]

As stated in SHTM08-01 it can be difficult to fit windows that meet the full acoustic specification into the width of partitions, therefore in these cases a derogation of the acoustical requirement regarding airborne sound insulation between rooms is needed (acoustical requirement stated on Table 5 of SHTM08-01).

Proposal

[what is Project Co alternative Proposal]

It is proposed that in cases where observation windows are included between adjacent rooms, the glazing configuration alone should achieve an Rw 10 dB below that of the required Rw for the partition alone.

Reference Docts - Sketches, drawings, reference material extracts etc

[give all items a full ref code which can be tracked on Aconex]

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	01 Lifts	IHSL-FIRE-001

BCR Clause

2.3 NHS Requirements
In addition to the standards listed in paragraph 2.4 of this Sub-Section C, unless the Board has expressed elsewhere in the Board's Construction Requirements, a specific and different requirement, the Facilities shall comply with but not be limited to the provisions of the NHS Requirements as the same may be amended from time to time:
i. Firecode
Project Co shall ensure the Facilities comply with the NHS Scotland Fire Safety Management - a suite of documents which explains the policy and technical guidance in fire precautions in hospitals and other healthcare premises, comprising the Health Facilities Scotland Fire Safety Policy, the Scottish Health Technical Memoranda (SHTM) and Scottish Fire Practice Notes (SFPN) which all comprise NHS Scotland Firecode, the Fire Safety Documentation Reference Guide and A Model Management Structure for Fire Safety.
Project Co shall prepare proposals in accordance with NHS Scotland Firecode to be submitted to the Board as Reviewable Design Data for review by the Board in accordance with Schedule Part 8 (Review Procedure) and clause 12.6 of the Project Agreement prior to the submission of the proposals for approval by the Relevant Authority including without limitation building control department.
In the event of a conflict between the requirements of the local building control officers and NHS Scotland Firecode the more onerous requirements shall take precedence. Project Co shall notify the Board as soon as such conflict is known or suspected and shall further advise the Board of Project Co’s proposed relevant design solution as early as possible before formal submission for review by the Board. When the more onerous requirement is to be used the Board will have the right to decide what constitutes the more onerous requirement.
Any fire strategy which affects the Site will also have to have regard to, be compatible with and operate in conjunction with the fire strategy and procedures for the RIE Facilities and/or Retained Estate, as applicable.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 81 part 1 July 2009
5.19 Where vertical travel is a component of the escape arrangements and bed lifts are installed in the building, they should be escape bed lifts.

Requirement

The guidance within SHTM 81 part 1 recommends that bed lifts are designed as escape bed lifts however the guidance within SFPN 3 Escape Bed Lifts notes that provision should be sufficient.
4. Physical requirements for escape lifts
Escape lift provision
4.1 Sufficient escape lifts should be provided and sited appropriately to accord with the fire evacuation strategy for the premises, developed with full consideration
of the issues outlined in Section 3.
4.2 Where an escape lift is one of a group of lifts within one protected enclosure, all the lifts in the group should be escape lifts in accordance with the standards
specified in this SHTM.
4.3 Sufficient escape lifts should be provided, appropriately remote from each other so that should a fire affect one escape lift, sufficient escape lifts will remain
available for use to enable the organisation’s fire evacuation strategy and procedures to be implemented.

Derogation

Not all bed lifts will be designed as escape bed lifts however a sufficient number of escape bed lifts will be provided.

Proposal

It is Project Co's intention to negotiate the number and location of lifts designed as escape bed lifts with the NHS. It is acknowledged that due to the management requirements for the use of lifts during evacuation only a limited number would be used at any one time and therefore providing a limited number is more practical.
It is noted that in England and Wales the applicable HTM guidance recommends a minimum of 2 escape bed lifts. RHSC + DCN will be provided with at least 2 escape bed lifts.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014

NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	*04 Department Adjacencies (Links to C30 - 051 Summary Item)*	IHSL-FIRE-002

BCR Clause

2.3 NHS Requirements

In addition to the standards listed in paragraph 2.4 of this Sub-Section C, unless the Board has expressed elsewhere in the Board's Construction Requirements, a specific and different requirement, the Facilities shall comply with but not be limited to the provisions of the NHS Requirements as the same may be amended from time to time:

i. Firecode

Project Co shall ensure the Facilities comply with the NHS Scotland Fire Safety Management - a suite of documents which explains the policy and technical guidance in fire precautions in hospitals and other healthcare premises, comprising the Health Facilities Scotland Fire Safety Policy, the Scottish Health Technical Memoranda (SHTM) and Scottish Fire Practice Notes (SFPN) which all comprise NHS Scotland Firecode, the Fire Safety Documentation Reference Guide and A Model Management Structure for Fire Safety.

Project Co shall prepare proposals in accordance with NHS Scotland Firecode to be submitted to the Board as Reviewable Design Data for review by the Board in accordance with Schedule Part 8 (Review Procedure) and clause 12.6 of the Project Agreement prior to the submission of the proposals for approval by the Relevant Authority including without limitation building control department.

In the event of a conflict between the requirements of the local building control officers and NHS Scotland Firecode the more onerous requirements shall take precedence. Project Co shall notify the Board as soon as such conflict is known or suspected and shall further advise the Board of Project Co's proposed relevant design solution as early as possible before formal submission for review by the Board. When the more onerous requirement is to be used the Board will have the right to decide what constitutes the more onerous requirement.

Any fire strategy which affects the Site will also have to have regard to, be compatible with and operate in conjunction with the fire strategy and procedures for the RIE Facilities and/or Retained Estate, as applicable.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 81 part 1 July 2009

3.11 The departments in the following List A should:

never be directly below, nor directly adjoin, operating theatres, intensive therapy units or special care baby units; and be provided with a fire suppression system where they are directly below, or directly adjoin, any other hospital department to which patients have access.

List A
- Boiler House
- Central Stores
- Commercial enterprises
- Flammable stores
- Laundry
- Main electrical switchgear
- Main kitchens
- Refuse collection and incineration
- Works department

Other high hazard departments may be adjacent to very high dependency patient access areas if an automatic fire control system is installed in addition to fire resistant structural separation.

A hospital department in List B should be provided with an automatic fire suppression system where it is directly below, or directly adjoins, operating theatres, intensive therapy units, or special care baby units.

List B
- Central staff change
- Central sterile supplies
- Hospital sterilizing and disinfecting unit
- Health records
- Pathology
- Manufacturing pharmacy

('Non-domestic technical handbook'; 2008; Section 2; Annex B; paragraph 2.B.1.)

Requirement

The guidance recommends that certain departments are not located next to one another or are provided with sprinklers.

Derogation

Theatres will adjoin the atrium space and suppression is not proposed for the basement kitchen or plant areas.

Proposal

The theatres will be fire separated from the atrium space with medium duration and the basement kitchen and plant areas will be low risk.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 2 – department adjacencies

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	10/11/2014

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RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	04 Dampers to Ductwork REWORDED	IHSL-FIRE-004

BCR Clause

2.3 NHS Requirements
In addition to the standards listed in paragraph 2.4 of this Sub-Section C, unless the Board has expressed elsewhere in the Board's Construction Requirements, a specific and different requirement, the Facilities shall comply with but not be limited to the provisions of the NHS Requirements as the same may be amended from time to time:
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Project Co shall ensure the Facilities comply with the NHS Scotland Fire Safety Management - a suite of documents which explains the policy and technical guidance in fire precautions in hospitals and other healthcare premises, comprising the Health Facilities Scotland Fire Safety Policy, the Scottish Health Technical Memoranda (SHTM) and Scottish Fire Practice Notes (SFPN) which all comprise NHS Scotland Firecode, the Fire Safety Documentation Reference Guide and A Model Management Structure for Fire Safety.
Project Co shall prepare proposals in accordance with NHS Scotland Firecode to be submitted to the Board as Reviewable Design Data for review by the Board in accordance with Schedule Part 8 (Review Procedure) and clause 12.6 of the Project Agreement prior to the submission of the proposals for approval by the Relevant Authority including without limitation building control department.
In the event of a conflict between the requirements of the local building control officers and NHS Scotland Firecode the more onerous requirements shall take precedence. Project Co shall notify the Board as soon as such conflict is known or suspected and shall further advise the Board of Project Co's proposed relevant design solution as early as possible before formal submission for review by the Board. When the more onerous requirement is to be used the Board will have the right to decide what constitutes the more onerous requirement.
Any fire strategy which affects the Site will also have to have regard to, be compatible with and operate in conjunction with the fire strategy and procedures for the RIE Facilities and/or Retained Estate, as applicable.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 81 part 1 July 2009
6.8 Ductwork passing through a compartment or sub-compartment boundary must be provided with remotely resettable fire and smoke dampers operated by
smoke detection.

Requirement

Fire / smoke damper recommended to all compartment / sub-compartment walls.

Derogation

Derogation required since these areas would not benefit from fire / smoke dampers; fire only are considered more appropriate.
Dampers to ductwork between the following spaces shall operate on fire actuation only.
Dampers between plant spaces
Dampers within ductwork serving Intensive Treatment Areas

Proposal

It is proposed that within the above noted spaces that the guidance within BS9999 Clause 33.4 Method 1 is followed.
This method does not require the ductwork to provide any degree of fire resistance, since the fire is isolated in the compartment of origin by the automatic actuation of fire dampers within the ductwork system.
Fire dampers are therefore sited in the duct at the point where it penetrates a fire-separating element:
Fire Rated walls between noted spaces
Compartment floors between risers and noted spaces
Agreement is required to be reached with the Board and Boards Fire Officer, and the derogation is not approved by the Board until that agreement is obtained through design yet to be fully developed and presented through the RDD process.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note1 damper actuation

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	10/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	01 Adjacencies LINKS TO C30 (Summary 050)	IHSL-FIRE-005

BCR Clause

2.3 NHS Requirements
In addition to the standards listed in paragraph 2.4 of this Sub-Section C, unless the Board has expressed elsewhere in the Board's Construction Requirements, a specific and different requirement, the Facilities shall comply with but not be limited to the provisions of the NHS Requirements as the same may be amended from time to time:
i. Firecode
Project Co shall ensure the Facilities comply with the NHS Scotland Fire Safety Management - a suite of documents which explains the policy and technical guidance in fire precautions in hospitals and other healthcare premises, comprising the Health Facilities Scotland Fire Safety Policy, the Scottish Health Technical Memoranda (SHTM) and Scottish Fire Practice Notes (SFPN) which all comprise NHS Scotland Firecode, the Fire Safety Documentation Reference Guide and A Model Management Structure for Fire Safety.
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In the event of a conflict between the requirements of the local building control officers and NHS Scotland Firecode the more onerous requirements shall take precedence. Project Co shall notify the Board as soon as such conflict is known or suspected and shall further advise the Board of Project Co's proposed relevant design solution as early as possible before formal submission for review by the Board.
When the more onerous requirement is to be used the Board will have the right to decide what constitutes the more onerous requirement.
Any fire strategy which affects the Site will also have to have regard to, be compatible with and operate in conjunction with the fire strategy and procedures for the RIE Facilities and/or Retained Estate, as applicable.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 81 part 3 April 2013
3.6 Departments that provide care for very high dependency patients should not be located adjacent to an atrium, nor should any part of the department or their
supporting facilities be located within the atrium.

Requirement

theatres not permitted next to atrium.

Derogation

High dependency areas (theatres) are located adjacent to the atria therefore a fire engineered approach has been taken to demonstrate that with the proposed level of fire protection in the atria and adjacent areas the functional requirements of the guidance will be achieved.

Proposal

During the reference design stage the adjacency of the theatres to the atrium was discussed with NHS Lothian fire officer. This adjacency still exists with the proposed design and the same mitigation principles are proposed:
Medium duration fire protection to walls of theatres adjacent to atrium,
Sprinkler protection to atrium,
Smoke control to atrium.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 10 atrium

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	*05 Atrium REDRAFTED 13/11/14*	IHSL-FIRE-006

BCR Clause

2.3 NHS Requirements
In addition to the standards listed in paragraph 2.4 of this Sub-Section C, unless the Board has expressed elsewhere in the Board's Construction Requirements, a specific and different requirement, the Facilities shall comply with but not be limited to the provisions of the NHS Requirements as the same may be amended from time to time:
i. Firecode
Project Co shall ensure the Facilities comply with the NHS Scotland Fire Safety Management - a suite of documents which explains the policy and technical guidance in fire precautions in hospitals and other healthcare premises, comprising the Health Facilities Scotland Fire Safety Policy, the Scottish Health Technical Memoranda (SHTM) and Scottish Fire Practice Notes (SFPN) which all comprise NHS Scotland Firecode, the Fire Safety Documentation Reference Guide and A Model Management Structure for Fire Safety.
Project Co shall prepare proposals in accordance with NHS Scotland Firecode to be submitted to the Board as Reviewable Design Data for review by the Board in accordance with Schedule Part 8 (Review Procedure) and clause 12.6 of the Project Agreement prior to the submission of the proposals for approval by the Relevant Authority including without limitation building control department.
In the event of a conflict between the requirements of the local building control officers and NHS Scotland Firecode the more onerous requirements shall take precedence. Project Co shall notify the Board as soon as such conflict is known or suspected and shall further advise the Board of Project Co's proposed relevant design solution as early as possible before formal submission for review by the Board. When the more onerous requirement is to be used the Board will have the right to decide what constitutes the more onerous requirement.
Any fire strategy which affects the Site will also have to have regard to, be compatible with and operate in conjunction with the fire strategy and procedures for the RIE Facilities and/or Retained Estate, as applicable.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 81 part 3 April 2013
3.48 An atrium should be enclosed to provide compartmentation between the atrium space and adjacent accommodation, with construction having a minimum
period of fire resistance of medium duration (60 minutes.) for integrity, insulation and load bearing capacity.

Requirement

Enclosing structure (including glazing) of atrium should be medium duration since access to adjoining areas is possible above the atrium base.

Derogation

Atrium glazing (with the exception of those to theatres) to be toughened glass in a suitable framing structure.

Proposal

It is proposed that the atrium enclosure walls meet the medium duration fire protection integrity and insulation. Calculations show that the smoke temperature will be significantly below 140°C therefore it is proposed that glazing within the atrium enclosure will be fixed lights of toughened glass in a suitable framing structure with the
exception of glazing serving the first storey theatre department. This area has an obvious higher patient dependency category therefore 60 / 60 glazing in a suitable framing will be provided to these areas. The glazing which will be used in the atrium has been confirmed by HLM as a choice of two. These options would be either:
• Single glazed unit at least 12mm thick
• Double glazed unit at least 6mm and 4mm thick
The above types of glass would fail at 470°C-600°C therefore flame impingement is not considered an issue.
This shall be further demonstrated by calculation during RDD. Agreement is required to be reached with the Board and Boards Fire Officer, and the derogation is not approved by the Board until that agreement is obtained through design yet to be fully developed and presented through the RDD process.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	*02 Fire Alarm & Detection*	IHSL-FIRE-008

BCR Clause

2.3 NHS Requirements
In addition to the standards listed in paragraph 2.4 of this Sub-Section C, unless the Board has expressed elsewhere in the Board's Construction Requirements, a specific and different requirement, the Facilities shall comply with but not be limited to the provisions of the NHS Requirements as the same may be amended from time to time:
i. Firecode
Project Co shall ensure the Facilities comply with the NHS Scotland Fire Safety Management - a suite of documents which explains the policy and technical guidance in fire precautions in hospitals and other healthcare premises, comprising the Health Facilities Scotland Fire Safety Policy, the Scottish Health Technical Memoranda (SHTM) and Scottish Fire Practice Notes (SFPN) which all comprise NHS Scotland Firecode, the Fire Safety Documentation Reference Guide and A Model Management Structure for Fire Safety.
Project Co shall prepare proposals in accordance with NHS Scotland Firecode to be submitted to the Board as Reviewable Design Data for review by the Board in accordance with Schedule Part 8 (Review Procedure) and clause 12.6 of the Project Agreement prior to the submission of the proposals for approval by the Relevant Authority including without limitation building control department.
In the event of a conflict between the requirements of the local building control officers and NHS Scotland Firecode the more onerous requirements shall take precedence. Project Co shall notify the Board as soon as such conflict is known or suspected and shall further advise the Board of Project Co's proposed relevant design solution as early as possible before formal submission for review by the Board. When the more onerous requirement is to be used the Board will have the right to decide what constitutes the more onerous requirement.
Any fire strategy which affects the Site will also have to have regard to, be compatible with and operate in conjunction with the fire strategy and procedures for the RIE Facilities and/or Retained Estate, as applicable.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 82 Fire Alarm & Detection Systems April 2013
3.6 A Category L2 or L3 system should be provided for healthcare premises other than hospitals. A category L1 system should be provided throughout all parts of
hospital premises. However, detectors need not normally be provided in the following areas:
voids and roof spaces of any depth that contain only:
MICC wiring, or wiring clipped to a metal tray or within metal conduit or trunking;
non-combustible pipework and ducts;
metal or plastic pipes used for water supply or drainage.
bath/shower rooms;
toilets in staff areas;
small cupboards (less than 1m2);
operating theatres.
In any case the omission of detectors should be subject to a fire risk assessment taking into account the specific matters identified in paragraph 3.4.

Requirement

The guidance within SHTM 82 recommends that detection is provided within voids unless they only contain items as noted within the guidance.

Derogation

The recommended list of acceptable items within ceiling voids has been expanded upon to include further items that are considered to be of a similar acceptable risk level.

Proposal

Design Note 5 provides an explanation for the methodology to be adopted for the risk assessment of the void content and an overview of the types of items considered to be acceptable.
The items have been assessed on being an ignition source, their ignition potential and their flammability.
It is proposed to develop this process as part of the design development to risk assess the specified products and the quantity to be installed to establish the risk to patients.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 5 void detection

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	*02 Fire Stopping*	IHSL-FIRE-009

BCR Clause

2.4 Minimum Design & Construction Standards
Project Co shall also ensure that the Facilities comply with Good Industry Practice, NHS Scotland requirements, relevant statutory requirements (including highways) and required consents including, but not limited to, the following as the same may be amended from time to time:
r) The Non-Domestic Technical Handbook 2011 to The Building (Scotland) Regulations 2004 and its amendments (note the current version is 2013 and this will be applicable to the project under Building Warrant application).

Relevant Regulation - HBN, SHTM, Building Regulations etc

2.1.14 Ventilation ductwork should be fire-stopped in accordance with BS 5588: Part 9: 1999. Section 6 of BS 5588: Part 9: 1999 provides guidance on design and construction including fire resisting enclosures, fire resisting ductwork and the use and activation of fire dampers.

Requirement

the recommendations within BS5588 refer to SHTM guidance (SHTM 81 and 82 are the relevant documents).

Derogation

Derogation required since these areas would not benefit from fire / smoke dampers; fire only are considered more appropriate.
Dampers to ductwork between the following spaces shall operate on fire actuation only.
Dampers between plant spaces
Dampers within ductwork serving Intensive Treatment Areas

Proposal

It is proposed that within the above noted spaces that the guidance within BS9999 Clause 33.4 Method 1 is followed.
This method does not require the ductwork to provide any degree of fire resistance, since the fire is isolated in the compartment of origin by the automatic actuation of fire dampers within the ductwork system.
Fire dampers are therefore sited in the duct at the point where it penetrates a fire-separating element:
Fire Rated walls between noted spaces
Compartment floors between risers and noted spaces

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note1 damper actuation

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	01Compartmentation	IHSL-FIRE-010

BCR Clause

2.4 Minimum Design & Construction Standards
Project Co shall also ensure that the Facilities comply with Good Industry Practice, NHS Scotland requirements, relevant statutory requirements (including highways) and required consents including, but not limited to, the following as the same may be amended from time to time:
r) The Non-Domestic Technical Handbook 2011 to The Building (Scotland) Regulations 2004 and its amendments (note the current version is 2013 and this will be applicable to the project under Building Warrant application).

Relevant Regulation - HBN, SHTM, Building Regulations etc

2.1.14 Compartment walls and compartment floors (including a fire resisting ceiling) are intended to prevent fire passing from one compartment to another. Openings
and service penetrations through these walls or floors can compromise their effectiveness and should be kept to a minimum.

Requirement

Hospitals require compartment floors at each level (atrium passes through compartment floors).

Derogation

Derogation required for inclusion of atrium, (atrium to be designed using fire engineering).

Proposal

Atrium to follow appropriate fire engineering principles and guidance for atria design.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 10 atrium

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	*04 Escape Routes*	IHSL-FIRE-011

BCR Clause

2.4 Minimum Design & Construction Standards
Project Co shall also ensure that the Facilities comply with Good Industry Practice, NHS Scotland requirements, relevant statutory requirements (including highways) and required consents including, but not limited to, the following as the same may be amended from time to time:
r) The Non-Domestic Technical Handbook 2011 to The Building (Scotland) Regulations 2004 and its amendments (note the current version is 2013 and this will be applicable to the project under Building Warrant application).

Relevant Regulation - HBN, SHTM, Building Regulations etc

2.9.12 Escape routes in residential buildings
In residential buildings occupants are particularly vulnerable to fire when asleep. Occupants may also be unfamiliar with their accommodation and escape routes.
Those occupants on the fire floor should be provided with the opportunity to reach a protected zone (or other escape route) in relative safety and as quickly as possible, therefore, the movement of fire and smoke to the escape route should be inhibited.
In a residential building, where any corridor escape route serves sleeping accommodation it should be constructed of walls providing a short fire resistance duration and any door in the wall should be a suitable self-closing fire door with a short fire resistance duration. However the fire door to the cleaners cupboard need not be self closing provided it is lockable.
This guidance may need to be adapted in a residential building used as a place of lawful detention due to the unique operational factors.
For additional guidance on residential care buildings and hospitals see annex 2A and 2B.

Requirement

Ward corridors are recommended to be short duration fire protection.

Derogation

Derogation is required since making all these walls / doors / glazing / peentrations fire rated reduces the day to day functionality of the spacesand creates a significant increase in cost / ongoing maintenance without improving fire safety.

Proposal

Project Co consider that the development of reduced patient numbers per room has a positive impact on limiting fire spread and ability to evacuate those at immediate risk within the room of fire origin.
Open Nightingale wards and multiple bed wards require a significantly greater evacuation time to move those at immediate risk of a fire within the room; the same principle also applies to bed bay wards and in each case no further division is required.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 8 residential corridors

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	*02 Temporary Waiting Spaces*	IHSL-FIRE-012

BCR Clause

2.4 Minimum Design & Construction Standards
Project Co shall also ensure that the Facilities comply with Good Industry Practice, NHS Scotland requirements, relevant statutory requirements (including highways) and required consents including, but not limited to, the following as the same may be amended from time to time:
r) The Non-Domestic Technical Handbook 2011 to The Building (Scotland) Regulations 2004 and its amendments (note the current version is 2013 and this will be applicable to the project under Building Warrant application).

Relevant Regulation - HBN, SHTM, Building Regulations etc

2.9.30 Temporary waiting spaces
The speed of evacuation of occupants with sensory, cognitive and/or mobility impairments can be much slower than other building users. Therefore, a space
should be provided to allow them to wait temporarily, before completing their escape to a place of safety.

Requirement

Temporary waiting spaces required to stair enclosures.

Derogation

Evacuation within the clinical part of the buildingwill be managed by PHE; including those visiting/ working in the areawho require additional assistance with vertical movement therefore temporary waiting spaces are considered necessary within clinical areas.

Proposal

Parents, guardians or carers will remain with child (patient) during an incident and their evacuation will be managed by staff through PHE.
Others will be directed to adjoining compartments not affected by fire where stairs and lifts will remain in use.
The functionality of these vertical routes (lifts & stairs) during a fire incident is considered as adequate mitigation for non-provision of temporary waiting spaces within the stair enclosures.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 4 temporary waiting spaces

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	01 Fire Supression	IHSL-FIRE-013

BCR Clause

2.4 Minimum Design & Construction Standards
Project Co shall also ensure that the Facilities comply with Good Industry Practice, NHS Scotland requirements, relevant statutory requirements (including highways) and required consents including, but not limited to, the following as the same may be amended from time to time:
r) The Non-Domestic Technical Handbook 2011 to The Building (Scotland) Regulations 2004 and its amendments (note the current version is 2013 and this will be applicable to the project under Building Warrant application).

Relevant Regulation - HBN, SHTM, Building Regulations etc

2.14.7 / 2.B.6
If a building is not fitted with an automatic fire suppression system, no point on any storey should be more than 45m from the nearest main outlet measured along an unobstructed route for laying a fire hose.

Requirement

Hose laying distances to be max. 45m from outlet.

Derogation

Small sections of the design at ground, first, second and third floors result in areas in excess of the 45m distance. The worst case scenario is 54m, 9m in excess of the guidance requirements.
The number of areas in which the hose laying distance exceeds 45m is negligible. All area in which non-compliance occurs are highlighted in Figure 14, Figure 16, Figure 15 and Figure 16 of the fire strategy document.

Proposal

Historically up until the issue of NDTH 2010, a hose laying length of 60m was permitted within buildings not fitted with an automatic fire suppression system. This change in guidance which resulted in reducing the hose laying length from 60m to 45m came following The Building Disaster Assessment Group research on behalf of the UK Government. This research was to assess the interaction between building design and the operational response of fire and rescue services.
Within this technical report the evaluation in reduction of fire hose laying lengths during fire fighting operations derived from the physiological demands on firefighters engaged in search and rescue and on the restrictions that may be imposed by their equipment.
In practice, attending Fire and Rescue Services appliances are fitted with hoses which are much longer than 45m this is to take account of when operating fire hoses within buildings the fire hoses have a tendency to "snake" when charged thus limiting their effective length. The marginal increase is not considered by Project Co to affect functionality of fire fighting operations.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 9 hose laying

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
05/09/2014	01 Fire Hazard Rooms	IHSL-FIRE-015

BCR Clause

2.4 Minimum Design & Construction Standards
Project Co shall also ensure that the Facilities comply with Good Industry Practice, NHS Scotland requirements, relevant statutory requirements (including highways) and required consents including, but not limited to, the following as the same may be amended from time to time:
r) The Non-Domestic Technical Handbook 2011 to The Building (Scotland) Regulations 2004 and its amendments (note the current version is 2013 and this will be applicable to the project under Building Warrant application).

Relevant Regulation - HBN, SHTM, Building Regulations etc

2.B.1
Fire hazard rooms
In order to contain a fire in its early stages, the listed rooms are considered to be hazardous and should be enclosed by walls providing a short fire resistance duration (see annex 2.D).

Requirement

Fire hazard rooms to be fire rated.

Derogation

Enclosure of individual fire hazard rooms can cause functionality / maintenance issues due to provision of fire rated walls and fire protection of services passing between adjoining rooms.
The provision of clusters will still ensure that fire and smoke are inhibited from spreading beyond the fire enclosure of origin until any occupants have had the time to leave that compartment and any fire containment measures have been initiated.

Proposal

Where two or more fire hazard room are adjacent, then the enclosure of the rooms (the cluster) will be treated as a fire hazard room.
Patient-access fire hazard rooms are not to be regarded as part of a cluster.

Reference Docts - Sketches, drawings, reference material extracts etc

See fire strategy WSP-SZ-XX-DC-572-500_03 Appendix Design note 11 clustering

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	02 Fire Suppression REWORDING ACCEPTED	IHSL-MEP-001

BCR Clause

PART 6 (CONSTRUCTION MATTERS)

SECTION 3 (BOARD'S CONSTRUCTION REQUIREMENTS)

Page 127, Item 8.10 Project Co to provide fire suppression systems in NHS Lothian Server rooms, IPS Room and main HV and LV switchrooms

Relevant Regulation - HBN, SHTM, Building Regulations etc

Not Applicable

Requirement

Project Co to provide fire suppression systems in NHS Lothian Server rooms, IPS Room and main HV and LV switchrooms

Derogation

IHSL Project Co Proposals (PCP) Section 4.12 Fire Strategy, developed for the project has a fire engineered solution that will provide gas suppression to the IT Server Room only . Other areas referenced in the BCR will not be provided with fire suppression systems.

Proposal

IHSL Project Co Proposals (PCP) Section 4.12 Fire Strategy, developed for the project has a fire engineered solution that will provide gas suppression to the IT Server Room only. The PS Room and main HV and LV switchrooms as ~~other areas~~ referenced in the BCR will not be provided with fire suppression systems noting that fire suppression will be provided for in therisk areas identified in the Fire Strategy such as the atrium, and local hood suppression to the basement kitchen.
Consideration of the type of electrical installation within the basement will be carried out to review the need for sprinklers (e.g. by the use of low hazard installations such as cast resin dry type or replacement of oil with Midel in transformers).

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	02 25% Cabling Capacity	IHSL-MEP-002

BCR Clause

PART 6 (CONSTRUCTION MATTERS)

SECTION 3 (BOARD'S CONSTRUCTION REQUIREMENTS)

Page 139, Item 9.6.1 All cabling installed shall allow for a minimum of 25% spare capacity.

Relevant Regulation - HBN, SHTM, Building Regulations etc

Not Applicable

Requirement

Cat6 Cabling to allow 25% spare capacity

Derogation

The Cat 6 cabling shall be installed to connect the various IT field device outlets with the local IT node room locations. As agreed with the NHS E Health at the ICT meeting workshops, see ICT Meeting Minutes 03 07 14 item 4.09, the provision of 25% spare capacity will be allowed in cabinets and containment systems, not loose cabling.

Proposal

As agreed with the NHS E Health at the ICT meeting workshops, see ICT Meeting Minutes 03 07 14 item 4.09, the provision of 25% spare capacity will be allowed in cabinets and containment systems, not loose cabling.

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	03 Clinical Equipment Alarms-Rewording Accepted	IHSL-MEP-003

BCR Clause

PART 6 (CONSTRUCTION MATTERS)
SECTION 3 (BOARD'S CONSTRUCTION REQUIREMENTS)
Page 144 Item 9.17.10 Clinical Equipment Alarms
Each ward drug fridge shall be alarmed to warn of common faults. The sounder alarm shall be located locally.

Relevant Regulation - HBN, SHTM, Building Regulations etc

Not Applicable.

Requirement

Each ward drug fridge shall be alarmed to warn of common faults. The sounder alarm shall be located locally.

Derogation

As agreed in the M&E Workshops, the Fridge alarms are by NHS Pharmacy not Project Co.

Proposal

Fridge alarms are by NHS Pharmacy not Project Co.
Project Co will provide local power and data outlets to the ward drug fridge locations. No connections to NHS Pharmacy alarm system.

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable.

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	*01 DRAFT Routes through common services*	IHSL-MEP-005

BCR Clause

PART 6 (CONSTRUCTION MATTERS)
SECTION 3 (BOARD'S CONSTRUCTION REQUIREMENTS)
Page 128 Item 8.14
In order to minimise potential disruption to the Board due to maintenance of building services, Project Co shall where practicable route services through common spaces such as corridors and avoid through routing within department areas.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 2023 Access and Accomodation for Engineering Services.

Requirement

In order to minimise potential disruption to the Board due to maintenance of building services, Project Co shall where practicable route services through common spaces such as corridors and avoid through routing within department areas.

Derogation

Generally pipe work and electrical services will run in corridor zones, but due to structural restrictions and available ceiling void depth in certain area of the developing design (such as level 1 downstand beams) the ventilation ductwork will run above the following occupied rooms in the following rooms only:
G-I1-002, 003, 004, 005, 006, 007, 014
G-D5-002, 003, 004, 005, 006, 008, 009
G-D8-001, 002
G-K1-002, 003, 004, 005, 006, 007, 008, 010, 011, 012, 013, 015, 016, 017, 018, 019, 021, 022, 025, 026, 028
G-E1-003, 004, 007, 008, 012
G-D2-005, 006, 007, 008, 009, 010, 011, 012, 013, 014
G-D1-001, 003, 005, 006, 008, 010, 016, 021, 022, 023, 025, 026, 027, 028, 031, 032, 034, 035, 036, 037, 038, 039, 042
G-D10-001
In addition the Pneumatic Tube System will pass through the following rooms only:
Dirty Utility G-A1-007
Plant room 15 B-PLANT-015

Proposal

Generally pipe work and electrical services will run in corridor zones, but due to structural restrictions and available ceiling void depth in certain area of the developing design (such as level 1 downstand beams) the ventilation ductwork will run above the following occupied rooms in the following rooms only:
G-I1-002, 003, 004, 005, 006, 007, 014
G-D5-002, 003, 004, 005, 006, 008, 009
G-D8-001, 002
G-K1-002, 003, 004, 005, 006, 007, 008, 010, 011, 012, 013, 015, 016, 017, 018, 019, 021, 022, 025, 026, 028
G-E1-003, 004, 007, 008, 012
G-D2-005, 006, 007, 008, 009, 010, 011, 012, 013, 014
G-D1-001, 003, 005, 006, 008, 010, 016, 021, 022, 023, 025, 026, 027, 028, 031, 032, 034, 035, 036, 037, 038, 039, 042
G-D10-001
In addition the Pneumatic Tube System will pass through the following rooms only:
Dirty Utility G-A1-007
Plant room 15 B-PLANT-015

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable.

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	01 Luminaire Colour/Temperature	IHSL-MEP-009

BCR Clause

PART 6 (CONSTRUCTION MATTERS)
SECTION 3 (BOARD’S CONSTRUCTION REQUIREMENTS)
Page 121 Item 8.8.5
Luminaires, their colour and material finish shall be selected to co-ordinate with the architectural intent throughout the circulation areas. Low wattage 2700K luminaires to be used in particular rooms shall be selected on their ability to create a calm and “homely” atmosphere. Project Co shall consider the inclusion of wall mounted luminaires and /or uplighters.
All lamps used in clinical areas shall have as a minimum a colour rendering capability of ≥ 85 CRI. For practical reasons consideration shall be given by Project Co to using the same luminaire in both clinical and non-clinical spaces within the same ward. A reading light with an on/off switch shall be provided at each bedhead location. Project Co shall provide an additional switch on the nurse call handset.

Relevant Regulation - HBN, SHTM, Building Regulations etc

BSEN12464-1/SLL Code For Lighting

Requirement

Luminaires, their colour and material finish shall be selected to co-ordinate with the architectural intent throughout the circulation areas. Low wattage 2700K luminaires to be used in particular rooms shall be selected on their ability to create a calm and “homely” atmosphere. Project Co shall consider the inclusion of wall mounted luminaires and /or uplighters.
All lamps used in clinical areas shall have as a minimum a colour rendering capability of ≥ 85 CRI. For practical reasons consideration shall be given by Project Co to using the same luminaire in both clinical and non-clinical spaces within the same ward. A reading light with an on/off switch shall be provided at each bedhead location. Project Co shall provide an additional switch on the nurse call handset.

Derogation

The specified 2700K colour temperature can refer to a tungsten source, the modern luminaires we will utilise have 3000K for a warm white lamp that still provides a 'homely' atmosphere and using compact fluorescent or LED energy efficient lamp.

Proposal

The specified 2700K colour temperature can refer to a tungsten source, the modern luminaires we will utilise have 3000K for a warm white lamp that still provides a 'homely' atmosphere and using compact fluorescent or LED energy efficient lamp.

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	01 Sprinkler Protection	IHSL-MEP-010

BCR Clause

PART 6 (CONSTRUCTION MATTERS)
SECTION 3 (BOARD'S CONSTRUCTION REQUIREMENTS)
Page 126 item 8.10
Project Co shall provide sprinkler protection to those departments surrounding High Dependency departments (above, below and adjacent on the same level) as required by SHTM 82 Section 3

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM82

Requirement

Project Co shall provide sprinkler protection to those departments surrounding High Dependency departments (above, below and adjacent on the same level) as required by SHTM 82 Section 3.

Derogation

IHSL Project Co Proposals (PCP) Section 4.12 Fire Strategy, developed for the project has a fire engineered solution that will provide Sprinkler Protection for Atrium only. Other areas referenced in the SHTM 82 guidance will not be provided with sprinkler protection.

Proposal

IHSL Project Co Proposals (PCP) Section 4.12 Fire Strategy, developed for the project has a fire engineered solution that will provide Sprinkler Protection for Atrium only. Other areas referenced in the SHTM 82 guidance will not be provided with sprinkler protection.

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	03 Fibre Optic Cables	IHSL-MEP-011

BCR Clause

PART 6 (CONSTRUCTION MATTERS)
SECTION 3 (BOARD'S CONSTRUCTION REQUIREMENTS)
Page 140 Item 9.11.1 & Appendix B 3.4
Project Co shall provide two 24 core single mode fibre optic cables (Topology: - Diverse Star; Type: - OS1 - 9 micron; Cores: - 24 for each type with 100% expansion capacity to be provided in the cable tray runs), from the NHS Lothian Server Room in the Facilities to the RIE Facilities, following independent routes for resilience. The connection will be to the Communications Rooms 1 and 2 in the RIE Facilities.
It is the Board's understanding that within the Old Dalkeith Road / Little France Crescent cable duct, cables belonging to providers BT (Route 1-NHS), THUS (Route 1 – N3)) and VIRGIN (University), run into the two RIE Facilities Communication Rooms. If the Board are correct then Project Co shall provide a second ICT connection route from the Facilities to the RIE Facilities within the Old Dalkeith Road / Little France Crescent cable duct, cables belonging to providers BT (Route 1-NHS), THUS (Route 1 – N3)) and VIRGIN (University), run into the two RIE Facilities Communication Rooms.
Project Co shall provide two 200 pair copper (minimum) multi-core cables following independent resilient routes to support back up telephones linked from the Facilities Server Rooms to the RIE Facilities PBX.

Relevant Regulation - HBN, SHTM, Building Regulations etc

Not Applicable

Requirement

Project Co shall provide two 48 core single mode fibre optic cables (Topology: - Diverse Star; Type: - OS1 - 9 micron; Cores: - 24 for each type with 100% expansion capacity to be provided in the cable tray runs), from the NHS Lothian Server Room in the Facilities to the RIE Facilities, following independent routes for resilience. The connection will be to the Communications Rooms 1 and 2 in the RIE Facilities.
It is the Board's understanding that within the Old Dalkeith Road / Little France Crescent cable duct, cables belonging to providers BT (Route 1-NHS), THUS (Route 1 – N3)) and VIRGIN (University), run into the two RIE Facilities Communication Rooms. If the Board are correct then Project Co shall provide a second ICT connection route from the Facilities to the RIE Facilities within the Old Dalkeith Road / Little France Crescent cable duct, cables belonging to providers BT (Route 1-NHS), THUS (Route 1 – N3)) and VIRGIN (University), run into the two RIE Facilities Communication Rooms.
Project Co shall provide two 200 pair copper (minimum) multi-core cables following independent resilient routes to support back up telephones linked from the Facilities Server Rooms to the RIE Facilities PBX.

Derogation

Project Co will provide two 48 core Fibre connections. One to Comms Room 1 via the upper floor link building and one to Comms Room 2 via the ground floor of the link building.
Project Co will provide cable ducts within the service strip to Old Dalkeith Road . Project Co will provide 200 pair copper to Comms Room 2 through the first floor void of the link building.
Project Co will provide 200 pair copper to Comms Room 1 through the ground floor void of the link building.

Proposal

Project Co will provide two 48 core Fibre connections. One to Comms Room 1 via the upper floor link building and one to Comms Room 2 via the ground floor of the link building.
Project Co will provide cable ducts within the service strip to Old Dalkeith Road . Project Co will provide 200 pair copper to Comms Room 2 through the first floor void of the link building.
Project Co will provide 200 pair copper to Comms Room 1 through the ground floor void of the link building.

Reference Docts - Sketches, drawings, reference material extracts etc

All as ehealth signed off drawings

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	*03 Environmental Matrix REWORDED 12.11.14*	IHSL-MEP-015

BCR Clause

8 Mechanical & Electrical Engineering Requirements

Project Co shall provide the Works to comply with the Environmental Matrix

Relevant Regulation - HBN, SHTM, Building Regulations etc

Not Applicable

Requirement

8 Mechanical & Electrical Engineering Requirements

Project Co shall provide the Works to comply with the Environmental Matrix

Derogation

Anomalies within the environmental matrix have been reviewed and proposals incorporated within the room data sheets (refer to schedule for proposed variations).

Proposal

Anomalies within the environmental matrix have been reviewed and proposals incorporated within the room data sheets (refer to schedule for proposed variations).This shall be further developed in conjunction with the board on the basis of the schedule of comments contained in Section 5 (RDD) Part IV.

Reference Docts - Sketches, drawings, reference material extracts etc

Room Data Sheets

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	*02 Sustainability*	IHSL-MEP-016

BCR Clause

5.25 Sustainability

Item n Part 6
The Board's target of utilising some 20% of renewable energy sources shall be achieved by Project Co.

Relevant Regulation - HBN, SHTM, Building Regulations etc

Not Applicable.

Requirement

5.25 Sustainability

Item n Part 6
The Board's target of utilising some 20% of renewable energy sources shall be achieved by Project Co.

Derogation

As detailed in C30 Part 6 section3 The gas CHP is LZC but not a renewable fuel.

Proposal

As detailed in C30 Part 6 section3 The gas CHP is LZC but not a renewable fuel.

Reference Docts - Sketches, drawings, reference material extracts etc

Refer to Enegy Centre Ground Floor Plan drawing reference WW-EC-00-PL-500-001

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes MER	Reference
05/09/2014	02 Mech Vent / Air Con	IHSL-MEP-017

BCR Clause

8.7.8 Mechanical Ventilation & Air Conditioning

Project Co shall incorporate provision to include humidification to the AHU plant at a future date.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM03-01 - Ventilation for healthcare premises.

Requirement

8.7.8 Mechanical Ventilation & Air Conditioning

Project Co shall incorporate provision to include humidification to the AHU plant at a future date.

Derogation

As discussed and agreed during the various workshops and confirmed by the Board Humidity Conrol is not required. However Air Handling Units for Theatres, Critical Care and High Dependency Unit areas to be fitted with space for future humidification. (In compliance with SHTM03-01)

Proposal

As discussed and agreed during the various workshops and confirmed by the Board Humidity Conrol is not required. However Air Handling Units for Theatres, Critical Care and High Dependency Unit areas to be fitted with space for future humidification. (In compliance with SHTM03-01)

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable.

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh	Derogation Request		
	Date	Notes MER	Reference
	04/11/2014	Fiscal Metering	IHSL-MEP-023

BCR Clause

8.7.1 Building Management Systems & Controls q) Application of energy metering, via the BMS, will allow Renewable Heat Incentive and energy saving schemes and to be implemented. This will require heat meters to be installed on each plate heat exchanger and heating circuit and connected into the BMS via MODBUS type interface. These meters may be used for fiscal purposes and would assist in providing information as to energy use.

Relevant Regulation - HBN, SHTM, Building Regulations etc

Not Applicable

Requirement

8.7.1 Building Management Systems & Controls q) Application of energy metering, via the BMS, will allow Renewable Heat Incentive and energy saving schemes and to be implemented. This will require heat meters to be installed on each plate heat exchanger and heating circuit and connected into the BMS via MODBUS type interface. These meters may be used for fiscal purposes and would assist in providing information as to energy use.

Derogation

The heat meters shall not be "fiscal" meters. However Utility company approved meters shall be provided to measure the output of the Photo Voltaic system.

Proposal

The heat meters shall not be "fiscal" meters. However Utility company approved meters shall be provided to measure the output of the Photo Voltaic system.

Reference Docts - Sketches, drawings, reference material extracts etc

Not Applicable

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	10/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Clinical Output Specifications 1/4	IHSL-ARC-001

BCR Clause

Section 3: Board's Construction Requirements
Sub-Section D - Specific Clinical Requirements clause 1.9 Design Guidance

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 04-01

Requirement

Attention is drawn to the design guidance contained in the following documents:-HBN 04-01

Derogation

Delete reference to HBN 04-01 from clause 1.9 of the Clinical Output Based Specifications for the following departments:- A3, Q1, M1, I1, N1, L1, P1, L2, M3, M2, M4, N2, R2, and R1

Proposal

Clinicial output specs to be revised to account for anomalies.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Clinical Output Specifications 2/4	IHSL-ARC-001 (2)

BCR Clause

Section 3: Board's Construction Requirements
Sub-Section D - Specific Clinical Requirements clause 1.9 Design Guidance

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 08

Requirement

Attention is drawn to the design guidance contained in the following documents:-HBN 08

Derogation

Delete reference to HBN 08 from clause 1.9 of the Clinical Output Based Specifications for the following departments:- M2

Proposal

SHPN 08 should substituted in clause 1.9 of the Clinical Output Based Specifications for the following departments:- M2

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Clinical Output Specifications 3/4	IHSL-ARC-001 (3)

BCR Clause

Section 3: Board's Construction Requirements
Sub-Section D - Specific Clinical Requirements clause 1.9 Design Guidance

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 12

Requirement

Attention is drawn to the design guidance contained in the following documents:-HBN 12

Derogation

Delete reference to HBN 12 from clause 1.9 of the Clinical Output Based Specifications for the following departments:- D1, D5, M1, E1, D1, D7, D3, D4 and M2

Proposal

SHPN 12 should substituted in clause 1.9 of the Clinical Output Based Specifications for the following departments:- D1, D5, M1, E1, D1, D7, D3, D4, and M2.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Clinical Output Specifications 1/4	IHSL-ARC-001

BCR Clause

Section 3: Board's Construction Requirements
Sub-Section D - Specific Clinical Requirements clause 1.9 Design Guidance

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 14

Requirement

Attention is drawn to the design guidance contained in the following documents:-HBN 14

Derogation

Delete reference to HBN 14 from clause 1.9 of the Clinical Output Based Specifications for the following departments:- A1,A2, F1, Q1, D1, D2, D5, M1, E1, L1, B1, H2, P1, D1, D7, D3, D4, L2, D9, C1.1, C1.2, C1.8, C1.3 and C1.4.

Proposal

HBN 14-01 should substituted in clause 1.9 of the Clinical Output Based Specifications for the following departments:- A1,A2, F1, Q1, D1, D2, D5, M1, E1, L1, B1, H2, P1, D1, D7, D3, D4, L2, D9, C1.1, C1.2, C1.8, C1.3 and C1.4.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Single Bedroom Arrangement	IHSL-ARC-002

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 23

Requirement

Hospital Accommodation for Children & Young People, Appendix 4 Sheet 1, shows a particular arrangement for a single bedroom with en-suite assisted shower room.

Derogation

Single bedroom layout shown in Appendix 4 sheet 1 not utilised

Proposal

Project Co propose a variant based on the HBN layout for the single bedroom but with an ensuite shower room design based on HBN 00-02 figure 60 proposal. This layout was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Multibed Room Bed Spaces	IHSL-ARC-003

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 23

Requirement

Clause 3.117 The minimum size of each bed space in a multi-bed room is 3.4 x 3.5 m (see HBN 4). Clause 3.148 Multi-bed rooms should also incorporate a dedicated play area. The area should be large enough to accommodate a children's play table and seating, storage cupboards and shelving. This area can either be located as in Appendix 4 Sheet 3 or in a bay window.

Derogation

Delete Clause 3.117. Omit dedicated play area and storage cupoboards required by clause 3.148.

Proposal

Project Co propose a room layout which is a cruciform arrangement which includes an ensuite shower room and separate assisted WC without a dedicated play area and storage cupboards.
Requirement for play area superceded by room layouts signed off through UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	*02 Theatres Size WORDING AMENDED 07/11/14*	IHSL-ARC-004

BCR Clause

2.3 NHS Requirements

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 26

Requirement

Facilities for Surgical Procedures: Vol 1, Operating Theatres, para 4.69 - A standard size of 55 sq.m.is recommended for all in-

Derogation

This HBN recommendation is based on providing maximum flexibility in use of theatres by opting for the largest space requirement for minimally invasive procedures. Project Co through design development with the agreement of the Board have reduced the size of two theatres in RHSC, one of which is used for day surgery and the other as a general theatre (including burns). This has enabled the introduction of a Preparation Room for the sixth RHSC theatre and four DCN Theatre suites.

Proposal

Theatre 6 (Day Surgery) 1-P-050 to be 47.5 sq.m. Theatre 5 (Burns) 1-P-140 to be 49.7 sq.m.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Sanitary Spaces - Alternative Layout	IHSL-ARC-005

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 00-02

Requirement

Core Elements: Sanitary Spaces,

Derogation

Proposal

Project Co Proposals adopt a variant design for the en-suite shower room and separate assisted WC for the childrens multi-bed rooms in A2 PARU, C1.8 Surgical Short Stay and C1.1 Medical In-patients.
This layout was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	01 Sanitary Spaces - Alternative Layout	IHSL-ARC-006

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 00-02

Requirement

Core Elements: Sanitary Spaces,

Derogation

Proposal

Project Co Proposals adopt a variant design for the shared en-suite wet room and separate assisted WCs for the childrens multi-bed rooms in C1.2 Surgical Long Stay, and C1.3 Neuroscience In-patients wards.
This layout was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	*01 Consult Exam Room Sizes*	IHSL-ARC-007

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 00-03

Requirement

Core Elements: Clinical and Clinical Support Spaces.

Derogation

Consulting/ Exam rooms do not meet the minimum area specified within the HBN - i.e. 16.0sqm.

Proposal

Project Co Proposals are for Clinical Rooms such as Consulting / Exam Rooms in M1 DCN Out Patients sized at 15.0 sq m.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	*01 Treatment Room areas*	IHSL-ARC-008

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 00-03

Requirement

Core Elements: Clinical and Clinical Support Spaces,

Derogation

Consulting/ Exam rooms and Treatment Rooms do not meet the minimum area specified within the HBN - i.e. 16.0sqm and 16.5sqm respectively.

Proposal

Project Co Proposals are for generic Clinical Rooms such as Consulting / Exam Rooms and Treatment Rooms in D1 RHSC Out Patients sized at 15.5sqm and 16.0sqm respectively.
This proposal was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

IHS LOTHIAN
INTEGRATED HEALTH SOLUTIONS

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	*01 Infection Control*	IHSL-ARC-009

BCR Clause

2.3 NHS Requirements

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 00-09

Requirement

Infection Control in the Built Environment

Derogation

HBN / SHFN conflict

Proposal

Substitute HBN 00-09 with SHFN 30 Version 3

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/09/2014	*01 100% Single Bedrooms*	IHSL-ARC-010

BCR Clause

2.3 NHS Requirements

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHPN 04-01

Requirement

Adult In-Patient Facilities, Paragraph 1.5, requires all new build hospital to provide 100% single bedrooms.

Derogation

The building does not provide 100% single bedrooms.

Proposal

Project Co have accommodated the substitution of 2 x 4 bed rooms within L1- DCN Acute Care in lieu of 8 single bedrooms. This proposal was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	03 Assisted Shower toom to multi-bed rooms	IHSL-ARC-013

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ix, SHPN

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHPN 04-01

Requirement

Adult In-patient Facilities, Paragraph 3.17, recommends for multi-bed rooms the provision of an assisted shower room (withWC, shower and whb) and a separate semi-ambulant WC (with hand-rinse basin).

Derogation

A separate semi-ambulant WC will not be provided in DCN multi-bed rooms.

Proposal

Project Co will provide an assisted shower room (with WC, Shower & whb) and a staff base base (services only, to allow for the future wc installation) in line with the NHSL requirements. This proposal was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*01 Open Linen Bays*	IHSL-ARC-014

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ix, SHPN

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHPN 04-01

Requirement

Adult In-patient Facilities, Paragraph 3.45, recommends that for infection control purposes linen should be kept in a closed store rather than on trolleys in an open bay.

Derogation

Linen will not be stored in closed bays.

Proposal

Project Co's proposals provides for open linen bays in line with NHSL requirements. Refer to project Co's Fire Strategy Proposals.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*03 4 bed layout*	IHSL-ARC-015

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ix, SHPN

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHPN 04-01

Requirement

Adult In-patient Facilities, Appendix 1 Example bedroom layouts, figure 15, example layout for 4 bedded room, shows both the assisted shower room and the separate semi-ambulant WC located adjacent to the corridor wall.

Derogation

Project Co will not provide 4-bedded bays in line with figure 15.

Proposal

Project Co will provide a variant layout with the assisted shower room located on the outside wall and a staff base adjacent to the corridor wall at the entrance to the multi-bed room. This arrangement improves the visibility into and out of the room from the corridor while maintaining optimum natural light and external views. This proposal was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*01 Viewing Zones*	IHSL-ARC-016

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 55:2.18

Requirement

The ideal viewing zone and ranges of eye levels for all types of occupants is shown in Figure 2.

Derogation

The viewing zones may not be as illustration contained in clause 2.18, figure 2

Proposal

Size of windows/ elevational treatment is detailed in Project Co's building elevation drawings. Project Co's proposals are compliant with clause 5.12 of the BCRs re: day lighting/ cill levels.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	02 Georgian wired glass Pco revised confirmation	IHSL-ARC-017

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 57: 2.8

Requirement

All glazing above 2,100mm, whether designated fire-resisting or not, should be glazed with 6mm Georgian wired or other fire-resisting glass to reduce the risk of breakage from raised temperatures in a fire.

Derogation

Georgian wired glass will not be used.
Glass above 2100mm will not be fire-resisting unless required by the fire strategy.

Proposal

Project Co shall not use georgian wired glass but shall use appropriately fire rated glass as required by the fire strategy and subject to full review and agreement with the Board.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*01 Georgian Wired Glass*	IHSL-ARC-018

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 57: 2.12

Requirement

Where fire-resisting glass is required, panes of Georgian safety wired glass should be used, except where 'small panes' of ordinary wired glass are permitted. In other cases the glass may also be required to possess insulating properties.

Derogation

Georgian wired glass will not be used

Proposal

Due to advances in glazing technology where fire resisting glass is required – Georgian safety wired glass need not be used.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

Comments [NHSL]

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*01 Vision Panels*	IHSL-ARC-019

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 57: 2.33

Requirement

Where through-vision is required for wheelchair users, the minimum zone of visibility should be between 500 mm and 1,500 mm from the finished floor level.

Derogation

Conflict between SHTM and BS8300. The viewing panel does not require to be continuous between 500 and 1500mm

Proposal

The vision panels as indicated in Project Co's Proposal's comply with BS8300 paragraph 6.4.3 and Figure 13.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

Comments [NHSL]

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*03 Georgian wired glass REWORDED 07/11/14*	IHSL-ARC-020

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 57: 2.64

Requirement

Generally, where glass panels are not more than 900 mm wide, 6 mm Georgian
wired safety glass, which gives both fire resistance and Class C impact performance to BS 6206:1981, should be used. It is available at a slight additional cost. For 'small panes', 6 mm 'ordinary' Georgian wired glass may be used.

Derogation

Georgian glass shall not be used however appropriate FR glass shall be used where required by the Fire Strategy.

Proposal

Due to advances in glazing technology where fire resisting glass is required – Georgian safety wired glass need not be used. Non-wired glass is a more contemporary look in keeping with modern hospital environment.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*01 Door widths*	IHSL-ARC-021

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 58: 2.10

Requirement

Door width requirements. Minimum width doors to multi bed areas and treatment areas to be min 1700mm.

Derogation

Conflict between SHTM and HBN. Multi bed areas and treatment areas not provided with 1700mm wide doors.

Proposal

Project Co will provide 1500mm wide doors to Multi-bed rooms and treatment rooms. 1500mm doorsets are consistent with HBN. Project Co will comply with HBN.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
16/09/2014	*05 Extent of Shielding*	IHSL-ARC-022

BCR Clause

5.14 Partitions
Project Co shall ensure partitions address special construction requirements including x-ray protection and gamma ray shielding i.e. concrete or lead. It is important that Project Co comply with the shielding requirements from the Board's Radiation Protection Advisor.
Partitions shall be designed to take account of following criteria:
a) Structural strength of overall partition, and adequacy of support for fittings, fixtures and equipment, both planned and future;
b) Sound reduction;
c) Fire resistance;
d) Moisture resistance;
e) Resistance to biological infection;
f) X-ray shielding;
g) Gamma ray shielding; and
h) Protection from damage.

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 58: 2.49

Requirement

as above

Derogation

As agreed during the Capex discussion, Project Co shall be providing radiation protection as per the completed schedule by the Board RPA, for the avoidance of doubt any lead lined doors shall be instructed as a change by the Board, and Faraday cages shall be provided by the Board.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	*01 Ironmongery*	IHSL-ARC-023

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 59

Requirement

Appendix: CL of latch spindle set at 800mm above FFL

Derogation

Door handles will not be provided at 800mm above FFL.

Proposal

Door spindle mounting height of 800mm above FFL considered too low. Lever handle heights will be consistant and compliant with BS8300 (900 and 1100mm)

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	*01 Equipment - Carcasses*	IHSL-ARC-024

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 63: 2.7
SHTM 63: 3.37

Requirement

With the Corbel carcass type lower storage units are fitted 300 mm above floor level to permit the use of floor-cleaning machines and to reduce prolonged bending down.

Cantilever brackets may be used to support the 600 mm (as Figure 1) and 500 mm assemblies and the standing and sitting work-surface heights in each case.

Derogation

Units will not be mounted 300mm above floor.
Cantilever brackets will not be used.

Proposal

Base units will be floor mounted and not fitted 300mm above floor. Worktops will therefore be supported on base units.
This proposal was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh	**Derogation Request**		
	Date	**Notes**	**Reference**
	17/09/2014	*01 Flexible Hoses-CAMHS*	IHSL-ARC-025

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3v, HTM & SHTM

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 64: 2.42

Requirement

Flexible hose to hand-held showerheads should be provided, and the design of the unit should be such that the head cannot become immersed in water, to accord with back-siphonage prevention requirements. It must be constrained to give a type AUK3 air gap above the spillover level of the bath or shower tray, and any other fluid Category 5 risk (for example a WC), by a robust means that cannot be removed without destroying the fitting.

Derogation

Flexible hoses will not be utlised in F1 CAMHS en-suites

Proposal

Anti Ligature showers with fixed heads will be utlised in F1 CAMHS

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	02 Anti- Ligature	IHSL-ARC-026

BCR Clause

5.12 Windows
All windows and fittings shall be compliant with anti-ligature requirements.

Relevant Regulation - HBN, SHTM, Building Regulations etc

n/a

Requirement

All windows and fittings shall be compliant with anti-ligature requirements.

Derogation

As this is not a practical solution, the Board and IHSL have agreed the extent of anti-ligature provision and this is now identified on drawing HLM-SZ-00-PL-330-100 Rev 04 which will form part of the Part 4 Section 5 (RDD) Schedule Part 6 (Construction Matters) and associated comments.

Proposal

Reference Docts - Sketches, drawings, reference material extracts etc

as above

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

Comments [NHSL]

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	01 Single Rooms - Bed Spacing 02 Proposal wording revised 22/09/14	IHSL-ARC-027

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3viii, Scottish Government Health Directorates Circulars (CEL and HDL)

Relevant Regulation - HBN, SHTM, Building Regulations etc

CEL 27 (2010)

Requirement

Provision of Single Room Accommodation and Bed Spacing - Para 5. Accordingly, the Chief Medical Officer has concluded that the guidance set out in the above CEL (CEL 48 2008) that there should be a presumption of 100% single rooms in future hospital developments, is confirmed as the policy for NHSScotland except for:
• existing accommodation which is being refurbished, where taking into account the constraints of the existing building, a minimum of 50% single room accommodation would be allowed but as close to 100% as possible would be expected; and
• in new developments where there are clinical reasons for not making 100% single room provision they should be clearly identified and articulated in the appropriate Business Case. However, each case would be subject to Scottish Government agreement as part of the Business Case approval process.

Derogation

The following wards / in-patient areas will be provided with less than 100% single rooms:- A2 PARU, B1 PICU,L1 DCN Acute Care, C1.1 Medical In-patients, C1.2 Surgical Long Stay, C1.3 Neurosciences In-patients, C1.4 Haematology & Oncology, C1.8 Surgical Short Stay and D9 Medical Day Care.

Proposal

Project Co have complied with the Boards Clinical Output Based Specifications for the following wards / in-patient areas which will be provided with approximate % single rooms as follows:- A2 (65%), B1(38%),L1(67%), C1.1(65%), C1.2 (47%), C1.3 (33%), C1.4 (67%), C1.8 (43%) and D9 (40%). Only F1 CAMHS and L2 DCN Adult In-Patients will have 100% single rooms. There are 149 single-bed rooms out of a total of 223 beds which is approximately 67% overall.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	04 Bed Spacing REWORDED	IHSL-ARC-028

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3viii, Scottish Government Health Directorates Circulars (CEL and HDL)

Relevant Regulation - HBN, SHTM, Building Regulations etc

CEL 27 (2010)

Requirement

Provision of Single Room Accommodation and Bed Spacing - Para 6. In relation to the issue of bed spacing for multi-bedded rooms, the current advice remains unchanged. That is, taking account of ergonomic criteria, primarily the space required for patient handling and other activities which take place in the immediate vicinity of the bed, it is recognised that the minimum bed space should not be less than 3.6m (wide) x 3.7m (deep).

Derogation

The multi-bedded rooms in RHSC Wards A2, B1, C1.1, C1.2, C1.3, C1.8 do not comply with this as the beds are not laid out in a parrallel configuration with rectangular bed spaces.

Proposal

Project Co's proposals have adopted NHSL reference design generic room layout which is a cruciform (St Andrew's Cross)arrangement with only one bed on each of the four walls. This room type is proposed for the following RHSC Wards :- A2, B1, C1.1, C1.2, C1.3, C1.8which were signed off during the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	*01 Single Room Accommodation*	IHSL-ARC-029

BCR Clause

3.5.6 Single Room Accommodation

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

DCN and CAMHS will have 100% of inpatient spaces in single rooms.

Derogation

The building does not provide 100% single bedrooms to DCN.

Proposal

Project Co have accommodated the substitution of 2 x 4 bed rooms within L1- DCN Acute Care in lieu of 8 single bedrooms.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	01 Car Parking	IHSL-ARC-030

BCR Clause

3.9.2 Emergency Department Parking

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Project Co shall provide as a minimum 24 free spaces for emergency visitors to the ED for the Facilities and the RIE Facilities. Of these spaces:
a) 50% must be of a size for disabled or parent and child parking, and marked as appropriate.
b) 50% must be non-disabled spaces for short term parking for emergency visitors to the ED facilities.

Derogation

Project Co propsoals do not provide 50% accessible spaces.

Proposal

Project co will provide 24 spaces at the ED entrance. 3no, of these spaces will sized as accessible spaces (14% of overall number) and appropriately marked in line with NHSL requirements.
This was agreed with NHSL during the pre-planning applciation dialogue process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	*01 Drop Off*	IHSL-ARC-031

BCR Clause

3.9.4 Drop-off / Pick-up Arrangements

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Project Co shall provide designated, covered "drop-off / pick-up" area(s) directly adjacent to the principal entrances to the Facilities including the ED entrance. This shall allow direct access to the Facilities, for a wide range of vehicles including private cars, taxis, ambulances and patient transport vehicles. The design should discourage any other use other than dropoff in this area.

Derogation

Project Co are not providing cover to designated drop off / pick up areas

Proposal

Project Co will provide canopies to the main entrances at DCN, RHSC and Emergency Department ambulance drop off.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	*01 Building Envelope REDRAFTED 30/10/14*	IHSL-ARC-032

BCR Clause

5.7 Building Envelope

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

d) Any cladding systems chosen for use on this Project shall be designed and constructed to resist silently, without detriment to the required performance or appearance, the action of the elements including wind, rain, hail, snow, ice, solar radiation, temperature changes, moisture movement, structural movements, construction tolerances, thermal movements, the internal environment of the buildings and dead or imposed loads.

Derogation

Not all cladding systems may be able to resist silently, the action of the elements. Those which posed a problem - ETFE roof and standing seam metal roof over clinical areas - have had additional treatment agreed. There shall be a rain suppressant membrane over the ETFE roof and an integral anti drumming membrane to the standing seam.

Proposal

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	01 Corridor WidthsREDRAFTED 30/10/14	IHSL-ARC-033

BCR Clause

5.10 Corridor Widths and Heights

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

The hospital streets are to have a minimum unobstructed width of 3 metres.
Minimum widths and heights shall apply along the whole length of the corridor.

Derogation

Hospital street does not have an unobstructed width of 3m along its whole length.

Proposal

Localised widths below 3m will occur at agreed seating/ resting points for DCN patients along the Hospital Street as agreed with the Board.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	*02 Windows redrafted 10.11.14*	IHSL-ARC-034

BCR Clause

5.12 Windows

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Project Co shall ensure all windows required for ventilation shall be provided with controllable trickle ventilators within the head of the frame or with two stage key lockable handles giving 5 – 10mm ventilation gap.

Derogation

Project Co will not provide tricke vents to the head of all windows required for ventilation.

Proposal

Project Co will provide controllable trickle ventilators within window frames. Locations of vents within frames subject to appointment of specialist supplier/ manufacturer and also to Board agreement/sign off of sample/mock up of actual window system proposed.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	10/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	01 Flooring	IHSL-ARC-035

BCR Clause

5.13.2 Flooring

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHS Safety Action
Notice SAN(SC)05/08

Requirement

Project Co shall ensure that all entrances to the Facilities incorporate sufficient length of appropriate floor matting designed to remove contaminants including water, dirt and leaves from footwear, trolley wheels etc. A water evaporation system such as a hot air curtain shall be provided at each entrance.

Derogation

Project Co will not provide the recommended 6m of barrier matting at the ambulant emergency department entrance.

Proposal

Project Co will provide a maximum of 3.7m length barrier matting to the ambulant emergency department entrance due to limited entrance lobby depth.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	02 Gas Cylinder Storage REWORDED	IHSL-ARC-036

BCR Clause

5.28 Storage of Gas Cylinders

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 2023

Requirement

Project Co shall ensure that all gas cylinders, whether they are connected to external supplies or not, are stored in accordance with SHTM 2023.

Derogation

Gas cyclinder storage does not comply with SHTM 2023

Proposal

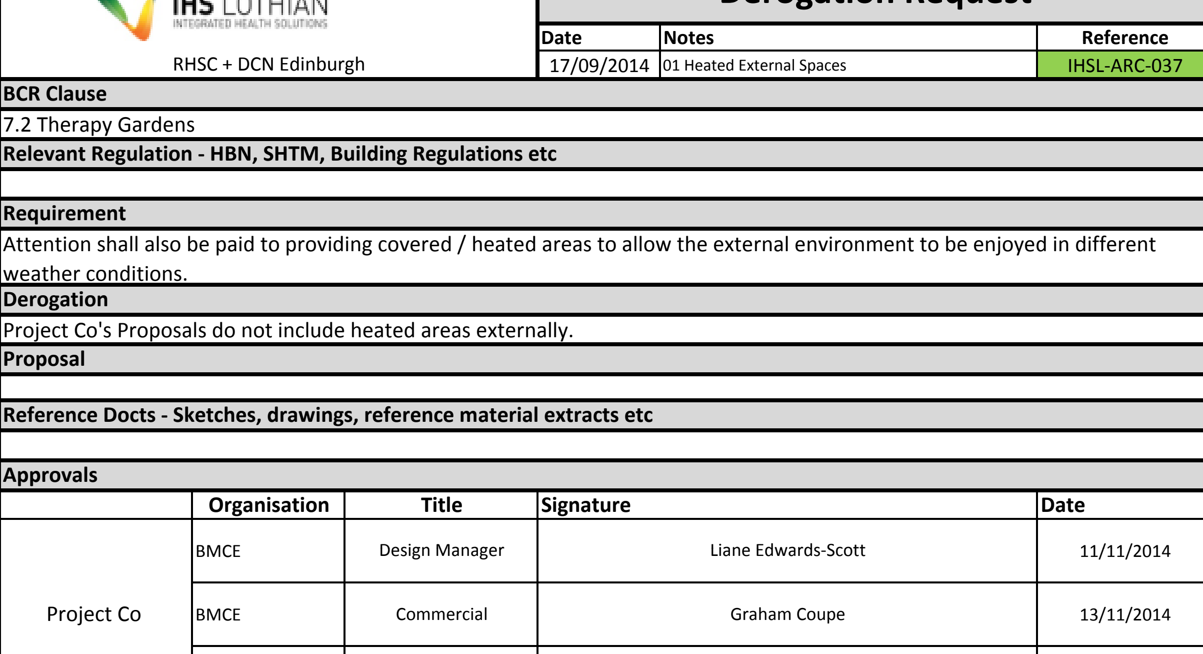
A number of gas cylinder stores are located within departments and not on external walls in accordance with NHSL requirements as per user request during UGM and subsequent sign off. This relates only to a number of gas cylinder stores where no external wall is present.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936



IHS LOTHIAN INTEGRATED HEALTH SOLUTIONS RHSC + DCN Edinburgh			Derogation Request	

Date	Notes	Reference
17/09/2014	01 Heated External Spaces	IHSL-ARC-037

BCR Clause

7.2 Therapy Gardens

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Attention shall also be paid to providing covered / heated areas to allow the external environment to be enjoyed in different weather conditions.

Derogation

Project Co's Proposals do not include heated areas externally.

Proposal

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
17/09/2014	*01 Escalators*	IHSL-ARC-038

BCR Clause

8.8.12 Escalators

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Where Project Co provides escalators within the buildings they shall adhere to the requirements of all relevant British Standards and in particular with BS EN 115 Safety of escalators and moving walks.

Derogation

No escalators are provided as part of Project Co's Proposals

Proposal

No escalators are provided as part of Project Co's Proposals as accepted by the Board.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
22/09/2014	*03 Handrails REVISED WORDING*	IHSL-ARC-039

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

HBN 00-04

Requirement

Core Elements: Circulation & Communication Spaces

7.10 The top of the handrail should be:
• 900–1000 mm above the surface of a ramp, ramp landing or pitch line of a flight of steps or along a corridor;
• 900–1100 mm from the surface of a stair
landing.

7.11 A second lower rail at a height of 600 mm should be provided in corridors, stairs and landings in children's healthcare facilities and on ramps (for wheelchair users). They should also be provided on
stairs and landings in healthcare premises where there are likely to be a significant number of semi- ambulant users.

Derogation

Project Co shall provide 2 handrails to stairs.

Proposal

Project Co shall provide 2 handrails to stairs per NHSL request.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/10/2014	01 Helipad Ramp Gradient	IHSL-ARC-040

BCR Clause

2.3 NHS Requirements

Relevant Regulation - HBN, SHTM, Building Regulations etc

HTM 15-03

Requirement

Ramp gradient suggested at 1:20.

Derogation

Project Co propose a ramp gradient of 1:12 for the patient helipad access. Patient transfers times would be improved by adopting the design proposal as this would substantially decrease the travel distance from the helipad to the hot core lift thus improving patient care. A ramp of similar gradient was inspected (at the New Southern General Hospital, Glasgow) by the NHSL team including Jon McCormack and Mark Dunn of the helicopter operations team on 30th June 2014 and no issues with the ramp gradient were noted. Further discussed at meeting 15.10.14.

Proposal

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
31/10/2014	01 Drainage Life Expectancy	IHSL-ARC-041

BCR Clause

Section 5. General Construction Requirements 5.1 d

Relevant Regulation - HBN, SHTM, Building Regulations etc

N/A

Requirement

Life expectancy of drainage and below ground civil engineering infrastructure - 70 years

Derogation

To reduce the requirement period from 70 years to 50 years

Proposal

Project Co are unable to source a material supply for drainage pipework and fittings whose manufacturer is prepared to provide a warranty on their products for a 70 year period. Project Co therefore propose to offer a specification compliant product with a 50 year life expectancy

Reference Docts - Sketches, drawings, reference material extracts etc

Marley Products BBA certificate

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014
NHSL				

A42675936

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
12/11/2014	01 Lift Door Widths	IHSL-ARC-042

BCR Clause

5.18 Any passenger or bed / passenger lifts required for vertical transportation shall have a minimum clear entrance of 1300 mm.

Relevant Regulation - HBN, SHTM, Building Regulations etc

n/a

Requirement

As noted above

Derogation

Not all lift doors provide 1300mm clear.

Proposal

1275kg capacity lifts provide 1100mm clear door widths. This is as agreed and detailed in PCP 4.15 Vertical Transportation.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

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RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
12/11/2014	01 (Submitted C30) Single bedroom/ensuite layout HBN 23	DER Arch 02

BCR Clause

HBN 23

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Hospital Accommodation for Children & Young People, Appendix 4 Sheet 1, shows a particular arrangement for a single bedroom with en-suite assisted shower room

Derogation

Ignore single bedroom layout shown in Appendix 4 sheet 1.

Proposal

Project Co propose a variant based on the HBN layout for the single bedroom but with an ensuite shower room design based on HBN 00-02 figure 60 proposal. This layout was signed off through the UGM process.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

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<tr><td colspan="2">
RHSC + DCN Edinburgh</td><td colspan="3">Derogation Request</td></tr>
<tr><td colspan="2"></td><td>Date</td><td>Notes</td><td>Reference</td></tr>
<tr><td colspan="2"></td><td>12/11/2014</td><td>(Submitted C30) Critical care layout HBN 57</td><td>DER Arch 04</td></tr>
</table>

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Derogation

Proposal

HBN 57 Facilities for Critical Care: This document is referred to in the Clinical OBS for B1 Critical Care, PICU, HDU and NICU. We have based our design on your reference design and HBN 04-02 Critical Care Units

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

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Derogation Request

Date	Notes	Reference
12/11/2014	(Submitted C30) Clinical support spaces layout HBN 00-03	DER Arch 07

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

The HBN requirement is 16.0sq m for clinical rooms.

Derogation

Rooms shall be provided at less than the required area.

Proposal

HBN 00-03 Core Elements: Clinical and Clinical Support Spaces, we propose to adopt your reference design for Clinical Rooms such as Consulting / Exam Rooms in a number of departments which are scheduled at 15.5 sq m and drawn at 15.0 sq m. The HBN equivalent is 16.0sq m.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

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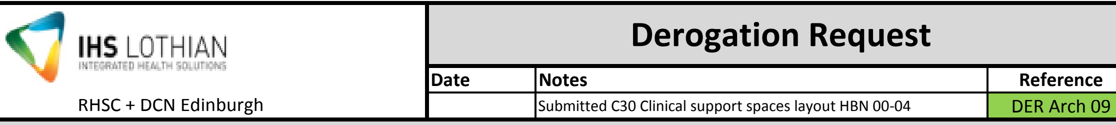

	Derogation Request	
IHS LOTHIAN RHSC + DCN Edinburgh		
Date	Notes	Reference
	Submitted C30 Clinical support spaces layout HBN 00-04	DER Arch 09

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Derogation

Some department corridors may result in reduced compliancy in terms of clear widths.

Proposal

HBN 00-04 Core Elements: Circulation & Communication Spaces, minimum corridor widths were adopted in line with the reference design and then were fully reviewed during the UGM process. Final setting out will be provided during the RDD process to confirm.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

Comments [NHSL]

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Derogation Request

Date	Notes	Reference
	Submitted C30 Adult in-patient assisted shower rooms HBN 04-01	DER Arch 12

BCR Clause

2.3 NHS Requirements
Sub-Section C, para 2.3ii, HBN

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Derogation

Proposal

SHPN 04-01 Adut In-patient Facilities, Paragraph 3.17, recommends for multi-bed rooms the provision of an assited shower room (withWC, shower and whb) and a separate semi-ambulant WC (with hand-rinse basin). We have provided a separate accessible WC (with hand-rinse basin) in lieu of the semi-anmbulant WC in line with the NHSL requirements.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

Comments [NHSL]

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RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
12/11/2014	Submitted C30 Ceilings	DER/Aco/01

BCR Clause

2.7

Relevant Regulation - HBN, SHTM, Building Regulations etc

SHTM 08-01

Requirement

Derogation

Proposal

SHTM 08-01 Ceilings - We would suggest that there may be a conflict between SHTM 08-01 - Acoustics and any infection control requirements.SHTM 08-01 notes that room acoustics are to be considered:It recommends that all rooms be treated with acoustically absorptive surfaces with exception for acoustically non-important rooms (such as store rooms) and rooms where there are over-riding factors such as cleaning, infection control, patient safety, and clinical and maintenance requirements.2.106 Sound-absorbent treatment should be provided in all areas (including all corridors), except acoustically unimportant rooms (for example storerooms etc), where cleaning, infection-control, patient-safety, clinical and maintenance requirements allow. (underlined by me). 2.110 Acoustically-absorbent materials should have a minimum absorption area equivalent to a Class C absorber (as defined in BS EN ISO 11654:1997) covering at least 80% of the area of the floor, in addition to the absorption that may be provided by the building materials normally used. If a Class A or B absorbent material is used, less surface area is needed. (See Appendix B for an example of how to calculate the absorption area required for materials with different absorption class.) In rooms / corridors / streets provided with lay in grid tiles Clause 2.110 is achieved by the specification of tiles (Armstrong Bioguard Acoustic would suffice). However the following rooms may have solid plasterboard ceilings (which do not provide the sound-absorbent requirements as Clause 2.110) but due to infection control issues may not require additional absorption:

• Theatre suites
• Isolation rooms and lobbies
• Interventional Radiology / Cardiac Cath Lab
• Food preparation areas
• Decontamination suite
• Treatment rooms
• Plaster rooms
• DCFP
• Operating Theatres

• Anaesthetic Rooms
• Prep Rooms
• Scrub
• Interventional Radiology
• DCFP(We believe that this covers all clinical areas)

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

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RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
15/10/2014	*Rev 02 07/11/14 Helicopter Weights*	As/Hel/02

BCR Clause

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Derogation

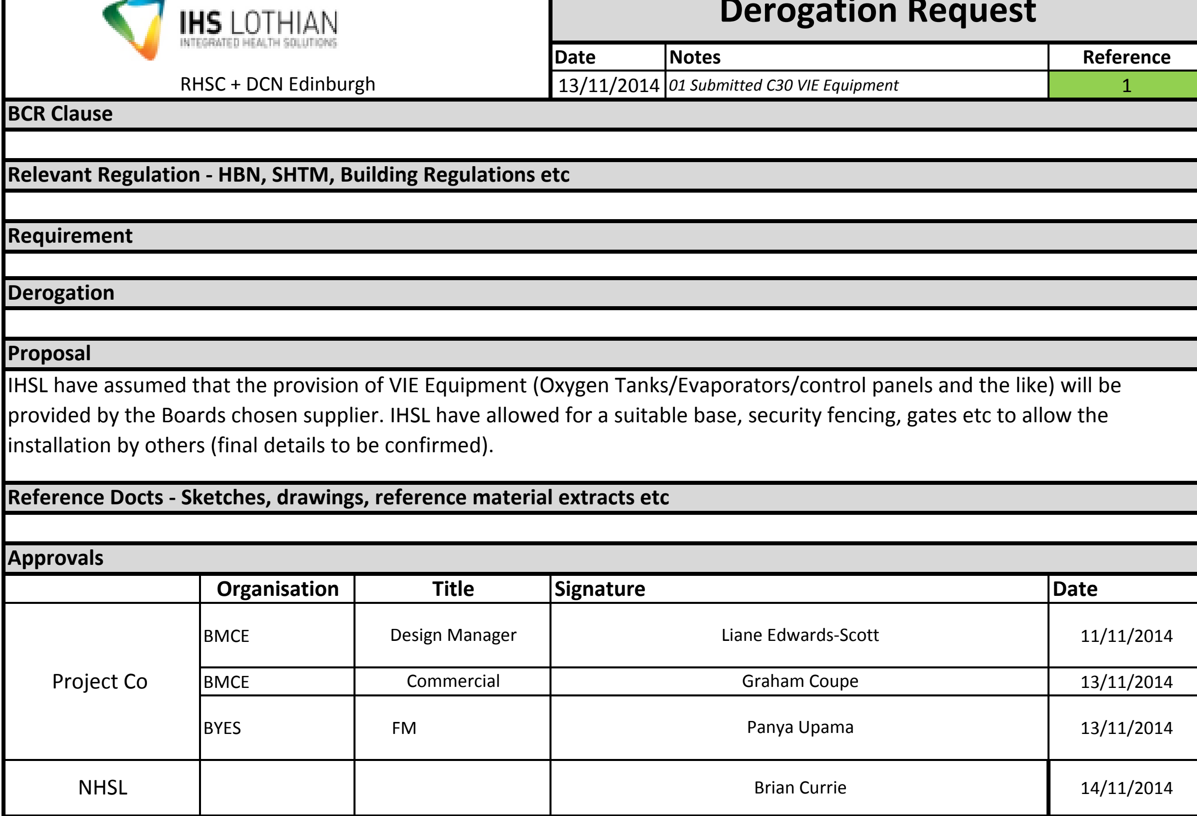
Proposal

As noted in PCP appendix A it has been established that the Sikorsky S92 does not have a current approved vertical procedure for operations in PC1 to allow it to operate from an elevated helipad. There are no initiatives to establish one. The design weight of the helicopter has been agreed as AW189 operating at a gross weight of 8.3t.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014



IHS LOTHIAN
INTEGRATED HEALTH SOLUTIONS

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
13/11/2014	*01 Submitted C30 VIE Equipment*	1

BCR Clause

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Derogation

Proposal

IHSL have assumed that the provision of VIE Equipment (Oxygen Tanks/Evaporators/control panels and the like) will be provided by the Boards chosen supplier. IHSL have allowed for a suitable base, security fencing, gates etc to allow the installation by others (final details to be confirmed).

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

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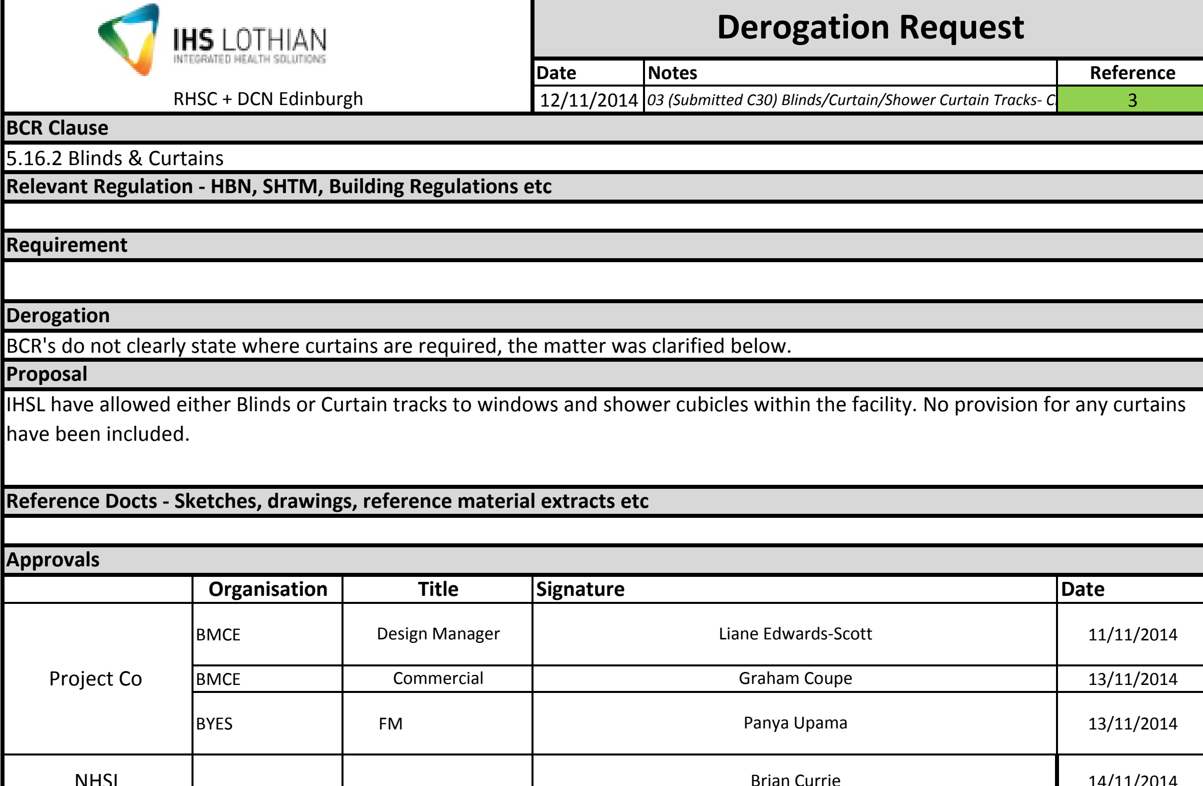

IHS LOTHIAN
INTEGRATED HEALTH SOLUTIONS

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
12/11/2014	*03 (Submitted C30) Blinds/Curtain/Shower Curtain Tracks- C*	3

BCR Clause

5.16.2 Blinds & Curtains

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Derogation

BCR's do not clearly state where curtains are required, the matter was clarified below.

Proposal

IHSL have allowed either Blinds or Curtain tracks to windows and shower cubicles within the facility. No provision for any curtains have been included.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

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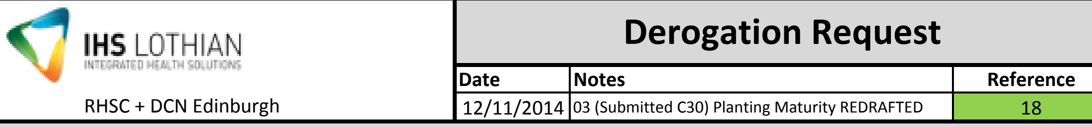


RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
12/11/2014	03 (Submitted C30) Planting Maturity REDRAFTED	18

BCR Clause

7.1 Landscaping Requirements

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

The soft landscaping shall be easy to maintain, and plants and shrubs shall reach a state of maturity within three years of Actual Completion Date.

Derogation

The Boards requirement that external planting should reach full maturity within 3 years of PC of the construction contract may not be achievable in all instances.

Proposal

Project Co shall continue to monitor against programme/planting season and advise the Board accordingly. Project co shall use reasonable endeavours to meet the requirements.

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
12/11/2014	01 (Submitted C30) 25% extra capacity	23

BCR Clause

8.7.10 Medical Gases, 8.7.13 Non-Medical Gases, 8.8.1 Main and Sub-Main Distribution, 8.8.2 Standby Generation, 8.13 Services Capacity Reserve, 8.14 Service Routes, 9.6.1 Cabling & 9.7 NHS Lothian Server and NHS Lothian Node Rooms

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Derogation

25% increased capacity for future services installations within services voids/ risers; this has been provided where possible but may not be available in all risers/ service voids due to the space constraints of the building footprint/ storey heights.

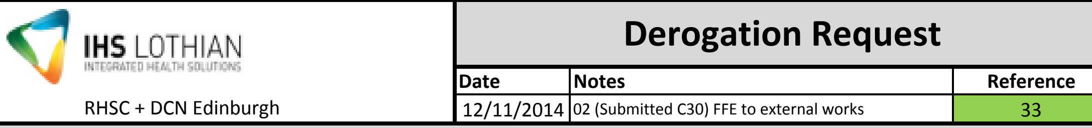
Proposal

Project Co shall continue to review during the RDD process in conjunction with the Board

Reference Docts - Sketches, drawings, reference material extracts etc

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014



RHSC + DCN Edinburgh

Derogation Request

Date	Notes	Reference
12/11/2014	02 (Submitted C30) FFE to external works	33

BCR Clause

7 External Works

Relevant Regulation - HBN, SHTM, Building Regulations etc

Requirement

Hard and soft landscaping - FF&E

Derogation

Cost allowances for external works FF&E

Proposal

FF&E to External Works - Project Co have indicated within the drawings / plans the position of FF&E within the external works. The specifications for the FF&E items will be within the cost allowances contained within the Cost Plan. For clarity, project Cowill provide the requisite external FF&E in the positions indicated on the drawings / plans but within the constraints of the cost allowances within the Cost Plan.

Reference Docts - Sketches, drawings, reference material extracts etc

HLM External Works Drawings - Hard & Soft Landscaping

Approvals

	Organisation	Title	Signature	Date
Project Co	BMCE	Design Manager	Liane Edwards-Scott	11/11/2014
	BMCE	Commercial	Graham Coupe	13/11/2014
	BYES	FM	Panya Upama	13/11/2014
NHSL			Brian Currie	14/11/2014

A42675936

SCOTTISH HOSPITALS INQUIRY

Witness Statement of

Peter Reekie

In response to Rule 8 Request dated 1 March 2022

28 April 2022

Professional background

1. My name is Peter Reekie. I am the Chief Executive Officer (**CEO**) of the Scottish Futures Trust (**SFT**). SFT is a company wholly owned by Scottish Government, working with organisations across the public and private sectors to plan infrastructure investment; innovate in the funding, financing and delivery of social and economic infrastructure; deliver major investment programmes and improve the management and effective use of existing assets.

2. I have held leading roles in SFT since its inception in 2008 initially as its first Director of Finance & Structures and then as Deputy CEO and Director of Investments from 2014. I have held the role of CEO since 10 January 2018. During the time of the pre-procurement phase of the Royal Hospital for Children and Young People (**RHCYP**) / Department of Clinical Neuroscience (**DCN**) Project (**Project**), that is the phase to which this witness statement relates, I was the Director of Finance & Structures and led SFT's work on the NPD Programme. Prior to my involvement in the Project and my role at SFT, I worked in an advisory role at PricewaterhouseCoopers (PwC), including acting as Financial Advisor on PPP hospital procurement. I worked at PwC for 9 years prior to joining SFT and prior to that worked in a civil engineering consultancy.

3. I have a Masters of Engineering Degree in Engineering Science and a Diploma in Organisational Leadership from the University of Oxford. I am a Fellow of the Institution of Civil Engineers and sit on SFT's Board.

4. SFT is an executive Non Departmental Public Body of the Scottish Government. It is a company limited by shares and wholly owned by the Scottish Ministers. Its activities are overseen by a board appointed by the Scottish Ministers. SFT was established by the Scottish Government in 2008. The Management Statement and Financial Memorandum dated 26 October 2009, agreed between Scottish Government and SFT, (Bundle 7, doc 1 p.9) provided that:

"The aim of the Scottish Futures Trust is to improve the efficiency and effectiveness of infrastructure investment in Scotland by working collaboratively with public bodies and commercial enterprises, leading to better value for money and providing the opportunity to maximise the investment in the fabric of Scotland and hence contribute to the Scottish Government's single overarching purpose to increase sustainable economic growth.

The SFT will act across all phases of the infrastructure investment cycle: needs identification, options investigation, investment appraisal, procurement, financing, design, construction, life cycle management / maintenance and disposal with a particular focus on planning financing and procurement."

SFT's activities are mainly funded by a grant from the Scottish Government.

5. Barry White was SFT's Chief Executive until December 2017, when I replaced him.

Summary of Role of SFT

6. A programme of investment using the non-profit distributing public private partnership model (**NPD model**) was introduced in the Scottish Government's draft 2011-12 budget (Bundle 7, doc 2 p.51) following recommendations of the Independent Budget Review group (**IBRG**). The IBRG was commissioned by the Scottish Government to inform decision-making in relation to the Scottish budget in the face of anticipated reductions in the available resources.

7. The IBRG report recommended:

- an enhanced role for SFT; and
- use of alternative financing models, including the NPD model.

8. Following the IBRG's recommendations, Scottish Government requested that SFT support the delivery of the £2.5bn revenue funded NPD Programme.

9. In leading the NPD programme, SFT performed two distinct roles: (i) a project assurance role; and (ii) a guidance and advice role.

10. These roles were performed at three distinct levels:

- Programme Level: Support to Scottish Ministers and to the Capital and Risk Division of Scottish Government at a strategic programme level;

- Portfolio Level: Support to sponsor departments in the delivery of revenue funded projects; and

- Project Level: Support to individual project teams.

11. SFT is also responsible for appointing the Public Interest Director to each project.

Overview

12. In this statement I will provide answers to questions posed in the Rule 8 request dated 1 March 2022, as follows:

1. SFT's Role - Governance and decision making;
2. Overview of SFT role in development/approval of Outline Business Cases (**OBC**);
3. Individuals from SFT involved in development of OBC;
4. Overview of Key Stage Review (**KSR**) process;
5. Site constraints and contractual dispute with Consort;
6. Switch to NPD Model;
7. Reference Design;
8. Design Assurance; and
9. NHS Design Assessment Process (**NDAP**).

SFT's Role - Governance and decision making

13. SFT was the NPD programme lead for the Scottish Government. The Project formed part of the NPD Programme. The SFT team for the Project was led by myself and at that time I reported to the then Chief Executive, Barry White, who was accountable to SFT's Board.

14. In terms of the governance between SFT and NHS Lothian, it was stated in the attachment to an email issued by Barry White to James Barbour, Chief Executive of NHS Lothian, on 22 July 2011 that SFT would perform a dual role in relation to the Project. SFT's note entitled, "*Role of SFT in Project Delivery – RHSC/ DCN Project*" dated 21 July 2011 states at paragraph 1.1(Bundle 7, doc 8 p.293):

"*Scottish Futures Trust has a dual role in relation to the Project. It has been established as a national centre of expertise in infrastructure procurement and it is in this role that SFT will seek to provide advice to NHS Lothian ('the Support Role'). This role is generally fulfilled through attendance at key project meetings as part of the governance*

process of the Project (we currently attend both the Working Group and Project Board), as well as ad hoc support on other tasks agreed with NHS Lothian.

It also has an oversight role for the Project in acting as a guardian of value for money for Scottish Government ('the Oversight Role'). This role is generally fulfilled through the carrying out of key stage reviews ('KSR') for the Project and by providing input to SG's Capital Investment Group when they are considering the approval of the Outline Business Case and Full Business Case for the Project. SFT also sits on the Infrastructure Investment Board (IIB), which has an oversight role over all infrastructure procurement in Scotland.

There are 4 KSRs being proposed for the Project and the objective of these reviews is to check that organisationally and commercially the Project is ready to progress to the next stage in the procurement process. These KSRs will take place pre OBC, pre OJEU, pre Invitation for Final Tenders and pre Financial Close. It is possible that any of these KSRs may indicate that certain identified issues should be addressed before the project can progress. Each KSR as a matter of course will be distributed to the Project Team and to the Capital Investment Group.

SFT's Oversight Role also extends to the terms of the standard NPD project agreement and the financing terms agreed with the preferred bidder. SFT will discuss with the project team any changes requested by bidders to the standard contract and indicate whether these are acceptable. With regard to the financing terms, we reserve the right to call for a debt funding competition during the preferred bidder period and would expect to approve the terms of the interest rate swap at financial close.

We expect that most of these matters, arising either from the Support Role or Oversight Role, are of sufficient importance to the Project that they would be resolved at project team level between NHS Lothian and SFT. This has certainly been our experience elsewhere. Where such agreement doesn't exist, a dialogue between the Chief Executives of SFT and NHS Lothian should take place to attempt to address any issues.

In the unlikely event that agreement on key issues cannot be reached then a three way discussion would take place between the Chief Executives of SFT and NHS Lothian and the Finance Director of NHS Scotland. Beyond that, referral to firstly the Infrastructure Investment Board and secondly Ministers remain as options should very significant issues remain unresolved.

The benefit of SFT's dual role is to reduce the chances of significant issues being raised during the approvals process or elsewhere and therefore reduce the chances of delay to the Project. We aim to undertake these roles as part of a cooperative and respectful relationship between SFT and NHS Lothian and in so doing improve the chances of a successful delivery of the Project."

SFT's role was also clearly set out in a number of additional documents, including:

(i) the letter from the Scottish Government to the NHS Health Board dated 22 March 2011; (Bundle 3, vol.2, doc 43(i), p.377)

(ii) the letter from me, on behalf of SFT, to Jackie Sansbury, of NHS Lothian, dated 1 June 2011; (Bundle 3, vol.2, doc 46, p.399);

(iii) the email exchange referred to in this paragraph above between Barry White (SFT Chief Executive) and James Barbour (Chief Executive of NHS Lothian) on 22 July 2011; (Bundle 7, doc 9 p.295);

(iv) the SFT note entitled "Role of SFT in Project Delivery – RHSC/DCN Project" dated 21 July 2011(Bundle 7, doc 8, p.293); and

(v) in the Revenue Funded Projects guidance. (Bundle 3, vol.2, doc 43, p.388)

I do not recall any stakeholders raising substantive concerns at the time about the dual roles performed by SFT. Similarly, I do not recall any stakeholders raising such concerns with Scottish Government, on whose behalf SFT was managing the NPD programme. SFT put in place an escalation route for NHS Lothian at an early stage in the process in relation to its dual roles. That escalation route is set out in the "*Role of SFT in Project Delivery – RHSC/DCN Project*" note dated 21 July 2011. I have no recollection of the escalation routes ever being used.

15. I have been asked to comment upon the Grant Thornton Report, at paragraph 315, (Bundle 3, vol.1, doc 2, p.63) which states:

"*Between 2010 and 2014 Scottish Futures Trust were represented on the NHS Lothian project board providing advice and supporting decision making. Alongside this role, they were providing independent assurance. Whilst each key stage report has a second reviewer, there may remain a potential conflict in fulfilling both roles*".

In response to this, I would refer you in general to the shared understanding of SFT's dual role established at the outset and set out above, and specifically for the KSR process, to SFT's guidance titled "*Project Assurance*" dated May 2013. This document sets out SFT's approach to resourcing of KSRs and preserving the integrity of the independent assurance. That document states as paragraph 7 (Bundle 7, doc 30, p.684);

"7. ***SFT Resourcing of KSRs***

As outlined above, KSRs provide a formal checklist for project teams to consider in relation to their project and also provide a benchmarking opportunity to test the readiness of projects in advance of key milestones in the procurement process. They are designed to require the reviewer, as well as the reviewee, to consider whether the project teams: a) have sufficient clarity over the requirements of the competitive dialogue process, b) have the necessary information and resources available for the tender process to be run efficiently and c) are satisfied that the project will produce a good

value for money outcome. In order to ensure a degree of separation between the immediate project team and project sponsoring department and to incorporate external commercial expertise, KSRs were traditionally undertaken by PUK based on the review of paper submissions completed by the project team.

Following its establishment in late 2008, SFT has grown into a fully resourced organisation and now directly employs a dedicated team with both commercial and technical expertise previously unavailable within the public sector. As a result the need to bring in external expertise (at additional cost) as part of the KSRs has disappeared and instead SFT resources KSRs by assembling a small team internally to undertake each review. These review teams normally consist of individuals not directly involved with the specific project. This approach ensures that KSRs are carried out with no external cost to SFT or the project sponsor. In addition, in line with SFT's evolving approach to supporting the revenue funded investment programme the approach to carrying out validation was remodelled during 2011 to remove the burden on project teams in providing additional background information together with completed KSR checklists to reviewers unfamiliar with the specific circumstances of each project. These KSR checklists are now completed by the relevant SFT staff member as part of his or her ongoing project support role. This reduces the overall delay impact of reviews and ensures that the review process is integrated into the overall project development. It also allows relevant aspects of the review to be considered on an ongoing basis. In order to preserve the integrity of independent assurance each KSR report is separately reviewed and signed off by a member of the SFT senior management team unconnected with the project. Consequently, the KSR pro-forma checklists have been updated and relevant guidance made available to project teams as well as SFT staff members undertaking KSRs.

The approach has now been fully operational for 12 months and feedback from project teams and sponsors has been entirely positive."

In my view there was no actual or potential conflict of interest arising from SFT's dual roles in the Project. For an actual or potential conflict of interest to arise, one must be

able to define and identify two separate interests that were or could potentially be seen to be in conflict with one another. SFT had a single interest in the Project, which was to maximise value for money and deliver a workable programme.

16. In general, the "support" element of SFT's role was more significant for the Project than for many others in the NPD programme, and I would point to three reasons for that.

    i) The Project was the first acute healthcare project in the NPD programme and, therefore, certain aspects such as the payment mechanism within the contract were being refined for the healthcare sector;

    ii) The site already identified for the Project overlapped the site of the existing Royal Infirmary of Edinburgh (**RIE**) which was a PFI project, and SFT's expertise in projects of that nature was used to support NHS Lothian in resolving those project-specific site issues (see paragraphs 54 to 70 (Site constraints and contractual dispute with Consort) below).

    iii) SFT set out in my letter to Jackie Sansbury of NHS Lothian of 1 June 2011 (Bundle 3, vol.2, doc 46, p.399) that we did not consider the project team for the Project to have "*sufficient experience of PPP project delivery*". We advised that the "*skills and experience of the Project Director and the wider project team are of vital importance in delivering the Project successfully. A key part of this is experience in delivering revenue funded projects, as this brings significant additional demands on the project team over and above those required on capitally funded construction projects*".

    In the short-term this led to the informal secondment of a member of SFT's team to support the project (paragraph 34 below) and in the longer-term, SFT provided more support on this Project than perhaps would otherwise have been the case.

Overview of SFT role in development/approval of the OBCs

17. For major capital projects, such as the building of a new hospital, organisations in the public sector require budget allocations in order to deliver the project and there must be governance around approvals to proceed. Accordingly, there has to be a governmental process of allocating those budgets and giving approvals. The central process of allocating budgets for major capital projects and governing approval to proceed is done through the business case process. Once the business cases are approved, the necessary budget will be allocated to undertake the project. Approvals are managed in stages with the OBC evaluating options and leading to an approval to proceed to procurement and the Full Business Case (**FBC**) setting out the finalised parameters of the investment leading to an approval to enter into a contract.

18. In my view, an OBC process falls into three phases: (i) development; (ii) evaluation; and (iii) approval.

19. SFT had a supporting role in the OBC process, providing comment to Scottish Government as part of the evaluation phase. This was set out by Scottish Government generically for all health NPD projects in the '*Scottish Government Funding Conditions for Delivering Projects through the Non Profit Distributing ("NPD") Model'*, issued to NHS Scotland Board Chief Executives and Directors of Finance, dated 22 March 2011 (Bundle 3, vol.2, doc 43, p.376).

20. The SFT's role during the OBC was clarified to NHS Lothian in a letter from me, on behalf of SFT, to Jackie Sansbury of NHS Lothian dated 1 June 2011, (Bundle 3, vol.2, doc 46, p.399), which confirmed that SFT would review and provide support to the Scottish Government's Capital Investment Group (**CIG**) in its evaluation of the OBC and that such comments would include whether, from SFT's perspective, there were any issues that should be rectified prior to the approval of the business case. This letter further confirmed that, ahead of the formal submission of the business case, SFT was willing to work with NHS Lothian in the development of those documents. SFT "*discussed the contents of this*

letter with the Scottish Government Health Directorate" as stated within that letter (page 1 of 10, para 1).

i) OBC Development

21. Part of our role was to help and support procuring authorities at the project level. In the development of the OBC, this help and support was given, in particular, with regards to NPD-specific elements. The main area in which SFT provided assistance was in the development of the shadow bid model, which is used to understand the affordability of the Project. That shadow bid model was an Excel-based financial model produced by NHS Lothian's Financial Advisors. It contained a number of financial assumptions and had to be structured in such a way as to make it as accurate as possible when calculating the shadow unitary charge, being the amount which the shadow bid model estimated that the procuring authority would pay each year for the hospital. The majority of SFT's work with NHS Lothian at that stage was to help them structure what, in the end, would be seen as an acceptable shadow bid model which would accurately represent the affordability of the NPD project. The shadow bid model included costs for the construction and operational phases and financing assumptions used to calculate the unitary charge, payable over the 25-year contract term. SFT, as managers of the NPD programme, particularly in relation to the financing aspects, provided NHS Lothian with some of those assumptions and provided some help in the approach to modelling. NHS Lothian would have then used its own financial advisors to utilise those assumptions to finalise its model.

22. Involvement of SFT team members during the development of the business case by NHS Lothian and its team was to provide early challenge and guidance with a view to streamlining the appraisal stage, in which increased re-work by NHS Lothian would have been likely to be required had SFT only become engaged at that later stage. The organisation with overall ownership of and responsibility for the business case was NHS Lothian, as the procuring authority.

ii) OBC Evaluation

23. Another part of SFT's role was to support the Scottish Government Health Directorate (**SGHD**) at the portfolio level. In respect of the OBC, this involved providing input on NPD-specific elements to the Scottish Government's evaluation of the OBC.

Mike Baxter (Deputy Director (Capital and Facilities), Directorate for Health, Finance and Information Scottish Government Health Directorate and the then chair of CIG), prepared a paper entitled, "*Scottish Government Governance arrangements for Royal Hospital for Sick Children / Department of Clinical Neurosciences (RHSC/DCN) – Outline Business Case*" dated 7 October 2011 (Bundle 7, doc 13, p.455). That paper set out the arrangements within Scottish Government for the evaluation of the OBC that was, at that time, being prepared for the Project and set out the interface with other organisations, including SFT, in that process. This document confirmed that SFT's response to the OBC would, in addition to feeding into the design review process, also cover the areas within SFT's remit within the context of both the 22 March 2011 and 1 June 2011 letters, noted at paragraphs 40 and 20 respectively. The design review process formed part of the OBC process in order to validate the capex cost of the Project which would be funded by Scottish Government.

24. Donna Stevenson (then Associate Director, now Senior Associate Director, of SFT) provided comments and appraisal on the OBC. This included the preparation of a list of issues (Bundle 7, doc 16, p.480) to be covered in SFT's comments on the OBC, which confirmed what SFT would do as part of the evaluation process.

25. Donna Stevenson also prepared a letter to be sent to Mike Baxter, in relation to the Project's OBC, ahead of the CIG's meeting of 31 January 2012 (Bundle 7, doc 19, p.493) (This letter contained SFT's comments and issues requiring clarification in relation to the OBC as submitted by NHS Lothian to SGHD on 22 December 2011).

26. That letter was circulated in draft to me on 24 January 2012, together with a paper entitled "*NHS Lothian, RHSC/DCN Project Outline Business Case Comments and Issues for Clarification*" (Bundle 7, doc 15, p.475). The letter set out SFT's comments and recommendations on the OBC. The accompanying note set out the comments and issues for clarification by NHS Lothian on the OBC.

27. The issues raised as part of that note fall under the following headings; (i) Negotiations with Consort; (ii) Project Review; (iii) Governance; (iv) Resourcing; (v) Unitary Charge; (vi) Letters of Support; (vii) Planning Permission in Principle; and (viii) Market Interest.

28. A member of SFT's staff, Colin Proctor, sat as a member of CIG, which led on the evaluation of the OBC on behalf of Scottish Ministers, and he fed his comments into the CIG evaluation process.

29. On 16 January 2012, Colin Proctor (as a member of CIG) provided comments on the OBC to Mike Baxter, SGHD by email (Bundle 7, doc 17, p.482). He attached a paper with NHS Lothian's comments and clarification requests in relation to the OBC, together with an updated action plan relating to SFT's project review, provided as Appendix 2 of the OBC (Bundle 7, doc 12 p.441). He also confirmed within that email that Donna Stevenson would be in touch to discuss SFT's written response commenting on the OBC, with particular reference to the draft 'Funding Conditions' in relation to the provision of revenue support for health NPD projects.

30. Donna Stevenson's input included liaising with Iain Graham (Bundle 7, doc 18 p.483), Director of Capital Planning and Projects at NHS Lothian, on a number of clarification points in relation to the OBC and liaising with both Kenneth Ngai, whose role at NHS Lothian I cannot recall, and Brian Currie, Project Director, at NHS Lothian.

31. On 8 March 2012, Donna Stevenson provided Brian Currie with an update in relation to the various clarification issues and noted where, in her view, there were no further updates required prior to OBC approval (Bundle 7, doc 23 p.534). On 9 February 2012,

she also provided Mike Baxter with a paper containing SFT's comments on NHS Lothian's comments and clarification requests in relation to the OBC (Bundle 7, docs 20 & 21, pp.515 & 520) .

iii) OBC Approval

32. SFT had no role in the approval of the OBC. The OBC required to be approved by both NHS Lothian prior to its submission, and ultimately the Scottish Ministers, to enable the project to proceed to the procurement stage.

33. I was asked whether or not I considered the business case process to be a collaborative process. The business case process can be described as collaborative, in the sense that each of the parties involved in the business case process (its preparation, appraisal and approval) was working with the others with the common purpose of progressing the Project. However, in my view, a collaborative activity involves the parties having a common interest and working hand-in hand on the specific task in which they are engaged, for example drafting a section of the business case or evaluating the case. In that way, I view NHS Lothian and its advisors as collaborating on the production of the business case, and SFT collaborating with Scottish Government on its appraisal. Scottish Ministers were responsible for approval of the OBC. However, as I have described, there was a close working relationship between SFT and the other parties, certainly with regards to NPD-specific elements of the OBC.

Individuals from SFT involved in development of OBC

34. At one stage during the project, Gordon Shirreff, a SFT employee, was briefly informally seconded to NHS Lothian on a part-time basis (in or around June 2011) to provide an additional resource with PPP procurement experience to NHS Lothian's team. Whilst on that secondment, he provided input as a member of the project team to the development of the OBC.

35. Gordon Shirreff acted under the direction of Brian Currie during the period of his informal secondment and any contributions provided by him to the management and administration of the project, in whatever form, were not in any way to be taken as the SFT view. This was acknowledged by Brian Currie of NHS Lothian in his email to Andrew Bruce, SFT, dated 24 June 2011 (Bundle 3, vol.2, doc 48, p.422). Gordon Shirreff was a member of the "*RHSC + DCN - Little France: Business Case Working Group*", during the short period whilst he was on informal secondment.

36. The SFT input into NHS Lothian's development of the OBC was carried out principally by Andrew Bruce and supported by Donna Stevenson. Andrew provided the financing assumptions for the shadow bid model as described at paragraph 21 above.

Overview of KSR process

37. At the time that the Project was procured, it was a condition of Scottish Government funding support that all projects in the NPD Programme were, in addition to any existing project approvals processes, externally validated by SFT. This was set out in the letter from the Scottish Government to NHS Board Chief Executives dated 22 March 2011 (Bundle 3, vol.2, doc 43(i), p.377).

38. SFT undertook that validation by carrying out KSRs of projects at key stages of the procurement. Please see document entitled, "*Validation of Revenue Funded Projects: The Key Stage Review Process Information Note to Projects*" dated December 2011. (Bundle 3, vol.2, doc 58, p.650) The KSR process was designed to support the successful delivery of revenue funded projects by providing an assessment of the readiness and application of best practice (including SFT Value for Money (**VfM**) guidance) of projects before they moved onto the next stage in the procurement process.

39. The KSR process was a tool for assessing a project's readiness to commence and

proceed through the various stages of procurement. It was also used to periodically verify compliance with or satisfaction of the conditions of Scottish Government revenue funding support, as contained in the OBC approval or funding award letter.

40. In the letter from the Scottish Government to the NHS Board Chief Executives dated 22 March 2011 titled, "*Scottish Government Funding Conditions for Delivering Projects Through the Non-Profit Distributing Model*", (Bundle 3, vol.2, doc 43(i), p.377), the NPD model is explained. Under the heading, "*Project Assurance*" it states:

"*Both the procuring body and the Scottish Government require assurance about the robustness of project management and the prospects for successful procurement, delivery and operating Key Stage Review provides a structured, independent "due diligence" review of projects, supporting Project Managers and Sponsors at commercially critical procurement stages. Key Stage Reviews help to ensure that procuring authorities are sufficiently advanced in their project development and have put in the place the necessary delivery arrangements and documentation in order to secure high quality sustainable bids. They also ensure that authorities are adequately resourced to effectively and efficiently carry out the procurement, construction and operational stages of the projects. Key Stage Reviews are a formal requirement for all projects delivered through the NPD model and will be conducted by SFT.*"

41. For NPD projects, the KSR process involved reviews at the following stages:

(i) Pre-issue of Official Journal of the European Union (**OJEU**) notice;

(ii) Pre-issue of Invitation to Participate in Dialogue (**ITPD**);

(iii) Pre-Close of Dialogue;

(iv) Pre-Preferred Bidder Appointment; and

(v) Pre-Financial Close

These were carried out by SFT in relation to the Project as follows:

Key Milestone	KSR	Date	Second Reviewer
Issue of OJEU Notice	Pre-OJEU Key Stage Review NPD KSR1 – Pre-OJEU	4 December 2012	Tony Rose
Issue of Invitation to Participate in Dialogue	Pre-ITPD Key Stage Review – Pre-ITPD KSR	7 March 2013	Tony Rose
Close of Dialogue	Pre- Close of Dialogue Key Stage Review NPD KSR 2 – Pre-CoD	11 December 2013	Tony Rose
Preferred Bidder Appointment	Pre-Preferred Bidder Appointment Key Stage Review	28 February 2014	Tony Rose
Financial Close	Pre-Financial Close Key Stage Review NPD KSR 4– Pre FC	11 February 2015	Colin Proctor

42. Each review was an assessment of whether the project was suitably developed in terms of "Project Readiness"; "Affordability"; "Value for Money"; and "Commercial robustness".

43. The KSRs were carried out at no cost to the procuring authority by the member of the SFT team who normally provided support to the Project (**Reviewer**).

44. The KSR process involved the assessment of the readiness of projects against a pro-forma list of questions at each key stage of the procurement. In the run up to each review point, the Reviewer considered the status of the Project against the relevant pro-forma list on the basis of information obtained in his/her day to day dealings with the project and sought, where required, contributions from the project team to allow completion of the list and prepare a written draft report with comments and recommendations.

45. The process of undertaking the KSR was designed to be the right balance of providing external assurance and minimising imposition on the project team to provide the evidence for the review. These sorts of reviews had been undertaken previously in PPP-type projects, where it had been the responsibility of the procuring authorities to complete a lot of the paperwork which provided evidence to the reviewers. SFT was trying to make that a lighter touch activity for the procuring authorities by requiring the SFT team member with the greatest knowledge of the Project to gather evidence from the project team and to complete the documentation alongside the procuring authority. The review was then done separately by a senior member of the SFT team who had not been involved in the Project (**Second Reviewer**). The alternative to that approach would have been to require the project team to collate evidence and complete the KSR documentation and it would then have gone to someone who was not involved in the project to review it. That would have placed more demand on time and resources of the project team who, in the best interests of the project, I thought were best dedicated to continuing to do their work rather than to complete KSR documentation.

46. Although there was no formal submission required from the procuring authority, the project team was required to provide the Reviewer with information to allow him/her to complete the list and compile his/her report. The Reviewer could also ask the project manager to specifically confirm certain points or that there were no outstanding issues that would impede the progress of the project to the next stage of the procurement process.

47. The Reviewer also prepared a short report and made recommendations as to whether in his or her view the Project was ready to proceed to the next stage of procurement and what actions were required to achieve the appropriate state of readiness either to proceed to the next stage or in advance of the next review.

48. Once completed by the Reviewer the draft report was scrutinised by a member of SFT's senior management team as Second Reviewer before being issued to the relevant Project Sponsor / Scottish Government and copied to the procuring authority. The relevant Project Sponsor and/or Scottish Government would, as part of its overall sign-off, determine whether and on what basis the Project should proceed to the next stage taking into consideration any recommendations made in the KSR report.

49. The precise timeframe for completing the review and submission of SFT's report was prepared with the Project Sponsor and/or Scottish Government to integrate with other project approvals processes.

50. The Reviewer for each of the 5 KSRs for the Project was Donna Stevenson. The Second Reviewer for each of the KSRs is noted in the table provided above at paragraph 41, being either Tony Rose, Director or Colin Proctor, Director.

51. The Second Reviewer was a senior member of the SFT management team who did not have a direct role in supporting the Project during the procurement. Their role was to review and challenge the contents of each KSR and sign it off before it was issued.

52. The dates of each of the 5 KSRs for the Project are noted in the table provided above at paragraph 41.

53. In summary, the key finding from each KSR was that the Project was ready to proceed to the next stage of the procurement, subject to the recommendations noted, which

required to be addressed by the Project Team within the timescales specified.

Site constraints and contractual dispute with Consort

54. SFT was not involved in identifying the site for the Project. The decision had already been made to build the RHCYP at Little France and NHS Lothian had already decided that the Project interacted with the redline boundary of the existing RIE hospital. It was clear from the Project Dashboard Report dated 12 November 2010 (Bundle 3, vol.1, doc 27, p.1102) that the issue of interface with the RIE project had been identified before the Project was included in the NPD programme, but SFT is not aware of when this identification occurred.

55. On 8th December 2010, immediately following the announcement that the Project was to be part of the NPD programme, SFT sent a letter to Iain Graham, (Bundle 3, vol.2, doc 31, p.108), which stated:

"*Interface with Existing PFI Contract*

We agreed that SFT would start to assemble some of the key issues associated with Consort and the existing PFI contract, for further discussion with the Health Board. We understand these to include resolution of a car park land swap, the potential removal of soft services from the contract, decisions with regard to any potential time extension to the contract and any reconfiguration of the contract required to accommodate the Project. All of these issues potentially do not require to be resolved ahead of the start of the procurement of the new contract, but as discussed, we firmly believe that the land swap does require early resolution and a full agreement with Consort should be pursued as a matter of priority. Proceeding to a procurement of the Project without full Health Board control of the land required could compromise the procurement, especially given the role of Consort as a potential bidder for the Project".

56. Given that the hospital was to be sited within the confines of land that had already been leased to a PFI contractor under the RIE's PFI contract, it was the view of SFT that NHS Lothian had to procure the necessary rights to enable the development of the RHCYP / DCN within that site, to connect into the existing RIE hospital and for all enabling works to be carried out before proceeding to procurement. This was to allow for open competition in the Project and to ensure there were no hold-ups either during or after procurement. Not least because the funders of the existing PFI Contract required to give their consent to a variation to that contract and the potential compromise to the procurement given the role of Consort, the PFI Contractor under the existing RIE PFI Contract, as a potential bidder for the project.

57. Whilst SFT did provide NHS Lothian with assistance with the development of a strategy to deal with Consort about the variation, the approach and negotiation were for NHS Lothian, which I believe were carried out by Susan Goldsmith. (Bundle 3, vol.1, doc 28(i), p.1111)

58. SFT advised NHS Lothian that the issues with the site should be resolved with the PFI Contractor, Consort, prior to the Project launching to procurement. The Scottish Government also advised NHS Lothian that the OBC could not be considered until the land transaction was concluded. (Bundle 3, vol.2, doc 39, p.354)

59. Ultimately, the procurement was launched prior to the issues being resolved on the condition that they would be resolved prior to the ITPD stage on the basis that giving clarity to the market that this would be the case would manage the impact on bidder confidence discussed above. The Pre-OJEU KSR confirmed that NHS Lothian should finalise the Supplemental Agreement for signing by NHS Lothian and Consort during December 2012.

60. It is my recollection that the Supplemental Agreement (**SA6)** negotiated between NHS Lothian and Consort (and its funders) reflecting all the amendments required to the

existing PFI Contract was signed prior to the issue of the ITPD. NHS Lothian should be able to confirm this.

61. The SA6 was a contract variation to the RIE PFI Contract which was required to enable the land to be released, enabling works to be completed and connection to be made to the building, to allow the Project to proceed. Whilst there were prolonged discussions and negotiations around the terms of SA6, including with the funders (as their consent was required), I was not aware of there being a formal dispute requiring resolution under the dispute resolution procedure within the existing RIE PFI Contract.

62. For clarity, the decision to build on the Little France site was made independent of the funding route. Accordingly, the necessary rights to the land required to be obtained regardless of the funding route.

63. I do not recall whether or not the time it took to negotiate the variation was ever on the critical path for the NPD delivery route programme, as the activity was undertaken in parallel with other project development and procurement activities, including the development of the reference design and the pre-qualification stage as noted above. It was certainly one of the time- critical activities being undertaken at that time.

64. Separately, the Project Dashboard Report dated 12 November 2010 (Bundle 3, vol.1, doc 27, p 1,104) suggests that the activity may have been on the critical path for the delivery of the RHCYP as a capital project, which was in development prior to November 2010. Reviewing that document, which I do not believe I have seen previously (prior to it being provided to me in Inquiry documentation), suggests that if all other activities under that delivery route had progressed as planned, resolving the SA6 with Consort would have led to a delay from the programme in place at that time. Negotiating the SA6 with Consort required substantial internal resource from NHS Lothian and input from its advisors. I cannot not say whether there was a wider cost impact on the Project.

65. I supported the negotiations with Consort's funders, whose consent was required in accordance with the RIE PFI Contract, in order for any variation to be effected. I know that, at one stage, I wrote a letter to at least one of the funders to try to assist to resolve this and I think I had conversations with at least one of the funders, but I do not recall any more than that. My colleague, Donna Stevenson, gave guidance with regard to the discussions with NHS Lothian and Consort, and also provided commercial support on the variations required to the existing RIE PFI Contract.

66. I have been asked if the Project was particularly complex. I believe any project to build an acute hospital is a particularly complex project. In my experience there are a number of factors which contribute to the complexity of a project including:

(i) Scale: – the scale of a project (generally measured as capital cost) affects its complexity, as larger projects require a greater volume of activity at all stages to be effectively coordinated. As a capital project, this Project was larger than most, but was not the largest acute hospital project in the NPD programme, and in other sectors, such as roads, there were other projects in the programme which were larger by some margin.

(ii) Sector: – some building sectors are generally accepted to imply more technical complexity than others. My view is that healthcare buildings are generally more technically complex than education buildings, which was the other main sub-sector of buildings in the NPD programme, and there are different but similarly significant complicating factors in roads projects.

(iii) Stakeholders: – the internal and external stakeholder environment in the procuring organisation affects complexity. In this case, NHS Lothian was a single and stable procuring organisation within a well-established overall set of organisational arrangements – the NHS – so not particularly complex. Internally, the stakeholder complexity would come from the number of clinical specialities to be dealt with. The Project was for a children’s hospital and DCN

rather than a general hospital, with a wide range of specialities meaning, I expect, that less interaction across different specialities and departments would have been required compared to some other healthcare projects.

(iv) Regulatory environment: - undertaking a project subject to external regulation adds complexity as there is a third party undertaking scrutiny and often providing opinion at key stages. Whilst the Project was delivered with the sector-specific standards and guidance, there was no external regulatory involvement.

(v) Location, Land and site constraints: – by the time of SFT's involvement, it had been decided to deliver the Project at Little France. As such, there was no need for a site search or acquisition of land in the market, which avoided a significant complexity faced by some projects. The Project was also undertaken on a single site which avoided the multiplication of issues across sites which adds complexity to some projects and was in a reasonably accessible location removing some logistic complexities. There was, however, a known interface with the RIE site and a relatively constrained operational site on which to deliver the Project, which added complexity.

(vi) Physical Interfaces: - the Project had a physical interface with the existing RIE building which added complexity compared to many other building projects, but did not present as many interfaces as say a roads project which requires linking into a wider network.

(vii) Planning: - I was not involved in town planning issues for the Project, but as it was delivered on a single site, which was already in use as a hospital by NHS Lothian, that does not seem to suggest comparative complexity with other projects.

(viii) Utilities: - in some projects, clearing utilities from the site, or getting required utilities to the site present very significant enabling projects in their own rights.

I was not close to the detail of utilities issues on the Project but was not aware of any that would be considered particularly out of the ordinary or complex.

(ix) Ground Conditions: - the ground conditions at the site can create additional complexity and I was not close to the detail of whether the Project faced any unusual complexity in that regard.

(x) Funding / commercial arrangements: - NPD and other forms of PPP funding arrangement involve contracting for a 25-30 year life cycle of an asset and for the provision of finance. This adds complexity to the technical work streams as the requirements for services over the life cycle require to be defined along with the requirements for the building itself. The legal and financial work streams are more complex as the NPD Project Agreement and associated documentation is more extensive than for a capital procurement and a financial model for the asset life cycle is required.

67. Overall, the Project was a major and complex project. It had a number of features that I felt generally added complexity, and every project has a unique combination of those characteristics. However, I did not consider that overall it was “particularly” complex.

68. As stated, the NPD structure did add complexity, but it was probably the simplest of a number of the options which were considered by NHS Lothian, given that the project was no longer able to be capitally funded. The options that NHS Lothian considered were summarised within paragraph 3 of the letter from SFT to Iain Graham of NHS Lothian dated 8 December 2010 (Bundle 3, vol.2, doc 31, p.109), as follows:

"Procurement Options

We discussed a number of options when we met:

3.1. Susan confirmed at the meeting that a capital funded route is not an option, given budgetary pressures.

3.2. *For the reasons we discussed (e.g. scope of the existing procurement and the nature of the project) incorporating the project within the South East hub is not an option.*

3.3. *You mentioned the possibility of retaining the existing PSCP for construction (with a revised scope to include the DCN), NHSL providing the lifecycle and ongoing maintenance and seeking to procure financing through an SPV (Option 6). As we said at the meeting, in order for the project not to be classified as a government asset (and hence count against the Scottish Government's capital budget) the requirements of European System of Accounts (ESA 95) need to be met. In short this involves the transfer of construction and one of demand or availability risk to the private sector. We do not see how this proposal would meet those tests, though if you wish to pursue this option we suggest that you take advice from your financial advisor.*

3.4. *Another proposed option was the retention of the existing PSCP for construction (with a revised scope to include the DCN) and the introduction of finance (Option 3) or finance and maintenance/operation (Option 4). We discussed this briefly and ruled both options out given the scope of the original OJEU for the Health Framework.*

3.5. *A further option concerned the retention of the existing PSCP for construction (with a revised scope to include the DCN) which you suggested would involve the PSCP being novated to an SPV which would contract with NHSL to provide the NPD DBFM solution (Option 5). In the first instance we agreed that NHSL would seek advice as to whether it would be legally possible and we attach at Annex 2, for discussion, our suggested questions for your legal advisers in that regard. Given the differences in the underlying construction contracts envisaged in the Health Framework and within an NPD contract structure, our strong view*

is that a further party would need to be introduced who would take on the risks associated with a D&B contract required for the NPD procurement and subcontract with the PSCP for the Health Framework construction contract (i.e. 'wrap' the Health Framework contract). Beyond the legal issues associated, we believe this could cause commercial issues in receiving strong value for money proposals from the private sector. We would be happy to discuss this further if appropriate.

3.6. There is the option of concluding the existing PSCP arrangements and tendering the RHSC/DCN project using a traditional NPD DBFM procurement route. (Option 1) In that case NHSL could provide bidders with an exemplar design to show the adjacencies etc which it has worked through internally including with clinicians to date. NHSL will want to be satisfied from its legal advisers that, as was indicated yesterday, the existing framework arrangements can be concluded without penalty, except for payment for work to date.

3.7. As discussed yesterday, Option 1 appears the most likely route, but the other options need to be further considered further, in consultation with legal advisers along with any options not currently listed. As discussed, this needs to be done as a matter of urgency such that a recommendation can be made to a Committee Meeting on 12th January 2011."

69. The options put forward by NHS Lothian were hybrid funding models, which were more complicated than the NPD model. The NPD model had been used previously and was familiar to the market. NPD shared similar characteristics to other PPP approaches. Paragraph 5.1 of SFT's document titled "*Revenue Financing Opportunities for Infrastructure Investment*" (Bundle 3, vol.1, doc 25, p.1,082 states);

"*Scotland has a long and successful history in the delivery of PPP healthcare projects, including acute; community; mental health and ACADs, 31 in total."*

70. There was an active and mature market for PPP healthcare and the NPD structure had been market tested in health via the Tayside Mental Health Development Project; and deliverability had been previously demonstrated for the wider PPP healthcare projects in Scotland.

Switch to NPD Model

71. A large part of the scope of what latterly became the Project, formerly the Royal Hospital for Sick Children, was under development as a capital project. It is my understanding that the Department for Clinical Neurosciences was under consideration as a separate capital project and others will be better placed to answer what its position in the capital programme was at that time.

72. I have been asked to explain why the change was made from a capital funded project to the NPD model and the driving factors behind the decision. The change was made in the context of the funding position at the time, as set out in Scotland's Spending Plans and Draft Budget 2011-2012 published by the Scottish Government in November 2010 ("**Draft Budget**"). (Bundle 7, doc 2 pp.55&89)That Draft Budget stated that:

"This is a Budget set against the most dramatic reduction in public spending imposed on Scotland by any UK Government. The Comprehensive Spending Review confirmed that the Scottish Budget will be cut by £1.3 billion next year compared to this. Within that, Scotland's revenue budget has been cut by more than £500 million and our capital budget, which is so vital to our efforts to support economic recovery, has been cut by around £800 million (or about 24 per cent in cash terms)."

It goes on to state that:

"[the] Budget also takes steps to leverage additional private sector investment to maintain levels of aggregate investment in the Scottish economy. In the absence of borrowing powers, the Scottish Government will work with the Scottish Futures Trust and local authorities to generate additional funding to support higher levels of capital investment than would be possible through the capital budget alone. In addition to the planned capital investments in 2011-12 and future years, the Scottish Government will use all available levers to: take forward a new pipeline of revenue financed investment, worth up to £2.5 billion, to be delivered through the Non Profit Distribution (NPD) model".

73. In the context of the July 2010 Independent Budget Review Group report (para 4 and 5) and the October 2010 UK Spending Review (para 70), SFT assisted the Scottish Government to identify priority projects which were suitable for procurement using the NPD revenue funded model. SFT provided potential options to the Scottish Government for revenue financed investment to deliver "*additionality*" over the capital budgets in October 2010 prior to the publication of the Draft Budget on 17 November 2010.

74. The "*CSR Options – Revenue Financed Investment*" document was drafted on or around 13 October 2010. (Bundle 3, vol.1, doc 24, p.1075). The "*Revenue Financing Opportunities for Infrastructure Investment*" document (Bundle 3, vol.1, doc 25, p.1,082) was provided to Scottish Ministers on 20 October 2010 which, amongst other sectors and projects, suggested four health capital plan projects that could be potentially suitable for revenue funding, which included the Project.

75. I assume that the Scottish Government's Capital and Risk division provided advice to Scottish Ministers relative to the change of the funding basis of the Project. I do not know whether any other party provided advice to the Scottish Ministers regarding this decision.

76. Each of the projects and programmes considered by SFT, including the Project, were evaluated at pace against a set of suitability criteria in assessing whether they were suitable for procurement under the NPD model. These criteria are reflected within

Appendix A of the Value for Money Assessment Guidance: Capital Programmes and Projects dated October 2011 (Bundle 7, doc 11 p.353) :

"

- *a major capital investment programme, requiring effective management of risks associated with construction and delivery;*
- *the private sector has the expertise to deliver and there is good reason to think it will offer value for money;*
- *there is significant constraint upon capital budget availability at either Government or Directorate level;*
- *proven track record in delivery;*
- *the structure of the service is appropriate, allowing the public sector to define its needs as service outputs;*
- *the nature of the assets and services identified as part of the projects are capable of being costed on a whole-of-life, long term basis;*
- *the value of the projects/programme is sufficiently large to ensure that procurement costs are not disproportionate;*
- *the technology and other aspects of the sector are stable, and not susceptible to fast paced change;*
- *planning horizons are long terms, with assets intended to be used over long periods into the future; and*
- *there are robust incentives on the private sector to perform."*

77. The NPD model had previously been used on the £95 million Tayside Mental Health Development Project, the first non-education PPP procured under the NPD model, which reached financial close in June 2010. SFT advised in the "*NPD – Way Forward*" document (Bundle 3, vol.1, doc 28(i), p.1,111) that the NPD project documentation had been used in the health sector at Tayside and that there should be consideration of any lessons learned from that use.

78. The NPD model is, in many ways, similar to other forms of revenue funded PPP projects of which there had been 31 in total at that time (including acute hospitals, community hospitals, mental health and ACADs). NHS Lothian was familiar with those other forms of PPP projects, including NHS Lothian's use of the Private Finance Initiative in respect of the design, build, finance and operation of the RIE PFI Project. The critical differences in NPD in comparison to other forms of PPP do not materially affect the specification of technical requirements (with which they will have been familiar given the RIE PFI).

79. As stated above, the private sector had proven expertise and track record in PPP and other NPD projects to deliver health projects and there was already an established portfolio of revenue-funded health projects in Scotland. In reviewing the suitability of the Project for the NPD model, SFT concluded that the Project met the criteria and was, therefore, suitable for procurement under the NPD model.

80. The decision that the Project should be included in the NPD programme was taken by the Scottish Ministers as part of Scotland's Spending Plans and Draft Budget. That document names the Royal Sick Children's Hospital and Department of Clinical Neurosciences in Edinburgh (c.£250 million) as one of the projects in the new pipeline of NPD investments to help support key projects across core public services. That document states that the "*new pipeline of NPD projects is being targeted to provide the maximum support for the wider capital programme and for Scotland's key public service*". It goes on to state: "*We will also ensure the delivery of a range of other health projects, including the Royal Sick Children's Hospital and Department of Clinical Neurosciences in Edinburgh through the NPD approach*."

81. Due to this unprecedented and significant cut in capital budgets, not all planned capitally funded projects would have been able to go ahead. It is far from clear whether the RHCYP project would have been able to go ahead as a capital funded project, far less the DCN, which was at an earlier stage of development.

82. The capital constraints were recognised by NHS Lothian, along with the fact that the Project could not go ahead under capital procurement. Susan Goldsmith (Director of Finance) acknowledged that at a meeting which SFT and NHS Lothian attended in early December 2010, as reflected within paragraph 3.1 of the letter from SFT to Iain Graham dated 8 December 2010, (Bundle 3, vol.2, doc 31, p.109), which stated: "*Susan confirmed at the meeting that a capital funded route is not an option, given budgetary pressures*".

83. NHS Lothian briefly considered a number of alternative suggestions but was aware that capital funding route was not an option, given budgetary pressures. For the reasons stated within the letter from SFT to Iain Graham dated 8 December 2010, referred to above at paragraph 68, it was considered that Option 1 (the NPD route) was the most likely route but that NHS Lothian should consult with their legal advisers on all of the routes discussed and any other potential routes as a matter of urgency so that a recommendation could be made to the Committee meeting on 12 January 2011.

84. The use of the NPD model as the only available option was also stressed by John Matheson, Head of Health Finance at the Scottish Government, at a meeting on 12 July 2011 attended by NHS Lothian, SGHD and SFT (Bundle 3, vol.2, doc 50, 434).

85. NHS Lothian noted at the meeting on 12 January 2011 (Bundle 3, vol.2, doc 34(i), p.315) that NPD had previously been used in the health sector in the Tayside Mental Health NPD project and the minute confirmed that "*dialogue was already underway with colleagues in NHS Tayside, in particular to highlight any lessons learned*".

86. I have been asked if NHS Lothian was consulted about the switch to NPD prior to decision being made. I do not have any recollection of SFT consulting with NHS Lothian in relation to this decision. SFT's advice to government was part of confidential advice in relation to a pre-budget consideration which stated that "*The paper is the work of Scottish Futures Trust alone and presents our views. It gives a high level view of opportunities from our perspective and does not include assessment of deliverability from*

officials with portfolio responsibilities'. (Bundle 3, vol.1, doc 25, p.1077) I do not know whether Scottish Government consulted with NHS Lothian.

87. I have been asked why NHS Lothian were not consulted on the switch to NPD and if this was unusual. As stated in paragraph 86 above, SFT did not consult with any of the projects which it identified as suitable for NPD, as we were working confidentially with the Scottish Government in relation to the development of the Draft Budget and were required to confirm to the Scottish Government what projects (across a range of sectors) may be suitable for delivery using the NPD model.

88. SFT was required to provide the Scottish Government with a rapid assessment and in that context, it was not possible for SFT to consult with all of the potential projects stated as being suitable regarding their potential to be taken forward as a revenue funded investment. I do not know whether Scottish Government consulted with NHS Lothian. If it was not discussed, then in a different set of circumstances, with more time available, I would perhaps have expected it to have been discussed with NHS Lothian by the Scottish Government prior to the announcement of the switch to NPD, although the processes around the confidentiality of budget announcements are a matter for Scottish Government.

89. At the time of the switch to NPD funding, the Project was re-scoped to include the DCN to deliver an integrated facility incorporating both the RHCYP and the DCN in one building to meet NHS Lothian's clinical requirements. (Bundle 3, vol.2, doc 31, p.108)

90. I have been asked, following the switch to NPD model, who was responsible for the decision to reincorporate the DCN. Whilst SFT identified within the "*Revenue Financing Opportunities for Infrastructure Investment*" document (Bundle 3, vol.1, doc 25, p.1,077) provided to Scottish Ministers on 20 October 2010, that it would seem appropriate to combine the RHCYP and DCN projects at the ERI site and to procure this as an individual NPD project, it was not SFT's decision whether or not the DCN should be incorporated into the Project.

91. SFT's letter to Iain Graham at NHS Lothian dated 8 December 2010, (Bundle 3, vol.2, doc 31, p.109), confirmed that NHS Lothian's preferred option for meeting its clinical requirements was an integrated facility incorporating both the RHCYP and the DCN in one building. In the minute of an NHS Lothian meeting on 12 January 2011 (Bundle 3, vol.2, doc 34(i), p.316) it stated that:

"*The Business Case for the DCN development, approved by the Board in the November 2009 recommended the preferred and best clinical option as a combined build with RHSC. This has been reaffirmed by the outcome of a non-financial benefits appraisal undertaken on 16th* December 2010".

92. This was also later noted by the Infrastructure Investment Board (**IIB**) at their meeting on 26 September 2011 (Bundle 3, vol.2, doc 54, p.484):

"the integrated project allows the generation of a number of physical and operational synergies that would not have been possible had the developments been taken forward separately (e.g. the ability to deliver paediatric and adult neurosurgery in the same theatre suite)".

93. I assumed that the decision was welcomed by NHS Lothian as the integration of the DCN was a preferred option put forward by them.

94. The switch to NPD funding also required a change in procurement approach for the Project. NHS Lothian had available frameworks for the delivery of capital projects, and I understand that they were utilising one of those frameworks to deliver the project as a capital build, or elements of what turned out to be the RHCYP project as a capital project. However, procurement of an NPD Project was not covered by these frameworks. It is not the custom and practice to procure NPD-type projects or other PPP-type projects, of that scale through framework arrangements. When the project switched to NPD, it had

to use the procurement route that is appropriate for NPD projects, which had previously been the 'negotiated procedure' under the European procurement directives. The 'competitive dialogue' procedure was introduced in 2006 and was regarded as the appropriate procurement route to procure a standalone NPD project of that scale.

95. Frameworks tend to be set up for types of procurement where an organisation or organisations are going to be buying multiple products / items that are broadly similar over a long period of time. Accordingly, every time you are looking for something new, you do not have to go to the whole market - you have a framework of people/firms and you can deal directly with those. If you are going to be buying broadly similar products / items over a three or four-year period of time, then it makes more sense for efficiency and effectiveness to pre-select a group of those people/firms within your framework. The drawback to this option is that you do not get access to everything that the whole market potentially has to offer for each and every project.

96. There were 10 NPD projects in the programme at the time. The nature of these projects was varied, for example, some were colleges, some were hospitals and some were roads. It is a different market for each of these different types of project. There are also different layers to NPD project provision, such as the facilities management, the contractor who will build it, and the special purpose company which will provide the equity and bring it all together. Ultimately, open procurement, through the EU competitive dialogue processes for each individual project in the programme, was considered to be the best way to deliver value for money.

97. I have been asked if the switch to NPD model resulted in delays to the Project. There was insufficient capital to complete the capital project at that time. I am unable to speculate as to if, or when, further capital would have become available and therefore when, or if, that project could have ever actually been completed due to the capital constraints. The switch to the NPD model gave the project a route to completion.

98. As noted at that time, there were still land issues that needed to be resolved between NHS Lothian and the PFI Contractor under the RIE PFI Project Agreement, regardless of the funding and procurement model.

99. Noting the substantial uncertainty around the delivery programme for the RHCYP project as a capital project, it was the case that the change in scope of the project discussed in paragraph 89 above and the change in procurement route, including the preparation of the reference design for the revised project scope discussed took time. The switch to NPD, therefore, led to a later completion date than that which was programmed for the RHCYP project as a capital project at the time of the switch.

100. I have been asked if the switch to NPD model resulted in increased costs for the Project. The scope of the Project changed with the inclusion of the DCN and so there would have been an increased cost. In addition, there were advisory costs associated with NPD procurement which in my experience are generally higher than advisory costs under capital procurement. There was an additional cost of financing the Project as a result of the NPD funding route and NPD includes costs for the whole lifecycle of the building including facilities management service. Setting the cost of finance, life-cycle and advisory element aside, it is not possible to say whether there were any “increased costs” in the capital build cost element of the project given that the scope changed.

101. I have been asked if the existing design work which had been completed by BAM was retained following the switch to NPD model. It is my understanding that elements were retained and taken forward as the reference design. This was a decision taken by NHS Lothian. This decision was addressed at NHS Lothian's Finance and Review Committee Meeting on 12 January 2011 (Bundle 3, vol.2, doc 35, p.323).

102. The committee was invited to "*Approve the continuation of Stage 3 of the BAM contract, under Frameworks Scotland, to develop the reference design for the joint facility for the Royal Hospital for Sick Children and Department of Clinical Neurosciences*".

103. In a later meeting of the RHCYP / DCN Project Working Group (Bundle 7, doc 5 p.283, Brian Currie advised that "*NHSL is making progress re the reference design. BAM had stated that using their existing design team to produce the reference design might preclude BAM from being a bidder. MacRoberts has advised that as long as the design team's work is strictly limited to the reference design this will not be an issue*." I understand that MacRoberts were legal advisers to NHS Lothian.

104. It was my understanding that NHS Lothian was keen to avoid losing the work that had been carried out to date on the capital project development by BAM and its design sub-contractors and to avoid any delay associated with re-procuring a separate design team.

105. I have been asked if the NPD model is still used for public sector capital projects. The NPD model is no longer used. It was developed to deliver additionality of capital investment capacity, i.e. in any year to deliver a value of new projects greater than the Scottish Government's overall capital budget. This additionality depends on the project being classified to the private sector under national accounting rules which followed European statistical guidelines. This meant that the Project could be paid for from revenue budgets over the 25-year life of the NPD contract, rather than capital budgets in the years in which it was built. These rules were set by Eurostat and changed from "ESA95" to "ESA10" in 2014. Following a detailed analysis of one of the NPD projects, Eurostat ruled that NPD projects should be classified to the public sector, meaning that capital budget would be required in the years in which they were built and they would, therefore, not meet the objective of delivering additional capital investment. No new projects were added to the NPD programme following that decision.

Reference Design

106. I have been asked to explain my understanding of the difference between an exemplar design and a reference design. I do not believe there to be prescriptive definitions of exemplar design and reference design, however in the context of the Project, I understand the term reference design was used to signify a more detailed stage in design development

than an exemplar design. The definition and the meaning that should be attached to those words will depend upon the status and definition they are given in the context of the whole procurement process and in the ITPD for any particular project.

107. In the context of the Project, it is noted from an extract of a draft NHS Lothian Committee paper from around February 2011 (Bundle 3, vol.2, doc 42, p.374) that there is a comparison table of the issues being considered comparing a traditional PPP procurement with a reference design approach. That table notes:

Traditional PPP procurement	**Reference Design**
Exemplar design undertaken by Board's technical advisers to Stage C – Concept Design	Detailed design work to Stage D – Design Development (or even into Stage E – Technical design).

108. On reading the above table, I agree with the premise that the level of pre-procurement design under the reference design approach was more detailed than had been the norm for previous generations of PPP building procurement.

109. SFT promoted the adoption of the reference design believing that it would reduce procurement timescales and procurement costs, particularly for bidders as it would reduce the need for multiple designs to be produced by multiple bidders during the bid period. It would also minimise the extent to which the clinical teams required to be involved with multiple bidders during the procurement as key aspects of the building lay-out, room adjacencies etc. were resolved in the reference design prior to the procurement phase. It had also been made clear through national accounting guidance issued by HM Treasury in September 2009 that the classification of the Project to the private sector, which was required to deliver additionality of investment, did not require the design risk

to be fully transferred to the private sector contractor. SFT considered that all of these benefits were of value and therefore promoted and supported the adoption of the reference design approach. This was set out in a letter I drafted to Iain Graham dated 8 December 2010, (Bundle 3, vol.2, doc 31, p.111), which states at paragraph 5.1:

"*Consideration will be needed at an early stage of how much the design should be progressed in-house and how much in competition through the NPD procurement. There is an opportunity with recent accounting rules changes to undertake more design especially overall massing, adjacencies and even layouts in-house; with the preferred bidder taking on detailed design for construction. Such a move will involve more design work ahead of the procurement, but is overall likely to save time to a start on site*."

110. Further comments on the reasons for adopting a reference design were included within the following documents:

- The Infrastructure Investment Board Paper: RHSC briefing for 26 September 2011, (Bundle 3, vol.2, doc 54, p.486), which states:

  "*NHS Lothian is developing a "reference design" for an integrated RHSC/DCN in order to facilitate a speedy delivery and minimise the up-front costs for bidders. This means that most of the design development (except in relation to mechanical and electrical design) will be done before the project enters procurement, rather than bidding contractors preparing detailed designs themselves. Although it potentially limits innovation, this approach should increase the attractiveness of the project to bidders and allow for a more certain overall cost for the project at Outline Business Case stage. As part of a 'needs not wants' challenge SFT is undertaking an independent review of the design*."

- NHS Lothian Paper for Project Steering Board Meeting titled "*RHSC + DCN Little France – Reference Design*" dated 11 May 2012 (Bundle 3, vol.2, doc 66, p.893):

  "*Discussion of Key Issues*

  3.1 The Reference Design has been concluded following the Project Steering Board's approval in July 2011 of the strategy for its development given the benefits arising. These remain as previously reported:

  - *Enhanced cost certainty at OBC*
  - *Clinical Design complete – very limited future engagement of scarce clinical resource*
  - *Shortens Competitive Dialogue Phase*
  - *Utilises available programme time – parallel with Consort Negotiations i.e. no overall delay to strategic programme*
  - *Minimises abortive design cost for unsuccessful bidders".*

- The Mott MacDonald report of May 2012 states at paragraph 2.1 (Bundle 3, vol.2, doc 68, p.909) that:

  "The benefits offered by the use of Reference Designs in NPD projects in the health sector are as follows:

  - *To give greater certainty in OBC costings;*
  - *Since Operational Functionality design risk sits with the Procuring Authority anyway, this can be developed by the Procuring Authority to inform the procurement process;*

- *To give greater certainty over final design – to reduce the risk of the Board ending up with a design it does not wholly favour;*
- *To avoid detailed input being required from Clinicians during the Competitive Dialogue process where the Clinicians would have to consider in detail, three solutions with three separate Bidders;*
- *Very limited engagement of a scarce clinical resource being required during the Competitive Dialogue process*
- *Capitalises use of available programme time. At RHSC + DCN, design development running parallel with Consort Negotiations i.e. no overall delay to strategic programme;*
- *Minimises abortive design cost for unsuccessful bidders; and,*
- *To streamline the NPD procurement process thus reducing the cost and programme to both the Procuring Authority and Bidders*."

111. I have been asked to describe the role of NHS Lothian with regards to the decision to adopt the reference design approach. I am of the view that NHS Lothian was in favour of the decision to adopt the reference design approach, given all of the previous design work that it had undertaken and invested in prior to the decision being made that the Project would be revenue funded. This is reflected in the NHS Board Meeting minute of 26 January 2011, (Bundle 3, vol.2 doc 38, p.351), which states under the heading "*Procurement Options*" that NHS Lothian had an objective, amongst others, to minimise both the delay to the programme and any abortive and on-going costs and that to achieve that, NHS Lothian's ideal "*being to have utilised the exiting design work completed to date, build on the market testing of packages already undertaken and construct the new building*".

112. I also note from an email exchange on 27 September 2011 to 22 October 2011 (Bundle 7, doc 10 p.299) between Victoria Bruce (Scottish Government), Andrew Bruce (SFT), Susan Goldsmith (NHS Lothian), Brian Currie (NHS Lothian), Jackie Sansbury (NHS Lothian) and Mike Baxter (Scottish Government) that the reference design also allowed the NHS to *"ensure that some of the investment in the detailed design for a standalone*

Children's hospital was not lost following the announcement that the project would be funded through NPD".

113. I believe that the Scottish Government was supportive of the decision to adopt the reference design approach. The reference design approach was discussed at the Scottish Government Infrastructure Investment Board meeting on 26 September 2011 (Bundle 3, vol.2, doc 54, p.484) and the Scottish Government knew it was happening and agreed to it in principle.

114. I am aware that Mott MacDonald were advisors to NHS Lothian, and that on the instruction of NHS Lothian, they prepared a report titled "*RHSC+DCN Approach to Reference Design*" (Bundle 3, vol.2 doc 68, p.898). However, I do not know what role was played by Mott MacDonald, if any, with regards to the decision to adopt the reference design approach.

115. I do not know what other parties, if any, were involved in the decision to adopt the reference design approach. However, the Minute of Meeting of NHS Lothian's Board for their Finance and Performance Review Committee dated 12 January 2011 (Bundle 3, vol.2, doc 34(i), p.314) reflects the fact that NHS Lothian was in discussion with its technical and legal teams in relation to the decision. I understand that NHS Lothian's legal advisors at the time were MacRoberts LLP, as mentioned in paragraph 103 above.

116. I have been asked as to my knowledge of when the decision to adopt the reference design approach was made. On 12 January 2011, a meeting of NHS Lothian's Finance & Performance Committee 2011 (Bundle 3, vol.2, doc 34(i), p.314) considered a paper drafted by the Director of Finance and the Chief Operating Officer, which invited the Committee to:

"*Approve progressing with a detailed reference design for a combined project as a key component of the NPD procurement route utilising either the current Framework*

Contract with BAM or by procuring the design team through the Office of Government Commerce (OGC) procurement solution."

It was also noted within that meeting paper that a "*recommendation based on legal advice for procuring the Reference Design will be available for Committee members at the meeting"*.

117. This reference to a recommendation to the Finance and Performance Committee appears to align in timing but not in relation to the decision making party with the statement at paragraph 105 of the Grant Thornton Report, (Bundle 3, vol.1, doc 2, p.43), which states:

"*105. In January 2011 it was decided by the Project Director and project board to use the completed early design work through the creation of a reference design. This was to recognise early work completed including involvement of clinicians in design and the costs NHS Lothian incurred between 2008 and 2010 on the project*."

118. The above referenced documents would suggest that NHS Lothian's Finance and Performance Committee was invited to take the decision. However, SFT does not have a Minute for that meeting so I cannot confirm whether the decision was taken by that body at that time. NHS Lothian made the decision to adopt the reference design approach, which was promoted by SFT and it is my understanding that it was supported by the Scottish Government.

119. The reference design approach was thereafter developed during the course of 2011 and 2012.

120. I have been asked to describe the role of healthcare planners in the development of the reference design. Other than what was included in the Mott MacDonald Report and the Grant Thornton Report, I do not know the extent to which, if at all, healthcare planners

were involved. I note that the Grant Thornton Report (Bundle 3, vol.1, doc 2, p.50) states;

"*173. Healthcare planners were commissioned by NHS Lothian in 2011 to support with the preparation of the COS.*

The remit was to review the COS's focused on ensuring that single clinical solutions were not presented in error, and incorrectly transferring risk to NHS Lothian which should rest as Project Co risk."

121. I further note that within the Mott MacDonald Report it states;

"*It is recognised that Bidders are likely to suggest revisiting the Reference Design during the Competitive Dialogue in order to differentiate themselves from other Bidders. NHSL will resist any such suggestions on the basis that the Reference Design represents the operational and clinical solution agreed by NHSL and Stakeholders. The absence of an external Healthcare Planner on NHSL's advisory team during procurement could be perceived as a risk. Given however the previous healthcare planning input to the project and NHSL's internal resource, this is deemed by NHSL to be a minor and manageable risk".*

122. On or around 26 May 2011, SFT raised a concern with NHS Lothian in relation to the reference design team arrangements. The concern related to bidders gaining a competitive advantage if members of the reference design team joined organisations bidding on the procurement. This is specifically set out in a letter from myself to Jackie Sansbury dated 01 June 2011, (Bundle 3, vol. 2, doc 46, p.406) in which I stated:

"*With regard to current advisory appointments we do not believe it is sensible to appoint advisors with significantly overlapping remits (as appears to be the case with regard to technical advisory appointments). Our experience is that this leads to excessive levels of*

advisory costs and more internal management time to handle this situation. We are also concerned that the architects employed to carry out the reference design for the Project are not restricted from working for one of the bidders once this stage is complete. This will make it difficult to create a level playing field amongst bidders for the Project, as at least the perception will be that whichever bidder employs this architect will be at a significant advantage. We would welcome a dialogue with you as to how these issues are resolved."

123. I have been asked about my understanding of "mandatory" and "non-mandatory" elements of a reference design. My understanding of the mandatory elements in the reference design is that bidders would be non-compliant if they did not include mandatory elements in their tender submission.

124. If the mandatory elements of a reference design are too detailed, it can stifle the ability of bidders to innovate. It is, therefore, important to strike a balance. If a design feature is specified as a mandatory element and a procuring authority expects to have that included in the final design, then it hampers the ability of the bidders to come up with different solutions which could potentially deliver better value for money and might create competitive advantage. For example, one architectural solution may include curved walls which could add cost to the building, whereas another may include straight walls, with both designs delivering the same '*Operational Functionality*'. Bidders should be free to determine their design solution to the greatest extent possible whilst meeting NHS Lothian's requirements for Operational Functionality. The different solutions offered would be evaluated through the competitive process. The process is designed to deliver the best solution through competition

125. In light of this it is important to understand what items were listed as mandatory within the reference design and the implications of being mandatory.

126. The Mott MacDonald report dated May 2012 set out to NHS Lothian how the former intended to develop the reference design work which would inform the ITPD instructions

to bidders. The Mott MacDonald "RHSC + DCN Approach to Reference Design" Report (Bundle 3, vol.2, doc 68, p.913) defined mandatory elements as follows:

"4.1 Reference Design Mandatory Elements

The Operational Functionality requirements for the RHSC + DCN will be outlined in the Clinical Output Specification, Schedule of Accommodation and the Adjacency Matrix.

The ITPD will state that it is mandatory that Bidders develop proposals that comply with the Operational Functionality solution as detailed in the Reference Design.

The Operational Functionality will be defined in the following constituents of the Reference Design:

- *1:500 Interdepartmental Layouts;*
- *1:200 Layouts; and*
- *1:50 Generic and Key Room layouts…"*

127. At the NHS Lothian Project Steering Board Meeting held on 11 May 2012 (Bundle 3, vol.2, doc 67, p.896), the Board was recommended to;

"2.1 Approve the implementation of the following as described in Section 7 Conclusions of the report "RHSC + DCN – Approach to Reference Design dated March 2012":

2.2 Mandatory Elements - comprising the information that defines Operational Functionality and as indicated in Interdepartmental Layouts (1:500), Departmental Layouts (1:200) and Room Layouts (1:50) for Key and Generic Rooms. As a consequence

of the particular project and site issues, departmental corridor layouts are also mandated as a result."

128. The Information Memorandum and Pre-Qualification Questionnaire issued to bidders stated at 1.6 and 3.2.1 (Bundle 7, doc 25 pp. 543 & 548) that:

"*The Board has, in conjunction with experienced private sector organisations, undertaken a significant amount of work to develop a reference design for the Project, parts of which will be mandated within the Invitation to Participate in Dialogue (ITPD).*"

…

"The Board welcomes and encourages Candidates to bring innovation, and expertise from within the UK and/or overseas to develop their own design proposals but it should be noted that elements of the design as they relate to operational functionality will be mandatory; as will be more fully set out in the ITPD."

129. In the draft ITPD Vol 1 (Bundle 3, vol.3, doc 74, p.178) (we have a copy of Rev K but not the final version of the ITPD), paragraph 2.5 states:

"*The mandatory elements of the Reference Design (the "Mandatory Reference Design Requirements") are those elements of the Reference Design relating to Operational Functionality. The agreed Operational Functionality is generally set out in the following constituents of the Reference Design:*

- *1:500 Departmental Adjacency Layouts;*
- *1:200 Departmental Layouts;*
- *1:50 Generic and Key Room Layouts*

…"

130. The mandatory elements of the reference design were therefore to be referred to those that defined "*Operational Functionality*". The definition of "*Operational Functionality*", related to spatial elements of the design as set out in paragraph 131 below, as opposed to any environmental or engineering aspects, such as ventilation.

131. The term "*Operational Functionality*" is a defined term within Schedule Part 1 of the Project Agreement and is as follows (Bundle 7, doc 26 p.589) :

"Operational Functionality"	means (a) the following matters as shown on the 1:500 scale development control plan and site plans; (i) the point of access to and within the Site and the Facilities; (ii) the relationship between one or more buildings that comprise the Facilities; and (iii) the adjacencies between different hospital departments within the Facilities, as indicated on the following drawings in Section 4 *(Project Co's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-Z0-00-PL-700-020 Rev 6; • HLM-SZ-B1-PL-400-400 Rev 2; • HLM-SZ-00-PL-400-400 Rev 3;

	• HLM-SZ-01-PL-400-400 Rev 2; • HLM-SZ-02-PL-400-400 Rev 2; • HLM-SZ-03-PL-400-400 Rev 2; • HLM-SZ-04-PL-400-400 Rev 2; (b) the following matters as shown on the 1:200 scale plans: (i) the points of access to and within the Site and the Facilities; (ii) the relationship between one or more buildings that comprise the Facilities; (iii) the adjacencies between different hospital departments within the Facilities; and (iv) the adjacencies between rooms within the hospital departments within the Facilities, as indicated on the following drawings in Section 4 *(Project Co's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-SZ-00-PL-220-001 Rev 6; • HLM-SZ-01-PL-220-001 Rev 6; • HLM–SZ–02–PL–220–001 Rev 6; • HLM-SZ-03-PL-220-001 Rev 6;

	• HLM-SZ-04-PL-220-001 Rev 6; • HLM-SZ-06-PL-240-001 Rev 5; • HLM-SZ-B1-PL-220-001 Rev 7; • HLM-Z5-SL-PL-220-001 Rev 6; (c) the quantity, description and areas (in square metres) and minimum critical dimensions of those rooms and spaces as indicated on the following drawings in Section 4 *(Project Co's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-SZ-00-PL-220-001 Rev 6; • HLM-SZ-01-PL-220-001 Rev 6; • HLM-SZ-02-PL-220-001 Rev 6; • HLM-SZ-03-PL-220-001 Rev 6; • HLM-SZ-04-PL-220-001 Rev 6; • HLM-SZ-06-PL-240-001 Rev 5; • HLM-SZ-B1-PL-220-001 Rev 7; • HLM-Z5-SL-PL-220-001 Rev 6; (d) the location and relationship of equipment, furniture, fittings and user terminals as shown on the 1:50 loaded room plans in respect of: (i) all bed and trolley positions;

	(ii) internal room elevations; (iii) actual ceiling layouts; (iv) the Non-Clinical Services supplies, storage, distribution and waste management spaces; and (v) the ICT requirements; (e) the location of and the inter-relationships between rooms within the departments within the Facilities, as indicated on the following drawings in Section 4 *(ProjectCo's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-SZ-00-PL-220-001 Rev 6; • HLM-SZ-01-PL-220-001 Rev 6; • HLM-SZ-02-PL-220-001 Rev 6; • HLM–SZ–03–PL–220–001 REV 6; • HLM-SZ-04-PL-220-001 Rev 6; • HLM-SZ-06-PL-240-001 Rev 5; • HLM-SZ-B1-PL-220-001 Rev 7; • HLM-Z5-SL-PL-220-001 Rev 6; but only insofar as each of the matters listed in (a) to (e) above relate to or affect Operational Use;

132. The Mott McDonald Report states (Bundle 3, vol.2, doc 68 pp.907-908) :

"1.2 *Definition of Functionality*

To date, reference has been made to Reference Design in relation to Clinical Functionality. The following note extracted from the Design Development Protocol indicates how this could lead to some confusion:

Clinical functionality refers to, and only to, the project's capacity for use by the Board or its staff for carrying out the trust's clinical functions and non-clinical functions. The Board's non-clinical functions are deemed to include all hard and soft Facilities Management services retained by the Board that are out-with the bidder's responsibility.

Since 'Clinical Functionality' refers to both clinical functions and nonclinical functions, we should refer to Operational Functionality as opposed to Clinical Functionality since some of the mandatory areas of the Reference Design will cover non-clinical functions. This is in line with the SFT Standard Form Project Agreement (NPD Model) where the reference is to Operational Functionality (See Appendix A) – largely because the standard form will also be adopted in non- healthcare projects. (Note that Operational Functionality is not defined in the Standard Form as noted in the extract in the SGHD Standard Form also indicated at Appendix A. This will need to be considered by the Procurement Workstream when developing the draft PA for inclusion in the ITPD.)."

133. For this Project, there were some additional elements of mandatory requirement in the reference design due to the particular site constraints and interfaces.

134. The NHS Lothian Paper for Project Steering Board Meeting titled "*RHSC + DCN Little France –Reference Design*" (Bundle 3, vol.2, doc 66, p.893) states:

"3*.3 The Project Steering Board are reminded that because of the particular and unique issues surrounding the development of this facility on this site, greater input and a more mature Reference Design has been necessary than may be the case in other Healthcare NPD projects.*

These issues include:

- *The connections required to the existing RIE building – predetermined by the location of the existing A&E department and Critical Care.*
- *The restricted nature of the site bounded on all sides as it is by existing road and services infrastructure and key access/egress points.*
- *Height and massing restrictions imposed by the local planning authority.*
- *Flood protection measures and Public Transport Infrastructure requirements.*
- *The site being part of an existing PFI / PPP site*
- *Interface and Access requirements with the existing RIE PFI service provider*".

135. Similarly, the Mott MacDonald Report states:

"The level of development of the Reference Design is predicated upon the definition of Operational Functionality defined in the Project Agreement. This is based on the Standard Form definition outlined in Appendix A. The constituents of the Reference Design are detailed in the matrix of Reference Design Deliverables at Appendix B. The level of development can be described as approximating the RIBA Plan of Work, Stage C – Concept Design (See Appendix C).

On the RHSC + DCN project greater input is required in the preparation of the Reference Design than would normally be the case. This is because of the particular and unique issues surrounding the development of this facility on this site. These issues include:

- *The connections required to the existing RIE building – predetermined by the location of the existing A&E department;*
- *The restricted nature of the site bounded on all sides as it is by existing road and services infrastructure;*
- *Height restrictions imposed by the local planning authority*
- *Flood protection measures required;*
- *The site being part of an existing PFI / PPP site; and*
- *Interfaces required with the existing RIE PFI service provider*

The requirement however to prepare and detail services interfaces, detailed site information, 1:50 layout drawings and attendant equipment requirements goes beyond the normal Stage C level of development thus the Reference Design should be described as being at RIBA Stage C+.

These issues have combined to make the development of the RHSC + DCN Reference Design considerably more complicated and resource intensive exercise than would normally be required in other NPD projects of this scale.

The Reference Design can be described as a graphic representation of NHSL's accepted design solution to the requirements of:

- *The Clinical Output Specification;*
- *The Board's Construction Requirements;*
- *The Soft FM Specification;*

- *The Schedule of Accommodation; and*
- *The Adjacency Matrix.*

To achieve this the 1:500 scale departmental adjacency layouts, the 1:200 scale department layouts and 1:50 scale generic and key room layouts were developed in conjunction with and signed-off by NHSL."

136. SFT raised issues in respect of the "mandatory" also known as "non-negotiable" elements of the reference design, which related to spatial considerations and building layout. SFT raised issues that could reflect on value for money considerations, consistent with SFT's role and interest in maximising the value for money of the Project. In an internal email from Donna Stevenson to Grant Robertson of SFT on 8 February 2011 (Bundle 7, doc 3 p.273), attaching the "*RHSC DCN Update extract Reference Design*" document (prepared by NHS Lothian), Donna stated;

"NHS Lothian have provided more information as to what it envisages in relation to its reference design (in a draft Committee paper upon which we were asked to comment). The relevant extracts are attached.

As you see the degree of prescription is greater than we have advised, though NHSL is saying the scope is to be finalised and Mike Baxter has issues on cost and timescale. There is a project specific issue concerning the interfaces with the existing RIE and the RIE PFI contract, which I will explain when we meet"

137. On 17 February 2012, as part of the OBC process, Donna Stevenson prepared a note (Bundle 7, doc 22 p.531) , which was shared with NHS Lothian on or around the same date, recommending that "*the Funding Conditions Template be completed to reflect the following recommendations so as to enable certain information to be completed and to set out issues which require to be delay with prior to the issue of OJEU, the ITPD documentation or on an ongoing basis as the case may be*".

138. Under the heading "Reference Design. Recommendation 4" Donna Stevenson's note stated:

"That the extent of negotiable and non-negotiable elements is developed by the Board on the basis that bidders should be provided with maximum flexibility to propose their own design and engineering solution, within defined parameters, and avoiding the need to open up the clinical adjacencies which has been settled with the Board's clinicians to date and reflecting the constraints in the site as reflected in SA6. The final position is to be reviewed by SFT as part of the Pre ITPD KSR".

139. On 26 April 2012, members of SFT met with NHS Lothian to discuss the Mott MacDonald Report "RHSC + DCN – Approach to Reference Design" dated March 2012 (Bundle 3, vol.2 doc 68, p.898), which had been instructed by NHS Lothian. In advance of that meeting, my colleague Donna Stevenson prepared a note of topics to be discussed and circulated those internally at SFT by email on 26 April 2012 (Bundle 3, vol.2, doc 65, p.889). That list included queries relative to the mandatory and non-mandatory aspects of the design. On 30 April 2012 Donna Stevenson emailed Brian Currie (Bundle 3, vol.2, doc 69, p.941) stating:

"Further to the useful meeting on reference design, as arranged, I note below the actions which we agreed.

1. You confirmed that bidders will be able to change the shape of the building eg to change curved walls or corridors to straight lines and that you will revise the paper and consider the wording to be included in the ITPD documentation to make this clear. You said that you would also look at my suggested wording in the IM/PQQ."

When Donna Stevenson references "*IM/PQQ*" above, she is referring to the "*Information Memorandum*" and the "*Pre-qualification Questionnaire*".

140. Donna Stevenson's comments in that regard were ultimately reflected in the Mott MacDonald Report, particularly at paragraph 4.1 (Bundle 3, vol.2, doc 68 p.913-914) which states;

"In *the ITPD, Bidders will be advised that features such as curved walls and the external landscaping forming part of the Reference Design are indicative only given that these have no influence on the Operational Functionality. Bidders will therefore be encouraged to apply a unique design strategy founded on sound architectural principles whilst complying with the mandatory elements of the Reference Design".*

141. On 4 December 2012, in the Pre-OJEU Key Stage Review "*Section 2: project Requirements*" number 7 (Bundle 7, doc 28 p.606) of the table states:

"SFT has raised issues as to the extent to which the Reference Design is to be mandatory and has commented on this issue in the context of the draft ITPD that clarity is required in relation to this issue.

The Funding Conditions provide that "the extent of negotiable and non- negotiable elements is developed by the Board on the basis that bidders should be provided with flexibility to propose their own design and engineering solution, within defined parameters, and avoiding the need to open up the clinical adjacencies which has been settled with the Board's clinicians to date and reflecting the constraints in the site as reflected in SA6. The final position is to be reviewed by SFT as part of the Pre ITPD SR." Accordingly the finalisation of this issue will be considered as part of the pre ITPD KSR."

142. On or around 11 February 2013 (Bundle 7, doc 4 p.275) , Donna Stevenson sent an email to Brian Currie, attaching "Volume 1 of the draft ITPD" upon which she had noted her comments. She highlighted SFT's key points in the body of the email, including comments on the reference design as follows:

"2. Reference Design: I raised again yesterday the issue which I had highlighted in my email of 25 October when I commented on the original draft, namely:

"...it would be useful to understand where the reformulation of the options available to bidders even in relation to items which are described as mandatory elements such as the layouts of the departments. The example which we gave when we met some months ago was the ability to make curved walls and corridors straight and in my email of 9 August we suggested "something along the lines of a statement that the Reference Design achieves the Operational Functionality required but the Board and that there has been full engagement with clinicians. While this represents the preferred layout, there is scope to change the layout provided the same [or an equivalent] Operational Functionality is achieved. The example of the non mandatory nature of the curved walls and corridors could be stated. Any changes would need to be evaluated by the team, including its members with clinical expertise, and the evaluation basis made clear."

143. This issue was addressed in the ITPD, as noted in SFT's KSRs.

144. SFT signed off the pre-ITPD KSR as it was comfortable with the position reached by NHS Lothian on the number of mandatory elements. My recollection is that initially NHS Lothian had wished the majority of the architectural design completed in the reference design phase to be mandatory, including elements such as curvature of particular elements of the building lay-out, which are a feature of a specific design solution rather than representing Operational Functionality. In the end, the definition of the spatial mandatory elements followed the definition of Operational Functionality, with which SFT was content.

145. SFT did not provide technical advice nor was it involved in technical decision making. The discussions SFT had with NHS Lothian as to the mandatory elements of reference design was in relation to those impacting on "*Operational Functionality*" i.e. the spatial elements as set out above.

146. In addition to the Operational Functionality definition of Mandatory Reference Design Requirements set out above, paragraph 2.5 of the draft ITPD (rev K) goes on to state (Bundle 7, doc 27 p.593):

"Other areas of Operational Functionality are contained in other deliverables within the Reference Design. Full details of the Mandatory Reference Design Requirements are set out in Appendix E (Reference Design Deliverables).

147. In the version of the ITPD (Rev K) that we have, the list of Deliverables in Appendix E that were stated to be mandatory included the environmental matrix even though it was not included within the definition of Operational Functionality.

148. The draft ITPD (Rev K) makes it clear that bidders were required to develop proposals which complied with the Mandatory Reference Design Requirements. It was the bidders' responsibility to satisfy themselves that the Mandatory Reference Design Requirements complied with the Board's Construction Requirements which included relevant technical standards:

"*Bidders are required to develop design proposals which comply with the Mandatory Reference Design Requirements.*

For the avoidance of doubt, the Board will not enter into any Dialogue on alternative solutions to the Mandatory Reference Design Requirements. Bidders proposals must be developed to reflect these Mandatory Reference Design Requirements and Bidders will be fully responsible for all elements of the design and construction of the Facilities including being responsible for verifying and satisfying themselves that the Mandatory Reference Design Requirements can be designed, built, and operated to meet the Board's Construction Requirements."

149. The Pre-ITPD KSR "*Validation of Revenue Funded Projects: NPD Programme Pre-ITPD Key Stage Review*" (Bundle 3, vol.2, doc 58, p.650) (Pre-ITPD KSR) re-iterates SFT's understanding of the approach to mandatory elements of the reference design being spatial elements relating to Operational Functionality:

"The ITPD, Volume 1 section 2.5 and Appendix E sets out the elements of the Reference Design which is being provided to bidders are mandatory. These relate to the Operational Functionality as defined in the Project Agreement and there are elements of flexibility in relation to non mandatory elements of the Reference Design."

150. The non-mandatory elements of the reference design were all of the design elements that were not specified as mandatory. The bidders could choose, subject to remaining compliant with the Board's construction requirements, whether or not they wished to include these elements within their Tender submission. The draft ITPD stated that the Board's Construction Requirements would always take precedence over the reference design for matters which do not define Operational Functionality.

151. The Mott MacDonald report states at paragraph 4.2 under the heading "*Non-mandatory elements of the Reference Design"*

"Outwith those mandated elements of the Reference Design, Bidders will have freedom to develop proposals constrained only by the requirements of the Board's Construction Requirements. Bidders will be positively encouraged to develop innovative solutions in those areas not prescribed by the Reference Design. Notwithstanding this, the information forming the Reference Design also includes elements that Bidders must address during the bidding process as follows.

As noted above, only certain elements of the information included in the Reference Design will be mandatory; those that define the Operational Functionality."

152. The draft ITPD refers to the non-mandatory elements as *"Indicative Elements of the Reference Design"* and section 2.6 of the ITPD states (Bundle 7, doc 27 p.595)::

"During the preparation of the Mandatory Reference Design Requirements, other information has been generated both as a by-product of preparing the Reference Design itself and as a general Project requirement as follows:

(i) FM goods handling and distribution;

(ii) Structural engineering solutions;

(iii) Building services engineering solutions;

(iv) Servicing strategies and space allocations; and

(v) Hard FM solutions and space allocations.

*This constitutes the "**Indicative Elements of the Reference Design**"*

Such information is issued to the Bidders for "information only" so that they may understand the intent of the Reference Design. Bidders must however refer to the Board's Construction Requirements for the detailed requirements for all such Indicative Elements of the Reference Design for which they will ultimately carry the risk. Bidders are advised that the Board's Construction Requirements will always take precedence over the Reference Design for matters which do not define Operational Functionality. The full distinction between Mandatory Reference Design Requirements and Indicative Elements of the Reference Design are set out in Appendix E (Reference Design Deliverables)."

153. At the NHS Lothian Project Steering Board Meeting held on 11 May 2012, (Bundle 3, vol.2 doc 66, p.893) the Board was recommended to note:

"2.3 Non Mandatory Elements - Information that has been developed to verify the feasibility of the Reference Design in terms of architecture and engineering and information developed for issue to Bidders in regard to site and servicing information".

154. I have been asked if the adoption of the reference design approach was unusual given the number of mandatory elements. SFT promoted the use of the reference design as part of the NPD programme and therefore did not deem the use of the reference design as unusual for the programme, although the difference from previous PPP projects is noted in paragraph 107.

155. I would say that the Operational Functionality and project specific spatial aspects of the reference design were reasonable to have as mandatory. Whilst I have not gone back to compare directly with other projects I have worked on, I would say that the number of mandatory elements would align with what was mandatory on other projects in the NPD programme, in my experience. However, it was unusual to have the environmental matrix included as a mandatory element (discussed paragraph 147 above), given that it was not within the definition of "Operational Functionality".

156. I believe that it is important to consider the extent to which anyone knew or understood at the time that the environmental / ventilation aspects had become mandatory. I think the process of having aspects in relation to Operational Functionality as mandatory was well understood. With regards to the environmental matrix, I think that is a different thing. I do not know what processes were in place to check that particular element. Although, ultimately, NHS Lothian and their advisors take responsibility for what was included within their ITPD.

Design Assurance

157. I have been asked to describe the role of SFT in respect of design assurance in the period up to the commencement of the procurement exercise. It is important to understand that design review is different to design assurance. The role that SFT played was not an

assurance role; it was not any form of assurance demonstrating that technically the design would work. The review was a value for money assessment of whether the amount of space looked right for the level of clinical activity required and whether the cost per square metre look reasonable. The end product of SFT's design review, prepared by Atkins on behalf of SFT, was not an assurance document.

158. As is stated under the "*Summary and Recommendations*" heading of the report prepared by Atkins dated 12 December 2011 (Bundle 3, vol.2, doc 57, p.571):

"*The purpose of this Independent Review was to assess the design brief for the project to replace the Royal Hospital for Sick Children and the Department of Clinical Neurosciences (RHSC/DCN) on the Little France site. The review assessed the capacity of the project to deliver value for money by meeting the strategic aims of the programme; by making best use of space and opportunities for maximising sharing with other assets; and by minimising the whole-life costs.*

The recommendations are intended to indicate actions which will help to de-risk the specification and the reference design as the project progresses towards OBC and the preparation of tender documentation and to improve value for money."

159. SFT drafted the standard form NPD contract and undertook a detailed process regarding derogations to the standard form, whereby SFT signed-off on the contractual amendments to ensure that the standard form contract was retained unless there were project specific reasons to derogate from that. SFT therefore had a ‘hands on’ approach with the contractual position relating to the standard form NPD contract. However, SFT did not, in any way, provide technical support in relation to the design and did not review, or input into, the technical parts of the ITPD and contract documents. It is my understanding that NHS Lothian had its own external advisers to advise on this. As stated in Donna Stevenson's email to Brian Currie of 30 April 2012: (Bundle 3, vol.2, doc 69, p.941)

"I attach the table of recommendations from the Project Review. As you will appreciate, SFT is not signing off on the design. Rather at the Pre ITPD KSR, we will look to the Board to confirm that it has taken account of and implemented the recommendations. Given that the reference design is now completed it would be useful at this stage if you could return the table confirming the implementation of the recommendations. "

160. SFT's design review formed part of the pre-ITPD KSR. I made Jackie Sansbury aware of this in a letter dated 01 June 2011 (Bundle 3, vol.2, doc 46, p.400), which stated:

"As *part of an updated Key Stage Review process, that will be applied uniformly on NPD projects in the health sector, we propose to engage in the ongoing design process of the Project to provide an independent review and challenge to the overall size of the facility and its specification on behalf of the ultimate funder of the project. To do this we are likely to employ an external adviser. This should provide independent validation of some of the key high level metrics of the proposed design and a valuable external benchmark on value for money*."

NHS Design Assessment Process (**NDAP**)

161. I have been asked if, to my knowledge, a NHS Design Assessment (NDAP) took place in respect of the Project. SFT's role was not associated with the NDAP process and comprised the design review process discussed in paragraphs 157 to 160 above as part of its role in assessing value for money in the NPD programme.

162. In respect of the Project, the design review which was prepared by Atkins on behalf of SFT was for the purpose of assessing and measuring value for money. SFT did not, as part of this design review, provide any input or views as to the technical accuracy of the design or the ability for it to be deliverable.

163. My colleague Donna Stevenson of SFT met with Health Facilities Scotland (**HFS**) and Architectural and Design Scotland (**A&DS**) in August 2011. The outcome from that meeting was that A&DS and HFS were to review the design review report prepared by Atkins and consider whether there were any gaps from that design review which still need be covered. On 28 December 2011, Donna Stevenson emailed Mike Baxter (Bundle 3, vol.2, doc 59, p.655) to advise that she did not know whether or not matters had developed with A&DS or HFS. She stated:

" *In August Colin, Viv and I met with Bettina and Heather of A&DS and Peter Henderson of HFS to discuss the relationship between the SFT design review and the input of A&DS and HFS to the project review. At the meeting we agreed that we would send A&DS and HFS the independent design review report once it was completed and they will consider the gaps which still need to be covered. At the time we sent on the remit of the review to Heather.*

In view of the time which has elapsed since then (as the costing information became available) I do not know whether matters have developed. Perhaps when you are back after the festive season you could let me know whether you wish me to send on the report or whether you wish to do so in the context of any other discussions which may have taken place."

Mike Baxter replied stating:

"*Thanks. I would suggest the report is sent on and that we convene a discussion early in the new year to ensure all review activity fits together. I was discussing this with Bettina last week and we will pick up in the new year.*

Mariane - Can you organise a meeting involving me, Bettina, Norman, Donna Stevenson, Pete Henderson (HFS) and Heather Chapple (A&DS) to discuss project reviews please."

164. I can see from a meeting diary invite with the subject "*Updated: RHSC/DCN Project SFT Design Review A&DS*", issued to Donna Stevenson, Peter Henderson (HFS), Norman Kinnear, Bettina Sizeland (A&DS), Heather Chapple (A&DS) and Andrew Bruce, that the meeting mentioned by Mike Baxter above was scheduled for 20 January 2012. Whilst I cannot locate any Minutes or notes of that meeting, it appears from the email correspondence that followed the week after, that the meeting did take place. On 27 January 2012, Peter Henderson of HFS sent an email to Donna Stevenson, (Bundle 3, vol.2, doc 62, p.880) referring to the meeting of the week before, attaching a document which contained HFS's comments on the Atkins Report. The majority of the comments suggest that HFS supported the conclusions of the Atkins report.

165. On 31 January 2012, in an email sent by Heather Chapple of A&DS to Donna Stevenson and Peter Henderson (HFS), (Bundle 3, vol.2, doc 62, p.880) A&DS provide its comments on the Atkins Report. The email goes on to state:

"We understand it is expected that the recommendations in relation to the reference design and the brief will be addressed by the Board prior to the ITPD. We would be happy to:

- *help the Board capture design quality standards to be incorporated into the brief*
- *and/or help the pre-ITPD KSR consider if the 'design' recommendations (16-19 & 20 'design shape' being those most within our area) have been addressed before the reference scheme and briefing documents are presented to bidders; and Pete has suggested that HFS can carry out a high level check of the reference scheme against guidance at this point if this is not being done out by others.*
- *help with evaluating the bidders' responses to the developed design brief: for our part in relation to the design quality standards etc & HFS could carry out a high level check against guidance if this is not being done out by others.*

Once NHSL come back with their response to the recommendations please let us know how/ when we can help move forward briefing for improvements and evaluating the design responses."

166. I have been asked to comment upon a document shown to me by the Inquiry. This is a meeting minute from a meeting of the "*RHSC & DCN Reference Design Team*" of 10 January 2012. (Bundle 3, vol.2, doc 60, p.667) SFT was not in attendance at that meeting. The minute notes at paragraph 7.05:

"*NDAP Review - MML confirmed that a meeting is scheduled to take place on 20th Jan between SFT/HfS/A&DS/Scottish Government. The outcome of this meeting will determine if the NDAP review is required for NPD contracts*".

167. As is noted above, it seems a meeting did take place between SFT, HFS, A&DS and the Scottish Government on 20 January 2012. However, I have not seen any documentation or subsequent correspondence to suggest that those at the meeting discussed the requirement of a NDAP review. I do not know whether an NDAP or any other design review was carried out by HFS and A&DS. If HFS and A&DS, or any other party, reached a decision that they did not require to do an NDAP or any other design review, this was a decision which was made independently of SFT and in relation to which SFT did not provide any input.

168. I have been asked to describe the role of NHS Lothian in respect of design assurance. NHS Lothian undertook the reference design with its advisors and the reference design formed part of the ITPD. It was their project and their reference design and I assume that NHS Lothian had internal assurance processes around the material that was to be included within the ITPD. I do not know what those NHS Lothian internal processes were.

169. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

SFT's Response to Questions contained within the "Procurement Paper".

10 August 2022

Q. 1. 2.1 Please confirm whether the guidance set out below was applicable to the procurement process of the RHSC/DCN provision project:

1. Treasury Green Book, 2003
2. Procurement Handbook and Scottish Procurement Policy Notes 2008
3. Scottish Capital Investment Manual SCIM 2009 with amendments including
    a. NPD Guide Section 1 of 4: Preparing for NPD Procurement
    b. NPD Guide: Section 2 of 4; From OJEU to Contract Award
    c. NPD Guide Section 3 of 4: Technical and Commercial Issues
    d. NPD Guide: Section 4 of 4; Plain English Guide to the Scottish Standard Form Project Agreement
    e. SCIM Supporting Guidance: Design Assessment in the Business Case Process (2011)
4. A policy on Design Quality for NHS Scotland, 2010
5. Scottish Government Construction Procurement Manual
6. Scottish Public Finance Manual, 2011
7. Scottish Futures Trust Key Stage Review Guidance
8. Scottish Futures Trust Value for Money (VfM) Assessment Guidance, 2011[1]
9. Scottish Futures Trust NPD Guidance Note on Approach to Tender Evaluation, 2013[2]
10. Policy on Sustainable Development for NHSScotland

SFT is only able to comment upon the relevant guidance as prepared by SFT. The guidance listed at 7, 8 and 9 above were prepared by SFT and were applicable to the procurement process of the RHSC/DCN provision project from their date of publication.

We wish to highlight that the guidance noted at 7 above should be titled, "*Validation of Revenue Funded Projects: The Key Stage Review Process Information Note to Projects*" dated from December 2011.

SFT is not able to comment on when the NPD Guide elements were included in the SCIM, and which elements of SCIM guidance were applicable at what time.

1b. Provide the name and where possible a copy of any other guidance applicable to the Procurement process for this project.

We refer the Inquiry to the NPD Guidance Inventory submitted by SFT in response to para. 6.1 of the Inquiry's First Request for Information. The additional applicable guidance notes contained within that Inventory are as follows:

1. Value for Money Supplementary Guidance for projects in £2.5bn Revenue Funded Investment Programme October 2011[3]

[1] SFT_00001222; SFT_00001223
[2] SFT_00001224
[3] SFT_00001222

2. Standard Project Agreements(hub DBFM & NPD Model) User's Guide June 2011[4]

3. Standard Project Agreements(hub DBFM & NPD Model) User's Guide June 2012[5]

4. Standard Form Project Agreement (NPD Model) 2 June 2012[6]

5. Standard Form Project Agreement (NPD Model) July 2011[7]

Q. 4.2 State your understanding of the role of the following organisations in the procurement process:

a. NHSL

NHSL was the contracting authority and had responsibility for the procurement of the RHCYP / DCN Project (the "Project").

b. SFT

Please see Peter Reekie's witness statement at para. 14.

SFT's note entitled, "*Role of SFT in Project Delivery – RHSC/ DCN Project*" dated 21 July 2011 states at para. 1.1[8]:

"*Scottish Futures Trust has a dual role in relation to the Project. It has been established as a national centre of expertise in infrastructure procurement and it is in this role that SFT will seek to provide advice to NHS Lothian ('the Support Role'). This role is generally fulfilled through attendance at key project meetings as part of the governance process of the Project (we currently attend both the Working Group and Project Board), as well as ad hoc support on other tasks agreed with NHS Lothian.*

It also has an oversight role for the Project in acting as a guardian of value for money for Scottish Government ('the Oversight Role'). This role is generally fulfilled through the carrying out of key stage reviews ('KSR') for the Project and by providing input to SG's Capital Investment Group when they are considering the approval of the Outline Business Case and Full Business Case for the Project. SFT also sits on the Infrastructure Investment Board (IIB), which has an oversight role over all infrastructure procurement in Scotland.

There are 4 KSRs being proposed for the Project and the objective of these reviews is to check that organisationally and commercially the Project is ready to progress to the next stage in the procurement process. These KSRs will take place pre OBC, pre OJEU, pre Invitation for Final Tenders and pre Financial Close. It is possible that any of these KSRs may indicate that certain identified issues should be addressed before the project can progress. Each KSR as a matter of course will be distributed to the Project Team and to the Capital Investment Group.

SFT's Oversight Role also extends to the terms of the standard NPD project agreement and the financing terms agreed with the preferred bidder. SFT will discuss with the project team any changes requested by bidders to the standard contract and indicate whether these are acceptable. With regard to the financing terms, we reserve the right to call for a debt funding competition during the preferred bidder period and would expect to approve the terms of the interest rate swap at financial close.

We expect that most of these matters, arising either from the Support Role or Oversight Role, are of sufficient importance to the Project that they would be resolved at project team level between NHS Lothian and SFT. This has certainly been our experience elsewhere. Where such agreement doesn't exist, a dialogue between the Chief Executives of SFT and NHS Lothian should take place to attempt to address any issues.

In the unlikely event that agreement on key issues cannot be reached then a three way discussion would take place between the Chief Executives of SFT and NHS Lothian and the Finance Director of NHS

[4] SFT_00001212
[5] SFT_00001213
[6] SFT_PPR_00000037
[7] SFT_00001214
[8] Bundle 7, doc 8 p.293

Scotland. Beyond that, referral to firstly the Infrastructure Investment Board and secondly Ministers remain as options should very significant issues remain unresolved.

The benefit of SFT's dual role is to reduce the chances of significant issues being raised during the approvals process or elsewhere and therefore reduce the chances of delay to the Project. We aim to undertake these roles as part of a cooperative and respectful relationship between SFT and NHS Lothian and in so doing improve the chances of a successful delivery of the Project."

Please also see para. 12.4 of the "SFT Role Note" produced by SFT in response to Request for Information Number 1, Para. 3.

c. Mott MacDonald

Mott MacDonald was the technical advisor to NHSL.

d. Scottish Government (including Capital Investment Group)

Scottish Government held a wide ranging role with ultimate responsibility for health services in Scotland, including funding and oversight. The Scottish Government was the funder of the RHCYP/ DCN Project and was the decision maker in relation to how the Project was to be funded and implemented.

Scottish Government also had an approval role as a condition of that funding, as set out in the SCIM. We refer the Inquiry to SCIM for the details of that role.

e. HFS

HFS was the Manager of Framework Scotland under which the project was being developed prior to the launch of the NPD programme. It was the NHS centre of expertise in relation to the technical aspects of healthcare facilities. HFS is a division of National Services Scotland.

Q. 4.3 With regard to the preparation of the Invitation to Participate in Dialogue (section 3.1)

a. Who advised NHSL on the how to set out the technical specifications for construction works? What reasons were given for this approach?

SFT's role did not involve any advice or support in relation to the technical specification for the construction works.

Q. b. What was the process for deciding the quality evaluation criteria weighting for the ITPD?

SFT's involvement in the decision regarding the quality evaluation criteria weighting can be summarised as follows:

- SFT produced programme level guidance in relation to the approach to tender evaluation including reference to a 60:40 price:quality split. That guidance, set out below, refers to the "shift in focus in the current economic climate" and places an emphasis on cost in alignment with Scottish Government requirement to demonstrate that cost was minimised within the agreed scope as set out in Conditions 1e and 5b of the funding conditions letter from Scottish Government to all NHS Board Chief Executives dated 22 March 2011.[9] The question of what criteria was to be used within the quality section of that evaluation was not a matter for SFT, that was a matter for NHSL;

- SFT's guidance informed discussions between NHSL, NHSL's advisors and SFT in relation to the RHCYP / DCN Project and the price/quality split in evaluating bids;

- NHSL, together with its advisors, proposed an approach to tender evaluations for the Project; and

- The ultimate decision around the quality evaluation criteria weighting was one for NHSL.

[9] Bundle 3 vol. 2, Doc 43(i), page 377

SFT produced guidance entitled, "*NPD Programme Guidance Note on Approach to Tender Evaluation January 2013*".[10] That guidance set out some key principles on tender evaluation, which SFT advised were to be adopted on NPD projects within the Scottish Government's £2.5bn revenue funded investment programme at that time.

That guidance contains a section, at para. 5, headed, "*Price/Quality*". That section states:

> *"The evaluation methodology needs to reflect an appropriate balance between the price and quality of bids. Procuring authorities should be mindful of the fact that, in contrast to previous revenue funded programmes, there is now more scope to manage the risk of poor quality proposals. The reasons for this include (i) use of exemplar / reference designs that give bidders greater clarity on the procuring authority's expectations (ii) a narrower range of FM services to be included in the projects and (iii) opportunity to use the competitive dialogue procedure to ensure that bidders develop proposals that meet the procuring authority's requirements. Combined with a shift in focus in the current financial climate to "needs" rather than "wants", and in order to capitalise on the opportunity in the current financial climate to take advantage of competitive pricing, this suggests that it is appropriate for price to carry a heavier emphasis than it perhaps has in the past.*
>
> *SFT requires that, in the absence of project-specific factors that might indicate otherwise, price carries a weighting of at least 60% and, correspondingly, that quality is weighted at no more than 40%. In developing a tender evaluation strategy it will be important to run sensitivities, based on likely bidding scenarios for the project. SFT will review each project's evaluation methodology to ensure that the mechanisms that are applied in scoring the individual elements of price and quality do not undermine the overall relative weightings that they carry.*
>
> *The appendix to this paper contains an outline strategy and sensitivity analysis that SFT considers relevant to projects in the NPD programme and which procuring authorities should refer to in developing the evaluation strategies for their particular projects…"*

Annex 1 of the guidance sets out the suggested outline strategy as follows:

Price 60% : Quality 40%	
Price Assessment	**Quality Assessment**
Maximum score – 100	Maximum score – 100
Lowest priced bid scores 100	10 criteria each scored out of 10 and weighted equally
Other bids score [100 – (a% x 100)] where "a" represents % difference between price and lowest price	Each bid scored out of 10 against each criteria and marks aggregated to award a score out of 100
Scores converted to scores out of 60	Scores converted to scores out of 40
Scores from price assessment and quality assessment combined to arrive at an overall score out of 100 for each bid	
Highest overall score out of 100 = winning bid	

As noted at para.3.1.9 of the Inquiry's Procurement Paper, NHSL, with assistance from its advisors at Ernst Young, prepared a paper in relation to the price / quality split as NHSL had concerns around the 60/40 price/quality split as recommended in the SFT guidance.

[10] SFT_00001224

In that regard, Brian Currie of NHSL emailed Donna Stevenson at SFT on 19 October 2012[11], attaching 3 papers relative to NHSL's view on the proposed weighting. That email stated:

> "*Following on from our conversation yesterday, I've attached a few documents relating to the development of our collective thinking around evaluation, all really stemming from NHSL's view of the 60/40 split.*
>
> *The first is a paper from Feb/March this year that was the first attempt to get thoughts down on paper on how this might work. This was the first time we'd formally looked at the ideas we subsequently adopted eg the use of pass/fail, including commercial evaluation entirely within price etc.*
>
> *This second one, from June, developed the thinking a bit further.*
>
> *The excel spreadsheet also attached can be used to calibrate the scoring applied to the price. The shape of the curve is set to the shape that we think may be appropriate, but isn't fixed - the final calibration is to be agreed.*
>
> *Hope this is helpful to assist in next week's discussions*."

Donna Stevenson replied to Brian Currie by email on 24 October 2012[12], which stated (amongst other matters):

> *" Cost v Quality evaluation*
>
> *Thank you for sending the previous EY papers by way of further background information to EY's most recent paper. We like to focus on compliance with the 60:40 ratio as well as ways of driving added value through the quality scoring mechanism, taking account of the mechanisms being proposed and the calibration of the price scoring. We could also touch on the evaluation of deliverability of financing and derogation from the standard project documentation."*

Accordingly, it is clear from the above emails that whilst it was part of SFT's role, as the NPD Programme manager, to provide this guidance at a programme level as to the price/quality split, the question of what criteria was to be used within the quality section of that evaluation was not a matter for SFT. In relation to the RHCYP / DCN Project, that was a matter for NHSL. The SFT guidance notes that weightings can be applied to reflect the procuring authority's priorities in relation to the various quality aspects of bidders' proposals

SFT's guidance also acknowledges that there may be project-specific factors that might indicate a different percentage split. Again, this would be a matter for the appropriate Board to demonstrate. In the case of the RHCYP / DCN Project, a matter for NHSL.

This quality scoring point is further emphasised in an internal email from Donna Stevenson to Kerry Alexander and Andrew Bruce on 2 November 2013, in relation to NHSL's position on the price / quality discussion. Donna states:

> *" A key issue is the quality evaluation but at the end of the day from our discussion on Thursday that is for NHSL to decide: I am proposing to test that they appreciate the ramifications. It would also be helpful if you can run some figures to check that the price evaluation is ok : our initial look suggested that it slightly elevated price's important as against that used in Glasgow college, for example?"*[13]

Ultimately, whilst NHSL noted its concerns in relation to the price / quality split, it appears from the Ernst & Young paper prepared on its behalf and from the ITPD that this split was, in fact, used. The precise breakdown and nature of that split was a matter for NHSL.

[11] SFT_PPR_00000021
[12] SFT_PPR_00000025
[13] SFT_PPR_00000030

c. NPD guidance suggests that "weightings can be applied to reflect the procuring authority's priorities in relation to the various other aspects of bidders' proposals." Was regard had to any further guidance on how priorities were to be determined for healthcare projects?

This is not a question SFT can answer.

d. Was the ITPD, including the tender evaluation criteria, reviewed from an infection control/design compliance perspective? If yes,

i. who conducted the review, what were their qualifications, and what was their input?

This is not a question SFT can answer.

ii. Is it expected that the quality evaluation criteria weighting would have any impact on bidders approach to developing their proposals?

Bidders can be expected in the first instance to seek to ensure that their tenders met the minimum (pass/ / fail) criteria and / or mandatory requirements, including compliance with technical standards as set out in the ITPD. Following compliance with mandatory requirements, bidders can be expected to scrutinise evaluation criteria and seek to focus resources in their tender on elements with high weightings, which represent the highest area of interest to the contracting authority.

Q. 4.4 With regards to the Pre-OJEU KSR (section 3.3)

a. How was the issue regarding interface/conflict with SFT's multiple roles addressed?

We refer the Inquiry to SFT's response to question 4.2 b above and to Peter Reekie's witness statement at paras. 14 and 15.

SFT's role clearly set out in a number of documents, including:

i. the letter from the Scottish Government to the NHS Health Board dated 22 March 2011[14];

ii. the letter from Peter Reekie on behalf of SFT, to Jackie Sansbury, of NHSL, dated 1 June 2011;[15]

iii. the email exchange between Barry White (SFT Chief Executive) and James Barbour (Chief Executive of NHSL) on 22 July 2011;[16]

iv. the SFT note entitled "Role of SFT in Project Delivery – RHSC/DCN Project" dated 21 July 2011[17]; and

v. in the Revenue Funded Projects guidance[18].

SFT does not recall any stakeholders raising substantive concerns at the time about the dual roles performed by SFT. Similarly, SFT does not recall any stakeholders raising such concerns with Scottish Government, on whose behalf SFT was managing the NPD programme. SFT put in place an escalation route for NHSL at an early stage in the process in relation to its dual roles. That escalation route is set out in the "*Role of SFT in Project Delivery – RHSC/DCN Project*" note dated 21 July 2011. SFT has no recollection of the escalation routes ever being used.

We also refer the Inquiry to the shared understanding of SFT's dual role established at the outset, and specifically for the KSR process, to SFT's guidance titled "*Project Assurance*" dated May 2013.

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[14] Bundle 3, vol.2, doc 43(i), p.377
[15] Bundle 3, vol.2, doc 46, p.399;
[16] SFT_PPR_00000012
[17] Bundle 7, doc 8, p.293
[18] Bundle 3, vol.2, doc 43, p.388

This document sets out SFT's approach to resourcing of KSRs and preserving the integrity of the independent assurance. That document states as para. 7[19] ;

"*7. SFT Resourcing of KSRs*

As outlined above, KSRs provide a formal checklist for project teams to consider in relation to their project and also provide a benchmarking opportunity to test the readiness of projects in advance of key milestones in the procurement process. They are designed to require the reviewer, as well as the reviewee, to consider whether the project teams: a) have sufficient clarity over the requirements of the competitive dialogue process, b) have the necessary information and resources available for the tender process to be run efficiently and c) are satisfied that the project will produce a good value for money outcome. In order to ensure a degree of separation between the immediate project team and project sponsoring department and to incorporate external commercial expertise, KSRs were traditionally undertaken by PUK based on the review of paper submissions completed by the project team.

Following its establishment in late 2008, SFT has grown into a fully resourced organisation and now directly employs a dedicated team with both commercial and technical expertise previously unavailable within the public sector. As a result the need to bring in external expertise (at additional cost) as part of the KSRs has disappeared and instead SFT resources KSRs by assembling a small team internally to undertake each review. These review teams normally consist of individuals not directly involved with the specific project. This approach ensures that KSRs are carried out with no external cost to SFT or the project sponsor. In addition, in line with SFT's evolving approach to supporting the revenue funded investment programme the approach to carrying out validation was remodelled during 2011 to remove the burden on project teams in providing additional background information together with completed KSR checklists to reviewers unfamiliar with the specific circumstances of each project. These KSR checklists are now completed by the relevant SFT staff member as part of his or her ongoing project support role. This reduces the overall delay impact of reviews and ensures that the review process is integrated into the overall project development. It also allows relevant aspects of the review to be considered on an ongoing basis. In order to preserve the integrity of independent assurance each KSR report is separately reviewed and signed off by a member of the SFT senior management team unconnected with the project. Consequently, the KSR pro-forma checklists have been updated and relevant guidance made available to project teams as well as SFT staff members undertaking KSRs.

The approach has now been fully operational for 12 months and feedback from project teams and sponsors has been entirely positive."

There was no actual or potential conflict of interest arising from SFT's dual roles in the Project. For an actual or potential conflict of interest to arise, one must be able to define and identify two separate interests that were or could potentially be seen to be in conflict with one another. SFT had a single interest in the Project, which was to maximise value for money and deliver a workable programme.

b. Was there a final policy position regarding Key Stage Reviews, Gateway Reviews and IIB reviews? If yes could you provide the final document/paper that clarified this position?

Please find enclosed IIB Meeting paper entitled, "INFRASTRUCTURE INVESTMENT BOARD, 24 May 2012, Simplifying The Project Assurance Landscape (Update)", which sets out the final policy position.

c. Is the Inquiry correct in its view that this KSR does not consider the project from an SHTM compliance, patient, safety or infection control perspective?

Yes, the Inquiry is correct.

Q.4.5 Was any Market Sounding done? If yes,

[19] Bundle 7, doc 30, p.684

SFT carried out programme level market sounding. NHSL undertook Project specific market sounding as described in Question 37 in the Pre-OJEU KSR. We would refer the Inquiry to NHSL for further details of the market sounding carried out by them.

What did this involve?

SFT's market sounding included speaking to market participants to gather insight as to whether there would be bidders for the projects and whether or not they would be bankable. The principal question of the market sounding was "is there a market for 25-year project finance" as that was anticipated to be the greatest challenge in the period following the global financial crisis.

In response to the following question noted within the Pre-OJEU KSR:

"Please describe any market testing activities that have been carried out to encourage interest in the project from potential bidders"

NHSL stated:

"*The Board has provided the following clarification on the OBC:*

"NHS Lothian's Project Director and Director of Capital Planning & Projects have responded to market interest in the project by meeting with representatives of firms potentially interested in bidding for the project.

These meetings commenced from shortly after the procurement route change and have continued to the current date. It is planned that these informal discussions will cease before publication of the OJEU notice.

There have been a variety of bid managers and similar coming forward and the Board representatives have received differing levels of assurance as to the respective corporate interest and depth of consortium members in the project - see abridged list attached.

It is clear from the meetings that initial concerns over a dominant bidder have been alleviated, subject to this being borne out through procurement contract documentation.

Similarly all the interested parties have indicated high level engagement with SFT regarding the project as part of the NPD programme. NHS Lothian has not been represented at SFT meetings, but the project working group has received feedback from SFT consistent with our informal discussions.

The abridged list attached has been produced for the sole purpose of CIG consideration of the Outline Business Case and should not be more widely distributed.

The Board at this time cannot confirm that there will be multiple bidders as that will be dependant on a positive response from the market to the project."

NHSL subsequently advised that

The Project Director and Director of Capital Planning & Projects and / or Associate Director of Finance have met with the following parties (listed alphabetically) to maximise their knowledge of the project, pre-procurement, and to elicit the levels of interest forthcoming. Where a consortium has been identified, this is shown as a single entry.
All have demonstrated a track record in major UK healthcare/ PFI / PPP projects, except FCC whose experience is international.

1. *BAM / Balfour Beatty*
2. *Bouygues*
3. *Brookfield*
4. *Carillion*
5. *FCC*
6. *John Laing Investments / Laing O Rourke*
7. *Skanska/ Miller*

More recently, Carillion advised that it did not intend to bid and the Board considers that Bouygues and FCC are not likely to proceed".

a. What was the result?

The market sounding exercise was completed during the OBC phase. The Full Risk Register documented against Risk numbers 1[20] (Sufficient Market Interest) and 2 (Limited availability of investment for NPD) that a market testing exercise had been completed showing extensive market interest.

b. If the answer to the above question is no, then why was market sounding not done?

N/A

Q. 4.6 With regard to the PQQ evaluation (section 3.9)

a. Was the PQQ evaluation process shortened and what impact did that have?

Project Steering Board Minutes of 25 January 2013 under the heading "PQQ Returns – three received" states:

"*PR asked that where possible the programme to recommend bidders is accelerated given three PQQ's obtained. BC replied that due and proper process is upper most in the evaluation team's mind and that a detailed programme of evaluation activities has been agreed which may prove difficult to re organise at short notice. However, the intention is to make final recommendation to next P St Bd on the 22nd February, some 7 business days ahead of current programme. A subsequent extraordinary F+R Meeting may be required to be called to authorise progression to dialogue – SG to advise. 11th March commencement of dialogue remains target.*"

b. Three PQQ responses is a relatively low number of responses to receive which prompted Peter Reekie's question around the possibility of shortening the evaluation programme. Without sight of all the contemporary project management documentation, SFT is not in a position to say whether the evaluation process was shortened or from what baseline that question would be measured. Was any significance attributed to IHSL's designated organisation, Wallace Whitte, having no health PPP experience? Is this usual for a hospital re-provision project?

This is not a question SFT can answer.

Q.4.7 With regard to Key Stage Review 2a: Pre-invitation to participate in dialogue (section 3.10)

a. Was SFT satisfied that the ITPD clearly reflected the mandatory and non-mandatory elements of the reference design, as well as the concept of Operational Functionality?

We refer the Inquiry to Peter Reekie's witness statement, paras. 106 to 156, which provides full details of SFT's view of the use of the reference design and the development of the mandatory and non-mandatory elements of the design, as well as the concept of Operational Functionality.

b. Is the Inquiry correct in its view that this KSR does not consider the project from an SHTM compliance, patient safety or infection control perspective?

Yes.

[20] SFT_7.1_00000498 Risk Registered attached to Agenda for Project Steering Board Friday 21 November 2014.

Q.4.8 With regard to the Invitation to Participate in Dialogue (section 3.11)

a. Was volume 4 of the ITPD produced?

This is not a question SFT can answer.

b. Could you confirm or provide the final version of the ITPD issued to bidders?

This is not a question SFT can answer.

Q 4.9 With regard to competitive dialogue (section 3.12)

a. Was the timetable for competitive dialogue considered ambitious and/ or adequate?

SFT's response to the question at 4.9 b below covers this question in so far as SFT can address it.

We would also refer the Inquiry to the Project Board Action Notes of Meeting of 13 May 2011 entitled, " RHSC + DCN – Little France – PROJECT BOARD #2", which states:

"*A "Dashboard" Report was tabled and the following views expressed and actions agreed regarding proposed strategic programme dates:*

As presented the programme is unacceptable to NHSL, SFT and SGHD given the estimated slippage in operational date from the previous Treasury funded project.

Need for Town Planning Pre Application Consultation Period to be challenged by NHSL. BC to write formally to CEC Planning.

"Land Transfer Agreement" to be known as "Conclusion of SA6 and Key Requirements with Consort Healthcare" and moved forward to June 2011. Action by BC.

Mike Baxter confirmed that issue of PQQ can commence on NHSL Board Approval of OBC. Action – BC.

Reference Design Phase whilst already reduced to two rounds of clinical interface at each design stage is to be reviewed again with a view to shortening it as far as is practically possible. Action – BC

SFT and SGHD expressed a strong view that the period indicated for "Competitive Dialogue" did not reflect the production of a reference design and was based on an exemplar design. This period, in their view, needs review with a considerable reduction in duration likely. Action – BC

SFT and SGHD also commented that the period from "Selected Bidder" to Financial Close" was also too long and there is gain considerable scope for reduction. _ Action – BC.

Both SFT and SGHD are to review and provide feedback on the NPD activities and timelines tabled. Action – MB, DS + AB

The actual construction duration time requires review and previous advice given by BAM Construction challenged. Action – BC.

It was agreed that in order to progress an amended programme asap a meeting should be arranged with NHSL their Technical Advisors and SFT / SGHD. Action – BC"

Accordingly, it is clear from the above that the programme in circulation at that time was unacceptable to SFT, NHSL and Scottish Government. All parties were keen to reduce timescales where possible, without impacting the effectiveness of the process.

In response to those concerns, SFT suggested areas where NHSL could look to shorten the programme, which included shortening the period for Competitive Dialogue.

It was important that the programme worked (i.e. was adequate) and also that it was ambitious, given shared view at the time that it was unacceptable and should be compressed as much as possible.

b. What advice or input did NHSL receive regarding the programme for Competitive Dialogue and from whom?

SFT is only able to comment upon any advice and support provided to NHSL by SFT in relation to the programme for Competitive Dialogue. It will be a matter for NHSL to advise as to what other advice, if any, it received from other parties and what that advice was.

We would highlight the following documents / points to the Inquiry:

i. The Minutes of the "RHSC + DCN – Little France – PROJECT BOARD" meeting of 13 May, 2011 state:

> *"Mike Baxter confirmed that issue of PQQ can commence on NHSL Board Approval of OBC. Action – BC.*
>
> *Reference Design Phase whilst already reduced to two rounds of clinical interface at each design stage is to be reviewed again with a view to shortening it as far as is practically possible. Action – BC*
>
> *SFT and SGHD expressed a strong view that the period indicated for "Competitive Dialogue" did not reflect the production of a reference design and was based on an exemplar design. This period, in their view, needs review with a considerable reduction in duration likely. Action – BC*
>
> *SFT and SGHD also commented that the period from "Selected Bidder" to Financial Close" was also too long and there is gain considerable scope for reduction. _ Action – BC.*
>
> *Both SFT and SGHD are to review and provide feedback on the NPD activities and timelines tabled. Action – MB, DS + AB*
>
> *The actual construction duration time requires review and previous advice given by BAM Construction challenged. Action – BC.*
>
> *It was agreed that in order to progress an amended programme asap a meeting should be arranged with NHSL their Technical Advisors and SFT / SGHD. Action - BC"*

ii. At one stage during the project, Gordon Shirreff, a SFT employee, was briefly informally seconded to NHSL on a part-time basis (in or around June 2011) to provide an additional resource with PPP procurement experience to NHSL's team.

As part of that role, Gordon Shirreff prepared a "Procurement Paper" in June 2011. That paper covered the procurement strategy for the RHCYP / DCN Project and in particular the Competitive Dialogue Phase. This was input specifically requested by NHSL of Gordon Shirreff.[21]

Under the section of the paper headed "Competitive Dialogue" it states:

> *" The competitive dialogue stage is the longest and arguably most important stage of the procurement. As such it is vitally important that it is carefully structured to ensure that each bidder is treated equally. Bidders must have equal access to those who will ultimately score the final bids. The dialogue stage will be structured as a number of*

[21] SFT_7.1_00000053

bilateral meetings with each bidder. The programme of meetings should be set out in the ITPD although NHSL will retain the right to vary these and to accommodate bidder's requests for additional meetings. NHSL need to ensure that there is sufficient structure to the dialogue stage to allow the relevant individuals from each bidder's team, which will include their advisers, and NHSL to meet to discuss all relevant technical, financial, legal and other issues. This will normally take place over a number of rounds of dialogue spread over several months with two or three weeks between each round. Having meetings any closer together results in there being insufficient time between meetings for points to be auctioned. Meetings on each topic will generally take place concurrently during each round.

The dialogue stage should begin with an initial meeting where NHSL will explain their requirements and engage in discussion around these with each bidder. Successive rounds of dialogue will allow bidders to discuss and clarify NHSL's requirements and explain their emerging proposals. Full details of how the dialogue stage will be conducted must be contained in the ITPD documentation and the fact of making these details available will help in building the confidence of potential bidders. To build potential bidders confidence further, details of how the dialogue stage will be conducted should be set out in summary in the MoI and should form part of the Project Director's presentation at the Bidders Day.

NHSL will need to decide whether to take all three bidders through to the final bid stage or whether to down select one bidder i.e. only take two bidders to the final stage. There are advantages and disadvantages of each approach. The main advantages are;

- *Reduced workload. Workload is reduced by33% if two bids only have to be understood and assessed rather than three*
- *Reduced timescales. Time to evaluate bids will be reduced if only two bids are involved*
- *Reduced adviser input leading to reduced adviser costs*

Against the above the following disadvantages need to be considered;

- *Additional time has to be allowed in the timetable for a down selection process*
- *NHSL, with its advisers, will need to determine the criteria to be used to determine which bidder is down selected*
- *If, for whatever reason, following down selection, one of the two remaining bidders were to drop out then the project faces very real difficulties in securing the best commercial deal*
- *Maintaining three bidders to the end may ensure greater competitive tension than would be the case with two bidders*

NHSL will have to state in the ITPD whether it intends to take three bidders to the final stage or only two bidders. Ideally its position on this issue should be clear in the Memorandum of Information and at the Bidders Day. NHSL could state that it intends to take all three bidders to the final stages but reserve the right to down select. In any event the decision on which bidder to down select must be taken against clear criteria and NHSL must be able to provide feedback and to justify its decision to the bidder down selected. At the moment it is understood that NHSL envisage taking all three bidders through to final bid stage.

Once NHSL are happy that there is sufficient understanding of bidders proposals and that all question from bidders have been answered and that all commercial, technical and financial points have been resolved, they will give notice of the date when the dialogue stage will close. This provides a final opportunity for bidders to ask questions of NHSL. It is important to recognise that following the close of dialogue there should be no further negotiations with bidders on technical, financial or commercial issues.

Therefore NHSL can only declare the competitive dialogue stage complete when they are satisfied that all substantive matters have been resolved to their satisfaction.

A further Key Stage review will be carried out when NHSL indicate that they are ready to close the dialogue, but before this is confirmed to bidders.

Key points for NHSL decision/Confirmation

- *Confirm whether all three bidders will be taken to final bid stage or whether down selection will take place part way through competitive dialogue*
- *Identify NHSL and adviser resource necessary to engage with bidders during competitive dialogue*
- *Identify clinician and wider stakeholder engagement with bidders"*

Brian Currie at NHSL (by email of 13th June)[22] and Denise Kelly at Davis Langdon (by email of 14 June 2011)[23], reviewed and provided comments on Gordon Shirreff's Procurement Paper.

iii. On 27 June 2011 a "Procurement Workstream Meeting" was held, at which Brian Currie (NHSL), Gordon Shirreff (SFT), Denise Kelly (David Langdon), Paul Hampson (Mott MacDonald and David Cunningham (David Langdon) were present. Ahead of that meeting Paul Hampson circulated to all attendees' additional papers including, "Developed procurement/CD programme - including proposed dialogue meeting dates, Draft PQQ questionnaire, Draft ITPD structure/progress tracker".[24]

The Minutes[25] of the workstream meeting state under the heading "Competitive dialogue process – developed programme":

"*A revised procurement programme was circulated, with suggested days for CD activity included. Discussions took place around format of meetings. Confirmed that allocating 1 full day of dialogue for each bidder during each dialogue cycle was the preferred option. PH/DK/DC to consider how ISOS and ISDS should be handled. Initial thoughts are that these interim phases should be high level review of activity and direction rather than full evaluation given that bidders will also submit a draft final tender as part of the procurement process. This will be reviewed at the next workstream meeting".*

iv. On 4 November 2011, Brian Currie emailed Donna Stevenson and others, papers for review and comment, ahead of the Project Board Meeting taking place the following week[26]. Those papers comprised the OJEU Notice, the PQQ and PQQ evaluation criteria and procurement strategy. The procurement strategy paper was a paper prepared by Davis Langdon and includes a draft procurement programme, including time scales for the Competitive Dialogue process.

v. The Minutes of the Project Steering Board Meeting of 11 May 2012 note that:

"3.*1 The Reference Design has been concluded following the Project Steering Board's approval in July 2011 of the strategy for it's development given the benefits arising. These remain as previously reported: • Enhanced cost certainty at OBC • Clinical Design complete – very limited future engagement of scarce clinical resource • Shortens Competitive Dialogue Phase • Utilises available programme time – parallel with Consort Negotiations ie no overall delay to strategic programme • Minimises abortive design cost for unsuccessful bidders*"

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[22] SFT_PPR_00000001
[23] SFT_PPR_00000005
[24] SFT_PPR_00000008
[25] SFT_7.1_00000089
[26] SFT_PPR_00000016

This is the position set out in Peter Reekie's witness statement in relation to SFT's views on adopting a reference design (para. 109 of the statement). Whilst this was not direct advice on the programme of Competitive Dialogue, SFT was of the view that the Reference Design should be used as it would reduce procurement timescales and procurement costs, particularly for bidders as it would reduce the need for multiple designs to be produced by multiple bidders during the bid period.

vi. On 24 October 2012 Donna Stevenson emailed Brian Currie[27] which stated:

> *" …Programme and Down selection*
>
> *We think that the programme is longer than it need be in certain respects.*
>
> *The preceding item relates to down selection which we can discuss. In the context of the Board's view that there all three bidders should be taken through to final tender we consider that the dialogue period of over 8 months could be shortened particularly in the context of the advanced stage of the reference design and the Board's views on the extent of mandatory elements.*
>
> *The other area where we consider that there is the potential for a reduction in timescale is the period for return of tenders and evaluation, in the dialogue and draft final tenders process."*

vii. The Project Steering Board Minutes of 9 November 2012 states[28]:

> *" Project Procurement Update*
>
> *Further to an email from SFT (PR) of 1st November, 2012 to NHSL (SG) instructing NHSL, as a condition of funding, to reduce the current length of Competitive Dialogue and consider down selecting, a proposal has been prepared by the Project Team for the Project Steering Board's consideration.*
>
> *Down Selection*
>
> *All agreed that given the particular circumstances of this project and the need to maintain a "level playing field" continuously through the procurement process down selection to two bidders would not be prudent.*
>
> *Compression of Competitive Dialogue + Tender Evaluation Programme.*
>
> *SFT reiterated the need to create an attractive as possible proposition to the market given the current economic situation. SFT continued that given the decision not to down select, seen as attractive to the market, there was an ever more pressing need to shorten the Competitive Dialogue process. The use of a Reference Design and a Standard Form of Agreement should, in SFT's view, allow such a compression.*
>
> *The issue of market attractiveness was queried by BC who through soft market testing was only aware of one potentially credible bidder from four who had expressed concern that they may not be able to secure Board approval to bid for the project given the potential bid costs. BC added that one potential bidder had expressed concern that too short a programme may inhibit their ability to offer an appropriate package and sufficiently robust tender to secure their Board approval.*
>
> *MB commented that Scottish Government's view was that of SFT's and that there is and established general market view prevailing that the current procurement*

[27] SFT_PPR_00000025
[28] Document provided by the ILT.

programme for this project is too long causing difficulties when considering bid intentions.

An alternative compressed programme of some 155 days to close dialogue compared to current duration of 209 days was tabled by BC and the merits or otherwise discussed at length by all parties present. The Evaluation duration has also been shortened from 75 days to 39 days in this alternative programme. Be advised that this programme did give the Project Team a number of concerns, particularly given the complexity of the project. After much debate, all present unanimously agreed to adopt the compressed programme. NHSL, however, stated that their reservations remain and that in practice the decision to close dialogue would still dictate the achievement of this revised programme.

NHSL to communicate the following actions to the project team immediately:

1 OJEU Notice release date to be set as 26th November, 2012.

2 Bidders Day to be set for 3rd December, 2012.

3 The PQQ period is to be extended to allow for the Festive Period with a return date of 11th January, 2013.

4 The activities and durations proposed in the "Compressed Programme (as per SFT Condition of Funding)" recently prepared are to be adopted in full.

5 Financial Close is to remain as 7th August, 2014.

6 All other milestones / dates and activities post FC are to remain as the current programme.

7 The programme is to contain all relevant information for the following parallel activities:

TAWO's 156 – 161 (with best estimate of impact of recently instructed variations). Note that key completions of elements critical for delivery of a cleared and ready site for NPD Co are to be highlighted with all float, if any, advised.

Off Site Flood Works

Clinical Enabling Works and all Displaced Services.

All known works within the existing RIE (Additional Capacity Initiatives, Endoscopy/MRI etc) and out with RIE which will directly impact on the RHSC + DCN Project.

8 Down Selection of Bidders will not be adopted. Current strategy to prevail ie., 3 Bidders through to close of dialogue and final tender.

9 Detailed, individual Bidder interface information will not be shared with Consort Healthcare prior to PB, all as previously advised. PR asked that given next P St Board not until 14th December, 2012, an email is issued as soon as appropriate to all members of the P St Board advising of progress with Consort on SA Enabling and confirmed OJEU Notice release date."

viii. Project Steering Board Minute of 22 Feb 2013 states[29]:

" The Project Steering Board unanimously approved the recommendation that all three candidates are invited to participate in dialogue. Note: Delegated authority for the Project Steering Board to approve the shortlist and proceed to competitive dialogue was

[29] SFT_PPR_00000031

approved by the NHSL Finance and Resources Committee on 13 February, 2013. BC also summarised the next stage of competitive dialogue, the composition of Vols 1- 4 of the ITPD Documentation and the key risks remaining."

ix. Regular updates are provided to the Project Steering Board on Competitive Dialogue progress (meetings of 31 May 2013[30] and 13 September 2013[31]).

c. Did NHSL receive advice during the Competitive Dialogue period in respect of infection prevention and control, clinical needs/requirements, and compliance with SHTMs and other regulations? If so, from whom and in relation to which topics?

This is not a question SFT can answer.

d. Could NHSL provide a detailed explanation of the design review process during Competitive Dialogue.

This is not a question SFT can answer.

e. What does an AEDET review of 'performance, engineering and construction' involve?

This is not a question SFT can answer.

f. Specifically, would an AEDET review pick up any issues with ventilation proposals including their compliance with SHTM 03-01?

This is not a question SFT can answer.

g. Was 'performance, engineering and construction' scored at any other time during the procurement process?

This is not a question SFT can answer.

h. What impact did the Brief Change have on the Competitive Dialogue Process?

This is not a question SFT can answer.

Q 4.10. With regard to the draft final tender (section 3.13)

a. What is the purpose of the draft final tender?

As set out in para. 3.15.1 of the Inquiry's Procurement Paper, draft final tenders are used in Competitive Dialogue procurements to allow contracting authorities to confirm that Bidders' final tenders will be capable of acceptance by the contracting authority prior to closing dialogue. Draft final tenders also allow contracting authorities to provide final feedback to Bidders in relation to any aspect of the draft tender which may be regarded as unacceptable or non-compliant. Affordability is often an issue which is considered as part of the draft final tender review.

Draft final tenders are used in many Competitive Dialogue procurements (not just procurements of NPD Projects) to minimise the risk of Bidders' submitting non-compliant or unacceptable bids which do not meet the needs of the contracting authority.

Under The Public Contracts (Scotland) Regulations 2006 (which applied to the Project) once dialogue was formally closed and final tenders submitted, contracting authorities were only permitted to clarify, specify or fine-tune a tender. This was considered to be very restrictive and prohibited any changes to the basic features of the tender or any other change which could risk distorting competition or causing discrimination.

[30] SFT_7.1_00000294
[31] SFT_7.1_00000318

If draft final tenders submitted prior to dialogue contained anything which was unacceptable to the contracting authority, because the dialogue had not closed, the contracting authority had the opportunity to raise and resolve the issue with the relevant Bidder.

The above explanation is consistent with the documents in relation to the draft Final Tender process on the Project which SFT have examined.

We refer the Inquiry to the document prepared by MML and Davis Langdon for procurement meeting of 11 July 2011[32] and the paper entitled, " *Re-provision of RHSC and DCN Project Steering Board 13 September 2013 Project Director PROJECT PROCUREMENT*[33].

b. What is meant by "compliant design' in the context of tender submissions?

This is not a question SFT can answer.

c. Against what criteria was compliance assessed?

This is not a question SFT can answer.

d. Who conducted the review of the draft final tender?

This is not a question SFT can answer.

e. Did the timetable allow sufficient time for bidders to do all the additional work required in the timeframe provided before submission of final bids?

This is not a question SFT can answer.

f. According to SCIM Guidance, interim submissions during Competitive Dialogue can be used to further down-select or short-list bidders depending on their performance, and only two bidders need to be issued with an ISFT. Did NHSL consider down-selecting

We refer the Inquiry to our response to the question at 4.9b above. The reference in SCIM Guidance to "interim submissions" is not a reference to draft Final Tenders. Some Competitive Dialogue procedures provide for down selection of Bidders during the Competitive Dialogue, based on an "interim" or detailed submission, which is not as detailed or full as the final tender (and draft final tender).

Down selection is used where it is not practicable to take all Bidders invited to participate in dialogue through to the final tender stage, because Bidders will only commit sufficient resources to preparing a final tender where they have a 50% chance of winning, where the contracting authority does not have enough resources to carry out a full dialogue with more than two Bidders or the contracting authority wishes to accelerate the Competitive Dialogue and it is considered that shortlisting to 2 Bidders will allow dialogue to be completed earlier.

We note that the Actions Notes following a meeting of the Project Steering Board on Friday 9th November[34] record that the Project Steering Board took the decision not to down-select to two bidders in order maintain a level playing field continuously throughout the procurement process. Down selection in this context refers to down-selection during the Competitive Dialogue and not at PQQ stage as stated in para. 3.9.7 of the ILT's Procurement Paper.

There would be no benefit to down selecting at draft Final Tender stage after all of the detailed dialogue and bid preparation has been carried out by Bidders and the contracting authority.

Q. 4.11 With regard to the closure of competitive dialogue (section 3.15)

a. What guided the decision to close Competitive Dialogue?

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[32] SFT_7.1_00000094
[33] SFT_7.1_00000318
[34] Provided to us by the ILT on 12th July 2022.

Three bidders participated in the Competitive Dialogue stage of the procurement. This stage took place between March 2013 and November 2013.

Generally, decisions to close Competitive Dialogue are guided by the likelihood of receiving compliant tenders. SFT's role did not involve reviewing the tenders and so SFT would not have decided when Competitive Dialogue should close in relation to the Project.

We also refer the Inquiry to Peter Reekie's witness statement, paras. 37 – 53 which sets out an overview of the KSR process and the purpose of that process. The Inquiry will note that the KSR process involved reviews at various stages, including Pre-Close of Dialogue. A copy of the Pre-Close of Dialogue KSR for the RHCYP / DCN Project has been provided to the Inquiry as part of SFT's response to the First Request for Information.

The Inquiry will note the following from that KSR in relation to the query around what guided the close of Competitive Dialogue:

- entry 2 of the table at page 9 of 49 states:

  "*Recommendation: That, prior to close of dialogue, the Board receives and copies to SFT, letters, in the form of the drafts which the Board have earlier provided to SFT, from each of its financial, legal and technical advisers confirming that each consider that it is appropriate for the Board to close dialogue*"

The most important point in relation to closing dialogue was that NHSL and its advisors believed that it was the right thing to do. The point of the KSR was to impose on them a need to reflect. It was not to allow SFT to determine if dialogue was to be closed.

b. Were any concerns raised by members of the Steering Board about closing competitive dialogue?

SFT is not aware of any concerns raised by Steering Board members around the closing of Competitive Dialogue.

c. Before closing Competitive Dialogue was the Board comfortable that one or more solutions were capable of meeting its needs?

This is not a question SFT can answer.

However, Question 3 of the Pre-close of Dialogue KSR asks, "*Based on dialogue with bidders is the Procuring Authority satisfied that the final tenders will contain solutions that satisfy its operational and functional requirements*?" The answer provided by NHSL is "*yes*".

Q.4.12 With regard to the invitation to submit final tender (section 3.16)

a. Did the design produced by bidders at this stage include 1:200 plans and 1:50 for key areas, cross sections, site plans, area schedule, performance specifications? Are these required for providing an accurate fixed price bid?

This is not a question SFT can answer.

b. Did NHSL, Mott MacDonald or SFT raise concerns about the state of designs submitted by bidders?

As articulated in Peter Reekie's witness statement at para. 157, the role of SFT in respect of design was in relation to value for money, not design assurance.

As part of the Key Stage Review process SFT did ask NHSL to confirm the status of the technical documents.

In Section 2, Question 16 of the Pre CoD KSR NHSL confirmed that:

> "*100% compliance for operational functionality and minimum room layouts has now been achieved with all bidders. The Board has reviewed the bidders' programmes for design development through to financial close. The Board consider that the programme from preferred bidder to financial close is challenging*"

In the Pre-PB Key Stage Review, Section 2, Question 3, NHSL confirmed that:

> *"The Board has confirmed that all bidders have provided detailed programmes to cover the activities for the period until FC and that the development of the technical information is at least as advanced as the Board anticipated at this stage.*
>
> *The Board and its advisers are satisfied that any further development of technical information from PB appointment to FC is achievable within the current project timetable*"

In the Pre-FC Key Stage Review, Section 3, Question 3, NHSL confirmed that:

> *"The Board has confirmed that the technical documentation is at a level of development consistent with the current stage of the Preferred Bidder to Financial Close programme. The Board advises that they are content with the documentation subject to further development through RDD following Financial Close and that the construction proposals are of sufficient detailed to provide sufficient certainty to the Board as to what is to be provided and to permit a timely start on site".*

Q4.13 With regard to the evaluation of final tenders (section 3.18)

a. What qualifications did the individuals scoring C8 (M&E engineering) and C10 (energy management) have?

   This is not a question SFT can answer.

b. What was the final tender evaluation of C10 (energy management proposals) for IHSL? Can we be provided with the full report.

   This is not a question SFT can answer.

c. IHSL's tender submission was marked satisfactory notwithstanding that many elements were said to be 'basic', 'lacking detail' and 'minimal'. What was considered to the threshold for a "satisfactory" marking and how was the marking and the threshold calculated?

   This is not a question SFT can answer.

d. Did IHSL's final tender submission on C8 mechanical and electrical engineering and C10 energy management address concerns raised in the draft final tender feedback?

   This is not a question SFT can answer.

Q.4.14 With regard to the selection of the preferred bidder (section 3.20), please provide a copy of the final tender evaluation report showing the final scoring of the three bidders.

This is not a question SFT can answer.

Q.4.15 With regard to preferred bidder letter (section 3.22)

a. Do points 4.4 and 4.5 in Schedule 1 of the appointment letter indicate that IHSL had not developed their design to the stage required by the ISFT? What were the implications of this?

This is not a question SFT can answer.

b. Did any of the bidders develop their design to the stage required by the ISFT?

This is not a question SFT can answer.

c. Is it usual to have this number of outstanding issues, gaps and points for clarification in relation to the final tender?

This is not a question SFT can answer.

Q.4.16 With regard to Design Development (section 3.23)

a. What were the governance arrangements in respect of design development and review between the selection of the preferred bidder and financial close?

This is not a question SFT can answer.

b. What was the RHSC Clinical Design Task Group, what did they advise on and who did they advise?

This is not a question SFT can answer.

c. Did the late delivery of design and technical documents allow time for proper review before financial close?

This is not a question SFT can answer.

Q.4.17 With regard to the HAI-Scribe Review (section 3.25)

a. What was the evidentiary basis for the results of this review, particularly in relation to the answer given for 3.2 and 3.3 of HAI-Scribe?

This is not a question SFT can answer.

b. Apart from HAI-Scribe, were any other design reviews conducted before Financial Close that considered infection control?

This is not a question SFT can answer.

c. What were the qualifications of members of the review team?

This is not a question SFT can answer.

Q. 4.18 With regard to the NDAP (section 3.26)

a. What was the advice given in respect of HFS involvement in design review, including the NDAP process for full business case?

We refer the Inquiry to paras. 161 – 169 of Peter Reekie's witness statement in relation to SFT's position on the NDAP procedure.

b. Regardless of whether an NDAP took place or was required, were the submission requirements for an NDAP met before consideration of the Full Business Case by CIG, or could they have been?

We refer the Inquiry to paras. 161 – 169 of Peter Reekie's witness statement in relation to SFT's position on the NDAP procedure.

c. What does HFS review of the required submission documents involve?

We refer the Inquiry to paras. 161 – 169 of Peter Reekie's witness statement in relation to SFT's position on the NDAP procedure.

4.19 With regard to Gateway 3 Review (section 3.27), did the pre-Financial Close KSR address the questions assessed in a Gateway Review specifically:

We refer the Inquiry to Peter Reekie's witness statement paras. 37 – 53, which outlines the KSR process.

There are more KSRs than Gateways, accordingly the questions addressed in one Gateway are likely to be spread over one or more KSR.

a. whether the process has been well managed

Section 5 of the Pre-OJEU KSR covers project management arrangements

Question 23 of the Pre-ITPD KSR covers project management arrangements

Question 55 in the Pre-COD KSR addresses project management arrangements

Question 35 in the Pre-PB KSR covers project management arrangements

Section 7 of the Pre-Financial Close KSR looks forward, covering "Readiness" for the delivery phase of the project.

b. whether the business needs are being met

Section 1 of the Pre-OJEU KSR addresses the project requirements and whether the OBC which sets out the rationale for the project has been approved and issues addressed

Question 33 of the Pre-ITPD KSR covers the completion of all consultations have been carried out and approvals (internal and external) obtained to allow the project to proceed.

Questions 1 (covering changes in scope) and 2 / 3 (covering confirmation that bidders proposals are capable of meeting the Board's requirements) address this issue in the Pre-COD KSR

Questions 1 (covering changes in scope) and 2 (covering confirmation that the proposed preferred bidder's proposals are capable of meeting the Board's requirements) address this issue in the Pre-PB KSR

Question 2 "Is the Procuring Authority satisfied that the preferred bidder's solution satisfies its operational and functional requirements and delivers the project objectives, benefits and outcomes?" address this issue in the pre-FC KSR.

A detailed explanation of the ability of the proposed solution to meet the needs of the Authority is included in the Full Business Case.

c. that both the client and the supplier can implement and manage the proposed solution

In respect of the supplier, this question would primarily have been resolved during the tender evaluation stage.

The 20 questions in Section 7 "Readiness" of the Pre-FC KSR address the issue in respect of the client, NHSL.

d. that the necessary processes are in place to achieve a successful outcome after contract award

In respect of the relationship between the client and the supplier, the Project Agreement sets out robustly the processes in place to achieve a successful outcome after contract award.

The 20 questions in Section 7 "Readiness" of the Pre-FC KSR address the issue in respect of the client, NHSL.

Q. 4.20 With regard to the Pre-Financial Close KSR (section 3.30), on what basis did the Board/Procuring authority and SFT have confidence to answer question 2 and 3 in the affirmative? Please provide copies of any advice or other documents that were relied upon in this regard.

As shown in the Pre-Financial Close KSR document, SFT relied on the confirmations by NHSL in relation to questions 2 and 3. SFT did not undertake a design or technical assurance role and this element of the KSR was intended to prompt NHSL to reflect, with its advisors as necessary, on the stage of development of the technical solution and documentation at this critical stage.

This paper includes comments by SFT. The comments are intended to assist the Inquiry and reflect SFT's understanding. The absence of any comment does not indicate endorsement or acceptance by SFT of any element of the paper which does not refer to SFT's role or activity. SFT is content with the content of the paper which refers to its role, subject to the comments and suggested amendments included below

The Procurement Process for the RHSC/DCN Re-Provision Project

1. Introduction

1.1 This paper provides an overview of the procurement process as per procurement guidance available for NPD projects between 2011 and 2014. It also provides some commentary on the RHSC/DCN project's progress through these stages, with a particular focus on matters relating to governance, design and the development of ventilation specifications (although this is not in great detail). You are asked to confirm whether you agree with this commentary, and if you do not, to provide any necessary corrections and clarifications. In addition, there are questions relating to what happened at different stages of the procurement process, and who was involved.

2. Guidance

2.1 Could you please confirm whether the guidance set out below was applicable to the procurement process of the RHSC/DCN re-provision project?

- Treasury Green Book, 2003
- Procurement Handbook and Scottish Procurement Policy Notes, 2008
- Scottish Capital Investment Manual (SCIM) 2009 with amendments including:
  - NPD Guide Section 1 of 4: Preparing for NPD Procurement
  - NPD Guide: Section 2 of 4; From OJEU to Contract Award
  - NPD Guide Section 3 of 4: Technical and Commercial Issues
  - NPD Guide: Section 4 of 4; Plain English Guide to the Scottish Standard Form Project Agreement ○ SCIM Supporting Guidance: Design Assessment in the Business Case Process (2011)
- A policy on Design Quality for NHS Scotland, 2010
- Scottish Government Construction Procurement Manual
- Scottish Public Finance Manual, 2011
- Scottish Futures Trust Key Stage Review Guidance
- Scottish Futures Trust Value for Money (VfM) Assessment Guidance, 2011
- Scottish Futures Trust NPD Guidance Note on Approach to Tender Evaluation, 2013
- Policy on Sustainable Development for NHSScotland

2.2 Please provide the name and where possible a copy of any other guidance applicable to the procurement process for this project.

3. Procurement Process

Commented [AG1]: The inquiry may wish to include a high-level description of the key stages of the Competitive Dialogue procurement process and relevant dates before stepping through the detail of the stages.

3.1 Preparation of the **Invitation to Participate in Dialogue** (ITPD) took place over 2011 and 2012.

3.1.1 According to para 5.9 of SCIM "NPD Guide: OJEU to Contract Award" the ITPD "provides a framework for the prequalified participants to develop their detailed proposals during the dialogue process. A well drafted and comprehensive ITPD is vital to the smooth running of a project. It will help the participants produce accurate proposals and will avoid misunderstandings that can lead to later problems. The NHSScotland body should have substantially completed its proposed ITPD including the draft contract, NPD principles, payment mechanism and performance regime prior to advertising for the scheme in the OJEU. In particular, areas such as the development of output specifications are very time consuming to produce and the

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NHSScotland body should have completed work on these before commencing the formal procurement process."

3.1.2 The SCIM further recommends that the ITPD should follow a 'standard form' specifically including:

- Volume 1: Instructions to Participants (include schedule of deliverables, weightings and contact details)
- Volume 2: Standard Form Project Agreement including project specific amendments
- Volume 3: Technical Specification for Construction Works
- Volume 3 Annex A: Clinical Output Specifications
- Volume 3 Annex B: Non-clinical Output Specification
- Other standard documents will form further appendices

3.1.3 NHSL, with its advisors Mott MacDonald, began work on the ITPD for the RHSC/DCN re-provision project in 2011. They drew on work that had been undertaken in respect of the RHSC project and DCN projects separately, before the switch to a non-profit distributing model in November 2010, when these two projects were combined. For a number of reasons the decision was made to use a 'Reference Design' which provided a more detailed design brief and supporting documents to bidders than an Exemplar Design.

Commented [AG2]: It would be normal for legal and financial advisors to support elements of ITPD development. SFT cannot be sure whether this was the case for the Project.

3.1.4 In 2012 Mott MacDonald prepared various drafts of a paper titled "Approach to Reference Design". This assisted with the development of volume 1 of the ITPD and associated documents, which was to provide instruction to bidders and outline the tender submission requirements. The "Approach to Reference Design" paper provided advice on how the mandatory and non-mandatory elements of the reference design were to be presented in the ITPD. It also included a section on how "room information" was to be provided to bidders. This included the use of the Environmental Matrix, which was a document initially developed to replace the use of Activity Database Room Data Sheets.

3.1.5 With regard to Evaluation criteria and weightings, the SCIM guide notes that contracts should be awarded on the basis of an offer that offers the lowest price or is most economically advantageous overall to the NHSScotland body. The factors for evaluating economic advantage of the bid include: period for completion or delivery, quality, aesthetic and functional characteristics, technical merit, after-sales service, technical assistance and price."

Commented [AG3]: Can the Inquiry clarify whether or this is a quote from the SCIM?. We reviewed the SCIM and cannot find reference to the words "lowest price" and consider that this is different to "economically advantageous".

We note that the SCIM, under the heading "Competitive Dialogue" states:

"The main features under this procedure are:
• dialogue is allowed with selected suppliers to identify and define solutions to meet the needs and requirements of the contracting authority
• the award is made on the most economically advantageous tender criteria
• dialogue may be conducted in successive stages, with the aim of reducing the number of solutions/bidders
• there are explicit rules on post-tender discussion"

3.1.6 According to the SFT NPD Guidance Note on Approach to Tender Evaluation, SFT requires a 60:40 price/quality split. This is justified in para 5, page 4, where it is stated, "Procuring authorities should be mindful of the fact that, in contrast to previous revenue funded programmes, there is now more scope to manage the risk of poor quality proposals. The reasons for this include (i) use of exemplar / reference designs that give bidders greater clarity on the procuring authority's expectations (ii) a narrower range of FM services to be included in the projects and (iii) opportunity to use the competitive dialogue procedure to ensure that bidders develop proposals that meet the procuring authority's requirements. Combined with a shift in focus in the current financial climate to "needs" rather than "wants", and in order to capitalise on the opportunity in the current financial climate to take advantage of competitive pricing, this suggests that it is appropriate for price to carry a heavier emphasis than it perhaps has in the past."

3.1.7 The SFT Guidance note provides a table for evaluating the quality of bidders proposals, and notes that weightings can be applied to reflect the procuring authority's priorities in relation to the various quality aspects of bidders' proposals.

3.1.8 A tender Evaluation Criteria workshop was held in 2011. A draft ITPD document in connection with that workshop provides suggestions for a scoring approach and

relative importance of various criteria. The comments for D8 (mechanical and electrical engineering) state, "High [importance] as it relates to environmental comfort". The scoring approach suggested is 'pass/fail or marked to relate to comfort'. For D12 "Sustainability proposals and strategy" (which later became the energy management proposal) a medium weighting is suggesting, with the comments, "Important that this is assessed and that Bidders give due attention to this important aspect." The document also recommends that Architectural strategy is scored very high as it is a "key area for consideration of quality", and interior design scored high because it is "a key area of interest for the Board" .

3.1.9 NHSL did not agree with the 60% weighting for price and 40% weighting for quality, arguing that it undervalued quality. Ernst and Young provided advice on the evaluation framework for the final evaluation of bids and developed an evaluation methodology that "incorporates features that maximise the impact of quality evaluation." This would achieve "the desired balance between price and quality" while still meeting SFT requirements that price accounts for 60% of the available marks and quality 40%.

3.1.10 Some of the proposals by Ernst and Young were that:

- The majority of quality evaluation elements are assessed on a pass/fail basis, with the scored element reserved for key differentiating factors
- Commercial considerations are dealt with entirely within the price score, freeing the available quality marks to be focussed on design, build, FM and management/strategic issues
- The lowest price bid is awarded the maximum 60 marks. The quality mechanism has been set up so that the highest scoring quality proposals are given the maximum 40 marks, with the quality score of other bids being marked in proportion to this
- The price marks awarded are calibrated so that proposals that are close in price terms are given similar price marks, thus making the quality score more likely to be the deciding factor. As price differentials become greater, the price marking system becomes more sensitive so that a bid significantly more expensive than the lowest priced will lose a far higher number of price marks.

3.1.11 In the final ITPD, C8 'M&E' was given a quality evaluation criteria weighting of 1.06, C10 'Energy Management' was given a weighting of 1.85. These were relatively low in comparison to other criteria, such as interior design, architectural and landscape design, adaptability and flexibility, which had a score impact of 2.64

3.2 SFT waswere responsible for the **preparation of standard form Contract Documents**, which included the Standard Form Project Agreement and Articles of Association. These formed the basis of the proposed project agreement and Articles of Association for the project company that were included in the ITPD and ISFT.

3.2.1 However, European System of Accounts2010(ESA 10) came into effect in September 2014, introducing new rules around classifying investment projects to the public or private sector. This had significant budgetary implications, and led to changes being made to the governance arrangements outlined in the NPD contract documents, such as the NPD Articles of Association, in order to maximise the potential that they were classified as private sector/revenue funded projects.

3.2.2 The Articles of Association were amended between November 2014 and February 2015. This resulted in a more limited role for the B Director than initially envisaged for NPD projects, and the introduction of the role of an Independent Expert. The B shareholder veto was removed and replaced with a requirement for written consent from all Shareholders or the opinion of an Independent Expert and meeting certain conditions

3.2.3 The changes required to contract documents following ESA 10 coming into effect contributed to slippage in the programme to meet financial close.

Commented [AG4]: The inquiry may wish to be aware that it is relevant to consider whether elements are "mandatory" alongside their scoring weight. Where it is possible to define a requirement on a pass-fail basis, that can be done such that quality sores can be weighted to areas where that is more challenging. This has been set out in our response to the Procurement Paper Questions 4.3b and 4.3 d. ii.

Commented [AG5]: SFT cannot say whether these changes were made in 2010, or whether the naming was on the basis that they were intended to be made in that year.

Commented [AG6]: The Inquiry may wish to be aware that following review by the ONS and Eurostat which was completed after the project reached Financial Close, it was classified to the public sector

Commented [AG7]: The Inquiry produced ESA 10: Classification of privately funded capital projects (audit-scotland.gov.uk) as the document which supports the statement that it "contributed to the slippage in the programme to meet financial close".

We do not see contemporary evidence to support the finding made in that external paper and SFT cannot say whether the implementation of these changes ever fell on the critical path of activities leading to Financial Close.

Accordingly, we would ask the Inquiry to include a contemporary reference supporting the statement or to remove this statement from the Procurement Paper.

3.3 The **Pre-OJEU Key Stage Review** was signed-off on 4/12/2012. The SFT reviewer was Donna Stevenson, and Secondary Reviewer was Tony Rose. The review was signed on behalf of NHS Lothian by Susan Goldsmith on 4 December 2012.

3.3.1 Following the switch to the NPD model, SFT took a major role in project assurance, by carrying out "Key Stage Reviews". A Key Stage Review is an assessment of whether the project is suitably developed to have created conditions for success in terms of:

- Project requirements
- Affordability
- Value for Money
- Commercial
- Readiness

3.3.2 At this time the Key Stage Review process for the NPD programme was under development, and the final policy position on the full assurance process for NPD projects had not yet been worked out.

3.3.3 Some of the questions to be determined were whether the KSR would replace Gateway Reviews, or how the two would work together without duplication, and the role of the Infrastructure Investment Board in relation to NPD projects and SFT's assurance role.

3.3.4 A further question raised by Scottish Government as well as NHSL was around potential conflict between SFT's advisory role on the Project Board, and its role in project assurance/review. In January 2012 Mike Baxter commented "The provision of direct advice and independent scrutiny need some thought."

3.4 **Ongoing VfM monitoring and assessment** is expected to take place throughout the procurement process after the approval of the OBC.

3.4.1 According to SFT's Value for Money assessment guidance, this is "to ensure awareness of any potential market failure or abuse, maintain competition, minimise transaction costs, ensure risk allocation remains deliverable, assess bidders financial standing, monitor cost stability, assess financial flexibility and financial structures and assess alternatives."

3.5 **Prior Information Notice**

3.5.1 According to SCIM NPD Guide Section 2 "From OJEU to Contract Award" a Prior Information Notice is useful for gauging the level of market interest, however it is not compulsory other than in exceptional circumstances.

3.6 **Market Sounding usually takes place before the issue of the OJEU notice.**

3.6.1 According to the SCIM NPD Guide Section 2: From OJEU to Contract Award, market sounding is useful in situations where assessment of the viability of the project for PPP reveals it to be 'borderline', or there are unusual elements in the project. "Approaching the market should enable the NHSScotland body to gain insight into the likely level of interest in the market but without giving any one potential participant a head start in the procurement process. The NHSScotland body should ensure that its actions do not prejudice the future procurement process."

3.7 The **OJEU notice** was issued on 5/12/2012.

3.8 The MoI ("Memorandum of Information"), Pre-Qualification Questionnaire and evaluation criteria were issued on 5/12/2012.

3.8.1 The Information Memorandum set out:

Commented [AG8]: We note that these are the chapter headings within the Key Stage Review documents. However, we would recommend using the description and purpose of the Key Stage Review process as set out in Peter Reekie's witness statement at para 42, which reflects the applicable KSR guidance. It states that

"Each review was an assessment of whether the project was suitably developed in terms of "Project Readiness"; "Affordability"; "Value for Money"; and "Commercial robustness".

Commented [AG9]: We have removed the reference to KSR being a "new" process as the KSR process had been operated for PPP projects in Scotland prior to the establishment of SFT by Partnerships UK: Devolved Scotland : Partnerships UK - delivering investment through public private partnerships | PUK]

Commented [AG10]: We query the statement that the KSR project "had not yet been worked out" due to the combination of the publication of the Guidance Document 7 dated December 2011 and the IIB paper dated 24 May 2012 which predated the KSR referred to above. The inquiry may wish to consider the wording of this paragraph.

Commented [AG11]: The inquiry may wish to refer to the IIB Meeting Paper, "Infrastructure Investment Board, 24 May 2012, Simplifying The Project Assurance Landscape (Update)" which sets out the final policy position and predates the KSR referred to above. See also our response to the Procurement Paper Question 4.4b.

Commented [AG12]: This is an incomplete / inaccurate quote, which we consider misrepresents the position. Mike Baxter states in his email:

"Nothing dramatic but I do think that the role SFT plays on project Boards and the interface/ conflict with other roles - provision of direct advice and independent scrutiny need some thought".

If the above quote is to be included, can the ILT please include a section that explains how Mike Baxter's point was dealt with? The dual role of SFT has been set out in detail in Peter Reekie's witness statement and in our response to the Procurement Paper Question 4.4a.

Commented [AG13]: This is referred to as IM later in the document.

(a) Background details of the procuring authority, this being the Board;
(b) An overview of the Project;
(c) A description of the proposed site and work carried out to date by the Board;
(d) A description of project management arrangements Board had in place;
(e) Details of how the Pre-qualification Questionnaire ("**PQQ**") should be completed and submitted;
(f) Details of conditions for participation in the process;
(g) The evaluation process for the PQQ.

3.8.2 The PQQ had various sections to be completed by candidates, these are summarised as follows:

(a) Section A: Details of candidate including its internal organisation and details about candidate members, including their roles;
(b) Section B: Information on the candidates construction contractor;
(c) Section C: Information on the candidate's FM service provider;
(d) Section D: Information on the Designated Organisations (these being the lead architect, lead civil and structural engineer and lead mechanical and electrical engineer) including background information and legal form plus relevant PPP experience;
(e) Section E: Declaration to be signed by the candidates upon completing PQQ to best of their knowledge;
(f) Section F: Statement of good standing to be signed by each candidate member.

3.8.3 Four bidders took part in the Board's "Bidder's Day" in relation to the Project, which was held on 13th December 2012. These bidders were B3, Mosaic, Integrated Health Solution Lothian, and Skanska Miller. Skanska Miller subsequently withdrew and did not submit a PQQ.

Commented [AG14]: "bidding consortia" may be clearer

3.9 **Evaluation of PQQ responses** and the preparation of the PQQ shortlist took place from 21/01/2013 – 8/03/2013

3.9.1 According to the SCIM NPD Guide "OJEU to Contract Award", "The aim of this stage is to prequalify a number of participants, normally between three and eight, who will progress to the later stages of the bid process i.e. to be invited to participate in dialogue. The decision on whether to longlist or shortlist participants at this stage depends upon the choice of procurement route taken at the Invitation To Participate in Dialogue (ITPD) stage" (para 4.1).

3.9.2 The PQQ Core Evaluation Team included: Brian Currie (Project Director), Carol Potter (Finance), Iain Graham (Capital Planning) Jackie Sansbury (Operations) Janice Mackenzie (Clinical), Richard Cantlay (Technical Advisor), Michael Pryor (Financial Advisor) and Andrew Orr (Legal Advisor).

3.9.3 They received Evaluation Support, including technical advice on design and construct and facilities and management. The lead on Design and Construct was Andrew Scott (Mott MacDonald) and on Facilities Management was Simon McLaughlin (Davis Langdon). The Evaluation Support team also received additional specialist support. Specialist support on NHSL Infection Control was provided by Fiona Cameron.

3.9.4 The PQQ submission deadline for all bidders was 21st January 2013. The Board then had a period to review and evaluate the PQQ submissions. On 25 January 2013 Peter Reekie of SFT asked that where possible, given that there were only 3 PQQs obtained, the programme to recommend bidders be accelerated. Brian Currie emphasised the importance of due & proper process but noted that the intention was to make final recommendation to the next Project Steering Baird was 7 business days ahead of current programme.

Commented [AG15]: We are concerned that this statement misrepresents the position. On reading, it suggests that SFT wanted a fast process and were not concerned about whether or not It was done properly.

We would also refer the Inquiry to our response to the Procurement Paper Question 4.9a and the Project Board Action Notes of Meeting of 13 May 2011 entitled, " RHSC + DCN – Little France – PROJECT BOARD #2", which states:

"*A "Dashboard" Report was tabled and the following views expressed and actions agreed regarding proposed strategic programme dates:*

As presented the programme is unacceptable to NHSL, SFT and SGHD given the estimated slippage in operational date from the previous Treasury funded project."

Whilst this was an earlier meeting, it was clear that all parties were concerned about reducing the delay to the programme.

3.9.5 The PQQ evaluation and short list was issued by the Board on 8th March 2013. The three short listed bidders were as follows: (a) B3 (also referred to as “Bidder A”); (b) Integrated Health Solutions Lothian (also referred to as “Bidder B” or “IHSL”); and (c) Mosaic (also referred to as “Bidder C”).

3.9.6 IHS Lothian scored 72 out of 100, putting them in third place (out of 3). The scores for ‘Candidate’ and ‘Designated Organisations’ pulled the overall score down. With regard to ‘designated organisation’, it was noted “that Wallace Whittle have no health PPP experience.”

Commented [AG16]: The Inquiry may wish to set out what “Candidate” and “Designated Organisations” are.

3.9.7 Peter Reekie of SFT had previously suggested NHSL consider downselecting to 2 bidders rather than 3, to reduce workload and meet shortened timeframes. A proposal was prepared by the Project Team for the Project Steering Board’s consideration. All agreed that given the particular circumstances of this project and the need to maintain a “level playing field” continuously through the procurement process, down selection to two bidders would not be prudent.

Commented [AG17]: Document produced by ILT to back this statement up (Action Notes 091112) does not relate to the PQQ process. It relates to the Competitive Dialogue. Therefore, this should be deleted.

Do the ILT have the 1 November 2012 email from Peter Reekie referred to in the Action Notes 091112? We are unable to locate it within SFT's systems

3.9.8 According to the Mott MacDonald Evaluation Manual: p.12, para 3.4 “in the event that less than three Candidates meet the Board’s minimum requirements / thresholds, the Board reserves the right to invite to participate in the dialogue fewer Candidates than three, provided the Board considers the number of Candidates is sufficient to ensure genuine competition.” However SCIM guidance “from OJEU to Contract Award” recommends at least 3 bidders at the end of the pre-qualification stage.

3.10 **Key Stage Review 2a**: Pre-Invitation to Participate in Dialogue was finalised on 7/03/2013.

3.10.1 Question 4 under section 2 “Project Requirements” asked “Please explain the approach that the Procuring Authority is taking in presenting its design and specification requirements to bidders (e.g. use of exemplar or reference designs) and the opportunities available for bidders to propose alternative or innovative solutions. Please demonstrate that this approach is consistent with (i) allowing opportunity for improved value for money through bidder innovation (ii) allowing scope for value engineering required to deliver the project within the affordability limits (iii) the procurement timetable and (iv) bidder access to project stakeholders during the procurement.”

3.10.2 The answer provided was “The ITPD, Volume 1 section 2.5 and Appendix E sets out the elements of the Reference Design which is being provided to bidders are mandatory. These relate to the Operational Functionality as defined in the Project Agreement and there are elements of flexibility in relation to non mandatory elements of the Reference Design. The Pre OJEU KSR stated that ‘the Funding Conditions which provide that “the extent of negotiable and non negotiable elements is developed by the Board on the basis that bidders should be provided with flexibility to propose their own design and engineering solution, within defined parameters, and avoiding the need to open up the clinical adjacencies which has been settled with the Board’s clinicians to date and reflecting the constraints in the site as reflected in SA6. The final position is to be reviewed by SFT as part of the Pre ITPD KSR.” Accordingly the finalisation of this issue will be considered as part of the pre ITPD KSR.’ This has now been satisfied.”

3.10.3 NHSL were then required to demonstrate whether they had a clear position in relation to a number of matters, and that this position was clearly explained in the ITPD documents. None of the matters in this list related to compliance with SHTMs, patient safety or infection control.

3.11 The **Invitation to Participate in Dialogue (the “ITPD”)** was issued by the Board to all three bidders, including IHSL, on 11th March 2013.

3.11.1 The ITPD comprised of four volumes:

(a) Volume 1: This set out the general requirements of the Board in relation to the Project, these being: (i) Background information on the Project, the arrangements for competitive dialogue; use of the Reference Design including mandatory and indicative elements and the concept of Operational Functionality; the informal submissions bidders should provide, the Draft Final Tender requirements, the envisaged Final Tender requirements and evaluation requirements; and the evaluation weighting criteria.

(b) Volume 2: This set out the contractual requirements of the Board in relation to the Project:

(i) NPD Project Agreement and NPD Articles of Association

(ii) The NPD Project Agreement and Articles of Association were based upon standard forms produced by SFT

(iii) The NPD Project Agreement included project specific amendments, which had been pre-agreed by the Board and SFT. Bidders were encouraged to accept positions within the NPD Project Agreement, which reflected SFT's standard form project agreement

(iv) However, bidders were also encouraged to raise any comments in relation to the project specific amendments by dialogue meeting 3, in order that these issues could be flagged to SFT at that time. Any proposed bidder amendment to the NPD Project Agreement would be a derogation. All derogations required the approval of SFT;

(v) In general, all matters in relation to the NPD Project Agreement were to be raised with the Board prior to close of dialogue. Only matters in relation to fine tuning and clarification would be permitted post-close of competitive dialogue.

(c) Volume 3: This set out the specific technical requirements of the Board in relation to the Project, these being: (i) The construction (clinical and nonclinical requirements), equipment requirements and facilities management requirements; Appendix A included 'interface with Campus Site and/or Campus Facilities; Appendix B included the Interface Output Specification and Appendix C included the Environmental Matrix.

Commented [AG18]: The Inquiry may wish to consider and set out how compliance with SHTMs was treated in the ITPD.

(d) Volume 4: This set out the room data available to bidders.

The Inquiry has received Revision A and Revision B of Volume 1, revision A and revision C of Volume 3. The inquiry has not received volume 4 of the ITP.

3.12 **Competitive Dialogue** took place from 11 March 2013 to 13 December 2013.

3.12.1 According to para 5.15 of the NPD Guide: OJEU to Contract Award, the aim of Competitive Dialogue "is to "*identify and define the means best suited of satisfying [the contracting bodies'] needs."* This stage formally acknowledges the need in complex projects to talk around solutions, develop ideas and explore options as part of the tender process. All aspects of the project can be discussed and discussion can constitute far more than round table meetings (which could be implied by the terminology). It can include, for example, formal presentations, written bid type responses, development of design, formal clarification and negotiations of solutions and contract terms. It is important to recognise that the dialogue phase is the phase in the procedure which offers the greatest flexibility. It should therefore continue until the contracting body is satisfied that it has identified the solution or solutions capable of meeting its needs and requirements with sufficient precision to enable Final Tenders (which fully meet these requirements) to be submitted."

Commented [AG19]: Where does this quote start and end?

3.12.2 According to Para 5.11 of the NPD Guide: OJEU to Contract Award, "The NHSScotland body should establish clear lines of communication with participants to enable swift and effective exchanges of information. For example, specified contact points should be identified for clarification of the ITPD and ISFT documents and to arrange access to any further information or meetings with NHSScotland body officials. It is likely that standard documents such as Request for Information (RFI) Forms and full programme of meetings will be attached as appendices to the ITPD. This will help in ensuring compliance with the procurement regulations and in securing equal treatment of participants."

3.12.3 And para 5.12 states "Direct contact between Participants and Authority Advisers should be avoided where practicable. Ideally all communication should be through the Project Office using the standard RFI procedure. Information which is supplied to one participant should also be shared with other participants."

3.12.4 An NHSL Diagram outlines the Information Flow and Communications structure for Competitive Dialogue. Bidders would communicate with M Brown, Project Manager, who would communicate with S Cosens from NHSL, F MacQuarrie (senior Project Manager) Graeme Greer from Mott MacDonald, M Pryor from Ernst and Young, and A Orr from MacRoberts. Graeme Greer communicated with a team of technical advisors in Mott MacDonald. S. Cosens communicated with the Project Team in NHSL. M[a]cQuarrie, Michael Pryor and Andrew Orr communicated with their counterparts in NHSL (Brian Currie, C Potter and Iain Graham respectively).

3.12.5 Technical Advisors from Mott MacDonald included:

Graeme Greer
R Cantlay (lead TA)
David Stillie (Design and Construct)
Colin Macrae (Mechanical and Electrical)
S. Alderson (payment mechanism)
C. Thorburn (Facilities management)
S. Cull (ICT)

3.12.6 The NHSL Project team included

S Cosens (Project Manager)
Brian Currie (Design and Construct)
Janice MacKenzie (Design and Construct)
Jackie Sansbury (Facilities Management, and Commissioning and Equipment)
H Royston (Facilities Management)
J Stureon (ICT)
Fiona Halcrow (ICT)
N McLennan (Commissioning and Equipment)
Iain Graham (Legal and S&M)
C Potter (Financial)

3.12.7 NHSL did not have a healthcare planner to advise them during the Competitive Dialogue process.

3.12.8 The initial period indicated for Competitive Dialogue was from 07/05/2012 to 22/02/2012 when tender evaluation would begin. However SGHD and SFT felt this period could be reduced as it did not reflect the creation of the 'reference design' rather than the use of an exemplar design, which would have required additional work by bidders. In November 2012, after much debate between NHSL, SFT and SGHD, it was unanimously agreed to adopt a compressed programme for competitive dialogue [155 days rather than 209 days]. However, NHSL stated that their reservations remain and that in practice the decision to close dialogue would still dictate the achievement of this revised programme.

Commented [AG20]: When was this initially indicated? It is likely that there were a lot of versions of the programme.

Commented [AG21]: Should this be 2013?

Commented [AG22]: We would refer the Inquiry to our response to the Procurement Paper Question 4.9a and the Project Board Action Notes of Meeting of 13 May 2011 entitled, " RHSC + DCN – Little France – PROJECT BOARD #2" (which this reference is taken from), which states:

"*A "Dashboard" Report was tabled and the following views expressed and actions agreed regarding proposed strategic programme dates:*

As presented the programme is unacceptable to NHSL, SFT and SGHD given the estimated slippage in operational date from the previous Treasury funded project."

It is clear from the above that the programme in circulation at that time was unacceptable to SFT, NHS Lothian and Scottish Government. All parties were concerned about unnecessary delay and were keen to reduce timescales where possible, without impacting the effectiveness of the process.

In response to those concerned, SFT suggested areas where NHS Lothian could look to shorten the programme, which included shortening the period for Competitive Dialogue.

It was clearly important that that the Programme worked but equally we wanted it to be ambitious, given everyone's view that the programme was unacceptable.

3.12.9 A timetable of dialogue meetings was set out in paragraph 4.2 (Timetable of Dialogue Meetings) of the ITPD. This original timetable referred to six dialogue meetings. The week before each of the dialogue meetings each of the three bidders were required to submit an "informal submission" to the Board. There were five informal submissions in total set out in the ITPD.

3.12.10 In terms of agenda topics for the dialogue meetings and informal submission requirements, these can be summarised as follows:

(a) Appendix A of the ITPD set out the technical agenda topics and informal submission requirements;

(b) Appendix B of the ITPD set out the financial agenda topics and submission requirements; and

(c) Appendix C of the ITPD set out the legal agenda topic and submission requirements.

3.12.11 By early July 2013 NHSL had concerns about bidders progress on design and in July a decision was made to prolong the dialogue period by eight weeks to promote design compliance. On 12/07/2013 bidders received a brief change from NHSL. This brief change notified Bidders of Scottish Government support for single room derogation in DCN Acute Care. Bidders were requested to design DCN Acute Care to meet the clinical output specification. Changes were also made to the Project Brief for Theatres in both RHSC & DCN.

3.12.12 Additional dialogue meetings focused "primarily on Bidders' compliance with operational functionality and room sizes. These meetings were held with the Clinical Director, an NHSL Project Manager with detailed knowledge of the Reference Design, and an Architectural Adviser from Mott MacDonald.

Commented [AG23]: This designation is not used in the list of individuals above

This meant that there were additional dialogue meetings.

3.12.13 Thus the actual meetings for CD were as follows:

(a) Dialogue Meeting 1;
(b) Dialogue Meeting 2;
(c) Dialogue Meeting 3;
(d) Dialogue Meeting 4;
(e) Dialogue Meeting 4A;
(f) Dialogue Meeting 4B;
(g) Dialogue Meeting 4C;
(h) Dialogue Meeting 4D;
(i) Dialogue Meeting 5;
(j) Dialogue Meeting 5A; and
(k) Dialogue Meeting 6.

3.12.14 The NPD Guide OJEU to Contract Award, Section 2, figure 2 shows the 'Commitment expected at each stage of procurement from Participants on major projects':

State of contract discussions at end of stage:	Confirmation of acceptance of key positions in contract summary. Statement of acceptance of standard contract in principle.
Designer:	1:1000 plans with key depts at 1:500 moving to 1:500 with key departments at 1:200
Design and construct subcontractor:	Construction approach
Services sub-contractor:	Services approach

Bidding consortium:	confirmation that standard contract terms set out in ITPD will be acceptable to consortium members and sub-contractors.
Financial and Economic Standing/Funding:	Proposed methods of finance

3.12.15 An AEDET (Achieving Excellence in Design Evaluation Toolkit) review was undertaken during Competitive Dialogue. This review did not score the "Performance, Engineering & Construction" categories.

3.13 A **Draft Final Tender** was submitted by bidders on the 21st October 2013. This was a "dry run" for the Final Tender.

3.13.1 A summary of the Draft Final Tender requirements were as follows:

(a) For technical these included:
- (i) Executive summary summarising the bid;
- (ii) Strategic and management approach proposals;
- (iii) Approach to design and construction proposals, including the design deliverables set out in Appendix AP1.1 (Design Deliverables) of the ITPD;.
- (iv) Approach to facilities management proposals.

(b) For financial, these included:
- (i) Financial Model;
- (ii) Information to support the funding package;
- (iii) Payment Mechanism calibration commentary;
- (iv) Insurance premiums for construction and operational insurances.

(c) For legal, these included:
- (i) Mark-up of NPD Project Agreement, in clean and comparison form;
- (ii) Detailed commentary accompanying mark-up of NPD Project Agreement;
- (iii) Contractual matrix showing relationship between bidder and its supply chain;
- (iv) Fully developed signed heads of terms for the Contractor, Services
- (v) Provider and relevant Key Sub-contractors;
- (vi) Final versions of parent company guarantees;
- (vii) Final versions of the Articles of Association.

3.13.2 The Draft Final Tender was not evaluated by the Board. This was because the Draft Final Tender was used as a tool during the competitive dialogue period:

(a) for bidders to set out their solutions to the Board;

(b) for the Board to provide subsequent feedback on whether aspects of the Draft Final Tender met the Board's requirements as set out in the ITPD.

3.13.3 The Draft Final Tender review was completed on 13/11/13 with Compliance and Feedback Reports issued to each Bidder

3.13.4 The report for IHSL states: "The Bidder should note there are a number of responses submitted in the Draft Final Tender that are unsatisfactory and, as such, currently constitute a "fail" against the Board's minimum requirements; these unsatisfactory responses (clearly identified by inclusion of "the Bidder has not provided a satisfactory response") MUST be addressed and failure to do so within the Bidder's Final Tender is likely to result in the Final Tender being rejected… *The Bidder has not provided all the requirements as set out in ITPD Volume 1 Appendices AP1.1 Design Deliverables and AP1.2 Specifications; where these have not been submitted the Bidder has not provided a satisfactory response and this is likely to result in the Final Tender being rejected.*

The Board is disappointed that submissions have not developed in line with feedback and discussions in dialogue to date. The Board is unable to confirm whether the Bidder would meet the minimum requirements where an incomplete submission has been provided.”

3.13.5 With regard to C10 (energy management proposals) the report states “Energy modelling template matrix relied on too many rooms being assigned the “ward” tem[plate] in almost all instances where “Ward” template is applied, there is a more appropriate room template which could be used instead (dirty & clean stores, treatment rooms, diagnostic imaging rooms, offices etc. all have “ward” template applied).

3.13.6 A final dialogue meeting then took place between the Board and each bidder. This final meeting took place on the following dates:

(a) 19th November 2013 for Bidder A/B3;
(b) 20th November 2013 for Bidder B/IHSL;
(c) 21st November 2013 for Bidder C/Mosaic.

3.13.7 At this meeting the Board provided its feedback to each bidder in relation to their Draft Final Tender. This meeting was also an opportunity for the Board to clarify any outstanding points with bidders.

3.14 **Key Stage Review 2b**: Invitation to Submit Final Tenders was finalised on 13/12/2013.

Commented [AG24]: This reference should be to the "Pre-Close of Dialogue KSR" rather than "Invitation to Submit Final Tenders"

3.14.1 With regard to project requirements in section 2 of the review NHSL is asked to confirm, at question 2: “Is the Procuring Authority, and are its advisers, satisfied with the overall quality and level of detail supplied by bidders during dialogue in respect of the design and build and service delivery solutions and that bidders’ proposals are capable of meeting its requirements?” No answer is provided to this. Instead, there is a recommendation “That, prior to close of dialogue, the Board receives and copies to SFT, letters, in the form of the drafts which the Board have earlier provided to SFT, from each of its financial, legal and technical advisers confirming that each consider that it is appropriate for the Board to close dialogue”

3.14.2 Question 3 asks, “Based on dialogue with bidders is the Procuring Authority satisfied that the final tenders will contain solutions that satisfy its operational and functional requirements?” The answer provided is yes.

3.14.3 A second part of the question elaborates, “Are the Procuring Authority’s requirements in relation to the following matters clearly expressed in the IFT documents” is followed by a list of matters, one of which is Q.8. “the interface between design and the delivery of FM services (e.g. cleaning) and risks (e.g. energy consumption, security) retained by the Procuring Authority”.

Commented [AG25]: We would query the relevancy of this statement in referring to very specific elements of the KSR and suggest that it be removed.

3.14.4 Question 16 asks, “Please confirm what further development of technical information is required from bidders between now and final tender submission and from the preferred bidder between appointment and financial close. Is the Procuring Authority, and are its advisers, satisfied that this is achievable within the current project timetable?” The answer provided is “yes” with the comment: “100% compliance for operational functionality and minimum room layouts has now been achieved with all bidders. The Board has reviewed the bidders’ programmes for design development through to financial close. The Board consider that the programme from preferred bidder to financial close is challenging.”

3.15 **Competitive Dialogue closed** on 13/12/2013.

3.15.1 Once competitive dialogue closed, in line with the procurement regulations only fine tuning and clarification of bids were allowed in relation to each bidder’s submission (this being the Final Tender). Thus, all bidder issues had to be raised with the Board during the competitive dialogue period.

3.15.2 Paragraph 5.15 of SCIM Guide “From OJEU to Contract Award” states that the competitive dialogue stage should “continue until the contracting body is satisfied that it has identified the solution or solutions capable of meeting its needs and requirements with sufficient precision to enable Final Tenders (which fully meet these requirements) to be submitted.”

3.15.3 Similarly, paragraph 5.19 states “There is no limit on the number of stages which can be used provided that, at the end of the dialogue, there are sufficient participants to allow for a genuine competition”.

3.15.4 And paragraph 5.24 states, “It is vital that the dialogue continues until the contracting body has clearly identified and specified its detailed requirements, the solution(s) capable of meeting its needs and this, the basis upon which final tenders should be submitted. It must be confident that the remaining participants have sufficient information/clarity to be able to submit fully developed and “final” tenders as the next stage only permits “fine tuning””

3.16 **Bidders were invited to submit a Final Tender** on 16th December 2013 in accordance with the Invitation to Submit Final Tender (“ISFT”).

3.16.1 The ISFT comprised of four volumes:

- Volume 1: This set out the general requirements of the Board, this being background information on the Project, Final Tender requirements and how the Board intends to evaluate the Final Tender, award the Project and communicate with bidders;
- Volume 2: This set out the contractual requirements of the Board, which included the Final Tender (Bidder Specific) NPD Project Agreement, the Articles of Association and the Payment Mechanism;
- Volume 3: This set out the specific technical requirements of the Board, these being construction (clinical and non-clinical requirements), equipment requirements and facilities management requirements;
- Volume 4: This set out the room data available to bidders.

3.16.2 The Inquiry has not seen volume 4 of the ISFT.

3.16.3 The ISFT was issued in identical terms to each of the three bidders. The only exceptions were the following two documents which were tailored to each of the three bidders:

(a) Final Tender (Bidder Specific) Project Agreement

(i) This was set out in Volume 2 of the ISFT;.

(ii) This was the NPD Project Agreement which reflected all bidder specific amendments agreed between the Board, SFT and each bidder during the competitive dialogue period;

(b) Final Tender (Bidder Specific) Service Level Specification (i) This was set out in Volume 3 of the ISFT.

3.16.4 Only issues of fine tuning and clarification could be addressed by both the Board and the bidders once the competitive dialogue period had closed.

3.16.5 According to para 5.44 of the SCIM NPD guide “OJEU to Contract Award”, the final tenders “are equivalent to ITN responses under the negotiated procedures. However, unlike previously key issues cannot be negotiated following submission of final tenders.”

3.16.6 Para 6.1 states that agreement should be reached “on all contract issues with each bidder during the dialogue and require each bidder to submit its final tender on that

basis, such that any new contract issues raised in the final tender submission can render the bid noncompliant."

3.16.7 Para 6.22 states, "It is important that the Body is happy that a number of participants have developed acceptable solutions which will require minimum development following submission of Final Tenders. No material changes can be made to bids following submission of final tenders, unlike the previous negotiated procedures approach adopted in many PPP projects."

3.16.8 The design at this stage is expected to include 1:200 plans and 1:50 for key areas, cross sections, site plans, area schedule, performance specifications (amongst other things) to be used to provide a fixed price bid.

3.16.9 SCIM: 'Commitment expected at each stage of procurement from Participants on major projects':

State of contract discussions at end of stage:	Agreement on all key contractual issues affecting price and risk allocation, including payment mechanism and performance regime.
Designer:	1:200 plans with key departments at 1:50
Design and construct subcontractor:	Confirmation of acceptance of draft contract, payment mechanism, performance regime and allocation of risks within consortium.
Services sub-contractor:	Confirmation of acceptance of draft standard contract, payment mechanism, performance regime and allocation of risks within consortium.
Bidding consortium:	Full financial model. Agreement on all points of principle on specifications.
Financial and Economic Standing/Funding:	Statement of support from funders/equity with draft term sheet and acceptance of standard contract terms, payment mechanism and performance regime, financial model and allocation of risks within consortium.

3.17 **Final tenders** were submitted on 13/01/2014.

3.17.1 A summary of the Final Tender requirements is as follows:

(a) For the technical submission, these included:

(i) Executive summary summarising the bid. This would not be scored;

(ii) Strategic and management approach proposals. These proposals would be scored as a mixture of both pass/fail and scoring. If scored, this section would represent 5% of the available marks;

(iii) Approach to design and construction proposals, including the design deliverables set out in Appendix AP1.1 *(Design Deliverables)* of the ISFT. These proposals would be scored as a mixture of both pass/fail

and scoring. If scored, this section would represent 23% of the available marks;

(iv) Approach to facilities management proposals. These proposals would be scored as a mixture of both pass/fail and scoring. If scored, this section would represent 12% of the available marks;

(v) All technical submissions formed part of the "Quality Evaluation Mark", of which there were 40 marks in total.

(b) For the financial submission, these included:

(i) Potential funder details;

(ii) Funding competition methodology;

(iii) Programme to financial close and funding specific actions;

(iv) Exclusivity of funders;

(v) Risk capital information;

(vi) Extent of funder due diligence;

(vii) Security package information;

(viii) Financial Model;

(ix) Databook to support the Financial Model;

(x) Proformas;

(xi) Tax and accounting risk;

(xii) Tax advisor opinion;

(xiii) Detailed tax assumptions;

(xiv) Bid validity;

(xv) Surplus treatment;

(xvi) Hedging;

(xvii) Payment Mechanism.

In terms of financial evaluation, responses to questions (i) to (viii) would be on a scored basis. However, responses to questions (ix) to (xvii) would also be taken into account where these would have a bearing on the deliverability of funding. Such scoring would be applied as an adjustment to the Price Evaluation Mark. All financial submissions formed part of the "Price Evaluation Mark", of which there were 60 marks in total.

(c) For the legal submission, these included:

(i) Final Tender (Bidder Specific) Project Agreement. This required to be submitted without amendment unless removing Quantifiable Bidder Amendments (these being legal amendments which would result in an adjustment to the Bidder's Provisional Economic Cost Score, which would in turn impact upon the Price Evaluation Mark). This submission would be evaluated on a pass/fail basis. A pass would be

awarded if bidders accepted the Final Tender (Bidder Specific) Project Agreement. A fail would be awarded if this was not the case;

(ii) Additional Documentation, including:

- Contractual matrix showing relationship between bidder and its supply chain;
- Fully developed signed heads of terms for the Contractor, Services Provider and relevant Key Sub-contractors; • Final versions of parent company guarantees;
- Final versions of the Articles of Association.

This Additional Documentation submission would be evaluated on a pass/fail basis. A pass would be given if the additional documentation was based upon that submitted as part of the Draft Final Tender and addressed issues resolved during the final dialogue meeting. A fail would be awarded if the above was not the case.

(iii) Interface Proposals, including:

- Construction Access Proposal;
- Traffic Management Strategy;
- Oversail Strategy;
- Access Strategy;
- Supplemental Drainage Proposal;
- Substation Proposal;
- Service Proposal;
- Connection Proposal.

This Interface Proposal submission would be evaluated on a pass/fail basis;

3.18 **Evaluation of final tenders** took place from 13/01/2014 – 28/02/2014.

3.18.1 This was a shorter period than initially programmed. In November 2012, after much debate between NHSL, SFT and SGHD, it had been unanimously agreed to adopt a compressed programme with tender evaluation duration shortened from 75 days to 39 days.

3.18.2 The Board established a Core Evaluation Team to evaluate the Final Tender. The Board members of this Core Evaluation Team were as follows:

- Brian Currie as Project Director;
- Iain Graham representing Commercial and Legal;
- Janice MacKenzie representing Clinical and Service Users; and
- Jackie Sansbury representing Operations and Commissioning.

3.18.3 The evaluation of each criteria set out in the Final Tender was led by a member of the Core Evaluation Team and included members of the Board's project team and external advisers. The Board's external advisers were as follows:

- Mott MacDonald as technical adviser;
- Ernst & Young as financial adviser; and
- MacRoberts LLP as legal adviser.

3.18.4 In terms of the Quality Evaluation Criteria, which comprised of evaluating Section B *(Strategic and Management),* Section C *(Approach to Design and Construction)* and Section D *(Approach to Facilities Management)*, this was arranged as follows:

- Iain Graham led the evaluation of Section B *(Strategic and Management)* and was supported by Mott MacDonald, MacRoberts LLP and Ernst & Young. This was a scored and pass/fail evaluation;
- Brian Currie led the evaluation of Section C *(Approach to Design and Construction)* and was supported by Mott MacDonald. This was a scored and pass/fail evaluation;

- Jackie Sansbury led the evaluation of Section D *(Approach to Facilities Management)* and was supported by Mott MacDonald. This was a scored and pass/fail evaluation.

3.18.5 The Price evaluation was led by Iain Graham, supported by Ernst & Young.

3.18.6 Evaluation reports or letters were issued to the Board by the following advisors:

- Ernst & Young issued a report titled “Final Tender Financial Evaluation Report re-provision of RHSC & DCN at Little France” dated February 2014;
- MacRoberts LLP issued a report titled “Legal Report in relation of the Final Tender legal submissions submitted by Bidder A, Bidder B and Bidder C relating to the re-provision of the Royal Hospital for Sick Children, child and adolescent mental health service and the Department of Clinical Neuroscience at Little France” dated 12th February 2014;
- Willis issued a report titled “Insurance Evaluation Report prepared for NHS Lothian in relation to RHSC & DCN Project”, version 5 dated 17th January 2014.
- Motts issued a letter titled “Re-provision of RHSC & DCN at Little France– Evaluation”, dated 4th March 2014.

3.18.7 Each of the evaluation teams for Section B *(Strategic and Management),* Section C *(Approach to Design and Construction)* and Section D *(Approach to Facilities Management)* completed pro forma “Reviewer comments” excel spreadsheets for each individual submission from each bidder.

3.18.8 Brian Currie and E Bain from NHSL were responsible for evaluation of C8 – M&E engineering design proposals and C10: energy management proposals. They were advised by Kamil Kolodziejczyk and Colin Macrae, technical advisors from Mott MacDonald. They gave IHSL’s submission for C8 “Clarity, robustness and quality of M&E engineering design proposals” an overall score of 5, meaning “satisfactory”. This meant they assessed that the Bidder’s approach:

- demonstrates a satisfactory understanding of all aspects of the Board’s requirements; and/or
- proposes a solution which performs satisfactorily in complying with the Board’s requirements.

3.18.9 However, according to the Reviewers Comments with regard to specific components of the submission, many of the components “lacked detail” or were ‘basic’ or ‘minimal’, and some things were not provided. For example under
x. An environmental conditions / room provisions matrix for both mechanical and electrical services for each room in the Facilities (Reviewer comments: “No matrix provide, (sic) but environmental layout drawings provided.”)

xi. Major plant life cycle statements… to support the lifecycle costing analysis completed in the technical costs proforma. (Reviewers comments: Basic statement referring to CIBSE guidance for life cycles. No costs provided).

3.18.10 The Inquiry does not have the proforma report for C10, but this was scored 7,meaning ‘good’.

3.19 **Key Stage Review 3**: Pre-Preferred Bidder was finalised on 28/02/2014.

3.19.1 In this KSR the procuring authority confirms that they are satisfied that the proposed preferred bidders solution will satisfy its operational and functional requirements and deliver the project objectives, benefits and outcomes. The procuring authority also confirms that it, and its ~~it's~~ advisors, are satisfied that further development of technical information required from the preferred bidder appointment to financial close is achievable within the current project timetable.

3.20 **Selection of the preferred bidder** took place between 28 February 2014 and 5 March 2014.

3.20.1 On 28 February 2014 Sorel Cosens submitted a paper to the Steering Board on Project Procurement and Recommendation of Preferred Bidder, confirming completion of the evaluation of Final Tenders. Brian Currie/Iain Graham highlighted that the three bids were extremely close which was a testament to the success of the competitive dialogue in ensuring that all three bids met NHSL's requirements. George Walker, Non-Executive Director, NHSL, commented that it was an important point that if cost is close then quality wins.

Commented [AG26]: George Walker's comment was recorded in the Minute. However, it does not align with the agreed evaluation methodology. It would perhaps be relevant to include the scoring in this section.

SFT was not involved directly in the evaluation and does not have a copy of the scoring matrices.

3.20.2 The Board held Core Evaluation Team meetings with its advisers on 3rd March 2014. At this meeting, the Quality Evaluation Mark and the Price Evaluation Mark was combined for each bidder, i.e. the mark out of 100 for each bidder.

3.20.3 On 5th March 2014, the Project Director prepared a report dated 5th March 2014 for the Board's Finance and Resources Committee. This report recommended that IHSL be appointed as Preferred Bidder. The Finance and Resources Committee approved this recommendation on 5th March 2014.

3.20.4 On 6th March 2014 a further Core Evaluation Team meeting was held by the Board and its advisers in relation to de-brief preparation and the first Preferred Bidder meeting.

3.21 Preferred Bidder Clarification and confirm commitments

Commented [AG27]: Is this a complete paragraph?

3.22 Following authorisation by the Finance & Resources Committee, the Board issued a **Preferred Bidder letter** to IHSL on 5th March 2014. Standstill letters were issued to both B3 and Mosaic on 5th March 2014.

3.22.1 This Preferred Bidder Appointment stated that:

- IHSL's Final Tender submitted on 13th January 2014, as clarified and amended by Schedule Part 5 (Clarifications in respect of IHSL's Final Tender) of the Preferred Bidder Appointment, had been evaluated as the most economically advantageous Final Tender; and
- Subject to IHSL and its consortium accepting the terms of the Preferred Bidder Appointment, the Board approved the recommendation to appoint IHSL as the Preferred Bidder for the Project on the basis of its Final Tender.

3.22.2 This letter was the basis for the Preferred Bidder Appointment as follows:

- Schedule Part 1 *(Terms of Preferred Bidder Appointment)* set out the terms of IHSL's appointment as Preferred Bidder; this included at 4.4 developing certain technical schedules of the Final Tender NPD Project Agreement, including room data sheets. And under 4.5 "IHSL shall further develop their Design included within their Final Tender to the level set out in the Invitation to Submit Final Tender (as a minimum)."
- Schedule Part 2 *(Preferred Bidder to Financial Close)* set out the timetable to reach financial close of the Project;
- Schedule Part 3 *(IHSL's outstanding issues to be addressed in respect of the Project)* set out the issue to be resolved, including legal and contractual issues, interface issues, strategic and management issues, design and construction issues, facilities management issues and planning issues;
- Schedule Part 4 *(IHSL's gaps in relation to the Final Tender (Bidder B) NPD Project Agreement)* set out any "gaps" in this Project Agreement, such as where square brackets required to be completed;
- Schedule Part 5 (*Clarifications in respect of IHSL's Final Tender)* sets out the clarifications raised by the Board in respect of IHSL's Final Tender. These clarifications clarified or amended IHSL's Final Tender.

3.22.3 IHSL returned a signed Preferred Bidder letter to the Board on 7th March 2014. The first meeting between the Board and IHSL as Preferred Bidder was held on Thursday 13th March 2014.

3.23 **Further design development** took place from March 2014 to Financial Close

3.23.1 According to para 5.67 of the NPD guide, "The design at Final Tender stage must be sufficiently developed to enable the best tender to be selected but does not need to be at the level of detail which would be expected at contract signature stage. The process of design development, provided it has no or minimal impact on overall cost, should be regarded as clarification of design which should still be permissible under competitive dialogue."

3.23.2 An RHSC Clinical Design Task Group was formed to progress the design of the new hospital.

3.23.3 During this period NHSL became concerned about the design development undertaken by IHSL. The delayed delivery of detailed design 'sufficient to proceed to financial close' resulted in a delay to the programme.

3.23.4 A Special Steering Board meeting was held on 22/08/2014 involving NHSL, Mike Baxter from the Scottish Government Health Department, Peter Reekie from SFT and Richard Osborne and Ross Ballingall from ISHL. The purpose of the meeting was to raise NHSL's 'significant concern' and give IHSL an opportunity to discuss progress. The NHSL project team presented a revised programme with slippage of 8 weeks, and IHSL tabled their own programme. IHSL said that there was a mismatch between the expectations of NHSL and IHSL "where IHSL were being asked to deliver much more than on other projects, and considerably more than was required for comfort of operational functionality".

3.23.5 By 23 September 2014 NHSL still had concerns, including that the designers were 'not up to speed' and that Brookfield Multiplex were controlling the position for commercial reasons.' Iain Graham outlined some options, which included the option to reject IHSL as Preferred Bidder. His recommendation was to "accept the position "next week or so" to nearly meet the programme", but that the timeframe for "next week or so" and the meaning of "nearly" had still to be decided.

3.23.6 By the end of October 2014 the Board had agreed latitude on signing off operational functionality where 100% technical info was not yet produced. The Board's Construction Requirements had been updated in dialogue with IHSL, which reduced the extensive list of derogations that would be required of IHSL.

3.23.7 On 13 November 2014 Mott MacDonald undertook a review of IHSL's Schedule of Accommodation and Environmental Matrix with a view to updating the Gross Service Unit Table (GSU) for inclusion in Schedule Part 14 (Payment Mechanism). Mott MacDonald found a number of issues with both IHSL documents. They undertook a review to mitigate risk of using inaccurate data in the Payment Mechanism, but "there is a residual risk of inaccuracies in the GSU table that could impact the Boards ability to apply deductions." They provided recommendations for how to proceed with the Schedule of Accommodation (SoA), GSU table and Environmental Matrix (EM). Option 1 was to request IHSL to issue an updated SoA and EM, and the Board update GSU table based on the updated SoA. Option 2, "due to programme constraints" was to simply add a caveat to Part 4 of Section 5 (Reviewable Design Data) of Schedule Part 6 (Construction Matters).

3.23.8 On 18 November 2014 the Board prepared a paper "Board Commentary on the Technical Information Requested by the Board and Technical Information issued by IHSL." Which concluded that

- The level of information requested by the Board and accepted by IHSL has been clearly documented;

- The level of information requested is considered reasonable and in line with other projects;
- The Preferred Bidder has been late in providing information at each stage;
- The quality of the information submitted has not been in line with the level expected"

3.23.9 By Financial Close risk registers recorded that there was significant amount of Reviewable Design Data with the risk that if the Board was unable to respond in 15 days due to resourcing constraints the item under review would be deemed to be accepted. Furthermore the design of single-room ventilation was non-compliant with SHTM 03-01.

Commented [AG28]: Whilst this is not a point for SFT, this appears to be a significant statement for which more supporting context and evidence should be set out in greater detail.

3.24 **Contract negotiation** took place between 13/03/2014 and 11/02/2015.

3.24.1 Contract negotiation took longer than expected. Following appointment of the Preferred Bidder the initial target to reach financial close (FC) was 27/11/2014. By 31/10/2014 it was recognised that this would be 'impossible' to achieve and that even an FC date of 12/12/2014 would be 'very challenging' and 'possibly unachievable'.

3.24.2 The delays in the development of the design and project co proposals, and provision of technical information had a knock-on effect. For example Juan MiguelCustodio, Associate- Macquarie Capital Group Ltd noted on 31 October 2014 he was not comfortable with the pressure for the finance team to deliver when the technical info was late.

3.24.3 Other issues were that the list of derogations submitted by IHSL was longer than that submitted at final tender, IHSL continued to raise legal issues closed out at final tender and discussions with the European Investment Bank proved lengthy and had a knock-on effect on the appointment of a commercial funder.

3.25 On 15 April 2014 an **HAI-Scribe review** took place.

3.25.1 Attendees included Andrew Wills, Janette Richards and Norman Lee from NHSL, Emma Heggarty from Hub South east, David Geddes from Morrison Construction and Alex McDonald from Rybka.

3.25.2 HAI-SCRIBE is an acronym for 'Healthcare Associated Infection System for Controlling Risk in the Built Environment". It was developed by Health Facilities Scotland "as an effective tool for the identification and assessment of potential hazards in the built environment and the management of those risks" It includes a question set relating to different stages of the development and maintenance of the healthcare facility including amongst other things, design and planning.

3.25.3 On page 2 (of 31) it is noted "Care needs to be taken to ensure that the System does not become a mechanical 'box-ticking' exercise, but rather a rigorous questioning and auditing of proposals and of operating facilities'. Furthermore, "The implementation of HAI-SCRIBE should be the responsibility of a multidisciplinary team of specialists with appropriate skills, and may include: an architect, a building services engineer, an infection control specialist, a risk manager, an estates/facilities manager and other appropriate specialists"

3.25.4 In the question set for Development Stage 2: HAI-SCRIBE applied to planning and design stage of development the following questions have been ticked 'yes'

- 3.2 Is the ventilation system design fit for purpose, given the potential for infection spread via ventilation systems?

- 3.3 Has account been taken of the use of natural ventilation being affected by neighbourhood sources of environmental pollution as discussed in Development Stage 1?

- 3.13 Is there satisfactory provision of isolation facilities for infectious and potentially infectious patients? (a star has been pencilled in next to this question, although the 'yes' box is ticked)

3.26 A **Formal NDAP report** is usually required before consideration of the Full Business Case by Capital Investment Group, but did not take place for the RHSC/DCN project.

3.26.1 According to SCIM Supporting Guidance: Design Assessment in the Business Case Process (2011), "There are two complimentary areas of consideration in the design of healthcare buildings. These can broadly be described as healthcare specific design aspects – the areas generally covered by guidance issued by Health Facilities Scotland - and general good practice in design considering the human experience of being in and around buildings, sustainability and the effective and efficient use of resources directed towards achieving whole life value for money." Consideration of these was brought together in the NHSScotland Design Assessment Process (NDAP), facilitated by Health Facilities Scotland (HFS) and Architecture and Design Scotland (A&DS).

3.26.2 Submission requirements for the Full Business Case NDAP are as follows *For all projects*

- Completed submission pro-forma identifying key contacts and dates.
- Design Statement , with any updates in benchmarks highlighted.
- Evidence of completion of self assessment on design in line with the procedures set out in your design statement.
- Extract from draft FBC detailing benefits and risks analysis (appendix 3 in SCIM).
- Completed AEDET review at current stage of design development.
- 3D sketches of design proposals for key spaces identified in Design Statement.
- Updated list of relevant design guidance to be followed (see section 1.1) and schedule of any derogations in relation to these.
- Evidence that DDA compliance will be achieved
- Evidence that Activity Data Base (ADB) is being fully utilised during the preparation of the brief and throughout the design and commissioning process

For NPD schemes, the following information.

- Design proposals from the Preferred bidder
- Site layout showing wider context and landscape proposals
- Plans rendered to distinguish between use types (circulation, consult)
- Elevations showing design in context
- 3D visualisations of the building in context - perspectives should be constructed from a human eye height (rather than birds eye views).
- Evidence of consultation with Local Authority Planning Department on their approach both to site development and the strategy adopted by the preferred bidder.

3.26.3 According to para 1.4 of the guide, Projects that have not received approval of their Outline Business Case (OBC) by 1st July 2010 shall be considered for the assessment process on a case by case basis.

3.26.4 In April 2013 Mike Baxter wrote to Brian Currie that he "would not expect our position on NDAP to change…therefore would expect HFS to contribute via the planning process. With regard to the type of review that would have been conducted via HFS as part of the Design Assessment Process I would expect to challenge this as part of the questioning around the FBC."

3.27 **Gateway 3 Review** usually takes place before the Full Business Case is submitted to CIG, but did not take place for the RHSC/DCN project.

3.27.1 The purpose of the Gateway 3 review is to confirm that the recommended investment decision is appropriate before the contract is placed with a supplier or partner (or a work order placed with an existing supplier or other delivery partner). It provides assurances on the processes used to select a supplier (not the supplier selection decision itself). The Review also assesses:

- whether the process has been well managed
- whether the business needs are being met
- that both the client and the supplier can implement and manage the proposed solution
- that the necessary processes are in place to achieve a successful outcome after contract award (or equivalent)"

3.27.2 After the switch to NPD the RHSC was subject to a new assurance process. SFT conducted Key Stage Reviews. According to SFT, projects that were also subject to Gateway Reviews would in future follow a single Integrated Project Assurance Model (IPAM) process. IPAM reviews "will be led by SFT and the Reviewer will liaise with the Gateway Review Team as appropriate. Under IPAM the KSR element of the review will follow the format outlined above with the exception of the final report for each stage forming part of a single overall assurance response and set of recommendations." It was noted that this approach was being piloted on a transport project and that in the meantime both processes would apply.

3.27.3 In an update for CIG in March 2015 it was noted that Gateway 3 was cancelled, with the comment "subject to KSR – possible GR4 2016"

Commented [AG29]: We would refer the Inquiry to our response at Question 4.4 b of the Procurement Paper question.

The IIB Minute of Meeting entitled, **"INFRASTRUCTURE INVESTMENT BOARD, 24 May 2012, Simplifying The Project Assurance Landscape (Update)"** notes that a policy decision was made whereby Gateway 2 and Gateway 3 were no longer required for Revenue Funded NPD projects as that area of assurance was provided by the Key Stage Review process.

3.28 The **Full Business Case** was initially submitted to CIG on 8 August 2014, with an addendum and final version produced in April 2015 after financial close.

3.28.1 The purpose of the Full Business Case is to

- identify the 'market place opportunity' which offers optimum Value for Money
- set out the negotiated commercial and contractual arrangements for the deal
- demonstrate that it is 'unequivocally' affordable
- put in place the detailed management arrangements for the successful delivery of the scheme

3.28.2 The FBC includes:

- Strategic Case: Strategic Case confirmed/updated
- Economic Case confirmed or updated
- Commercial Case:
  - Detail each procurement selection process
  - Confirm scope of procured works & services
  - Confirm main contractual arrangements
- Financial Case
  - Confirm financial implications of project and project & affordability
  - Stakeholder sign-off
- Management Case:
  - Confirm details of management arrangements outlined in OBC to demonstrate that organisation is ready & capable of proceeding to contract award & implementation
- According to SCIM guidance the following commitments are expected for the Full Business Case (at the end of the 'preparation of full business case').

3.28.3 NPD Guide section 2 'Commitment expected at each stage of procurement from Participants on major projects' p.9:

State of contract discussions at end of stage:	Fully developed contract drafts
Designer:	1:200 plans with key departments at 1:50
Design and construct subcontractor, services subcontractor and bidding consortium:	Final sign-off on draft contract, payment mechanism, performance regime and allocation of risks within consortium
Financial and Economic Standing/Funding:	Due diligence commences prior to submission of Full Business Case

3.28.4 However, para 7.9 states that "It is expected that while the FBC is being considered for approval, the NHSScotland body and private sector partner will continue to work up the detailed contractual documentation and that due diligence on behalf of the financiers will be continuing. NHS bodies will be required to demonstrate that schemes are sufficiently close to financial close before FBC approval will be given."

3.28.5 Version 1 of the business case was approved by the Board on 6 August 2014 for initial submission to CIG on 8 August 2014. Comments were received from CIG on 20 August and the FBC was submitted again to SGHD Capital Investment Group on 21 August 2014

3.28.6 In order to progress contract negotiations in February 2015, funders said that they required an FBC approval letter. Iain Graham, Director of Capital Planning and Projects, NHSL, was concerned to 'get the balance right' in this letter by confirming approval of the FBC while not raising further questions about the project.

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3.29 The **Full Business Case was approved** by CIG on 9/02/2015.

3.29.1 An addendum to the Business Case was approved by the NHS Lothian Board on 1 April 2015 for submission to the Scottish Government Health and Social Care Directorates. The final version of the FBC was produced thereafter in April 2015 but did not go through any SG approval. A public version was shared in May 2015.

[The process of completing an FBC Addendum after Financial Close is normal for NPD projects as certain elements including the final Unitary Charge cannot be known until the interest rates for the finance are agreed at Financial Close.]

3.29.2 Following the final stage of negotiations there were some changes from what was described in the initial Full Business Case. These are outlined in the FBC addendum and include.

- Commercial Case:
  - Standard form NPD Project Agreement and risk allocation updated to include the specific funding model arising from the funding competition and capital expenditure changes.
  - The construction and delivery programme was updated to reflect the delay in achieving financial close.
  - Contractual changes to address the ESA 2010 accounting treatment to maximise the potential for the project to be classified to the private sector ~~remain off balance sheet~~ – "removing sector control from the corporate affairs of the special purpose vehicle (SPV) and to vest this in the hands of an independent expert rather than through the public sector director.

Commented [AG30]: This email chain refers to the agreement between NHS Lothian and SG of the SG's FBC Approval Letter. Sight of such a letter is a normal Condition Precedent of reaching Financial Close required by Funders.

We believe that Iain Graham's comment was around the level of detail included in SG's letter rather than, as this paragraph appears to infer, some wider concern. The paragraph could perhaps be removed or if it is retained it should be explained in more detail.

Commented [AG31]: See comments made at para. 3.2.1 above.

The amendment was principally to the Articles of Association of the SPV with consequential minor changes in the Project Agreement."
  - Changes to funding package made after "a post preferred bidder funding competition, completed on 13 October 2014". Involves lower rates due to 'more liquid and competitive' debt market.
- Financial Case:
  - Increase in total capital value of the project, from £227m at FBC to £230m. "Design development and inflation are the key drivers of the £3.3m increase in NPD capital costs"
  - "The projected annual service payment (ASP) over the 25 year period is estimated at £432m, a reduction of £75m compared to the FBC."
    - NHSL face minor increase in costs in first year of operations.
- Management Case:
  - "Developments since the FBC submission: SFT has~~ve~~ nominated Tony Rose as Public Interest Director for IHS Lothian Limited; and t~~T~~he chairmanship of the Project Steering Board will pass to the Director of Acute Services as the client, recognising responsibility for the operational facility once it opens."
  - "Key milestones in the project plan have been updated" with project completion with construction completion and handover to NHS Lothian moved to July 2017.

3.30 The **Pre-Financial Close KSR** was completed on 11/02/2015.

3.30.1 The KSR could only be completed once some issues in relation to ESA10 were resolved.

3.30.2 Under "Project requirements" the following questions are asked:

- Question 2, "Is the Procuring Authority satisfied that the preferred bidder's solution satisfies its operational and functional requirements and delivers the project objectives, benefits and outcomes?" The answer provided was "Yes. The detail of the design has been discussed with user groups to ensure clinical support and the Board confirms that it has received appropriate internal sign off."

- Question 3, "confirm the status of the technical documentation (i.e. design, construction and FM requirements)"… etc The answer provided was that "The Board has confirmed that the technical documentation is at a level of development consistent with the current stage of the Preferred Bidder to Financial Close programme. …Board is "content with the documentation subject to further development through RDD following Financial Close"

3.31 Contract documents including the Project Agreement and all of the contracts setting out the financial arrangements, were signed on 13/02/2015, marking **financial close**.

4. Questions:

1. Please provide any corrections or clarifications to the above narrative that you feel necessary or appropriate. Where such corrections or ~~clarificaitons~~clarifications are made, please provide supporting documentation.

2. Please state your understanding of the role of the following organisations in the procurement process:
   a. NHSL
   b. SFT
   c. Mott MacDonald
   d. Scottish Government (including Capital Investment Group)
   e. HFS

3. With regard to the preparation of the Invitation to Participate in Dialogue (section 3.1)

   a. Who advised NHSL on the how to set out the technical specifications for construction works? What reasons were given for this approach?
   b. What was the process for deciding the quality evaluation criteria weighting for the ITPD?
   c. NPD guidance suggests that "weightings can be applied to reflect the procuring authority's priorities in relation to the various other aspects of bidders' proposals." Was regard had to any further guidance on how priorities were to be determined for healthcare projects?
   d. Was the ITPD, including the tender evaluation criteria, reviewed from an infection control/design compliance perspective? If yes,
      i. who conducted the review, what were their qualifications, and what was their input?
      ii. Is it expected that the quality evaluation criteria weighting would have any impact on bidders approach to developing their proposals?

4. With regard to the Pre-OJEU KSR (section 3.3)
   a. How was the issue regarding interface/conflict with SFT's multiple roles addressed?
   b. Was there a final policy position regarding Key Stage Reviews, Gateway Reviews and IIB reviews? If yes could you provide the final document/paper that clarifies this position?
   c. Is the Inquiry correct in its view that this KSR does not consider the project from an SHTM compliance, patient safety or infection control perspective?

5. Was any Market Sounding done? If yes,
   a. What did this involve?
   b. What was the result?
   c. If the answer to the above question is no, then why was market sounding not done?

6. With regard to the PQQ evaluation (section 3.9)
   a. Was the PQQ evaluation process shortened and what impact did that have?
   b. Was any significance attributed to IHSL's designated organisation, Wallace Whittle, having no health PPP experience? Is this usual for a hospital re-provision project?

7. With regard to Key Stage Review 2a: Pre-invitation to participate in dialogue (section 3.10):
   a. Was SFT satisfied that the ITPD clearly reflected the mandatory and non-mandatory elements of the reference design, as well as the concept of Operational Functionality?
   b. Is the Inquiry correct in its view that this KSR does not consider the project from an SHTM compliance, patient safety or infection control perspective?

8. With regard to the Invitation to Participate in Dialogue (section 3.11)
   a. Was volume 4 of the ITPD produced?
   b. Could you confirm or provide the final version of the ITPD issued to bidders?

9. With regard to competitive dialogue (section 3.12)
   a. Was timetable for competitive dialogue considered ambitious and/ or adequate?
   b. What advice or input did NHSL receive regarding the programme for Competitive Dialogue and from whom?
   c. Did NHSL receive advice during the Competitive Dialogue period in respect of infection prevention and control, clinical needs/requirements, and compliance with SHTMs and other regulations? If so, from whom and in relation to which topics?
   d. Could NHSL provide a detailed explanation of the design review process during Competitive Dialogue.
   e. What does an AEDET review of 'performance, engineering and construction' involve?
   f. Specifically, would an AEDET review pick up any issues with ventilation proposals including their compliance with SHTM 03-01?

g. Was 'performance, engineering and construction' scored at any other time during the procurement process?

h. What impact did the Brief Change have on the Competitive Dialogue Process?

10. With regard to the draft final tender (section 3.13)
    a. What is the purpose of the draft final tender?
    b. What is meant by "compliant design' in the context of tender submissions?
    c. Against what criteria was compliance assessed?
    d. Who conducted the review of the draft final tender?
    e. Did the timetable allow sufficient time for bidders to do all the additional work required in the timeframe provided before submission of final bids?
    f. According to SCIM Guidance, interim submissions during Competitive Dialogue can be used to further down-select or short-list bidders depending on their performance, and only two bidders need to be issued with an ISFT. Did NHSL consider down-selecting to 2 bidders based on the draft final tender submissions received?

11. With regard to the closure of competitive dialogue (section 3.15)
    a. What guided the decision to close Competitive Dialogue?
    b. Were any concerns raised by members of the Steering Board about closing competitive dialogue?
    c. Before closing Competitive Dialogue was the Board comfortable that one or more solutions were capable of meeting its needs?

12. With regard to the invitation to submit final tender (section 3.16)
    a. Did the design produced by bidders at this stage include 1:200 plans and 1:50 for key areas, cross sections, site plans, area schedule, performance specifications? Are these required for providing an accurate fixed price bid?
    b. Did NHSL, Mott MacDonald or SFT raise concerns about the state of designs submitted by bidders?

13. With regard to the evaluation of final tenders (section 3.18)
    a. What qualifications did the individuals scoring C8 (M&E engineering) and C10 (energy management) have?
    b. What was the final tender evaluation of C10 (energy management proposals) for IHSL? Can we be provided with the full report.
    c. IHSL's tender submission was marked satisfactory notwithstanding that many elements were said to be 'basic', 'lacking detail' and 'minimal'. What was considered to the threshold for a "satisfactory" marking and how was the marking and the threshold calculated?
    d. Did IHSL's final tender submission on C8 mechanical and electrical engineering and C10 energy management address concerns raised in the draft final tender feedback?

14. With regard to the selection of the preferred bidder (section 3.20), please provide a copy of the final tender evaluation report showing the final scoring of the three bidders.

15. With regard to the preferred bidder letter (section 3.22)
    a. Do points 4.4 and 4.5 in Schedule 1 of the appointment letter indicate that IHSL had not developed their design to the stage required by the ISFT?
    What were the implications of this?
    b. Did any of the bidders develop their design to the stage required by the ISFT?
    c. Is it usual to have this number of outstanding issues, gaps and points for clarification in relation to the final tender?

16. With regard to Design Development (section 3.23)
    a. What were the governance arrangements in respect of design development and review between the selection of the preferred bidder and financial close?
    b. What was the RHSC Clinical Design Task Group, what did they advise on and who did they advise?

c. Did the late delivery of design and technical documents allow time for proper review before financial close?

17. With regard to the HAI-Scribe Review (section 3.25)
    a. What was the evidentiary basis for the results of this review, particularly in relation to the answer given for 3.2 and 3.3 of HAI-Scribe?
    b. Apart from HAI-Scribe, were any other design reviews conducted before Financial Close that considered infection control?
        c. What were the qualifications of members of the review team?

18. With regard to the NDAP (section 3.26)
    a. What was the advice given in respect of HFS involvement in design review, including the NDAP process for full business case?
    b. Regardless of whether an NDAP took place or was required, were the submission requirements for an NDAP met before consideration of the Full Business Case by CIG, or could they have been?
    c. What does HFS review of the required submission documents involve?

19. With regard to Gateway 3 Review (section 3.27), did the pre-Financial Close KSR address the questions assessed in a Gateway Review specifically:
    a. whether the process has been well managed
    b. whether the business needs are being met
    that both the client and the supplier can implement and manage the
        c. proposed solution
        d. that the necessary processes are in place to achieve a successful outcome
    after contract award

20. With regard to the Pre-Financial Close KSR (section 3.30), on what basis did the Board/Procuring authority and SFT have confidence to answer question 2 and 3 in the affirmative? Please provide copies of any advice or other documents that were relied upon in this regard.

Scottish Hospitals Inquiry

Hearing commencing on 24 April 2023

Bundle 10 – Miscellaneous