

Midland Metropolitan Hospital

Final Business Case

January 2016

Appendices Volume 4



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APPENDIX 16a – MARKET SHARE ANALYSIS

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Sandwell and West Birmingham Hospitals NHS Trust

Defining Service Development Investment in our LTFM

Purpose

This briefing note describes the activity, capacity and productivity implications associated with our service development income and in particular the repatriated activity element of this. Based on agreement with Sandwell and West Birmingham (S&WB) CCG it focuses on:

- Elective inpatient catchment loss assumptions
- The potential for attracting S&WB CCG activities from other local providers (in Sandwell CCG modelling) to us across the timeline.
- The transfer of activity from acute services to community provision.

Context

The LTFM presents the following position:

REPATRIATION & COMMUNITY DEVs BUILT INTO LTFM MODELLING									
Acute & Community	Future Years								
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Developments	£m	£m	£m	£m	£m	£m	£m	£m	£m
Repatriation Targets									
Income Forecast	0.0	3.0	5.9	7.6	10.5	14.0	17.0	18.7	18.7
Forecast Costs									
Pay	-	- 1.8	- 2.5	- 2.6	- 2.9	- 4.3	- 5.6	- 6.1	- 6.1
Non Pay	-	- 0.2	- 0.4	- 0.5	- 0.8	- 1.0	- 1.2	- 1.3	- 1.3
Total	-	- 2.0	- 2.9	- 3.1	- 3.6	- 5.3	- 6.9	- 7.4	- 7.4
Contribution Modelled	-	1.0	3.1	4.4	6.9	8.7	10.2	11.2	11.2
% of Investment		33%	51%	59%	65%	62%	60%	60%	60%
WTE Growth	-	40.0	55.0	57.8	64.3	96.9	126.3	136.2	136.2
Community Based Developments									
Income Forecast	-	-	2.4	6.6	9.8	11.8	14.4	17.5	19.7
Forecast Costs									
Pay	-	-	- 1.9	- 4.9	- 6.8	- 8.7	- 9.9	- 11.7	- 14.2
Non Pay	-	-	-	- 0.7	- 2.0	- 1.9	- 3.0	- 4.0	- 3.5
Total	-	-	- 1.9	- 5.6	- 8.8	- 10.6	- 12.9	- 15.8	- 17.7
Contribution Modelled	-	-	0.5	1.0	1.0	1.2	1.5	1.8	1.9
% of Investment			19%	15%	10%	10%	10%	10%	10%
WTE Growth	-	-	46.6	117.4	164.2	209.9	238.1	281.9	340.9
SDEV 1 & 2 Combined									
Income Forecast	-	3.0	8.3	14.1	20.3	25.9	31.5	36.2	38.3
Forecast Costs									
Pay	-	- 1.8	- 4.4	- 7.5	- 9.7	- 13.1	- 15.5	- 17.8	- 20.3
Non Pay	-	- 0.2	- 0.4	- 1.2	- 2.7	- 2.9	- 4.3	- 5.4	- 4.9
Total	-	- 2.0	- 4.8	- 8.7	- 12.4	- 16.0	- 19.8	- 23.2	- 25.2
Contribution Modelled	-	1.0	3.5	5.5	7.9	9.9	11.7	13.0	13.2
% of Investment		33%	42%	39%	39%	38%	37%	36%	34%
WTE Growth	-	40.0	101.6	175.2	228.5	306.8	364.4	418.1	477.1
Nominal View									
Tariff Deflation	100%	100%	98%	96%	95%	95%	95%	95%	96%
Pay Inflation	100%	102%	102%	103%	105%	107%	110%	112%	114%
Non Pay Other Inflation	100%	101%	104%	107%	110%	114%	118%	122%	127%
When Converted to Nominal View with future Inflation , then in total:									
Combined Future Price Base									
Income Forecast	-	3.0	8.1	13.5	19.2	24.5	29.8	34.5	36.7
Forecast Costs									
Pay	-	- 1.8	- 4.5	- 7.7	- 10.2	- 14.0	- 17.0	- 19.9	- 23.2
Non Pay	-	- 0.2	- 0.4	- 1.3	- 3.0	- 3.3	- 5.0	- 6.6	- 6.2
Total	-	- 2.0	- 4.9	- 9.0	- 13.2	- 17.3	- 22.1	- 26.5	- 29.4
Contribution Modelled	-	1.0	3.2	4.5	6.1	7.2	7.8	8.0	7.4
% of Investment		32%	39%	33%	31%	29%	26%	23%	20%
WTE Growth	-	40.0	101.6	175.2	228.5	306.8	364.4	418.1	477.1

Approach

In order to define our service development income a number of themes have been created that reflect potential service model and related activity changes. These are:

1. No Elective Catchment Loss

Withdraw the elective inpatient catchment loss rule for S&WB CCG and assume this activity will no longer be lost to us on the basis that initial access is via outpatient and diagnostic services which we will continue to offer locally at STC, BTC and RRH. It is rare once patients have received an initial diagnosis and decision to admit, to choose an alternative clinical team and therefore provider for planned inpatient care. The Emergency catchment rule still stands.

2. Catchment Gain

Based on a review at specialty and POD (activity type) level of the historic activity for S&WB residents provided by non SWBH providers (primarily University Hospitals of Birmingham Foundation Trust – UHBFT; Dudley Group of Hospitals Foundation Trust – DGoHFT; Heart of England Foundation Trust; Walsall Healthcare Trust and Birmingham Community Healthcare Trust - BCHT), a judgment has been made about the proportion of activity that might, over time be provided by us instead. The underlying assumption is that service and pathway redesign in partnership with our local GPs and under the RCRH Partnership will result in greater integration of pathways across primary and secondary care along with other pathway improvements including access which will attract an increased market share of activity for S&WB residents. The trajectory assumes this repatriation commences from 2015-2016. The assessment takes account of the regional specialty status for a number of services provided by UHBFT and assumes the related activity for these specialties continues at UHBFT. For all others providers, typically an estimate of 20% for elective and 10% for emergency admissions (including related outpatient and A&E activity) repatriation of S&WB CCG work to us (for services we provide) has been applied. This is based on our on-going joint redesign of pathways with GPs, new integrated service offerings etc. Appendix 1 summarises repatriated activity and income by specialty and activity type.

3. Future Annual Growth

S&WB CCG has modelled future annual growth with non SWBH providers at circa 2%. In line with the catchment gain assumption we have assumed circa 50% of that growth will be with us.

4. Community Opportunities & Better Care Fund

We are aiming to widen our community service offering as part of the transfer of activity from traditional acute care to community (in line with RCRH) and to support additional service offerings in primary care. This has two components – the first being expansion of our current community service offering to Sandwell residents to accommodate the transfer of more outpatient and inpatient non-acute bed day activity into alternative community services.

The second component being in line with the Better Care Fund theme and in order to ensure an integrated approach to care we intend to extend our community service offering more broadly for all S&WB CCG residents. On this basis we have assumed a transfer of activity for these residents to us from other community providers including across services such as intermediate care, community physiotherapy, case management and district nursing service provision.

5. Maternity Pathways

The opening of Midland Met will return our birthing service to Sandwell MBC area resulting in new, improved facilities and babies delivered by us having a Sandwell birth certificate. We have therefore assumed a repatriation of births primarily from DGoHFT (circa 30% of their births to Sandwell residents).

A trajectory has been created to model the service development and related activity changes across the timeline. Within the LTFM the service development investment relating to repatriated activity is modelled to commence in 2015/16.

Capacity Implications

At OBC the capacity requirements related to the service development activity were identified based on the established productivity measures (e.g. AVLOS, patients per theatre, patients per clinics etc.) used to plan Midland Met and future Community Facilities capacity. We then reviewed our productivity measures to identify additional productivity gains that could be made to enable us to accommodate this activity within the planned capacity in Midland Met and the cost assumptions in the LTFM. The analysis of productivity implications to deliver the additional activity within the planned Midland Met capacity identified an additional improvement in average length of stay (to that already planned) of 3.8% for emergency admissions and 11.8% for elective admissions. This was tested with our clinical and operational leadership teams and considered deliverable with further service improvements to pathways. Appendix 2 sets out the productivity and capacity implications at OBC and is included for information.

Within the updated ABC Activity and Capacity Model the service development activity was embedded within our modelling and so included within the productivity and capacity assumptions and trajectories for Midland Met as set out in Appendix 5a (table 1, page 5) of the ABC.

Costs related to these services developments have been set aside in the LTFM. The acute element of the developments will be delivered through improved productivity and so will only generate direct costs, allowing a greater contribution towards Midland Met affordability. The community element of the developments requires a higher level of investment.

Appendix 1

Repatriated Activity by Specialty and Activity Type

	Income (£)								Cases								
	POD								POD								
SPECIALTY	A&E	Day Case	Elective	Emergencies	Outpatients	Maternity Pathway	OCL Community	TOTAL	A&E	Day Case	Elective	Emergencies	Outpatients	Maternity Pathway	OCL Community	TOTAL	
100 - General Surgery		234,244	548,015	294,583	158,547			1,235,388		271	247	177	1,365			2,060	
101 - Urology		126,480	538,511	5,095	193,081			863,168		183	208	3	933			1,328	
104 - Colorectal Surgery		32,841	49,751		5,469			88,061		48	16		46			110	
106 - Upper Gastrointestinal Surgery		7,243	26,934		1,050			35,227		17	9		6			31	
107 - Vascular Surgery		685						685		1						1	
110 - Trauma & Orthopaedics		419,214	490,806	90,547	252,535			1,253,102		254	62	38	2,653			3,007	
120 - Ent		97,886	131,420		145,414			374,720		94	75		1,265			1,435	
130 - Ophthalmology		37,948	637		58,798			97,383		63	1		683			747	
160 - Plastic Surgery		13,941	14,545	15,193	11,818			55,496		12	8	8	136			164	
180 - Accident & Emergency				65,424	30,508			95,932				108	282			390	
190 - Anaesthetics		3,001			10,884			13,885		5			176			181	
191 - Pain Management		39,153	507		1,450			41,110		57	1		14			71	
300 - General Medicine		23,823	587	908,181	55,822			988,413		40	1	656	425			1,122	
301 - Gastroenterology		70,640	5,059	41,486	32,703			149,888		152	6	10	255			423	
302 - Endocrinology		2,277		6,886	21,709			30,872		5		3	194			202	
303 - Clinical Haematology					1,476			1,476					6			6	
307 - Diabetic Medicine		6,564			47,321			53,885		15			480			496	
314 - Rehabilitation					3,252			3,252					49			49	
320 - Cardiology		110,050	25,202	49,220	65,223			249,696		73	9	19	588			689	
327 - Cardiac Rehabilitation					364			364					16			16	
330 - Dermatology		121,543	5,661	240	219,359			346,802		192	6	0	2,449			2,647	
340 - Respiratory Medicine		8,044	5,443	44,181	71,939			129,606		13	2	14	677			706	
361 - Nephrology		7,288	2,999	22,911	49,097			82,295		18	2	6	382			408	
400 - Neurology					26,388			26,388					154			154	
410 - Rheumatology		2,778			8,203			10,980		5			76			81	
420 - Paediatrics		21,609	21,392	122,410	101,061			266,472		35	31	161	606			833	
430 - Geriatric Medicine			532	116,997	21,438			138,967			0	48	119			167	
501 - Obstetrics				392,936		85,349		478,285				235		121		357	
502 - Gynaecology		35,815	69,452	53,407	68,627			227,300		50	32	74	556			712	
503 - Gynaecological Oncology					417			417					6			6	
560 - Midwife Episode				78,601		32,182		110,783				50		45		94	
650 - Physiotherapy					30,486			30,486					933			933	
651 - Occupational Therapy					2,587			2,587					64			64	
654 - Dietetics					407			407					17			17	
655 - Orthoptics					7,468			7,468					193			193	
658 - Orthotics					-			-					5			5	
822 - Chemical Pathology					450			450					5			5	
A&E	834,170							834,170	8,316							8,316	
Community Nursing							1,513,007	1,513,007							38,921	38,921	
Community Respiratory Service							319,555	319,555							4,029	4,029	
Continence							467,702	467,702							568	568	
Diabetes Nursing							387,710	387,710							3,052	3,052	
Heart Failure Nursing							56,511	56,511							1,146	1,146	
Integrated Care Service (icares)							2,957,552	2,957,552							26,333	26,333	
Intermediate Care - Henderson							2,717	2,717							214	214	
Grand Total	834,170	1,423,067	1,937,452	2,308,296	1,705,351	117,531	5,704,753	14,030,619	8,316	1,603	715	1,610	15,812	166	74,263	102,485	

Appendix 2

Capacity & Productivity Schedule – As at OBC

2019/20	Base Capacity	Serv Dev Capacity	Base + Serv Dev Capacity	Productivity Improvement to Maintain Base Capacity
MMH Inpatients				
Bed Numbers	611	22	633	611
AVLOS - Emergency	4.05			3.90
% Productivity Improvement Required				3.80%
AVLOS - Elective	3.08			2.76
% Productivity Improvement Required				11.77%
Theatre Numbers	10.2	0.6	10.8	11
MMH Maternity Pathway				
Clinics	1,083		1,096	1,083
Throughput per Clinic	16.19			16.36
% Productivity Improvement Required				1.04%
Births	6,259		6,574	
Variance to base	315			
Beds Numbers	55	1	56	55
AVLOS	1.75			1.68
% Productivity Improvement Required				3.67%
Delivery Suite Rooms*	12.00	0.60	12.60	12
% Productivity Improvement Required				5.03%
Theatres*	2.00	0.1	2.10	2.00
% Productivity Improvement Required				5.03%
Day Cases (Community Facilities)				
Theatre Numbers	11	0.5	11.5	11
Throughput per session	4.27			4.36
% Productivity Improvement Required				2.12%
Intermediate Care (BCHS repatriation)				
Bed numbers	148	30	178	158
Bed days Repatriated			10,541	10,541
AVLOS	20.38			17.05**
% Productivity Improvement Required				19.24%
Clinics (Community Facilities)				
Clinics	32,957		33,777	32,957
Throughput per Clinic	17.42			17.85
% Productivity Improvement Required				2.40%
Notes:				
*Maternity pathway theatres and delivery Suites based on standard metrics of Delivery Suites/Theatres to Births				
**Alternative is to provide 20 beds worth of additional Intermediate Care activity as community contacts				

APPENDIX 16b – DOWNSIDE CASE

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

MMH Downside Scenario for Appointment Business Case (ABC)

1. Key messages

The downside case presented in the MMH OBC has been updated and demonstrates that a credible set of mitigations have been identified which would result in a minimum CoSSR of level 2 in 2019/20 and 2020/21, recovering to a level 3 thereafter.

In addition, a sensitivity stress test has been applied which increases the level of downside risk to 10% of turnover within 5 years. Under this scenario, the CoSSR level would reduce to level 2 from 2019/20 and remain at that level thereafter.

2. Background

A downside scenario is required as part of the ABC. This is to demonstrate whether the trust's ability to afford the scheme is sufficiently resilient. A downside case was prepared and submitted as part of the MMH Outline Business Case (OBC). The downside case has 2 elements: the downside scenario (reflecting the Trust's corporate risk register) and the mitigations in response.

This downside case has been refreshed to ensure that it reflects relevant and potential risks within the risk register and that the mitigations are sufficient. Some of the mitigations are inevitably inherently unattractive for the Trust to contemplate and thus they would only be implemented in a downside scenario.

3. Revisions to the downside scenario

The downside scenario presented in the OBC is at Annex A. Since OBC the risks have been subject to significant review and the challenge addressed in this ABC has been increased to £42m by year 9 (some 25% higher than OBC).

In the Trusts view it is reasonable to mitigate against the base downside fully through a range of credible yet challenging actions which result in a minimum CoSSR level 2. In the downside base case this recover to level 3 by 2021/22.

The case now also includes a stress test sensitivity with a risk level of £62m at year 9 and an accelerated impact in the early years. In this sensitivity the CoSSR reduces to level 2 in 2019/20 and remains at that level.

The downside case tackles risk through cost reduction with minimal reliance on additional income expectations. The cost reduction specifically includes a review of workforce terms and conditions which is more aggressive in the stress test sensitivity.

The Trust has been explicit with commissioners that its final stage mitigation to deal with the sensitivity scenario would see site retrenchment. It is recognised that any such plan would require consultation and a robust quality impact assessment.

The risks have now been revised to reflect the risks identified through the trust's Board Assurance Framework (BAF). These are:

- a) Non-achievement of the CIPs driven by national efficiency targets
- b) Non-achievement of the CIPs driven by trust's efficiency targets (over and above national targets and thus more challenging)
- c) Delay in the implementation of Electronic Patient Record, postponing the expected financial benefits and incurring the additional cost of an interim off site solution given that MMH will be a 'paperlite' hospital
- d) Loss of market share relating to elective activity
- e) Failure to secure the repatriation of SWB CCG activity as set out in the base case
- f) Impact of fines and non-achievement of CQUINs due to poor performance
- g) Activity out-with Right Care Right Here model which does not attract full tariff
- h) Monitor 'downside stretch' to cover a range of more minor risks
- i) The additional impact of inflation and interest as a result of the above risks crystallising

These risks are described in more detail at Annex B, including their respective risk profiles and how they link to the BAF.

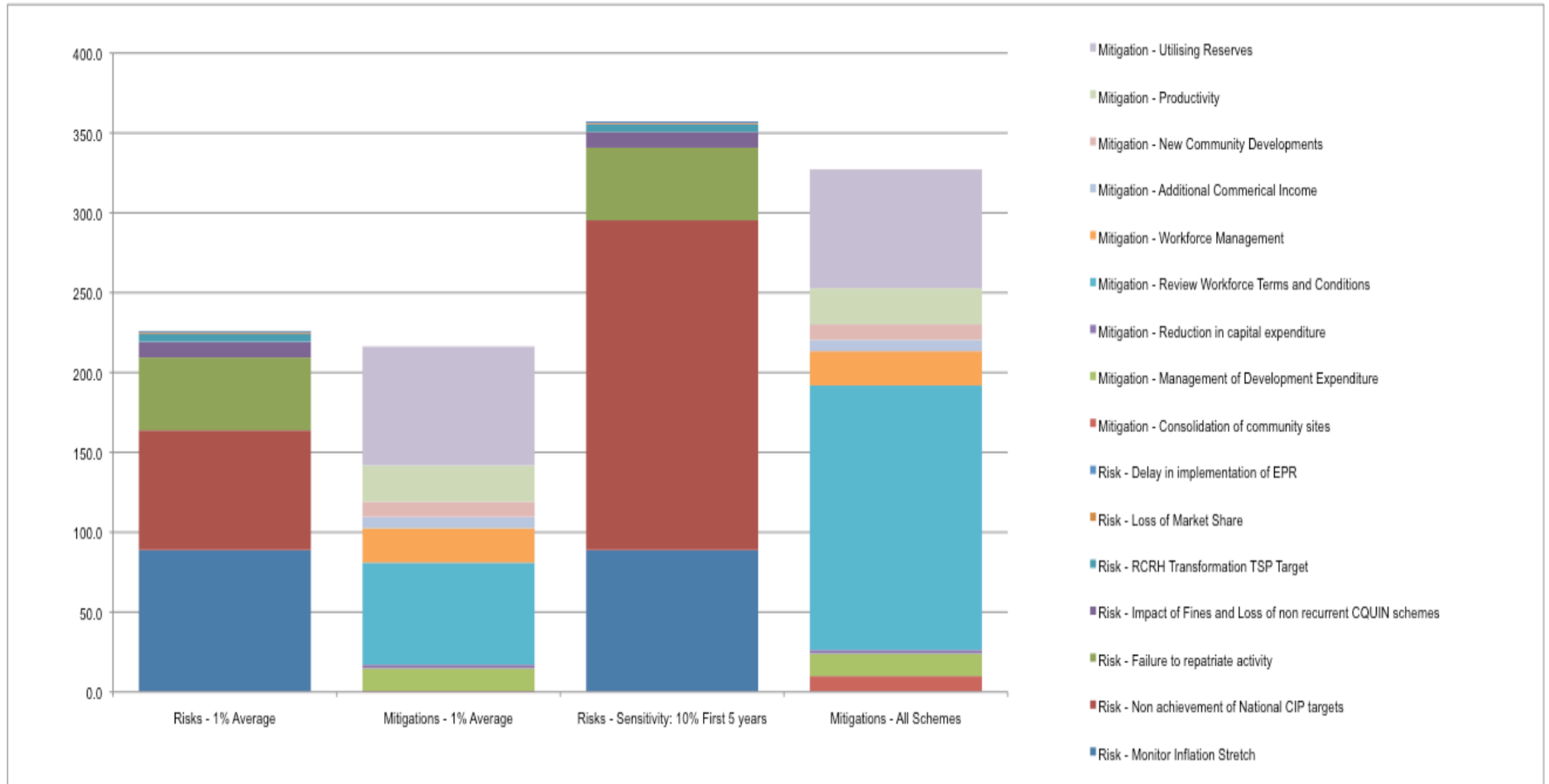
4. Summary of downside base case and stress test

In summary the downside base case and stress test is presented in the following table:

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Base Case									
Total Risks(£m)	7.7	12.4	16.7	21.1	25.5	29.9	33.9	37.3	41.3
% cum. downside risk as % income	1.77%	2.85%	3.85%	4.73%	5.6%	6.41%	7.09%	7.63%	8.25%
CoSRR after mitigation	4	3	4	3	2	2	2	3	3
Stress Test									
Total Risks(£m)	8.7	17.4	26.1	35.7	45.5	49.9	54.0	58.0	62.0
% cum. downside risk as % income	2.0%	4.0%	6.0%	8.0%	10.0%	10.7%	11.3%	11.9%	12.4%
CoSRR after mitigation	3	3	4	3	2	2	2	2	2

5. Summary of the downside base case and stress test

The aggregate of risks and mitigations in both the base case and stress test are shown in the figure below.



6. Trust Downside Mitigation 2015/16 to 2023/24

The base case downside is at the table below. This shows an average of 1% downside risk impact as a percentage of turnover.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Base case annual surplus	3.4	4.3	6.4	9.3	4.6	4.2	4.2	4.3	4.2
CsRR in the base case	4	3	4	3	3	3	3	3	3

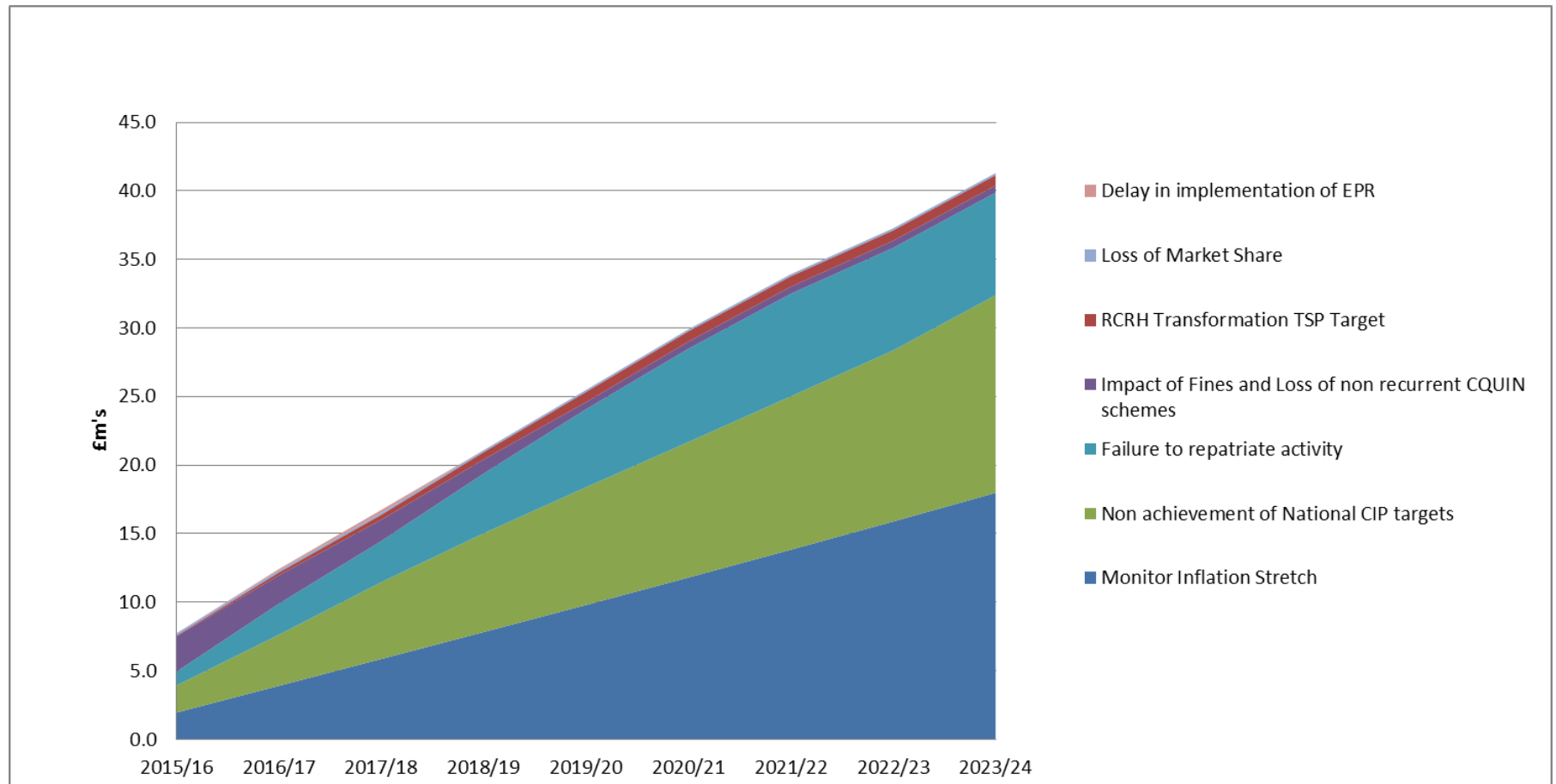
Downside Risk

Monitor Inflation Stretch	(2.0)	(3.9)	(5.9)	(7.8)	(9.8)	(11.8)	(13.8)	(15.9)	(18.0)
RCRH Transformation TSP Target	(0.1)	(0.2)	(0.4)	(0.5)	(0.7)	(0.8)	(0.8)	(0.8)	(0.8)
Non achievement of National CIP targets	(2.0)	(3.7)	(5.6)	(7.2)	(8.6)	(9.9)	(11.2)	(12.5)	(14.4)
Loss of Non Recurrent CQUIN schemes	(2.1)	(1.7)	(1.3)	(0.8)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
Non-compliance to national targets resulting in Fines	(0.5)	(0.4)	(0.3)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Failure to repatriate activity	(1.0)	(2.3)	(3.0)	(4.4)	(5.7)	(6.8)	(7.5)	(7.5)	(7.5)
Loss of Market Share	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.2)
Delay in implementation of EPR	0.0	(0.1)	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0
Total downside risks	(7.7)	(12.4)	(16.7)	(21.1)	(25.5)	(29.9)	(33.9)	(37.3)	(41.3)
Net Surplus/(Deficit) post downside: Exc Inflation and Interest	(4.29)	(8.10)	(10.3)	(11.8)	(20.9)	(25.7)	(29.7)	(32.9)	(37.1)
Annual Downside risk	(7.7)	(4.7)	(4.3)	(4.4)	(4.4)	(4.4)	(4.0)	(3.4)	(4.0)
Annual Income	436.4	435.2	434.9	446.1	455.1	466.5	478.5	488.4	500.9
Cumulative Downside as a percentage of Annual income	-1.77%	-2.85%	-3.85%	-4.73%	-5.60%	-6.41%	-7.09%	-7.63%	-8.25%
In year Downside as a percentage income	-1.77%	-1.08%	-0.99%	-0.88%	-0.87%	-0.81%	-0.68%	-0.54%	-0.61%
Memo: 1% Downside Target for Information	(4.4)	(4.4)	(4.3)	(4.5)	(4.6)	(4.7)	(4.8)	(4.9)	(5.0)
Memo: Cumulative 1% Downside Target for Information	(4.4)	(8.7)	(13.1)	(17.5)	(22.1)	(26.7)	(31.5)	(36.4)	(41.4)
Average Downside position (%)									-1.00%

Mitigations

Consolidation of community sites	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Management of Development Expenditure	0.2	0.5	0.9	1.2	1.6	2.0	2.3	2.5	2.9
Reduction in capital expenditure	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.4
Review Workforce Terms and Conditions	0.0	0.0	3.0	4.6	8.3	9.8	11.3	12.8	14.2
Workforce Management	3.4	5.4	5.1	2.2	2.2	2.2	0.3	0.3	0.3
Additional Commerical Income	0.0	0.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
New Community Developments	0.0	0.0	0.0	0.0	1.2	1.4	1.4	2.8	2.8
Productivity	0.0	0.0	1.8	2.3	2.3	3.3	4.3	4.3	4.3
Utilising Reserves	3.5	4.6	6.2	3.6	8.8	9.7	11.6	12.5	14.0
Total Mitigations Only	7.2	10.68	18.3	15.2	25.7	29.8	32.7	36.7	40.0
Net Movements caused by Inflation & Interest	0.0	0.1	0.1	(0.2)	(0.1)	0.1	0.1	(0.3)	(0.6)
Sub Total of Mitigations & Downside Base	3.0	2.7	8.1	3.2	4.7	4.1	3.1	3.4	2.3
Surplus in the mitigated downside case	3.0	2.7	8.1	3.2	4.7	4.1	3.1	3.4	2.3
CsRR in the mitigated downside case	4	3	4	3	2	2	2	3	3

7. Profile of downside risks for base case



8. Review of the mitigations

The weaknesses in the mitigations presented in the downside case for the OBC were principally that there was:

- an over reliance upon 'Additional CIPs' being used as a mitigation without any detail;
- and a dependence upon some high risk mitigations such as deviating from national NHS terms and conditions for staff.

The mitigations have been reviewed to check that they remain credible. This has resulted in the need to identify additional mitigations. The revised mitigations under consideration are:

- a) The utilisation of the trust's financial reserves
- b) Developing new service lines in the community in collaboration with SWB CCG in order to provide a more integrated and complete offering
- c) Commercial income - reviewing charges and fees across all sites
- d) Deploying a combination of short and medium term measures to reduce the workforce pay bill
- e) Reducing the trust's capital expenditure programme
- f) Reducing development expenditure through improved productivity
- g) Driving service productivity to the upper decile of peer group performance in key areas
- h) Reviewing staff terms and conditions
- i) Consolidating the community estate

These measures vary in their financial value and risk of implementation and the trust would re-assess the order of priority in the event of a downside scenario.

A summary of the OBC and the revised mitigations under consideration is shown below (total value over the 9 years 2015/16 – 2023/24). A description of these mitigations is at Annex C.

	OBC mitigations £m	ABC mitigations (for downside 'base' case) £m
Reduction in capital expenditure	9	2
Delay development expenditure through productivity	10	14
Workforce management	17	22
Additional CIPs	24	0
Upper decile productivity	0	23
Commercial income	20	7
Ceasing loss making services	15	0
Developing new services lines in the community	0	10
Reserves	32	75
Community estate consolidation	2	0
Review of staff T&Cs	71	64
TOTAL	200	217

9. Response to downside stress test

The detail of the trust's response to a downside stress test of a 10% cumulative impact in the first 5 years is at Annex D. The trust would need to deploy the full range of mitigations. Whilst a more detailed risk analysis and prioritisation would be undertaken at the time, the likely response to the 2 downside scenarios described above would be in the form of a plan A and plan B for the base case and stress test respectively.

Downside scenario	Response	Total value (£m)
1% of turnover	PLAN A <ul style="list-style-type: none">• Reduction in capital expenditure• Delay development expenditure through productivity• Workforce management• Additional CIPs• Upper decile productivity• Charges, costs and fees• Ceasing loss making services• Developing new services lines in the community• Additional Commercial Income• Reserves	217
10% of turnover in first 5 years	PLAN B <ul style="list-style-type: none">• Community estate consolidation• Review of staff T&Cs	327

10. Conclusion

A base downside case of an average impact of 1% of turnover per year has been developed. Additionally, a sensitivity case of 10% of turnover in the first 5 years has been modeled as a 'stress test', albeit deemed an extremely unlikely scenario.

The trust expects to be able to mitigate against the base downside case fully through a range of challenging but credible actions (Plan A mitigations).

In order to mitigate against the 'stress test', the trust would need to use higher risk mitigations (Plan B) which would involve community estate retrenchment and moving staff away from national terms and conditions of employment. Such mitigations would only be considered in the extremely unlikely event that the 'stress test' scenario occurred.

11. Annexes

A: OBC downside scenario

B: Revised downside risks

C: Description of mitigations

D: Change in risk profile to generate sensitivity analysis

Annex A - OBC downside scenario

	I&E Impact								
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Base case annual surplus	3.1	3.5	6.0	8.7	6.5	6.1	4.2	3.3	5.3
CsRR in the base case	3	3	4	4	3	3	3	3	3
Downside risks									
Risk 1 - Non-achievement of CIP.	0.00	(1.97)	(5.94)	(9.95)	(13.63)	(18.08)	(20.94)	(23.80)	(26.42)
Risk 1a - Non-achievement of RCRH cost efficiency	(0.52)	(1.13)	(1.51)	(1.88)	(2.07)	(2.07)	(2.07)	(2.07)	(2.07)
Risk 14/15 - Additional Monitor Inflationary efficiency.	(0.75)	(1.51)	(2.26)	(3.01)	(3.76)	(4.52)	(5.28)	(6.05)	(6.83)
Risk 2 - Reduction in targeted margin from developments.	(0.31)	(0.58)	(0.80)	(0.86)	(1.11)	(1.42)	(1.64)	(1.69)	(1.69)
Risk 3 - Loss of Non-Recurrent CQUIN Funding.	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)
Risk 5a - Increase Community demand above block threshold.	(0.06)	(0.06)	(0.06)	(0.13)	(0.13)	(0.13)	0.00	0.00	0.00
Risk 5b - Loss of Community Services to other providers.	0.00	0.00	(0.15)	(0.15)	(0.15)	(0.15)	(0.16)	(0.16)	(0.16)
Risk 6b - High recruitment and retention levels leading to additional agency cost.	0.00	0.00	0.00	(0.03)	(0.06)	(0.08)	(0.11)	(0.13)	(0.16)
Risk 10a - Backlog maintenance (Capital) increases by 50% above planned levels.	(0.02)	(0.04)	(0.06)	(0.09)	(0.11)	(0.16)	(0.20)	(0.21)	(0.21)
Risk 10b - Fines imposed if statutory maintenance standards are missed.	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
Risk 10c - APC loss (Elective) activity and income.	0.00	0.00	0.00	0.00	0.00	(0.02)	(0.02)	(0.02)	(0.02)
Risk 12a - Additional catchment loss above RCRH assumptions in A&E and outpatients as a result of MMH opening.	0.00	0.00	0.00	0.00	0.00	(0.59)	(0.59)	(0.59)	(0.59)
Risk 12b - AVLOS remains unchanged from predicted reductions.	(1.21)	(0.36)	(0.48)	(0.43)	(0.45)	(0.24)	0.00	0.00	0.00
Risk 12c - RCRH reduction in outpatients is missed by 10%.	(0.14)	(0.17)	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Risk 13 - Insufficient restructuring reserve.	0.00	0.00	(0.12)	(0.12)	(0.12)	(0.06)	0.00	0.00	0.00
Risk 17 - UP affordability (Inflationary pressure above modelled estimate)	0.00	0.00	0.00	0.00	(0.37)	(0.44)	(0.52)	(0.60)	(0.69)
Risk 18a - MMH delay 3 months, Tail end Additional dual running costs.	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.07)	0.00
Risk 18b - MMH delay 6 months, Tail end Additional dual running costs.	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.13)	0.00
Risk 18c - Extension to the transitional move to MMH result in loss activity.	0.00	0.00	0.00	0.00	(0.03)	0.00	0.00	0.00	0.00
Sub Total From Base Start Point	0.08	(2.41)	(5.41)	(8.03)	(15.49)	(21.92)	(27.39)	(32.24)	(33.58)
Inflation & Interest on the downside risks	(0.04)	(0.15)	(0.50)	(1.20)	(2.64)	(4.99)	(7.73)	(11.15)	(14.73)
Total downside risks	(3.11)	(6.04)	(11.94)	(17.89)	(24.68)	(33.01)	(39.31)	(46.73)	(53.62)
Income	430.6	430.3	432.0	432.8	444.0	452.4	463.5	475.1	484.6
Percentage of income	-0.72%	-1.40%	-2.76%	-4.13%	-5.56%	-7.30%	-8.48%	-9.83%	-11.06%
In year % tage of income		-0.68%	-1.36%	-1.37%	-1.43%	-1.74%	-1.18%	-1.35%	-1.23%
Annual surplus in the downside case	0.04	(2.6)	(5.9)	(9.2)	(18.1)	(26.9)	(35.1)	(43.4)	(48.3)
CsRR in the downside case	3	2	3	3	3	1	1	1	1

Annex B - Revised downside risks

Board Assurance Framework (November 2014)	Key Downside Impacts	OBC Downside Risks
Trust may be unable to or delayed in completion of the procurement of a private sector partner [DNHP-02]	CIPs	MMH delay 6 months, tail end additional running costs [Risk 18a]
Failure to deliver model of intermediate care [COO-6]		MMH delay 6 months, tail end additional running costs [Risk 18b]
Reliance on temporary nurse agency, and bank staff [COO-8]		Non Achievement of CIP [Risk 1]
Insufficient policy levers to ensure effective delivery of Trust workforce plan [DOD-9]		Non-achievement of RCRH cost efficiency [Risk 1a]
Failure to deliver efficiency improvement and cost reduction at necessary scale and pace [DOF-10]		High recruitment and retention levels leading to additional agency cost. [Risk 6b]
Fail to invest in our leadership [COO-15]		Backlog maintenance (Capital) increases by 50% above planned levels. [Risk 10a]
Failing to develop robust 3 year outline CIP plans as part of the FT application [DOD-18]		AVLOS remains unchanged from predicted reductions. [Risk 12b]
High readmission rates following emergency admission [COO-1]		RCRH reduction in outpatients is missed by 10% [Risk 12c]
Emergency Care Standards [COO-2]		Increase Community demand above block threshold [Risk 5a]
Under-delivery on CQUIN schemes [CN-3]		Loss of Non-Recurrent CQUIN Funding [Risk 3]
Compliance re Francis Enquiry [COO-5]	Impact of fines and loss of quality payments	Fines imposed if statutory maintenance standards are missed [Risk 10b]
Excess overheads reduce resources available for front line care [DOF-11]		APC loss (Elective) activity and income [Risk 10c]
Not achieving compliance with the PAF framework, Monitor Compliance Framework and NHS Performance Assessment Framework [DOF-16]	Loss of existing market share	Reduction in targeted margin from developments [Risk 2]
Failure to secure levels of activity and income from key commissioners consistent with medium term strategic and financial plans. [DOF-17]		Loss of Community services to other providers [Risk 5b]
Failure to secure business from competitive tender processes [DOD-23]		Additional catchment loss above RCRH assumptions in A&E and outpatients as a result of MMH opening [Risk 12a]
Delivery of the IT elements of the 2014/15 capital plan [MD-13]	Delay in EPR	
	Monitor downside	Additional Monitor Inflationary efficiency [Risk 14/15]

The following BAF risks were assessed as having an insignificant financial impact:

- Delivery of the 18 week standard at specialty level **[COO-4]**
- Transfer of 27 clinics into Rowley Regis Hospital as part of the Rowley Max' project **[COO-7]**
- Failure to deliver key milestones delays approval by TDA to be considered for FT status by Monitor. **[DOF-14]**
- The validity and reliability of reports produced for management of the Trust key activities are bespoke, variable and lack controls on release. **[COO-20]**
- Inability to achieve external validation of Quality Governance Assurance Framework or Board Governance Assurance Framework standards **[DG-21]**
- Organisation is unable to design and implement arrangements for the body of the organisation to be well-led **[DOD-22]**

The following risks have been discarded from the OBC downside due to them also being assessed as too insignificant:

- Insufficient restructuring reserve [Risk 13]
- UP affordability (Inflationary pressure above modelled estimate) [Risk 17]
- Extension to the transitional move to MMH result in loss activity [Risk 18c]

The risk of the UP inflation being high has been removed from the downside risks due to its impact being very low. The proportion of the UP which is subject to inflation is c.37%. A 1% inflation increase above that factored into the LTFM would add c. £80K / year to the UP.

Annex C - Description of mitigations

- a. The utilisation of the trust's financial reserves*
The Trust has set aside reserves for a range of scenarios and unforeseen eventualities. Use of these reserves would provide a 'one off' contribution to ameliorating a downside position whilst longer term initiatives were implemented.
- b. Developing new service lines in the community in collaboration with SWB CCG in order to provide a more integrated and complete offering*
The Trust would work with the CCG and local authority to explore opportunities which would be of mutual benefit and enable the Trust to maintain income and a critical mass of services. Opportunities are expected to be mainly within the community in integrated care, long term conditions and social care.
- c. Commercial income*
The Trust would develop new income streams and review charges and fees to ensure that they were equitable and sustainable.
- d. Deploying a combination of short and medium term measures to reduce the workforce pay bill*
This includes a temporary freeze on some vacancies and further staffing efficiencies beyond the Trust's transformation programme. A risk assessment would be conducted to ensure that patient safety and organisational resilience was not compromised.
- e. Reducing the trust's capital expenditure programme*
The capital expenditure programme would be reduced by c. 10% by re-prioritising developments to ensure that patient care was not compromised.
- f. Reducing development expenditure through improved productivity*
New service development expenditure would be minimised through improving productivity and delivering more activity within the existing resource envelope.
- g. Driving service productivity to the upper decile of peer group performance in key areas*
Productivity would be increased beyond that assumed within the Trust's LTFM in the key areas of outpatients, theatres and wards in line with the top decile of national performance. This would enable a further capacity and cost reduction.
- h. Reviewing staff terms and conditions*
Opportunities would be explored to amend staff terms and conditions in the areas of annual leave, sickness policy, pay awards, incremental drift and the length of the working week. Most of these changes would only be considered in the 'stress' scenario of the downside case.
- i. Consolidating the community estate*
Opportunities would be reviewed to reduce the footprint of the existing community estate beyond the changes already agreed as part of the MMH plan. Such a review would respond to a smaller capacity requirement as a result of the downside case and the increased productivity. This option would only be explored in the 'stress' scenario of the downside case.

Annex D - Sensitivity analysis – ‘Stress test’

1. A sensitivity analysis has been conducted to consider the impact of a 10% (of turnover) cumulative impact in the first 5 years, compared with 5.6% in the downside ‘base’ case. The modelling of this 10% cumulative impact in the first 5 years is shown below:

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Base case annual surplus	3.4	4.3	6.4	9.3	4.6	4.2	4.2	4.3	4.2
CsRR in the base case	4	3	4	3	3	3	3	3	3

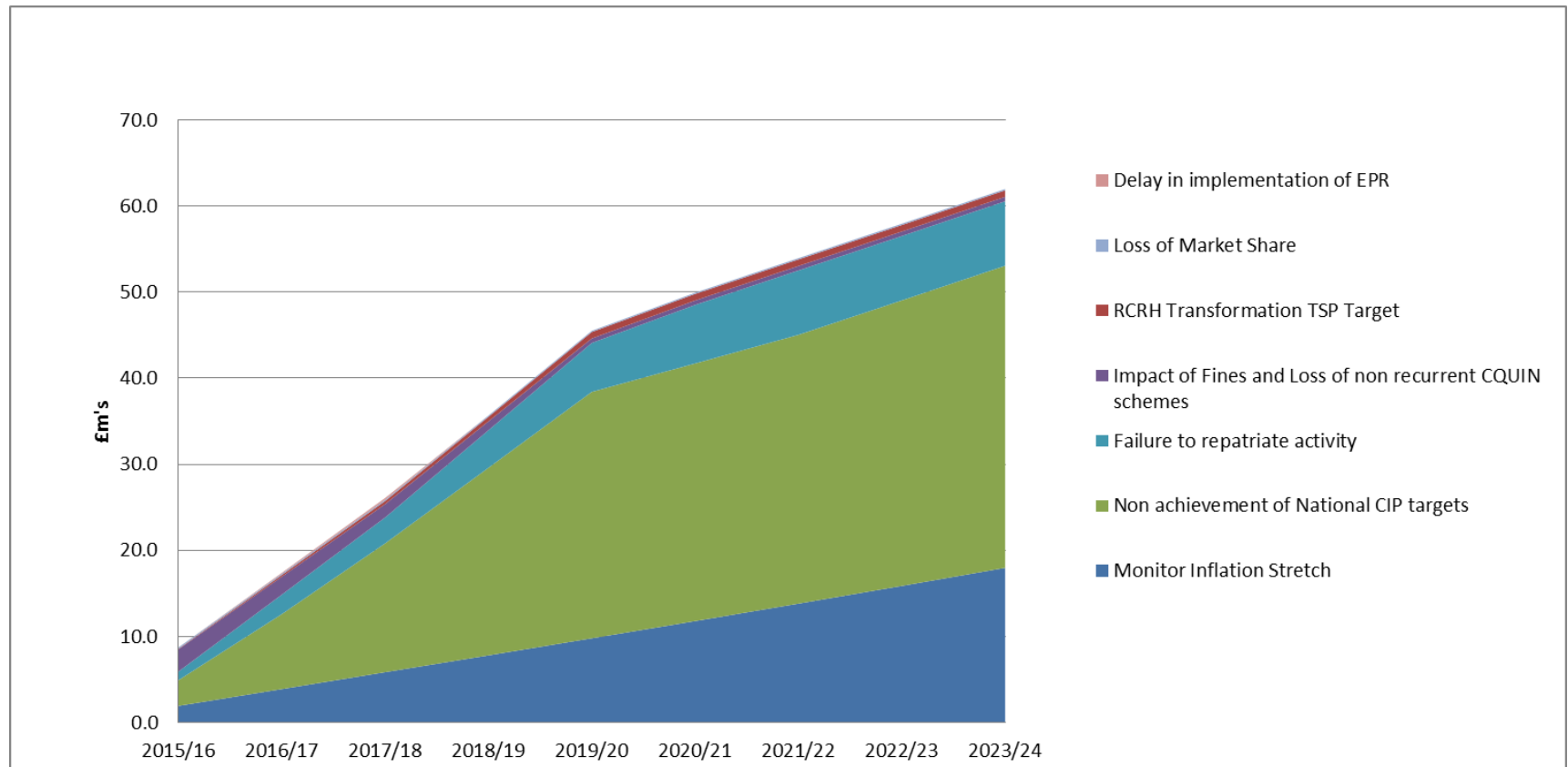
Downside Risk

Monitor Inflation Stretch	(2.0)	(3.9)	(5.9)	(7.8)	(9.8)	(11.8)	(13.8)	(15.9)	(18.0)
RCRH Transformation TSP Target	(0.1)	(0.2)	(0.4)	(0.5)	(0.7)	(0.8)	(0.8)	(0.8)	(0.8)
Non achievement of National CIP targets	(3.0)	(8.7)	(15.0)	(21.8)	(28.6)	(29.9)	(31.2)	(33.2)	(35.1)
Loss of Non Recurrent CQUIN schemes	(2.1)	(1.7)	(1.3)	(0.8)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
Non-compliance to national targets resulting in Fines	(0.5)	(0.4)	(0.3)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Failure to repatriate activity	(1.0)	(2.3)	(3.0)	(4.4)	(5.7)	(6.8)	(7.5)	(7.5)	(7.5)
Loss of Market Share	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.2)
Delay in implementation of EPR	0.0	(0.1)	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0
Total downside risks	(8.7)	(17.4)	(26.1)	(35.7)	(45.5)	(49.9)	(54.0)	(58.0)	(62.0)
Net Surplus/(Deficit) post downside: Exc Inflation and Interest	(5.3)	(13.1)	(19.7)	(26.4)	(40.9)	(45.8)	(49.8)	(53.6)	(57.8)
Annual Downside risk	(8.7)	(8.7)	(8.7)	(9.6)	(9.8)	(4.4)	(4.0)	(4.0)	(4.0)
Annual Income	436.4	435.2	434.9	446.1	455.1	466.5	478.5	488.4	500.9
Cumulative Downside as a percentage of Annual income	-2.00%	-4.00%	-6.00%	-7.99%	-10.00%	-10.70%	-11.27%	-11.86%	-12.37%
In year Downside as a percentage income	-2.00%	-2.00%	-2.00%	-2.00%	-2.00%	-0.71%	-0.57%	-0.59%	-0.51%
Memo: 2% Downside Target between 15/16 - 19/20, 1% downside thereafter	(8.7)	(8.7)	(8.7)	(8.9)	(9.1)	(4.7)	(4.8)	(4.9)	(5.0)
Memo: Cumulative 2% Downside Target between 15/16 - 19/20 - 1% downside thereafter	(8.7)	(17.4)	(26.1)	(35.1)	(44.2)	(48.8)	(53.6)	(58.5)	(63.5)
Average Downside position (%)									-1.50%

Mitigations

Consolidation of community sites	0.0	0.1	0.3	0.4	0.4	2.2	2.2	2.2	2.2
Management of Development Expenditure	0.2	0.5	0.9	1.2	1.6	2.0	2.3	2.5	2.9
Cessation of services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reduction in capital expenditure	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.4
Review Workforce Terms and Conditions	0.0	0.4	3.7	5.7	24.2	27.7	31.2	34.7	38.1
Workforce Management	3.4	5.4	5.1	2.2	2.2	2.2	0.3	0.3	0.3
Additional Commerical Income	0.0	0.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
New Community Developments	0.0	0.0	0.0	0.0	1.2	1.4	1.4	2.8	2.8
Productivity	0.0	0.0	1.8	2.3	2.3	3.3	4.3	4.3	4.3
Utilising Reserves	3.5	4.6	6.2	3.6	8.8	9.7	11.6	12.5	14.0
Total Mitigations Only	7.2	11.0	19.1	16.6	42.0	49.8	54.8	60.7	66.0
Net Movements caused by Inflation & Interest	0.0	(0.1)	(0.3)	(1.2)	(0.8)	(0.3)	(0.1)	(0.3)	(0.2)
Sub Total of Mitigations & Downside Base	2.0	(2.1)	(0.8)	(10.9)	0.2	3.7	4.9	6.8	8.0
Surplus in the mitigated downside case	2.0	(2.2)	(0.1)	(10.4)	0.2	3.8	5.0	6.7	7.9
CsRR in the mitigated downside case	3	3	4	3	2	2	2	2	2

2. Profile of downside risks for stress case



APPENDIX 16c – DISTRICT VALUER ASSESSMENT OF MMH FIXED ASSET

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

**Estimate Asset
Valuation Report for
Sandwell & West
Birmingham
Hospitals NHS Trust**

BY EMAIL ONLY

Report for:
Mansoor Zaman
Sandwell & West Birmingham
Hospitals NHS Trust

Prepared by:
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Principal Surveyor
RICS Registered Valuer
DVS

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Case Number: 1489680/NR

Date: 27 August 2015

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**ESTIMATE ASSET VALUATION: PROPOSED MIDLAND METROPOLITAN
HOSPITAL (PFI)
SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST
VALUATION DATE : 1 AUGUST 2015**

1. Introduction

- 1.1 I refer to my draft report dated 20 May 2014 and my email of 16 July 2015, confirming acceptance of your instruction to provide an updated valuation report and our understanding of your requirements.

The valuation comprises an estimate valuation of the proposed PFI Midland Metropolitan Hospital, for use in initial forward financial planning estimates and for forecasting the potential financial reporting requirements by the Trust, once the project has been completed in a number of years time. It is based upon information supplied by the Trust together with a number of special assumptions requested and/or agreed between the Trust and Valuer. It does not comprise a formal valuation and must not be adopted as such by the Trust for formal capital accounting purposes. The report is valid for no other purpose and the valuation figures stated are provisional, subject to revision on final completion of the hospital

The information provided by the Trust and its advisors for the draft report of 20 May 2014 included estimate cost details, proposed Gross Internal Area figures and land area. These have now been updated by you and slightly revised Gross Internal Area figures adopted. You have confirmed that the general nature of the proposals remains unchanged.

The valuation provided is an approximate estimate only, based on levels of value pertaining to the date of this report and must not be regarded as a forecast of value to the date of Hospital completion, as market conditions and levels of value may differ at that time.

The basic assumption is that the Hospital will provide services typical of those within an Acute Hospital but with limited outpatient services. The latter will be provided from other sites owned by the Trust that are not included in this estimate valuation report.

- 1.2 The estimate value is stated below at the "Opinion of Value" section, together with a summary apportionment between land and buildings. More detailed valuation information is provided in the electronically supplied Excel spreadsheet, titled Block Summary. The Schedule forms an integral part of this estimate asset valuation report
- 1.3 To avoid an unduly lengthy report, descriptions of the individual properties have not been included, as agreed.

2. Date of Valuation

- 2.1** The date of valuation is 1 August 2015

3. Confirmation of Standards

- 3.1** As the valuation provided is an estimate only of a proposed building the report is provided strictly on the basis of restricted information and subject to complete review should a final valuation be required on building completion. Notwithstanding the fact that no actual property exists to be valued the valuations have been undertaken, so far as possible, in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by, respectively, the NHS Manual for Accounts or the NHS Foundation Trust Annual Reporting Manual, each of which is largely compliant with HM Treasury Financial Reporting Manual (FReM) guidance for the United Kingdom public sector. Similarly the valuation also accord, in terms of approach only, with the requirements of the RICS Valuation - Professional Standards 2014 UK edition (known as 'the Red Book'), including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.14 refers. Any departure from these Standards agreed with you is highlighted in this report and includes the provisional nature of these figures only, in view of the absence of an actual existing building.
- 3.2** The valuations supplied have been prepared specifically to meet the reporting requirements stated in 1.1 above, and should not be used in any other context.
- 3.3** Unless otherwise stated, the assumption has been made that the proposed property valued, when completed and operational, will continue to be held by you for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

4. Agreed Departures from the RICS Professional Standards

In addition to the nature of the assumptions and qualifications stated in previous paragraphs, the following agreed departures from the RICS Professional Standards and special assumptions are noted below:

- 4.1** The Instant Building approach has been adopted, as required by HM Treasury FReM for the UK public sector. Therefore, no building periods or consequential finance costs have been reflected in the costs applied when the DRC approach is used.
- 4.2** It should be noted that the use of the terms "Existing Use Value" and "Market Value" in regard to the valuation of the NHS estate may be regarded as not inconsistent with those set out in the RICS Professional Standards, subject to the additional special assumptions that:
- (a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously

and in the respect of the Market Value of 'held for sale' assets only;

(b) the NHS is assumed not to be in the market for the property interest; and

(c) regard has been had to appropriate lotting to achieve the best price.

The precise approach to the valuation has been specified by you to reflect:

- The Trust's previous advice that no other site will be available for the building and that, therefore the Modern Equivalent Asset for valuation will reflect the actual physical parameters for the building;
- The actual buildings proposed, as the best viable solution to the Trust's operational requirements, rather than any alternative Modern Equivalent Asset;
- As the property is assumed to be new and purpose built for this estimate asset valuation, you have informed us that functional and external obsolescence are de-minimus. Further, as the building is new, there is no physical obsolescence in our assessment of the estimate Net Replacement Cost figure, which reflects the estimated full service potential of the actual asset on completion.

5. Basis of Value

The basis of value will be as follows:

5.1 In Use Asset

5.1.1 The proposed asset is to be occupied and used by you in the delivery of services for which you have a responsibility. The basis of valuation required from 1st April 2015 is Current Value in existing use, as defined in FReM and the adaptation which it makes to IAS 16. Current Value has regard to the service potential that an asset provides in support of the entity's service delivery. The measurement approaches used to arrive at the Current Value of in use assets are for non-specialised operational assets Existing Use Value (EUV) as defined at UKVS 1.3, and for specialised operational assets Depreciated Replacement Cost (DRC) in accordance with UKVS 1.15 and UKGN 2.

5.1.2 Existing Use Value is defined in the RICS Valuation – Professional Standards at UKVS 1.3 as:

'The estimated amount for which an asset or liability should exchange on the valuation date between a willing buyer and a willing seller in an arm's length transaction after proper marketing and where the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the asset required by the business, and disregarding potential alternative uses and any other characteristics of the asset that would cause its market value to differ from that needed to replace the remaining service potential at least cost.'

- 5.1.3 Existing Use Value (EUV) ignores any element of hope value for an alternative use, any value attributable to goodwill and any possible increase in value due to special investment or financial transactions which would leave the owner with a different interest from the one which is to be valued.

However, it includes any value attributable to any possibilities of extensions or further buildings on undeveloped land or redevelopment of existing buildings (all for the existing use) providing such construction can be undertaken without major interruption to the continuing business.

- 5.1.4 The assumption has been made that the proposed property valued will continue, after completion, to be held by you for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.
- 5.1.5 The estimate valuation figure is apportioned between land, buildings, engineering services and external works. These apportionments are included in the detailed Block Summary Report, which also features estimated remaining life figures for each of the individual building elements.
- 5.1.6 It is recognised that you normally require being aware of whether the highest and best use of an asset differs from its current value use. Where the Current Value of an asset for accounting purposes is considered materially different from Market Value (reflecting potential alternative uses including land as a redevelopment site). For the purposes of this estimate valuation report for an asset which is yet to be built, this is not appropriate, or required.

6. Method of Value

6.1 Specialised Assets

- 6.1.1 As a specialised asset, there is no market-based evidence to support the use of EUV to arrive at Current Value so the Depreciated Replacement Cost (DRC) approach has been used. Specialised assets are properties which are rarely sold in the market, except by way of a sale of the business or entity of which it is part, due to uniqueness arising from its specialised nature and design, its configuration, size, location or otherwise. The land and building parts have been valued separately and when combined these figures give the proposed asset's total value. To assist you, the report provides these figures in both their combined and separate forms.
- 6.1.2 As depreciated replacement cost (DRC) is used, the valuer has had regard to RICS UKGN 2, titled 'Depreciated Replacement Cost (DRC) Method of Valuation for Financial Reporting', as supplemented by Treasury guidance.
- 6.1.3 RICS UKGN 2 paragraph 2.3 defines DRC as:
- 'The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.'
- 6.1.4 It is confirmed that as DRC is used, the modern equivalent asset (MEA) principle has been applied; it being the underlying use for which the asset is being used that

determines the valuation treatment. In the present case you have confirmed that the actual proposal comprises the Modern Equivalent Asset.

- 6.1.5 As a specialised property, the Gross Replacement Cost (GRC) of providing a new modern equivalent asset is assessed.

This GRC is then normally adjusted to reflect physical, functional and external obsolescence, as appropriate, producing a Net Replacement Cost (also known as Depreciated Replacement Cost – DRC) which reflects the remaining service potential of the actual asset.

As the property is brand new and purpose built for this estimate asset valuation, you have informed us that functional and external obsolescence are de-minimus. Further as the building is new then there is no physical obsolescence in our assessment of the estimate Net Replacement Cost figure, which reflects the estimated full service potential of the actual asset on completion.

- 6.1.6 An estimate of the Remaining Economic Life has been provided, based upon information provided by the Trust's Cost Advisor.
- 6.1.7 It is confirmed that no deductions or other adjustments will be made in DRC calculations in respect of capital based Government grants.
- 6.1.8 For the DRC method of valuation, external works have been deemed to include below ground drainage, hardstandings, formal landscaping, site fencing and walls, all services on site, distribution and incoming supplies, and minor buildings as appropriate.
- 6.1.9 All DRC figures supplied are inclusive of professional fees, but exclude finance charges, in accordance with Treasury guidance.
- 6.1.10 VAT: For assets valued using the depreciated replacement cost approach, the replacement cost figures normally include VAT, but see the separate section concerning PFI schemes

For the purposes of this report two separate valuations have been provided, one with VAT included (in the buildings and external works figures) and one with VAT excluded.

- 6.1.11 Land has been assessed to Fair Value, interpreted as market value for existing use, having regard to the cost of purchasing a notional replacement site in the same locality, equally suitable for the existing use and of the same size, with normally the same physical and locational characteristics as the actual site, other than characteristics of the actual site that are irrelevant, or of no value, to the existing use. Where the use is too specialised to categorise in market terms, the land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the actual site.

In selecting the site on which the modern equivalent asset would be situated, the valuer has discussed the matter with you, in accordance with section 7 of UKGN 2. You have informed us that the actual site remains the most appropriate and indeed the only available locality for the proposed scheme. For public sector bodies, HM Treasury guidance is that the choice of whether to value an alternative site will

normally hinge on whether the proposed alternative site will meet the locational requirements of the service that is being provided (Treasury Guidance Note paragraphs 1.14 to 1.16).

7. Private Finance Initiative (PFI) Assets

7.1 Assets provided under a PFI scheme qualify for asset valuation:

- when it is probable that future economic benefits associated with the asset will flow to the organisation; and
- when the cost of the asset can be measured reliably

This is generally accepted to be when the asset is brought into use.

7.2 The proposed asset is identified by you as qualifying as a PFI asset and have been valued to Current Value in existing use. Where the asset is a specialised asset and the value cannot be determined by reference to market based evidence, the Depreciated Replacement Cost (DRC) approach has been used.

7.3 For the avoidance of doubt, **the DRC valuation figures are normally supplied including VAT at the prevailing standard rate.** You may wish to consider with your advisers whether VAT is recoverable in respect of each of your PFI properties, with a view to making any consequent appropriate adjustments for current appraisal purpose purposes and as stated previously a second valuation estimate has been provided on a VAT exclusive basis.

8. Component Accounting

8.1 IAS 16 requires componentisation of the depreciable amount to be considered and applied as appropriate where material. Components with cost which is significant in relation to the total cost of the asset require to be depreciated separately, although it is permissible to group together for depreciation charge calculation purposes those significant parts which have similar remaining useful lives. A body may also as a policy decision elect to require the separate identification of selected components whose costs are not significant or remaining useful lives different.

8.2 The depreciable amounts of the assets valued in this report have been componentised having regard to IFRS, HMT and RICS guidance on the matter and in accordance with our discussions with you regarding your specific componentisation requirements.

9. Special Assumptions

Please see paras 1, 3, and 4 above. Additionally you have advised that the actual proposed hospital solution is the best available, accordingly it has been assumed for the purposes of this estimate report that there is no Modern Equivalent Asset better suited as a representation of value.

The estimate valuation is provided without projection forward to the building completion date. It assumes a notional completed building as at the stated valuation

date and with figures appropriate to that date. **Accordingly it is highly likely that the valuation figures on actual building completion will differ from those provided within this estimate through the effluxion of time and changes in the market. It is assumed that the Trust will account for this risk separately.**

The following assumptions and approaches apply to this report.

1. It is an estimate only and applies to market conditions appropriate to the stated valuation date (1 August 2015). It must not, therefore, be taken forward for application to any formal financial accounting on actual building completion and occupation.
2. It assumes, on your instruction, that the actual Hospital proposal, including the layout number of storeys and overall size comprises the best or only Modern Equivalent Asset solution available to deliver the service intended in the geographical area required.
3. Consideration has been given to estimates of cost provided by the Trust's cost advisor.
4. The future expansion "shell" element of the building proposed has not been included in the valuation, on your instruction.
5. It adopts a Depreciated Replacement Cost approach as a specialised operational asset proposal, on an "instant building" approach (ie no finance costs added, in accordance with NHS asset valuation requirements).
6. It includes External Works at rate of 11.50% of the buildings figures totals (ie main building, multi storey and underground car parks).
7. It excludes the proposed shell accommodation.
8. It includes main fees at 10% of the buildings and external works totals.
9. For the valuation that includes VAT, this is at a rate of 20% on the Building, external works and fees totals.

10. Nature and Source of information Relied Upon

I have assumed that all information provided by, or on behalf of you, in connection with this instruction is correct without further verification – for example, details of tenure, tenancies, planning consents, areas, etc.

My advice is dependent upon the accuracy of this information and should it prove to be incorrect or inadequate, the accuracy of my valuation may be affected.

Gross Internal Areas (GIAs) have been supplied by the Trust and its advisors and adopted by the valuer without check measurements from plans being undertaken.

11. Extent of Investigations, Survey Restrictions and Assumptions

An assumption in this context is a limitation on the extent of the investigations or enquiries undertaken by the valuer. The following agreed assumptions have been applied in respect of your instruction, reflecting restrictions to the extent of our investigations.

No site inspection or detailed site survey has been carried out for the purpose of this report and the estimate land value assumes a site cleared and ready for development.

- It has been assumed that good title can be shown and that the proposed property will not be subject to any unusual or onerous restrictions, encumbrances or outgoing. Original documents of title and lease documentation have not been read.
- It has been assumed that the proposed property and its value are unaffected by any statutory notice or proposal or by any matters that would be revealed by a local search and replies to the usual enquiries, and that neither the construction of the property nor its condition, use or intended use was, is or will be unlawful or in breach of any covenant.
- Valuations include that plant that is usually considered to be an integral part of the building or structure and essential for its effective use (for example building services installations), but exclude all machinery and business assets that comprise process plant, machinery and equipment unless otherwise stated and required.
- It has been assumed that no deleterious or hazardous materials or techniques will be used in the construction of the property.
- No access audit has been undertaken of the proposals to ascertain compliance with the Equality Act 2010 and it has been assumed that the premises will be compliant, unless stated otherwise in this report.
- No environmental assessment of the proposed property (including its site) and neighbouring properties has been provided to or by the VOA, nor is the VOA instructed to arrange consultants to investigate any matters with regard to flooding, contamination or the presence of radon gas or other hazardous substances. No search of contaminated land registers has been made. No allowance has been made for contaminated land in the valuation.
- It has been assumed that the proposed property (including its site) and neighbouring properties are not and will not be contaminated and are and will be free of radon gas, hazardous substances and other adverse environmental impacts.
- No flood risk assessment has been carried out and no guarantee is given that flooding can never occur.
- No allowances have been made for any rights obligations or liabilities that may arise from the Defective Premises Act 1972.

12. Mineral Stability

12.1 The site may be situated in an underground mining area. No report on any risks in this respect have been provided to the VOA or commissioned from it and you are deemed to have instructed the Agency to assume in arriving at its estimate valuation:

- (1) that the proposed property valued is not at the date of valuation affected by any mining subsidence and will not be so affected in the future, and
- (2) that the site is stable and will not occasion any extraordinary costs with regard to Mining Subsidence.

You hereby accept that the Board of HMRC for and on behalf of the Agency and its employees cannot, in these circumstances, provide any warranty, representation or assurance whatsoever to you or any third party as to the mineral stability or otherwise of the subject property valued and you hereby agree to waive any claim which you might otherwise have had against the Board, the Agency or any of their employees for negligence or breach of contract arising from any loss or damage that may be suffered as a result of the fact that the Agency's estimate valuation on your specific instructions, is to take no account of any matters which might reasonably be expected to have been disclosed by an Underground Mining Subsidence Report.

13. Date of Inspection

As indicated above the site of the proposed property has not been inspected.

14. Taxation

14.1 In preparing this Report, no allowances have been made in the valuations for notional taxation.

14.2 No additions have been made for Stamp Duty Land tax (SDLT).

15. Acquisition and Disposal Costs

15.1 It is confirmed that no notional directly attributable acquisition costs have been applied to the Current Value figures.

15.2 For indicative accounting purposes only to assist you in the application of notional directly attributable acquisition costs, where material, to Existing Use Values we are of the opinion that the notional directly attributable acquisition costs would be represented by the application of a 2% addition in respect of each property valued to EUV.

16. Estimate Opinion of Value

In respect of the proposed property interest shown on the electronically supplied Block Summary Schedule, the total estimated value, as at 20 May 2014 may be taken to be as follows,

Inclusive of VAT

£269,313,055 (Two Hundred and Sixty Nine Million, Three Hundred and Thirteen Thousand and Fifty Five Pounds)

For your convenience, this total capital value figure may be apportioned between land and buildings as follows:

Total Land Value:
£6,675,000

Total Buildings Value (including car parks and external works; excluding shell space):
£262,638,055

Exclusive of VAT

£225,540,046 (Two Hundred and Twenty Five Million, Five Hundred and Forty Thousand, and Forty Six Pounds)

Total Land Value:
£6,675,000

Total Buildings Value (including car parks and external works; excluding shell space):
£218,865,046

17. Restrictions on Disclosure and Publication

- 17.1 The client will neither make available to any third party or reproduce the whole or any part of the report, nor make reference to it, in any publication without our prior written approval of the form and context in which such disclosure may be made.
- 17.2 We will do all that we can to keep any information gathered or produced during this assignment confidential. The Freedom of Information Act 2000 or Environmental Information Regulations 2004, and subordinate legislation, may apply to some or all of the information exchanged between yourself and the Valuation Office Agency under this engagement. Therefore the Valuation Office Agency's duty to comply with the Freedom of Information Act may necessitate, upon request, the disclosure of information provided by you unless an exemption applies.

The Valuation Office Agency undertakes to make reasonable endeavours to discuss the appropriateness of disclosure, or the applicability of any exemptions allowed by the Act, with you prior to responding to any third party requests. However, the Valuation Office Agency reserves the right to comply with its statutory obligations under the Act in such manner as it deems appropriate.

The Valuation Office Agency requires you to make all reasonable endeavours to discuss with us the appropriateness of disclosure, or the applicability of any exemptions allowed by the Act, prior to your responding to any third party requests for information provided to you by the Valuation Office Agency.

18. Limits or Exclusions of Liability

This report has been produced specifically on behalf of Sandwell & West Birmingham Hospitals NHS Trust for financial planning and estimating purposes in connection with a potential future formal asset valuation on building completion.

The report should only be used for the stated purpose and for the sole use of your organisation and your professional advisers. No responsibility whatsoever is accepted to any Third Party who may seek to rely on the content of the report unless previously agreed.

In particular, the estimate asset valuation figures must not be used for insurance valuation purposes as there are significant differences between the way asset valuation figures are arrived at and the approach adopted for insurance valuations.

19. Identity of Responsible Valuer and their Status

- 19.1 It is confirmed that the valuation has been carried out by a RICS Registered Valuer, acting in the capacity of an external valuer, who has the appropriate knowledge and skills and understanding necessary to undertake the valuation competently, and is in a position to provide an objective and unbiased valuation.

The lead valuer responsible is Neil Rayner and contact details are as stated above in the letterhead.

- 19.2 In accordance with the requirements of the RICS standards, the VOA has checked that no conflict of interest arises before accepting this instruction. It is confirmed that I am unaware of any previous conflicting material involvement and am satisfied that no conflict of interest exists.

20. Public interest Disclosures required by the RICS

- 20.1 Valuations prepared for public sector accounting purposes are not Regulated Purpose Valuations under the RICS Valuation - Professional Standards.
- 20.2 Having regard to the requirements of PS 2, paragraph 8, it is confirmed that the Valuation Office Agency has been carrying out asset valuations for Sandwell & West Birmingham Hospitals NHS Trust continuously since 2005.
- 20.3 Neil Rayner has continuously been the signatory to the valuations provided for this purpose since 2009.

- 20.4 Rotation: It is recognised that use of the same individual valuer over a long period of time could lead to over familiarity with the client and the property, and if unchecked could lead to insufficient questioning of the factors affecting the valuation, as well as perceptions that the valuer's objectivity could be compromised.

Our internal project management and quality assurance policy & practices are designed to address and mitigate such risks. We also recognise that clients do like continuity and therefore do not put a specific limit on the number of years an individual can sign a report, always subject to the client's agreement and satisfaction.

- 20.5 It is confirmed that this report does not include any properties acquired by Sandwell & West Birmingham Hospitals NHS Trust within the 12 months preceding the date of valuation where the Valuation Office Agency negotiated that purchase on your behalf.
- 20.6 It is confirmed that the proportion of the total fees payable by Sandwell & West Birmingham Hospitals NHS Trust during the preceding year relative to the total fee income of the Valuation Office Agency during the preceding year is very minimal and not material.
- 20.7 The VOA operates a rigorous QA/QC system. This includes the inspection by Team Leaders of a sample of work carried out during the life of the instruction together with an audit process carried out by experienced Chartered Surveyors upon completion of casework. The approach adopted includes a feedback cycle to ensure continuous improvement

21. Further Information

If you require any further information or advice relating to this report or the properties valued herein, please contact Neil Rayner the contact details of which are on the covering page of this report



Neil Rayner BSc (Hons) MSc DIC MRICS
Principal Surveyor
RICS Registered Valuer
DVS

Appendix – Key Documents

- NHS Manual for Accounts or NHS Foundation Trust Annual Reporting Manual
- HM Treasury Financial Reporting Manual (FreM) – specifically Chapter 6: Tangible Assets
- HM Treasury “Guidance on Asset Valuation” paper (interpreting RICS UKGN 2 - formerly known as VIP 10)
- RICS Valuation - Professional Standards 2014 UK edition

And:

- International Accounting Standard 16 (IAS 16): Property, Plant and Equipment
- International Accounting Standard 17 (IAS 17): Leases
- International Accounting Standard 40 (IAS 40): Investment Assets
- International Financial Reporting Standards 5 (IFRS 5): Non-current Assets Held for Sale and Discontinued Operations

APPENDIX 16d – REVIEW OF PF2 ACCOUNTING TREATMENT

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case



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Private & confidential

Mr Tony Waite
Director of Finance
Sandwell and West Birmingham Hospitals NHS
Trust
City Hospital, Birmingham
West Midlands, B18 7QH

Our ref

Contact **Clare Partridge**
0113 231 3922

Private & confidential

25 September 2015

Dear Tony

Review of the consistency and application between the Trust's Long Term Financial Model, Accounting Model and the Bidder's Model in respect of the Midland Metropolitan Hospital.

In accordance with the terms of our engagement letter dated 20 August 2015 agreed with Sandwell and West Birmingham Hospitals NHS Trust ("the Trust"), we have reviewed documentation associated with the Trust's new Midland Metropolitan Hospital Private Finance Initiative ("PFI") project to consider:

- The Trust's translation of the preferred bidder model into its PF2 accounting model; and
- The Trust's application of the underlying accounting model in its LTFM.

Sources of information for our review

On the 4 September 2015, we received and based our assurance on the following three spreadsheets:

1. *IFRS PFI Model ABC Final Position- sABC.xls* – the "Accounting Model" produced by the Trust to set out the accounting impact of the PFI and specifically to calculate the semi-annual inflation factor adjustments necessary to compensate for the partial indexation applied to PFI costs in the bidder's model. It also included a five year analysis of the Unitary Payment (UP) charges in a format for its separate financial planning spreadsheet (see 3 below).
2. *MMH_FinancialModel_July2015_NewBaseBid_100m.xlsm* - the "Bidder's Model" prepared by HSBC Bank plc for Carillion Private Finance Limited. This spreadsheet

details the financial costs and impact of the new base bid to the concession period end of 13 July 2048. It is based on a £100 million capital contribution by 2018.

3. *SWBH LTFM S-ABC Version Values inc Taper & UP Adj.xls* – the Long-Term Finance Model v5.1 (“the LTFM”) produced and owned by the Trust to assess its long term finances. This specifically models the impact of the proposed unitary payment and associated financial flows together with its existing PFI scheme, financial plans and activity modelling over a ten year period to the end of March 2024.

We have also considered our review in the context of International Financial Reporting Standards (“IFRS”) insofar as these standards, or pronouncements, are applied to NHS Trusts under accounts directions issued by the Secretary of State for Health, through the NHS Manual for Accounts (MfA) and associated communications through the Department of Health Finance Manual website. We have also referred to other relevant guidance such as the Treasury Financial Reporting Manual (FReM) where appropriate.

Key findings

Our work focussed on consideration of the consistency between:

1. The Bidder's Model and the Accounting Model and specifically the inputs in the ‘*global inputs*’ worksheet of the Accounting Model; and
2. The Accounting Model and the LTFM and specifically the ‘*UP Breakdown*’ worksheet of the Accounting Model to the ‘*I_PFI*’ worksheet of the LTFM.

We were able to confirm the consistency of the key figures used in the models.

There is one matter of judgement which we would draw to the Trust's attention.

IFRS recognises that it is a matter of judgement as to how the fair value of a capital addition is determined for the purposes of accounting asset recognition.

The Trust has included in its accounting model a capital addition of £305 million taken from the figures contained in the ‘*S1-Summary*’ worksheet of the Bidder's Model (cell references E38, E39 and E50). The sum appropriately reflects the costs of construction and bid costs.

We note that the Bidder's Model separately recognises £19 million of SPV costs as arising during the period of construction. We further note that the Bidder's Model records a fair value of construction, including those SPV costs, of £323.9 million (taken from cell E2411 of ‘*C1_WKS*’ worksheet of the Bidders model) and that the Bidder sets this sum as the finance debtor and therefore the present value of the unitary payment due from the Trust for all costs incurred in the construction phase.

We recognise that the Trust has been consistent in those costs which it has included in its assessment of the value of the capital addition.

Whilst the treatment of SPV costs during construction has varied across PFI schemes, we recommend that the Trust should review its application of the capital addition in its Accounting Model and the future accounting treatment when it recognises the scheme on its Statement of Financial Position in 2018.

Further detailed considerations

We confirmed consistency in many of the key figures used in the models. As a result of our work in the first area outlined above, we have:

- Agreed the following inputs in the 'global inputs' worksheet from the Accounting Model to the Bidder's Model:
 - The relevant Scenario number (1);
 - The Operator model inflation base date (01/04/2014);
 - The number of semi-annual service periods (60);
 - The three capital contributions, between 1 June 2016 and 1 April 2018, match in total the £100 million in the figure Bidder's Model. We note the phasing is different over the three years;
 - The Asset fair value or construction cost (£305,075,000). We also matched the individual components comprising this figure to each of its underlying categories; namely Construction Costs, Pre-funded EPC Retention Account and Bid Development Costs (see above); and
 - Operator model annual RPI indexation (2.5%).
- Identified a few differences in the dates input of a few days that will only have a trivial impact on the accounting model, for example a difference of 22 days for the construction start date and 12 and 13 days for the services start and end dates respectively.
- Agreed the following Unitary Charge Facilities Management (FM) and Special Purpose Vehicle (SPV) management costs in the 'Operator Model Inputs' worksheet of the Accounting Model to the Bidder's Model:

- The two total Unitary Charge figures for April to September 2018 and October 2018 to March 2019 to the Annual Service Payment figure (£21.16 million) in the Bidder's Model;
- The inflated Hard FM costs (totalling £109,798,200 to take account of the lower indexation charge) to the Nominal Total Operating period operating costs of the Bidder's Model comprising Estates services, Utilities management, Pest control and General Services; and
- The Special Purpose Vehicle management (incl insurance) costs (totalling £19,676,822) to the figures in the Bidder's Model comprising Senior Debt Technical Advisor, Monitoring fees, SPV Management, Annual Audit, Legal Costs, Contingency and Directors Fees.
- Agreed the following lifecycle figures in the 'Asset Inputs' worksheet of the Accounting Model to the Bidder's Model:
 - The Actual nominal expensed lifecycle costs (totalling £101.169 million) to the figures contained in the 'SI_SUMMARY' worksheet (and supporting schedules); and
 - The same figures in the bullet point above through to the 'UP Estimate workings' and 'Operator Model Inputs' worksheets.
- Noted that the Trust's Accounting Model adjusted the profiling of the Public Dividend Capital receipts of £100 million from the Bidder's Model (over the period from 1 June 2016 to 1 April 2018). We found the three amounts received were profiled appropriately within the LTFM. The values are included in the accounting model using a different profile. However this different profile results in the correct impact on the finance lease liability. In conclusion we have no issues to report on this and the mismatch between models is in fact appropriate.

In reviewing the LTFM, we have:

- Agreed the following inputs in the 'I_PFI' worksheet of the LTFM to the 'UP Breakdown' worksheet figures in the Accounting Model:
 - Each of the annual interest payments (totalling £91.692 million) over the five year period to March 2024; and
 - Each of the capital repayments (totalling £132.862 million) over the five year period to March 2024.

- Noted that the Facilities Management (Operating Charge totalling £36.866 million) omitted the IM&T charges totalling £358,000. The Accounting Model had provided a narrative noting this exclusion in its description next to the cell values.

Closing observations

We note that the Trust is expensing lifecycle costs when incurred (£101m across 30 years). We do not disagree with this treatment on the basis of its relatively low materiality. Also, the irregular nature of lifecycle expenditure and the smooth nature of the Unitary Payment means that you would have to take an element of the Unitary Payment to payments in advance and then release it when the work is carried out. This is likely to require high levels of cooperation between the grantor and the operator when the amounts involved are not material.

In undertaking this review, we also draw your attention to the following observations on which we do not provide a view:

- The 'Annual Statements' worksheet of the Accounting Model details an impairment of £30.508 million in 2018/19. This figure is approximately 10% of the capital construction cost. The Trust will have a greater degree of precision on this figure as it agrees more detailed plans and this may result in a higher impairment value typical in other PFI schemes. Our understanding is that the Trust has engaged an independent valuer to report on the likely impairment which supports the Trust's judgement.
- The Model assumes a 60 year asset life. This is a view provided by the Trust's valuer on which they are best placed to assess.

Your external auditors retain the responsibility of forming an opinion on your financial statements as a whole and will continue to review any future accounting treatment when the scheme is recognised in the Trust's Statement of Financial Position in 2018.

Please do not hesitate to contact me to discuss any aspect of our findings.

Yours sincerely



Clare Partridge
Director
KPMG LLP

APPENDIX 16e – DFC STAGE 2 EVALUATION SUMMARY

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Midland Metropolitan Hospital Project

DFC – Stage 2 Responses

Date: September 2015

DRAFT

RESTRICTED

Contents



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Section 1

INTRODUCTION

Stage 2 Responses

- The following parties were shortlisted in Stage 1 of the Preferred Bidder Funding Competition and invited to submit credit approved offers in Stage 2:
 - A Bank Club of KfW, CACIB and SMBC
 - M&G / SMBC
 - LGIM / Lloyds
- Each of the funders above attended a due diligence surgery with Ashurst, MAMG and Willis, together the “Due Diligence Advisors”, and were invited to submit a series of follow-up clarifications, to which the Sponsors and the Due Diligence Advisors collectively responded.
- M&G and LGIM have not been able to maintain their pricing proposed at Stage 1 of the DFC and had to increase their margins. They have stated that this is due to rising bond spreads. LGIM have not approached their investment committee as they do not believe their pricing is competitive versus a bank club solution.
- CACIB offers financing terms aligned with the “Conformed Terms” defined at the end of Stage 1 of the DFC, SMBC is above these Conformed Terms and KfW is proposing lower financing terms compared to the two other banks.
- None of the banks had appetite to do 50% of the senior debt alongside only the EIB at ‘conformed terms’ pricing.
- All of the terms proposed by the Funders are summarised in the next slides of this report.

Section 2

TERMS SUMMARY

Terms Summary



	CACIB	KFW Ipx	SMBC	L&G	M&G
Capacity	25% of the Senior Debt	25% of the Senior Debt and 100% of the EBL	c. 11.5% of the Senior Debt (ie. c. £25m) and 100% of the EBL	50% of the Senior Debt and 100% of the EBL	50% of the Senior Debt and 100% of the EBL
Gearing	90:10	90:10	90:10	90:10	90:10
Term Loan Tenor	31y and 4 mths	31y and 4 mths	31y and 4 mths	30y and 10mths	31y and 4 mths
Equity Bridge Tenor	n/a	Construction period	Construction period	Construction period	Construction period
ADSCR (combined for senior & junior tranches if applicable)					
Minimum	1.18x	1.18x	1.18x	1.27x	1.20x
Average	1.18x	1.18x	1.18x	1.27x	1.20x
Lock-up	[TBC]	1.10x	1.10x	1.10x	1.10x
Default	[TBC]	1.05x	1.05x	1.05x	1.05x
LLCR					
Minimum	1.20x	1.20x	1.20x	1.30x	1.20x
Lock-up	[TBC]	1.15x	1.15x	1.15x	1.15x
Default	[TBC]	1.10x	1.10x	1.10x	1.10x
Security Package					
Adjudication Bond	7%	7%	7%	10%	7%
Construction retention cashflows	3%	3%	3%	3%	3%
Construction Letter of credit	3%	3%	3%	3%	3%

Terms Summary

bps unless stated otherwise		CACIB	KFW Ipex	SMBC	L&G	M&G
Term Loan						
Arrangement Fee		120bps	120bps	120bps	140bps	100bps
Commitment Fee		35%	35%	35%	40%	40%
Construction Margin		120bps	115bps	120bps	135bps	155bps
Ops Margin	Margin 1	Yr 1 to 9: 110bps	Yr 1 to 9: 110bps	Yr 1 to 9: 115bps	135bps	155bps
	Margin 2	Yr 10 to 16: 120bps	Yr 10 to 19: 115bps	Yr 10 to 16: 130bps	-	-
	Margin 3	Yr 17 to 23: 130bps	Yr 20+: 125bps	Yr 17 to 23: 140bps	-	-
	Margin 4	Yr 23+: 140bps	-	Yr 23+: 150bps	-	-
Equity Bridge Loan						
Arrangement Fee		N/A – No appetite for the EBL	50bps	100bps	100bps	100bps
Commitment Fee			35%	35%	40%	35%
Margin			75bps	75bps	80bps	75bps
Hedging						
Swap Credit Margin (Senior / EBL)		20bps / n/a	19bps / 4bps	20bps / 5bps	n/a / 5bps	n/a / 5bps
Hedging on the EIB Facility		50% of the EIB should it be needed	EIB swaps pro rata to their participation in the Term Loan	One third of the hedging for the EIB facility.	n/a	n/a
Agency Trustee Fees (per annum)						
Facility Agent		£15k p.a, reducing to £10k p.a post completion	n/a	-	£40k during construction and £30k thereafter	£31.5k
Security Trustee		£10k p.a	n/a	-		
Account Bank		£5k p.a	n/a	-		

Additional Comments from Banks

Funder	Additional comments
CACIB	<p>The proposed terms are subject to finalisation of documentation and satisfactory final due diligence (e.g. legal, insurance and technical). CACIB will specifically be looking for adequate clarifications regarding:</p> <ul style="list-style-type: none"> (i) the final assessment of the SFP levels and comfort around Clause 44.3(c) of the Project Agreement; (ii) confirmation of the appropriateness of the lifecycle costs; (iii) remediation / Ground Conditions risks; (iv) final position of the sub-contract look-forward tests, and (v) worst case scenarios for the lifecycle costs, opex and deductions (in revenue terms).
KfW	<p>The margins proposed apply in the following scenarios:</p> <ul style="list-style-type: none"> - Where they have 100% of the Equity Bridge Loan and at least 33.3% of the Term Loan Facility - Where they have 50% of the Equity Bridge Loan and at least 50% of the Term Loan Facility. <p>If they are able to increase the margin in years 1-9 of operations from 110bps to 115bps, then they are able to reduce the arrangement fee from 120bps to 100bps. This would give a flat margin of 115bps for years 1-19 and 125bps years 20+. If they have no participation in the Equity Bridge Loan, then they are unable to offer the pricing sets out in the previous slide.</p> <p>The same swap margin as shown for the Senior Debt facilities will apply to any hedging they provide to the EIB should a floating rate loan be offered by them. Any hedging offered will be pro rata to our participation in the Term Loan Facility.</p> <p>KfW IPEX-Bank would prefer not to have the Agency and Security Trustee roles, but if required for them to perform these roles, then their original terms would apply (ie. £80k p.a during construction and £60k p.a. during operation).</p>
SMBC	<p>SMBC only have approval for £25m in the term loan because they need to go to a higher level in the bank for a larger loan amount and have not been able to do so at this stage. They could do this if requested post-selection.</p> <p>SMBC would be interested in performing the role of Account Bank, for which they would not charge a fee (except for standard bank fees for operating the account);</p> <p>They also confirm they would be interested in providing one third of the hedging for the EIB facility should a floating rate loan be offered by them.</p>

Funders Comments

Funder	Additional comments
M&G	<p>Make Whole: Voluntary repayment of the Senior Facility ("SF") and Senior Subordinated Facility ("SSF") will be subject to Spens based compensation: - Voluntary prepayment – modified spens : gilts + 50 bps For completeness, compensation on other events: - Trust default – full spens - Project company default – full spens - Force majeure – par - Corrupt gifts – par</p> <p>Cancellation of SF and SSF will be subject to Spens based compensation (full spens).</p>
L&G	<p>Due diligence points: L&G would expect full satisfactory resolution of points mentioned in provided due diligence reports, addendum and technical Q&A responses. Technical Q&A Preliminary Responses include: • Confirmation of timing for the look forward test; • Energy target; • Confirmation of adequacy of level SFPs step down in the subcontract from the Project Agreement; • Ground Contamination; • Lifecycle fund sufficiency;</p> <p>Points mentioned in Ashurst addendum to executive summary report include: • Mechanics for the capital contribution injection and suspension of the construction works • Pensions</p> <p>Make Whole: Make Whole clause from Royal Liverpool documentation to be replicated replacing 50bps by 30bps.</p>

Section 3

FINANCIAL MODEL AND NPV ANALYSIS

Methodology



For the purposes of the Financial Modelling HSBC has assumed the terms provided in each of the Funders' responses. However, certain assumptions have been made to evaluate the different responses received. The key assumptions are set out below:

1. Equity: The evaluation is based on the "EFC model", the financial model has been provided the 11th September 2015 and reflects the outcome of the EFC.

2. EIB: As per the EIB indicative termsheet, HSBC has assumed an upfront fees of 100bps, commitment fees of 50% of the credit margin. EIB has also advised HSBC to assume a credit margin of 80bps for modelling purposes only.

3. Tenor / ratio: HSBC has assumed the same tail for the EIB loan and for the Commercial Term Loan. The minimum tenor has been assumed between the EIB's requirement and Banks/Investors' requirement. The table below describes the different level of tail/ratios proposed by EIB.

Tail	ADSCR
21 months	1.18x
15 months	1.20x

4. Indexation: For the purposes of the evaluation, HSBC has assumed the same % or revenue indexation as the Bid Case. This is due to the complexity and time required to optimise this for each individual solution.

Methodology (cont.)

5. Interest Base Rate:

- HSBC markets provided updated LIBOR mid-swap rates (for loans) and Gilt rates (for bonds), as at the 21 August 2015, based on the 31 year and 4 month loan and bond profiles and 31 month EBL profile.
- EIB provided a quote for its fixed rate as at 15 August which was 30bps higher than the LIBOR mid-swap on the day. We have maintained this 30bps differential vs the LIBOR mid-swap rate on 21 August is setting our EIB fixed rate. We have assumed that EIB provide floating rate debt with interest rate hedging for the bank club solution and fixed rate debt for the M&G and LGIM solution as there will be no banks to provide hedging in these solutions.
- The 'all-in' interest rates assumed in the financial model are set out in the table below.

	Term Loan	EIB Facility	Bond facility	EBL
Base Rate	2.13%	2.13% floating rate / 2.43% fixed rate	2.29%	1.39%
Buffer	50bps	50bps	50bps	50bps
Total	263bps	263bps floating rate / 293bps fixed rate	279bps	189bps

- 6. Construction Security Package:** HSBC has assumed the construction security package proposed by the different funders. Note, EIB did not revert on the appropriateness of the construction security package.

- 7. Remediation works:** The remediation allowance of £1.5m in the final bid has been adjusted to £1.491m.

Preliminary Modelling Results

The table below sets out the key results in terms of Annual Service Payments, NPV and debt / equity structure based on the terms bid by each funder and the assumptions set out on the previous slides

		Banks 1			Bond / Private Placement	
In GBP m	Final bid	CACIB	KfW	SMBC	L&G	M&G
NPV of SP	[265.48]	[240.26]	[239.88]	[240.89]	[247.41]	[244.27]
Annual Service Payment (at base date)	[21.16]	[19.15]	[19.12]	[19.20]	[19.72]	[19.47]
Total Debt (£m)	[221.39]	[213.67]	[213.62]	[213.60]	[206.43]	[214.04]
Total Equity (£m)	[30.96]	[27.33]	[27.27]	[27.43]	[35.77]	[27.89]
Project Cost (£m)	[352.49]	[341.14]	[341.03]	[341.17]	[342.34]	[342.07]
Gearing	[87.73%]	[88.66%]	[88.68%]	[88.62%]	[85.23%]	[88.47%]
Minimum and Average ADSCR	[1.22]	[1.20]	[1.20]	[1.20]	[1.27]	[1.20]
Tail	1y and 3mth	1y and 3mth	1y and 3mth	1y and 3mth	1y and 7mth	1y and 3mth

1. The three banks scenarios assume:

- The most competitive terms proposed by the banks for the EBL, ie. the KfW offer;
- The terms proposed by CACIB for the Facility Agent, Security Trustee and Account Bank roles;
- A floating rate note for the EIB facility;

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Preliminary Modelling Results

As detailed on slide 18 and 19, for the purposes of this evaluation HSBC has made a number of assumptions and there is a degree of uncertainty / variability in these assumptions that could result in different NPVs. We have run additional scenarios below that indicates the impact on the NPV by changing key assumptions.

1.ADSCRs/Tail: An ADSCR of 1.18x and a tenor of 30y and 10mths for the bank club solution 'conformed terms' would increase the NPV of SP by c. £0.5m (analysis based on the CACIB financing solution).

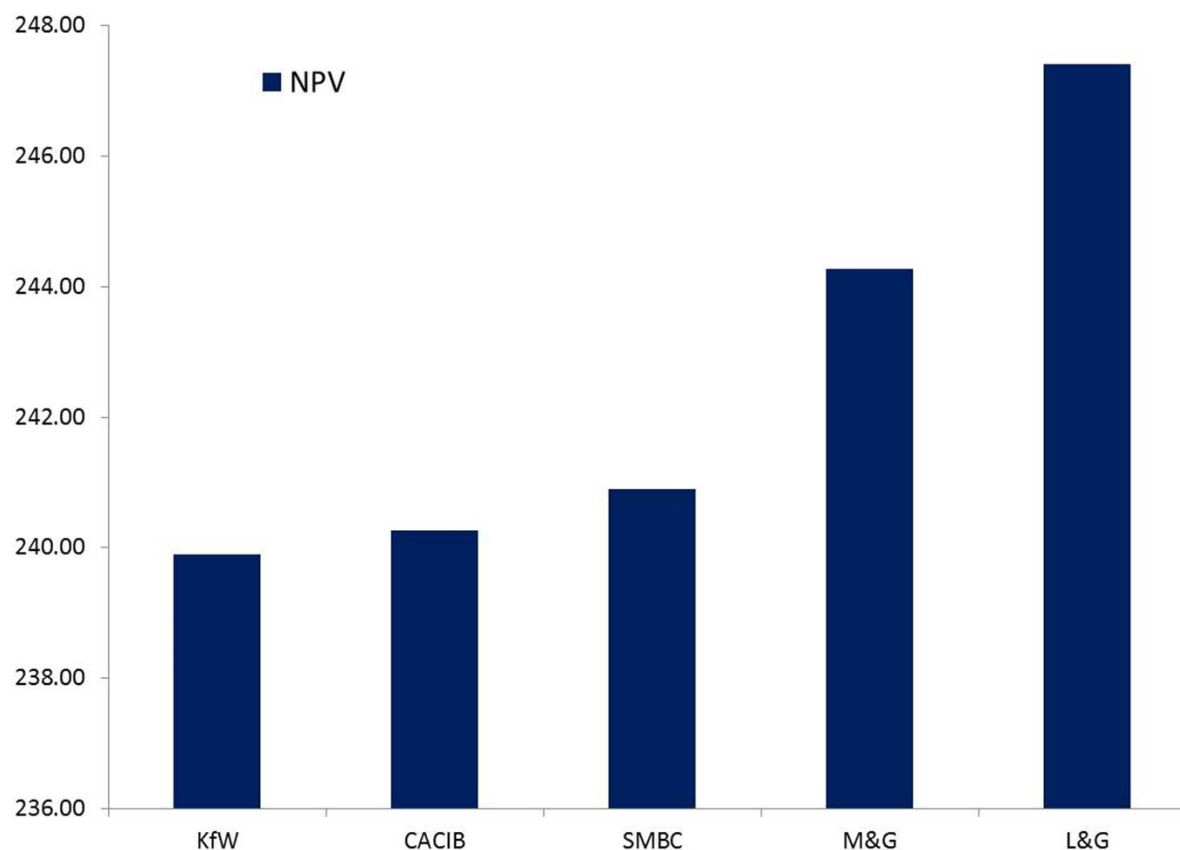
See below summary table of the two different levels of ratios/ tails:

In GBP m		Option 1: 1.18x ADSCR	Option 2: 1.20x ADSCR
NPV of SP		[240.76]	[240.26]
Annual Service Payment (at base date)		[19.19]	[19.15]
Gearing		[89.26%]	[88.66%]
Minimum and Average ADSCR		1.18	1.20
Tail:	EIB facility Commercial Facility	1y and 9mth 1y and 9mth	1y and 3mth 1y and 3mth

2.EIB facility - Fixed rate: The reference rate is c. 2.43% for a fixed rate solution (quote provided by EIB 15th September). If EIB provide fixed rate debt for the bank club solution this increases the NPV of SP by c. £0.80m (analysis based on the 'conformed terms').

Preliminary Modelling Results

- The chart below sets out the £ NPV based on the different offers received from banks /investors in the Stage 2 responses:



Section 5

CONCLUSIONS

Conclusions

- The analysis shows that in NPV terms there is a significant difference between the bank club and the two other funding solutions. The Bank Club is c. £4.0m (1.7%) better value in NPV terms than M&G and c. £7.1m (2.9%) than L&G. We would therefore recommend that a bank club is selected as the preferred funding solution.
- KfW is proposing lower financing terms compared to the two other banks, CACIB offers financing terms aligned with the “Conformed Terms” defined at the end of Stage 1 of the DFC and SMBC is above these Conformed Terms.
- Based on feedback received from CACIB they would not be able to improve their pricing and match margins proposed by KfW so there is no fully funded solution at the KfW pricing level.
- The selection decision is therefore between KfW and CACIB providing 25% of the total senior debt each at the Stage 2 Conformed Terms or selecting a three bank group including SMBC. Assuming SMBC will not move on pricing, which is the case based on initial discussions, the cost to the Trust of selecting a 3 bank group compared to a 2 bank group is £0.6m in NPV terms.
- Although it is unusual for a funder to pull out of a transaction post-credit approval there is always a higher degree of risk posed by selecting bank group with no contingency. Currently, SMBC is proposing to finance only £25m of the Senior Debt so there selection does not provide for a fully funded solution should one of the other banks drop out. However, SMBC have said they could go for a higher approval level if selected and if approved this would allow for a fully funded solution without one of KfW or CACIB.
- We would also note that KfW and CACIB will be assuming that they will be participating in a three bank group with each bank providing 13.3% of the total senior debt each and they may try to revisit pricing if they are selected as part of a 2 bank group.
- Our recommendation would be to select all 3 banks and ask them each to get final approvals for 25% of the Senior Debt to de-risk deliverability of a fully funded solution being achieved by 9 December. We note that this is still significantly better value than any of the other funding solutions in the DFC.

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Appendix 1

STAGE 1 RESPONSES

Terms Summary - Bank



	Final Bid	CACIB	Helaba	KFW Ipex Option 1	KFW Ipex Option 2	Nord LB	SMBC	Shinsei
Capacity	n/a	100% of the total Senior debt with or without EIB Same terms with or without EIB	100% of the total Senior debt with or without EIB Same terms with or without EIB	25% of the total Senior debt	50% of the total Senior debt	25% of the total Senior debt with EIB 50% of the total Senior debt without EIB Same terms with or without EIB	50% of the total Senior debt with or without EIB	40m with EIB involved 40-50m without EIB
Gearing	87.73%	90 : 10	90 : 10	90 : 10	90 : 10	90 : 10	90 : 10	[TBC]
Term Loan Tenor	31yr 4mth	31yr 7mth	30yr7mth	31yr 7mth	31yr 4mth	31yr 7mth	32yr 1mth	[31yr]
Equity Bridge Tenor	32mth	32mth	32mth	32mth	32mth	32mth	32mth	[TBC]
ADSCR (combined for senior & junior tranches if applicable)								
Minimum	1.20	1.18	1.15	1.18	1.18	1.15	1.15	[TBC]
Average	1.22	1.18	1.15	1.20	1.20	1.15	1.15	[TBC]
Lock-up	1.10	1.10	1.10	1.10	1.10	[TBC]	1.10	[TBC]
Default	1.05	1.05	1.05	1.05	1.05	[TBC]	1.05	[TBC]
LLCR								
Minimum	1.25	1.20	1.18	1.20	1.20	1.17	1.17	[TBC]
Lock-up	1.15	1.15	1.15	1.15	1.15	[TBC]	1.15	[TBC]
Default	1.10	1.10	1.10	1.10	1.10	[TBC]	1.10	[TBC]
Security Package								
Performance Bond	-	15-18% of the contract value	-	10%	10%	10%	-	-
Construction retention cashflows	3%		3%	3%	3%	3%	3%	3%
Construction Letter of credit	3%		3%	3%	3%	3%	3%	3%

Terms Summary - Bank

bps unless stated otherwise		Final Bid	CACIB	Helaba	KFW Ipex Option 1: 25% of the total Senior debt	KFW Ipex Option 2: 50% of the total Senior debt	Nord LB	SMBC	Shinsei
Term Loan									
Arrangement Fee		225	110	125	110	150	125	135	200
Commitment Fee		50%	35%	40%	35%	35%	40%	35%	40%
Construction Margin		140	110	130	120	130	130	125	150
Ops Margin	Margin 1	Yr 1 to 30: 140	Yr 1 to 9: 110	160	Yr 1 to 12: 115	Yr 1 to 12: 125	Yr 1 to 10: 130	Yr 1 to 10: 115	Yr 1 to 10: 140
	Margin 2	-	Yr 10 to 16: 120	-	Yr 13 to 29: 125	Yr 13 to 29: 135	Yr 11 to 20: 120	Yr 11 to 20: 125	Yr 11 to 20: 150
	Margin 3	-	Yr 17 to 22: 130	-	-	-	Yr 21+ : 115	Yr 21+ : 135	Yr 21 to 28: 160
	Margin 4	-	Yr 23+: 150	-	-	-	-	-	-
Equity Bridge Loan									
Arrangement Fee		200	100	50	100	100	125	100	[TBC]
Commitment Fee		50%	35%	40%	35%	35%	40%	35%	[TBC]
Margin		125	100	100	85	85	100	75	[TBC]
Swap Credit Margin (Senior / EBL)		25 / -	25 / 5	20 / 20	20 / 5	20 / 5	20 / 15	20 / 5	15-20 / [TBC]
Agency Trustee Fees (per annum)									
Construction		£40k	[TBC]	[TBC]	£80k	£80k	[TBC]	[TBC]	[TBC]
Operations		£30k	[TBC]	[TBC]	£60k	£60k	[TBC]	[TBC]	[TBC]

Terms Summary - Bond / Private Placement



	Final Bid	BTMU / Allianz		Assured Guaranty / Lloyds	Babson Capital / SG	L&G Option 1: implied rating BBB	L&G Option 2: implied rating A-	M&G / SMBC	Standard Life / Sun Life / MUFG
Capacity	n/a	T1: Floating rate	T2: Fixed rate	100% of the total Senior debt with or without EIB	50% of the total Senior debt with or without EIB	100% of the total Senior debt with or without EIB	100% of the total Senior debt with or without EIB	50% of the total Senior debt with or without EIB	50% of the total Senior debt
		50m	75m	Same terms with or without EIB		Same terms with or without EIB	Same terms with or without EIB		
Gearing	87.73%	90 : 10		90 : 10	92 : 8	90 : 10	90 : 10	90 : 10	90 : 10
Term Loan Tenor	31yr 4mth	15 yr	31 yr 7 mth	32 yr 1 mth	32 yr 1 mth	31yr 7 mth	31 yr 1 mth	31 yr 7 mth	31 yr 7 mth
Equity Bridge Tenor	32mth	32 mth	n/a	32 mth	32 mth	32 mth	32 mth	32 mth	[TBC]
ADSCR (combined for senior & junior tranches if applicable)									
Minimum	1.22	1.23		1.18	1.18	1.21	1.27	1.20	1.18
Average	1.22	1.25		1.18	1.18	1.22	1.27	1.20	1.18
Lock-up	1.10	1.10		1.10	1.10	[TBC]	[TBC]	1.10	1.10
Default	1.05	1.05		1.05	1.05	[TBC]	[TBC]	1.05	1.05
LLCR									
Minimum	1.25	1.25		1.18	1.20	1.25	1.30	1.20	1.20
Lock-up	1.15	1.10		1.10	1.15	[TBC]	[TBC]	1.15	1.15
Default	1.10	1.05		1.05	1.10	[TBC]	[TBC]	1.10	1.10
Security Package									
Performance Bond	-	-		-	-	9%	10%	Would expect a performance bond	10%
Retention cashflows	3%	3%		3%	3%	3%	3%	3%	3%
Letter of credit	3%	10%		3%	8%	2%	2%	3%	3%

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Terms Summary - Bond / Private Placement



bps unless stated otherwise]		Final Bid	BTMU / Allianz		Assured Guaranty / Lloyds	Babson Capital / SG	L&G Option 1: implied rating BBB	L&G Option 2: implied rating A-	M&G / SMBC	Standard Life Sun Life / MUFG
Term Loan										
Arrangement Fee		225	100	-	40	80	150	150	100	100
Commitment Fee		50%	35%		15%	35%	40%	40%	50%	35%
Construction Margin		140	105		140	140	140-150	120-130	130	150
Ops Margin	Margin 1	Yr 1 to 30: 140	Yr 1 to 15: 105	Yr 1 to 15: 170	140	140	140-150	120-130	130	150
	Margin 2	-	-	Yr 16 to 30: 180	-	-	-	-	-	-
Guarantee Fee		n/a	n/a		20bps 25% paid up-front and 75% over time	n/a	n/a	n/a	n/a	n/a
Drawdown			Deferred drawdowns		Deferred drawdowns (Quarterly)	Deferred drawdowns	Deferred drawdowns		Deferred drawdowns	Deferred drawdowns
Reference Rate		Libor	Libor	Gilt	Gilt	Gilt	Fixed rate solution, LGIM intend to use appropriate screen based LIBOR swap rate as the reference rate.		Gilt	Gilt
Equity Bridge Loan										
Arrangement Fee		200	85		100	125	100	100	100	85
Commitment Fee		50%	35		40%	35%	40%	40%	50%	35%
Margin		125	85		100	125	90	90	75	85
Swap Credit Margin (Senior / EBL)		25 / -	10 / 7	n/a	n/a	n/a / 5	n/a	n/a	n/a / 5	n/a / 6
Agency Trustee Fees (per annum)										
Construction		£40k	[TBC]		6k up-front + 8k p.a	[TBC]	[TBC]	[TBC]	36.5	[TBC]
Operations		£30k	[TBC]			[TBC]	[TBC]	[TBC]	36.5	[TBC]

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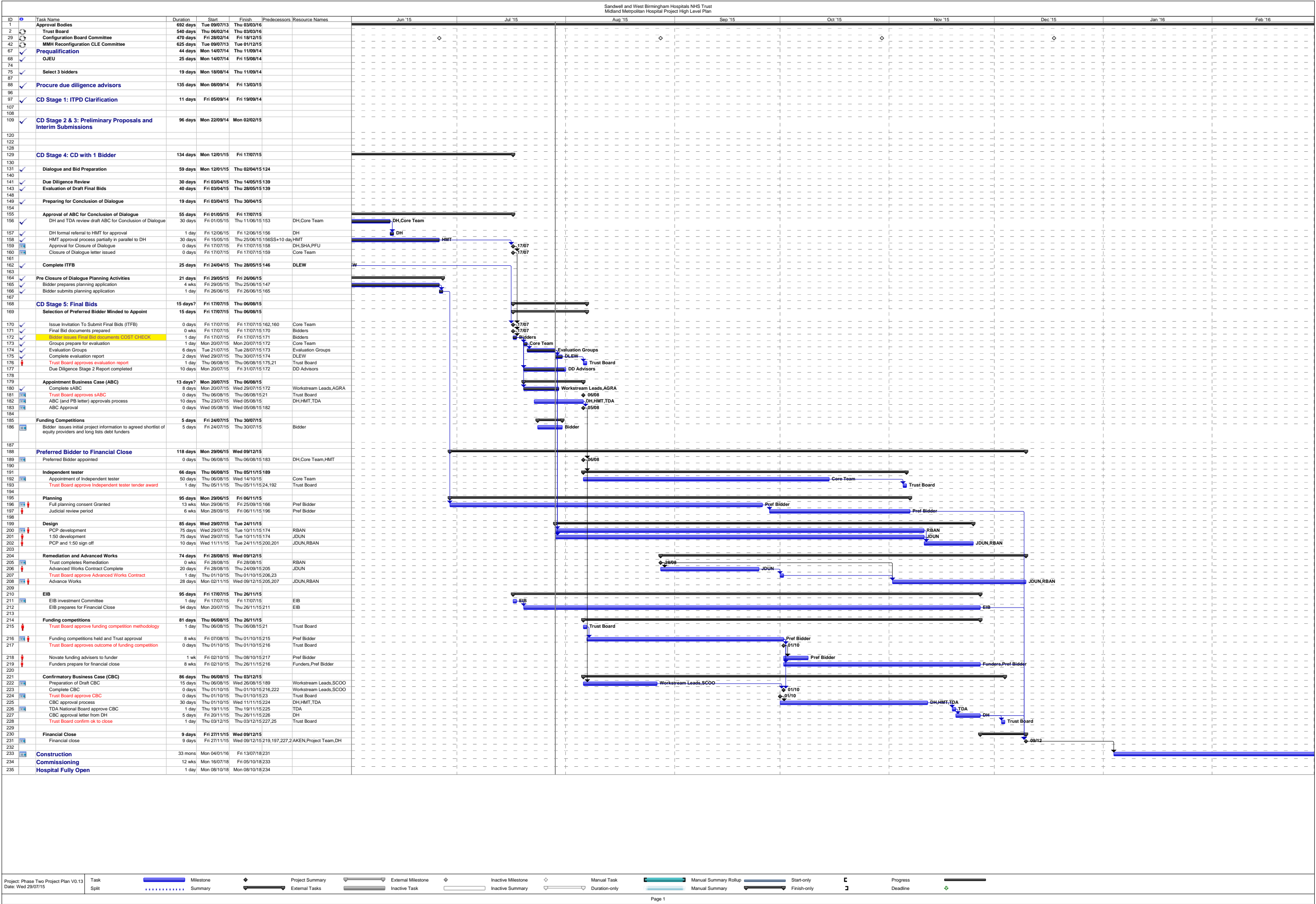
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APPENDIX 18a – PROJECT PLAN

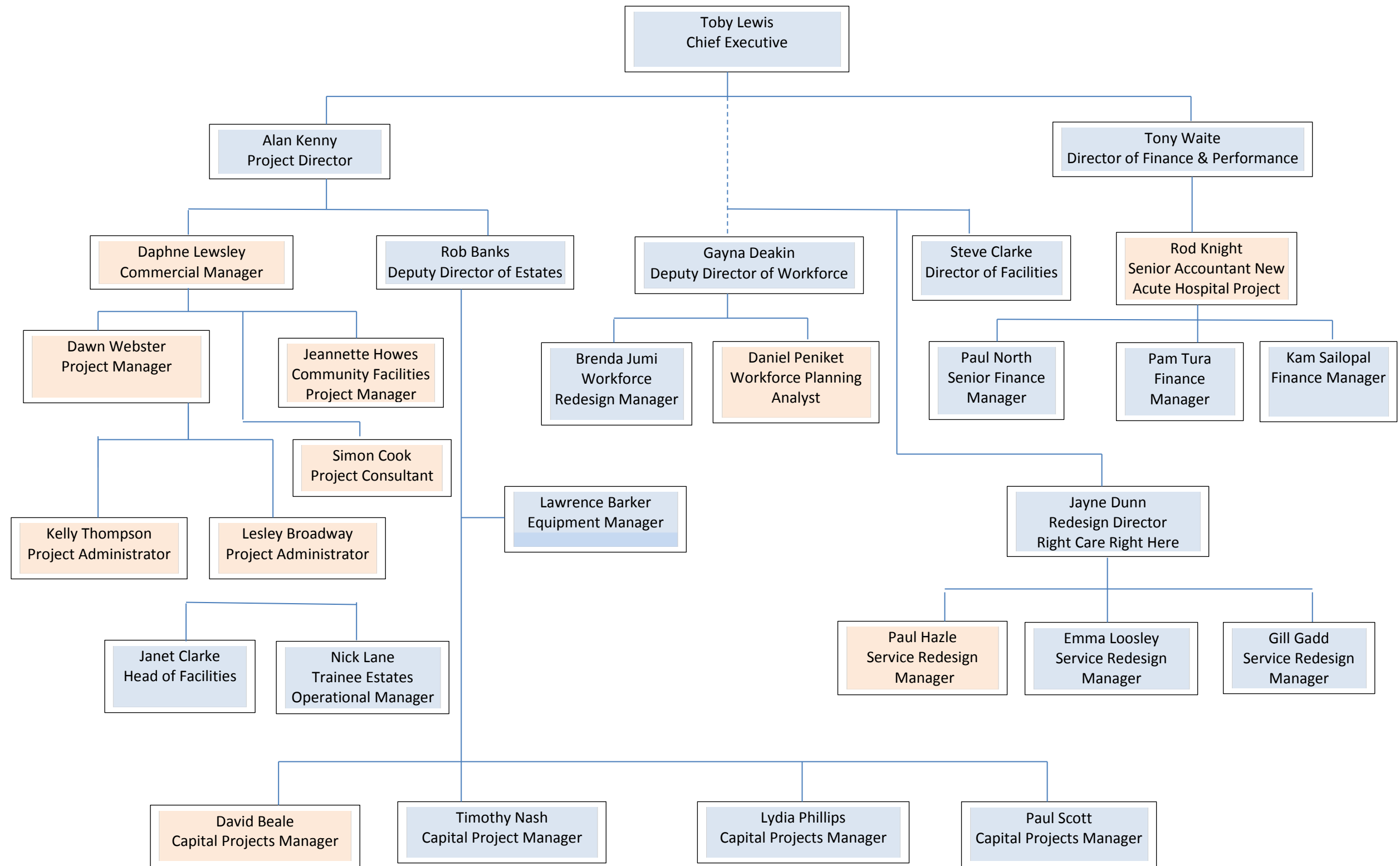
Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case



APPENDIX 18b – PROJECT STRUCTURE

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

MMH PROJECT TEAM



Key: Dedicated to MMH Project
Split between MMH and other Trust Role

APPENDIX 18c – PROJECT EXECUTION PLAN

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Midland Metropolitan Hospital Project

Project Execution Plan Procurement Phase

Version 2.2

Document History

Document Location	PEP, Project Management, Project Library on SharePoint
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Revision History

Version	Date	Author	Summary of Changes
0.01	20.06.08	Andrea Bigmore	First draft for discussion with Core Project Team
0.02	27.06.08	Andrea Bigmore	Updated with comments from Core Project Team
0.03	15.07.08	Andrea Bigmore	Updated with comments from the Project Team
0.04	10.10.08	Andrea Bigmore	Updated with project resources and budget
0.05	29.10.08	Andrea Bigmore	Updated with Project Team, Core Project Team and Project Board comments: Addition of information about competitive dialogue and project structure
1.00	05.1.08	Andrea Bigmore	Final version for OBC submission with final adjustments
1.1	04.08.10	Andrea Bigmore	Update for OBC Update submission on 11.08.10
2.0	16.12.13	Daphne Lewsley	Update for OBC submission March 2013
2.1	07.05.15	Dawn Webster	Updated Roles and Responsibilities of MMH & Reconfiguration Sub-Committee – section 5.6
2.2	20.05.15	Dawn Webster	Updated roles and responsibilities and replacement electronic procurement system

Distribution

This document has been distributed to:

Name	Date of issue	Version
Core Project Team	20.06.08	0.01
Project Team	30.06.08	0.02
Project Team and Project Board	20.10.08	0.04
Project Team, Core Project Team, Project Board	31.10.08	0.05
Maureen Conneely for OBC	12.11.08	1.00

Approvals

This document requires the following approvals.

Version	Approved by	Comment	Date
1.0	Project Board	Approved subject to final adjustments which have been incorporated	23.10.08

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1. Introduction

This document has been updated for submission with the OBC Update.

1.1 *Purpose of Document*

This Project Execution Plan (PEP) describes how Phase Two: the Procurement Phase of the Midland Metropolitan Hospital Project will be delivered.

The PEP sets out the systems and processes by which the Project will be planned, monitored and managed. It is owned, maintained and used by the Trust's MMH and Reconfiguration Committee and Core Project Team to ensure the successful day-to-day operational management and control of the Project and the quality of the outputs.

The purpose of the PEP is to:

- Establish the background and review the project definition and brief
- Review the project objectives
- Define the governance arrangements and the roles and responsibilities of those delivering the Project
- Set out the resources available and the budgetary control processes
- Set out the project timetable
- Define the approach and the project management arrangements
- Present the approach to engagement and communication
- Identify the assumptions, constraints and risks relating to the Project and set out the risk management processes

This is a live document that will be updated by the Core Project Team during this Phase of the project. This baseline version of the document will be retained in the project library once approved by the MMH and Reconfiguration Committee, with subsequent releases also retained. A new PEP will be developed for the Construction and Commissioning Phase of the Project.

1.2 *Document Scope*

The scope of this PEP covers the Procurement Phase, from OJEU to the approval of a Concluding Business Case, the award of contracts and financial close.

It includes the activities required to procure a new hospital through the Private Finance Initiative (PF2) route.

The document refers to the Midland Metropolitan Hospital Project; the wider RCRH Programme is outside the scope of this project.

2. Background

2.1 *Right Care Right Here (RCRH)*

Sandwell and the West of Birmingham have some of the highest levels of deprivation in the country. This is a major factor in determining the poor health of the diverse and disadvantaged communities. Local health and social care services face very challenging health needs that are a major cause for concern. For example:

- Men and women live three to four years less than the national average
- Infant mortality rates are high, in some parts they are twice the national average
- One in five people have a long-term illness that affects their daily life
- There is significant variation in health status within the area, and in general Black and Minority Ethnic groups have poorer health than others

The need for major investment to develop and improve health and social care services to address these needs was formally recognised by the development of a Strategic Outline Case (SOC) during 2003 and 2004. The SOC set out a clear direction of travel to deliver a vision of improved physical, mental and social well-being for the population of Sandwell and the west of Birmingham, and described the need to redesign the whole health and social care system by creating a major step change in service provision.

The SOC indicated a required re-balancing of capacity to reflect a substantial transfer of care into a primary care setting alongside a demanding performance improvement in acute hospital services. Substantial reductions in hospital lengths of stay are anticipated, with much of the consequent reduction in acute hospital capacity being re-provided in new services and facilities closer to people's homes. Investment in community health and social care services, as well as investment in new acute hospital facilities, is seen as key to making the vision a success. This investment will also enable new models of care to be put in place in advance of any changes to acute hospital facilities. The SOC was approved by the Department of Health in July 2004.

The *RCRH Programme* is governed by the Partnership Board, which was formally established in March 2005, and now comprises the following partner organisations:

- Sandwell and West Birmingham Clinical Commissioning Group
- Black Country Partnership
- Birmingham Community Health Services
- Sandwell and West Birmingham Hospitals NHS Trust (SWBH)
- Birmingham City Council (BCC)
- Sandwell Metropolitan Borough Council (SMBC)
- Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)

The Partnership Board agreed that the lead responsibility for the preparation of an Outline Business Case for and the procurement of, the acute hospitals services component should be assumed by the SWBH NHS Trust.

An Outline Business Case (OBC) was produced for development of a new Acute Hospital to be built on a brown field site in Smethwick. This will bring the most acute / specialised SWBH services onto one site and facilitate the delivery of a new model of care. It is assumed that the Hospital will be procured using the Private Finance Initiative (PF2) approach.

This OBC was approved by the Strategic Health Authority (SHA) in January 2009 and the Department of Health in August 2009. This allowed the Trust to commence the land acquisition through a CPO process.

An OBC update is currently being prepared and reviewed by the NHSTDA / DH and HM Treasury prior to progression to the procurement phase of the project.

Separate Outline Business Cases will be produced where necessary for the SWBH capital developments outside the scope of the MMH PFI i.e. work required to develop retained estate on current hospital sites into future community facilities.

2.2 Progress with the Midland Metropolitan Hospital Project

2.2.1 Phase One: The Solution Phase

Progress with approvals can be outlined as follows:

- Outline planning consent was granted in October 2008
- Trust Board OBC approval in December 2008
- SHA Board OBC approval in January 2009
- DH OBC approval in August 2009
- CPO granted January 2010
- Outline planning consent refreshed July 2013
- Land Acquired January 2013
- Vacant Possession of land January 2014

Acquisition of land on the Grove Lane site, in Smethwick, is on the critical path of this project. A land business case was developed in parallel with the OBC to seek approval for purchase of the land. The Trust has now acquired the land and has achieved vacant possession.

2.2.2 Phase Two: The Procurement Phase

This document sets out the processes by which Phase Two: The Procurement Phase will be taken forward from OJEU to financial close.

3. Project Definition and Brief

3.1 Definition

It is assumed that the acute hospital facilities will be procured using the Government's Private Finance Initiative as amended by "Infrastructure – a new approach to public private partnerships" issued in December 2012 (PF2) . A private sector company or consortium will be selected using a competitive dialogue process, to design, build, finance and operate the facilities and provide a range of non-clinical support services. The NHS will provide and manage all clinical and most soft Facilities Management (FM) services.

Delivery of the acute hospital procurement involves a number of discrete phases:

3.1.1 Phase One: The Solution Phase

This phase is nearing completion. It involves completion of the following work required to take the project to OJEU:

- Preparation and approval of an Outline Business Case
- Preparation and approval of the facilities and services specifications and associated documentation required to enable the procurement stage to commence
- Preparation of the documents required for initiation of the procurement process
- Preparation and approval of a Business Case for the purchase of the land required for the new hospital
- Preparation and execution of a compulsory purchase order if required to acquire the land for the new hospital site
- Preparation of an updated OBC for HMT approval prior to initiation of the procurement
- Pre market engagement with potential bidders

3.1.2 Phase Two: The Procurement Phase

This phase involves the following activities to take the PFI procurement from OJEU to Financial Close:

- Placement of an advertisement in the Official Journal of the European Union (OJEU)
- Pre-qualification resulting in a shortlist of viable bidders
- Issue of Invitation to Participate in Competitive Dialogue (ITPD) and initiation of the competitive dialogue process
- Competitive dialogue with three bidders and interim bids are prepared
- Evaluation of proposals reducing bids from three to two
- Competitive dialogue with two bidders and draft bids are prepared
- Approval of Appointment Business Case (ABC)
- Permission to close dialogue
- Submission and evaluation of Final Bids
- Selection of Preferred Bidder (PB) the Trust is minded to appoint
- Due Diligence
- Appointment of PB

- Funding competitions for senior debt and equity, planning approval, Concluding Business Case (CBC)
- Financial Close

3.1.3 Phase Three: Construction and Commissioning

This phase will deliver the new hospital facility, commission the building and end in the opening of the new hospital

3.1.4 Phase Four: Evaluation

This phase will consist of evaluation of the project and of the new hospital services. Evaluation will take place at intervals determined by the Post Project Evaluation Plan.

Post Project Evaluation will be supported by the activities of benefits realisation to ensure that the objectives of the new hospital are fully met.

3.2 Project Scope

The project scope is outlined below for the procurement, service development and workforce redesign elements of the project.

Procurement:

Included	Excluded
Procurement of a new acute hospital through the PF2 route.	Development of retained estate to provide community facilities including the new community hospitals including Sandwell General Hospital, Rowley Regis Hospital, Leasowes and the Sheldon Block. (A separate PEP will be prepared for these projects) Development of a staff gym and day nursery on the Grove Lane site Development of a separate academic education and research building on the Grove Lane site
Installation and commissioning of ICT network infrastructure in the new hospital	Computer hardware and software solutions
Procurement, supply and installation by Project Co of defined items of equipment	Equipment management services and transfer of equipment from existing premises
Maintenance, repair and lifecycle of the new acute hospital facility	
All hard facilities management (FM) services and pest control	All other soft FM services

Service Development:

Included	Excluded
Development of the new acute hospital service model	Interim reconfiguration service programme and ongoing Trust service performance improvement and transformation programmes
Acute hospital care pathways	Whole system care pathways being developed by the <i>Right Care Right Here Programme</i>
Operational policies for the new Acute Hospital services (includes soft FM services which are excluded from the PFI)	Development of new outreach services delivered by Acute Hospital staff

Workforce Redesign:

Implementation of the workforce transition model supporting the new acute hospital service model	
Development of new medical and nursing models to support the new acute hospital service model	Ongoing Trust workforce development activities outside the scope of the new acute hospital project
Training, development and recruitment of staff required to fulfill new roles for the new acute hospital service model	

3.3 Interfaces

Phase two of the project will interface with the following:

- The *RCRH Programme*
- Development of the Community Facilities to be provided in retained estate
- Third parties involved in the development of the day nursery , staff gym and academic building to be developed on the hospital site
- Local regeneration activities involving Advantage West Midlands, English Partnerships and Sandwell MBC
- Implementation of plans supporting Foundation Trust development

4. Programme and Project Objectives

4.1 RCRH Programme

The expected outcomes of the RCRH Programme are significant. Local people will have improved physical, mental and social well-being through:

- Prevention of ill health and promotion of healthy lifestyles through education and leisure
- Earlier identification and intervention of specific conditions which improves life expectancy and chances of recovery
- Re-organisation of services to reduce professional isolation, achieve greater critical mass, deliver better clinical quality of services and achieve greater sustainability for services
- Delivery of care closer to people's homes e.g. local diagnostic services
- Development of a single care pathway for service users by integrating services across towns and wards with agencies working together to manage people's care, underpinned by information sharing
- Support to enable people to stay in their own homes e.g. teams dedicated to maximising people's independence and quality of life and support packages
- Better physical environments for service users and staff which encourage more rapid recovery and give greater privacy and dignity
- Involvement of local people as active participants in the development of services so they provide choice, are culturally sensitive and convenient which contributes to the regeneration of their communities through the provision of improved health and social care services
- More effective use of staff resources and greater diversity in the workforce that reflects local communities
- Integration of health plans with local regeneration developments e.g. transport, housing

4.2 Midland Metropolitan Hospital Project

The objectives for the Midland Metropolitan Hospital Project are summarised below:

- To move to a single acute hospital site
- To develop a high quality hospital building
- To implement a new model of care
- To deliver the best possible quality of care
- To develop staff and provide an optimal working environment

4.3 Objectives of Phase Two: The Procurement Phase

The objectives of the Procurement Phase of the Midland Metropolitan Hospital Project are to:

- To attract a shortlist of viable bidders to launch the competitive dialogue process
- To work effectively with bidders through the competitive dialogue process to achieve the best possible outcome for SWBH in the procurement of the Midland Metropolitan Hospital facility
- To select the Preferred Bidder and gain approval for the ABC
- To gain full planning approval
- To gain approval of the FBC and to reach financial close
- To continue the development of a new service model that will provide effective, patient focused, clinical care
- To implement the first stages of a robust workforce transition plan

5. Governance, Roles and Responsibilities

The project will be managed in line with best practice ensuring that roles and responsibilities are clearly defined. Decision making will be transparent and will be documented appropriately to ensure a robust audit trail. Key roles have been identified in line with Office of Government Commerce (OGC) guidance. Detail about what these roles involve can be found in the OGC Successful Delivery Toolkit:
http://www.ogc.gov.uk/resource_toolkit.asp

5.1 The Senior Responsible Owner (SRO)

The SRO is personally accountable for the success of the project ensuring that the project meets its objectives and delivers benefits. The SRO should ensure that the project maintains business focus in a changing healthcare context and that risks are managed effectively. The Chief Executive undertakes the SRO role for this project.

5.2 The Project Director

The Project Director is responsible for day to day decision making on behalf of the SRO and setting high standards for delivery of the project. The Director of Estates undertakes the Project Director role for this project.

5.3 The Project Manager

The Project Manager coordinates the activities of the Core Project Team on a day to day basis and is responsible for ensuring that:

- The competitive dialogue process runs smoothly
- The Project Office runs effectively
- Requests for information are managed transparently to avoid unfair advantage or that commercial confidence is respected when intellectual property requires protection
- Issue and change management processes are managed in line with policy
- Project standards are maintained
- The project plans and budgets are managed effectively

The Commercial Manager undertakes the Project Manager role for this project.

5.4 The Trust Board

The Trust Board is the investment decision maker for the project ensuring that the project has a viable and affordable business case. The Board will require evidence that the project can deliver value for money and best quality healthcare for the local community through effective management of the procurement process.

5.5 The Configuration subcommittee

The Configuration subcommittee of the Trust Board will provide assurance to the Trust Board. The Configuration subcommittee will:

- Oversee the competitive dialogue process ensuring that best practice is carried out in line with EU regulations
- Approve project plans and monitor progress against plan
- Approve and sign off the key outputs and decisions at each stage of the project
- Review and act on factors affecting the successful delivery of the project
- Review serious issues, which have reached threshold level, considering requirement for changes to the project scope, budget or timescale if required
- Broker relationships with stakeholders within and outside the project to maintain positive support for the acute hospital development.
- Maintain awareness of the broader perspective advising the SRO on how it may affect the project

The Configuration subcommittee will delegate authority, to the MMH and Reconfiguration Committee of the Clinical Leadership Executive and Core Project Team to ensure that the project meets its objectives.

The Configuration subcommittee is chaired by the Chair of the Trust Board. Membership is presented below:

Title	Organisation
Trust Chair (Chair)	SWBH NHS Trust
Non-Executive Director	SWBH NHS Trust
Non-Executive Director	SWBH NHS Trust
Non-Executive Director	SWBH NHS Trust
Chief Executive	SWBH NHS Trust
Director of Estates and New Hospital Project	SWBH NHS Trust
Medical Director	SWBH NHS Trust
Director of Finance and Performance Management	SWBH NHS Trust
Chief Operating Officer	SWBH NHS Trust

The quorum will be at least six members including one Non-Executive Director.

5.6 The MMH and Reconfiguration Committee

The MMH and Reconfiguration Committee is a committee of the Clinical Leadership Executive comprising a group of SWBH Executive Directors and representatives of the seven Clinical Groups who manage the operational services of the Trust. They will provide leadership within the organisation to ensure successful delivery of the project and assurance to the Clinical Leadership Executive and Trust Board about the project. The group will provide guidance to the Project Director and ensure that Trust resources will be available to support the project.

The group will:

- Provide leadership, mandate and focus within the Trust ensuring that Clinical Group objectives will drive effective delivery of the competitive dialogue process

- Provide advice to the Project Director, Configuration subcommittee and Trust Board, raising any concerns and providing expert opinion to support decision making
- Resolve issues at organisational level when the Core Project Team requires assistance
- Resolve issues which impact on SWBH involving senior external stakeholders, the press, Government, arms-length bodies etc.
- Provide assessment of serious issues
- Manage changes to the project where required ensuring tight control of cost
- Ensure that project plans are achievable and facilitate delivery as required
- Review the risk register on a monthly basis and provide assurance to the Configuration subcommittee that action plans are in place to mitigate the risks
- Monitor key milestones in competitive dialogue process, ensuring best practice is being carried out in line with EU regulations.

Ensure alignment of the project to the long-term financial model (LTFM). The MMH and Reconfiguration Committee will report to CLE, be chaired by the SRO and will comprise the following membership:

Title	Organisation
Chief Executive Officer(Chair)	
All Executive Directors	SWBH NHS Trust
Commercial Manager	SWBH NHS Trust
Deputy Chief Operating Officer – Change Team	SWBH NHS Trust
Representatives of each Clinical Group	SWBH NHS Trust

Issues exceeding the delegated authority of The MMH and Reconfiguration Committee will be referred to CLE or to Trust Board

5.7 Core Project Team

The Core Project Team is the group of individuals with appropriate and complementary professional, technical or specialist skills who, under the direction of the Project Director and coordinated by the Commercial Manager, are responsible for carrying out the work detailed in the project plan. (See OGC Toolkit: Project Team for more information)

The Core Project Team is responsible for:

- Planning and delivering the competitive dialogue and bidder evaluation process and all other activities to financial close
- Developing and maintaining project plans
- Co-ordinate working groups and evaluation teams as required
- Monitoring progress and reporting to MMH and Reconfiguration Committee and Configuration subcommittee
- Managing issues as they arise in line with the issue management policy and escalating those above threshold to the MMH and Reconfiguration Committee

- Managing project advisors, ensuring that their contribution is well understood and that the Trust obtains best advice and value
- Managing risks in line with project risk management strategy
- Ensuring effective development and delivery of the Engagement and Communications Plan

Title	Organisation
Director of Estates and New Hospital Project	SWBH NHS Trust
Commercial Manager MMH	SWBH NHS Trust
Deputy Chief Operating Officer – Change Team	SWBH NHS Trust
Head of Estates	SWBH NHS Trust
Deputy Director of Workforce	SWBH NHS Trust
Deputy Director of Nursing	SWBH NHS Trust
Lead Project Accountant	SWBH NHS Trust
Project Manager MMH	SWBH NHS Trust

The Core Project Team will meet weekly, or as required, to co-ordinate the work required by the project. The group will manage delivery in line with:

Agreed project management procedures and standards (see section 8)

Delegated authority, referring all matters outside their scope to the Configuration subcommittee and MMH and Reconfiguration Committee

The Core Project Team reports to the MMH and Reconfiguration Committee -see Project Governance Structure below.

5.8 Dialogue and Evaluation Groups

Dialogue and Evaluation Groups will be formed prior to OJEU. Terms of Reference will be established with the groups at initiation. These groups will report to the MMH and Reconfiguration Committee through the Core Project Team.

Further detail about the roles and responsibilities of these groups will be presented in ITPD Volume 4.

Technical, Legal and Finance advisors will support the procurement process as outlined in their tender documents.

5.10 The Clinical Leadership Executive

The Clinical Leadership Executive maintains an overview of the clinical brief and the activity and financial parameters set by the MMH and Reconfiguration Committee. It provides clinical leadership in relation to the design process and will inform evaluation of

bidders' proposals in the PF2 process.

The Clinical Leadership Executive includes the management teams of the Trusts seven Clinical Groups and the Executive Directors of the Trust.

5.11 Land Acquisition

A Land Acquisition Group was formed during Phase One of the project to acquire the land required to build the hospital. This group will continue to meet until the final amounts due for the land acquired under compulsory purchase have been agreed and paid.

This group is responsible for:

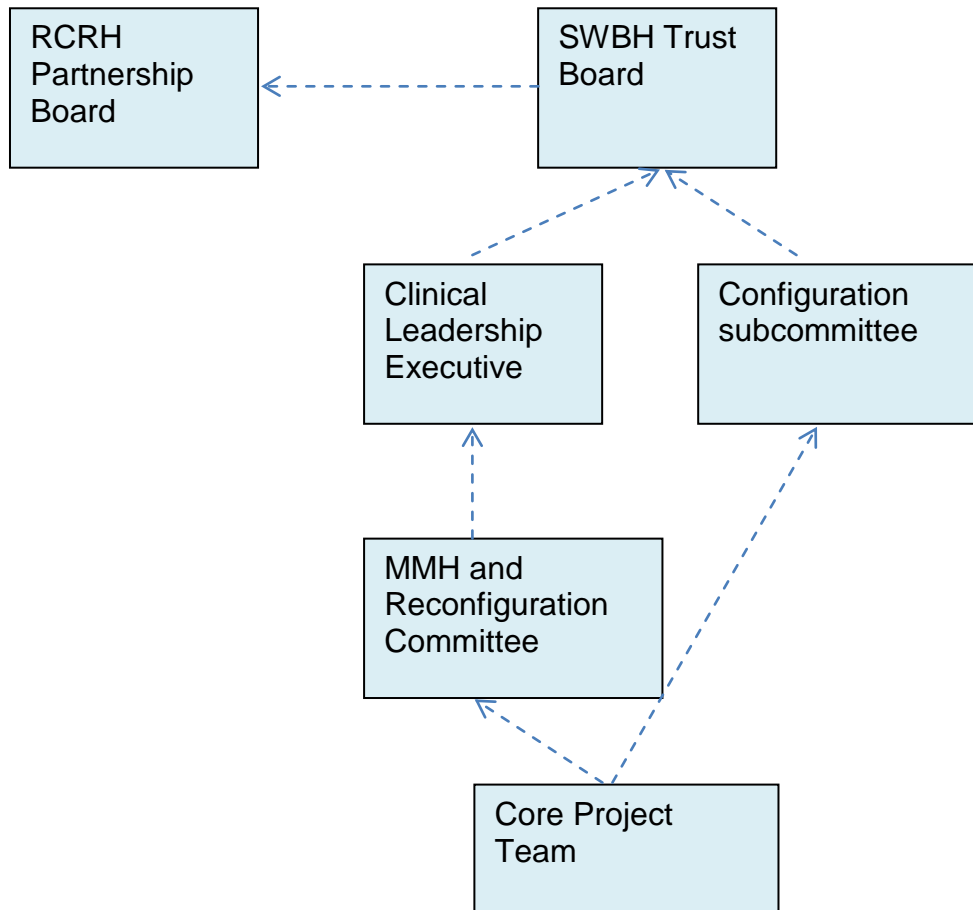
- Completing purchase of land required for the hospital site
- Arranging agreed demolition works on the land acquired
- Ensuring that this work is completed to timeframe achieving path to land before initiation of the procurement process
- Managing budget in line with the capital programme

Membership of the group is presented below:

Title	Organisation
Director of Estates and New Hospital Project	SWBH NHS Trust
Head of Estates	SWBH NHS Trust
Commercial Manager	SWBH NHS Trust
Finance Director	SWBH NHS Trust
Advisors as required	Various

5.12 The Project Structure

The project structure is shown below



The Project Structure and the terms of reference of all groups will be reviewed prior to initiation of Phase Two of the Project and at the end of each stage until financial close.

5.13 Project Audit and Review

The project is subject to external assurance and review through internal audit, Gateway Review and the Design Review Panel.

5.13.1 Audit and Project Assurance

CW Audit provides Internal Audit services to the Trust. The Internal Audit department has appointed an Auditor to this Project.

The Project Auditor and Finance Director will consider whether aspects of the project should be reviewed as part of the Trust Audit Programme.

5.13.2 Gateway Review

Gateway review forms part of a Government initiative to support the improved management of major public sector projects.

Gateway 2: Delivery Strategy will be undertaken prior to initiation of Phase Two of the Project.(note – the project undertook a Gateway 2 review in 2010 and achieved an amber green rating. This will be repeated in 2014 prior to going to market)

Gateway 3: Investment Decision will be undertaken during the Procurement Phase.

Gateway 3a investigates the Appointment Business Case and the governance arrangements for the investment decision. The review is undertaken prior to selection of the preferred bidder in Stage 3 of the Procurement Phase.

Gateway 3b does the same prior to submission of Concluding Full Business Case.

5.14 Freedom of Information (FOI)

All Project information will be made public except where it would be in breach of patient or staff confidentiality and commercial interests.

5.15 Conflicts of Interest

- A Register of Interests of all project staff and advisors has been established and will be formally updated and reported to the Project Board at intervals determined by key decision points in the project.
- All project staff, advisors and other persons who may have access to commercially sensitive information will be required to complete a declaration of interest, including a nil return, prior to gaining access to such information.
- Where a person is found to have a conflict of interest they will not be given access to such information and will be required to take no active part in the relevant part of the programme.

5.16 Confidentiality

- All project staff, advisors and other persons who may have privileged access to information that is considered to be commercially confidential will be required to sign a confidentiality agreement before gaining access to such information.

6. Project Resources

6.1 Personnel

6.1.1 Posts Funded by the Project

The project will be staffed by the following posts (14/15) :

Project Director	0.8WTE
Commercial Manager	1 WTE
Project Manager	1 WTE
Workforce Lead	1 WTE
Accountants / Commercial	3 WTE
Deputy Chief Operating Officer – Change Team	0.4 WTE
Service Development Managers/Change Team	2 WTE
Clinical Lead	0.1 WTE
Head of Estates	0.65WTE
Project Managers Capital Projects	1WTE
Equipping Manager	1 WTE
Estates Managers	2 WTE
Facilities Managers	1 WTE
Project Administrators:	2 WTE

6.1.2 Project Advisors

- The following project advisors have been appointed:

Advice requirement	Company
Legal advisors	Pinsent Masons
Financial Advisors	Deloitte
Co-ordination of technical advice	Capita Consulting
Health Planning	Capita Consulting
Facilities Management	Capita Consulting
Equipping	MTS
Architecture	Nightingale Associates
Town Planning	Nightingale Associates

Advice requirement	Company
Engineering	Hulley & Kirkwood
Traffic & Transport	Hulley & Kirkwood
Quantity Surveying	Cyril Sweett Limited (incorporating Nisbet)
Life Cycle Analysis	Cyril Sweett Limited (incorporating Nisbet)
Health & Safety	Cyril Sweett Limited (incorporating Nisbet)
Costing Services	Cyril Sweett Limited (incorporating Nisbet)
Insurance	Willis Ltd

6.1.3 Support from SWBHT Trust's existing workforce

These posts will provide active input into the project and will have the requirement described in their personal objectives:

- Executive Directors
- Lead Clinicians in Clinical Leadership Executive
- Clinical , operational and corporate staff input as required during 1:200 development
- Deputy Nurse and Medical Directors
- Group and departmental managers
- Project Auditor
- Staff side representatives

6.1.4 Partner Organisations

The following resources will be made available from within partner organisations when required:

- RCRH Programme Director and team
- Support for joint work on workforce, service and financial planning

6.2 *Project Budget*

The project budget is presented at **Appendix A**.

7. *Project Timetable*

7.1 *Project Phase Structure*

The project is divided into five phases:

Phase		End Date
Phase One:	The Solution Phase	April 2014
Phase Two:	The Procurement Phase	January 2016
Phase Three:	The Construction and Commissioning Phase	October 2018
Phase Four:	The Evaluation Phase	Dec 2020

This document describes the Project Execution Plan for Phase Two: The Procurement Phase.

7.2 *Stage Structure for the Procurement Phase*

The Procurement Phase of the project is divided into the following stages:

- Prequalification (from Issue of OJEU notice to short listing of bidders for the competitive dialogue (CD) process)
- ITPD Clarification
- CD to interim submission and selection of two bidders
- CD to draft final bid proposals
- Draft Final Bid Proposals
- Approval of Appointment Business Case and Closure of Dialogue
- Final Bid Proposals
- Selection of Preferred Bidder
- Preferred Bidder to Financial Close

The project plan (**Appendix B**) provides an overview of the Procurement Phase of the project.

The key dates and processes are summarised in the following diagram.

Summary of key dates and processes MMH program v019 -021213												
	24/04/2014	03/07/2014	06/11/2014	18/02/2015	27/05/2015	19/08/2015	24/03/2016	26/07/2018	18/10/2018			
	OJEU issued	Appoint 3 bidders	Trust Board approve 2 bidders	2 bidders issue draft final bids	Conclusion of dialog	Preferred Bidder Appointed	Financial Close	Practical Completion	Hospital fully open			
PQQ - appoint 3 bidders	50 working days											
CD with 3 -interim submissions - reduce to 2		90 working days										
CD with 2 - draft final bids			75 working days									
Evaluation and approvals - conclusion of dialog				70 working days								
Conclusion of Dialog - appointment of preferred bidder (includes due diligence)					60 working days							
Full planning permission, judicial review , funding competitions to Financial Close						156 working days						
Construction							28 months					
Commissioning									12 weeks			

8. Project Management

8.1 Project Approach

The procurement of the new hospital will be managed through the competitive dialogue process in line with EU regulations and based on the draft guidance documents listed below:

- The Private Finance Initiative: How to Conduct a Competitive Dialogue Procedure (Draft guidance), 14/11/2006
- The Design Development Protocol for PFI Schemes, Consultation draft of procedural guidance for Competitive Dialogue, August 2007

In addition the Core Project Team will network with others already working through the process ensuring that the project responds to best practice and lessons learned elsewhere.

The Core Project Team will undertake training in negotiation skills, briefing from Trust advisors and planning prior to each stage of the competitive dialogue process. This will ensure that the team is prepared for the process. Robust communication and evaluation tools will be developed / procured to provide a clear audit trail for decision making and information exchange.

Clinical and other stakeholders involved in the dialogue process will prepare for dialogue in briefing and planning workshops prior to each stage of their involvement.

Prior to initiation of Phase Two of the project the full set of procurement documentation, including the Memorandum of Information (MOI), Invitation to Participate in Dialogue (ITPD), Project Agreement (PA), schedules and other associated documents will be developed.

A programme for review of the procurement documents has been agreed with the DH and Private Finance Unit (PFU). This work will be undertaken during January and February 2014.

A summary of the approach to procurement is presented at **Appendix C**

8.2 Project Policies and Procedures

The project will continue to be managed in line with PRINCE2 and OGC standards. The following sections outline the policies, procedures and control processes to be used to ensure effective delivery of the project.

8.4 Management of the Approvals Process

The Core Project Team will maintain effective communication with PFU and NHSTDA throughout Phase Two of the project seeking advice at each stage to ensure progress of the project.

The approvals timetable will be agreed with NHSTDA, PFU and HMT with review steps included prior to formal submissions to smooth the way to approval at each stage.

8.5 Management of Project Advisors

The Core Project Team will work closely with advisors ensuring that project objectives are met effectively with best use of resources and maximising knowledge transfer. The advisors will be tasked with developing the capability of their clients for the benefit of the project.

The approach to this will be as follows:

- Advisors will share best practice from other projects they are aware of
- Core Project Team members will network with peers from other projects to seek lessons learned in relation to working with their advisors
- Only work requiring specialist knowledge and skills will be completed by the advisors; preparatory work and work requiring local knowledge will be managed by Core Project Team members
- The advisors will support the bidding process by being in attendance at key meetings with bidders, advising the team on their approach to bidders and providing technical advice to ensure the best possible outcome for the Trust
- Contract management arrangements will be used to ensure that Trust expectations are met. For example the '*Client Service Partner*' at Pinsent Masons will undertake reviews with the Project Director at key points in the project to determine whether Trust requirements are being met
- The legal advisors will provide regular advice on project governance and will check that Board papers meet requirements for the procurement process

8.5.1 Monitoring of costs for Project Advisors

The fee position for each of the advisors will be reviewed on a monthly basis.

Invoices and timesheets will be reviewed and authorised by the lead manager.

Advisors will identify any new work required outside tendered services.

8.6 Issue Management

An issue is an immediate problem or concern requiring resolution. This is distinct from a risk, which is the chance of something happening in the future that will have an impact upon delivery.

Issue management is the process for ensuring that issues are recorded, assessed and resolved to ensure successful delivery of the project. It may involve a requirement to use change control procedures to enable the project to move forward.

Issues in relation to timescale, design, cost, quality, performance and stakeholder opinion can be raised at any time in the project. Issues can be raised by anyone involved in the project or by anyone with an interest in the project.

The Project Manager will be responsible for:

- Capturing issues in the Issue Log as they are reported
- Presenting issues to the Core Project Team for assessment
- Documenting action taken
- Recording change control procedures
- Following through to review outcome
- Recording closure of issues when resolved

The Core Project Team will be responsible for:

- Identifying issues as they arise
- Assessing issues to consider solutions
- Determining action required
- Allocating an issue owner
- Referring issues to the MMH and Reconfiguration Committee when it is outside their authority to act
- Referring the issue to change control procedures as required
- Confirming resolution of issues
- Reviewing the issue log to monitor progress

Any issues that cannot be resolved by the Core Project Team will be referred to the MMH and Reconfiguration Committee. This might include matters that require Executive Directors working to resolve issues with the wider organisation or wider context.

All other issues will be documented, assessed and resolved by the Core Project Team.

The MMH and Reconfiguration Committee will be responsible for:

- Helping the Core Project Team resolve issues at organisational level
- Helping the Core Project Team resolve issues involving senior external stakeholders, the press, Government, arm's length bodies etc.
- Providing assessment and recommendations for issues requiring change control

8.7 Change Control

All changes are treated as project issues and managed through the process outlined above.

When an issue requires a change within the project a Change Control Notice should be completed and recorded in the Change Control Register.

If the change can be absorbed within the authority of the Core Project Team it will be the responsibility of the designated lead to manage the change. Any change in design that does not impact on cost will be managed by the Core Project Team

The following changes will be outside the authority of the Core Project Team and will be managed in line with the issue management policy:

- Any change to the scheme which will have a cost impact
- Change in timescale outside threshold of one month or which move the end date of any phase
- Any change impacting on the RCRH Programme service model

8.9 Project Administration

The work of the Core Project Team is facilitated by the following systems:

8.9.1 Bravo

Bravo will provide:

- Electronic data room
- Collaborative working space
- An evaluation module to assist in evaluation of bidder deliverables

8.9.2 Competitive Dialogue Data Room

All documents required by bidders during the Competitive Dialogue process will be kept electronically on Bravo

All documents required by Trust staff involved in the project will be kept electronically on the Trust Sharepoint system.

8.9.3 Project Support Office

Job Role	Project Responsibility	Managed by
Project Administrators	Core Project Team Administration E-Box Administration Project Office support Register of Interests Project management support Technical administration support User group administration Administrative support for the project	Project Manager

The administrators are able to provide cross cover for each other providing a seamless project office function.

There is a Project Office e-mail address and phone number managed by the Project Administrators. These contacts will be available on the Project website page to facilitate access to the Project Office.

The Old Management Block will act as the Project Headquarters providing a focus for project meetings and activities during the procurement phase.

8.9.4 Meetings

Minutes will be produced for all meetings of the MMH and Reconfiguration Committee and Configuration subcommittee with approved copies kept on central project files.

The Trust Board will receive minutes of the Configuration subcommittee.

9. Engagement and Communication

Engagement and Communication will be a continuous process throughout the life of the project.

A member of the Communications team will coordinate the delivery of the engagement plan and work closely with the Core Project Team to ensure that consistent messages are being conveyed. They will report on progress to MMH and Reconfiguration Committee.

9.1 The Engagement Strategy and Plan

A range of engagement activities will be delivered in line with the principles of the 'RCRH' Engagement and Communications Strategy.

The Trust will develop an Engagement Plan which outlines the methodology, activities and timeframe for delivery of the Engagement and Communications strategy.

. This will demonstrate the approach to involving staff and the public through the procurement phase of the project.

9.2 Equality Impact Assessment (EIA)

An Equality Impact Assessment Plan has been developed to ensure that EIA takes place at key stages in the project. The process will involve the following activities:

- EIA screening and assessment
- Action planning with engagement from interest groups and the wider public
- Publication of reports and plans
- A Steering Group will oversee the process and ensure delivery of the EIA plan.

10. Assumptions, Constraints and Risks

10.1 Assumptions

The project will proceed on the basis of the following assumptions:

- Authority to proceed with the project will be granted by the Trust Board, NHS TDA, DH and Treasury
- Adequate funding for the project will be maintained and costs contained within plan
- Key staff will be available to support the project
- The development will move through each stage of Phase Two to end successfully in Financial Close

10.2 Constraints

The project will be delivered within the following constraints:

- The project will stay within the scope of the 'RCRH' service model
- The project will stay within affordability constraints
- Proposed solutions will deliver to nationally set clinical standards and technical /building standards
- The procurement will be managed in line with EU and PFU regulations

10.3 Risks and Risk Management

The risk categories for the project are as follows:

- **Project resources** – loss of staff / advisors or insufficient funding to complete the project
- **Procurement process** – lack or loss of bidders, process fails to deliver an acceptable bid, disagreement between partners
- Errors or poor data in baseline documents - OBC / PSC / other sources
- **Stakeholder concerns** – change in partners' positions, delay in community developments, failure to obtain approvals, staff / public objections etc.
- **Financial** – ensuring an affordable programme of investment which demonstrates Value for Money
- **Maintaining strategic fit** - with national, regional and local strategic health planning requirements
- **Clinical support** – lack of clinical support for development
- **Organisational change** – Organisational instability could slow decision-making or delivery or result in poor decisions being made
- **Local support** - the significant service changes proposed by the *RCRH Programme* will need the support of the local population and their representatives
- **Estates issues** - including those associated with a new brown field site

- **Workforce** - both in terms of numbers and skill mix
- **Transport** - policies and infrastructure

A current stage Risk Register has been established and is being maintained for the project. A next stage Risk Register will be established and agreed prior to Phase 2.

Qualitative and quantitative measures are being used to calculate the overall level of risk according to their impact and probability.

The register records:

- A description of the risk and the scope of its potential impact
- The probability of the risk occurring (with a score of between 1-5, 1 being the highest, 5 the lowest)
- The level of impact (with a score of between 1-5 as above)
- Risk management arrangements to minimise the probability and /or impact

The Risk Register for the current stage is reviewed and updated on a quarterly basis / or at project milestones by the Core Project Team. The outcome will be reported to the MMH and Reconfiguration Committee and Configuration subcommittee.

Red risks will be entered onto the corporate risk register.

New risks will be reported as they arise. They will be placed on the risk register and the Core Project Team will analyse them for impact and probability. The Core Project Team will consider potential approaches to mitigation and identify a risk owner. Risk owners will be contacted to agree an approach to mitigation.

Risks analysed as red, following first line mitigation action planning, will be reported to the Project Director straight away.

The other risks will be managed by the risk owner and reviewed by the Core Project Team.

Appendix A- Budget

MMH /Community Facilities	Budget 2014/15 to 2019/20					
	14/15	15/16	16/17	17/18	18/19	19/20
	£	£	£	£	£	£
Pay						
Project Office	382000	382000	317000	317000	317000	317000
Human Resources	46000	46000	106000	106000	106000	46000
Finance	180000	180000	130000	130000	130000	130000
Redesign	405000	230000	170000	350000	350000	260000
Estates	366000	366000	446000	446000	466000	295000
Total Pay	1379000	1204000	1169000	1349000	1369000	1048000
MMH Project Office Non Pay						
Engagement and Comms	30000	20000	10000	10000	30000	30000
Boot Camp expenses	50000	50000				
Market Engagement						
Misc (stationery,printing,travel etc)	40000	40000	40000	40000	40000	40000
Sub-Total Project Office NonPay	120000	110000	50000	50000	70000	70000
Advisor Costs						
OBC						
Development of workforce model						
Development of activity model						
External Assurance						
Update Outline Planning Permission						
Business Case Production	15000	15000				
PSC refresh						
Sub-Total - OBC	15000	15000	0	0	0	0
PFI PROCUREMENT						
Insurance Advisor	3000	900				
Estates & Technical Against Tender	300000	188000	104000	39000	39000	
Estates & Technical Out of Scope						
Legal Advice Against Tender	100850	80000				
Legal Advice Outside Scope	100850	80000				
Corporate Finance Advice Against Tender	109850	60000				
Corporate Finance Advice Outside Scope	109850	60000				
Business, Finance, Activity & Project Management		4800				
IT Advisor	20000	20000				
Regeneration Advisor	5000	5000				
Warranty of Title -legal costs		50000				
Independent Tester			50000	100000	150000	
Due Diligence Advisors						
Bidder Costs						
Advisor Contingency	260000	220925	210000	210000	150000	210000
Sub-Total - PFI Procurement	1,009,400	769,625	364,000	349,000	339,000	210,000
Total Advisor Costs	1,024,400	784,625	364,000	349,000	339,000	210,000
Total Non Pay	1,144,400	894,625	414,000	399,000	409,000	280,000
Total Pay and Non Pay	2,523,400	2,098,625	1,583,000	1,748,000	1,778,000	1,328,000

Appendix B -Programme

Appendix C- High Level Procurement Strategy

1. Introduction

In December 2012, HMT launched the new PF2 procurement route by issuing “A new approach to public private partnerships”. This guidance detailed the way PF2 differed from PFI. There were a limited number of changes proposed. Some contractual changes were described in detail in the initial document and in a new standard PF2 contract issued at the same time. Where appropriate, these have already been incorporated into our documentation.

There were four areas where the PF2 principle was set out in the initial guidance but further detailed guidance was promised. These were

- Reducing the competitive phase of the procurement to 18 months
- Issuing standard output specifications/ payment mechanism
- New Value For Money calculations
- The new equity funding model

The area which has required the most work has been the procurement plan itself.

The purpose of this paper is to describe the work that has been completed to date and the principles that are emerging.

2. Procurement Plan

2.1 Initial Targets

The procurement plan prior to reactivation of the project reflected a 36 month period from issuance of OJEU to financial close. 27 months was allowed from issuance of OJEU to appointment of Preferred Bidder. This reflected the actual experience of schemes running PFI procurements under competitive dialogue and in particular a long and complex approvals process prior to appointment of preferred bidder.

Under PF2 the competitive tendering stage (OJEU to preferred bidder) cannot take longer than 18 months without prior exemption from the Chief Secretary at HMT. The guidance states that after this point funding will not be approved.

In addition the trust has an aspiration to run as speedy and efficient procurement process as possible to reduce the risks during the design stage. A further target has been to aim for completion and opening of the new hospital outside of the winter months.

2.2 Key Measures

The project team have considered how we might redesign the process to meet these challenges.

Treasury have shared some draft guidance on lean procurement for PF2 which gives some pointers as to how they expect that this may be done. In addition we have

approached the Building Schools for the Future programme who launched the first PF2 OJEU at the end of June 2013. Their approach is not directly relevant to an acute hospital and they have the advantage of a single approval authority but they were helpful in sharing the level of design they intend to complete under competition.

The key measures we need to take are as follows:

- Significant pre market preparation and engagement both internally and externally.
- Use of intensive “boot camp” phases in the competitive dialogue stages
- Minimise the non-design stages of the procurement to the minimum possible.
- Engage with approvals bodies to resolve the procedure for approvals before the procurement starts

3. Proposed Procurement Stages

3.1 *Pre Qualification Questionnaire stage*

The first stage in the procurement is for the trust to issue an OJEU notice and invite responses from interested consortia by completion of a standard Pre Qualification Questionnaire. At this stage the test is only about the capacity and capability of the consortia.

Provided that there are three or more consortia that are above the line at PQQ, the trust must select a minimum of three with whom to conduct dialogue.

The previous plan allowed 3 months to conduct the PQQ stage. The new plan assumes the minimum period for the OJEU to run (30 calendar days) and a short evaluation period. This reduces the time needed on the basis currently anticipated OJEU date to just over 2 months.

The risk with this strategy is that an otherwise good consortium may make some error with its PQQ submission which we will not have time to clarify and sort out. This is a problem both from the possibility of excluding a good candidate and also from an increased risk of challenge to the process.

The mitigation for this is to hold pre market engagement which makes absolutely clear how the process will run and when the bidders need to be ready.

3.2 *Design stage*

The design stage runs from the point the bidders are appointed at the end of the PQQ stage and the trust issues its Invitation to Participate in Dialogue to the point at which they submit their first draft bids.

There is often a planned interim submission part way through the design stage which allows the authority to reduce the number of bidders with whom they develop a very detailed design.

The previous plan assumed that 3 bidders would be appointed initially (with a 4th as reserve for the first month), that we would reduce to 2 after 6 months and that a fully

finished design must be completed by both at the end of this stage to achieve price certainty. The stage in total was expected to last 15 months.

This is the riskiest stage of the process when bidders incur the most cost. It is important to retain competition throughout the process and to have a degree of certainty that a viable solution can be achieved before eliminating bids but we need to be realistic about how many bidders can be carried a significant way into the process. There is a clear tension between many highly developed bids and the resources needed on both the public and private sector side and indeed the time available to conduct the process.

We now propose to appoint three 3 bidders (with a 4th as a reserve) and to reduce to 2 bidders after four months. The stage in total is now expected to last seven and a half months with a total of 26 weeks in dialogue.

We are considering how to reduce the number of deliverables required at final bids stage to those required for price certainty. For example many 1:50s can be deferred to post preferred bidder appointment.

Another strategy we are adopting is to complete a refresh of our PSC and use this as an “exemplar” model.

This has a not insignificant cost both in terms of advisor time and input from trust staff however the advantages are potentially great.

They include:

- Up to date engagement on MMH design with the majority of trust staff can happen in house in a “safe” environment.
- We can form a small group of trained and expert staff who will be better able to participate in dialogue in a controlled way but will also maintain the internal engagement.
- This in turn allows us to fully use the “boot camp” approach where dialogue is short but continuous and intensive. Staff who participate in boot camps will need to be available for several weeks at a time, not for a series of two hour meetings over a matter of months which was the traditional approach.
- We can engage with bidders on the basis that we have a PSC we would be content with. It is our default position and affordable and we are happy to share the details with them. We are looking for design proposals which improve on this option. This approach is similar to that taken in Enniskillen. Two of our advisors worked on this project and we will take clear advice as to how to avoid taking design risk back to the trust whilst stopping bidders reinventing the wheel.

By utilising all these strategies we hope to reduce the design stage to less than 8 months.

3.3 *Evaluation and approvals stage*

In previous PFI competitive dialogue procurements this has been a stage where much time has been lost. The rules have been changing as each Trust goes through the process and no doubt will change again for us.

In principle the events that make up the stage are as follows:

- Bidders submit draft final bids
- Trust performs an evaluation on draft final bids
- Trust completes a generic appointments business case on the basis of the submitted bids (either could still be appointed preferred bidder at this stage)
- The appointments business case needs:
 - Confirmation of affordability by CCG
 - Agreement by NHSTDA or Monitor that the transaction is acceptable ie does not reduce the risk ratings to an unacceptable level
 - Approval by the DH PFU function (currently uncertain where this will be based in future)
 - Approval by the Treasury
- Once all the approvals have been achieved the Trust is given permission to close dialogue by the DH
- During the approvals period the Trust has carried on in dialogue with the bidders clarifying and feeding back in detail on weak areas in the draft final bids. The aim of this process is to ensure that there are two above the line bids submitted at the end and that there are no surprises in those bids.
- Once approval is received to close dialogue, the Trust closes dialogue and issues an Invitation to Submit Final Bids. From this point there can be no further significant changes to the scheme.
- Bidders submit Final Bids
- Trust evaluates Final Bids and decides on the Bidder it is minded to appoint as preferred bidder.
- Due Diligence advisors appointed early on on behalf of the senior debt funders review the bid at this stage.
- Once the Due Diligence advisors are content the Trust can appoint a preferred bidder.

This stage has been taking a year and more in many procurements.

The approvals have been happening sequentially and some approvals bodies have realised at this stage that there is no further opportunity to change the scheme and have taken the opportunity to reassess the strategic case. The approvals bodies, particularly Monitor have required extremely detailed information at this stage.

Previously we assumed 9 months for this stage and we considered this challenging. We have reduced this to 6 months in part by streamlining our expected evaluation processes but mainly by assuming that the approvals bodies can conduct a process in parallel that lasts no longer than two months. This is currently the most significant risk to timeline in the plan. The need to do it is acknowledged but there is currently no plan as to how this may happen.

3.4 *Post Preferred Bidder Stage*

Following the appointment of Preferred Bidder there will be a final procurement stage leading to financial close.

Activities in this stage include:

- Bidder to apply for and receive full planning permission. This takes 16 weeks. In previous PFIs funders have also required the 3 month judicial review period to expire.
- Senior Debt Funding Competition
- Equity Funding Competition (senior debt providers need to be known before this can commence)
- Finalise design eg complete the remaining 1:50s
- Finalise documentation
- Preparation of a confirmatory business case which confirms the scheme is still viable and affordable given the actual funding rates which emerge from the funding competitions

We have allowed 7 months for this stage (previously 9 months). The critical path is currently the planning permission. If as expected the equity and senior debt competitions need to run sequentially and be completed 3 months prior to financial close this may become the critical path.

4. Summary

The procurement plan described reduces the previous estimate of 36 months to 23 months. The competitive stage at 16 months lies within the tolerance set by the PF2 guidance. The hospital based on a build period of 28 months and a commissioning period of 12 weeks will open in October 2018 provided that we place an OJEU in March 2014.

The programme is very challenging and considerably less than other similar projects have actually achieved. The lack of clarity on the approvals process is the biggest single risk to this timeline

There needs to be a detailed plan behind this high level strategy. The procurement will need to be well managed on a day by day basis to succeed.

APPENDIX 18d – BENEFITS REALISATION PLAN

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Midland Metropolitan Hospital Benefits Realisation Plan

Benefits Realisation Plan (This has been updated on 20/02/2015 for economic valuation of benefits and Better Care Indicators)
The whole document will require update at key stages of the project including the setting of appropriate baselines.

Benefit Category A: Improved Clinical Quality and Sustainability of Clinical Services								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Reduction in hospital acquired infections	MRSA C Difficile rates	2017/18 figure	Trajectory to be set at / above national target	No per 1000 bed days No per 1000 admissions	Facilities will be easier to keep clean and best practice will be maintained	Head of Infection Prevention and Control	Yearly	1 year after hospital opening
Reduced number of deaths in hospital	Hospital standardised mortality rate (HSMR) Human cost saving based on improved life expectancy – reduced variance from national average measured in cost per Quality Adjusted Life Year (QALY)	2017/18 figure	Target to be set following base lining activities	Reports from Dr Foster cost per Quality Adjusted Life Year (QALY)	Improved access to diagnostics, rapid access to first line treatment, effective model of care and improved LHE pathways will reduce admission for palliative care. Assumed this will result in HSMR improved to top quartile.	Medical Director	Yearly	Trajectory to 2 years after hospital opening
Improved integration means that patients will receive seamless care and support tailored to their needs.	Better Care Indicators	2017/18 baseline	TBA	TBA	RCRH model of care embedded and sustainable in LHE.	Medical Director	Yearly	1 year after hospital opening
Consistent standards of care are maintained with few errors and untoward incidents	Reduced serious untoward clinical incidents	2017/18 figure	Target to be set following base lining	Risk management systems	That new models of care, new care pathways, staff training and new	Director of Governance	Yearly	Trajectory to 2 years after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category A: Improved Clinical Quality and Sustainability of Clinical Services								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
			activities		facility will facilitate better care			
Patients will be able to die in place of choice	Reduction in number of patients who die in hospital having chosen to die in a different setting	2017/18 figure	Target to be set following base lining activities	Gold Standards Framework audit	That model of care will ensure that patients can be supported in their stated wishes relating to place of death	Medical Director	Yearly	Trajectory to 2 years after hospital opening
Improved clinical outcomes	Patient reported outcome measures (PROMs): <ul style="list-style-type: none"> ◆ Patient Generated Index sampling ◆ Disease specific questionnaires 	Samples taken during 2017/18	Targets to be set following base lining activities	<ul style="list-style-type: none"> ◆ Interviews ◆ Questionnaires 	Working to evidence based protocol, greater critical mass of medical staff and reduced professional isolation	Medical Director	Rolling programme of yearly samples	Trajectory to 2 years after hospital opening
Reduced requirement for overnight hospital stay	Combined percentage of day case and 23 hour stay	2017/18 figure	Targets to be set following base lining activities	Hospital Information Systems	That new model of care will reduce the ALOS to a maximum 23 hours for appropriate patients	Medical Director	Yearly	Trajectory to 2 years after hospital opening
Faster admission to hospital when required	Time from decision to admit	2017/18 figure	Targets to be set following base lining activities	A&E system reports	That the new care model will improve assessment and patient flows	Medical Director	Yearly	Trajectory to 2 years after hospital opening
Ability to deliver excellent acute services	Aggregated results of peer review (across two year	TBA	100% good / excellent	Clinical Governance Reports	That the facility will meet peer	Medical Director	Bi yearly	3 years after hospital

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category A: Improved Clinical Quality and Sustainability of Clinical Services								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
	periods)				review standards and that working to evidence based protocol will improve standards			opening
Enhanced assessment in intermediate care will reduce the number of people discharged from hospital into long term residential care / nursing home	Cost savings released by patient care in own home	TBA	20% reduction	Source of data TBA	20% reduction assumed. (detailed assumptions in economics update)	COO	Yearly	1 year post hospital opening
Reduction in DNA rates due to improved service model	Reduction in cost of DNAs (national average for new / follow up)	TBA	TBA	No DNA x cost	Improvement to upper quartile	COO	Yearly	1 year post hospital opening
Increased day case rate resulting in fewer patients requiring elective inpatient surgery. More rapid return to work with associated loss GDP.	GDP saving	TBA	TBA	Day case rate x GDP saving / case	Return to work 20 days earlier than if patient admitted (detailed assumptions in economics update)	COO	Yearly	1 year post hospital opening
Increase in stroke thrombolysis rates will generate cost savings to society	Reduction of deaths from stroke and increase in patients retaining independence	TBA	TBA	Human cost savings expressed in Quality Adjusted Life Year (QALY)	(detailed assumptions in economics update)	Service Lead	Yearly	1 year post hospital opening
Earlier diagnosis and treatment for heart disease will reduce number of people being unable to work because of the disease.	Reduction in number of working days lost expressed in DGP per capita per annum	TBA	TBA	Unclear how this would be measured	50% reduction in people unable to work	Service Lead	Yearly	1 year post hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category B: Improved Customer Care								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Patients and visitors will be treated with respect	Patient satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Patient Questionnaire	That a patient centred, customer focussed culture is in place with a well educated workforce delivering care.	Director of Workforce and OD	Yearly	1 year after hospital opening
Patients will feel that their privacy and dignity has been maintained	Patient satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Patient Questionnaire	That single room accommodation is available for patients who want it. That facilities are 'single' sex. That staff meet the spiritual and personal needs of patients.	Chief Nurse	Yearly	1 year after hospital opening
Patients will feel that they have received the best possible treatment	Patient satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Patient Questionnaire	The leading edge design of the facility will inspire confidence in patients that they are receiving the most up to date care available. The models of care will ensure they have been involved in decisions about their treatment	Medical Director	Yearly	1 year after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category B: Improved Customer Care								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
Patients can be confident that treatment will be completed as planned	Hospital cancelled procedure rate	2017/18 figure	Targets to be set following base lining activities	Sit Rep reports	That separation of emergency and planned care will enable consistent delivery and improve patient experience.	Medical Director	Yearly	1 year after hospital opening
Improved information for patients	Patient satisfaction measures	2017/18 figure	Targets to be set following base lining activities	Patient Questionnaire	That information will be readily accessible to patients in all formats. That clinicians will use information to allow informed choice to patients in their treatment pathways.	Head of Comms	Yearly	1 year after hospital opening
Patients and visitors can find their way around the hospital with ease	Patient satisfaction measures	2017/18 figure	Targets to be set following base lining activities	Patient Questionnaire	That the design is logical and that organisation of space helps navigation. That signage is effective	Director of Estates	Yearly	1 year after hospital opening
Communication with patients from different ethnic groups will be improved	Increased take up of interpretation services	2017/18 figure	Targets to be set following base lining activities	Interpretation service activity	That staff will be trained to access an effective service	Director of Nursing	Yearly	1 year after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category C: More Effective Use of Staff Resources								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Staff will be satisfied with their experience at work	Staff satisfaction measures Sickness rates	2017/18 outcomes	Targets to be set following base lining activities	Staff Questionnaire Routine workforce reporting systems	That the workforce transition model has been effective and that staff enjoy working in a fit for purpose building	Director of Workforce and OD	Yearly	1 year after hospital opening
Improved extended scope nursing and AHP skills	Number of accredited nurse / AHP consultants and extended scope practitioners	2017/18 outcomes	Targets to be set following base lining activities	Workforce reporting systems	Strategic workforce plan completed that identifies the new roles. That a programme has been implemented to deliver the enhanced skills	Director of Workforce and OD	Yearly	1 year after hospital opening
Staff will have improved knowledge and skills	Number of staff with NVQ grade 3 / 4 Personal development review rates	2017/18 outcomes	Targets to be set following base lining activities 100% PDR	Training and Education system reporting	That education requirements have been identified and training completed effectively	Director of workforce and OD	Yearly	1 year after hospital opening
Improved teamwork	Staff satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Staff Questionnaire	That the workforce transition model has been effective and that training has taken team working approaches into account	Director of workforce and OD	Yearly	2 years after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category C: More Effective Use of Staff Resources								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
Improved workforce Productivity	Income per WTE Consultant productivity indicator	2017/18 outcomes	Targets to be set following base lining activities	Hospital information systems and workforce systems	That the new service model, workforce transition plan and training programme will deliver improvements and that the facility will support efficient practice	Director of workforce and OD	Yearly	Trajectory to 2 years after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category D: Improved Patient Flows								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Patients will experience effective integrated care avoiding unnecessary admissions and delayed transfers.	Better Care Indicators	TBA	TBA	TBA	RCRH model of care embedded and sustainable in LHE.	Service Lead	Yearly	1 year after hospital opening
Patients will experience well planned, timely care with few delays and smooth discharge	Patient satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Patient questionnaire	That new model of care will be effective and that functional separation of emergency and planned care will improve consistency	Service Lead	Yearly	1 year after hospital opening
Patients will not need to stay in hospital any longer than required by their medical condition	Average length of stay	2017/18 figure	Targets to be set following base lining activities	Hospital Information Systems	That new model of care will be effective and that functional separation of emergency and planned care will improve consistency	Service Lead	Yearly	1 year after hospital opening
Expensive facilities will be fully utilised to support smooth patient flows	Theatre utilisation MRI and CT utilisation	2017/18 outcomes	Targets to be set following base lining activities	Departmental and hospital systems	That sessions will be planned effectively	Service Lead	Yearly	Trajectory to 2 years after hospital opening
That improved patient flows will result in financial efficiencies	Cost / income differential per spell	2017/18 outcomes	Targets to be set following base lining	Hospital Information Systems	Assumptions as above leading to reduced length of	Service Lead	Yearly	Trajectory to 2 years after hospital

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category D: Improved Patient Flows								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
			activities		stay leading to financial efficiency			opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category: E: Improved Accessibility of Services for the Local Population								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Transport costs will be reduced as the majority of patients will have a reduced distance to travel.	Travel time reduction expressed in: - Time saved (GDP per capita rate per annum) - Social carbon savings	TBA	Targets to be set following base lining activities	Distance mapping software	Outpatient, emergency and elective activity provided to top 10 post codes adjusted for catchment loss will be used to measure change in distance. Savings based on average GDP per capita per annum. Social carbon saving based on Grams per CO ² /km and social cost of carbon £/tCO ²	Project Director	Yearly	1 year after hospital opening
Patients will easily be able to access good local acute services	Percentage of patients within our catchment area treated in the new hospital	2017/18 outcomes	Targets to be set following base lining activities	CCG data systems	Centralisation will improve ability to deliver a comprehensive range of services that makes the new facility the hospital of first choice for the population.	COO	Yearly	Trajectory to 2 years after hospital opening
Patients will experience faster access to treatment	Average referral to treatment time	2017/18 outcomes	Targets to be set following base lining activities	Hospital information Systems	That new service model will support improved patient throughput	COO	Yearly	Trajectory to 2 years after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category: E: Improved Accessibility of Services for the Local Population								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Patients will be able to access services at times convenient to them	Increase in number of evening clinics Patient satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Count of evening clinics on hospital system Patient Questionnaire	That new operational policies will be agreed and resourced to extend working hours	COO	Yearly	Trajectory to 2 years after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category F: Improved Flexibility and Quality of Accommodation								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Patients will experience improvement in the hospital environment	Patient satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Patient questionnaire	That the design will improve the patient experience	Director of Estates	Yearly	1 year after hospital opening
Staff will experience improvement in the hospital environment	Staff satisfaction measures	2017/18 outcomes	Targets to be set following base lining activities	Staff questionnaire	That the design will improve the staff experience	Director of Estates	Yearly	1 year after hospital opening
The new hospital will be a high quality building	Hospital condition survey	2017/18 outcomes	100% at highest rating	Estate code performance management tools	That the PFI provider will build and maintain a high quality building	Director of Estates	Yearly	On opening
The new hospital will meet all statutory requirements	Statutory compliance standards survey	2017/18 outcomes	100% at highest rating	Estate code performance management tools	That the PFI provider will adhere to national standards and that flexible design will enable changes in response to legislation	Director of Estates	Yearly	On opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category F: Improved Flexibility and Quality of Accommodation								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
The hospital will record 'excellent' on facility stakeholder reviews	PEAT PPI / LINKs visits	2017/18 outcomes	Excellent rating	PEAT visit Survey by public scrutiny groups	That the hospital design and build will provide an excellent environment and that facilities management and working practices maintain best possible results	Director of Estates	Yearly	On opening
The hospital facility will provide the best possible environment for clinical care	Number of peer reviews recording excellent outcome in relation to facility care	TBA	Excellent rating	Aggregated results of peer review across 2 year periods	That the hospital design will provide the best environment for acute care	Director of Governance	Biyearly	Three Years after hospital opening
The facility will be flexible to change in use	Facility utilisation rates	2017/18 outcomes	Targets to be set following base lining activities	Estate code performance management tools	The generic space design will facilitate change in utilisation as healthcare develops	Director of Estates	Yearly	2 years after hospital opening
There will be minimal interruption to hospital services for maintenance and repairs	Service failure points review	measure against standards we set for scheme	Target set aligned to PA threshold	Payment mechanism process	That effective FM services are being maintained	Director of Estates	Yearly	2 years after hospital opening
Ability to contribute to reduced carbon emissions	Reduction in Kg CO ² Measures	Expected annual production: 105 KgCO ²	Reduce by 30% = 2665 tonnes CO ²	Carbon emission measures	That new building will meet targets set for energy consumption	Director of Estates	Yearly	1 year after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category G: Improved Ability to Develop / Sustain Services and Respond to Commissioning Intentions								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Achievement of the local health community vision for Towards 2010	Length of stay OP activity targets Planned admission activity targets Emergency admission activity targets	Activity model trajectory	Activity model trajectory	Hospital information systems	That the new service model will support effective implementation of the Towards 2010 model	COO	Yearly	Trajectory to 2 years after hospital opening
Ability to introduce new service developments	Number of new services introduced to Directory of Services	TBA	Targets to be set following base lining activities	Reports from Directory of Services	That centralisation will sustain new developments	COO	Biyearly	3 years after hospital opening
GPs will be satisfied with range of services provided	GP satisfaction measures	TBA	Targets to be set following base lining activities	GP Questionnaire	That GPs will endorse the new hospital and service model and will value services developing over time	COO	Bi Yearly	2 years after hospital opening
Improved academic and research services and facility	Number of nationally accredited research projects per year	2017/18 outcomes	20% increase in projects	Research project database	That a purpose built integrated research and education facility will attract new research business and best clinical leaders	Medical Director	Yearly	Trajectory to 2 years after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category H: Financial Benefits								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Responsibility	Review Frequency	Date for Realisation
		Baseline	Target					
Forecast PFI Unitary Payment will be delivered at Financial Close	Unitary Payment	OBC Baseline	OBC Forecast	PFI Financial Model	Discount inflation	Director of Finance	Once	At Financial Close
Variations to PFI Project Agreement limited to maximum of 5%	Forecast Capital Cost within PFI Project	OBC Baseline	OBC Forecast plus 5%	PFI Financial Model	Discount inflation	Director of Finance	Once	At Hospital Opening
Equipping requirements of the New Hospital delivered within agreed capital costs	Price adjusted Capital Equipping Budgets	OBC Baseline	OBC Forecast	Trust Capital Programme	Discount inflation	Director of Estates	Once	At Hospital Opening
Achievement of Budget Forecasts for New Hospital	Savings made due to service / workforce redesign enabled by new hospital development	OBC Baseline	OBC Forecast	Trust Budget Book	Discount inflation Excludes service changes agreed with commissioners	Director of Finance	Yearly	1 year after hospital opening
Achievement of Energy Budgets for New Hospital in real terms	Price adjusted energy costs	OBC Baseline	OBC Forecast	Trust Budget Book	Discount inflation	Director of Estates	Yearly	1 year after hospital opening
Forecast changes in Trust Income will be delivered	Price adjusted Trust Income	OBC Baseline	OBC Forecast	Trust Budget Book	Discount inflation	Director of Finance	Yearly	1 year after hospital opening
Improved Hard and Soft FM unit costs	Actual costs	OBC Baseline	OBC Forecast	Trust Budget Book	Discount inflation. Effective management of operational changes	Director of Estates	Yearly	1 year after hospital opening

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category J: Local Area Regeneration								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Resp for Measurement	Review Frequency	Date for Realisation
		Baseline	Target					
The local area environment will regenerate around the new hospital	Hectares under development	TBA	Targets to be set following base lining activities	Council Planning Department measures	That the hospital development will support development and implementation of regeneration plans	Director of Estates	Yearly	1 year after hospital opening
The diversity of the hospital workforce will be enriched	Workforce ethnicity compared to local community mix	TBA	Targets to be set following base lining activities	Workforce information systems	That the workforce transition model will consider local employment and that employment practices will support best practice	Director of Workforce and OD	Yearly	2 years after hospital opening
Construction related jobs & opportunities for local people	Number of local jobs created in construction	2017/18 figure	Targets to be set following base lining activities	KPI based on Targeted Recruitment & Training within the City Strategy Model.	Targeted recruitment and training opportunities identified from the out-set of clearance, demolition and construction works	Think Local Construction	Yearly	2012 - 15
Supply chain opportunities for local contractors and SME's in consequence to the construction and facility management	No of supply chain companies registering contract opportunities	TBA	Targets to be set following base lining activities	KPI based on supply chain companies registering contract opportunities on the Councils web portal.	That from the consequence of new development – smaller businesses within the borough will benefit from new procurement	Find it in Sandwell	Monthly	2010/13

Midland Metropolitan Hospital Benefits Realisation Plan

Benefit Category J: Local Area Regeneration								
Benefit Description	Indicator	Performance		Measurement	Assumptions	Resp for Measurement	Review Frequency	Date for Realisation
		Baseline	Target					
				www.finditinsandwell.co.uk	opportunities.			

APPENDIX 18e – GATEWAY 3 REPORT AND ACTION PLAN

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

NHS Healthcheck Review

Review 3a: Investment decision

Version number: Final

Date of issue to SRO: 04/06/2015

SRO: Toby Lewis

Organisation: Sandwell and West Birmingham Hospitals NHS Trust

Healthcheck Review dates: 02/06/2015 to 04/06/2015

Healthcheck Review Team Leader:

Tim Ainger

Healthcheck Review Team Members:

Frank Johnston

Peter Besley

NHS Healthcheck Review 3a: Investment decision

Project Title: Midland Metropolitan Hospital Project

Background

The aims of the project:

The objectives for the Midland Metropolitan Hospital (MMH) project are summarised as follows:

- To move to a single acute hospital site
- To develop a high quality hospital building
- To implement a new model of care
- To deliver the best possible quality of care
- To develop staff and provide an optimal working environment

These are consistent with and underpin the local health economy objectives within the overarching 'Right Care, Right Here' Programme (RCRH) of change.

The scope of the Project, which remains unchanged since approval of the Outline Business Case in July 2014, includes:

- Development of a new acute hospital on a brownfield site at Grove Lane which is now owned by the Trust;
- A design which responds to the Trust's design vision and clinical functionality as set out in the Functional Brief for Bidders at initiation of the procurement;
- A hard facilities management service to maintain the fabric of the hospital buildings and estate and ensure their lifecycle replacement for the duration of the Contract (30 years);
- The reactive and minor maintenance services as specified in the draft contract at Outline Business Case stage;
- The same equipment classifications and responsibilities for installation as agreed at Outline Business Case – equipment management services continue to be outside the Private Finance 2 contract;
- A single integrated IM&T network delivering wired and wireless coverage to agreed criteria at completion and at the operational stage as agreed at Outline Business Case; and
- The same expectation for environmental sustainability and minimising energy costs as well as for supporting local regeneration.

The scope does not include (and never has):

- Soft facilities management services; and
- Retail management (including retail catering).

This report is an evidence-based snapshot of the project's status at the time of the review. It reflects the views of the independent review team, based on information evaluated over a three day period, and is delivered to the SRO immediately at the conclusion of the review.

NHS Healthcheck Review 3a: Investment decision

Project Title: Midland Metropolitan Hospital Project

The driving force for the project:

Sandwell and the West of Birmingham have some of the highest levels of deprivation in the country. This is a major factor in determining the poor health of the diverse and disadvantaged communities. Local health and social care services face very challenging health needs that are a major cause for concern.

The need for major investment to develop and improve health and social care services to address these needs was formally recognised by the development of a Strategic Outline Case (SOC) for the 'Right Care, Right Here' (RCRH) Programme in 2003 and 2004. The SOC set out a clear direction of travel to deliver a vision of improved physical, mental and social well-being for the population of Sandwell and West Birmingham, and described the need to redesign the whole health and social care system by creating a major step change in service provision.

The SOC indicated a required re-balancing of capacity to reflect a substantial transfer of care into a primary care setting alongside a demanding performance improvement in acute hospital services. The SOC was approved by the Department of Health in July 2004.

The RCRH Programme is governed by the Partnership Board, which agreed that the lead responsibility for the preparation of an Outline Business Case (OBC) for, and the procurement of, the acute hospitals services component should be assumed by the Sandwell and West Birmingham Hospitals NHS Trust (SWBH).

The OBC was produced for development of a new Acute Hospital to be built on a brown field site in Smethwick. This will bring the most acute / specialised SWBH services onto one site and will be a major enabler of the delivery of the new model of care. The case proposed that the Hospital will be procured using the Private Finance Initiative (PF2) approach.

The procurement/delivery status:

The Invitation to Participate in Dialogue was issued to 3 bidders in the autumn of 2014 following the pre-qualification process. However, one bidder withdrew immediately after issue and one engaged in the early part of dialogue but did not submit a response by the interim submission deadline and was therefore deemed to have withdrawn in December 2014.

The remaining bidder (The Hospital Company), is therefore a single remaining bidder. The Department of Health (DH) and HM Treasury were closely involved in the development and approval of the single bidder proposition. The Trust set out the additional conditions and requirements of the bidder in procurement documentation which was approved by the DH and accepted by the bidder.

The Compulsory Purchase Order (CPO) for the Grove Lane site was granted in January 2010 and the land was acquired by SWBH in January 2013.

NHS Healthcheck Review 3a: Investment decision

Project Title: Midland Metropolitan Hospital Project

The new Acute Hospital project (the Midland Metropolitan Hospital or MMH) is now being progressed through the procurement phase to reach an investment decision to proceed to the construction phase in early 2016.

The Trust is driving the procurement forward to ensure that the MMH opens in October 2018 in accordance with its strategic objective of delivering high quality and sustainable patient care within the RCRH programme and the new model of care.

Current position regarding Health Gateway Reviews:

This Independent Assurance Review has not been commissioned through the accredited MPA or Health Gateway Hub (which ceased to exist on 31 March 2015). It is an independent healthcheck review commissioned by the Sandwell and West Birmingham Hospitals NHS Trust and has been undertaken in accordance with the procedures and principles of current assurance best practice and delivered by MPA and Health Hub accredited review team members. This approach has been endorsed by the Head of Property & Commercial Policy within the Procurement Investment & Commercial Division of the Department of Health and the Head of Capital and Cash within NHS TDA.

An earlier Health Gateway Review Gate 2 (DH434) was undertaken on the Project in March 2014.

Purposes and conduct of the Healthcheck Review

Purposes of the Healthcheck Review

The primary purpose of a Healthcheck Review 3: Investment decision, is to confirm the business case and benefits plan now that the delivery process has been confirmed and check that where a procurement is used all the necessary statutory and procedural requirements were followed throughout the procurement process.

This Healthcheck is an early Gate 3a Review to consider Project status at the Appointment Business Case (ABC) phase in advance of a further Gate 3b Review at the confirming business case stage at the point of 'Financial Close'.

This Review has focussed on activity to secure ABC approval and the preparations to secure the subsequent, and final, investment decision.

Appendix A gives the full purposes statement for a Healthcheck Review 3.

Conduct of the Healthcheck Review

This Healthcheck Review was carried out from 02/06/2015 to 04/06/2015 at Old Management Block, City Hospital, Dudley Road, Birmingham B18 7QH. The team members are listed on the front cover.

The people interviewed are listed in Appendix B.

This report is an evidence-based snapshot of the project's status at the time of the review. It reflects the views of the independent review team, based on information evaluated over a three day period, and is delivered to the SRO immediately at the conclusion of the review.

NHS Healthcheck Review 3a: Investment decision

Project Title: Midland Metropolitan Hospital Project

The Review Team would like to thank the Project Team for their support and openness, which contributed to the Review Team's understanding of the project and the outcome of this review. Particular thanks are passed to Dawn Webster for her excellent support to the Review Team during the course of this Healthcheck Review.

NHS Healthcheck Review 3a: Investment decision
Project Title: Midland Metropolitan Hospital Project

Delivery Confidence Assessment

The Delivery Confidence Assessment is **Green / Amber**

The Midland Metropolitan Hospital Project has made significant progress since the last Health Gateway Review. It has an approved Outline Business Case (OBC) and the current Generic Appointment Business Case is currently lodged with the relevant NHS, Department of Health and HM Treasury approval bodies to formally close the competitive dialogue phase and appoint a Preferred Bidder.

Support from senior stakeholders is strong and all parties are working well together to uphold the principles of the PF2 procurement for this scheme which continues to demonstrate that it can be delivered within the expectations expressed in the approved OBC.

The Trust Project Team is well led and has the resources, skills and time to finalise the Specific Appointment Business Case and secure Financial Close in accordance with the current declared timeframes.

We therefore believe that successful delivery is likely. There are, however, a number of key risks that will need to be monitored to ensure that successful delivery is secured.

The Project Team must continue to respond to queries in one or two key areas to secure the final approvals. Planning Permission has yet to be secured and strong controls must be exercised to secure a Financial Close within current VFM expectations and the declared cost envelope.

The pace of the Project will gather over the coming months and years and Project governance will need to be strengthened to fully control the Project and ensure that it fully integrates with wider Trust transformation and infrastructure investment.

We believe that the Trust is well positioned and capable of addressing these risks and issues in time for Financial Close by December 2015.

NHS Healthcheck Review 3a: Investment decision

Project Title: Midland Metropolitan Hospital Project

The delivery confidence assessment status uses the definitions below.

Colour	Criteria Description
Green	Successful delivery of the project/programme appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly
Green/Amber	Successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery
Amber	Successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/project if addressed promptly.
Amber / Red	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed.
Red	Successful delivery of the project/programme appears to be unachievable. There are major issues on project/programme definition, schedule, budget, required quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The project/ programme may need re-baselining and/or overall viability re-assessed

A summary of recommendations can be found in Appendix C.

Examples of Best Practice

The Project Team has utilised over a 160 “boot camp” meetings (workshops) to debate operational and design issues, clarify competitive dialogue queries and engage widely with stakeholders. This is a good example of a positive process to embrace and discuss issues with all stakeholders.

The National Stakeholder Board, consisting of senior stakeholders, has met regularly to ensure that they are closely aware of developments and are in a better position to make informed decisions when required to do so. This Board has facilitated an excellent approach to a faster approvals process.

Recommendations from last Health Gateway Review

The explicit and embedded recommendations from the last Health Gateway Review held in March 2014 have all be actioned and are either complete or substantially complete.

This report is an evidence-based snapshot of the project's status at the time of the review. It reflects the views of the independent review team, based on information evaluated over a three day period, and is delivered to the SRO immediately at the conclusion of the review.

Findings and recommendations

1: Assessment of the proposed solution

The current ABC sets out the case for the proposed solution at the Grove Lane site and makes it clear that the underlying case for the new development remains in line with that stated in the OBC. We have heard of no evidence that suggests anything to the contrary.

The procurement phase has not proceeded as planned in so far as the three selected bidders (after PQQ evaluation) have reduced to one bidder during the course of the competitive dialogue phase. Whilst this could be seen as a negative development (in connection with reduced competitive pressure) we were made aware of a number of advantages of this position. There has been an opportunity for the Project Team to provide far more for energy and input into a viable solution (the design, for example, is far more advanced as would have been expected at this stage) and the de-risking activity and programming means that the construction phase, with early works at Contractor's risk, should be able to start in early 2016. The Trust has worked hard with senior stakeholders and approving bodies to provide additional safeguards to secure a VFM and affordable solution to address the perceived reduction in competitive pressure.

There is a high level of commitment to this Project amongst commissioners, funding authorities and scrutineers. Given that this is an early PF2 initiative (and the first for the NHS and Department of Health) it is extremely pleasing to note the commitment of HM Treasury, DH and the NHS stakeholders to deliver the streamlined approvals process that is such a feature of the PF2 procurement route. There is a robust National Stakeholder Board to support a streamlined approval process. This is commended.

2: Business case and stakeholders

The ABC is a comprehensive document that is now under consideration by senior stakeholders with an expectation that it will complete the approvals journey by the 23rd June 2015. Stakeholders are aware of this milestone date and are working hard to achieve it.

The Project Team is aware of a number of further queries that have already been raised and are in the process of responding. There is, for example an on-going discussion about derogations (from Health Building Note standards) and the Project Team is commissioning some independent evaluation of the current design solutions to support the more sensitive derogations (revolving around space standards). This is a key piece of work that must be progressed and properly presented to the satisfaction of approvers to avoid prolonged debate and further delay into the approval process.

NHS Healthcheck Review 3a: Investment decision

Project Title: Midland Metropolitan Hospital Project

NHS England (as a key stakeholder) has yet to finally declare its support for activity assumptions within the ABC (which build on the OBC assumptions) and is using a new assurance process to do so. This process is in hand. Although we did not speak to NHS England during the course of this Review we understand that there are no major deviations or changes in circumstances that would undermine current statements and stakeholders interviewed were confident that the outcome of the Review would be positive.

The ABC sets out an argument to remain with a PF2 procurement rather than switch to a ProCure 21+ procurement to re-introduce a competitive environment. We believe that the case to remain with PF2 has been well made and delivers the outcomes (both for the Trust and Right Care, Right Here programme) at the earliest opportunity. This is essential given the Trust's requirement to make savings over the next five years.

The current governance arrangements were questioned in the previous Health Gateway Review. Whilst we still had the same question mark over the effectiveness of the arrangements we have absolutely no evidence that they are not effective and believe that they are working for the benefit of the Project. We believe that they have supported the Project so far and have helped secure the journey through the procurement process up to this point in time.

What is less clear to us is the demonstrable integration of the various project workstreams (construction, workforce, training, TUPE, clinical change, IT/EPR, MES, hard and soft FM, community and residual estate developments, communications etc.).

We understand that the SRO has plans to restructure the governance to embrace a 'Major Project and Programmes Committee' with non-executive membership.

We support this initiative and encourage the governance arrangements to embrace such a Committee and to focus on effective MMH Project governance across its workstreams and on its dependencies and links with wider Trust and RCRH transformation. Such governance must be in place to deliver Financial Close and the ensuing delivery of an effective construction and commissioning phase.

Recommendation 1: The SRO should refresh the Project governance arrangements to support effective monitoring, decision making on future MMH project procurement, delivery activity and to ensure that this integrates into wider Trust infrastructure and transformation activity.

We have seen a benefits realisation plan. This is a good start and captures an impressive range of benefits and starts to identify benefits baselines, measurements, owners and realisation dates.

NHS Healthcheck Review 3a: Investment decision

Project Title: Midland Metropolitan Hospital Project

The work is not yet complete and needs to be further developed into a working tool that is populated with data that can clearly identify the benefits that are being realised from this investment and who will deliver them. This data will be key to supporting the investment decision at Confirming Business Case (CBC) stage.

Recommendation 2: The SRO should ensure that the benefits realisation plan is sufficiently developed in time to support the Confirming Business Case.

3: Risk management

We have seen a good risk register that is kept up to date and that is used to capture and report on the risk profile of the Project. We found that risks are reviewed at each 'MMH and Reconfiguration Committee' and the top risks are escalated to and considered by the main Trust Board. This is a positive attribute and should continue.

4: Review of current phase

The Trust has secured a successful appointment of a highly regarded Project Director following the departure of his predecessor. There was a smooth handover at this critical point of change.

Current activity is focussed on securing Generic ABC approval and answering the queries that arise from the approving bodies. We understand that there have been over 200 of these so far and currently about 25 remain. The Project Team is working hard to respond in a timely manner.

Work is in hand to receive the final bid from the remaining bidder in order to prepare the Specific ABC in July 2015 and to move to a formal 'Preferred Bidder' status to conclude the funding competitions, secure a Planning Approval and prepare the CBC to secure Financial Close by the end of December 2015.

We have seen a resourced activity schedule and plan for the next six months to move from the ABC to CBC and onto Financial Close. This will need to be kept up to date, communicated to participants and regularly tracked and reported upon to mitigate against any critical path or progress shortfalls.

There appears to be a little uncertainty about the availability or source of funding for 'Taper Relief' to cover double running costs during the transition from current to new arrangements. Whilst we do not believe this to be a significant issue, we are not clear on the status or plans to resolve and is something that the SRO and Trust will need to continue to monitor and draw to a satisfactory conclusion. This is being further discussed at a meeting on the 8th June 2015.

5: Readiness for the next phase – Readiness for service

We note that plans for the contract management of the PF2 contract (post Financial Close) are emerging and that they will build on the expertise and experience that SWBH has built up in connection with its other PFI asset at the City Hospital site. Subject to ABC and CBC approval and the securing of Financial Close, the PF2 contract is planned to start in January 2016. It is important to identify and build the contract management capacity so that it has the competence and capability to manage the PF2 contract from the outset both through the construction phase and through into the live operational phase. This is especially important in view of the speed of the extremely challenging construction programme (33 months).

Recommendation 3: The Project Director should identify and build the contract management capacity so that it has the competence and capability to manage the PF2 contract from the outset.

We are also aware of plans to further consider the rationalisation of Hard Facilities Management across the SWBH property portfolio to maximise the opportunities for economies and service improvements. This should continue.

We are confident that the MMH Project continues to support and align with the objectives of the wider RCRH programme and it is a key enabler of transformation. It will be important to maintain the links with RCRH and it was good to note that the wider programme is adopting more of an implementation focus and resource to support the wider health economy change that will need to work alongside, and integrate with, the MMH outcomes.

Work has already commenced to reduce the cost of the workforce and an integral part of this Project is to change the ways of working, supported by new IT. This will not only reduce costs to help meet the financial challenge but also prepare the workforce for the new ways of working and organisation when MMH opens for business in 2018. This progress needs to be maintained and is an essential pre-requisite for a successful go-live.

The next Healthcheck/Assurance Review is expected in prior to Financial Close and publication of the final Confirming Business Case.

NHS Healthcheck Review 3a: Investment decision
Project Title: Midland Metropolitan Hospital Project

APPENDIX A

Purposes of the Healthcheck Review 3: Investment decision

- Confirm the Business Case and benefits plan now that the relevant information has been confirmed from potential suppliers and/or delivery partners.
- Confirm that the planned delivery process is robust and likely to deliver the expected outcomes.
- Confirm that the objectives and desired outputs of the project, are still aligned with the programme to which it contributes and/or the wider organisation's business strategy.
- Check that all the necessary statutory and procedural requirements were followed throughout the procurement/evaluation process.
- Confirm that the recommended contract decision, if properly executed within a standard lawful agreement (where appropriate), is likely to deliver the specified outputs/outcomes on time, within budget and will provide value for money.
- Ensure that management controls are in place to manage the project through to completion, including contract management aspects.
- Ensure there is continuing support for the project.
- Confirm that the approved delivery [or procurement] strategy has been followed.
- Confirm that the development and implementation plans of both the client and the supplier or partner are sound and achievable.
- Check that the business has prepared for the development (where there are new processes), implementation, transition and operation of new services/facilities and that all relevant staff are being (or will be) prepared for the business change involved.
- Confirm that there are plans for risk management, issue management and change management (technical and business) and that these plans are shared with suppliers and/or delivery partners.
- Confirm that the technical implications, such as 'buildability' for construction projects; and for IT-enabled projects information assurance and security, the impact of e-government frameworks (such as e-GIF, e-business and external infrastructure) have been addressed.

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NHS Healthcheck Review 3a: Investment decision
Project Title: Midland Metropolitan Hospital Project

APPENDIX B

Interviewees

All from Sandwell and West Birmingham Hospitals NHS Trust unless otherwise noted.

Name	Role
Toby Lewis	Chief Executive and SRO
Daphne Lewsley	Senior Project Manager and Commercial Manager
Jayne Dunn	Deputy Chief Operating Officer – Transformation
Giles Tinsley	Delivery & Development Manager, NHSTDA
Andy Williams	Accountable Officer, S&WB CCG
Paul Townsend*	Legal Consultant, DH
Sarbjit Clare	Project Clinical Lead
Matthew Lewis	Group Director – Medicine & Emergency Care
Danny Daniels*	Infrastructure UK/HM Treasury
Rachel Barlow	Chief Operating Officer
Alan Kenny	Director of Estates and New Hospital Project Director
Richard Samuda	Chairman
Colin Ovington	Chief Nurse
Tony Waite	Director of Finance
Rod Knight	Finance Lead on the LTFM
Simon Cook*	Management Consultant (Business Case)
Alison Dailly	Chief Informatics Officer
Roger Stedman	Medical Director

* Denotes interview by telephone

This report is an evidence-based snapshot of the project's status at the time of the review. It reflects the views of the independent review team, based on information evaluated over a three day period, and is delivered to the SRO immediately at the conclusion of the review.

APPENDIX C

Summary of recommendations

The suggested timing for implementation of recommendations is as follows:-

Do Now – To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately.

Do By – To increase the likelihood of a successful outcome the programme/project should take action by the date defined.

Ref. No.	Recommendation	Timing
1.	The SRO should refresh the Project governance arrangements to support effective monitoring, decision making on future MMH project procurement, delivery activity and to ensure that this integrates into wider Trust infrastructure and transformation activity.	Do By the end of September 2015
2.	The SRO should ensure that the benefits realisation plan is sufficiently developed in time to support the Confirming Business Case.	Do By the end of September 2015
3.	The Project Director should identify and build the contract management capacity so that it is has the competence and capability to manage the PF2 contract from the outset.	Do By the end of September 2015

NHS Health-check Review 3a: Investment Decision
Project Title: Midland Metropolitan Hospital Project

SUMMARY OF RECOMMENDATIONS

Ref No:		Timing
1	Recommendation:	
	The SRO should refresh the project governance arrangements to support effective monitoring, decision making on future MMH project procurement, delivery activity and to ensure that this integrates into wider Trust infrastructure and transformation activity.	Do by the end of September 2015
	Trust Response:	Implement by March 2016
	<p>Recommendation accepted. Toby Lewis to lead.</p> <p>The SRO will review the current MMH project governance arrangements by the end of August 2015.</p> <p>The Board's plan, outlined to the reviewers, is to create a Major Projects and Programme Committee (MP&PC) which will have oversight of and effectively monitor the delivery and decision making associated with the MMH project, and those other projects and programmes which have critical interdependencies with the Trust's future – notably EPR.</p> <p>The MP&PC will replace from February 2016 the current configuration committee of the Trust Board.</p>	
2	Recommendation:	
	The SRO should ensure that the Benefits Realisation Plan (BRP) is sufficiently developed in time to support the Confirming Business Case.	Do by the end of September 2015
	Response:	
	<p>Recommendation accepted. Alan Kenny to lead.</p> <p>The SRO will ensure that the MMH Benefits Realisation Plan (BPR) is developed by September 2015 to support the Confirmatory Business Case which is planned to be submitted for approval in October 2015.</p> <p>The BRP will be maintained to provide a working tool which enables the monitoring and delivery of the benefits set out in the MMH Business Case.</p>	

Ref No:		Timing
	The approach will use the new format proposed within HMG for projects of this scale.	
3	Recommendation:	
	The Project Director should identify and build the contract management capacity so that it has the competence and capability to manage the PF2 contract from the outset.	Do by the end of September 2015
	Response: Recommendation accepted. Alan Kenny to lead. The Project Director will by September 2015 identify, and build the contract management capacity to ensure that the Trust has both the competency and capability to robustly manage the MMH contract (PF2), BTC contract (PFI) and the Managed Equipment Service (MES) contracts. In building capacity consideration will be given to the need for the Trust's future estate and associated services to be reconfigured to maximise utilisation and scope for potential rationalisation.	