



*Our community,
we care, you matter....*

Full Business Case A New Replacement Rural General Hospital and Healthcare Facilities for Orkney



Contents

Foreword	10
EXECUTIVE SUMMARY	11
Purpose	12
Healthcare Facilities and Clinical and Service Change Programme	12
Strategic Case	13
Economic Case	13
Commercial Case	14
Development since OBC	15
Financial Case	15
Management Case	17
Project Structure	18
Conclusion and Recommendation	18
Further Information	18
STRATEGIC CASE	19
1. THE STRATEGIC CASE	20
1.1 STRATEGIC CONTEXT	20
1.1.1 Introduction	20
1.1.2 Overview	20
1.1.3 National context	21
1.1.4 Local context	22
1.1.5 Financial performance	24
1.1.6 Property and asset management strategy	24
1.1.7 eHealth strategy	25
1.2 OUR VISION	25
1.2.1 A case for change	26
1.2.2 The Orkney context	27
1.2.3 Reasons for change	28
1.2.4 Current health services	30
1.3 FUTURE HEALTH SERVICES	34
1.3.1 Introduction	34
1.3.2 Proposed model of care	35
1.3.3 Ambulatory Care	35
1.3.4 Outpatients	35
1.3.5 Primary care	37
1.3.6 Emergency care	37
1.3.7 Inpatient unit	39

1.3.8	Refreshed bed modeling	43
1.3.9	Theatres / day unit	46
1.3.10	Design solution	47
1.4	WORKFORCE PLANNING	47
1.4.1	Introduction	47
1.4.2	Developing the workforce plan	49
1.4.3	Nursing and midwifery	49
1.4.4	Allied health professionals including healthcare scientists	50
1.4.5	Medical workforce for new hospital	51
1.4.6	Support services	51
1.4.7	Administration	52
1.4.8	Management of workforce change	52
1.5	Human resource policy and guidance	53
1.6	Workforce development plans	54
1.7	Organisational development (OD) support	54
1.8	BUSINESS CASE OBJECTIVE AND SCOPE	54
1.8.1	Introduction	54
1.8.2	Key investment objectives	54
1.8.3	Summary of existing arrangements	57
1.8.4	Physical condition	58
1.8.5	Functional suitability, quality of the environment and space utilisation	59
1.8.6	Fragmentation of services	62
1.8.7	Appropriate room sizes	62
1.8.8	Ensuite single inpatient rooms	62
1.8.9	Overview of the service benefits of providing the new facilities	63
1.8.10	Project scope	64
1.8.11	Conclusion	64
1.9	BENEFITS, RISKS, CONSTRAINTS AND DEPENDENCIES	64
1.9.1	Introduction	64
1.9.2	Main outcomes and benefits	64
1.9.3	Main project risks	65
1.9.4	Key project constraints	71
1.9.5	Project dependencies	71
1.10	Conclusion	71
	ECONOMIC CASE	73
2.	ECONOMIC CASE	74
2.1	Introduction	74
2.1.1	OBC options appraisal	74

2.2	Net present value (NPV)	75
2.3	Non financial benefits	76
2.4	Non financial risks	77
2.5	Preferred option	78
2.6	VFM review of procurement method	78
2.7	Preferred bidder	80
2.8	Conclusion	80
	COMMERCIAL CASE	81
3.	THE COMMERCIAL CASE	82
3.1	Introduction	82
3.2	Agreed procurement strategy	82
3.3	Agreed scope of services	83
3.4	Agreed risk allocation	83
3.5	Prepayment agreement	86
3.5.1	Prepayment not credit	86
3.5.2	PPA and revisions to the PA	87
3.5.3	Security package	87
3.5.4	Early termination/compensation on termination	88
3.5.5	Subordinate debt	88
3.5.6	Secured liabilities	88
3.5.7	Agreed payment mechanism	88
3.6	Key contractual clauses	90
3.7	Community benefits	91
3.8	Personnel implications (TUPE)	91
3.9	Procurement process	91
3.10	Enabling works/new link road construction	92
3.11	Planning consent	92
3.12	Conclusion	92
	THE FINANCIAL CASE	94
4.	THE FINANCIAL CASE	95
4.1	Introduction	95
4.2	Funding conditions	95
4.3	REVENUE	97
4.3.1	OBC summary	98
4.3.2	Annual service payment (ASP)	98
4.3.3	Depreciation	100
4.3.4	Service running costs	101
4.3.5	Facilities management services	101

4.3.6	Building running costs	102
4.3.7	Other costs	102
4.3.8	Summary of additional recurring revenue costs	102
4.3.9	Additional non-recurring revenue costs	103
4.3.10	Conclusion – revenue costs	104
4.4	CAPITAL	104
4.4.1	Non NPD costs	105
4.4.2	Timing of non NPD costs	105
4.4.3	Future project team and advisors expenditure	106
4.4.4	Impairment	107
4.5	VAT recovery	107
4.6	Accountancy treatment	109
4.6.1	Impact of NPD contract on NHS Orkney balance sheet	109
4.6.2	Impact of NPD contract on national accounts	109
4.6.3	Impact of non NPD capital spend	110
4.6.4	Revenue costs	110
4.6.5	Impact on budgeting	110
4.7	Areas of risk	111
4.8	Statement of affordability	114
4.9	Conclusion	115
	MANAGEMENT CASE	116
5	MANAGEMENT CASE	117
5.1	Introduction	117
5.2	Project management strategy and methodology	117
5.3	The project framework	118
5.4	Project structure	118
5.4.1	Project roles and responsibilities	119
5.4.2	Individual roles within the project structure	121
5.4.3	External advisors	125
5.5	Project milestones	126
5.6	Communication and reporting arrangements	126
5.7	Key stage review	127
5.8	Conclusion	127
5.9	CHANGE MANAGEMENT	127
5.9.1	Change management philosophy	127
5.9.2	Service and operational change management principles	127
5.9.3	Changes arising in the project	128
5.9.4	Conclusion	128

5.10	BENEFITS REALISATION PLAN	129
5.10.1	Introduction	129
5.10.2	Project benefits	129
5.10.3	Conclusion	132
5.11	RISK MANAGEMENT PLAN	132
5.11.1	Introduction	132
5.11.2	Risk management philosophy	133
5.11.3	Risk management and quantification	133
5.11.4	Risk management process	134
5.12	CONTRACT MANAGEMENT ARRANGEMENTS AND PLAN	136
5.12.1	Introduction	136
5.12.2	Contract management philosophy	136
5.12.3	Roles and responsibilities	137
5.13	POST PROJECT EVALUATION	137
5.13.1	Introduction	137
5.13.2	Framework for post project evaluation	137
5.14	Conclusion	140
	GLOSSARY OF TERMS	141
	APPENDICES	145
Appendix A	CIG Approval Letter	146
Appendix B	OJEU 08.03.2016	156
Appendix 1	Bed Model Methodology	172
Appendix 2	Preferred Bidder Design Solution	178
Appendix 3	Risk Registers	192
Appendix 4	VFM Comparison	199
Appendix 5	Scope of Services	207
Appendix 6	Legal Summary	210
Appendix 7	Community Benefits	219
Appendix 8	PQQ Evaluation Report	222
Appendix 9	Final Tender Evaluation Report	248
Appendix 10	VAT Submission	263
Appendix 11	Internal Audit Report	268
Appendix 12	Benefits Realisation Plan	281
Appendix 13	Post Project Evaluation Plan	293

Table of Figures

Table i	Cost Movement from OBC	16
Table ii	Capital costs	17
Table 1	Consultant Led Outpatient Attendances – Balfour Hospital (2010 to 2015)	36
Table 2	Non - Consultant Led Outpatient Care Led by Other Professionals e.g. Nursing, Allied Health Professionals (AHPs) Attendances (2014 to 2015)	36
Table 3	Performance Against National Targets/Standards	37
Table 4	HRI and Non HRI Patient Numbers including those with Long Term Condition (LTC) and associated bed days, attendances and costs	42
Table 5	Care Home Bed Numbers	43
Table 6	Bed Modeling Scenarios	45
Table 7	Key Investment Objectives	54
Table 8	2015 extract from Annual State of NHS Scotland Assets and Facilities Report 2015	60
Table 9	PAMS Property Condition by NHS Board 2015	61
Table 10	Highest Scored Procurement Risks	66
Table 11	Highest Scored Operational Risks	69
Table 12	OBC Options Considered	75
Table 13	OBC Non Financial Benefits Criteria	76
Table 14	OBC Options Weighted Scores	77
Table 15	OBC Options Ranking	78
Table 16	NPD Risk Allocation	84
Table 17	Ratchet Deduction Calculations for Critical Spaces	89
Table 18	OBC Approval Letter Funding Conditions	96
Table 19	Calculation of the prepayment sum for the ASP	97
Table 20	OBC Recurring Revenue Funding Requirements	98
Table 21	ASP Components	99
Table 22	ASP Summary at Beginning and End of Contract Period	100
Table 23	Revised Annual Recurring Funding Requirement	102
Table 24	Capital Costs	104
Table 25	Non NPD Costs	105
Table 26	Revised Capital Profile	106
Table 27	Project Team and Advisors Projected Costs	106
Table 28	Impairment Costs and Valuation	107
Table 29	Budget Impacts – NHSO Board and Scottish Government	111
Table 30	Financial Risks	112
Table 31	Team/Group Project Roles and Responsibilities	119
Table 32	Individual Project Roles and Responsibilities	121

Table 33	Project Milestones	126
Table 34	Project Benefits	130
Table 35	Post Project Evaluation	138
Figure 1	Attendances to the ED for the period 2010 to 2015	38
Figure 2	Presentations by classification	39
Figure 3	Hospital Emergency and Elective admissions, daycases and off island transfers	41
Figure 4	Percentage Bed Occupancy	41
Figure 5	Inpatient Beds Required – Balfour Hospital, 2015/16	43
Figure 6	2015 Physical Condition Comparison - NHS Boards	60
Figure 7	2015 Functional Suitability Comparison - NHS Boards	61
Figure 8	Project Governance Structure	118
Figure 9	Risk Score Matrix	135
Figure 10	Risk Rating	135

If you require this or any other NHS Orkney publication in an alternative format (large print or computer disk for example) or in another language, please contact the Board Secretary:

Telephone: (01856) 888228

Email: ork-hb.alternativeformats@nhs.net

Foreword

NHS Orkney continues to transform the care and services it provides in preparation for the new hospital and healthcare facilities. This Full Business Case (FBC) describes these services and the benefits to be realised from this significant investment. It builds upon the Outline Business Case (OBC) (approved by the Scottish Government Health and Social Care Directorates on 8 July 2014 and updated on 4 August 2014 Appendix A) and provides further details on the case for change, details on the transition being undertaken in preparation for the new facility and records the findings of the subsequent procurement.

Our Board's aims are to:

- Improve the health of the population
- Improve the health care experience for people using or accessing our services and facilities
- Improve our return on capital spend

This FBC sets out an affordable healthcare solution which will deliver the benefits associated with the provision of high quality care and services and ongoing value for money as we move into purpose built facilities.

Our Board advertised the project in the Official Journal of the European Union ((OJEU Appendix B) on 17 July 2014 to invite expressions of interest for the provision of the new facility.

On 31 October 2014, after successfully completing Pre-Qualification, three consortia were selected and invited to participate in Phase One of the Competitive Dialogue (CD). One consortium was subsequently down selected from the procurement process in April 2015 in line with the pre-determined arrangements which followed on from the submission of interim tenders.

Following a further period of CD with the two remaining bidders, our Board received final tenders in May 2016 and the results were evaluated. Robertson Capital Projects was selected as the Preferred Bidder to design, build, maintain and provide 'hard' Facilities Management (FM) services to the new hospital and related healthcare facility (known locally as the new build). The Non Profit Distributing (NPD) Model (supported by the Scottish Government) is the procurement model chosen to deliver this project, with a funding variant whereby a significant prepayment of the Annual Service Payment (ASP) will be made.

The development of a new replacement Rural General Hospital (RGH) and related healthcare facility for NHS Orkney is viewed as a key enabler in supporting system wide changes that will facilitate the way health and care services are delivered. It will also provide a real opportunity to contribute to a wider range of community benefits, including employment and training opportunities, which will help to improve the overall health and wellbeing of our local population. Scottish Government have advised that an updated funding letter will be provided, reflecting the impact of the prepayment and a revision to the construction cost cap.

EXECUTIVE SUMMARY

Purpose

The purpose of this Full Business Case (FBC) submission is to secure approval for the provision of a modern Rural General Hospital (RGH) and related healthcare facility in Orkney on a site acquired by NHS Orkney at New Scapa Road which lies to the south of Kirkwall and close to the site of the existing hospital. This new build will replace unsuitable clinical accommodation and re-provide clinical services currently located in Skerryvore and Heilendi GP practices, Skerryvore Community Health Centre and King Street Dental Surgery. In addition, the new build will accommodate a number of clinical and non clinical staff and services as part of our NHS Orkney Board's strategy to reduce the number of premises it owns, leases and maintains and so redirect funding to frontline care delivery in a cost effective manner.

The Scottish Government Health and Social Care Directorates approved the Outline Business Case (OBC) in support of the project on 8 July 2014 (updated 4 August 2014) following earlier approval by the NHS Orkney Board.

This FBC confirms that the design and commercial solution offered by NHS Orkney's Preferred Bidder, Robertson Capital Projects, represents the best value solution for delivering the requirements of the New Hospital and Healthcare Facility Project within the project affordability limits. This FBC also demonstrates that the appropriate contractual, commercial and management arrangements are in place to deliver the project successfully. It updates the OBC and documents the outcomes of the procurement discussions.

There has been no significant change to the demography of Orkney since the OBC was approved, there have however been a number of changes to the range of healthcare services provided as part of our internal transformational change programme which includes service repatriation to support care delivery closer to home wherever possible. Our ongoing investment in Information and Communications Technology (ICT) enabled care and services will further contribute to and support our repatriation plans. To date we have invested in the installation of a CT scanner, a small High Dependency Unit (HDU) and a multi-purpose treatment area to free up theatre space to support increasing surgical activity and new services (e.g. gynaecology). All of these changes fully support the migration of services to the new Hospital and Healthcare Facility, referred to locally as the new build.

NHS Orkney, in line with other Health Board areas is facing a combined challenge of an ageing population with higher levels of co-morbidities resulting in increased demands on services, while at the same time the working age population available to meet these demands is decreasing.

Healthcare Facilities and Clinical and Service Change Programme

In addition to the procurement of a new replacement RGH and related healthcare build, our Board has also spent time considering a range of other wider issues within our overall clinical and service change programme. This includes greater utilisation of community and integrated health and care services as well as enhanced community services as detailed in Change and Integration Funding Plans. The organisational

development necessary to introduce the changes into clinical services to realign the way we deliver healthcare in Orkney is underway as part of our transitional planning and state of preparedness for relocating to the new build.

Strategic Case

NHS Orkney delivers a range of clinical hospital services consistent with being a RGH alongside both primary and community services. It also commissions a significant level of out of area care from neighbouring NHS Boards. The new build will address the significantly high risk relating to business continuity and service delivery risks associated with ageing and less than suitable functional buildings.

Repatriation of services is a key part of our Board's overall strategy as it looks to provide access to more services locally for our patients whilst at the same time avoiding significant patient travel costs where this is safe and appropriate to do so.

The FBC further examines our clinical strategy (Our Orkney, Our Health – Transforming Clinical Services) underpinning the project as well as strategies at both a national and local level. The FBC concentrates on the delivery of hospital services but also responds to a range of national strategies that support our Board's aims and vision, including:

- Better Health, Better Care: Action Plan (2007)
- Delivering for Remote and Rural Healthcare (2009)
- The Healthcare Quality Strategy for NHS Scotland (2010)
- 2020 Vision (2011)
- Reshaping Care for Older People: A Programme for Change (2011)
- The Patient Rights (Scotland) Act 2011
- Greenaway Report (2013)
- Public Bodies (Joint Working) (Scotland) Act 2014
- State of NHS Scotland Assets and Facilities Report (2015)
- National Review of Primary Care Out of Hours Services (2015)
- Chief Medical Officer's Annual Report (2016)
- Clinical Strategy for Scotland (2016)

Our local clinical strategy envisages that treatments/interventions are delivered in facilities that support newer models of care designed to deliver and support the right care, at the right time and in appropriate locations that are closer to people's homes.

This clinical strategy also acknowledges the demographic challenges facing our Board. Orkney has an ageing population requiring higher levels of care because of greater levels of comorbidity whilst at the same time the working age population available to deliver these services is reducing. Our Board, whilst recognising the service challenges that this demographic profile creates, is clear that there are many benefits to be realised by truly engaging the older population in the design and delivery of services.

Economic Case

The OBC considered five options for the reconfiguration of services.

The analysis of the options and associated sensitivities identified a new build on a greenfield site as the preferred option. This solution meets the project investment objectives and evidences the best overall value for money. It delivers the proposed models of care, the required capacity and an appropriate clinical environment for our patients and staff.

The assumptions underlying the choice of preferred option were re-visited as part of the FBC and support the original evaluation outcomes.

During 2016 we conducted a value for money review into the procurement method. This review took account of the delay in the project and the change in classification of the project due to the European System of Accounts ruling (ESA10). This review confirmed that continuing with a modified NPD procurement model with a funding variant was appropriate.

The preferred option for the project has not changed since OBC, namely the development of a new build with facilities to support introduction of new models of care as well as sustain current models in fit for purpose premises.

Commercial Case

Following approval of the OBC by the Scottish Government the project was advertised in the OJEU to seek potential bidders for the Project. The OJEU notice resulted in three bidders expressing an interest in the Project. The Pre-Qualification Questionnaire (PQQ) process resulted in all three bidders being issued with an Invitation to Participate in Dialogue (ITPD) on 31 October 2014. The evaluation of the PQQs and the selection of all three bidders was approved by the Programme Implementation Board (PIB).

Phase one of the CD commenced in November 2014 and was completed in April 2015 when one bidder was down selected, following the submission of interim tenders, in line with the pre-determined procurement arrangements. The remaining two bidders continued in phase two of the CD and submitted draft final tenders in July 2015 with final tenders in May 2016. The delay in the final submission date was attributable to:

- i. Both draft final tenders being in excess of the approved OBC construction cost cap (capex)
- ii. Determining the impact of national accounting classification issues arising from ESA10, and making variations to the funding mechanism as required by the change in accounting classification.

A comprehensive evaluation exercise was undertaken on the submitted final tenders resulted in the selection of a Preferred Bidder, Robertson Capital Projects. The PIB ratified the evaluation process and the final selection/recommendation, which was approved by the Board of NHS Orkney on 23 June 2016. The project has an estimated construction cost value of circa £[REDACTED].

The project is being procured using the NPD procurement model, with a variant in the funding mechanism whereby a significant prepayment of the Annual Service Payment (ASP) of £[REDACTED] is being made to Project Company (Project Co) during the initial years

of the project leaving a much reduced level of ASP to be paid over the 25 year contract period. This funding variant reflects the classification of the asset as a publicly classified scheme in the Statistical National Accounts, and preserves the NPD structure including external private investment and the associated transfer of risk.

The prepayment of the ASP removes the requirement for the successful bidder to secure senior debt investment. While the prepayment represents a change to the normal monthly payment funding arrangement, all other aspects of the NPD procurement model, including risk transfer, are preserved and there will be a standard 25 year NPD contract for the provision of the facilities/services.

The FBC outlines the scope of the NPD contract, including risk transferred to the private sector, based on the Scottish Futures Trust (SFT) standard form Project Agreement (PA). Hard facilities management (FM) is part of the contract. In line with NHS Scotland policy, all other FM services will be delivered by the Board of NHS Orkney. The FBC also sets out how our Board will seek to ensure performance and value from the prepayment of the ASP. This will be necessary to ensure that the investment and project deliver to specification and to the approved project timetable.

Development since OBC

The original investment objectives based on our Board's agreed strategic direction, reflects the consultation on the provision of hospital services in Orkney. These objectives have not changed from the OBC.

Financial Case

Our Board has committed to the funding and development of the new build for the population of Orkney and has support from both the Scottish Government and community planning partners including Orkney Islands Council (OIC).

The costs presented as part of the OBC have been updated in the FBC to reflect the final tender and the agreed service models, including workforce implications.

As part of the contract arrangements our Board will be making a prepayment of the ASP of £[REDACTED] and there will be a private sector investment of over £[REDACTED]. As a consequence, there will be a reduction in the level of ASP payable annually for the provision of the new build. The total ASP which includes the prepayment and annual payments for 25 years will cover the design, build, finance and maintenance of the new build over the life of the contract.

Scottish Government have confirmed their support for the change in the financing model and the anticipated increased final tender construction value of £65m. A revised funding conditions letter will reflect the final agreed annual support linked to the agreed PPA and annual payments set out in the financial close model.

In addition, Scottish Government has confirmed their commitment to support the increased non NPD capital costs for capital equipment, project team and the revised capital expenditure profile is reflected in our Board's Financial Plan.

The Board of NHS Orkney is required to support 50% of lifecycle maintenance costs and 100% of hard FM maintenance costs, with the Scottish Government supporting all other costs including construction, development, financing and Special Purpose Vehicle (SPV) running costs. As a consequence, in the first year, NHS Orkney will fund £[REDACTED] of the annual level of ASP and the remaining circa [REDACTED] will be met by Scottish Government as set out in the funding conditions letter to be issued at financial close. The total figure of £[REDACTED] covers lifecycle and facilities management costs. These costs are indexed annually.

The OBC identified an increase in revenue costs of £[REDACTED], of which our Board was required to fund £[REDACTED]. Our Board set aside additional funding of £[REDACTED], which remains intact, in the 2016/17 Financial Plan, thus allowing a £[REDACTED] contingency.

The updated costs now indicate an increase of £[REDACTED], this is £[REDACTED] higher than the level provided for by our Board at the stage of approving the OBC. Table i below shows that our Board's share has increased mainly due to additional depreciation and the increase in rates resulting from the increased floor area of the new build compared to the existing facility.

There are uncommitted recurring reserves available for future years in our Financial Plan which can provide cover for the additional £[REDACTED]. The Financial Plan will be amended at its next revision (mid year review 2016).

The Scottish Government share has reduced by £[REDACTED] to £[REDACTED] as a result of the prepayment of the ASP which in turn reduces the annually payable element of the ASP. In addition the public sector recurring revenue costs have decreased by £[REDACTED] as shown in table i below.

Table i Cost Movement from OBC

Recurring Revenue Costs	Original Baseline	Updated Requirement	Increase	Funded by NHSO	Funded by SG
	£'000	£'000	£'000	£'000	£'000
Annual Service Payment	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Depreciation	970	2,200	1,230	330	900
Service Running Costs	7,544	7,694	150	150	0
Facilities Management	1,526	1,572	46	46	0
Building Running Costs	882	1,008	126	126	0
Other Costs	0	25	25	25	0
TOTAL	10,922	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
OBC	10,922	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Increase / (Decrease)					

The total estimated capital requirement has been updated to reflect an increased requirement for equipment, particularly ICT infrastructure, equipment including call systems, pagers and telephony.

Table ii Capital costs

Capital Costs	OBC Estimate	Revised Estimate	Movement
Non NPD Costs	£10.115m	£11.615m	£1.500m
Prepayment of ASP	-		

The draw down from Scottish Government funds for the prepayment of the ASP of £[REDACTED] will match the prepayment profile schedule in the Pre Payment Agreement (PPA) and payments to Project Co outwith this profile will not be permitted.

The introduction of the prepayment has prompted a review of the VAT recovery position. Whilst we are confident that VAT is recoverable, we are awaiting a formal opinion from HMRC¹.

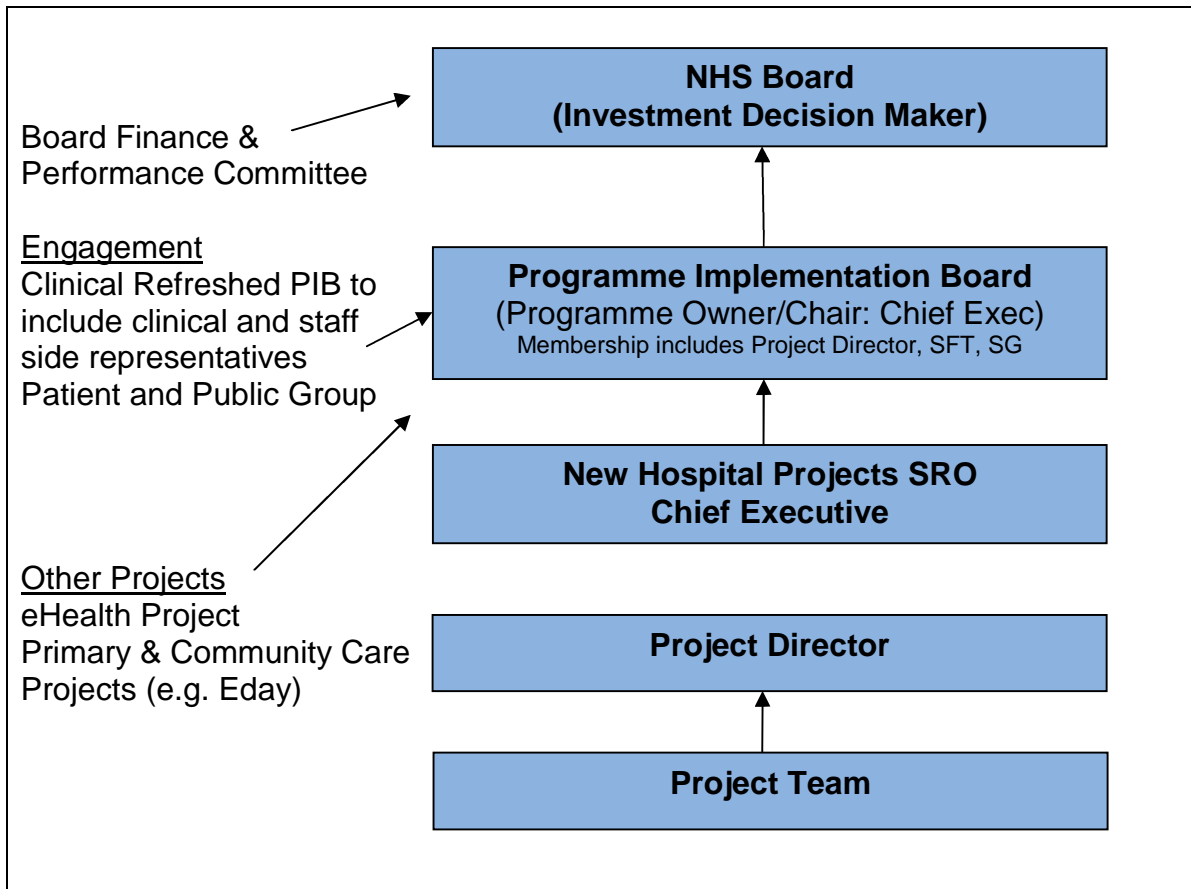
The Financial Case presents an affordable model for the Board of NHS Orkney however as with any significant investment considerable financial rigor will be required to ensure the affordability level is delivered. The financial consequences will be managed as part of our Five Year Financial Plan.

Management Case

The responsibility for Project Governance lies with the PIB chaired by the Chief Executive (Senior Responsible Officer) of NHS Orkney. The Project Sponsor is also the Chief Executive, supported by the Project Director. All Executive Board members are members of the PIB.

¹ A formal opinion on the VAT recovery position has been received from HMRC on 18 October 2016 which confirmed that NHS Orkney can recover the VAT, in relation to both the prepayment and the ongoing annual service payment, under Contracted Out Services (COS) Heading 45.

Project Structure



Conclusion and Recommendation

This FBC has outlined a compelling case for change and investment in a new build within Orkney. It has also shown a solution that provides all of the benefits identified at a value for money price.

The affordability and financial consequences of the investment will be managed as part of the normal financial and capital planning process undertaken by our Board.

This FBC follows the ‘Five Case Model’ as recommended in the current Scottish Capital Investment Manual (SCIM) Guidance.

The FBC is recommended for approval.

Further Information

Ann McCarlie, Project Director, Project Offices, Balfour Hospital
 New Scapa Road
 Kirkwall
 Orkney
 KW15 1BH
 Telephone 01856 888926

STRATEGIC CASE

1. THE STRATEGIC CASE

1.1 STRATEGIC CONTEXT

1.1.1 Introduction

The purpose of this section is to update the Strategic Context underlying the proposed project from that set out in the OBC. It considers the national priorities for health and care whilst addressing the local imperatives and the particular challenges facing our Board now and in the future. It will highlight significant changes since the OBC.

Our Board, in common with other Health Board areas, is facing a combined challenge of an ageing population with higher levels of co-morbidities resulting in increase demand on the service, while at the same time the working age population is decreasing. Our Board is developing new ways of working and new models of care to respond to these challenges. The work of our Board and its partners to deliver integrated services that take account of the wider determinants of health is a key enabler to support people to keep, stay and get well if they become ill and recognises the valuable contribution that our increased population of older people make to the health and wellbeing of our population.

There has been no significant change to the demography or the range of services provided by our Board since the OBC was approved in 2014. However during 2015 we secured and installed CT and mobile dxa scanning facilities and we also continue, with the agreement of NHS Grampian, to repatriate services from them when it is considered appropriate, affordable and safe to do so. The Consultant (medically) led care model has already enabled our Board to repatriate gynaecology services and we are now looking at other specialties in response to our ageing population. In addition, we now also provide an enhanced chemotherapy service in partnership with NHS Grampian. This has reduced the number of patient appointments to Aberdeen.

Public Bodies (Joint Working) Scotland Act 2014 received Royal Assent on 1 April 2014. The Act is a key national and local driver and has been further reflected in this FBC.

1.1.2 Overview

The NHS Scotland Quality Strategy makes a specific reference to the need to respect individual needs and values and to provide services that demonstrate compassion, continuity, and clear communication and shared decision-making. Themes that were reinforced in Catherine Calderwood, Chief Medical Officer's Annual Report when she encouraged her medical colleagues to further involve and discuss with their patients what is important for them as individuals – which may be deciding not to have treatment. Furthermore, she invited doctors to question variation in practice and outcomes, to reduce waste and encourage

innovative ideas to further enhance clinical practice.

In common with other Health Boards we are dealing with and facing challenges as to how care and services will be kept safe, effective and sustainable now and in years to come. These challenges provide us with real opportunities to explore how our healthcare system can be transformed through innovation and new ways of working with our partners in industry, academia and health and care.

We believe that we have a compelling case for change supported by both ambition and a sense of direction to address pressures in our local system which are both short and long term and centre on having:

- The capability and capacity to respond to and manage future demographic change affecting the ageing population, their health needs and our workforce
- The ability to respond to National Policy as detailed in the Clinical Strategy, the Quality Strategy and Integration of Health and Social Care to support the implementation of our local clinical strategy
- The ambition to be innovative and transformational as we pioneer new ways of working and support continuous improvement to deliver current and future public expectations and performance standards which will become more challenging as the population becomes older
- The need to address backlog maintenance and the lack of functional suitability of our current Balfour hospital facilities and to improve the ambience of our environment for our patients, visitors and staff.

1.1.3 National context

The national context for the development of health services in Scotland is set out in a range of policy initiatives, the most relevant of which are:

- Better Health, Better Care: Action Plan (2007)
- Delivering for Remote and Rural Healthcare (2009)
- The Healthcare Quality Strategy for NHS Scotland (2010)
- 2020 Vision (2011)
- Reshaping Care for Older People: A Programme for Change (2011)
- The Patient Rights (Scotland) Act 2011
- Greenaway Report (2013)
- Public Bodies (Joint Working) (Scotland) Act 2014
- National Review of Primary Care Out of Hours Services (2015)
- State of NHS Scotland Assets and Facilities Report (2015)
- Chief Medical Officer's Annual Report (2016)
- Clinical Strategy for Scotland (2016)

The most recent changes relate to the Clinical Strategy and the integration of health and social care functions. The proposed policy and legislative direction signals a much needed change to how we provide sustainable health and social care services fit for the future.

1.1.4 Local context

The local context for the development of our services both responds to the national drivers set out above and reflects other strategies that support the proposals set out within our approved OBC. The need for island proofing should be a key consideration when developing national policy and legislation. In our context we are mindful of our location and the constraints it imposes and opportunities it can provide in respect of our ability and costs to deliver care and services. The following strategic areas are important in the development of this FBC, some of which are described in more detail below:

- Our Orkney, Our Health – Transforming Clinical Services (2011)
- Communications and Engagement Strategy (2015)
- Strategic Commissioning Plan (2015)
- The Board's eHealth Strategy (2015)
- The Board's Property and Asset Management Strategy (2015)
- Corporate Plan (2016)
- Local Delivery Plan (LDP) (2016)
- Five Year Financial Plan (2016)
- Joint Strategic Needs Assessment (2016)
- Workforce Strategy and Workforce Projections (2016)

Our Board and OIC have established an Integrated Joint Board known locally as Orkney Health and Care (OHAC) to build on our integrated care approach and progress to date.

We have acknowledged through our Strategic Commissioning Plan (SCP) that there are a number of reasons why we need to change the way health and social care services are planned and commissioned in future based on current health challenges, health intelligence and future projections. Our Joint Strategic Needs Assessment demonstrates the challenges associated with an ageing population, with increasing numbers of people with long term conditions and complex needs all of which can put pressure on local health and social care services.

A key priority for us will be to support people and their carers to live at home and for people living with long term conditions we need to champion and encourage people to make life long changes. This is requiring us to move at pace to introduce more integrated care pathways between primary, community and hospital care to maximise support for self-care and self-management.

Greater integration of social care including Third Sector, primary, community and hospital care helps us achieve this ambition however Orkney is too small to support shifts in the balance of care and so we must find a unique way of working that has partnership working between individuals, families and communities at the heart of what we do.

OIC has recently approved investment in home care and care home beds in line with Scottish/Orkney benchmark needs assessment data which will enable people to be cared for in more appropriate care settings.

The poor physical condition of our estate is well evidenced through our Property Asset Management Strategy (PAMS) and condition surveys. It is also important to highlight additional factors that impact on service delivery and sustainability within an Island context. These include:

- The need to provide timely accessible emergency services to deal with acute illness or injury, including life threatening conditions
- The generalist nature of the staffing models in Orkney and the breadth of skills required
- The need for ongoing investment in training including working in other bigger NHS Boards to maintain and update skills to enable staff to respond safely and effectively
- The rurality and remoteness of Orkney
- Those aspects of services and staffing which have deminimus levels and costs attached to them.

Having considered the options for changing the nature and volume of healthcare services available to the population of Orkney, our Board took the decision that its preferred position in response to these factors would be one which includes the delivery of a range of services informed by our ability to deliver and support them ourselves and/or these are delivered by visiting clinicians, where we have deemed it safe to do so.

Our population accepts the need to attend specialist health services outwith Orkney but they have also challenged us to provide more care closer to home using technology. This of course is dependent on the rest of NHS Scotland being equipped to support us remotely in a number of care settings, notably GP including out of hours and community, outpatients, theatre and in our emergency settings, including closer working with Scottish Ambulance Service (SAS). Repatriation is also something we are committed to exploring especially given our ageing population and the associated conditions (e.g. failing joints and failing eye sight) that can manifest with becoming older.

Our Board has also invested in its Information and Communications Technology (ICT) infrastructure and systems including enhanced diagnostics to support more care closer to home.

We continue to develop integrated care pathways locally and with neighbouring NHS Boards to support more effective and efficient care delivery as we streamline and remove traditional boundaries and improve coordination and flow across our health and care system. Investment in good anticipatory care planning, re-ablement services and end of life care will help us deliver care as part of an integrated in and out reach workforce model.

To help us achieve greater workforce integration and to meet the outcomes set out in the AHP National Delivery Plan, Allied Health Professionals (AHPs) are redefining local services to work across acute and community care services to ensure focus on recovery and re-ablement that is appropriate to each setting and patient group.

To facilitate partnership working with the SAS, Out of Hours (OOH) service and NHS 24, as set out in the OBC, a central SAS base, GP OOH facilities and NHS 24 have been located within the Emergency Care Centre in the new build. This proximity will increase the opportunities for cross agency working.

Additionally Third Sector partnership working will be supported and enhanced by the provision of meeting room and conference facilities equipped with teleconference and other amenities available for both Third Sector and community use.

1.1.5 Financial performance

Our Board's Financial Plan supports the affordability of the FBC for the provision of the new build. The Plan provides the robust financial context within which our Board will progress this long anticipated capital development.

The Financial Case demonstrates both affordability and the overall financial implications which support the implementation of the care pathways and service delivery models as they will be provided in the new build.

1.1.6 Property and asset management strategy

The Board's PAMS supports the programme of service improvement and the delivery of the Board's vision for the future.

The Annual State of NHS Scotland Assets and Facilities Report (SAFR) 2015 shows our functional suitability as being the second worst in NHS Scotland. The existing Balfour Hospital has a number of constraints which has resulted in under utilisation due to a lack of functional suitability. For example:

- There are poor clinical adjacencies across the hospital which leads to ineffective patient and staff flows
- Many of the clinical departments are cramped and poorly laid out
- There is a lack of separation of public, clinical staff, and support transfer routes which compromises patient privacy and dignity
- The layout of the hospital does not support current models of care or optimum staffing models
- Privacy for inpatients is poor with no ensuite bathrooms facilities and limited sanitary / hygiene facilities within the wards
- There is limited single room accommodation within wards

- Poor ward layout results in difficulties with patient observation and challenges in meeting gender specific requirements which results in frequent bed moves and disruption to patients
- Therapy departments are located some distance away from inpatient accommodation leading to inefficient patient and staff flows

1.1.7 eHealth strategy

Our Board's eHealth Strategy will facilitate the transformational change required for moving to the new build by providing ICT systems which deliver enhanced electronic processing of, storage of and access to information. The strategy also anticipates increased use of tele-health, tele-medicine, and video conference facilities to support delivery of clinical services to remote areas from within the new build.

Key ICT projects underway in preparation for the transition include a move towards a single clinical record, electronic prescribing, and electronic ordering of diagnostic tests. In order to decrease the number of paper records held to an absolute minimum prior to the move to the new build, we have embarked on a project to digitise the clinical records currently held in the Hospital and by other services which will move into the new build.

Video conference facilities are increasingly being used to facilitate business and clinical meetings, as well as providing access to clinical decision making (in conjunction with increased use of remote monitoring equipment in patients' homes) and providing outpatient reviews at locations remote from the main hospital, negating the need for clinician or patient travel.

Successful implementation of the eHealth strategy is key to supporting us in modernising clinical services, reducing costs and improving patient experience in line with the service delivery models to be provided in the new build. In particular it is anticipated that key benefits will arise through timely access to relevant information (allowing for improved patient safety and more efficient delivery of care) as well as increasing flexibility in the way we utilise our workforce.

1.2 OUR VISION

As stated in the OBC our Board's vision to "offer everyone in Orkney access to an NHS that helps them to keep well and provides them with high quality care when it is needed whilst employing a skilled and committed local workforce who are proud to work for NHS Orkney" is derived from the overarching principles set out in Scottish Government policy including:

- The Better Health, Better Care: Action Plan (2007) – committing to improve the health of the population and to improve the quality of healthcare and healthcare experience
- The Quality Strategy (2010) - a development of Better Health, Better Care that builds upon key achievements and in particular:

- putting people at the heart of our NHS
 - building on the values of the people working in and with NHS Scotland and their commitment to providing the best possible care and advice compassionately and reliably
 - making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important.
- The 2020 vision and more recently the publication of NHS Scotland's Clinical Strategy in 2016 and the nationally led transformational change programme.

This FBC sets out how our investment objectives and the realisation of their benefits will ensure that we will deliver in line with the 2020 vision and our LDP priorities. The FBC also acknowledges the recent Clinical Strategy for Scotland 2016 and its proposals for how clinical services need to change over the next 10 to 15 years in order to provide sustainable health and social care services fit for the future.

Underpinning this is the continuing work to update our clinical models to reflect national, regional and local policy direction and in transforming our clinical services in line with our local clinical strategy we remain committed to achieving four things.

- Improved outcomes for our patients following their care
- A better experience for our patients when using our services
- A high quality engaged workforce with opportunities to develop their skills and careers locally
- Safe, effective and person centred services that are efficient, sustainable and affordable going forward.

1.2.1 A case for change

In Orkney we are all familiar with the challenges in delivering reliable and responsive high quality healthcare and in improving people's health in remote and rural settings that are disparate, fragile and only accessible in the main by ferry and/or air.

Despite our location, geography and climate we like other NHS Boards have to provide routine and urgent care whilst at the same time have the infrastructure to be able to respond to life threatening emergencies and in other situations resuscitate, support and care for patients of all ages whilst we wait for emergency retrieval services to transport patients to a more appropriate care setting. We need hospital and healthcare facilities that can meet the needs of all clinical presentations and which can support self management and our local prevention agenda. Our current facilities are no longer fit for purpose and despite our passion, ambition and best efforts we cannot provide the clinical care in ways that we want and need to.

In this regard the NHS Scotland Quality Strategy makes a specific reference to the need to respect individual needs and values and to provide services that demonstrate compassion, continuity, and clear communication and shared decision making. These themes were reinforced in Catherine Calderwood, Chief Medical Officer's Annual Report when she encouraged us to further involve and discuss with patients what is important for them as individuals regarding treatment and care options. Furthermore, she invited doctors to question variation in practice and outcomes, to reduce waste and encourage innovative ideas to further enhance clinical practice.

We endorse this direction and in response believe Orkney deserves better – better health, and better care. Doing things better often means doing things differently and as a Board we have demonstrated through our improved performance that we are committed to integration, quality improvement and innovation.

An ICT proficient new build enables us to *virtually* bring specialist decision making support into our clinical areas, notably the emergency care centre, maternity services (neonatal resuscitation), theatre and outpatients. Our ability to connect with other clinical centres including primary care and the remote isles, is a key part of our clinical strategy as we look to support a truly holistic health and care service based on a hub and spoke or networked arrangement.

1.2.2 The Orkney context

Orkney in common with the rest of Scotland will continue to have more people living with one or multiple long term conditions. However we recognise that many long term conditions are related to life style factors and our interventions may need to shift from an over reliance on medication to one that helps individuals make serious progress in life style changes from an early age. This will have implications for our workforce and how we work with partners.

In encouraging people to make life long changes we need to move from fragmented and often episodic care delivered in hospitals to greater coordinated team based care to support people with long term conditions.

Integrated care pathways need to stretch beyond our traditional care boundaries as we look to work with community planning partners to enable people to become independent through self care and self management. Orkney is too small to support major shifts in the balance of care and we are developing a unique way of working that supports a shift or change in clinical practice and which has partnership working between individuals, families and communities at the heart of what we do.

Working together to achieve wellbeing with multidisciplinary teams providing health and care services goes beyond coordination of care akin to the 'Nuka' model delivered in Alaska, (but adopting such a philosophy will require us to think and act differently to help people keep well and stay well).

Working with partners will be critical to ensure we can support health and care needs especially given our ageing population. For every 25 people over the age of 65 in Scotland, there is one care home bed, whereas in Orkney, for every 42 people over 65 there is one care home bed. Orkney has three care homes and three respite units within older people's supported accommodation. OIC acknowledges its responsibility and have committed to investment in social care to align itself with other local authority provision by increasing its capacity as set out in table 5, section 1.3.7. This increased capacity will help reduce the number of bed days lost due to delays in discharge. Equally contributing to building a vibrant Third Sector will also be very important to our future service delivery models of care.

1.2.3 Reasons for change

This FBC provides the basis for us all to focus our combined efforts on what is required to address these current and future challenges, and to ensure high quality healthcare for ourselves and for generations to come. In this regard we have good reasons for doing things differently.

Reason 1 Our ageing population and remote/rural context

In Orkney and across Scotland people are living longer due to improvements in our living standards and levels of care and support. It is estimated that between 2010 and 2035 the population of Orkney will increase by 6.8% to 21,479. However, whilst the population of Orkney's main settlement, Kirkwall has increased, population reduction in the outlying areas, and in particular the North Isles is significant and makes care delivery more challenging as we look to recruit from elsewhere to support the Isles.

In addition, the population of Orkney has a higher than national average proportion of older people. Between the 2001 and 2011 censuses, the number of people aged 65 and over grew by 31% (the highest of all Boards) and although this challenge is not unique to Orkney, our older population is increasing faster than the national average. In addition, significant numbers of our working age population are leaving the Islands, and so fewer people are available to provide the care and support required with the predicted levels of chronic illness and disabilities.

Our workforce is also getting older and in Orkney the percentage population of working age will decrease by 0.7% in contrast to a projected increase of 7.1% in Scotland. In addition, the percentage of the population aged 0-15 years will decrease in Orkney (4.6%) by 2035 and increase in Scotland by 3.2% by 2035.

Traditional workforce models and posts as we know them will also continue to change and we must be ready to have new posts supported by new profiles to meet health and care needs going forward. In Orkney we have invested in an up-skilled workforce through transformation and development of roles in particular to respond to hard to fill medical vacancies, this will continue.

Reason 2 Our need to improve health

NHS Orkney's key aim is to improve the health of everyone in Orkney. Improving health means focusing on Orkney's specific health challenges and tackling life style factors that put people at risk from an early age. Our current service delivery model will not meet the future health needs of the population, with the predicted rise in long term conditions and health problems associated with an ageing population. A stronger focus on prevention and re-ablement, and a move away from episodic care delivered in hospitals to greater coordinated team based care to support people with long term conditions is a key and ongoing priority for us.

Reason 3 Our need to accept that nationally and regionally hospital care is changing

Significant advances in medicine and technology mean that more care can be provided safely closer to home. New technology can support our staff with their decision making and such technology is influencing how we change traditional patterns of care that would have seen people previously treated outwith Orkney. These advances are resulting in repatriation of treatments and services to Orkney, which means greater access to healthcare availability locally and less travel and inconvenience for most people.

Reason 4 Our need to have access to more specialist care

Investing in diagnostic modalities and ICT enabled care to support decision making is vital to our remote context and the ability to provide routine, urgent and in the event of life threatening conditions, emergency treatment and care. For example, rapid access to a CT scan to determine the cause of a stroke allows us to begin immediate treatment with clot busting drugs (if appropriate). In this regard we intend investing significantly in remote decision making technology to help support people to stay well in their homes and communities as well as provide access to specialist virtual advice as and when required. Emergency retrieval also provides access to more specialist care for patients of all ages when we are not able to care for them in Orkney.

Reason 5 Our need to use our staff and building more effectively

Our Board in common with the rest of Scotland has faced challenges in employing a workforce in a way that helps them to move easily between hospital and community settings yet this is what is required to deliver sustainable services that are affordable going forward. We are currently looking at ways to support all staff to work flexibly to deliver the right care, in the right place, at the right time, every time.

Our buildings also need to be used more effectively in partnership with community planning partners, however recent Public Service Network (PSN) – IT Security Standards implementation has limited our ability to co-locate with some of our Community Planning Partners (CPP) and solutions to work around

this are being explored. Our property portfolio is under-utilised, not fit for purpose or surplus to requirements.

Our current hospital is old and is in poor physical condition. It currently fails to meet modern healthcare standards, in terms of functional requirements, special needs, and compliance with current clinical guidance, fire regulations and infection control measures. Furthermore, there is a significant backlog in maintenance. The plant and equipment are well beyond their design life, and hence are inefficient in terms of energy. ICT Infrastructure is overstretched and unable to meet future demands or service models we require to support health and care delivery in remote and rural settings.

Reason 6 Our need to improve the quality and value of our care

We are committed to providing person centred, safe and effective healthcare for the people of Orkney and whilst we recognise that there are areas of high quality care; there is also room for improvement across our health and care system. We have already begun work to understand and address variations in activity and spend.

We acknowledge that failure to address variation will mean that services are provided for patients who don't need them, and services withheld from those who could benefit from them. A balanced programme of quality and value initiatives is being informed by our investment in creating more improvement capacity and capability.

We also acknowledge the need to strengthen our health and business intelligence function and in doing so ensure we have the appropriate ICT systems in place to capture data effectively, support delivery of twenty-first century care and analyse data and provide feedback to clinicians and service managers on outcomes, activity, variation and spend.

1.2.4 Current health services

The Board of NHS Orkney is responsible for improving the health of the population and reducing health inequalities as well as improving the experience for patients and people using and/or accessing our facilities. We work closely with all community planning partners and OHAC, as we look to develop care and service models to meet the future needs of our population.

Transportation to the mainland of Orkney and its Outer Isles adds a layer of complexity to the models of care we are required to deliver and the facilities we need to be able to respond to life threatening presentations as well as routine and urgent outpatient, day and in-patient planned care.

The policy document Delivering for Remote and Rural Healthcare (2009), defines a Rural General Hospital (RGH) as a place able to "undertake the management of acute medical and surgical emergencies and is the emergency centre for the community, including the place of safety for mental health

emergencies. It is characterised by more advanced levels of diagnostic services than a community hospital and will provide a range of outpatient, day case and inpatient and rehabilitation services”.

The Balfour Hospital is a RGH; it is the only hospital in Orkney. It supports the delivery of a range of emergency and elective Medical, Surgical, Anaesthetic, Obstetric, Diagnostic, and Nursing, Midwifery and AHP services on an inpatient, outpatient or day attendance basis.

The staff we need to support care delivery from our RGH are very different to Mainland NHS Boards. Our population size means that our critical mass is small and yet the range of clinical presentations like other health and care systems will be varied in numbers and complexity. We therefore need clinical staff that are skillful generalists who can work remotely and know when to seek virtual specialist support to inform clinical decision making. This distinction is very important as we care for patients of all ages including neonatal and their clinical presentations which can range from minor to life threatening.

Currently NHS Orkney's emergency services (i.e. Emergency Department (ED), Minor Injuries and the GP OOH) operate separately. All referrals including GP referrals (except for Macmillan and maternity) go through the ED. The new build will offer integrated care with patients redirected to out of hours and minor injury services within primary care to enable the Emergency Care Centre (includes ED, SAS and GP OOH) to deal with urgent acute and life threatening emergencies when required.

Short stay capacity is also provided within the existing ED through the use of pop up beds however these are being replaced as part of the transition to the new build as we begin to operate in line with the planned mode of care i.e. two assessment beds aligned to the Inpatient Unit.

Inpatient care is currently provided within a care environment that is no longer fit for purpose and whilst we have and will continue to invest in our facilities to ensure the care we provide is person centred and safe we acknowledge the limitations of our current facility and the impact this has on 'flow', staffing requirements and backlog maintenance and costs to run the hospital.

We recognise the pressures that will be created from a rising number of older people living with co-morbidities. Our Board will remain responsible for service delivery for functions delegated to OHAC. The Board's ability to respond to strategic commissioning priorities is based upon the premis of investment in prevention and early intervention and a re-ablement model of care.

We will continue to work and further enhance our partnership working with Social Services and the Third Sector to further develop rapid response services that support older people to keep well and stay well at home whenever possible. When admission is required, our aim is to minimise the length of stay as it is recognised that this leads to less functional decline in older patients. There is scope to reduce our length of stay, e.g. in elective workload as demonstrated by

our admission on day of surgery data and in our zero based activity bed usage. For example, we know that older people are often admitted to hospital due to lack of adequate alternative services in the community.

Analysis of our delayed discharges data has shown that the main reasons for delay are the lack of availability of home care or a care home place as reported nationally. OIC have plans in place to support the development of additional care home capacity and increase the availability of home care services in line with national benchmarking data to meet an increasing social care demand across the Island. This timely and needed investment will contribute to both a reduction in avoidable admissions and the facilitation of timely discharge from hospital. The further development of multidisciplinary and multiagency teams across primary and secondary care, working together to bridge the gap, will ensure that the patient's journey is safe and effective.

At the time of writing the OBC all theatre services were being delivered from the single theatre within the Balfour Hospital. As part of transition planning a reconfiguration of existing hospital space was undertaken to provide additional capacity in the form of a multi-purpose room. This small facility is being used for a range of clinical procedures and/or services including endoscopies and chronic pain treatments. This has increased the availability of theatre time to support new services notably gynaecology.

We now have better alignment between the existing configuration and the model planned for the new build, however, our emergency theatre response capability remains impeded by the current model and limited space within the Balfour Hospital.

During the planning for theatres, endoscopy & day surgery services a wide range of factors were identified that impact on future requirements. These include but are not restricted to:

- The impact of the Bowel Screening Programme increasing demand for colonoscopy
- The impact of Joint Advisory Group (JAG) recommendations regarding endoscopy and the restrictions currently in meeting JAG standards as a consequence of our current site configuration
- Decontamination Guidelines and the need for improved decontamination areas
- Changes to waiting time standards and targets and the anticipated increase in planned surgery as the population ages
- Increasing day case activity
- Changes / developments in technology and clinical practice to support safe and effective repatriation
- Further development of enhanced recovery processes after surgery
- Realistic medicine and the need to tackle harmful variation
- Central Decontamination Unit (CDU) services remaining on the existing site.

Inpatient services at the Balfour Hospital are currently delivered from five locations:

- High Dependency Unit (HDU) (two beds with the ability to flex to three beds to accommodate resuscitation and transfer)
- Acute Ward – 15 beds for medical and surgical patients with the ability to flex to 17 beds
- Macmillan Unit – four beds
- Assessment and Rehabilitation Ward – 19 beds plus one mental health transfer bed
- Maternity – previously six beds but reduced to four in early 2016

Currently, our HDU location is limited in terms of adjacencies to support collaborative working arrangements and flexible use of staff across the breadth of our acute ward and HDU facility. Existing practice sees a range of patients cared for within HDU and although the purpose of the Unit is to care for Level two patients there is at times a requirement to admit, resuscitate and stabilise Level three patients until they are either suitable to remain in as a Level two patient in Orkney or are transferred to an Intensive Care Unit (ICU) facility in a mainland NHS Board.

On occasions where retrieval cannot be undertaken for Level three patients their ongoing care needs are met within the HDU, supported by 1 to 1 patient to nurse ratios with care led by the Consultant Anaesthetist in collaboration with the receiving clinician. As part of transition planning, work is underway to reconfigure our services in a way which will enable the utilisation of HDU staff as part of an integrated acute facility. Our current facility has small separate designated inpatient areas all of which need individually staffed and so this reduces our ability to utilise staff skills and numbers cost effectively. The future model of inpatient care supported by adjacencies in the new build will allow the pooling of staff, mainly nursing expertise, across larger units and enhance our ability to use staff more efficiently and effectively.

Failure to invest in a new RGH will lead to an inability to:

- Accommodate new models of care and to have a flexible approach to bed usage which are capable of responding to the anticipated needs of the population in the longer term
- Provide person centred care that supports and respects improvements in privacy and dignity for our patients and to meet requirements as described by Older People in Acute Hospital (OPAH) and those associated with infection control standards. (The increase in the number of single ensuite inpatient rooms will meet legislation requirements as well as offer greater flexibility to how we use beds to meet future demand)
- Address the current estate issues including:

- general poor physical condition of the building and engineering services which are at the end of their useful life
- fragmentation of clinical services due to less than optimal adjacencies
- improve the functional suitability of accommodation
- fully comply with the Equalities Act
- improve space utilisation
- improve the quality and ambience of the physical environment
- provide improved and more appropriate room sizes for clinical services in line with current and pending future Scottish Hospital Building Note (SHBN) guidance
- improve energy efficiency
- address back log maintenance costs for a significant part of our estate.

The proposed scope of services contained in this FBC is for the provision of a new hospital and healthcare facility in Orkney, which by definition incorporates all of the services currently being provided in the Balfour Hospital as well as elements of service provision currently provided for within other parts of the estate e.g. Primary and Community Care and Public Dental Services. In addition the SAS and NHS 24 services will be located within the new build.

The foregoing paragraphs demonstrate the profound pressures facing NHS Orkney attributed to our unsuitable current facilities which obstruct the way of supporting in full the introduction of new ways of working. In common with the rest of Scotland we face financial pressures, increased service user expectations and changes in demand as a result of demographic changes. These can only be addressed by the provision of a new RGH and supporting community facilities, reinforced by new commissioned services and organisational change that supports us, with key partners, to deliver island proofed integrated models of care and services.

1.3 FUTURE HEALTH SERVICES

1.3.1 Introduction

The purpose of this section is to describe the proposed new models of care and to highlight any further developments and changes since the original investment proposal was put forward.

There has been no significant change in planned models since the OBC was approved in June 2014. We, in collaboration with key community planning partners, continue to support a truly holistic model of care that treats our patients as a whole person. The model relies on team based care to provide the best possible treatment at the lowest cost.

The proposed models of care and the results of the capacity modeling have been revalidated since the OBC.

The development of a new build is a component in the range of changes that need to be made to the provision of our health and care services in Orkney. The introduction of new models of care across primary, community and hospital services is integral to health and care solutions that in turn meet a change in demand driven in the main by increased long term conditions, many of which are caused by life style choices that contribute to poor health.

1.3.2 Proposed model of care

This FBC takes account of the need to invest in prevention, early intervention and re-ablement services closer to home which in an Island context adds a layer of complexity. The FBC also recognises that the new build is a key element of delivering our vision for transformational change and new models of care that help to support a re-provision of how we support greater preventative and ambulatory care to enable people to live, to keep well and stay well in the community. Where a hospital stay is required, we ensure that it is for as short a period as safely and appropriately possible with a focus on the timely return of the patient back home or to a community setting.

Key areas for redesign have been identified and include:

- ambulatory care including primary care
- emergency care
- care of older people including rehabilitation and re-ablement
- theatres / day surgery
- acute care including high dependency care.

1.3.3 Ambulatory Care

Ambulatory care services provide care on an outpatient basis including diagnosis, observations, consultations treatments and interventions and rehabilitation. Our new build design has taken account of same day care principles and the need for greater provision to support repatriation and/or changes in future developments in care/treatment for conditions that may be treated without the need for an overnight stay in hospital.

1.3.4 Outpatients

A review of outpatient (OP) activity to build on data provided at OBC stage shows that OP activity has generally increased with particular growth in non-consultant led attendance, notably in nurse and AHP led care. This supports our direction of travel and is the anticipated trend going forwards as we introduce new models of care which better balance capacity and demand (e.g. General Practitioner with Special Interest in Dermatology is being established to review dermatology patients from 2017). Similar GP led care is being tested with other specialties. AHP and nurse led clinics will increase as will remote video conference medically led consultations supported by nurse/AHPs.

Table 1 below- shows how the profile of OP provision has changed over the preceding 6 year period.

Table 1 Consultant Led Outpatient Attendances – Balfour Hospital (2010 to 2015)

Year	New	Return	Grand Total
2010	3565	6575	10140
2011	3593	6651	10244
2012	3565	6640	10205
2013	3421	7252	10673
2014	4430	8026	12456
2015	4074	7912	11986

Source 2010 - 2014 data from Topas 2015 data from Topas and TrakCare

Table 2 Non - Consultant Led Outpatient Care Led by Other Professionals e.g. Nursing, Allied Health Professionals (AHPs) Attendances (2014 to 2015)

Year	New	Return	Grand Total
2014	3479	10661	14140
2015	4366	13235	17601

Source 2014 data from Topas 2015 data from Topas and TrakCare

Having an onsite CT scanning service has also resulted in us being able to repatriate patients requiring CT scans as well as patients with transient ischaemic attacks (TIA) or stroke. There were 771 CT scans carried out in Orkney in 2015. Additionally, there were 83 admissions for stroke/TIA patients in 2014 and 73 in 2015.

In regards to waiting times performance, NHS Orkney has continued to perform well against national standards as can be seen in Table 3 although performance in regards to the outpatients 12 week standard continued to be challenging. This is generally specific to two specialties – Ophthalmology and Orthopaedics which are both priorities for action, with new service models being explored, aligned to the developing regional strategy for elective services.

N.B - It should be noted that small numbers of patients can impact significantly on statistical information and presentation of data – for example the variation in the 62 day cancer standard (Oct 2014) is due to one of the two patients breaching resulting in a 50% compliance rate.

Table 3 Performance Against National Targets/Standards

	Outpatients 12 week wait	*TTG 12 week	*RTT 18 week combined	Diagnostic 6 week wait	A&E 4 hr wait	Cancer 62 days	Cancer 31 days
National standard	95%	100%	90%	100%	95%	95%	95%
Jan-14	97%	100%	95%	100%	97%	100%	100%
Feb-14	89%	100%	93%	100%	99%	100%	100%
Mar-14	93%	100%	97%	100%	99%	100%	100%
Apr-14	97%	100%	96%	94%	99%	100%	100%
May-14	90%	100%	95%	100%	98%	100%	100%
Jun-14	87%	100%	94%	99%	98%	100%	100%
Jul-14	78%	100%	95%	100%	99%	100%	100%
Aug-14	77%	100%	94%	100%	99%	100%	100%
Sep-14	84%	100%	90%	99%	99%	90%	100%
Oct-14	87%	98%	93%	99%	99%	50%	100%
Nov-14	81%	100%	94%	100%	99%	50%	100%
Dec-14	84%	100%	98%	100%	99%	50%	100%
Jan-15	80%	97%	89%	93%	99%	100%	100%
Feb-15	72%	92%	82%	96%	97%	100%	100%
Mar-15	83%	97%	90%	100%	99%	100%	100%
Apr-15	92%	94%	93%	94%	98%	100%	100%
May-15	79%	98%	89%	100%	98%	100%	100%
Jun-15	100%	97%	98%	85%	99%	100%	100%

Source ISD Published Information

*TTG – Treatment Time Guarantee

*RTT – Referral to Treatment

1.3.5 Primary care

The new facility will accommodate two Kirkwall GP practices; Skerryvore and Heilendi, the Public Dental Service and community led nurse and AHP services, within a dedicated area in the new build, so reducing the number of premises that we have to maintain and support. The co-location opportunities for primary, community and hospital services to work better together to inform unscheduled care planning and service delivery is something we will explore and using improvement methodologies, test as a series of small tests of change.

1.3.6 Emergency care

Our new emergency care model will continue to save people's lives and help people recover from injury or illness using the best clinical expertise and technologies. Our new build provides an opportunity to further improve the way we deliver care internally between our specialties/departments and externally by improving the links between the hospital, primary and community care, including

SAS, NHS 24, GP OOH and social care services. The traditional divide between these organisations and services can be a barrier to how we respond to and coordinate the care our patients need.

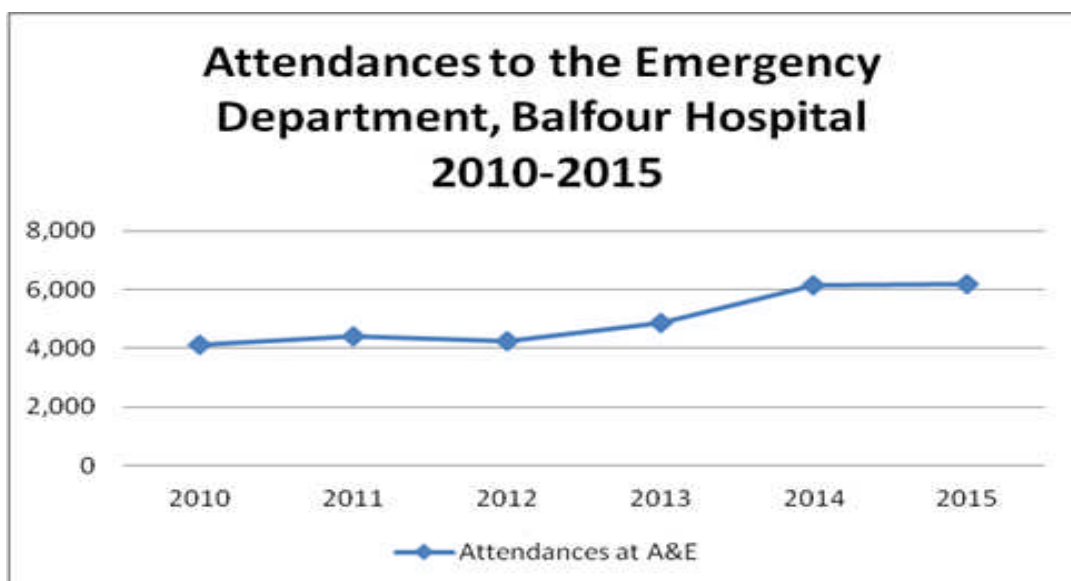
It is our intention in working with partners to dissolve these traditional boundaries and strengthen our networks of care especially in out of hospital services. Better integration and communication between these services can reduce unnecessary attendances at ED and enable people in hospital to return home sooner. This work is underway as part of our Local Unscheduled Care Action Plan and will continue to ensure a level of preparedness in advance of moving into the new build.

In this regard the new build will create a cohesive Emergency Care Centre (ECC) that operates as a “front and back door facility”, with a focus on “assess to admit” rather than “admit to assess”.

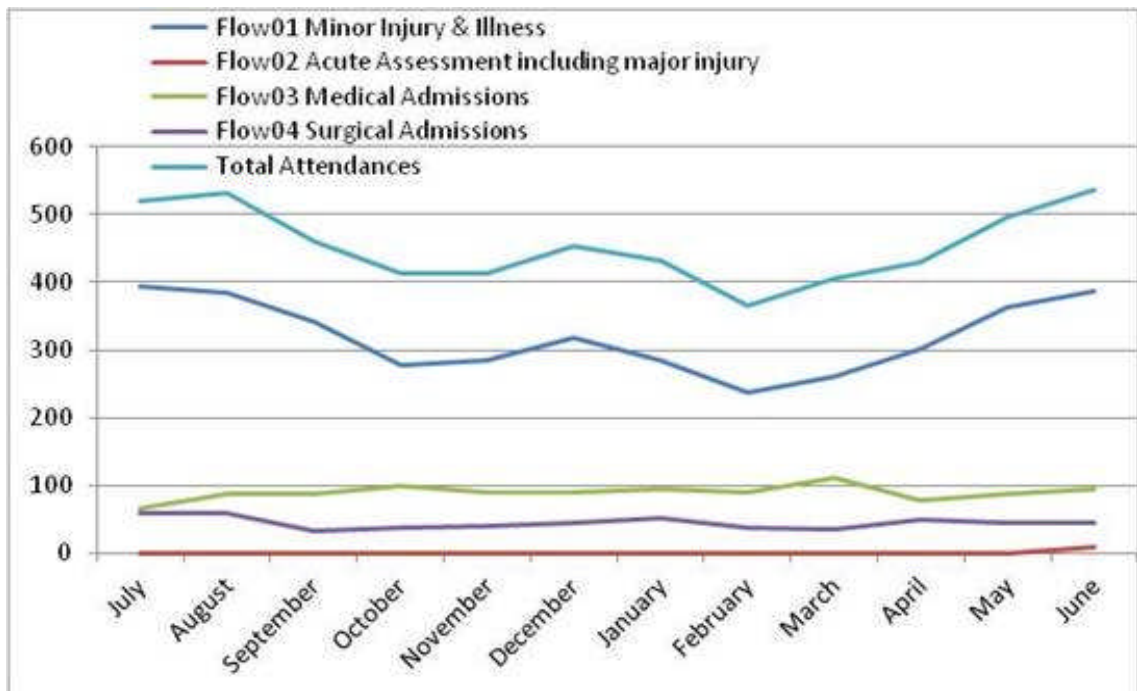
There will be increased access to the consultant of the week by specialty to provide decision making support for GPs and community care professionals and where appropriate rapid access to diagnostics. Therefore, it is anticipated that there will be a reduction in presentations to the ED with those presenting being more likely to require admission to hospital. Over the last five years (2010 to 2015) we continue to see an increase in attendances with the majority of presentations being minor injuries and illnesses. If these presentations were to be redirected to an unscheduled care provision both in and out of hours the overall presentations would reduce, however given our small numbers the impact, patient benefit and cost effectiveness of redirection is questionable.

Figure 1 and Figure 2 show the trends people presenting and presentations by classification.

Figure 1 Attendances to the ED for the period 2010 to 2015



Source Topas and Trakcare

Figure 2 Presentations by classification

Source Trakcare July 2015 to June 2016

An assessment/observation area will be located in the Inpatient Unit and will comprise of two single rooms. The anticipated length of stay in this area will be less than 12 hours.

The integration of the ED, GP OOH service and the SAS base will become known as the new ECC. This integration will lend itself to much more flexible team working across patient pathways and this is currently a key area of work as we prepare for the transition.

AHPs, the Intermediate Care Team and social work staff will have significant input into the ECC, to contribute to early assessment and effective discharge planning. In addition, timely intervention within the ECC from our rehabilitation and re-ablement services to offer alternatives to hospital admissions, where appropriate, is being provided now. It is our intention to further improve our ability to respond to emergency presentations, working with SAS and partners to help people stay at home with support as appropriate.

1.3.7 Inpatient unit

The key principle of our proposed model of inpatient care, through a purpose built facility with supporting adjacencies is to:

- provide maximum flexibility to enable inpatient provision to change in response to demand.

Of the 49 beds proposed for the new build, 44 beds will be able to be fully utilised to provide person centred care relevant to the needs of the individual. The only beds which will have specific purposes are the two assessment rooms, two Labour, Delivery, Recovery and Postpartum (LDRP) rooms in Maternity and the Mental Health Transfer Bed. Maternity bed numbers have been informed by obstetric activity which has remained relatively static since OBC. Revisiting this aspect of the bed modeling has confirmed that two LDRP rooms with the ability to flex to four will be sufficient. Day attendees continue to form a significant part of the Maternity Department activity and provision has been made for this to continue through the proposed day area.

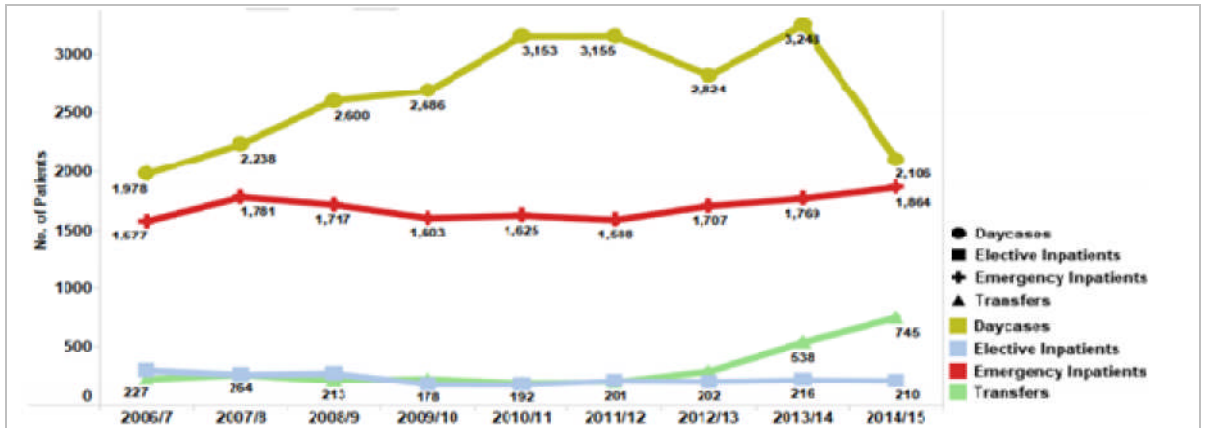
This new model of inpatient care will improve how we allocate and utilise our staff, notably nursing expertise across our inpatient facility. This will increase efficiency and productivity and better support our ability to respond to peaks in demand.

Development of an integrated rehabilitation approach which supports in-reach (hospital facing) and outreach (community facility) services for patients will also be central to our new model of care. This proposed way of working will ensure that those patients who are admitted to our inpatient facility are supported in their recovery and preparation for discharge back home or to a homely setting with access to a full range of rehabilitation and re-ablement services. This way of working will help facilitate early discharge where appropriate.

However, our average length of stay is 4.5 days (2014/2015) against a Scottish average of 4.3 days. On further review our elective and emergency data highlights that our emergency length of stay is comparable with Scotland however our elective length of stay is 8.2 days compared to NHS Shetland at 3.6 days and a Scottish average of 6 days. This provides opportunities to reduce our length of stay in our elective workload, to support repatriation of services and provide flexibility to cope with peaks in emergency demand.

Figure 3 details hospital activity for inpatient (emergency and elective admissions), day case and off island transfers for the period 2006/07 to 2014/2015. The drop in day case activity (2014/2015) is attributable to a change in classification of renal activity from day case to outpatient care, the rise in transfer is associated with improved data capture.

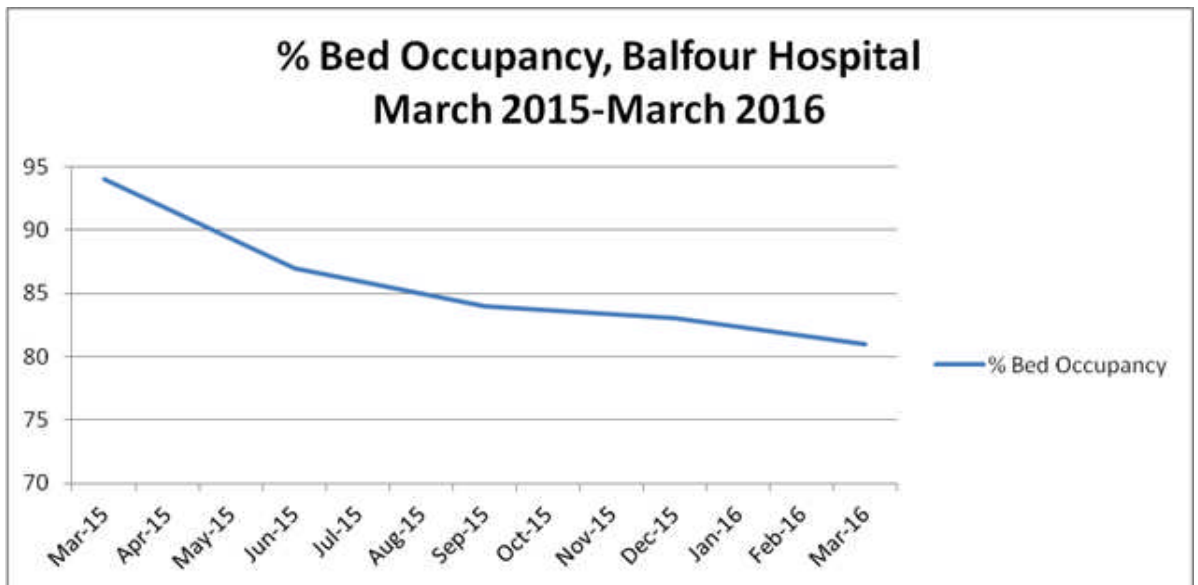
Figure 3 Hospital Emergency and Elective admissions, daycases and off island transfers



Source Topas and TrakCare

As shown in figure 4 below our bed occupancy has improved since we introduced our daily safety huddle to inform discharge planning with partners. We have also improved the capture of bed occupancy data.

Figure 4 Percentage Bed Occupancy



Source Trakcare

In addition, our Joint Strategic Needs Assessment demonstrates the opportunities to care differently for our ageing population and for those people with long term conditions and complex needs.

The Scottish Government estimates that in any given year, high resource individuals (HRI) - around 2% percent of the population account for 50% of hospital and prescribing costs and 75% of unplanned hospital bed days. In 2013/14, 2.3% or 393 people in Orkney consumed 50% of total health

expenditure and 68% of 13,924 bed days. These figures also include mental health activity and work is underway to provide enhanced support to care for and treat these patients in Orkney in a community setting.

Table 4 details the health expenditure of high resource individuals (HRI) compared to non high resource individuals.

Table 4 HRI and Non HRI Patient Numbers including those with Long Term Condition (LTC) and associated bed days, attendances and costs

Orkney 2013/14	HRI		Non HRI		All Patients
	Number	%	Number	%	
Number of Patients	393	2.3%	16,594	97.7%	16,987
Number (of above) with any LTC	331	84.2%	4,297	25.9%	4,628
Number of Bed days	13,924	67.6%	6,678	32.4%	20,602
Episodes/Attendances	29,147	8.0%	335,006	92.0%	364,153
Cost (Million £)	12.25	50.0%	12.26	50.0%	100
Cost per individual (£)	31,162	-	736	-	-

Source: ISD

On average we report three delayed discharges per day, with an average delay of three days. This means that 6% of our inpatient hospital capacity (not including maternity, pop up or mental health transfer beds) is not available for planned or emergency care on a daily basis as captured in our daily internal bed returns. Delays are in the main due to home care availability and access to a care home bed. OIC has approved investment in additional home care and care home based on Scottish/Orkney benchmark needs assessment data which will enable people to be cared for in more appropriate care settings. Table 5 shows the planned additional care home beds by Care Home and completion date.

Table 5 Care Home Bed Numbers

	St. Peter’s House / New Stromness Care Home	St. Rognvald House / New Kirkwall Care Home
Number of Beds in Current Care Facility	32	44
Number of Beds in New Care Facility	40	60
Scheduled Delivery Date	November 2018	June 2019

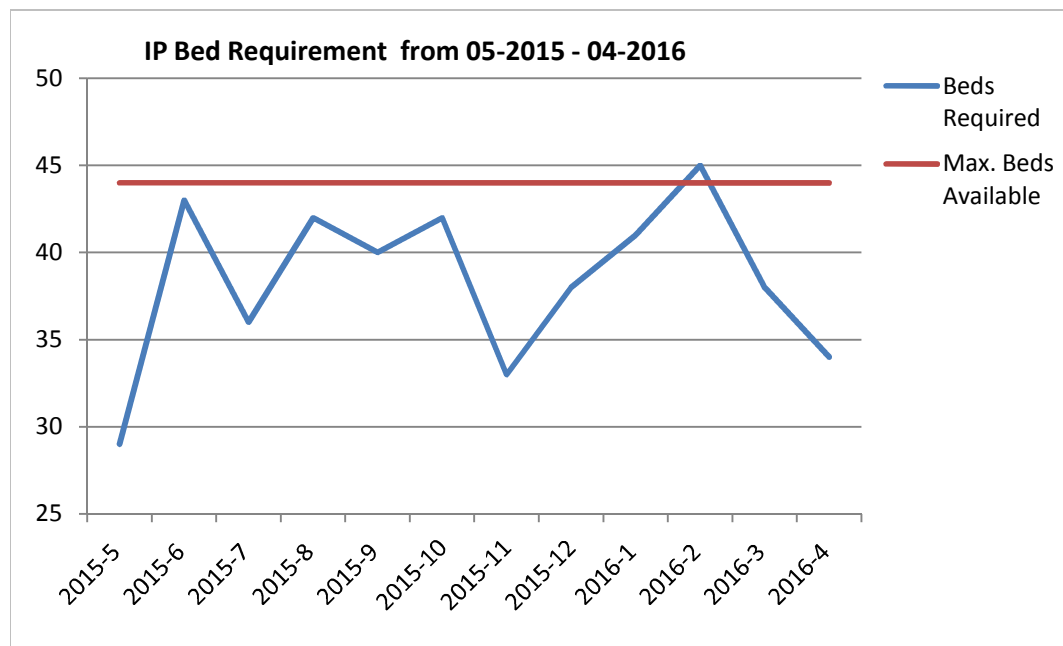
Source: Orkney Islands Council

1.3.8 Refreshed bed modeling

The full bed complement of the new build is 49 beds. Included in this total are 2 Assessment Beds, 2 LDRP Rooms and the Mental Health Transfer Bed which would not normally be available to receive general admissions. Excluding these beds from the total compliment provides a total of 44 available inpatient beds.

Admissions to the Balfour Hospital for the year 2015/16 have been mapped against this total as set out in the graph at figure 5 below. This indicates that at current activity levels and without the full implementation of the new models of care described in this section of the FBC, the inpatient bed provision of 44 would have met current demand with the exception of the month of February 2016.

Figure 5 Inpatient Beds Required – Balfour Hospital, 2015/16



Source Published SMR data

The implementation of the new models of care, which the new build will allow, coupled with the flexibility provided within the new build through single rooms will be sufficient to meet future projected demand as demonstrated in the bed model scenarios below.

ISD Scotland has undertaken a refresh of the OBC bed model to support the FBC development. The model has been enhanced to provide greater adaptability to aid scenario planning and has been updated to include a further 3 years of hospital activity data. The model provides the ability to take account of variability in regards to demographic growth, length of stay, percentage occupancy and the percentage of beds utilised by patients whose discharge has been delayed.

The background formulae used within the model are included in Appendix 1 for reference purposes.

The ISD bed model refresh has informed the development of a number of scenarios which show the implications for bed requirements within the new build, projected to 2037. Six of the developed scenarios are provided in Table 6 below, demonstrating that the flexibility afforded by our new model of care will enable us to respond well to predicted increases in demand associated with demographic changes over this time period. However the impact of delayed discharges on our bed availability over time is a key constraint. The bed model scenarios indicate that our hospital system needs to operate within a margin of no more than 6% of bed days lost to delayed discharges. The investment by OIC in home care and care placements to meet anticipated social care demand will support early facilitated discharge. This in turn will have a positive impact on the number of patients delayed in hospital waiting for home care or care placement, which currently stands at an average of 6%.

Bed Model Scenarios

The bed model produced by ISD allows for a number of variables to be adjusted, to test the resilience of the proposed bed complement in the new build.

The variables applied include:-

- The data covering the admission rates used can be selected for either 1, 3 or 6 years
- Adjustment to the census predicted population changes for Orkney
- Maximum length of stay for any patient
- Number of bed days 'lost' to delayed discharges
- Maximum % occupancy (85% or 90% to reflect small system variation).

The impact of the above variables on the bed complement can be tested by the selection of one of the 4 options listed below:-

Option 1: Applies a specific average length of stay (ALOS) target for each specialty (surgical or medical) and admission type (Elective or non-elective).

Option 2: Applies a specific reduction to the average length of stay (ALOS) (based on 1, 3 or 6 year average as selected).

Option 3: Applies a cut-off point for length of stay (LOS)

Option 4: Applies a selected percentage adjustment to the available bed days 'lost' due to delayed discharges (DDs).

Table 6 below provides the projected bed requirements for 4 selected years in 6 scenarios. Each scenario projection is the product of the application of one of the above options to the variables indicated at that scenario.

Table 6 Bed Modeling Scenarios

Please note all scenarios include 6 years of data

No:	Scenario	2022	2027	2032	2037
1	No increase above population growth; 85% occupancy; Option2 - 10% reduction in ALOS	38	38	38	39
2	Additional 3% population increase; 85% occupancy; Option 3 - maximum LOS 90 days.	39	39	40	40
3	No increase above population growth; 90% occupancy; Option 2 - 10% reduction in ALOS	36	36	36	36
4	Additional 3% population increase; 90% occupancy, Option 3 -- maximum LOS 90 days.	37	37	38	38
5	No increase above population growth; 90% occupancy; Option 4 at 10% "lost" bed days due to DDs	43	44	44	44
6	Additional 3% population increase; 90% occupancy; Option 4 at 10% - "lost" bed days due to DDs	45	45	46	46

Scenarios 5 and 6 were run as stress tests to test worst case scenarios in respect of bed days “lost” to delayed discharges. Other scenarios were run to test the degree of tolerance to bed days ‘lost’ due to delayed discharges. The model indicates the system could tolerate a delayed discharge impact of no more than a 6% reduction in available bed days. This equates to approximately 3 beds.

It is generally accepted that such bed modeling techniques have limitations and figures projected beyond 15 years into the future are less reliable. It is proposed that the bed model will be revisited every three to five years to allow the projections in the FBC to be updated, using the most recent data sets available.

1.3.9 Theatres / day unit

Within the new build, all theatre services will be provided from one location, and the range of provision will increase to create resilience and additional capacity to support repatriation and service developments. The scope of provision in the new facility will be:

- Main Theatre
- Emergency Theatre
- Endoscopy / Multi-purpose Room
- Day Surgery Unit

Our main theatre will have a laminar flow facility and so we have the potential to increase orthopaedic activity which is increasing as our population grows older. Urology day case activity is another specialty with an ageing population that we would wish to consider being led by a visiting clinical team and consultant. The opportunity to offer clinical services to neighbouring NHS Boards is also something we have been testing.

Access to an emergency theatre 24/7 (also with laminar flow) addresses a significant risk and helps us with scheduling which will become more important in meeting demand and waiting times standards in future.

The additional accommodation will enable us to provide increased theatre activity and to date we have repatriated gynaecology services. The investment in the Theatre Management System OPERA has provided us with data to help inform our theatre scheduling and in turn improve our utilisation.

The creation of a multi-purpose room will enable us to move less major procedures currently performed in theatre to this facility and improve our ability to better manage emergency theatre activity.

The revised model of care will improve all surgical and associated pathways through a re-design of processes, services and accommodation. The up-skilling of staff will improve care services and contribute to improvement in overall theatre and day care performance.

This work has already commenced, to ensure the department is prepared for the transition to the new build with a focus on improving pre-assessment processes: increasing admission on day of surgery (AODOS) (currently measuring a rate of 55%) to a minimum of 95% of surgical and endoscopy admissions and improving our BADS (British Association of Day Surgery basket of procedures) day case rates to exceed the national BADS target of 87% (current performance 87% (2014/2015) compared to Scottish average of 83%).

The revised arrangements will minimise duplication of effort and resources through improved physical adjacencies. This will also support a reduction in journey times within the operating department/support areas and between these and related areas including our inpatient facility and HDU designated area.

1.3.10 Design solution

A summary of Robertson Capital Projects design solution to support the delivery of the new models of care described above is provided at Appendix 2.

1.4 WORKFORCE PLANNING

1.4.1 Introduction

This section of the FBC describes the approach taken in relation to workforce planning. Our plans match workforce requirements to the new models of care being developed and implemented as part of our transitional planning arrangements. A number of national and local drivers impact on our approach to workforce planning:

- Better Health, Better Care: Action Plan (2007)
- Delivering for Remote and Rural Healthcare (2009)
- The Healthcare Quality Strategy for NHS Scotland (2010)
- The 20:20 Vision (2011)
- Greenaway Report (2013)
- Public Bodies (Joint Working) Scotland Act 2014
- National Review of Primary Care Out of Hours Services (2015)
- Public Health Review (2015)
- The National Clinical Strategy (2016)
- Everyone Matters: 20:20 Workforce Vision
- Local Workforce Strategy and Annual Workforce Plans and Projections
- Staff Governance Standards
- I-matter
- Knowledge & Skills Framework
- Schedule Part 12 (Project Company/Robertson Capital Projects obligations as per Project Agreement)

The National Clinical Strategy provides proposals for how clinical services need to change in order to provide sustainable health and social care services fit for the future. Island Boards have unique challenges and need to think differently

about how they attract and sustain a generalist (medical) hospital workforce to support routine, urgent and life threatening clinical presentations whilst at the same time maintain/update clinical skills. Opportunities for development of regional appointments have already begun and with NHS Highland we have introduced Clinical Development Fellow roles. In addition, we are currently looking to appoint to and/or offer honorary consultant contracts with NHS Grampian and NHS Highland. These are in place for obstetric services.

We believe that Rural General Surgeons and Physicians are specialists in their own right and appropriate training and career pathways are being developed to make these posts attractive. Ongoing education, mentorship and attachments to larger units are all areas that we are or have pursued.

Similarly all healthcare professionals should have the same opportunities to access education, mentorship and attachments to bigger units an area we are pursuing. This adds an additional cost to support training costs and backfill.

In addition, we have set up joint working opportunities with other NHS Boards and other partner organisations to offer placements. A memorandum of understanding is in place with the Ministry of Defence to qualified staff and students.

Other significant factors which will shape the workforce in the future include a number of specific regulatory and policy drivers such as Working Time Regulations.

The 2015 Review of Public Health in Scotland also highlighted the need for planned development of the public health workforce and a structured approach to using the wider workforce in delivery of the public health function. There are implications for the workforce locally as we engage in the “once for Scotland” shared services agenda and it will be important to safeguard local versus regional and/or national opportunities to improve the health and wellbeing of our local population.

Our local demographics demonstrate that by 2035 the projected population will be 21,479. The working age population (16-64) will reduce by 0.7% between 2010 and 2035. Both NHS Orkney and the OIC, as the two largest employers in the county, will be competing for staff with specific generic skills to support health and care in Orkney. This makes health and social care integrated workforce planning even more important. In this regard we wish to be seen as an employer of choice by ensuring we invest in achieving a positive experience for all our staff.

NHS Orkney has made significant progress in embedding the values of the NHS into “our promise” to our staff. In practice we are using iMatter to improve engagement and how we work together to deliver high quality care and services.

1.4.2 Developing the workforce plan

The overall vision for the workforce is to ensure the right staff are available in the right place with the right skills and competences to deliver high quality care and services. Future workforce models will be based on the clinical models described in section 1.3. The revenue costs of these models are outlined within the Financial Case at section 4.3.

We will continue to use the Workforce Planning process (6 Steps Methodology) to encourage services to look at how efficiently and effectively we are using our workforce. This process encourages services to identify opportunities for working differently and ensures that work and tasks are appropriately assigned to those best placed to carry out that work.

Workforce development will be a crucial element in delivering new models of care and ensuring a safe, skilled and effective workforce. Work has begun on the development of integrated team working. Work has already been undertaken to identify the learning and development needs of staff in relation to the new models of care.

A greater use of ICT including telemedicine and telecare is required to support new models of care as we look to provide care closer to peoples home.

Our ability to support a workforce that can provide care across our health and care system using an out and in reach model will become more important as we look to work across traditional boundaries.

In developing our workforce we are mindful that our patient, staff, systems, individual behaviours and partnership based approaches impact on each of us and in the care and services that we provide. Professional training and remote and rural specific education is being increased and we are looking at innovative ways of maintaining and updating required skills.

1.4.3 Nursing and midwifery

NHS Orkney has continued to make use of a range of the Workforce Planning Tools, using the Adult Inpatient and Small Wards tools, which have been triangulated with the Professional Judgement Tool and key quality indicators such as complaints, patient experience, falls and other contexts such as sickness absence and use of bank staff. We have tested a run of the Community Nursing Benchmarking Tool in one of our localities. In 2016/17 we need to support the rest of our nursing teams to make use of other tools as they become available.

In order to provide further scrutiny to the workforce tool findings we intend to continue to support Senior Charge Nurses in reviewing rotas, taking into consideration activity and dependency levels and ensuring safe staffing levels are in place across the 24 hour period.

Reconfiguration in our current facility has enabled some tests of change in workforce development and new ways of working. The new build will have an additional theatre and a multi-purpose room which will require some additional theatre/day unit staffing as determined in the OBC. A workforce model that considers activity and skill mix for the new build is well progressed, supported by a training needs analysis to inform our development programme.

The workforce change plan is supported by an extensive organisational development change programme to ensure staff, including generic and healthcare assistant roles are developed to work within our emerging models of care. Other key benefits from this plan are:

- The development of a new competency framework from which we will carry out a training needs analysis to inform our staff development programme as part of our transition planning
- The creation of a pool of nursing staff to ensure rapid response to short term/short notice absence
- The creation of a “mock up” single room to enable multi disciplinary training in anticipation of new ways of working in the new build
- Recognising the complexities of multiple long term conditions, NHS Orkney is committed to developing a multidisciplinary, multispecialty team approach to all patient care and the development of hybrid roles.

Future developments will necessitate a greater input into community services from a multidisciplinary/multi-agency perspective. Additional training in specific skills has already been given to community staff with investment in developing our health visiting and school nurse workforce.

1.4.4 Allied health professionals including healthcare scientists

AHP services will be developed to fully support the emerging models of care. Radiology, laboratory and physiotherapy staff currently provide on call support in the out of hours period and weekends. The Intermediate Care Team currently support services on a seven day per week basis and this will continue in the hospital (as required) and community. Further alignment using existing resources, across primary and secondary care will enable us to meet future need. Flexible integrated working between primary and secondary care will allow efficiencies and improved patient care and help us work across traditional boundaries.

The impact of the increasing older population will be significant and AHP interventions will play a key role in helping people be independent in their own homes or a homely setting. Complexity of case loads will require different approaches as we look to help people improve long term conditions associated with life styles. Re-ablement models will become even more important in supporting self-care and management to help people keep well and stay well in their own homes and communities

1.4.5 Medical workforce for new hospital

Medical staffing remains a challenging issue for us in NHS Orkney. We have struggled to recruit and retain both at consultant and non-consultant levels however we have taken an innovative approach to build a pool of regular part time staff across the consultant specialties to fill our current vacancies.

We also remain committed to providing education and training to medical students and have invested, through a Service Level Agreement (SLA) with NHS Highland, in a Director of Medical Education. Our work to date on developing our “brand” to encourage elective and student placements has proved to be extremely successful, which has resulted in doctors in training returning to work in Orkney and as with consultants we have a well developed pool of regular non-consultants for our rota.

Our Chief Executive is playing a key role in leading the development of a Regional Clinical Strategy for the North, with a particular focus on the development of a set of principles around collaborative working. This is being aligned with the recently published National Clinical Strategy to deliver care closer to home wherever possible whilst acknowledging the need for specialist centres supported by elective and/or ambulatory care centres of excellence.

1.4.6 Support services

Soft FM covers patient catering, restaurant for staff and general public, domestic services, laundry, portering, waste, grounds maintenance, medical physics, security, fire, stores, health & safety and switchboard. Soft FM services are carried out currently in a “fit for purpose manner” however going forward into the new build considerable change will be necessary. Using as a template Schedule Part 12 (Standard Form Contract) Service Level Specification, we have mapped the FM Project Co responsibilities and those which will remain the responsibility of NHS Orkney. There are also specific aspects of FM services which will be within the remit of both organizations which will be detailed in a responsibility matrix.

In addition new ways of working will be required as a result of the transition to the new building. The new accommodation will consist of single rooms and a near doubling of the square metres of areas to be cleaned and maintained, including two GP Practices and SAS. The OBC allowed for additional domestics and this has been confirmed in the FBC process.

While all Soft FM services, in line with policy, will be retained by the Board of NHS Orkney, there is an expectation that the services will be operated in the most efficient way possible, maximising all possible recourses.

We have worked closely with the local facility of University of the Highlands & Islands (UHI) and with the support of National Education Scotland (NES) to develop a new generic healthcare support worker SVQ programme to work across the soft FM services. Running parallel to this has been our Modern

Apprenticeship programme which to date has been very successful.

Building Maintenance and other hard FM duties are presently part of the remit of the Estates Team and includes various mandatory and statutory duties. As part of an NPD procured new build, hard FM services for the building will be transferred to Project Co under the terms of Schedule Part 12 of the standard contract. The Board will retain its responsibilities for the remainder of its estates, therefore there will be no TUPE of any estates staff to Project Co. The reprofiling of the soft FM workload will include increased grounds maintenance, an enhanced medical physics resource and increased liaison with the Project Co hard FM team.

1.4.7 Administration

The adjacencies and accommodation in the new build will provide enhanced opportunities for our already versatile administration teams to adopt new ways of working which will provide increased support to their teams. The reception desks are positioned so the staff can work together and provide increased cover to the clinical areas from a more central base. There are self check in facilities as well as the more traditional reception desk in the main atrium, supporting patients to use technology to manage their pathway to a certain extent whilst also releasing administrative time for staff to concentrate on other duties.

Open-plan office accommodation, with a mix of fixed desks and “hot-desks”, will be provided for administration, support, clinical and executive staff who require to be located on-site. A number of these staff will be required to “share” workstations and this will be supported by the ICT infrastructure making best use of technology available to us. Flexible working arrangements will be considered in relation to agile working opportunities and this will be explored to support our business service models.

Paper-lite working and effective use of technology will enable staff to access their documentation and files irrespective of where they are working and to move freely between locations.

The new build allows for a generous provision of confidential meeting spaces, for 1:1 meetings and larger meeting rooms, in addition to well equipped learning and education facilities.

1.4.8 Management of workforce change

Our objective is to ensure a competent workforce is in place, with effective managers and leaders to deliver the service for tomorrow. There are a number of important elements that will support us to achieve the transition into the new build. These include:

- Human Resource Policy and Guidance
- Workforce Planning and Development
- Organisational Development.

1.5 Human resource policy and guidance

Everyone Matters sets out clearly our five Strategic Workforce priorities, this includes our vision for the workforce as we move towards our new build. In moving forward through the various stages of this process, it will be essential to ensure compliance with the Staff Governance Standards (4th Edition) issued in July 2012, detailed below:

- Well informed
- Appropriately trained and developed
- Involved in decisions
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

These standards provide staff with a responsibility to:

- Keep themselves up to date with developments relevant to their job within the organisation
- Commit to continuous personal and professional development
- Adherence to the standards set by their regulator bodies
- Actively participate in discussions on issues that affect them either directly or indirectly or via their trade union / professional organisation
- Treat all staff and patients with dignity and respect while valuing diversity
- Ensure that their actions maintain and promote the health and safety and wellbeing of all staff, patients and carers.

Staff are supportive of the new build development and have signed off the outline specifications for their respective areas. They have been kept fully informed with progress at key milestone stages throughout the project.

We have reviewed our Communication and Engagement Strategy. The Chief Executive, supported by the Head of Organisational Development and Learning is responsible for its implementation. This has been supported by a multi-disciplinary Communication and Engagement Group, and a specific project sub group, which is currently developing a “key milestone” communication plan for the project.

We remain committed to partnership working and staff side colleagues are fully involved in this project. The employee director is a member of PIB and the Chief Executive provides regular updates to the Area Partnership Forum.

1.6 Workforce development plans

We are working in partnership with staff side colleagues to develop comprehensive workforce plans which are informed by the model of care or services. There is no additional investments to the workforce other than those previously costed within the OBC and our ongoing delivery plans.

Training plans will be developed to support staff in preparation for the move to the new build.

1.7 Organisational development (OD) support

We have invested in an Organisational Development and Learning Team who are responsible for contributing to the development and delivery of our significant change programme to support individual cultural organisational change.

Annual development reviews, will provide the framework for individual discussions around career development and planning. The associated learning and development activity required to achieve personal and professional career goals will be identified.

1.8 BUSINESS CASE OBJECTIVE AND SCOPE

1.8.1 Introduction

The purpose of this section is to summarise the case for change and the associated key investment objectives.

There has been no significant change to the scope of the project since the OBC was approved in July 2014. The scope remains the reshaping of health services through the development of a new RGH and healthcare facility.

1.8.2 Key investment objectives

The investment objectives originally identified in the OBC are reaffirmed and further developed for the FBC.

Table 7 Key Investment Objectives

Ref	OBC – Key Investment Objectives	Further development during the FBC process
1	To improve capacity and access to healthcare services – ensuring the	Provision of high quality clinical services for patients that is timely, accessible and available in care settings that are

Ref	OBC – Key Investment Objectives	Further development during the FBC process
	health needs of the population are met	<p>appropriate to patient needs. Build on the availability of and use of technology to support access, service delivery and communication for patients their families and carers and between secondary and primary and community care and the Third Sector, including in remote settings. The eHealth Strategy will facilitate the required transformational change by the delivery of ICT systems which will enhance electronic processing, storage and access for clinical and other information, including the digitisation of clinical records. Establish services and facilities which can respond flexibly to internal and external changes.</p>
2	<p>To provide facilities/services that are Fit for purpose Support safe and effective clinical working Improve clinical and functional relationships Enable the provision of modern NHS care Provide sufficient flexibility for future changes to service provision</p>	<p>Robertson Capital Projects design for the new build provides:- High quality public external and internal spaces. Logical progression from public space to private clinical environments. The provision of single ensuite inpatient rooms. Ability to flex bed availability so that staff follow the patient rather than patients being moved to meet staffing or other requirements. Identified “soft” expansion areas that require limited adjustment to provide future clinical space, plus identified “hard” expansion zones to provide additional building footprint, if required.</p>
3	<p>To ensure that the hospital and services are developed in such a way as to maximise performance and efficiency</p>	<p>The developing service models support closer integration of care delivery and improved communication between clinical teams both within Orkney and with our partner NHS providers in NHS Grampian, Highlands and elsewhere. Integrated care pathways are being</p>

Ref	OBC – Key Investment Objectives	Further development during the FBC process
		<p>developed to reduce, as far as is possible, the need for patients to travel outwith Orkney for the majority of routine care.</p> <p>The new build has been designed to provide a high quality, energy efficient building. The primary energy source for the new building will be electricity, backed up by diesel generators to provide resilience, and as such carbon emissions will be minimised.</p>
4	Maximise benefits of shared facilities	<p>Location of our two Kirkwall GP practices and the Public Dental Service within the new build. This will reduce expenditure on maintaining buildings that are becoming increasingly unfit for purpose, as well as aiding communication and supporting the patient journey.</p> <p>A central SAS base, GP OOH facilities and NHS 24 will be located adjacent to the ED in the new build design. This proximity will increase the opportunity for cross agency working.</p> <p>Opportunities to share facilities such as general rehabilitation and AHP therapy areas and staff rest and changing areas have been maximised within the building design.</p>
5	Enable innovative ways of working	<p>A major innovation is the ability to flex bed availability in inpatients so that staff can follow the patient rather than patients being moved to meet staffing or other requirements. A further innovation is the introduction of an open plan shared working space within the clinical support area of the building. This will allow for the co-location of a variety of hospital and community care teams who will often be providing care or services to the same patient or group of patients. This co-location will, for example encourage and enhance the sharing of information to</p>

Ref	OBC – Key Investment Objectives	Further development during the FBC process
		<p>support care and service delivery across and between teams.</p> <p>Other innovation opportunities include:-</p> <p>The use of technology to support communication with and for patients in remote locations to reduce the requirement to travel to the Orkney Mainland.</p> <p>Development of virtual clinics for appropriate specialties to reduce travel to mainland Scotland.</p>
6	<p>Develop a feasible solution within acceptable limits of overall costs having regard to cost and time taken to acquire and develop NHS premises</p>	<p>The development is value for money and affordable both in terms of capital as confirmed with Scottish Government Health Finance and in revenue terms in respect of our Board’s Five Year Financial Plan. The new build will replace the current Balfour Hospital, support services areas, Kirkwall based GP and community practices and the Public Dental Service, all of which are currently provided from ageing and poorly performing estate which is costly to maintain. In addition the new build enables NHS Orkney to relocate a number of other services notably its headquarters on the new site so reducing rental expenditure.</p>

1.8.3 Summary of existing arrangements

The issues with the existing Balfour Hospital and associated primary care estate were fully explored in the OBC. The following represents a summary of the key issues.

During the course of its 90 year lifespan, the Balfour Hospital’s fabric and infrastructure have been subjected to many changes, including built extensions, reconfigurations and refurbishments, as well as sustained use. Physical condition surveys have led to the conclusion that the hospital is no longer fit for purpose and would not support delivery of the models of care and the degree of integration and flexibility we require to continue to deliver person centred, safe, effective and efficient services in the future.

Since the completion of the OBC a number of projects have been undertaken within the Balfour hospital in order to provide environments within which new models of care can be implemented and embedded prior to transition to the new build. These ongoing changes have improved patient experience, enabled the Board to meet demand (outpatient and day case procedures) by increasing capacity albeit constrained on site, whilst providing more efficient services that in turn reduce operational costs. For example, we have invested in increasing the number of outpatient consultation rooms from six to thirteen whilst at the same time increased access to videoconferencing facilities. This allows us to provide a better service for our patients and prepare our staff to become familiar with working in ways more aligned to the outpatient function in the new build.

Such projects are part of a continuing transitional improvement process to support care and improve patient experience. However opportunities to make significant improvements in many areas are restricted by the condition and configuration of the current estate. While these projects can bring improvements to some individual areas and services their scope is limited and they cannot effect the whole system improvements which were identified in the OBC.

A new CT scanner was commissioned in February 2015 which has enhanced our Board's diagnostic capability and reduced the need for a range of patients to travel to Aberdeen or elsewhere for these services. In the financial year 2015/16 900 patients have received treatment or undergone a diagnostic in Orkney who would have previously travelled to other Boards (data as of February 2016).

Primary Care services have also changed over recent years with the Heilendi practice finding their building too small to deliver the comprehensive range of clinical services required of modern day primary care practices. In addition the King Street Public Dental service and NHS Orkney provides a dental service from a temporary portable building on the Balfour Hospital site with no scope to meet functional and other key requirements.

1.8.4 Physical condition

We are aware of the high and significant risk areas associated with the physical condition of our current estate, and its backlog maintenance requirements. We continue to manage this within the limited resources available. Investment in our current hospital building will only be made in works considered to be an absolute priority and / or urgent to keep the hospital functioning safely and efficiently. The strategy remains to replace the existing hospital with a new build.

The Balfour Hospital was surveyed in May 2013 with the finding that its buildings are all in Condition C, not satisfactory. The survey also found that many of the elements of the buildings' external infrastructure and engineering services are showing signs of their age and are operating beyond their expected life.

The most recent survey of our estate, which was carried out in November 2015, found no area was Condition 'D' (unacceptable) in the Balfour Hospital and this

is an improvement on previous surveys. However areas within the hospital remain recorded as Condition C (not satisfactory).

It is not possible to directly compare the 2015 survey with the one from 2013 as the methodology for conducting the survey is different. The following comparison information therefore looks at the NHS Orkney position relative to NHS Scotland.

Review of the Annual State of NHS Scotland Assets and Facilities Report (SAFR) for 2015 clearly indicates that NHS Orkney property assets are in very poor condition with 76% of our properties being in condition C or D, compared to the rest of Scotland at 35%. This is reflective of the condition of our single hospital, the Balfour.

We cannot accommodate the level of expenditure required to bring all our properties up to standard, and thus any unsatisfactory areas of the Balfour will be risk managed over the next three years as we move towards completion of the new build.

We have also invested in a new primary care facility for Eday, which replaces the poorest condition primary care facility. This project is nearing completion.

1.8.5 Functional suitability, quality of the environment and space utilisation

The OBC identified the main risk in respect of clinical service delivery on the Balfour site to be the inability to add additional theatre space on the site. This risk remains i.e. delays to emergency patients requiring urgent surgical intervention, as a result of no available theatre space; although we have provided some mitigation through the creation of a multi-purpose room.

The OBC detailed how service expansion and development over the years has impacted on service delivery. Some services have substantially outstripped the space available leaving them to operate from unsuitable facilities and/or settings which have been highlighted as unsatisfactory in a number of inspections. This is most notable in the number of temporary buildings aligned to clinical settings.

As stated the May 2013 assessment of functional suitability found that the vast majority of the Balfour Hospital site fell into either category C i.e. not satisfactory (37%) or D i.e. unsatisfactory (32%). Similarly, the Quality Assessment established that 36% of the building falls within either Category C or D.

The Annual State of NHS SAFR Report 2015 shows our functional suitability as being the second worst in NHS Scotland, with 50% of our buildings being unsatisfactory or satisfactory (Scottish average 28%).

In May 2013, in terms of space utilisation, 69% of the Balfour was classed as fully utilised and where under utilisation existed it was generally due to a lack of functional suitability of any available space.

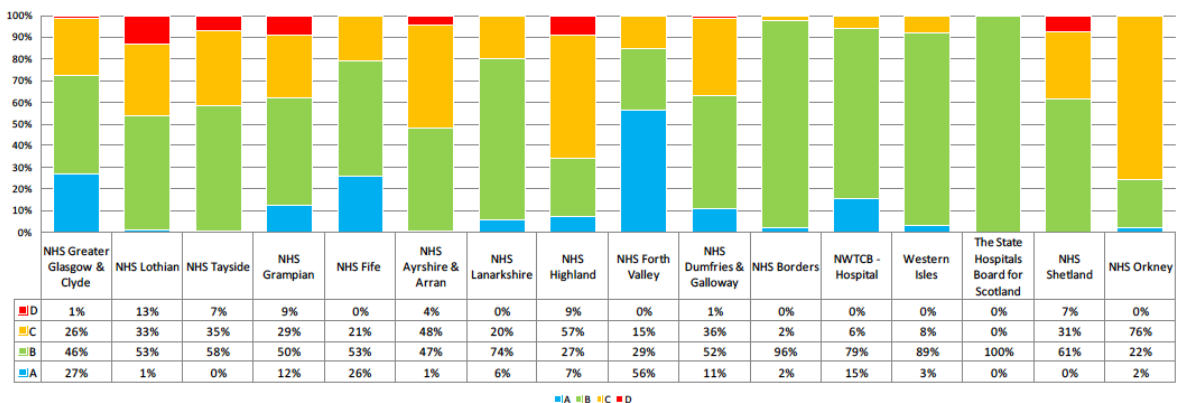
In terms of primary care facilities, the existing Heilendi building is too small to allow the practice to function in line with its service vision. Its ability to expand its range of services is impaired by a physical lack of building capacity. The Skerryvore health centre building lacks space to allow the development of the practice nursing service and does not have the physical capacity to enable us to deliver its vision for an East Primary Care Hub as outlined in our Clinical Strategy.

Table 8 2015 extract from Annual State of NHS Scotland Assets and Facilities Report 2015

	NHS Scotland	NHS Orkney
Age Profile 30 or more years old	46%	54% 5 th worst in Scotland
Physical Condition Condition C and D	35%	76% Worst in Scotland
Space Utilisation Under-utilised or empty	19%	47% 2 nd worst in Scotland
Functional suitability Condition C and D	28%	51% 2 nd worst in Scotland

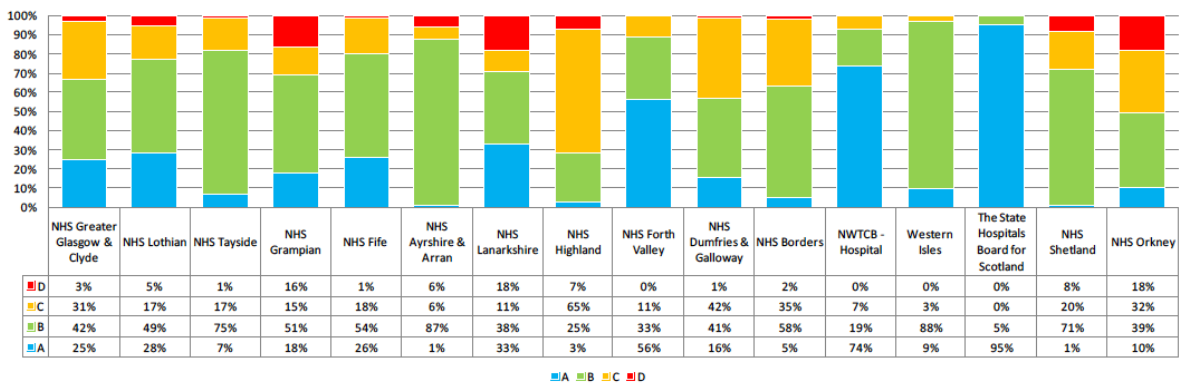
Source Annual State of NHS Scotland Assets and Facilities Report 2015

Figure 6 2015 Physical Condition Comparison - NHS Boards



Source Annual State of NHS Scotland Assets and Facilities Report 2015

Figure 7 2015 Functional Suitability Comparison - NHS Boards



Source Annual State of NHS Scotland Assets and Facilities Report 2015

Table 9 PAMS Property Condition by NHS Board 2015

NHS Board	Properties categorised as either A or B for Physical Condition	Percentage of significant and high risk backlog maintenance	Properties categorised as either A or B for Functional Suitability	Properties categorised as 'Fully Utilised' for space utilisation
NHSGreater Glasgow & Clyde	73%	58%	67%	88%
NHSLothian	54%	73%	77%	75%
NHSTayside	58%	62%	82%	84%
NHSGrampian	62%	25%	69%	90%
NHS Fife	79%	39%	80%	81%
NHSAyrshire & Arran	48%	21%	88%	69%
NHSLanarkshire	80%	29%	71%	90%
NHSHighland	34%	29%	28%	40%
NHS Forth Valley	85%	16%	89%	95%
NHSDumfries & Galloway	63%	56%	57%	47%
NHSBorders	98%	32%	63%	98%
NWTCB - Hospital	94%	3%	93%	100%
Western Isles	92%	38%	97%	96%

NHS Board	Properties categorised as either A or B for Physical Condition	Percentage of significant and high risk backlog maintenance	Properties categorised as either A or B for Functional Suitability	Properties categorised as 'Fully Utilised' for space utilisation
The State Hospital	100%	38%	100%	88%
NHSShetland	61%	64%	72%	98%
NHSOrkney	24%	20%	49%	53%
NHS Board Average 2015:	65%	45%	72%	81%

Source Annual State of NHS Scotland Assets and Facilities Report 2015

1.8.6 Fragmentation of services

The modernisation and development of clinical services has been compromised by lack of suitable adjacent space. For a number of specialties this has resulted in a fragmentation of service as additional space to support the service has been found in locations remote from their current area. This has resulted in service provision split between two locations within the hospital.

In addition clinical adjacencies are poor in many areas. For example inpatient beds are located in four different areas with pop up beds located in the Emergency Department. This results in reduced flexibility for managing peaks in capacity and a requirement to frequently move patients within the Acute Ward particularly in order to meet gender specific accommodation needs, infection control requirements and/or clinical acuity.

1.8.7 Appropriate room sizes

As stated in the OBC a significant proportion of the current estate does not meet minimum Health Building Note (HBN) guidance in terms of recommended minimum room sizes, which means in some areas clinical services are provided in cramped conditions.

The wards are all of various ages ranging from 1937 to 2000 and so do not meet current space standards. There is insufficient space for the use of lifting aids in bedrooms or bathrooms, nor are there adequate single rooms or isolation facilities. Overall there is much less support accommodation than in comparable modern wards.

1.8.8 Ensuite single inpatient rooms

The existing wards were designed with patient bedrooms either organised as four bedded rooms or large Nightingale type ward with bays varying in size. There are a total of eight single bedrooms across the Hospital (excluding

Maternity and MacMillan) resulting in significant constraints when patients require to be isolated or when end of life care is needed where a single room is required to provide the privacy and dignity expected.

The single rooms have ensuite facilities, but with no showers, and are significantly smaller than current guidance, resulting in operational difficulties. In some areas washing and toilet facilities are provided from temporary portacabins.

The inpatient bed complement has been reconfigured and adapted over recent years with additional toilet and bathing/shower facilities provided from additional portacabins which are nearing the end of their life.

1.8.9 Overview of the service benefits of providing the new facilities

The Benefits Realisation objectives and plan is more fully covered in section 5.10 of this FBC.

Investment in the new build will allow us to:

- Increase capacity to meet increasing demand and work in more efficient ways, whilst supporting the implementation of models of care for Emergency Care, Care of Older People, Theatres and Endoscopy and Critical Care
- Address privacy and dignity issues for inpatients by providing 100% single ensuite inpatient rooms
- Improve the management of Healthcare Associated infection (HAI), with the ability to isolate individual rooms and effectively segregate ward areas in the event of an infection outbreak
- Better meet the needs of the cognitively impaired
- Provide appropriate, modern primary care and dental facilities which enables the teams to meet the needs of their particular patient groups
- Address the fragmentation of clinical services
- Improve the clinical flow, by use of virtual clinical specialist support for children who require inpatient or ambulatory care services
- Improve the environment for those with sensory and/or cognitive impairment
- Fully address the issues arising from the general poor physical condition of the existing estate and engineering services which are at the end of their useful life, in particular to:
 - Fully comply with Equalities Act
 - Improve space utilisation
 - Improve the functional suitability of accommodation
 - Improve the quality and ambience of the physical environment
 - Provide improved and suitably appropriate room sizes for clinical services in line with current and pending future Scottish Health Planning Note guidance
 - Improve energy efficiency.

1.8.10 Project scope

The OBC had envisaged the provision of a separate building to house clinical support services, many of which are presently delivered from a range of properties in Kirkwall and Stromness. During the course of design development in the CD period all three bidders proposed design solutions which incorporated this accommodation within the new building, consequently Robertson Capital Projects design includes this as an element of the design solution.

1.8.11 Conclusion

The foregoing paragraphs demonstrate the pressures facing the Board of NHS Orkney including the unsuitable nature of current facilities to support and enable the new models of care that are being developed and introduced. We are facing financial pressures, increased service user expectations and challenging demographic health and social care pressures. These can only be addressed by the provision of a new build to support the new service delivery models and new ways of working required to support the current and future healthcare needs of the population of Orkney. In addition, there is a requirement for OIC to meet the social care needs now and in the future of people living longer at home or in homely community settings.

1.9 BENEFITS, RISKS, CONSTRAINTS AND DEPENDENCIES

1.9.1 Introduction

The purpose of this section is to set out the main benefits of the project and to highlight any significant risks to delivery and any constraints that could hamper delivery and dependencies.

Since the OBC, the benefits arising from the project have been further developed and will continue to be monitored and reviewed throughout the period. There are a number of risks that will be closely monitored and managed particularly in the early stages of the project.

1.9.2 Main outcomes and benefits

The Benefits Realisation Plan (BRP) included in the OBC has been reviewed in the light of the continued developments under the Transforming Clinical Services Programme to ensure the correct emphasis between the project development and the Transformation Programme. It is further discussed at Chapter 5 (section 10)

The high level outcomes and benefits the project is designed to deliver remain as stated in the OBC. These are:

- Benefits for patients and staff
- Improved patient and staff experience

- Improved staff recruitment and retention
- New ways of working and improved performance
- Service repatriations
- Locality based health and care delivery in partnership with other providers, including the Third Sector
- Improved adjacencies and environmental ambience
- Improved access and capacity.

Replacement of buildings (with significant high business continuity risks) will address:

- Overcrowding and lack of storage
- Poor accommodation and its impact on patient experience (temporary/portable buildings added to increase toilet and wash facilities in clinical areas)
- Infection control including decontamination risks
- Patient environment and site layout – austere interior and impersonal exterior, outdated space standards with poor clinical adjacencies and lacking in capacity
- Deteriorating ICT and engineering infrastructure (heating, plant etc) and the risk of business interruption
- Significant backlog maintenance
- Buildings no longer fit for purpose (care delivery) with high carbon emissions and costly to run.

Many of the issues are inter-connected, related and co-dependent. For example, issues with poor quality and dysfunctional estate impact on care delivery, models of care, clinical quality and recruitment and retention that in turn can mean costs are higher influencing sustainability and efficiency.

1.9.3 Main project risks

The new build project operates two related risk registers, the Procurement Risk Register which covers those risks directly related to the procurement process and the Operational Risk Register that deals with those risks associated with the operational phase of the project, as they are currently understood. Both registers are maintained and reviewed in parallel and both sets of risks are included in the monthly reports to the PIB. A recent internal audit of project management arrangements 2015/2016 confirmed “that NHS Orkney has robust controls in place for managing the new hospital and healthcare facility project and these are operating effectively”.

The current Project Procurement Risk Register contains 94 active risks.

The current Project Operational Risk Register contains 21 active risks.

The highest risks from both project risk registers (risk scores of 10 and above) as recorded at the time of this FBC, together with their mitigating

actions, are detailed below. The full Procurement and Operational risk registers are attached as Appendix 3.

Procurement Risk Register

The most significant procurement risks are all currently rated at high. These risks are listed in Table 10 below, in accordance with the project phase within which they have/or will impact and require to be actively managed.

Table 10 Highest Scored Procurement Risks

Risk Description	Risk Rating	Mitigation	Management Period
17 - Risk that the Project Team loses a key member of the team.	12	Succession policy developed. Record keeping and traceability of project processes kept up to date and in G drive to ensure information is not held by one individual. Fact File - reviewed on a monthly basis.	Ongoing throughout project procurement, construction and migration periods. Currently being actively managed.
110 - Risk that the FBC may not be supported by HFS/A&DS (NDAP) for approval by CiG resulting in delay and/or changes to the PB design incurring additional costs to our Board.	12	2 NDAP Panel Reviews completed and feedback shared with bidders. PB has responded to Panel feedback. Dialogue continuing with A&DS (and OIC Planners) and HFS.	Procurement to Financial Close Currently being actively managed.
107 - Risk that the Revised Timetable may slip and further delay Financial Close and start on site so compromising the project VfM position.	12	Revised timetable with 4th Oct 2016 Planning date agreed with PB. PT and Advisors working to achieve this timetable which is being kept under close review by the Project Director, Project Manager and SFT.	Procurement to Financial Close Currently being actively managed.
112 – Risk that due to the short timescale between appointment of PB and Financial Close our Board will have insufficient resource/capacity to address the range of specialist legal input required to conclude the PPA drafting and clarification of the	12	The PT confirmed with all Advisors the resource strategy, including named resources and a timetable to deliver the Draft PPA and the final PPA in the PB appointment and post PB period.	Preferred Bidder appointment to Financial Close Currently being actively managed.

Risk Description	Risk Rating	Mitigation	Management Period
principles with the PB.			
113 - Risk that due to the short timescale between appointment of PB and Fin Close our Board will have insufficient resource/capacity to manage the design review and RDD process to be completed in the period and/or staff are inappropriately diverted from day to day responsibilities.	12	Clinical and non clinical User Groups and memberships identified. PB equipment W/S took place with input from HFS and an outline programme of User Group meetings developed , in advance of PB appointment. Sufficient flexibility is built in to accommodate staff commitments and/or alternative methods of information consultation will be employed (i.e. one to one sessions) as required to achieve the programme.	Preferred Bidder appointment to Financial Close Currently being actively managed.
1b - Risk that efficiency from community based services is not achieved thus reducing the efficiency of the building.	10	IJB planning now in development phase, Project Director to maintain contact at various levels to gauge how developments supports Project objectives.	Procurement to Operational Phase Currently being actively managed.
34 - Risk of failing to provide appropriate resilience in systems to protect against critical services failure.	10	Critical services and disaster management planning to be developed by PB - requirements included in ITPD. Risk retained by Project Co re resilience of services. Paymech reflects critical areas.	Procurement to Operational Phase e Currently being actively managed.
35 - Risk that archaeological finds pre construction and post construction resulting in delay to project.	10	Site archaeological report included in data room, Project Co will not have access to identified archeological site. Preferred Bidder will carry out Top Soil Strip. Risk managed under commercial workstream via PA.	Procurement and construction phase. Currently being actively managed.
60 - Risk of failure to review and incorporate requirements of Equality Act could result in a change to requirements at a later date.	10	Arrangements underway for Equality Manager and Access Panel to input with PB as part of 1:50 programme.	Procurement to Operational Phase Currently being actively managed.

Risk Description	Risk Rating	Mitigation	Management Period
73 - Risk that Detailed Planning is not obtained as programmed.	10	PiP in place. Full Planning risk lies with PB, however NHSO remains in dialogue with OIC Planners to facilitate planning meetings with PB. Planning Process Agreement is in place. Full Planning Application submitted 04/07/16, on programme, verified by OIC Planners 08/07/16.	Preferred Bidder appointment to Financial Close Currently being actively managed.
89 - Risk that equipment costs are underestimated.	10	Group 1 and Group 2 equipment list completed and provided to PB. Detailed responsibility matrix and a range of room data sheets completed.	Procurement to Operational Phase Currently being actively managed.
108 - Risk that the delay to the Procurement Programme may result in Practical Completion of the new facilities occurring in the winter months with consequences in respect of transition and migration timetables.	12	At appointment of PB and confirmation of construction programme PT to review with clinical colleagues likely impacts and risk associated with service migration in winter months and develop mitigation programme.	Post Financial Close Period to Operational Phase.
30 - Risk that the complexity of the hospital commissioning programming results in poor transition and increased decanting costs.	10	Outline commissioning programme identified.	Post Financial Close Period to Operational Phase.
95 - Risk that insufficient time and/or budget will be identified to plan with specialist removes the decommissioning, transfer and re-commissioning of specialist equipment in the new building resulting in an extended period when these services are not available .	10	The development of a full Project Plan for the migration of patients, equipment and staff. Plan to incorporate best value options and experience from other projects.	Post Financial Close Period to Operational Phase.
32 - Risk of failing to	10	Project Co. Test failure will	Construction

Risk Description	Risk Rating	Mitigation	Management Period
obtain appropriate L8 testing for Legionella etc.		delay completion, operationally requires to be dealt with in QM and Method Statements by FM Provider - e.g. flushing regime etc.	Period
23 - Risk that construction activity will contaminate or foul the source of the water supplying Highland Park distillery.	10	All construction shall have constraining outflows from the site. No work will commence until details of containment measures are agreed with PB. Top soil strip responsibility of the PB who will risk assess the works involved and agree measures with	Construction Period
83 - Risk that revenue costs are underestimated.	12	Operational Risk Register created to capture and manage key TCS dependencies including revenue impacts on not achieving envisaged efficiencies from new models and ways of working, energy efficiency and lifecycle.	Operational Phase

Operational Risk Register

The highest operational risks are all currently rated at high. All risks on the operational risk register are reviewed on a monthly basis and are under active management.

Table 11 Highest Scored Operational Risks

Risk Description	Risk Rating	Mitigation
2 - Risk of failure to maintain services during course of service migration for example, by inappropriate phasing of service relocation.	15	<ol style="list-style-type: none"> 1. Develop detailed project plan 2. Plan all moves to ensure services continue to be provided on/off islands depending on timescales and duplication of equipment 3. IT equipment to be new to ensure no down time 4. Undertake full equipment audit to ascertain retention and new purchases and lead times for delivery 5. Identify storage requirements to assist

Risk Description	Risk Rating	Mitigation
		in transition requirements Transfer plan to be agreed in detail with services and PIB prior to migration
6 - Risk that if medical records are not adequately integrated by the time services relocate Clinicians may not have access to all of the information relating to a patient in a single record, therefore increasing clinical risk. No different from current risk.(Related to Risk No.7)	16	Scoping paper for realisation of NHSO's paper light vision reviewed at PIB and discussed at CMT. Risk escalated to Organisational Risk Register and now incorporated in Corporate Management Risk Register DMR Business Case approved by PIB July 2016.
7 - Risk that Community Care paper health records, held by each service, require the use of clinical accommodation and restrict the development of optimum clinical advances, co-locations and/or patient flows.	15	Scoping paper for realisation of NHSO's paper light vision reviewed at PIB and discussed at CMT. Risk escalated to Organisational Risk Register and now incorporated in Corporate Management Risk Register.
21 - Risk that the lack of finalised operational briefs for clinical services and non clinical services result in additional running costs.	15	Engagement with services and teams ongoing to ensure changes to ways of working are implemented prior to move to new build. Operational policies to be developed and aligned with service delivery plans and workforce planning strategy.
4 - Risk that over the lifetime of the project the development of new clinical or service delivery models render clinical design assumptions obsolete.	12	ITPD includes requirement for future expansion in new building, including "soft" expansion space internally and the ability to expand the building footprint to provide additional clinical space.
10 - Risk that during the operational phase the site may be subject to flooding resulting in disruption to service delivery.	12	In response to ITPD requirement PB design includes SUDs and related water management schemes to prevent site flooding. This formed part of the PB evaluation.
27 - Risk that failure to recognise the requirements for managing the contract with Project Co, within our Board's structure, creates operational difficulties in the management of the new facility going forward.	12	Contract management responsibilities to be included within the appropriate job description within our Board's structure.

The Project Risk Management Plan and Process is further discussed in the management case.

1.9.4 Key project constraints

The identified key project constraints are as follows

- The project must be delivered within the available capital and revenue envelope, as identified in local plans
- Project must be delivered within the parameters of the Funding Conditions (including the Construction Cost Cap) outlined in the Scottish Government OBC approval letter and subsequent correspondence
- The Preferred Bidder solution should provide sufficient flexibility and adaptability for future changes and/or increases in service requirements.

1.9.5 Project dependencies

The key project dependencies are:

- The successful implementation of the Transforming Clinical Services Programme and the component planned changes to service delivery models
- The successful implementation of the Digitised Medical Record project to support the “paper lite” environment within the new facilities
- The availability of financial resources from Scottish Government and NHS Orkney and adequate numbers of appropriately trained workforce
- Orkney Islands Council granting Project Co the required planning approvals
- The investment by OIC in home care and care placements to meet anticipated social care demand to support early facilitated discharge.

These dependencies will be carefully monitored throughout the lifetime of the project.

1.10 Conclusion

The strategic case and the case for change set out in the OBC are reconfirmed in this section of the FBC. The bed model for the new hospital has been refreshed with a further three years of clinical activity data and demonstrates that the bed numbers are sufficiently flexible to respond to predicted increases in demand in the period to 2037. The impact of delayed discharges over this period is also demonstrated by the model. OIC is committed to investment in social care and the provision of additional capacity to support the overall care requirements of the population of Orkney.

NHS Orkney has developed a robust process for managing the impact of change on staff as our Board plans and implements its transition into the new

facilities. Our Board has a comprehensive risk assessment process in place for all phases of the project and the projects Benefits Realisation Plan is kept under continual review to ensure that the benefits set out in the OBC are attained.

Within the case for change, there is a requirement to address both the national policy drivers and the local initiatives combined with a changing demography, a changing disease profile and a planned change to the models of care.

This FBC reaffirms the strong clinical service case for change and for the transformational investment in healthcare facilities within Orkney. The investment will act as a catalyst for the delivery of fundamental improvements in the way that healthcare is delivered in Orkney and this will bring major benefits to a population with significant demographic and geographic challenges.

ECONOMIC CASE

2. ECONOMIC CASE

2.1 Introduction

This section of the FBC reviews the results from the options appraisal work undertaken at OBC stage to determine if there are any material changes in the key variables which would affect the outcome.

- Options appraisal: evaluates how the options meet a range of key variables
- Economic Appraisal: identifies the Net Present Value (NPV)
- Financial Appraisal: assesses the affordability of the project
- Non Financial Appraisal: benefits arising from the project and risks
- Preferred option: taking into account economic, and non financial benefits and risks, identify the preferred option for approval at OBC.

The OBC was the culmination of a series of appraisals which led to the choice of the preferred option. It provided a robust appraisal which considered five options for reshaping care in NHS Orkney, and identified the preferred option as a replacement new build RGH on a greenfield site and re-provision of all general practice and dental services from existing Kirkwall premises.

In early 2016, responding to an increase in the anticipated tender value, and the impact of a change in classification of the project, we conducted a Value For Money (VFM) review of the procurement model. The review confirmed the benefits of continuing with a modified Non Profit Distributing (NPD) procurement model, with a funding variant.

We have not identified any material factors which provide a challenge to the OBC preferred option or procurement model.

2.1.1 OBC options appraisal

The economic evaluation follows the VFM “Supplementary Guidance for Projects in the £2.5 billion Revenue Funded Investment Programme” issued by Scottish Futures Trust (SFT) in October 2011. VFM is about achieving the ‘optimum available combination of whole lifecycle costs and quality’ (HM Treasury) to meet the user’s requirement and should not be confused with the lowest cost bid. In simple terms it is described as economy (doing things at a low price), efficiency (doing things the right way), and effectiveness (doing the right things).

The options appraisal undertaken in the OBC considered five options. All options were evaluated and a preferred option was identified. The evaluation was carried out by reference to three core elements:

- Economic appraisal (NPV)
- Non financial benefits
- Non financial risks.

Table 12 below provides further details on the options evaluated.

Table 12 OBC Options Considered

OPTION	DESCRIPTION	COMMENTS
Option 1	Do Minimum – Bring current Balfour site to functional suitability condition B standard through a phased upgrade and re-provision of all dental services from the existing Kirkwall facility.	Required to meet Scottish Capital Investment Manual (SCIM) requirements within OBC.
Option 2	Extensive refit /new development on existing Balfour hospital site and re-provision of all general practice and dental services from existing Kirkwall premises.	New build primary / community / dental facility moved to Acute facility upgraded as fit for purpose on Balfour site.
Option 3	New build hospital on existing or proposed public sector site e.g. Utilising Kirkwall Grammar School site and re-provision of all general practice and dental services from existing Kirkwall premises.	New build acute hospital on greenfield site. Primary / community / dental facilities moved to upgraded fit for purpose building(s) within existing estate – probably existing Balfour site.
Option 4	New build hospital on greenfield site and re-provision of all general practice and dental services from existing Kirkwall premises.	Effectively the same option as Option 3 with simply the definition of the chosen site differing.
Revised Option 4 Refer to 4a	New build facility incorporating hospital with Kirkwall general practice, community and dental services.	Single new integrated facility for acute hospital, Kirkwall general practices, community centre and dental services on greenfield site, with support block

2.2 Net present value (NPV)

The NPV is the measure used to compare options during the economic appraisal. NPV expresses costs of the project in present day prices. The costs taken into account are the capital costs of the project and relevant elements of

the revenue costs such as the Annual Service Payment (ASP).

Our Board will only undertake a full review of the economic appraisal in the FBC if any of the cost elements of the preferred option has increased significantly compared to the OBC.

The NPV, in accordance with the SCIM, has optimism bias applied to the base costs, and the figure is also adjusted for risk.

2.3 Non financial benefits

The OBC included benefit criteria which were developed in conjunction with stakeholders, against which the preferred option would be identified. These were weighted in terms of importance:

Table 13 OBC Non Financial Benefits Criteria

Weighting the Benefit Criteria	
Benefit Criteria / Theme	Weight
Wellbeing & patient experience	21%
Attract & retain staff	18%
Fit for purpose (legislation, standards, accreditation)	18%
Right clinical/non-clinical adjacencies/flows	13%
Access to services (transport, visibility, location)	11%
Provision of multifunctional rooms/spaces	8%
Shared plant & facilities	8%
BREEAM & sustainability	3%
	100%

Each option was scored out of 10 against the benefit criteria by a range of stakeholders, and the results were multiplied by the weighting to give an overall non financial appraisal and ranking.

Table 14 OBC Options Weighted Scores

Weighted Scores					
Benefit Criteria / Theme	Option 1	Option 2	Option 3	Option 4	Option 4a
Wellbeing & patient experience	0.42	0.63	1.47	1.68	1.68
Attract & retain staff	0.18	0.18	1.26	1.62	1.62
Fit for purpose (legislation, standards, accreditation)	0.18	0.36	1.26	1.80	1.80
Right clinical/non-clinical adjacencies/flows	0.13	0.13	0.91	1.30	1.30
Access to services (transport, visibility, location)	0.88	0.88	0.88	0.88	0.99
Provision of multifunctional rooms/spaces	0.16	0.32	0.40	0.72	0.80
Shared plant & facilities	0.24	0.32	0.48	0.80	0.80
BREEAM & Sustainability	0.03	0.06	0.12	0.24	0.27
Total (weighted score)	2.22	2.88	6.78	9.04	9.26
Ranking	5	4	3	2	1

The appraisal for non financial benefits clearly shows that the preferred option has the greatest overall score.

There have been no developments to require this exercise to be revalidated.

The result has been validated by the further work which has taken place since the OBC in developing the preferred option with bidders, resulting in a continued focus on delivering quality benefits.

2.4 Non financial risks

The OBC identified that the lowest risk option was a new build offsite solution.

The risk management activities undertaken by the Project Team and discussed elsewhere in the FBC have not identified any additional risks which require a review of the preferred option.

2.5 Preferred option

To assess the relative VFM a comparison of the NPV per benefit point was undertaken. The results are ranked with one being the lowest cost per benefit point (i.e. preferred option). From this process the preferred option was identified.

Table 15 OBC Options Ranking

Option	Risk Adjusted NPV £m	Non financial benefit score	Cost per benefit point	Rank
1 Do minimum	49.85	2.22	22.46	4
2 Refit Balfour and provide GP, Dental & Community New Build	81.96	2.88	28.46	5
3 New Build Acute and Re-provided Community	80.64	6.78	11.89	3
4 New Build (inclusive of retained office space)	86.76	9.04	9.60	2
4a New Build with Support Block	84.72	9.26	9.15	1

The preferred option as above was used as the basis for establishing a construction cost cap of £58.93m as a condition of the Scottish Government's funding support for the project.

Option 4a which was adopted as the preferred option achieved a higher score for non financial benefits including BREEAM and sustainability. In the course of the CD all three bidders opted to include the support block within the main build footprint as part of their design solutions, thus taking on the risk to achieve all the requirements identified in respect of option 4a including the BREEAM and sustainability targets set out in the ITPD. As preferred bidder, Robertson Capital Projects retains this risk.

2.6 VFM review of procurement method

The project encountered delays due to a combination of an increase in the anticipated tender value and the need to consider and agree the impact of the European System of Accounts 2010 (ESA 10). Both draft final tender submissions exceeded the construction cost cap set for our new build facility at the OBC approval stage which impacted on affordability. Affordability issues are covered in the Financial Case. The second factor was the need to consider and agree the impact of the ESA 10, on budgetary treatment, procurement route and VFM considerations.

Scottish Government confirmed that funding was available to provide a prepayment of the ASP of circa [REDACTED], which would cover up to [REDACTED] of the potential ASP as it relates to the construction costs. This prompted a comparison of VFM and related matters to inform a decision on the procurement model.

In early 2016, an evaluation report was submitted to both Scottish Government and SFT. This is attached as Appendix 4. The report identified a range of options of which all were ruled out other than continuing with a modified NPD procurement model with a funding variant (prepayment of the ASP), or recommencing as a Design & Build (D&B) capital procurement model.

The report sets out the comparison information which was accepted by the Scottish Government and SFT. The report confirmed the benefits of continuing with a modified NPD procurement model with a funding variant for the following reasons:

- Continuing with a modified NPD procurement model would deliver the project at least 18 months (possibly 24 months) earlier than a D&B
- Under the revised NPD model a sum estimated as circa £7m would require to be met to retain the model. In comparison a D&B model would cost an additional £[REDACTED] due to time delay and the need to maintain failing assets
- A new procurement would not be welcomed by the market and would carry a significant level of reputational risk
- In VFM terms the modified NPD is preferred as a direct consequence of the differential in increased costs mentioned above.

In April 2016, Scottish Government were advised of the anticipated construction tender value of £65m. The difference between the final tender value and the construction estimate in the OBC is £[REDACTED]. This cost difference is attributable to increased preliminaries, overheads and profit which accounts for the majority of the difference ([REDACTED]). The overall building area is 16,248 m² which is an increase of 2,360m² over the reference design area. The increase in area over the OBC is reflective of the design development process and is mainly due to increases in circulation and communication area and roof space plant.

Prior to issuing the Invitation to Submit Final Tender (ISFT) in June 2016 it was acknowledged by SFT and Scottish Government that the final construction cost tender value would exceed the approved OBC construction cost cap, and that the procurement process should continue using a modified NPD procurement model with a funding variant to provide for prepayment of the ASP. A revised funding conditions letter will reflect the final agreed annual support linked to the agreed PPA and annual payments set out in the financial close model.

The affordability, budgetary and accounting impact of the increase in the construction cost cap and the prepayment of the ASP is discussed in the Financial Case.

2.7 Preferred bidder

The Preferred Bidder tender at £[REDACTED] is within the anticipated construction tender value of £65m as described above. It covers the eligible construction costs including the cost of the building, ICT infrastructure, Group 1 (supply and installation) and Group 2 (installation only) equipment, and private sector design fees post financial close. There are no significant changes to the lifecycle or maintenance costs.

All our advisors confirmed that the Robertson Capital Projects final tender construction value of £[REDACTED] was a clean offer without conditions, and met the requirements of NHS Orkney both technically and clinically. Our technical advisors also confirmed that the submission was within acceptable limits of their benchmarking information. In addition, our legal advisors confirmed that the tender had met the legal compliance requirements.

The Preferred Bidder has therefore offered a solution which is in line with expectations.

The economic appraisal of the project options conducted for the OBC, the additional analysis of procurement models as described above, and analysis of the final tender by our technical advisors provided a robust basis for the NHS Board to appoint Robertson Capital Projects as the Preferred Bidder on 23 June 2016.

2.8 Conclusion

The OBC included a robust economic options appraisal and identified the preferred option as a new build RGH on a greenfield site and re-provision of all general practice and dental services from existing Kirkwall premises.

A VFM review of the procurement model was undertaken in response to the anticipated increased construction cost tender value and the impact of ESA10. Consideration was given to continuing the project as a modified NPD procurement model with a funding variant, or recommencing as a D&B procurement model. The review confirmed the benefits of continuing with a modified NPD procurement model with a funding variant.

A review of the economic appraisal has not identified any material matters that would lead to a challenge of the OBC preferred option or procurement model.

COMMERCIAL CASE

3. THE COMMERCIAL CASE

3.1 Introduction

This section of the FBC describes the key commercial details of the agreed contract between the NHS Orkney and Project Company (Project Co) for the construction, commissioning and operation of the new build.

The project is being procured using the NPD procurement model. As discussed in the Economic Case, during 2016, a modification of the funding mechanism was agreed. This section provides additional information on the modifications being made to the PA.

The NPD procurement model sets out a range of risks which are transferred to the private sector as part of the PA. Design, construction and operational risk, for example, lie with the private sector.

The prepayment of the ASP eliminates the senior debt funding and therefore introduces changes to the risk allocation requiring us to manage the risks associated with this funding variant.

We therefore as a Board require risk management arrangements to be in place to secure performance and value in return for its prepayment and payment of ASP. We need to have appropriate compensation for any failure in performance. These protections are provided for in a bespoke PPA, supported by a Security Package. Arrangements for transferring or assigning subordinate (junior) debt will also be in place.

The performance monitoring of the project will be through the standard NPD PA. We will only pay for available facilities and deductions will be made if facilities or services are not provided in accordance with the PA.

3.2 Agreed procurement strategy

As stated in the Economic Case, the project is being procured using the NPD procurement model. The model was introduced to respond to a pipeline of accommodation projects across a range of sectors including schools and the NHS.

The model retains the principles that:

- The private sector will provide serviced accommodation
- Payment will only commence when the accommodation is complete and ready for use. However, for this project a funding variant has been introduced. A prepayment of the ASP is being made to Project Co during the initial years of the project leaving a much reduced level of ASP to be paid over the 25 year contract period.

The NPD model is defined by three core principles of:

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

It is important to note that the NPD model is not a “not for profit” model. Contractors and lenders are expected to earn a normal market rate of return as in any other form of privately financed PFI/PPP model. Rather, the model aims to eliminate uncapped equity returns associated with the traditional PFI/PPP model and limit these returns to a reasonable rate, set in competition.

The traditional PFI/PPP model gives little visibility for the public sector over the governance and management of Project Co. The appointment of an independently nominated Public Interest Director (known as the “Independent Director”) to Project Co’s Board is a feature specific to the NPD model.

3.3 Agreed scope of services

A description of the services is included at Appendix 5.

The Project will be delivered by Robertson Capital Projects (Project Co) using a modified NPD procurement model with a funding variant. A Special Purpose Vehicle (SPV) will provide the funding for the subordinate (junior) debt underpinned by a 25 year service contract. The prepayment of the ASP removes the need for Project Co to secure senior debt funding.

Project Co will be responsible for providing all aspects of design, construction, ongoing hard FM (lifecycle replacement of components) and equity finance throughout the 25 year service contract.

Soft FM services (such as domestics, catering, and portering) are excluded from the PA with Project Co and will be provided by NHS Orkney.

3.4 Agreed risk allocation

The standard NPD PA introduces changes to the risk transfer mechanism that previously existed for PPP/PFI hospital agreements as follows:

The general principle underpinning risk allocation is to ensure that the responsibility for risk rests with the party best able to manage them. This means that the design, construction and operational risk lie with the private sector.

- Title risk (other than the risk of compliance with disclosed title information and/or Reserved Rights) is retained by the public sector
- Risk of physical works being required to the new build because of any unforeseen change in law during the operational period is retained by the public sector

- Energy usage and price risks are retained by our Board, but service standards have been added to incentivise the service provider to do those things that significantly influence energy consumption and are within its control
- Insurance premium risk sharing in relation to market related changes has been dropped so that insurance premiums become mainly a pass through cost, but measures have been added to ensure that the project insurances are procured on terms which represent best value for money for our Board. In previous PFI projects, malicious damage to the facility was a risk borne by the private sector, however, the NPD contract returns this to the public sector although Project Co will still provide reactive maintenance to rectify malicious damage, subject to reimbursement of costs. Internal decoration is excluded from the hard FM maintenance service and therefore our Board have periodic maintenance.

The NPD PA (reflecting the funding variant) assumes the following apportionment of risk

Table 16 NPD Risk Allocation

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

Design risk sits with Project Co, subject to the PA (Clause 12.5) and agreed derogations identified within the Authorities Construction Requirements (ACR).

Construction and development risk for the new build sits with Project Co, subject to the PA. For example, a small number of delay and compensation events could entitle Project Co to compensation if the events materialise, such as no access to the site and incomplete enabling works which impact upon the site.

Transition and implementation risk prior to the actual completion date sits with Project Co in accordance with the ACR and agreed commissioning timetable. After the actual completion date, transition and implementation risk will sit with our Board in line with the agreed commissioning timetable.

Availability and performance risk sits entirely with Project Co subject to the provisions of the PA.

Operating risk is a shared risk, subject to NHS Orkney and Project Co's responsibility under the PA. For example, Project Co will be responsible for hard FM and NHS Orkney will be responsible for soft FM.

Variability of revenue risk is a Project Co risk subject to adjustments to the ASP under the PA. However, our Board will be responsible for all pass through utility costs such as energy usage and direct costs such as insurance and business rates, all of which are subject to different factors such as indexation.

Termination risk is a shared risk under the PA and the PPA, with both parties being subject to events of default that can trigger termination.

Technology and obsolescence risk predominantly sit with Project Co, however, our Board could be exposed through specification and derogation within the ACR, obsolescence through service change during the period of functional operation and relevant or discriminatory changes in law under the PA.

Residual value risks sit with Project Co until the end of the contract and will sit with our Board thereafter. In relation to the handback of the new build by Project Co at the end of the 25 year contract, Project Co must ensure that the facility meet certain key standards or shall be required to pay to rectify the new build in order that it meets said standards.

Under the NPD procurement model financing risk predominantly sit with Project Co subject to the PA. However, the introduction of prepayment of the ASP alters the financing risk profile and that is why a PPA is being put in place with Project Co. Project Co retains the financial risk for equity finance subject to the terms of the PA. Relevant changes in law, events that trigger the need to compensate Project Co and changes under the PA all may give rise to an obligation to NHS Orkney to provide additional funding.

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

Sustainability risks are proportionately shared subject to the PA. Project Co is obliged to comply with the ACR and Service Level Specifications in terms of sustainable design, construction and operations, which includes achieving a Building Research Establishment Environmental Assessment Methodology (BREEAM NC 2011) overall score of 'very good', and an 'excellent' level of performance for the credit pertaining to Reduction in CO Emissions (a minimum

of 6 credits to be achieved for ENE01, which we confirm is being achieved at PB Stage), which sets the Energy Performance Target for the Facilities. Project Co is further obligated to perform tests on completion to demonstrate that its design, construction and operational energy meets acceptable limits of performance, and is required to ensure that these standards are continually upheld by ensuring energy efficient operation of Plant in line with an agreed energy strategy and through maintenance and lifecycle of hard FM components. It is expected that the design operational energy shall be in the range of 35 to 45GJ/100m³ and confirmed by Project Co by calculation in accordance with Encode SHTM 07-02. However, our Board ultimately carries the operational volume and price risk relating to the actual operating energy and utilities consumption of the new build.

The new replacement RGH and related healthcare facility replacement project will deliver a BREEAM rating of “Very Good” and includes a minimum of 6 credits in ENE01, an ‘excellent’ level of performance for the credit pertaining to reduction in emissions.

3.5 Prepayment agreement

Our Board requires to ensure that it secures performance and value in return for its payment (including the £ [REDACTED] prepayment during construction) of ASP for services under the PA.

The prepayment of the ASP during construction and the absence of senior debt finance requires some modifications to protect our Board’s interests. The changes are required to protect the entitlement of our Board to be satisfied that it receives the level of performance agreed under the PA throughout its term, and receives appropriate compensation for any failure of performance following default in priority to the subordinate debt holders.

The protections are provided for in the PPA.

3.5.1 Prepayment not credit

Our Board is not a creditor of Project Co in relation to prepayments made, in the sense that there is no obligation to repay such prepayments since, unlike the position in a senior debt structure, they are not made as a loan.

Nonetheless, with £ [REDACTED] expended in prepayment, our Board requires to meet all accountability requirements and it is appropriate to protect such public monies so that there are used for their intended purpose and our Board receives the service for which it is paying through the ASP.

The PPA sets out principles and protections to ensure that Project Co applies prepayments, and other payments of the ASP, for the purpose of being able to deliver the services contracted for within the NPD PA, and that the principles set out in the previous paragraph are met.

It is not appropriate nor intended to interfere with Project Co's operations and delivery of the services.

The prepayment eliminates the role of senior funders as set out in the standard NPD PA. The PPA will replicate, in part, rights exercisable by senior funders, to ensure operational robustness over the Project Term: for example, by exercising control over when payments should be made to subordinate (junior) debt and the application of lifecycle monies through the FM subcontract by using an Authorities Technical Advisor (ATA) to regularly monitor the project during the operational phase.

3.5.2 PPA and revisions to the PA

The PA and PPA address the risk of breach or default during the construction phase, failure to achieve service commencement, and the ability of Project Co to continue to provide the services during the term, or to address any default during the operational phase.

Prepayment as set out puts a slightly different perspective on the risk of partial performance of design and construction obligations. In a standard NPD, Project Co would recover any losses from its sub contractors and also normally allows senior funders to take steps to protect its debt. Under the revised structure Project Co has similar recourse to its sub contractors and our Board requires to be able to take similar steps to those of a senior funder, and to be able to protect the public interest in relation to prepayment sums.

However, it is for Project Co, not our Board, principally to manage construction phase risks, although the Independent Tester who will be appointed by our Board and Robertson Capital Projects will provide assurance that the value of work has been done for which payment is being requested. Our Board will consider recruiting a Clerk of Works to review the works as construction progresses.

Our Board require the ability in the event of Project Co default to exercise rights appropriate in the circumstances then prevailing, to reflect our Board's priority rights to receive service provision or to be able to take steps to enable the provision of services to continue. Accordingly, Project Co will grant a Security Package in favour of our Board in order to secure performance of its obligations to our Board, including compensation following default, to reflect failure in performance.

3.5.3 Security package

The Security Package will include a first and only floating charge over the assets of Project Co and assignments of each parent company guarantee granted to Project Co in respect of (a) the D&B Contract and (b) the Service Provider Contract, together with Collateral Agreements as are provided for under the standard NPD. The shares in Project Co are to be pledged to our Board.

There are other critical protections: for example, the handback provisions of the PA (Part 18 of the Schedule) protect our Board in respect of the condition of the new build at the expiry of the Project Term.

More detail on the Security Package are set out in the attached legal note at Appendix 6.

3.5.4 Early termination/compensation on termination

On early termination, Project Co may receive compensation under the PA, depending on the grounds and level of performance prior to termination.

Given the absence of senior debt, the compensation provisions reflect our Board's entitlement to be put in the same position as if there had been performance under the contract. This will allow our Board to access both the subcontract and funds held in Project Co through the Security Package.

Thus, in some instances, Project Co will owe our Board money. Contractual protections for that obligation will be enhanced by the Security Package in favour of NHS Orkney which will ensure that the interests of other creditors (e.g. subordinate or junior debt) are effectively subordinated to those of our Board.

3.5.5 Subordinate debt

Our Board appreciates the need of the subordinate debt holders to be able to transfer/ assign their interests to third parties and, in principle, this is acceptable. However, subordination arrangements similar to those usually expected by senior funders will be required. This matter is covered more fully in the attached legal note at Appendix 6.

3.5.6 Secured liabilities

The Security Package to be granted in favour of our Board by Project Co will be granted in security of the payment, performance and discharge of the "Secured Liabilities", namely:

"all present and future obligations and liabilities (whether actual or contingent and whether owed jointly or severally or in any other capacity whatsoever) of Project Co to the Authority under the Project Agreement and each [Project Document and Ancillary Document]."

3.5.7 Agreed payment mechanism

Subject to the exception set out below the performance monitoring for the Project will follow the standard NPD PA. Leaving aside the prepayment arrangement, payments of the ASP will only commence when the new build is complete and ready for use.

Our Board will only pay for available facilities. Deductions will be made if the facilities are not available or services are otherwise not provided in accordance with our Board’s requirements and specifications.

The Payment Mechanism provides a warning notice and termination trigger mechanism if the level of deductions exceed pre-determined limits.

The exceptions to the standard NPD form are as follows:

- Our Board has introduced Consequential Unavailable Areas – where an area as defined in the schedule of accommodation is affected by an Availability Failure, and other areas that cannot be used for their intended purpose as a result of the loss of the first area are deemed to have also been affected by an Availability Failure. Payment Mechanism deductions are applied to all Areas that are Consequentially Unavailable
- Our Board has also introduced a ratchet mechanism for key Critical Spaces such that the Payment Mechanism deductions for Availability Failure are applied at an increasing level over the period of the Failure. These areas are:
 - Resuscitation area
 - CT Control Room
 - CT Scanner Room
 - General computed radiography X-ray rooms incl control
 - General Reporting Room
 - HDU bed spaces
 - Multi-purpose Minor Procedure/Endoscopy Room
 - Anaesthetic Room
 - Operating theatres: ultra clean
 - Renal Water Treatment Plant.

As set out below in table 17 for the first three sessions the weighting is one, then for each further block of three sessions the weightings increase.

Table 17 Ratchet Deduction Calculations for Critical Spaces

Number of Consecutive Full Sessions that particular Critical Space has been Unavailable and not Used	Availability Deduction per Critical Space	Multiplier to be used in working out deduction	Critical Space deduction per Session	Cumulative Deduction
1	██████	1	██████	██████
2	██████	1	██████	██████
3	██████	1	██████	██████
4	██████	1.5	██████	██████

Number of Consecutive Full Sessions that particular Critical Space has been Unavailable and not Used	Availability Deduction per Critical Space	Multiplier to be used in working out deduction	Critical Space deduction per Session	Cumulative Deduction
5	████████	1.5	████████	████████
6	████████	1.5	████████	████████
7	████████	2.5	████████	████████
8	████████	2.5	████████	████████
9	████████	2.5	████████	████████
10	████████	4.5	████████	████████
11	████████	4.5	████████	████████
12	████████	4.5	████████	████████
13	████████	6.5	████████	████████
14	████████	6.5	████████	████████
15	████████	6.5	████████	████████
16	████████	8.8	████████	████████
17	████████	8.8	████████	████████
18	████████	8.8	████████	████████
19	████████	10	████████	████████
20	████████	10	████████	████████
21	████████	10	████████	████████

If a Critical Space is unavailable for 21 sessions the value of the payment mechanism deduction will equate to a warning notice.

All potential payment mechanism availability and performance deductions are calibrated on the basis of a “notional service charge” rather than actual ASP payable during operation. The “notional service charge” is the ASP that would have been payable if the SPV had financed the project via senior debt rather than a prepayment of the ASP during the early years of the project.

3.6 Key contractual clauses

As noted above, the PA is based on the standard NPD PA with a variant for the funding mechanism, thus is tailored to the requirements of the project. Bidders were given the opportunity to comment on and discuss potential changes to the PA during the CD phase of the procurement. SFT approved the list of proposed amendments to the PA as part of the close of dialogue and issue of ISFT.

No material changes will be accepted to the PA other than resolution of minor drafting and those issues approved from Project Co's bidder query list submitted at final tender stage. The contract has an agreed operational period of 25 years.

3.7 Community benefits

The PA includes specific clauses to enable a range of community benefits on behalf of the communities in Orkney:

- Apprentice and graduate opportunities
- Ensuring that local business are best placed to bid for sub contracts
- Providing learning opportunities
- Reaching other, sometimes disenfranchised, groups through social enterprise structures
- Engaging with local schools and colleges
- Sustainability.

Further details are included in Appendix 7. Failure to achieve the targets outlined in the PA will result in financial penalties for non compliance/delivery of the agreed benefits.

3.8 Personnel implications (TUPE)

The responsibility for hard FM will fall to Project Co as set out in the PA. Our Board will remain responsible for some aspects of the ongoing maintenance of the new build as well as being solely responsible for the remainder of the retained estate. No facilities staff will transfer under the Transfer of Undertakings Regulations (TUPE).

3.9 Procurement process

In July 2014, our Board published a contract notice in the Official Journal of the European Union (Ref: 2014/S 138-246970). Pre qualification submissions were received in September 2014 from the following applicants:

- Canmore
- Robertson
- Equitix.

Following a detailed review our Board agreed that all three applicants should be invited to participate in Phase one of the CD process.

A copy of the evaluation report on the PQQs of the bidding consortia which was approved by the Programme Implementation Board (PIB) is included as Appendix 8.

The Invitation to Participate in Dialogue (ITPD) was issued in October 2014.

Following a detailed dialogue period and the down selection of one bidder during

April 2015, the CD continued with the two remaining bidders and the ISFT was issued during May 2016 (Draft Final Tenders were submitted during July 2015).

A detailed evaluation was undertaken which resulted in the selection of Robertson Capital Projects as the most economically advantageous tender.

All our advisors confirmed that Robertson Capital Projects final tender construction value of £[REDACTED] was a clean offer without conditions, met the requirements of NHS Orkney both technically and clinically. Our technical advisors also confirmed that the submission was within acceptable limits of their benchmarking information. In addition, our legal advisors confirmed that the tender had met the legal compliance requirements.

The report containing the financial evaluation of Final Tenders and recommended selection of Robertson Capital Projects was approved by our Board on 23 June 2016 and is included as Appendix 9.

3.10 Enabling works/new link road construction

There are no enabling works planned to be undertaken prior to receipt of full planning consent during early October 2016. Subject to planning consent and financial close being achieved during October, construction will commence late October/early November with a two year construction period.

As indicated in the OBC, OIC intended to construct a link road, south of the site acquired for our Board's development. The link road is complete and operational having been funded and constructed by OIC. This significantly improves the access to our Board's site for patients, staff and service deliveries and removes the need for any roads/access enabling works to be undertaken.

3.11 Planning consent

Planning in principle for the project was achieved during 2014 as part of the OBC process.

Planning matters, in respect of detailed planning permission, are managed by Robertson Capital Projects and their planning advisors, with input as appropriate from our Board supported by our planning and technical advisors. The consultation period for the planning submission is ongoing at present and determination is expected on 4 October 2016.

3.12 Conclusion

The procurement process commenced in July 2014 and an ISFT was issued in May 2016. Robertson Capital Projects was identified and announced in June 2016.

The PA will follow a modified NPD procurement model with a funding variant. The model is based on a standard risk sharing profile and a performance regime

whereby payment is made when agreed availability and performance criteria are met.

A prepayment of £ [REDACTED] of the ASP is being made during the early years of the project thereby reducing considerably the level of the annually payable ASP over the remaining period of the 25 year contract.

A PPA along with a package of security measures has been developed to ensure that our Board secures value and performance in return for the prepayment of the ASP.

Our Board and Robertson Capital Projects will appoint an Independent Tester who will provide assurance that the value of work has been done for which payment is being requested. Our Board will consider the appointment of a Clerk of Works to ensure that the works are properly completed as programmed.

Access to the site has been significantly improved due to the link road funded and recently completed by OIC.

The consultation period for the planning submission is ongoing at present and determination is expected on 4 October 2016.

THE FINANCIAL CASE

4. THE FINANCIAL CASE

4.1 Introduction

This section of the FBC sets out the Financial Case. The primary aim is to reconfirm the overall affordability of the project, as presented in the OBC, for both NHS Orkney and Scottish Government. The case will clearly highlight the impact of the following:

- Recurring revenue costs
- Capital costs
- Non-recurring costs
- Impairment
- Impact on the Income & Expenditure Account and Balance Sheet
- The associated accountancy treatment
- Financial risks.

All costs and assumptions presented as part of the OBC have been reviewed to ensure that the Financial Case continues to clearly set out what additional costs are expected as well as the classification of these costs, provide clarity on the source of funding, and ultimately demonstrates affordability.

The cost models have been reviewed using assumptions generated with the input of external advisors and the senior management team. Additional costs have been identified arising from the increase in the floor area and additional capital equipment impacting on depreciation charges.

This project is being taken forward under a modified NPD model with a funding variant. This incorporates a significant prepayment of the ASP. The impact of the prepayment on funding flows is expanded upon, and the budgetary impact for our Board and Scottish Government is identified. The introduction of the prepayment has prompted a review of the VAT recovery position.²

Financial risks are explored, updating the position as identified in the OBC and reflecting on current financial risks as they relate to the project.

The accounting treatment of the various funding flows is explored, taking account of the impact of the ESA10.

4.2 Funding conditions

The OBC approved funding letter set out the construction cost cap at £58.93m, and laid out conditions on which the funding would be available.

The funding letter highlights that the construction cost cap assumes that the

² A formal opinion on the VAT recovery position has been received from HMRC on 18 October 2016 which confirmed that NHS Orkney can recover the VAT, in relation to both the prepayment and the ongoing annual service payment, under Contracted Out Services (COS) Heading 45.

project will deliver the scope as detailed in the OBC. However, if our Board choose to expand the scope beyond what is detailed in the OBC, or if the project is not deliverable within the construction cost cap, our Board will be required to fully fund any resultant increase in the ASP, including the inflationary impact over the term of the contract.

As discussed in the Economic Case, in early April 2016, Scottish Government were advised of an anticipated construction tender value of up to £65m and a modified NPD procurement model with a funding variant. The Economic Case and Commercial Case described the changes being made to the funding arrangements, including the introduction of a PPA and Security Package. The Financial Case takes this further and reviews all costs and the overall NPV of payments.

The estimated prepayment of the ASP was notified to Scottish Government at that time as being circa £[REDACTED]. This was based on the anticipated prepayment of up to 92% of the potential construction tender value of £65m (£59.80m).

Some comparisons with the terms of the OBC funding letter are no longer valid because of the increased tender value, and more significantly, the variation in funding arrangements, i.e. the prepayment of the ASP.

Scottish Government have advised that an updated funding letter will be provided, reflecting the impact of the prepayment and a revision to the construction cost cap.

Table 18 below sets out the financial conditions as per the OBC funding letter, along with the Preferred Bidder position at Final Tender.

Table 18 OBC Approval Letter Funding Conditions

Cost Element	Conditions Bidder	OBC Funding Letter	Preferred Bidder
Construction Cost Cap	Cap set at £49.55m Q1 2014 priced uplifted to assumed construction mid-point Q4 2017 using BCIS all in tender index	£ 58.930m	[REDACTED]
Private sector development costs	Estimate that these costs will be in the region of 5% of the capital value of the project	Circa 5%	5%
SPV Operating costs	Expectation per funding letter is £0.250m excluding insurance costs at Q1 2016 prices	£0.250m	[REDACTED]

Cost Element	Conditions Bidder	OBC Funding Letter	Preferred Bidder
Lifecycle maintenance costs	Board to seek to secure competitive, value for money proposal against relevant external benchmark for cost per square m	£27.92	████████

The ██████████ detailed above is the final tender construction value, however it is subject to ongoing design development as the project specifications are finalised in conjunction with Robertson Capital Projects. At this time, there are no material changes being discussed although there are discussions around some final room layouts and equipment schedules. Although the financial impact of such changes cannot yet be quantified the final tender price includes a contingency sum of over ██████████ to reflect design risk as well as other factors and we are looking to minimise any financial impact as the design development process progresses.

Our Board is aware that the final tender construction value of ██████████ now compares to the construction cost cap provisionally agreed by Scottish Government.

The total ASP will be ██████████ which is made up of 92% of the construction cost (████████) and the private sector development costs of £████████, as per Table 19 below. The ██████████ is in line with 5% of the construction costs as set out in the OBC approval letter. Any consequent increase in the ASP will be the responsibility of our Board.

Table19 Calculation of the prepayment sum for the ASP

Cost Element	Cost	ASP	Detail
Construction Costs	£████████	£████████	████████ of construction costs
Private Sector Development Fees	£████████	£████████	Equivalent to 5% of the construction costs as set out in the OBC approval letter
		£████████	

4.3 REVENUE

Recurring revenue expenditure are those costs which our Board incur on an ongoing basis to provide services. They continue year on year until a change is made which will increase, reduce, reallocate or remove these costs. These are unlike non-recurring costs which are one off.

As was highlighted in the OBC the business case process includes a detailed review of issues directly linked to the move to the new build. Any other financial risks to our Board are managed as part of our Board's Financial Plan.

The majority of the recurring revenue implications for the project are attributable to the ASP however there are a number of other cost elements which need considered as part of the overall affordability of the project including depreciation, service running costs, facilities management costs and building running costs.

4.3.1 OBC summary

The OBC identified an increased recurring revenue funding requirement of £[REDACTED] at March 2014/15 prices.

Table 20 OBC Recurring Revenue Funding Requirements

Additional Revenue Costs@ 2014/15 prices	Base	Required	Increase	Funded by NHSO	Funded by SG
	£'000	£'000	£'000	£'000	£'000
Annual Service Payment	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Depreciation	970	1,863	893	30	863
Service Running Costs	7,544	7,655	111	111	-
Facilities Management	1,526	1,546	20	20	-
Building Running Costs	882	930	48	48	-
Other Costs	0	25	25	25	-
	10,922	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Our Board approved additional funding of £[REDACTED] with the balance being supported by Scottish Government. The approved 2016/17 Financial Plan includes £[REDACTED] on a recurring basis which includes a contingency of £[REDACTED]. We have assessed the impact of inflation at £[REDACTED], which can be accommodated within the contingency above.

The following sections provide an update on the movement on these costs in relation to updated cost estimates and any additions identified since approval of the OBC.

4.3.2 Annual service payment (ASP)

As previously discussed, a variant of the funding mechanism means that there will be a prepayment of the ASP of [REDACTED]. This will leave a reduced annually payable ASP which covers the design, build, balance of finance and maintenance of the new build on a monthly basis over the 25 year life of the contract.

As part of the final tender, Robertson Capital Projects supplied a financial model which projected the ASP over the life of the contract, taking into account the prepayment. Table 21 below shows the components of the ASP over the 25 year life broken down by element.

Table 21 ASP Components

Components of ASP	Description	Cost over 25yrs £ m
Construction capital expenditure	Final tender value for construction costs	██████████
Other costs in construction	SPV costs in construction and FM mobilisation	██████████
Finance costs	Interest associated with subordinated debt borrowing and other finance costs	██████████
Special Purpose Vehicle (SPV) Costs	Administering, insuring, debt monitoring fee and running costs of the SPV	██████████
Facilities Management (Hard FM)	Cost of maintaining the building	██████████
Lifecycle maintenance costs	Replacement cost of major equipment during the life of the project, for example replacing boilers and lifts	██████████
Other	Including tax and interest on cash	██████████
Total		██████████

Our Board will be required to support 50% of lifecycle maintenance costs and 100% of hard FM costs with the Scottish Government supporting all other costs including prepayment of the ASP, development costs, financing costs and SPV running costs.

The following table 22 provides a summary of the ASP at the beginning and end of the contract and the proportion attributable to our Board and Scottish Government. The final tender shows a first full year (2019/20) ASP of ██████████ compared to the estimate at OBC of ██████████, a reduction of ██████████.

Table 22 ASP Summary at Beginning and End of Contract Period

	First Full Year impact 2019/20	Final Full Year Impact in 2042/43	Average over 25 years
█	█	█	█
█	█	█	█
█	█	█	█
█	█	█	█
█	█	█	█

Table 22 above shows an increase in the element of the ASP payable by our Board from █ in the first full year of operation to █ in 2042/43, reflecting the impact of inflation on the components of the ASP:

- The maintenance elements (lifecycle and FM costs) as well as the SPVs operational running costs are all within the cost cap set for each of them and are increased annually based on the Retail Price Index (RPI)
- The balance of the charge remains flat throughout the duration.

The inflationary aspect of the ongoing ASP is included in our Board’s Financial Plan.

The smoothing of lifecycle costs over the 25 years of the contract provides for the replacement of Group 1 equipment items thus avoiding fluctuations and significant budgetary pressures which are currently experienced.

4.3.3 Depreciation

Depreciation reflects the impact of capital expenditure over its useful life. The OBC assumption of £8.5m for Groups 2, 3 and 4 new equipment has been updated to reflect the increased requirement for equipment which has been identified, as well as the likely asset life identified by Health Facilities Scotland. The inclusion of essential ICT infrastructure and systems costs including telephony, call systems and paging, has added £1.5m to the capital expenditure profile. These assets are depreciated over a 5 year life span, adding £0.3m annually to anticipated depreciation costs.

As the equipment list continues to be refined, any further movement will require to be prioritised through normal planning processes to avoid any further increases.

The anticipated depreciation on the new build (█ per annum), and

impairment costs, are funded by Scottish Government, and are documented later in the Financial Case.

4.3.4 Service running costs

We have reviewed the service running costs against those in the OBC and concluded:

- The staffing model remains as previously presented reflecting the impact of single rooms and new models of care. The revised floor layouts will allow efficiencies to be delivered, particularly at night, when compared with existing staffing levels
- The only investment in relates to staff for the multi-purpose surgical facilities (3.20 WTE £111k, updated to £150k for incremental drift and inflation)
- Detailed reviews for all other areas have demonstrated that existing establishment levels are sufficient to deliver the revised models of care, although there may be changes to the underlying skill mix within individual departments
- The medical model will be continuously under review as models of care are introduced.

The scope of the ICT team will significantly increase with the opening of the new build when the range of services which they support will increase. Investment in staffing has been agreed and funded through the Financial Plan, with an increase of 4.00 WTE planned during 2016/17. This is an essential investment to meet core services requirements now and in the run up to the opening of the new build.

4.3.5 Facilities management services

In the OBC, existing FM services were used as a benchmark to assess the potential additional funding required. The final tender submitted by the Robertson Capital Projects for FM services comes within the cost cap which has been set, and has been market tested taking into account the design and service needs.

The service model for soft FM services is to introduce a multi-skilled workforce. This will allow existing staff to develop skills in new areas thus providing more resilient soft FM services for NHS Orkney, in particular the development of an enhanced Medical resource with on site staff supported by specialist expertise from NHS Highland through a service level agreement

- As anticipated in the OBC, the increased floor area and provision of single rooms costs will result in an increase for domestic services. The requirement has been calculated using current average costs and assumptions on the anticipated cleaning specification
- We do not anticipate an increase in running costs for catering

- The service delivery model for porters, laundry services and mail room services are not expected to increase
- The OBC anticipated the development of a Medical Physics resource which will improve equipment management and utilisation
- No provision was made in the OBC for minor repairs and changes that may be required at the new build and not covered by the ASP. At this time, it is expected that where such costs arise they will be flexibly managed within existing FM resources
- An additional sum has been included to recognise the increased grounds maintenance service.

Innovative solutions for the delivery of soft FM services will continue to be explored in advance of opening the new build to reduce as far as possible the net additional cost of £46,000 for all of these services.

4.3.6 Building running costs

There are a number of building related costs which will continue to be payable by our Board including electric, water and rates.

Utilities are included as part of the contractual agreement and will be charged back to our Board as a pass through cost. Energy prices were much higher at the time of the OBC and we have subsequently enjoyed the benefit of recurring savings. We will secure further savings from the new build. The energy model continues to be further developed with Robertson Capital Projects.

An indicative cost for rates was provided for the OBC in late 2013 by the local valuation office, however the floor space has increased. Therefore both the rate payable and the size of the building have increased resulting in an estimated additional cost of £93,000. Most of this increase relates to the size of the building.

4.3.7 Other costs

The OBC included provision in relation to the subsidised bus services to the new build and for other consumables. The overall provision remains unchanged at £25,000.

4.3.8 Summary of additional recurring revenue costs

As described earlier the Scottish Government will be required to support the majority of the ASP subject to a number of conditions. NHS Orkney are therefore required to support all the other additional costs.

Following the review of the indicative costs identified at OBC, and described throughout the Financial Case, the revised annual recurring funding requirement is [REDACTED] as per the table 22 below.

Table 23 Revised Annual Recurring Funding Requirement

Recurring Revenue Costs	Original Baseline	Updated Requirement	Increase	Funded by NHSO	Funded by SG
	£'000	£'000	£'000	£'000	£'000
Annual Service Payment	█	█	█	█	█
Depreciation	970	2,200	1,230	330	900
Service Running Costs	7,544	7,694	150	150	0
Facilities Management	1,526	1,572	46	46	0
Building Running Costs	882	1,008	126	126	0
Other Costs	0	25	25	25	0
TOTAL	10,922	█	█	█	█
OBC	10,922	█	█	█	█

Following approval of the OBC, where the additional recurring costs for our Board were identified as █ our Board set aside £█ (including █ contingency), which remains intact in the 2016/17 Financial Plan. Table 21 above shows that our Board's share has increased to £█. The increase is explained by additional depreciation and the increase in rates which is largely due to the increased floor area of the new build compared to the existing facility.

There are uncommitted recurring reserves available for future years in our Financial Plan which can provide cover for the additional £█. The Financial Plan will be amended at its next revision (mid year review 2016).

The Scottish Government share has reduced by █ to █ as a result of the prepayment of the ASP which in turn reduces the annually payable element of the ASP.

4.3.9 Additional non- recurring revenue costs

Non- recurring expenditure will be incurred as the new build is commissioned; services transferred and becomes fully operational. This will include initial cleaning costs, removal and transport costs, patient transport, building costs and double running for staff familiarisation, induction and equipment training as well as double running for staff as services operate on a dual site while the transfer is in operation.

A high level review of such costs has been carried out and estimated at £0.5m. These requirements and estimates will continue to be developed and refined in the years leading up to the handover. These costs are included within our Board's Financial Plan.

4.3.10 Conclusion – revenue costs

The additional recurring revenue costs for our Board have increased to [REDACTED] compared to the [REDACTED] already set aside. The Financial Plan includes sufficient flexibility to allow this additional cost to be set aside and this will take effect at the next revision of the Financial Plan. [REDACTED] is also set aside for transitional costs.

The risk that our Board’s revenue cost implications are underestimated is recorded on the project risk register. This risk has been updated to reflect the increased costs identified within the Financial Case. The risk score is considered to be an acceptable level for our Board. Work will continue to mitigate any further increase in costs.

The additional recurring revenue costs for Scottish Government have reduced to [REDACTED] as a direct result of the prepayment of the ASP.

4.4 CAPITAL

This section sets out an update of the capital funding required for the project. The total estimated capital requirement identified as part of the OBC was £10.115m. This has been updated to reflect any known changes to price, timing and the impact of inflation as well as the requirement for the funding for the prepayment of the ASP. The following table 24 sets out at a high level the movement against the OBC estimate.

Table 24 Capital Costs

Capital Costs	OBC Estimate	Revised Estimate	Movement
Non NPD Costs	£10.115m	£11.615m	£1.500m
Prepayment of ASP	-	[REDACTED]	[REDACTED]

The 2016/17 Financial Plan as submitted to Scottish Government was updated to reflect the revised capital profile including £2.2m of project team and advisor costs referred to below which now fall to be capitalised.

The draw down of Scottish Government funds will match the prepayment profile scheduled to the PPA and payments to Project Co outwith this profile will not be permitted. NHS Orkney will agree the profile with Scottish Government and will look to draw down funds at the beginning of each month. The anticipated timing of the prepayment is under discussion with Robertson Capital Projects but is likely to be in the region of:

2016/17	[REDACTED]
2017/18	[REDACTED]
2018/19	[REDACTED]

A capital receipt from the sale of the existing site has not been included as an offset. Under the current accounting treatment the receipt would be returned to Scottish Government. This is estimated for receipt in 2019/20 or thereafter. Work is underway with SFT to consider the most appropriate disposal options for the Balfour site.

4.4.1 Non NPD costs

Table 25 sets out the revised capital costs associated with the NPD project.

Table 25 Non NPD Costs

Non NPD Costs	OBC Estimate	Revised Estimate	Movement
Land acquisitions	£1.285m	£1.285m	0
Site clearance	£0.330m	£0.330m	0
Equipment	£8.500m	£10.000m	£1.500m
TOTAL	£10.115m	£11.615m	£1.500m

The main changes from the OBC are:

- Land acquisitions are complete and are priced at final cost
- The main change is the £1.5m increase in equipment cost, funded by Scottish Government. This is based on the draft equipment list provided by HFS and the internal ICT department. However, as work on the 1:50's is still ongoing with the workstreams this is still draft and will require further refinement. Opportunities for efficiencies have been explored to date with Health Facilities Scotland to ensure maximum procurement discounts can be achieved. This will be further explored as the equipment procurement is progressed. Any further requirements will need to be prioritised through normal financial and capital planning mechanisms, to ensure no further increase in requirements
- The OBC assumed a 15% level of transfers, which has been retained and equates to circa £1.5m
- A review of the equipment list has identified circa £1m that is below the £5,000 capitalisation threshold. The assumption remains the same as at OBC that this will be capitalised as one equipping asset and not funded from revenue
- The NHS Orkney Medical Equipment Group is actively involved in monitoring this plan.

4.4.2 Timing of non NPD costs

Table 26 below highlights the revised profile of non NPD funding required per year to complete the project. This reflects current estimates of the likely phasing

of the non NPD capital expenditure through until 2020/21. The main movement on this phasing since the OBC is linked with the anticipated completion date for the new build, acquisition of the site and the revised cost of equipment.

Table 26 Revised Capital Profile

Non NPD Costs	2014 /15	2015 /16	2016 /17	2017 /18	2018/ 19	2019 /20	2020 /21	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Site Acquisition	1,285	0	0	0	0	0	0	1,285
Site Clearance	0	0	0	0	0	330	0	330
Equipment Site	0	0	0	2,500	7,500	0	0	10,000
Total Capital	1,285	0	0	2,500	7,500	330	0	11,615
OBC	0	1,285	0	1,500	7,000	330	0	10,115
Difference	1,285	(1,285)	0	1,000	500	0	0	1,500

4.4.3 Future project team and advisors expenditure

Prior to the approval of the OBC, Project Team and external advisor costs were treated as non recurring revenue costs and funded accordingly. Since then these costs have been capitalised.

The following table 27 sets out the projections for the Project Team and external advisor costs for the periods 2016/17 to 2019/20 which will fall to be met from capital rather than non recurring revenue expenditure as was the situation set out in the OBC.

Table 27 Project Team and Advisors Projected Costs

Project Team and Advisors	Project team and associated costs	External advisors	Total
	£000s	£000s	£000s
2016/17	530	470	1,000
2017/18	400	100	500
2018/19	500	-	500
2019/20	200	-	200
	1,630	570	2,200

4.4.4 Impairment

As the building is constructed, we will add the building to our Balance Sheet as an Asset Under Construction. When the new build becomes operational, it will be transferred from an Asset Under Construction and become a fixed asset on the NHS Orkney Balance Sheet.

Under the International Accounting Standards, IAS 36 Impairment of Assets seeks to ensure that the asset is not carried at more than the recoverable amount. It is difficult to be precise in estimating the impairment value prior to practical completion. From examination of the final tender submission, the carrying value of the asset is likely to be in the region of [REDACTED] to [REDACTED]. Table 28 below shows the impairment based on the lower of these values, thus resulting in an impairment calculation of £[REDACTED] being applied.

Table 28 Impairment Costs and Valuation

Impairment calculations	Costs	Valuation	Impairment
	£m	£m	£m
NPD asset	[REDACTED]	[REDACTED]	[REDACTED]
NPD costs – fees	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]

4.5 VAT recovery

Under the standard NPD procurement model the legislative basis for recovery of VAT relates to Contracted Out Services (COS) as follows:

“COS Heading 45 – Operation of hospitals health care establishments and health care facilities and the provision of related services allows VAT recovery where the Board receives a building or facilities which enables it to treat and care for patients. This includes:

- *An entire hospital complex of buildings*
- *Part of a hospital complex of buildings*
- *A discrete part of a hospital, such as a ward, a theatre suite, a radiology department, a renal dialysis suite, a diagnostic suite or an MRI unit*
- *An off-site facility that provides services which would normally be carried out in a hospital or health care establishment, for example an off-site facility for renal dialysis or diagnostic purposes*
- *Non-residential mental health facilities which are part of the healthcare offered by the NHS body”.*

This allows NHS organisations to obtain VAT recovery on NPD arrangements where the contractor provides a sufficient level of services and support within the facility to allow the NHS Board to treat its patients.

The prepayment of the ASP represents a change to the normal monthly payments over the 25 year contract period. The estimated prepayment at that time was circa [REDACTED]. We sought specialist VAT advice at an early stage in the negotiation of the funding variant. This advice confirmed that as the fundamental nature of the NPD PA was not changing, VAT recovery should remain intact. As the negotiations progressed we sought further specialist VAT advice, which again confirmed that VAT recovery should remain intact.

Following discussion with SFT and Scottish Government, it was agreed to seek a formal ruling from HMRC as to whether or not VAT would be recoverable on the prepayments. Ernst & Young (EY) were contracted to submit a formal request for a VAT ruling to HMRC. The request was submitted on 3 June 2016.

A copy of the submission which sets out the basis for our Board's assertion that VAT should be recoverable on the prepayments is attached for information as Appendix 10. The submission concludes as follows:

- *“As you can see from the details outlined above, the Board is of the opinion that it will be receipted of a fully functioning facility which allows medical professionals to provide the care their patients require.*
- *Therefore, the Board is looking for clarity around any impact that the nature of the prepayment may have on the VAT treatment because HMRC's guidance is unclear. Ultimately, the Board is looking to confirm that the VAT incurred on both the prepayment of the Unitary Charge and the annual Unitary Charge (Annual Service Payments) will be recoverable in full under COS Heading 45.”*

EY have received a request from HMRC to supply a copy of the contractual documentation relating to our project including the PPA. This indicates that the request for a ruling is under active consideration and that a ruling should be forthcoming soon.

VAT was not a relevant factor at the time the decision was taken to proceed with the modified NPD model with a funding variant, nor when appointing Robertson Capital Projects. The cost calculations in the Financial Case are based on the assumption that VAT is recoverable on the prepayment and monthly payments of the ASP.

SFT and Scottish Government continued to be updated on matters as they progress between EY and HMRC.³

³ A formal opinion on the VAT recovery position has been received from HMRC on 18 October 2016 which confirmed that NHS Orkney can recover the VAT, in relation to both the prepayment and the ongoing annual service payment, under Contracted Out Services (COS) Heading 45.

4.6 Accountancy treatment

This section confirms the impact on the Balance Sheet that will apply to the assets created by the project and the impact of the transactions on the Income and Expenditure Account.

4.6.1 Impact of NPD contract on NHS Orkney balance sheet

Our Board are required to prepare annual accounts based on International Financial Reporting Standards (IFRS). An NPD procured project specifically requires to be tested against the guidance set out on Service Concessions (IFRIC12).

The project will be delivered using the standard contract for NPD projects. Having considered the guidance the assumption is maintained that the new facility is within the scope of IFRIC 12. The two conditions met are:

- The Procuring Authority (NHS Orkney) will control or regulate what services the operator must provide with the infrastructure, to whom it must provide them and at what cost
- The Procuring Authority (NHS Orkney) will control (through beneficial entitlement or otherwise) any significant residual interest in the infrastructure at the term of the arrangement. This second test is considered to have been met if the concession is for the whole of the useful economic life of the assets created.

The asset will be recorded as a fixed asset on NHS Orkney Balance Sheet.

4.6.2 Impact of NPD contract on national accounts

In October 2015, Audit Scotland issued a briefing note for Scottish Government on the impact of the European System of Accounts (ESA10) on the classification of privately funded capital projects. A key development of ESA10 is the inclusion of a section on Public-Private Partnerships (PPP). This and the accompanying Manual of Government Deficit and Debt (MGDD) provides guidance on how to assess the economic ownership of an asset created through a PPP contract. The assessment is based on the balance of risk and rewards shared between the public sector grantor and the private sector operator.

Publicly classified assets require HM Treasury capital budget (Capital DEL) at the point of initial investment. Privately classified assets require HM Treasury resource budget (Resource DEL) cover over the lifetime of the asset.

At the time of writing the FBC, a number of changes to the NPD standard contract, specifically in relation to the role of the Public Interest Director in the NPD Project Companies have been issued by SFT as an NPD programme wide change.

The changes are in response to the revised guidance in the MGDD and ESA10

which came into effect on 1 September 2014. The changes stem from the interpretation of the control characteristics of the NPD model and the determination as to whether the control of the Project Company vehicle sits with the public sector or the private sector. ESA10 defines control as “the ability to determine the general policy or programme of that entity” and sets out a number of control indicators that have been further defined in the revised version of the MGDD. The interpretation of the revised MGDD is that certain public sector rights and vetoes facilitated through the Public Interest Director appointment on the Project Company Board of Directors could appear to afford the public sector control over the “general policy or programme”. In response to this interpretation, SFT has taken steps to amend the contract to align with revised guidance and preserve the transparency and governance role exercised by the Public Interest Director in the NPD structure. These amendments have been made to the NHS Orkney project documentation and communicated to Robertson Capital Projects.

Scottish Government, having accepted that this facility will be a publicly classified asset, made available funds to support the variant in the funding mechanism by way of prepayment of the ASP this being the VFM option assessed by the Board and confirmed by Scottish Government. Accordingly this asset will require Capital DEL budget cover and will be recorded as a fixed asset on the Government Balance Sheet.

4.6.3 Impact of non NPD capital spend

All assets purchased in relation to the project, detailed under the capital (non NPD) section, will be recorded on both NHS Orkney and Scottish Government Balance Sheet as fixed assets.

4.6.4 Revenue costs

The additional recurring and non-recurring revenue expenditure highlighted in earlier sections will be included within the Statement of Consolidated Comprehensive Net Expenditure in NHS Orkney’s annual accounts.

4.6.5 Impact on budgeting

The likely impact on both our Board and Scottish Government’s budgets in relation to this business case are summarised below in table 29.

Table 29 Budget Impacts – NHSO Board and Scottish Government

Capital	Board Budget	SG Budget	Funding Source
Capital value of NPD asset	Core CRL	Capital DEL	Prepayment of ASP fully funded by SG
Capital cost of non NPD elements	Core CRL	Capital DEL	Fully Funded by SG as set out in business case
Revenue	Board Budget	SG Budget	Funding Source
Annual Service Payments (net of amortisation of the capital value)	Core RRL	Resource DEL	SG will fund all with exception of 50% lifecycle and 100% hard FM
Depreciation of NPD asset	Non Core RRL	Resource ODEL	Fully Funded by SG
Depreciation of capital financed assets	Non Core RRL	Resource DEL	Fully Funded by Board
Impairment of NPD assets	Non Core RRL	Resource ODEL	Fully Funded by SG
Impairment of non NPD elements	Non Core RRL	Resource DEL/AME	Fully Funded by SG

4.7 Areas of risk

Our Board acknowledges that a number of financial risks are not included within the investment highlighted in this Financial Case. Such risks are not directly related to the project.

Financial risks are reviewed monthly and reported to our Board. A risk based approach is taken to financial management, budgetary control, and budget setting.

For clarity, those risks that are not included, along with further risks/assumptions identified during this process are detailed below in table 30.

Table 30 Financial Risks

Areas of risk	Identified at OBC	Position as at FBC
Medical Staffing recruitment challenges	Yes	This continues to be a very high financial risk (over £1m) for our Board. We anticipate being able to reduce costs by up to £0.5m and have set aside a contingency budget of £0.5m. We are able to manage this risk at a corporate level through holding underspends and reserves.
Changes to models of care as a result of Allied Health Professionals National Delivery Plan	Yes	No financial risks identified.
Changes in working hours and on call arrangements across all professions	Yes	No financial risks identified.
Impact of Health & Social Care Integration	Yes	We have identified the need to capture integration risks on our corporate risk register. No specific financial risk identified at this time. We need to have further engagement about the required growth in social care capacity.
Impact of service redesign through Transforming Clinical Services programme and strategic change programme	Yes	We are linking the improvement and change programme with our requirements for cost reductions. Repatriation of services in particular has been helpful in reducing overall costs, where we can invest in local services and save travel and off island costs. Repatriation may require some investment in local services which can be funded from the reduction in service agreements with other Boards.
Changes required in community services	Yes	We have received funding requests as part of 2016/17 financial planning and we have some risks on the OHAC and corporate risk register relating to capacity of services. We are working our way through these issues.

Areas of risk	Identified at OBC	Position as at FBC
Local workforce demographics	Yes	We manage these on a service specific basis. Other than medical staffing, no specific risks at the moment.
VAT recovery on the Annual Service Payment	No	The introduction of a funding variant to the NPD PA is not considered to have changed our ability to recover VAT. Specialist VAT advice has been sought and we await a formal ruling from HMRC ⁴ .
National 2017 Rates Revaluation	No	The increase in rates directly attributable to the new build has been included in the FBC, the further increase anticipated in 2017 through the rates revaluation has not been included as it will impact on all properties held by our Board and is not a direct consequence of moving to the new facility. It should be noted however that this is of significant value estimated at circa £326,000 for the new facility alone. This will be managed through the financial plan.
Any change to the ASP as a result of project scope changes	No	We have funding set aside in the financial plan for service developments and will have to manage any such changes as part of the normal planning process.
Any change to the ASP as a result of service redesign affecting the project scope	No	As above.
Impact of the finalised energy model	No	The energy model currently shows a lower cost than in our financial assumptions. Any increase over assumptions will need to be covered through any inflation or growth funding in the Financial Plan.

⁴ A formal opinion on the VAT recovery position has been received from HMRC on 18 October 2016 which confirmed that NHS Orkney can recover the VAT, in relation to both the prepayment and the ongoing annual service payment, under Contracted Out Services (COS) Heading 45.

Areas of risk	Identified at OBC	Position as at FBC
Agreement of budget transfer from SG to cover annual service payment share and the prepayment arrangement	No	Ongoing engagement with SG finance team to ensure that financial planning and budgeting assumptions are understood and supported.
Backlog maintenance on remaining estate is contained within reduced budget	No	This position is no different from what it would have been at OBC. We have a limited capital budget and it will be applied to areas of greatest requirement, as currently.
Inflationary impact from 2016/17 to 2019/20	No	The additional funds set aside will be subject to inflation assumptions as with all other costs in the Financial Plan.
The continued level of Cash Releasing Efficiency Savings (CRES) can still be delivered taking cognisance of the level of ring-fenced budgets now included within this business case.	No	Savings targets are at a reduced level in the Financial Plan after the new facility becomes operational.

The challenges set in table 30 above will be addressed over the period up to the opening of the new facility, with most, if not all, of the issues identified being resolved through the planning processes including the LDP and OHAC Strategic Commissioning Plan.

4.8 Statement of affordability

Our Board confirms that the financial consequences will be managed as part of the approved Financial Plan, both revenue and capital. Our Board has previously supported the additional revenue funding commitment by setting aside £[REDACTED] in the approved 2016/17 Financial Plan.

The Financial Case identifies a further requirement for recurring revenue costs of £[REDACTED]. The approved Financial Plan has sufficient flexibility in future years to accommodate this increase, and will be amended to reflect that these funds are committed to support the FBC at its next revision (mid year 2016). The revised capital expenditure profile has already been reflected in the approved Financial Plan.

The Scottish Government has indicated their commitment to support a circa [REDACTED] prepayment of the ASP and the non NPD capital costs.

As discussed earlier in the Financial Case the ASP prepayment will be [REDACTED] which is made up of [REDACTED] of the construction cost ([REDACTED]) and the private sector development costs of [REDACTED]. The [REDACTED] is in line with 5% of the construction costs as set out in the OBC approval letter. Any consequent increase in the ASP will be the responsibility of our Board.

The Scottish Government annual revenue requirement has reduced by £ [REDACTED] to £ [REDACTED]. It is based on the assumption of a £ [REDACTED] prepayment which has in turn reduced the annually payable element of the ASP.

4.9 Conclusion

The cost models have been reviewed and additional recurring revenue costs of £ [REDACTED] have been identified arising from the increase in the floor area and additional capital equipment. There is sufficient flexibility in the Financial Plan to accommodate these costs.

Capital costs were updated as part of the 2016/17 Financial Plan which has already been approved by Scottish Government.

This project is being taken forward under a modified NPD model with a funding variant. This incorporates a prepayment of the ASP of circa [REDACTED]. The impact of the prepayment on funding flows is expanded upon, and the budgetary impact for NHS Orkney and Scottish Government is identified. The Scottish Government annual revenue requirement commitment has reduced to [REDACTED]. The introduction of the prepayment has prompted a review of the VAT recovery position. Whilst we are confident that VAT is recoverable, we are awaiting a formal opinion from HMRC.

Financial risks have been updated, with no new concerns identified in relation to this Business Case.

The accounting treatment of the various funding flows has been updated, taking account of the impact of the European System of Accounts (ESA10).

MANAGEMENT CASE

5 MANAGEMENT CASE

5.1 Introduction

Our Board recognises the challenges of bringing this project to a successful completion with the commissioning of the new building and equipment and transfer of Hospital and Healthcare services into state of the art facilities.

This section of the FBC addresses the ‘achievability’ of the project. Its purpose, therefore, is to build on the OBC by setting out in more detail the actions that will be required to ensure the successful delivery of the project in accordance with best practice.

5.2 Project management strategy and methodology

This project supports the principles of project and programme management to ensure that the project is successfully delivered. The New Hospital and Healthcare Facilities Project sits within a range of wider changes to the health system within Orkney, under the banner of NHS Orkney’s service redesign programme, Transforming Clinical Services. Reflecting this The New Hospital and Healthcare Facility Project, eHealth project, CT scanner project and a range of other services redesigns are brought together within the PIB structure.

Clear and appropriate project governance arrangements are fundamental to the success of the project. The governance arrangements adopted, taken together with the procurement strategy and the resources deployed to support the project, must ensure that NHS Orkney is able to procure the new hospital and healthcare facilities in an efficient and effective manner, whilst also allowing adequate scrutiny at key decision points.

It is the responsibility of our Board to ensure that an appropriate and robust governance structure is in place for the project. The procurement project management arrangements were audited by Internal Audit in Nov 2015, the assessment of which was Green across all five audit objectives. The definition of Green being “adequate and effective controls which are operating satisfactorily”. The Internal Audit Report is provided at Appendix 11.

The governance structure must be fully reflective of the revenue financed NPD procurement route and the significant level of prepayment of the ASP, being followed in relation to the new build. It should also recognise that our Board will be identifying a private sector partner with which it will engage on a daily basis for the next 25 years as a minimum. Our Board’s Scheme of Delegation was formally changed to ensure clarity of decision making authority at key points in this NPD project.

5.3 The project framework

This project is governed through the Transforming Clinical Services Programme Implementation Board (PIB) which reports to our NHS Orkney Board which has overall responsibility for this project as Investment Decision Maker.

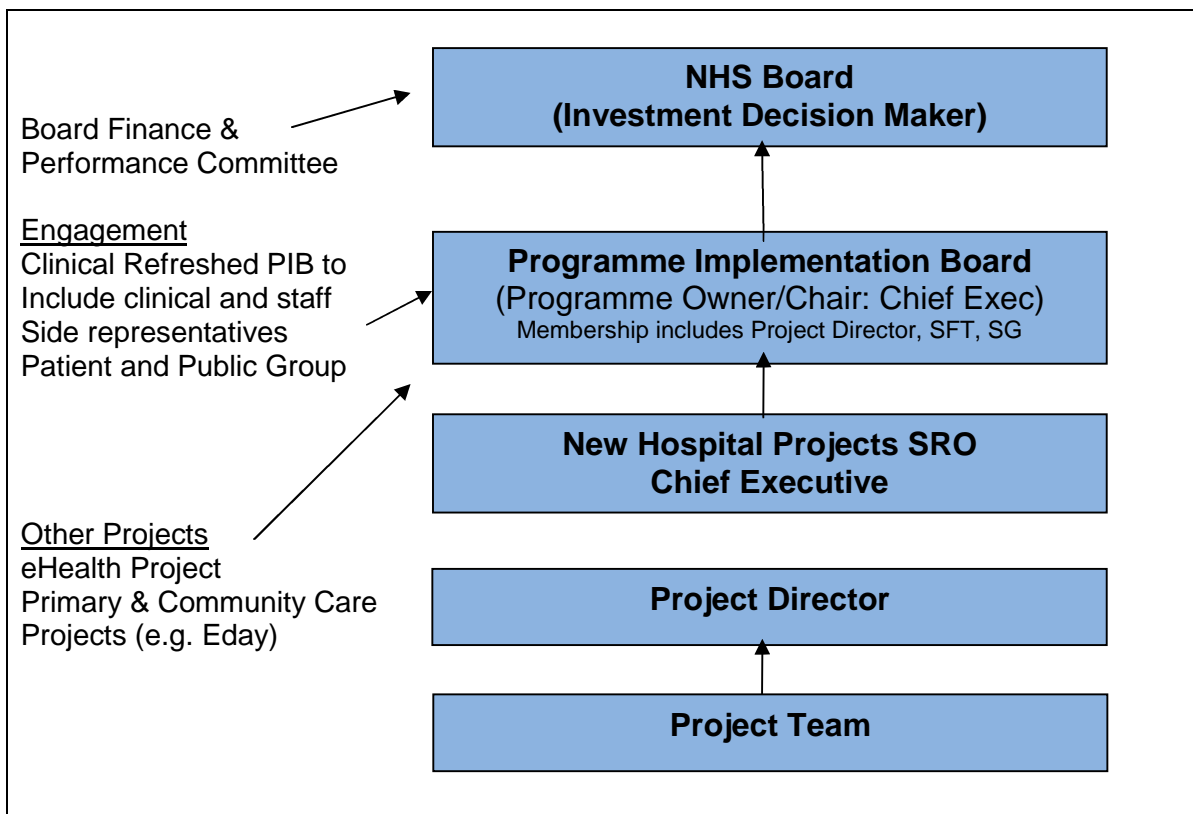
The Finance and Performance Committee performs a scrutiny role in support of our Board.

The diagram below sets out:

- The overall programme structure
- How the Programme Implementation Board and the Project Team for the new Hospital and Health Care Facilities Project fit into this structure
- The key roles for the new Hospital and Healthcare Facilities Project including the Project Sponsor and Project Director
- The key supporting mechanisms.

5.4 Project structure

Figure 8 Project Governance Structure



The detailed roles and responsibilities within the project structure are set out in table 31 below.

5.4.1 Project roles and responsibilities

Table 31 Team/Group Project Roles and Responsibilities

Team or Group	Role and Responsibilities
Orkney NHS Board – The Investment Decision Maker (IDM)	<p>It is essential that there is a clearly identified body with responsibility for approving the investment. The NHS Orkney Board is the Investment Decision Maker (IDM) for the project and as part of this is responsible for deciding what financial and other resources to invest in the project. Our Board considers whether the project fits with the strategic direction that it is developing.</p> <p>Our Board also needs to be satisfied that the project is affordable throughout its life. Our Board should also be satisfied that the project represents value for money in the context of the available funding. Ultimately our Board is accountable for the successful delivery of this project.</p> <p>Our Board ensures that an appropriate governance structure is put in place, and that adequate resources have been deployed including appointing the Project Sponsor.</p> <p>Our Board has approved a formal Scheme of Delegation that will allow certain of its responsibilities to be exercised at other levels within the organisation. A Scheme of Delegation has been developed for the project which reflects the NPD procurement process and the key decision making points that are required.</p> <p>A vital part of our Board's role as Investment Decision maker, and which will not be delegated, will be to approve the selection of the Private Sector Partner at the conclusion of the bidding exercise. The Private Sector Partner will be responsible for the design (to completion), construction, finance, maintenance and life cycle replacement of the new hospital building over a period of at least 25 years. Our Board meets on a bimonthly basis.</p> <p>On occasion, the procurement timescale of the project may require a meeting to be called at a crucial stage in the project and possibly at short notice.</p>
Finance and Performance Committee	<p>Whilst the NHS Board is the Investment Decision Maker and as such retains responsibility for the most major decisions, more detailed scrutiny is undertaken by our Board's Finance and Performance Committee. The Scheme of Delegation makes clear what authority is being delegated to the committee.</p> <p>Detailed scrutiny of issues at the Finance and Performance Committee gives the full NHS Orkney Board confidence in</p>

Team or Group	Role and Responsibilities
	<p>the progress of the project.</p> <p>The Executive Project Sponsor is a key member of the Finance and Performance Committee.</p> <p>The frequency and timing of Finance and Performance (F&P) Committee meetings are bimonthly. Additional meetings may be called at crucial stages in the project and possibly at short notice.</p>
<p>Programme Implementation Board (PIB)</p>	<p>The PIB takes decisions in areas delegated to it through the Scheme of Delegation, and will make recommendations to our NHS Orkney Board or F&P committee, on other issues where it does not have delegated authority.</p> <p>PIB membership has been agreed by the Project Sponsor and includes the Project Director.</p> <p>The PIB has a wide range of senior membership from a variety of stakeholders in the new hospital and healthcare facilities building project, including management with responsibility for the services and clinicians providing the services.</p> <p>The Scottish Government is represented on the PIB.</p> <p>The Scottish Futures Trust is represented on the PIB.</p> <p>The PIB is responsible for reviewing the risk register at regular meetings taking due consideration of the red risks highlighted along with the proposed mitigating actions.</p> <p>The Project Director brings a high level report on project progress to each meeting. This report identifies issues where decisions are required and those issues that are delaying progress on the project.</p> <p>The PIB ensures that the role of external advisors is clear and that their involvement in the project is appropriate and complementary to that of our Board's own staff resources, whilst recognizing that our Board's staff resources are limited.</p> <p>The PIB will also ensure that the involvement of the advisors stops short of them taking on a leadership role.</p> <p>The remit of the PIB covers the entire range of issues that needs to be addressed in the project.</p> <p>The PIB is chaired by the Project Owner and meets monthly with more frequent meetings where required.</p>
<p>Project Team</p>	<p>The Project Team is a small group of individuals who work largely full time on the project and their role is to ensure that the New Hospital and Healthcare Facilities Project is managed successfully throughout all stages of the project so that all project objectives are met and all benefits are</p>

Team or Group	Role and Responsibilities
	<p>realised. The Project Team is further supported by key individuals from within our Board and whose particular expertise and knowledge is essential to the project. In addition the Project Team has sourced and manages the inputs of a team of external advisors to provide expert technical, legal and financial advice.</p> <p>The Project Team is led by the Project Director. In addition to their specific functional roles and specialism members of the Project Team have an overarching responsibility to ensure that all relevant stakeholders are fully engaged in the project through the delivery of change plans and an agreed strategy for:</p> <ul style="list-style-type: none"> • Communication • Risk management • Change control • Quality assurance • Planning • Business case development • Programming • Design • Procurement • Construction • Commissioning <p>Post occupancy evaluation activities. The Project Director and the project team attend all PIB meetings.</p>

5.4.2 Individual roles within the project structure

The detailed roles and responsibilities of the key individuals within the project structure are set out in table 32 below.

Table 32 Individual Project Roles and Responsibilities

Individual	Role and Responsibility
Project Owner	<p>The Project Owner’s involvement in the project, whilst not on a full time basis, is held by one person that is the CEO. This arrangement avoids any ambiguity about who is fulfilling the role of Project Owner.</p> <p>The Project Owner ensures that the Board receives regular reports on project progress and is alerted to issues that risk impeding the course of the project. The</p>

Individual	Role and Responsibility
	<p>Project Owner is responsible for alerting the Board if the project is likely to be delayed or has other major difficulties, such as additional demands on NHS Orkney finance. The Project Owner also chairs the PIB. Notwithstanding the involvement of others at a senior level in the project, the Project Owner retains personal responsibility for the success of the project. It is the responsibility of the Project Owner to appoint a suitably senior and named individual as a Project Sponsor.</p> <p>Owing to the project's importance and scale, the Board's Chief Executive has been identified as the Project Owner for the project. . The Chief Executive is also the overall Executive Sponsor for the Transforming Clinical Services Programme.</p>
Project Sponsor	<p>Recognising the importance, scale and complexity of this project it requires a Project Sponsor, who is appointed by and reports direct to the Project Owner. The Project Sponsor provides more direct input to the project than can be expected of the Project Owner and ensures that the project is sufficiently resourced. While the input of the Project Sponsor is on a part time basis, an important responsibility of the Project Sponsor is to provide support and direction to the Project Director.</p> <p>The Project Sponsor role is not split or shared between individuals.</p> <p>Our Board's Chief of Executive has been identified as the Project Sponsor.</p>
Project Director	<p>Appointed by the Project Sponsor this is a full time role with a considerable degree of authority and responsibility for driving the project forward on a day to day basis by providing the project with visible leadership.</p> <p>In light of the procurement arrangements for the project the Project Director must have experience of procuring revenue funded projects i.e. PPP/PFI/NPD. It is very important that NPD skills are not provided exclusively by advisors.</p> <p>The Project Director is the senior individual working on the project on a full time basis and has support from a team of individuals working on the project either on a full-time or part-time basis.</p>

Individual	Role and Responsibility
	<p>The Project Director brings reports on project progress and issues requiring decision to the Project Board and is accountable to the Project Sponsor.</p> <p>The position of Project Director is currently fulfilled by a suitably experienced full time employee of our Board.</p>
<p>Project Manager</p>	<p>Responsible for the day to day management of the project in particular</p> <ul style="list-style-type: none"> • Developing and monitoring the project procurement programme, • Managing advisory team inputs • Developing and maintaining project documentation including ITPD and ISFT documents • Supporting the Project Team in the competitive dialogue phase • Supporting the project evaluations at Interim and Final Bid stages. <p>The role is currently fulfilled by a suitably qualified and experienced seconded individual.</p>
<p>Public Interest Director (Will be appointed as a Director to the Project Company at Financial Close)</p>	<p>The public interest is represented in the governance of the NPD structure, which increases transparency and accountability and facilitates a more pro-active and stable partnership between public and private sector parties.</p> <ul style="list-style-type: none"> • Monitoring the Project Company's compliance with the core NPD principles • Bringing an independent and broad view to the Project Company's board • Monitoring conflict of interest situations and managing board decisions where there is a conflict of interest for the other directors • Reviewing opportunities for, and instigating, refinancing • Reviewing opportunities for, and instigating, opportunities for realising cost efficiencies and other improvements in the Project Company's performance (on the basis that in the absence of equity return there is a potential lack of incentive for the other directors to explore or promote these). <p>It is anticipated that SFT will nominate a Public Interest Director for this NPD project post Financial Close.</p>
<p>Commercial Lead</p>	<p>Provides senior direction by</p> <ul style="list-style-type: none"> • leading the all commercial aspects of the Project • working within our Board's capital planning

Individual	Role and Responsibility
	<p>framework to ensure integration with any other relevant internal or external capital project</p> <ul style="list-style-type: none"> • directing the overall commercial management of the project from OBC to full service commencement • managing the costs across the Project • advising on procurement strategy and preparation of tender documents where appropriate. • being the senior interface between the Project and NPD Supply Chain Partners. <p>The role is currently fulfilled by a suitably qualified and experienced NHSO employee.</p>
Authority Observer	<p>Our Board will be entitled to appoint an "Observer" to attend and participate (but not vote) at the Project Company's board meetings.</p>
Contract Manager	<p>To ensure that expenditure is effective and efficient and that a productive relationship is maintained with Project Co.</p> <p>Ensure that contract monitoring is efficiently carried out and that all service parameters are being delivered. This role is endorsed by SFT and described in SCIM Guidance. This role will be filled once the contract is awarded.</p>
FM Lead	<p>Ensures all FM matters are clearly and completely defined and what is delivered by the project is fit for purpose and will meet the needs of users and stakeholders.</p> <p>Supports relevant aspects of Reviewable Design Data (RDD), Relief Events, Change and pre-Service Commencement information compliance issues.</p> <p>Finalises interface agreements with contractor leading up to financial close. Provides specific input on RDD items from cleaning/ground maintenance perspective.</p> <p>This role is filled by a suitably qualified member of NHS Orkney staff.</p>
ICT Lead	<p>Advisory role in respect of commissioning, handover of infrastructure. Oversees installation, commissioning and testing of Authority hardware (the network, servers and critical workstations). Responsible for transfer of NHS Orkney ICT equipment. This role is filled by a suitably qualified member of NHS Orkney staff.</p>
Clinical Programme	<p>Provides expert clinical advice in relation to all clinical</p>

Individual	Role and Responsibility
Lead	service planning and provides specialist clinical advice relating to all aspects of the project, ensuring that all clinical and non clinical services are consulted and have sufficient input into the service specifications for both transitional works and the new build. Works with senior clinical, managerial staff and the wider redesign and project team to ensure clinical developments and initiatives align with the new service models and building specifications in the new build to ensure that that clinicians act as key partners in the service planning, building and equipping requirements. This role is filled by a suitably qualified member of NHS Orkney staff.
Authority Site Representative/Clerk of Works	An NHSO appointment who will be the Authorities construction professional interface with Project Co. The site representative will <ul style="list-style-type: none"> • attend weekly meetings with Project Co site representatives, • be responsible for communications with Authority personnel regarding day to day activities. • be the first line interface for operational/business continuity issues and contact for any site access requirements • manage site related Health & Safety matters on behalf of the Authority Appointment to be considered.
Cost Consultant	Reviews and agrees variations/changes. Supports Project Director in responding to relief/compensation events. Cost reporting and review of Project Co and associated reports.

5.4.3 External advisors

The Project Team is supported by external advisors providing technical, financial, healthcare planning and legal advice to the project.

Following formal procurement processes the following appointments were made from SFT frameworks or, with respect to Healthcare Planners, from the Health Facilities Scotland framework

- Technical advisors – Sweett Group
- Financial advisors – Caledonian Economics, supported by QMPF
- Legal advisors –MacRoberts

- Healthcare planning advisors – Buchan and Associates
- Insurance advisors – Willis

These appointments are reviewed at each project stage to ensure appropriate advice is in place and to identify any opportunities for the transfer of skills to Project Team members.

5.5 Project milestones

Table 33 Project Milestones

Milestone	Date
Approval of FBC by NHS Board	August 2016
Submission of FBC to SGHSCD CIG	23 August 2016
Approval of FBC by the SGHSCD CIG	20 September 2016
Construction Commence (mobilisation)	October 2016
Construction Complete	December 2018
Commence Post Project/Post Occupancy Evaluation	December 2018

5.6 Communication and reporting arrangements

Public consultations were carried out in 2013 and 2014.

In parallel with these formal processes, the Board has pursued an active internal and external communications process to provide information to staff, patients and the public about the scheme as it has progressed.

The purpose of the communication plan is multi faceted and is designed to ensure that all stakeholders are informed and engaged, are aware of the status of the development and encourage wider community involvement. The communication plan is a dynamic document and is subject to review on a regular basis and communication initiatives are linked with the stages of the project.

A Project Communication Group has been established lead by the Chief Executive to ensure that project specific communications are developed that are consistent and appropriate across all stake holders including staff, the public and our partner organizations. The group membership includes the Employee Director, the Project Director and the Head of OD and Learning.

5.7 Key stage review

As part of the governance process for NPD projects, there is a requirement to participate in SFT Key Stage Reviews (KSRs) at specific stages up to Financial Close.

All KSR reviews are detailed below:

- Pre Issue of OJEU Notice – July 2014
- Pre issue of Invitation to Participate in Dialogue – October 2014
- Pre-Close of Dialogue – May 2016
- A further KSR will be required in advance of Financial Close.

The SFT recommendations for each of the above KSRs have been fulfilled within the appropriate project stage.

5.8 Conclusion

This section of the FBC demonstrates that NHS Orkney has developed a robust programme management framework outlining the following:

- Governance structure
- Project team structure
- The roles and responsibilities of key members
- Project and Programme plan including key milestones
- Key Stage Review
- Communications and reporting arrangements.

5.9 CHANGE MANAGEMENT

5.9.1 Change management philosophy

Our Board's change management philosophy is to:

- Recognise the significance of the change
- Take the opportunity to improve the quality of healthcare
- Implement the change in a structured and well managed way

5.9.2 Service and operational change management principles

Our Board has developed a series of principles that will underpin the service and operational change process. The principles established are to:

- Recognise the need to maximise the benefits of the change for patients, who are at the heart of the changes made
- Take advantage of the time available to complete the new build to start the change process and thereby avoid risks related to a 'big bang' approach
- Test and prove the changes through careful piloting of any aspects of the

new models and processes that can be implemented before the new facility is finally commissioned

- The change management philosophy and principles will be communicated to all staff
- Work in partnership with staff and other stakeholders both within and outside the hospital to engage all those involved in the delivery of care in the change process
- Focus on staff skills and development required so staff are both capable and empowered to deliver healthcare effectively and to a high quality standard in the new facility through new models of care

Our Board has a change management approach in place that encompasses the philosophy and principles above.

5.9.3 Changes arising in the project

In the Pre Financial Close phase of the procurement changes to Project Co's final tender may arise from Project Co or from the 1:50 process being managed by the Project Team. If such changes arise which incur costs that will impact on this FBC, these will be escalated to the PIB for agreement, prior to implementation. Changes will only be approved which are demonstrated or evidenced to be clinically or operationally required and affordable, using our Boards agreed internal procedure.

In the construction and commissioning phase, the change protocol in the PA governs the management of changes post Financial Close.

During the operational phase, the service provided by Project Co is enshrined in the PA. Day to day matters, performance delivery issues and the management and control of change will be through the NHS Orkney Contract Manager role.

This project represents a significant change for NHS Orkney. The change to the physical infrastructure is simply an enabler to a more fundamental change in the way that healthcare will be delivered for the population served by NHS Orkney.

The impact of the change to workforce, facilities and the model of care will be considerable, and the clinical and service change programme will manage this change agenda.

5.9.4 Conclusion

Robust change management processes are in place to support the management of change both in the wider context of our Board's transformational and development programmes and to support the procurement and delivery of the new build.

5.10 BENEFITS REALISATION PLAN

5.10.1 Introduction

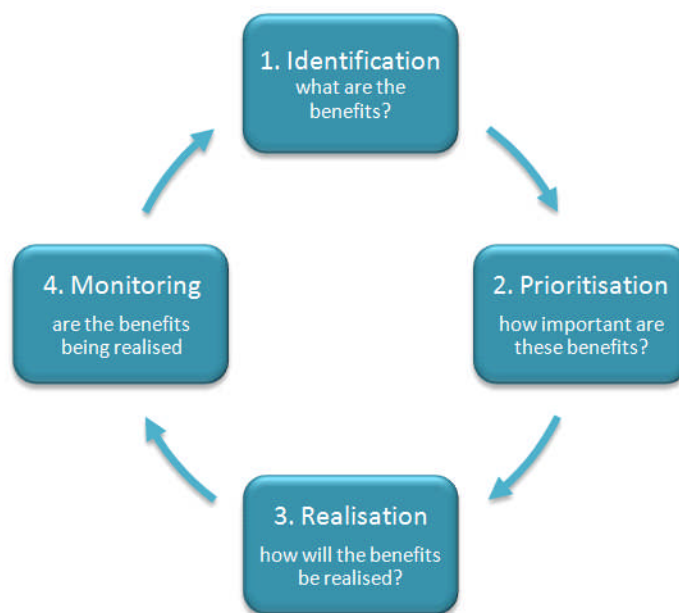
A Benefits Realisation Plan (BRP) outline was developed for the OBC. This section reviews the process undertaken in order to achieve the outcomes and includes the associated SMART measures.

A more detailed BRP has been further developed from the OBC version and will continue to be refined as the Project progresses.

5.10.2 Project benefits

Benefits management is the overarching process that incorporates the BRP as part of a process of continuous improvement. It takes due account of changes in the project during the operational phase which impact on, or alter the anticipated benefits.

As such, the benefits realisation is a planned systematic process consisting of 4 defined stages as shown below (reference: SCIM)



The BRP provides the means by which our Board will ensure that the potential benefits arising from the New Hospital & Healthcare Facilities Project are realised and will demonstrate that the investment has been worthwhile to key stakeholders.

Achievement of the benefits will be assessed as part of a structured approach to Post Project Evaluation. Post Project Evaluation will comprise a review of achievement of the Project's Objective, after completion of Financial Close and construction and two years into the operational phase.

Table 34 Project Benefits

Benefit	Features
Wellbeing & Patient Experience	<p>Appropriate range of accommodation to meet patient, staff and visitor needs</p> <p>Seamless transition from hospital to care in the community</p> <p>Improved privacy and dignity</p> <p>Dementia and cognitive impairment friendly</p> <p>Access to real time information regarding care and telehealth solutions to enable care at home/closer to home</p> <p>Clinical capacity maximized by optimum adjacencies that support new models of care and flexible workforce flows.</p> <p>Electronic self check in.</p>
Attract & Retain Staff	<p>Better employee experience</p> <p>Ability to repatriate services and retain and attract employees</p> <p>Sustains adequate numbers of staff and students</p> <p>Appropriate access to training and development</p> <p>Improving the working environment for staff</p> <p>Ability to both recruit and retain staff</p> <p>Makes best use of all available skills amongst the work force</p> <p>Complies with clinical staffing standards</p> <p>More flexible ways of working e.g. home working options and smarter offices</p> <p>Increased technology enabled support – access to remote clinical decision making.</p>
Fit for purpose (legislation, standards, accreditation)	<p>Provides appropriate and safe service provision within and outwith normal working hours</p> <p>Improved compliance with the Equalities Act</p> <p>Environment that supports effective prevention and control of infection</p> <p>Meets minimum size guidelines for clinical & non clinical accommodation</p>

Benefit	Features
	<p>Ability to meet quality standards and other guidelines Meets all clinical standards, guidelines and legislation.</p>
<p>Right clinical/non-clinical adjacencies/flows</p>	<p>Optimises use of staff resource staff follow the patient rather than patients being moved to meet staffing models. Supports standard care pathways Supports effective communication across the healthcare team Supports integrated team working Minimises duplication Improved quality of care through real time access and updates to care plans (which can be shared with primary and other specialists).</p>
<p>Access to services (transport, visibility, location)</p>	<p>Supports joint working with other providers Improved integration with SAS Improved way finding Increased accessibility – Travel Plan.</p>
<p>Provision of Multifunctional Rooms/Spaces</p>	<p>Maximises usage and likelihood of accessing suitable space Makes best use of expensive resources e.g. theatres, radiology etc Allows flexibility in work base.</p>
<p>Shared Plant & Facilities</p>	<p>Co-location of clinical and non clinical services within one central site Co-location with Primary Care, SAS, NHS 24, Dental and some community services Efficiency from rationalisation of plant and support services.</p>
<p>BREEAM & Sustainability</p>	<p>Achieves BREEAM very good rating as a minimum Supports a reduction in CO² emissions.</p>

As part of the further development of BRP, our Board will agree baseline measures reflecting the status of each benefit area and the benefits realisation monitoring process.

This will be linked to the change management plan to provide assurance on delivery.

Further work has been undertaken to fully identify the range of benefits that will result from delivery of this project. These are highlighted below and will be further developed during the BRP process outlined above.

5.10.3 Conclusion

A more detailed BRP, further developed from the OBC version, and attached as Appendix 12 will continue to be refined as the Project progresses.

5.11 RISK MANAGEMENT PLAN

5.11.1 Introduction

Risk management is the culture, processes and structures used to manage risk. Implementation of a comprehensive, effective risk management approach is an essential part of project management, which must control and contain risks if a project is to be successful.

The continuing development of a comprehensive Risk Register is a core part of risk management activity. The purpose of a Risk Register is primarily to focus attention on the risks related to the project, to provide a method of describing and communicating the risk, identifying and prioritising resources to mitigate the risk and to document actions to reduce the risk.

The process of risk analysis for the FBC followed four steps:

- Risk identification - developing a Risk Register covering key risk areas and individual risks within these areas
- Risk assessment - estimating the probability and timing of each risk occurring and the impact if it should occur
- Risk quantification - putting a value to each of the risks, using the estimates of probability, impact and timing
- Risk management - developing a plan to manage all the risks identified in the risk register for the preferred option, including responsible persons and monitoring mechanism.

This section of the FBC sets out NHS Orkney's approach to the management of risks associated with the project incorporating:

- Risk management philosophy
- Risk identification and quantification
- The approach to risk management.

5.11.2 Risk management philosophy

Our Board's philosophy for managing risks considers effective risk management to be a positive way of achieving the project's wider aims, rather than a mechanistic exercise, to comply with guidance. Inadequate risk management would reduce the potential benefits to be gained from the project.

Our Board recognises the value of an effective risk management framework to systematically identify, actively manage and minimise the impact of risk. This is done by:

- Having strong decision making processes supported by a clear and effective framework of risk analysis and evaluation
- Identifying possible risks before they crystallise and putting processes in place to minimise the likelihood of them materialising with adverse effects on the project
- Putting in place robust processes to monitor risks and report on the impact of planned mitigating actions
- Implement the right level of control to address the adverse consequences of the risks if they materialize.

5.11.3 Risk management and quantification

At the point at which the OBC was developed risk workshops were held involving members of the Project Team, the external advisors as well as a cross section of NHS Orkney staff with the outcome reported to PIB.

The workshops focused on establishing a range of project risks reflecting the scope of the project as well as the likely procurement route. Primary risks were identified across a range of categories incorporating:

- Clinical risks
- Contractual risks
- Design risks
- Enabling works risks
- Equipping risks
- FM risks
- Land acquisition risks
- Legal risks
- Procurement risks
- Project management risks.

These risks were further allocated across a range of categories depending on where these risks would apply within the overall structure of the project. These include:

- The phase of the project to which they apply
- Those that would have a major impact on the cost of the project

- The ownership of the risks including those, which can be transferred to the NPD contractor.

Each risk has subsequently been assessed for its probability and impact, and where relevant its expected value. The New Hospital and Healthcare Facilities Project operates two related risk registers, the Procurement Risk Register which covers those risks directly related to the procurement process and the Operational Risk Register that deals with those risks associated with the operational phase of the Project, as they are currently understood.

The risk registers are maintained as dynamic documents by the Project Director and are subject to monthly review by the Project Risk Group and updated at key milestones or as the need arises. This ensures that the risk profile for project is kept under constant review. The top ten risks are reported to the PIB on a monthly basis.

A copy of the full Procurement and Operational Risk Registers is provided at Appendix 3.

5.11.4 Risk management process

The process of risk management can be characterised as:

- Identifying the risk
- Assessing the risk
- Mitigating and reporting the risk
- Closing the risk.

Each risk is scored, for its likelihood and impact using the 1 to 5 matrix below. Multiplying the likelihood and impact ratings gives a single score which determines whether a risk is a Red, Amber Yellow or Green rating as set out in the matrix.

The risk register incorporates details of risk owners and appropriate counter measures to manage our Board's exposure to the risks and this has been maintained and updated throughout the procurement process.

The Project Risk Group has responsibility for the management of the risk process including ongoing assessment and quantification of risks. The group also review and develop the management strategies associated with the risks. This group comprises members of the Project Team with input from our Board's Technical and Financial Advisors as required.

The Risk Group meets on a monthly basis and identifies, manages and records risks, providing assurance to the PIB. The PIB receives a risk report on a monthly basis detailing the top 10 Risks and new risks as they are identified, including mitigation actions.

The risk management process outlined above, and explained in more detail at Section (1.6) aids the assessment of the transfer of risk under the NPD contract. This process also provides a “look forward” to risks associated with the Operational phase of the Project via the Operational Risk Register.

Figure 9 Risk Score Matrix

			Likelihood				
			Rare	Unlikely	Possible	Likely	Almost Certain
		Score	1	2	3	4	5
Impact	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Minor	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5

The risk rating then determines the risk action or treatment as set out below

Figure 10 Risk Rating

Risk rating	Combined score	Action/Treatment
Very High	20 - 25	Poses a serious threat. Requires immediate action to reduce/mitigate the risk. The risk must be escalated to PIB.
High	10 - 16	Poses a medium threat and should be pro-actively managed to reduce/mitigate the risk. May, at the discretion of the Project Director, be escalated to PIB for review.
Medium	4 - 9	Poses a threat and should be pro-actively managed to reduce/mitigate the risk.
Low	1 – 3	Poses a low threat and should continue to be monitored.

5.12 CONTRACT MANAGEMENT ARRANGEMENTS AND PLAN

5.12.1 Introduction

Contract management arrangements are in place to ensure that:

- The Project is implemented successfully with the minimum of adverse impact on NHS Orkney and the local health economy
- The health system elements of the Project are delivered effectively, on time and to cost without delay
- The value of the Project is maximised not only in terms of effective use of resources and meeting user needs; but also in regeneration of the local economy and providing health facilities of which the Orkney's population can justifiably be proud.

5.12.2 Contract management philosophy

The primary aim of contract management is to ensure that the needs of the project are satisfied and that NHS Orkney's Board receives the service it is paying for, within the boundaries of the contract whilst achieving value for money. This means optimising efficiency, effectiveness and economy of the service or relationship described in the contract, balancing costs against risks and actively managing the client contractor relationship.

The contract management for this project is based on collaborative working and joint decision-making. Whilst the NHS Orkney's Board is the Client and as such responsible for setting and agreeing the scheme objectives, the partnership approach enjoys the benefit of the Client and Project Co working together to resolve problems and objectively develop the best Value For Money (VFM) solutions.

Contract management also involves recognising the balance of the roles and responsibilities as defined within the contract and aiming for continuous improvement over the life of the project.

Our Board's contract management will:

- Maximise the chances of contractual performance in accordance with the contract requirements by providing continuous and robust contract management which supports both parties
- Optimise the performance of the project
- Support continuous development, quality improvement and innovation throughout the project
- Ensure delivery of best VFM
- Provide effective management of commercial risk
- Provide an approach that is open to scrutiny and audit
- Support the development of effective working relationships between both parties

- Allow flexibility to respond to changing requirements
- Demonstrate clear roles, responsibilities and lines of accountability
- Ensure that all works and services comply with the Authority's Requirements, current legislation, relevant changes in Law and Health and Safety requirements, and NHS Scotland policies and procedures.

5.12.3 Roles and responsibilities

The governance structure outlined within 5.4 has been utilised for all stages of this procurement and will continue into Construction and Handover, providing a clear and concise process for the flow of information and identifiable organisational governance arrangements within NHS Orkney.

Our Board Project Director is accountable for the delivery of the Project to meet the strategic and business needs of the NHS Orkney Board. Our Board Project Director reports to the PIB.

The contract has a role for the "Authority's Representative". The Project Director will represent NHS Orkney and will be the formal point of contact for Project Co in terms of formal contract notices, requests for changes etc.

The contract also has a role for an "Authority Observer". This is an individual, nominated by our Board, who will be invited to attend all board meetings of the NPD Company, for the purposes of observing proceedings and reviewing papers (although will not act as a director and will have no decision making role).

5.13 POST PROJECT EVALUATION

5.13.1 Introduction

Our Board set out its commitment to the Post Project Evaluation (PPE) process in the OBC. NHS Orkney will ensure that a thorough and robust PPE is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project.

The aim of PPE is to determine whether the original objectives set by the project have been achieved. It involves the consideration of the effectiveness and efficiency of the project.

5.13.2 Framework for post project evaluation

Scottish Government has published guidance on PPE, which supplements that incorporated within the SCIM. The key stages applicable for this project are set out in table 35 below:

Table 35 Post Project Evaluation

Stage	Evaluation Undertaken	When Undertaken
1	Plan and cost the of the PPE work at the project appraisal stage. This should be summarised in an Evaluation Plan	Plan at OBC, fully costed at FBC stage
2	Monitor progress and evaluate the project outputs	On completion of the facility
3	Initial PPE to evaluate the project outputs	Six months after the facility has been commissioned
4	Follow up PPE (or post occupancy evaluation-POE) to assess longer-term service outcomes after the facility has been commissioned. Beyond this period, outcomes should continue to be monitored. It may be appropriate to draw on this monitoring information to undertake further evaluation after each market testing or benchmarking exercise	Two years after the facilities have been commissioned

Within each stage, the following issues will be considered:

- The extent to which relevant project objectives have been achieved
- The extent to which the project has progressed against plan
- Where the plan was not followed, what were the reasons
- Where relevant how the plans for the project should be adjusted.

In the early stages, the emphasis will be on formative issues. In the later stages, the focus will be on summative or outcome issues. These are further described below:

Formative Evaluation

As the name implies, is evaluation that is carried out during the early stages of the project before implementation has been completed. It focuses on 'process' issues such as decision making surrounding the planning of the project, the development of the business case, the management of the procurement process, how the project was implemented, and progress towards achieving the project objectives.

Summative Evaluation

The focus of this type of evaluation relates to outcome issues which are carried out during the operational phase of the project. Summative evaluation builds on the work done at the formative stage and addresses issues such as: the extent to which the project has achieved its objectives; how out-turn costs, benefits and risks compare against the estimates in the original business case; the impact of the project on patients and other intended beneficiaries; and lessons learned from developing and implementing the project.

The Project Owner will be responsible for ensuring that the arrangements have all been put in place and that the requirements for PPE are fully delivered. The Project Director will be responsible for day to day oversight of the PPE process, reporting to the Project Owner and PIB.

The Project Owner and the Project Director will set up an Evaluation Steering Group (ESG), which will:

- Represent interests of all relevant stakeholders
- Have access to, professional advisors who have appropriate expertise for advising on all aspects of the project

The key principle is that the evaluation is objective.

The Evaluation Team will be multi-disciplinary and include the following professional groups, although the list is not exhaustive:

- Clinicians, including consultants, nursing staff, clinical support staff and Allied Health Professionals
- Healthcare Planners, Estates professionals and other specialists that have an expertise on facilities
- Accountants and finance specialists, ICT professionals, plus representatives from any other relevant technical or professional grouping
- Patients and/or representatives from patient and public group

The resulting PPE report will be submitted to NHS Orkney Board and onwards to the Scottish Government and will be written to address, as far as possible, the following issues:

- Were the project objectives achieved
- Was the project completed on time, within budget, and according to the specification
- Are users, patients and other stakeholders satisfied with the project results
- Were the business case forecasts/success criteria achieved
- Overall success of the project – taking into account all the success criteria and performance indicators, was the project a success?

- Organisation and implementation of the project – did the Board adopt the right processes? In retrospect, could the project have been organised and implemented better?
- What lessons were learned about the way the project was developed and implemented?
- What went well? What did not go according to plan?
- Project Team recommendations – record lessons and insights for the information of future major projects

An outline Evaluation Plan is attached at Appendix 13

5.14 Conclusion

Plans are in place to undertake the appropriate post project evaluation process following best practice

GLOSSARY OF TERMS

24/7	Twenty four hours a day seven hours a week
A&DS	Architecture and Design Scotland
ACR	Authorities Construction Requirements
AHP	Allied Health Professional
AME	Annual Managed Expenditure
AODOS	Admission On Day Of Surgery
ASP	Annual Service Payment
ATA	Authorities Technical Advisor
BADS	British Association of Day Surgery
BREEAM	Building Research Establishment Environmental Assessment Method
BRP	Benefits Realisation Plan
CAPEX	Capital Expenditure
CD	Competitive Dialogue
CDU	Central Decontamination Unit
CIG	Capital Investment Group
CMT	Corporate Management Team
CO ₂	Carbon Dioxide
CRL	Capital Resource Limit
CRES	Cash Releasing Efficiency Savings
CT	Computer Tomography
D&B	Design and Build
DEL	Departmental Expenditure Limits
DMR	Digital Medical Record
EAMS	Estates Asset Management System
ECC	Emergency Care Centre
ED	Emergency Department
ENE 01	BREEAM's Energy Efficiency Calculator
ESA10	European System of Accounts 2010
ESG	Evaluation Steering Group
EY	Ernst & Young
F&P	Finance and Performance Committee
FBC	Full Business Case
FM	Facilities Management
GP	General Practitioner
HAI	Healthcare Associated Infection
HBN	Health Building Note
HDU	High Dependency Unit
HFS	Health Facilities Scotland
HRI	High Resource Individuals
IA	Initial Agreement
ICT	Information Communications & Technology
IFRS	International Financial Reporting Standards
IFRIC	International Financial Reporting Interpretations Committee
IDM	Investment Decision Maker
ISD	Information Services Division (of National Services Scotland)
ISFT	Invitation to Submit Final Tender
ITPD	Invitation to Participate in Dialogue

ITU	Intensive Treatment Unit
JAG	Joint Advisory Group
KPI	Key Performance Indicator
KSR	Key Stage Reviews
LDP	Local Delivery Plan
LDRP	Labour, Delivery, Recovery and Postpartum
LTC	Long Term Conditions
MGDD	Manual of Government Deficit and Debt
MRI	Magnetic Resonance Imaging
NES	NHS Education Scotland
NDAP	NHS Scotland Design Assessment Process
NHSO	NHS Orkney
NPD	Non Profit Distributing
NPV	Net Present Value
OBC	Outline Business Case
OHAC	The Orkney Integrated Joint Board known as Orkney Health and Care
OD	Organisational Development
ODEL	Outwith Departmental Expenditure Limit
OIC	Orkney Islands Council
OJEU	Official Journal of the European Union
OOH	Out of Hours
OP	Out Patient
PA	Project Agreement
PAMS	Property and Asset Management Strategy
PB	Preferred Bidder
PFI	Private Finance Initiative
PIB	Programme Implementation Board
POE	Post Occupancy Evaluation
PPA	Prepayment Agreement
PPE	Post Project Evaluation
PPP	Public Private Partnership
PQQ	Pre-Qualification Questionnaire
PSN	Public Service Network IT Security Standards
PT	Project Team
QM	Quality Management
RDD	Reviewable Design Data
RGH	Rural General Hospital
RPI	Retail Price Index
RRL	Revenue Resource Limit
RTT	Referral to Treatment
SAS	Scottish Ambulance Service
SCIM	Scottish Government Capital Investment Manual
SoA	Schedule of Accommodation
SCP	Strategic Commissioning Plan
SFT	Scottish Futures Trust
SG	Scottish Government
SGHSCD	Scottish Government Health & Social Care Directorates
SHBN	Scottish Health Building Notes

SHPN	Scottish Health Planning Notes
SHTM	Scottish Health Technical Memorandum
SLA	Service Level Agreement
SMART	Specific, Measurable, Achievable, Realistic, Timely
SPV	Special Purpose Vehicle
SUDS	Sustainable Urban Drainage System
SVQ	Scottish Vocational Qualification
TIA	Transient Ischaemic Attack
TCS	Transforming Clinical Services
TTG	Treatment Time Guarantee
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
UHI	University of the Highlands and Islands
VAT	Value Added Tax
VFM	Value for Money
WTE	Whole Time Equivalent

APPENDICES

Appendix A

Director-General Health & Social Care and
Chief Executive NHS Scotland
Paul Gray



T: 0131-244 2410
E: dghsc@scotland.gsi.gov.uk

Cathie Cowan
NHS Orkney
Garden House
New Scapa Road
Kirkwall
Orkney
KW15 1BQ

In 2014 Scotland Welcomes the World



4 August 2014

Dear Cathie

NHS ORKNEY – NEW HOSPITAL AND HEALTHCARE FACILITIES IN KIRKWALL, ORKNEY – OUTLINE BUSINESS CASE

As you will be aware, an error has been identified in the schedule of Funding Conditions that accompanied my letter of 8 July 2014, approving the Outline Business Case for the above named project. I attach corrected Funding Conditions in the schedule accompanying this letter. These corrected Funding Conditions supersede those previously issued.

If you have any queries regarding the above please contact Mike Baxter on 0131 244 2079 or e-mail Mike.Baxter@scotland.gsi.gov.uk.

Yours sincerely

PAUL GRAY

Schedule : Funding Conditions

These are the conditions of conditional revenue funding referred to in the foregoing letter of approval of the Outline Business Case for the New Hospital and Healthcare Facilities in Kirkwall, Orkney.

The Outline Business Case (“**OBC**”) submitted by NHS Orkney (the “**Board**”) for the provision of a new hospital and healthcare facilities (the “**Project**”) has been approved by the Scottish Ministers on the basis set out in the foregoing letter and this Schedule and they have agreed that the Project should progress through the publication of a contract notice in the Official Journal of the European Union (“**OJEU notice**”) subject to the conditions listed in paragraph 9 below being satisfied. A firm offer of revenue funding support will be made at the end of the procurement process, subject to the Scottish Ministers’ overall and final approval of the Project after consideration of a Full Business Case (“**FBC**”) prior to contract signature/financial close. The scope and the conditions of this approval are set out in detail below.

As the procurement process for the Project progresses, Scottish Futures Trust (“**SFT**”) will apply scrutiny through the Key Stage Review (“**KSR**”) process and the approval of the Scottish Government’s Health and Social Care Directorates (“**SGHSCD**”) will be needed for the Project to proceed at each stage; and the approval of the Scottish Ministers for this Project will be required at FBC stage and will be dependent, inter alia, on the Board demonstrating that the Project offers value for money (see paragraph 5 below) and is affordable.

1. Project Costs

The revenue funding support will cover the following costs, which will be incurred by the private sector partner and included within its financial model for the Project and re-charged to the Board through an annual unitary charge, associated with the Project:

1.1 Construction costs

1.1.1 The nominal construction costs¹ eligible for revenue funding support are capped at £49.55m in Q1 2014 prices plus an inflation allowance calculated in accordance with paragraphs 1.1.3 and 1.1.4 below (exclusive of VAT) (the “**Construction Cost Cap**”).

1.1.2 This value is £8.0m below the construction costs presented in the Outline Business Case. This reflects the Independent Design Review cost report which recommended a quantified risk register to replace the general categories of design and construction contingency and optimism bias. It also reflects SFT discussions with the Board that programme level risks should be excluded from the risk register when calculating the construction cap for the project.

1.1.3 The OBC notes that the construction costs were prepared with a base date of Q1 2014. The Construction Cost Cap assumes a construction mid-point of Q2 2017, as specified in the OBC. The BCIS All In TPI Index indicates a

¹ These include the cost of the building, IT infrastructure, Group 1 (supply and installation) & 2 (installation only) equipment and private sector design fees post financial close, together being the effective build cost.

figure of 243 for Q1 2014 and forecasts a figure of 289 for Q2 2017. This implies an inflation allowance to be included in the Construction Cost Cap of 18.93% from the Q1 2014 pricing base date.

1.1.4 The Construction Cost Cap calculated on that basis is therefore, as at the date of this letter, a figure of £58.93m. The construction cap has been set on the basis that inflation allowance will be reassessed and recast periodically up to the Invitation to Final Tender (“IFT”) stage assuming financial close is not delayed beyond 30 September 2016. The adjustment to inflation is made by reference to any difference (positive or negative) between (a) the cost inflation from the pricing base date that is implied by this forecast and (b) the cost inflation from the pricing base date implied by the forecast (or reasonable extrapolation) of the same index at the time of publishing the IFT and will be reflected in a commensurate increase or decrease (as the case may be) in the revenue funding support for the Project’s construction costs, as determined by the Scottish Ministers. The Board is expected to limit project scope or design creep to ensure that any apparent surplus inflation allowance is not utilised. No further adjustments to the construction cap will be made after IFT and the final construction cap will be as detailed in the IFT document. Inflation risk is therefore passed to the bidder at final tender stage.

1.1.5 The Construction Cost Cap assumes that the Project will deliver the project scope as detailed in the OBC. Should the Board choose to expand the scope of the Project beyond what is detailed in the OBC, or if (subject to paragraph 1.1.3 above) the Project is not deliverable within the Construction Cost Cap, the Board will be required to fully fund any resultant increase in unitary charge, including any inflationary impact, over the term of the contract. Should the Board choose to decrease the scope of the Project below that agreed, the level of Scottish Government’s revenue funding support will reduce commensurately, as determined by the Scottish Ministers.

1.1.6 As referred to in the then Acting Director General Health and Social Care’s letter of 22 March 2011 the Board will be required to satisfy both the Scottish Government and the SFT that it has sought to minimise capital and operating costs within the agreed project scope and that it has undertaken a whole of life cost analysis of bidders’ proposals. This will be scrutinised at critical points in the procurement (i.e. Pre-OJEU, pre-dialogue, pre-final tender, pre-preferred bidder and pre-financial close) through the KSR process.

1.1.7 Indexation will not be applied to the construction cost element of the annual unitary charge.

1.2 Financing interest and financing fees

- 1.2.1 The Board must seek to secure a competitive and deliverable financing package for the Project.
- 1.2.2 The terms of the financing package (including, for example, interest rates, margins and fees) offered by the preferred bidder will be scrutinised by SFT through the KSR process and will form part of the Scottish Government's overall and final assessment of the Project (and its affordability) at FBC stage.
- 1.2.3 The Scottish Government reserves the right to call for a funding competition after the appointment of a preferred bidder and the Board must ensure that this right is expressly referred to in the tender documentation issued to bidders.
- 1.2.4 The Scottish Government will take the risk of movements in interest rates up to the point of financial close.
- 1.2.5 The Scottish Government and/or SFT will approve the interest rate proposed at financial close (or will provide instructions in relation to the interest rate swap process with which the Board will be required to comply).
- 1.2.6 The Board must promptly provide the Scottish Government and SFT with such information as they may request in connection with the bidders' financing proposals for the Project.
- 1.2.7 The Board must comply with any guidance and requests that the Scottish Government, or SFT on behalf of the Scottish Government, may issue in connection with the financing of the Project and securing value for money financing proposals.
- 1.2.8 Indexation will not be applied to the financing costs and financing fees elements of the annual unitary charge.

1.3 Private sector development costs

- 1.3.1 Private sector development costs are eligible for revenue funding support. SFT currently estimates that on this project these costs will be in the region of 5% of the capital value of the project (not indexed). This amount has been determined by SFT to provide an indicative annual unitary charge for the purposes of Scottish Government budgeting at this stage but will be reviewed throughout the procurement process. This estimate is assumed to include all costs incurred by the SPV during the bidding and construction periods including staffing, administration, office and equipment costs; employers agent, audit, and other SPV and lender external advisory (e.g. legal, technical and insurance) fees; and all SPV success fee costs (other than design success fees).

1.3.2 The Board must seek to secure competitive proposals from bidders. SFT will scrutinise the bidders' proposed development costs, and the manner in which the Board has factored these into the bid evaluation process, as part of the KSR process. SFT will comment on whether the bidders' proposals are reasonable in the context of their overall submissions and having regard to relevant external benchmarks. These costs will be included in the Scottish Government's overall and final assessment of the Project (and its affordability) at FBC stage.

1.3.3 The Board must promptly provide the Scottish Government and SFT with such information as they may request in connection with the bidders' proposals for recovery of development costs.

1.3.4 The Board must comply with any guidance and requests that the Scottish Government, or SFT on behalf of the Scottish Government, may issue in connection with private sector development costs and securing value for money in relation to these.

1.3.5 Indexation will not be applied to the private sector development cost element of the annual unitary charge.

1.4 **SPV operating costs (operational phases)**

1.4.1 The current expectation is for a total of £205,000 per annum (at Q1 2016 prices) for SPV operating costs. This figure excludes operational period insurance costs (which will be a direct pass through cost to be covered by revenue funding support).

1.4.2 Rather than specify a cap or a budget for these costs, Scottish Government requires that the Board seek to secure competitive, value for money proposals from bidders. SFT will scrutinise the bidders' proposed SPV operating costs, and the manner in which the Board has factored these into the bid evaluation process, as part of the KSR process. SFT will comment on whether the bidders' proposals are reasonable in the context of their overall submissions and having regard to relevant external benchmarks which will include recent projects and prevailing market conditions. These costs will form part of the Scottish Government's overall and final assessment of the Project (and its affordability) at FBC stage.

1.4.3 The Board should note that under the standard form NPD contract operational insurance premiums are recovered by the SPV as a pass-through cost rather than through the annual unitary charge. These should therefore not be included within bidders' proposed SPV operating costs (and hence unitary charge), but shown separately in the bidders financial model as a cost chargeable to the Board. Any working capital required by the bidder should be included in their financial model pricing.

- 1.4.4 The Board must promptly provide the Scottish Government and SFT with such information as they may request in connection with the bidders' proposals in relation to SPV operating costs.
- 1.4.5 The Board must comply with any guidance and requests that the Scottish Government, or SFT on behalf of the Scottish Government, may issue in connection with SPV operating costs and securing value for money in relation to these.
- 1.4.6 Indexation will be applied to the SPV operating costs (during the operational phase only) element of the annual unitary charge.

1.5 Lifecycle maintenance costs

- 1.5.1 Revenue funding support will cover 50% of the lifecycle maintenance costs for the scope of the Project that is eligible for NPD funding. For the avoidance of doubt the Board will be responsible for the remaining 50% of these lifecycle maintenance costs as well as 100% of the lifecycle maintenance costs for any additional space should it choose to expand the scope of the Project beyond that detailed in the OBC. The Board's estimate of lifecycle costs is £23 per sqm for Clinical Service Support areas and £30 per sqm for acute areas (in Q1 2016 prices). Costs are exclusive of VAT.
- 1.5.2 As referred to in the Scottish Government's letter of 22 March 2011 the Board will be required to satisfy both the Scottish Government and SFT that it has sought to minimise capital and operating costs within the agreed project scope and undertaken a whole of life cost analysis. Lifecycle maintenance costs will form part of the Scottish Government's overall and final assessment of the Project (and its affordability) at FBC stage.
- 1.5.3 The Board must seek to secure competitive, value for money proposals from bidders in relation to their lifecycle maintenance proposals and costs. SFT will scrutinise the bidders' proposed lifecycle maintenance proposals and costs, and the manner in which the Board has factored these into the bid evaluation process, as part of the KSR process. SFT will comment on whether the bidders' proposals are reasonable in the context of their overall submissions and having regard to relevant external benchmarks. The Board's current estimates for lifecycle set out at 1.5.1 are considered to be within the higher range of benchmark but recognise the bespoke nature of the project and the scope of the SPV's obligations under the standard NPD contract such as the internal decoration responsibilities that are retained by the Board.
- 1.5.4 The Board must promptly provide the Scottish Government and SFT with such information as they may request in connection with the bidders' lifecycle maintenance proposals and costs.
- 1.5.5 The Board must comply with any guidance and requests that the Scottish Government, or SFT on behalf of the Scottish Government, may issue in

connection with lifecycle maintenance costs and securing value for money in relation to these.

1.5.6 Indexation will be applied to the lifecycle maintenance costs element of the annual unitary charge.

1.6 Other costs

Other costs that are included within the unitary charge (i.e. hard facilities management and remaining lifecycle maintenance costs) will require to be funded by the Board, as will other project costs outwith the unitary charge (such as soft facilities management, utilities and rates).

2. Standard form contract

2.1 This approval and any offer of revenue funding support is and will be conditional on the Board using the standard form NPD contract documentation developed by SFT (available at www.scottishfuturetrust.org.uk).

2.2 All changes to the standard form contract documentation will require SFT's approval. Further information on the approval process is available in SFT's Standard Project Agreements User's Guide.²

2.3 The Board should note that it will be a condition of revenue funding support that any Surpluses and Refinancing Gains paid to the Board in terms of the NPD contract must be paid by the Board to SGHSCD. The Board must not agree a refinancing proposal under the Project Agreement for the Project without the prior approval of SGHSCD.

3. Staffing Protocol

The Board must comply with the terms of "Public Private Partnerships in Scotland – Protocol and Guidance Concerning Employment Issues" (available at <http://www.scotland.gov.uk/Topics/Government/Finance/18232/12271>).

4. Tender Development and Evaluation

4.1 The Board must develop and adopt an evaluation methodology that strikes an appropriate balance between assessments of price and quality and that in assessing price takes account of the net present value of the overall unitary charge (and not just those elements that are funded by the Board). The Board will be required to demonstrate this through the KSR process.

4.2 The Board will co-operate and liaise with SFT in relation to the tender evaluation methodology and process and must comply with any relevant guidance issued by SGHSCD and/or SFT.

4.3 The Board must consider how community benefits can be incorporated in the development of the project tender.

² http://www.scottishfuturetrust.org.uk/publication/standard_project_agreements_user_guide

5. Value for Money

The Authority must comply with relevant value for money guidance (available at http://www.scottishfuturetrust.org.uk/publications/funding_and_finance). This will be scrutinised through the KSR process.

6. Accounting treatment

It will be a condition of revenue funding support that the Project is assessed as being a service concession under IFRIC12 and as being classified as a non-government asset for national accounts purposes under relevant Eurostat guidance.

7. Resourcing and governance

It is a condition of this approval and will be a condition of revenue funding support that the Board has and maintains in place a dedicated, qualified and sufficiently resourced project team to lead the delivery of the Project which must include recognised expertise in project management and delivering revenue financed projects. Further, the Board must have in place a governance structure, clearly linked to its own organisational governance arrangements, which will ensure effective oversight and scrutiny (at a senior level) of the work of the project team and the development of the Project. The Board's continuing compliance with these conditions will be monitored through the KSR process.

8. Information

8.1 SFT will continue to provide support to the Board throughout the procurement process and the Board must continue to co-operate with SFT in this regard and keep SFT informed as to progress and developments on the Project. Scottish Government expects that SFT will be invited to attend Project Board meetings.

8.2 The Board must, promptly on request, provide the Scottish Government and/or SFT with any information that they may reasonably require to satisfy themselves as to the progress of the Project and compliance with the conditions set out in this schedule.

8.3 The Scottish Ministers may, at FBC stage, specify additional information and reporting requirements for the construction and operational phases of the Project.

9. Additional project-specific conditions

This approval is subject to the following additional conditions:

9.1 The timing of publication of the OJEU notice must be agreed with SFT who will be mindful of issues such as anticipated market response given activity across the wider NPD pipeline.

9.2 The Board must satisfy SGHSCD and SFT, in advance of OJEU, that its draft OJEU notice, Information Memorandum and Pre-qualification Questionnaire are in final form and reflect guidance and recommendations made by SGHSCD and SFT.

- 9.3 The Board must secure, before the issue of OJEU, additional experienced PPP project management resource to support the recently appointed Project Director and existing proposed team. In the event that this requires a short term appointment to facilitate an OJEU in the Board's proposed timetable, the Board will require to demonstrate to SFT an acceptable short term solution is in place before OJEU and a longer term solution for the project procurement is in place prior to issue of the tender documents to shortlisted bidders.
- 9.4 The Board has discussed a number of options for running the competitive dialogue sessions both in Orkney and on the mainland. The Board is asked to confirm prior to OJEU that it has considered the practical arrangements and cost considerations, taken advice from its advisors, and market tested the proposed strategy before finalising the approach.
- 9.5 The Board will implement the recommendations of the report by SFT following its Design Review of the Project dated February 2014 to the extent not yet implemented, prior to the issue of the tender documentation and at the Pre ITPD KSR. SFT will consider whether the recommendations have been satisfactorily addressed by the development of the Reference Design and Authority's requirements and as reflected in the ITPD documentation.
- 9.6 The Board must satisfy SGHSCD and SFT on the progress for concluding missives associated with the land purchase prior to OJEU.
- 9.7 The Board instigates an appropriate approach for managing the disposal of the surplus estate and involves SGHSCD and SFT in the discussions on the implications for the existing estates.
- 9.8 The OBC notes an indicative capital cost of £8.5 million for equipment costs and that this will be updated as a fully costed model is developed with HFS. The Board must satisfy SGHSCD and SFT on the arrangements for progressing the funding and procurement timetabling for all non NPD capital elements including equipment as the project progresses. This will be monitored through the KSR process.

10. Further assurance and approvals processes

Approval of the FBC will fix the level of Scottish Government's revenue funding support based on the out-turn construction costs, private sector development costs, SPV operating costs, lifecycle maintenance costs and anticipated financing terms. As stated at paragraph 1.2.4 above, the Scottish Government is taking the risk of movements in interest rates up to the date of financial close. As stated at paragraph 1.2.5 above, the interest rate proposed at financial close will be subject to the approval of SFT (on behalf of the Scottish Government) and the process for SFT approval will be confirmed to the Board in due course.

11. Timing/payment of revenue funding support

11.1 Subject to approval of the Project by Scottish Ministers at FBC stage, revenue funding support will become payable once the unitary charge becomes due and payable under the NPD contract.

11.2 Further detail on the timing and mechanics of payment of revenue funding support will be given in due course.

12. Withdrawal of provisional offer of revenue funding support

The Scottish Ministers reserve the right to withdraw this approval if the Board fails to comply with any of its conditions or if the Project fails to reach financial close by 30 September 2016.

Appendix B



European Union

Publication of Supplement to the Official Journal of the European Union

2, rue Mercier, 2985 Luxembourg, Luxembourg Fax: +352 29 29 42 670

E-mail: ojs@publications.europa.eu

Info & on-line forms: <http://simap.europa.eu>

Contract notice
(Directive 2004/18/EC)

Section I : Contracting authority

I.1) Name, addresses and contact point(s):

Official name: [NHS Orkney](#)

National ID: *(if known)*

Postal address: [Project Offices, Balfour Hospital, New Scapa Road,](#)

Town: [Kirkwall, Orkney](#)

Postal code: [KW15 1BH](#)

Country: [United Kingdom \(UK\)](#)

Contact point(s): [Albert Tait](#)

Telephone: [+44 1856888103](#)

For the attention of:

E-mail: albert.tait@nhs.net

Fax:

Internet address(es): *(if applicable)*

General address of the contracting authority/entity: *(URL)* <http://www.ohb.scot.nhs.uk/>

Address of the buyer profile: *(URL)* http://www.publiccontractsscotland.gov.uk/search/Search_AuthProfile.aspx?ID=AA00368

Electronic access to information: *(URL)*

Electronic submission of tenders and requests to participate: *(URL)*

Further information can be obtained from

- The above mentioned contact point(s) Other (please complete Annex A.I)

Specifications and additional documents (including documents for competitive dialogue and a dynamic purchasing system) can be obtained from

- The above mentioned contact point(s) Other (please complete Annex A.II)

Tenders or requests to participate must be sent to

- The above mentioned contact point(s) Other (please complete Annex A.III)

I.2) Type of the contracting authority

- Ministry or any other national or federal authority, including their regional or local sub-divisions
- National or federal agency/office
- Regional or local authority
- Regional or local agency/office
- Body governed by public law
- European institution/agency or international organisation
- Other: *(please specify)*

I.3) Main activity

- General public services

- Defence
- Public order and safety
- Environment
- Economic and financial affairs
- Health
- Housing and community amenities
- Social protection
- Recreation, culture and religion
- Education
- Other: *(please specify)*

I.4) Contract award on behalf of other contracting authorities

The contracting authority is purchasing on behalf of other contracting authorities:

yes no

information on those contracting authorities can be provided in Annex A

Section II : Object of the contract

II.1) Description :

II.1.1) Title attributed to the contract by the contracting authority :

New Orkney Hospital and Healthcare Facilities

II.1.2) Type of contract and location of works, place of delivery or of performance :

choose one category only – works, supplies or services – which corresponds most to the specific object of your contract or purchase(s)

- | | | |
|---|---|--|
| <input checked="" type="radio"/> Works | <input type="radio"/> Supplies | <input type="radio"/> Services |
| <input type="checkbox"/> Execution | <input type="checkbox"/> Purchase | Service category No: |
| <input type="checkbox"/> Design and execution | <input type="checkbox"/> Lease | Please see Annex C1 for service categories |
| <input type="checkbox"/> Realisation, by whatever means of work, corresponding to the requirements specified by the contracting authorities | <input type="checkbox"/> Rental | |
| | <input type="checkbox"/> Hire purchase | |
| | <input type="checkbox"/> A combination of these | |

Main site or location of works, place of delivery or of performance :

The new Orkney Hospital and Health Care Facility will be constructed on a site at New Scapa Road, Orkney. The contract is for the design, build, finance and maintenance of a new Hospital and Health Care Facility.

NUTS code:

II.1.3) Information about a public contract, a framework agreement or a dynamic purchasing system (DPS):

- The notice involves a public contract
- The notice involves the establishment of a framework agreement
- The notice involves the setting up of a dynamic purchasing system (DPS)

II.1.4) Information on framework agreement : (if applicable)

- Framework agreement with several operators Framework agreement with a single operator

Number :

or

(if applicable) maximum number : of participants to the framework agreement envisaged

Duration of the framework agreement

Duration in years : or in months :

Justification for a framework agreement, the duration of which exceeds four years :

Estimated total value of purchases for the entire duration of the framework agreement (if applicable, give figures only)

Estimated value excluding VAT : Currency :

or

Range: between : : and : : Currency :

Frequency and value of the contracts to be awarded : (if known)

II.1.5) Short description of the contract or purchase(s) :

NHS Orkney are seeking a Private Sector Partner to participate and invest in a new Orkney Hospital and Healthcare Facility ("the Project") The Project will involve the design, build, finance and maintenance of a new hospital on a site in Orkney with an estimated cost range of between [£180m and £220m] over a 25 year operational period. The capital cost of the construction works is estimated as [£59m]. This is to be delivered under the Scottish Futures Trust's Non-Profit Distributing (NPD) model which is in the form of public-private partnership preferred by the Scottish Government.
The objective of the Project is to provide NHS Orkney with a new hospital and health care facility to service the needs of patients in the Orkney area. Further information will be provided in the ITPD and contract documents.

II.1.6) Common procurement vocabulary (CPV) :

	Main vocabulary	Supplementary vocabulary (if applicable)
Main object	45215100	
Additional object(s)	98341000	
	79993000	
	31625200	
	32520000	
	35120000	
	45314300	
	50330000	
	50700000	
	51410000	
	66515200	
	71314200	
	72253000	
	77314000	
	90911300	
	90922000	

II.1.7) Information about Government Procurement Agreement (GPA) :

The contract is covered by the Government Procurement Agreement (GPA) : yes no

II.1.8) Lots: (for information about lots, use Annex B as many times as there are lots)

This contract is divided into lots: yes no

(if yes) Tenders may be submitted for

one lot only

one or more lots

all lots

II.1.9) Information about variants:

Variants will be accepted : yes no

II.2) Quantity or scope of the contract :

II.2.1) Total quantity or scope : (including all lots, renewals and options, if applicable)

(if applicable, give figures only)

Estimated value excluding VAT : Currency :

or

Range: between : 180000000.00 : and : 220000000.00 : Currency : GBP

II.2.2) Information about options : (if applicable)

Options : yes no

(if yes) Description of these options :

(if known) Provisional timetable for recourse to these options :

in months : or in days : (from the award of the contract)

II.2.3) Information about renewals : (if applicable)

This contract is subject to renewal: yes no

Number of possible renewals: (if known) or Range: between : and:

(if known) In the case of renewable supplies or service contracts, estimated timeframe for subsequent contracts:

in months: or in days: (from the award of the contract)

II.3) Duration of the contract or time limit for completion:

Duration in months : 324 or in days: (from the award of the contract)

or

Starting: (dd/mm/yyyy)

Completion: (dd/mm/yyyy)

Section III : Legal, economic, financial and technical information

III.1) Conditions relating to the contract:

III.1.1) Deposits and guarantees required: *(if applicable)*

Parent company or other guarantees may be required in certain circumstances. Full details to be set out in the information Memorandum/Pre-Qualification Questionnaire.

III.1.2) Main financing conditions and payment arrangements and/or reference to the relevant provisions governing them:

Finance to be provided by the Private Sector Partner in accordance with the Scottish Government's NPD Initiative. Full details to be set out in the ITPD and contract documents. The contracting authority reserves the right to consider alternative funding, financing and/or contractual arrangements to support the delivery of the Project.

III.1.3) Legal form to be taken by the group of economic operators to whom the contract is to be awarded: *(if applicable)*

An NPD company as per the Scottish Government's NPD Initiative. Full details to be set out in the ITPD and contract documents.

III.1.4) Other particular conditions: *(if applicable)*

The performance of the contract is subject to particular conditions : yes no

(if yes) Description of particular conditions:

The successful Private Sector Partner may be required to actively participate in the achievement of social and/or environmental objectives in the delivery of the Project. Accordingly, contract performance conditions may relate in particular, to social, environmental or other corporate social responsibility considerations. Further details of any conditions or specific requirements will be set out in the ITPD and contract documents.

III.2) Conditions for participation:

III.2.1) Personal situation of economic operators, including requirements relating to enrolment on professional or trade registers:

Information and formalities necessary for evaluating if the requirements are met:

Full details to be set out in the Information Memorandum / Pre-Qualification Questionnaire.

III.2.2) Economic and financial ability:

Information and formalities necessary for evaluating if the requirements are met:

Parties expressing an interest in the Project will be required to complete a Pre-Qualification Questionnaire to evaluate and verify economic and financial standing and professional and technical capacity in accordance with Regulations 23 to 26 of the Public Contracts (Scotland) Regulations 2012. Full details to be set out in the information Memorandum / Pre-Qualification Questionnaire.

Minimum level(s) of standards possibly required: *(if applicable)*

Certain minimum standards will apply. Full details set out in the Information Memorandum / Pre-Qualification Questionnaire.

III.2.3) Technical capacity:

Information and formalities necessary for evaluating if the requirements are met:

Parties expressing an interest in the Project will be required to complete a Pre-Qualification Questionnaire to evaluate and verify economic and financial standing and professional and technical capacity in accordance with Regulations 23 to 26 of the Public Contracts (Scotland) Regulations 2012. Full details to be set out in the information Memorandum / Pre-Qualification Questionnaire.

Minimum level(s) of standards possibly required: *(if applicable)*

Certain minimum standards will apply. Full details set out in the Information Memorandum / Pre-Qualification Questionnaire.

III.2.4) Information about reserved contracts: *(if applicable)*

- The contract is restricted to sheltered workshops
- The execution of the contract is restricted to the framework of sheltered employment programmes

III.3) Conditions specific to services contracts:

III.3.1) Information about a particular profession:

Execution of the service is reserved to a particular profession: yes no
(if yes) Reference to the relevant law, regulation or administrative provision :

III.3.2) Staff responsible for the execution of the service:

Legal persons should indicate the names and professional qualifications of the staff responsible for the execution of the service: yes no

Section IV : Procedure

IV.1) Type of procedure:

IV.1.1) Type of procedure:

- Open
- Restricted
- Accelerated restricted

Justification for the choice of accelerated procedure:

- Negotiated

Some candidates have already been selected (if appropriate under certain types of negotiated procedures) : yes no
(if yes, provide names and addresses of economic operators already selected under Section VI.3 Additional information)

- Accelerated negotiated

Justification for the choice of accelerated procedure:

- Competitive dialogue

IV.1.2) Limitations on the number of operators who will be invited to tender or to participate: *(restricted and negotiated procedures, competitive dialogue)*

Envisaged number of operators: 3

or

Envisaged minimum number: and *(if applicable)* maximum number

Objective criteria for choosing the limited number of candidates:

IV.1.3) Reduction of the number of operators during the negotiation or dialogue: *(negotiated procedure, competitive dialogue)*

Recourse to staged procedure to gradually reduce the number of solutions to be discussed or tenders to be negotiated : yes no

IV.2) Award criteria

IV.2.1) Award criteria *(please tick the relevant box(es))*

- Lowest price

or

- The most economically advantageous tender in terms of

the criteria stated below *(the award criteria should be given with their weighting or in descending order of importance where weighting is not possible for demonstrable reasons)*

the criteria stated in the specifications, in the invitation to tender or to negotiate or in the descriptive document

Criteria	Weighting	Criteria	Weighting
1.		6.	
2.		7.	
3.		8.	
4.		9.	

Criteria	Weighting	Criteria	Weighting
5.		10.	

IV.2.2) Information about electronic auction

An electronic auction will be used yes no

(if yes, if appropriate) Additional information about electronic auction:

IV.3) Administrative information:

IV.3.1) File reference number attributed by the contracting authority: (if applicable)

IV.3.2) Previous publication(s) concerning the same contract:

yes no

(if yes)

Prior information notice Notice on a buyer profile

Notice number in the OJEU: [2014/S 116-203797](#) of: [19/06/2014](#) (dd/mm/yyyy)

Other previous publications(if applicable)

IV.3.3) Conditions for obtaining specifications and additional documents or descriptive document: (in the case of a competitive dialogue)

Time limit for receipt of requests for documents or for accessing documents

Date: [22/08/2014](#) Time:

Payable documents yes no

(if yes, give figures only) Price: Currency:

Terms and method of payment:

IV.3.4) Time limit for receipt of tenders or requests to participate:

Date: [05/09/2014](#) Time: [12:00](#)

IV.3.5) Date of dispatch of invitations to tender or to participate to selected candidates: (if known, in the case of restricted and negotiated procedures, and competitive dialogue)

Date: [31/10/2014](#)

IV.3.6) Language(s) in which tenders or requests to participate may be drawn up:

Any EU official language

Official EU language(s):

[EN](#)

Other:

IV.3.7) Minimum time frame during which the tenderer must maintain the tender:

until: :

or

Duration in months : or in days : (from the date stated for receipt of tender)

IV.3.8) Conditions for opening of tenders:

Date : (dd/mm/yyyy) Time

(if applicable) Place:

Persons authorised to be present at the opening of tenders *(if applicable)* :

yes no

(if yes) Additional information about authorised persons and opening procedure:

Section VI: Complementary information

VI.1) Information about recurrence: *(if applicable)*

This is a recurrent procurement : yes no

(if yes) Estimated timing for further notices to be published:

VI.2) Information about European Union funds:

The contract is related to a project and/or programme financed by European Union funds : yes no

(if yes) Reference to project(s) and/or programme(s):

VI.3) Additional information: *(if applicable)*

1. Interested parties should express interest, receive and submit Pre-Qualification Questionnaire submissions via the contracting authority in line with the details contained in the Information Memorandum/ Pre-Qualification Questionnaire documentation. The Information Memorandum / Pre-Qualification Questionnaire can be obtained by contacting the Board via the project team at Ork-hb.projectteam@nhs.net.
2. NHS Orkney will hold a Bidders' Open Day on 14 August 2014 for those parties interested in the Project. The Bidders' Open Day will be held in Orkney. Interested parties wishing to attend the Bidders' Open Day should register as soon as possible to attend this event by either emailing Albert Tait at E-mail: Ork-hb.projectteam@nhs.net, or by writing to Project Office, NHS Orkney, Balfour Hospital, New Scapa Road, Kirkwall, Orkney, KW15 1BH. All correspondence should be clearly marked - NHS Orkney New Hospital and Healthcare Facilities Attendance at Bidders' Open Day. All correspondence should also confirm if the parties wish to request a short private meeting on the day. Private meetings will be restricted to consortia only, and NHS Orkney reserves the right to limit the duration of private meetings. Further details will be provided upon registration.
3. Further to Section II.3 the anticipated duration shall be 300 months (or 25 years) operational plus the period of construction. The total anticipated duration is therefore 324 months (or circa 27 years) from the award of the contract.
4. Further to Section II.1.9 variants may be accepted by the contracting authority. However, interested parties should note that the contracting authority will seek to limit or restrict the requirements on which variants will be accepted and evaluated. Full details will be set out in the ITPD and contract documents.
5. Further to Section IV.1.3 the process is detailed in the Information Memorandum/ Pre-Qualification Questionnaire. This will be updated in the ITPD and contract documents.
6. Further to Section IV.3.3 the Information Memorandum/ Pre-Qualification Questionnaire available from the contracting authority describes the process for obtaining specifications and additional documents.

VI.4) Procedures for appeal:

VI.4.1) Body responsible for appeal procedures:

Official name: [NHS Orkney](#)

Postal address: [Balfour Hospital, New Scapa Road, Kirkwall,](#)

Town: [Orkney](#)

Postal code: [KW15 1BH](#)

Country: [United Kingdom \(UK\)](#)

Telephone: [+44 1856888103](tel:+441856888103)

E-mail: albert.tait@nhs.net

Fax:

Internet address: *(URL)* <http://www.ohb.scot.nhs.uk/>

Body responsible for mediation procedures *(if applicable)*

Official name:

Postal address:

Town:

Postal code:

Country:

Telephone:

E-mail:

Fax:

Internet address: *(URL)*

VI.4.2) Lodging of appeals: *(please fill in heading VI.4.2 or if need be, heading VI.4.3)*

The contracting authority will incorporate a minimum of a 10 calendar day standstill period at the point information on the award of the contract is communicated to tenderers. This period allows unsuccessful tenderers to seek further debriefing from the contracting authority before the contract is entered into. Applicants can make a written request for de-brief information and this information must be provided within 15 days of this written request being received. Such additional information should be requested from the address in I.1. If an appeal regarding the award of a contract has not been successfully resolved, The Public Contracts (Scotland) Regulations 2012 (SSI 2012/88) provide for aggrieved parties who have been harmed or are at risk of harm by breach of the rules to take action in the Sheriff Court or Court of Session. Any such action must be brought promptly (generally within 30 days).

VI.4.3) Service from which information about the lodging of appeals may be obtained:

Official name:

Postal address:

Town:

Postal code:

Country:

Telephone:

E-mail:

Fax:

Internet address: *(URL)*

VI.5) Date of dispatch of this notice:

[17/07/2014](#) *(dd/mm/yyyy)* - ID:2014-094228

Annex A
Additional addresses and contact points

I) Addresses and contact points from which further information can be obtained

Official name: National ID: *(if known)*
Postal address:
Town: Postal code: Country:
Contact point(s): Telephone:
For the attention of:
E-mail: Fax:
Internet address: *(URL)*

II) Addresses and contact points from which specifications and additional documents can be obtained

Official name: National ID: *(if known)*
Postal address:
Town: Postal code: Country:
Contact point(s): Telephone:
For the attention of:
E-mail: Fax:
Internet address: *(URL)*

III) Addresses and contact points to which tenders/requests to participate must be sent

Official name: National ID: *(if known)*
Postal address:
Town: Postal code: Country:
Contact point(s): Telephone:
For the attention of:
E-mail: Fax:
Internet address: *(URL)*

IV) Address of the other contracting authority on behalf of which the contracting authority is purchasing

Official name National ID (if known):
Postal address:
Town Postal code
Country

----- (Use Annex A Section IV as many times as needed) -----

Annex B
Information about lots

Title attributed to the contract by the contracting authority

Lot No : **Lot title :**

1) Short description:

2) Common procurement vocabulary (CPV):

Main vocabulary:

3) Quantity or scope:

(if known, give figures only) Estimated cost excluding VAT:

Currency:

or

Range: between :

and:

Currency:

4) Indication about different date for duration of contract or starting/completion: (if applicable)

Duration in months : or in days : (from the award of the contract)

or

Starting: (dd/mm/yyyy)

Completion: (dd/mm/yyyy)

5) Additional information about lots:

Annex C1 – General procurement
Service categories referred to in Section II: Object of the contract
Directive 2004/18/EC

Category No [1]	Subject
1	Maintenance and repair services
2	Land transport services [2], including armoured car services, and courier services, except transport of mail
3	Air transport services of passengers and freight, except transport of mail
4	Transport of mail by land [3] and by air
5	Telecommunications services
6	Financial services: a) Insurances services b) Banking and investment services [4]
7	Computer and related services
8	Research and development services [5]
9	Accounting, auditing and bookkeeping services
10	Market research and public opinion polling services
11	Management consulting services [6] and related services
12	Architectural services; engineering services and integrated engineering services; urban planning and landscape engineering services; related scientific and technical consulting services; technical testing and analysis services
13	Advertising services
14	Building-cleaning services and property management services
15	Publishing and printing services on a fee or contract basis
16	Sewage and refuse disposal services; sanitation and similar services
Category No [7]	Subject
17	Hotel and restaurant services
18	Rail transport services
19	Water transport services
20	Supporting and auxiliary transport services
21	Legal services
22	Personnel placement and supply services [8]
23	Investigation and security services, except armoured car services
24	Education and vocational education services
25	Health and social services
26	Recreational, cultural and sporting services [9]
27	Other services

1 Service categories within the meaning of Article 20 and Annex IIA to Directive 2004/18/EC.

2 Except for rail transport services covered by category 18.

3 Except for rail transport services covered by category 18.

4 Except financial services in connection with the issue, sale, purchase or transfer of securities or other financial instruments, and central bank services. The following are also excluded: services involving the acquisition or rental, by whatever financial means, of land, existing buildings or other immovable property or concerning rights thereon. However, financial service contracts concluded at the same time as, before or after the contract of acquisition or rental, in whatever form, shall be subject to the Directive.

- 5 Except research and development services other than those where the benefits accrue exclusively to the contracting authority for its use in the conduct of its own affairs on condition that the service provided is wholly remunerated by the contracting authority.
- 6 Except arbitration and conciliation services.
- 7 Service categories within the meaning of Article 21 and Annex IIB of Directive 2004/18/EC.
- 8 Except employment contracts.
- 9 Except contracts for the acquisition, development, production or co-production of program material by broadcasters and contracts for broadcasting time.

Orkney bed model – methodology description

Calculation methodology

1 - Age specific admission rates

1.1 From national data, extract the total number of acute inpatient admissions for the six years period 2010 to 2015. “Adm”

- ⇒ Break this down to specialty group (Medical specialties (Med), Surgical specialties (Surg))
- ⇒ Break this down to admission type and LOS category (Day cases (DC), Elective Inpatients 0 days (EI0), Elective Inpatients 1 or more days (EI1), Non-Elective Inpatients 0 days (NEI0), Non-Elective Inpatients 1 or more days (NEI1))
- ⇒ Break this down to age groups (0-14, 15-24, 25-44, 45-64, 65-74, 75-84, 85 and over)

Calculate the three year (for example) average admissions for each category as;

$$\frac{Adm_{13} + Adm_{14} + Adm_{15}}{No.Years} \quad (A1)$$

1.2 Calculate total admissions (across all ages) for each admission type / specialty category as;

$$A1_{0-14} + A1_{15-24} + A1_{25-44} + A1_{45-64} + A1_{65-74} + A1_{75-84} + A1_{85+} \quad (A2)$$

This is the first table on the “Stays (consec eps) Bed days-jv” tab of the provided tables

1.3 Calculate crude rates per 1,000 population for each age / admission type / specialty category (using the population estimates shown on the “Orkney population -jv” tab of the provided tables) as;

$$\frac{A}{2013 \text{ to } 2015 \text{ Population Estimate average}} * 1,000 \quad (B)$$

1.4 Calculate total rate per 1,000 population (across all ages) for each admission type / specialty category as;

$$\frac{A1_{0-14} + A1_{15-24} + A1_{25-44} + A1_{45-64} + A1_{65-74} + A1_{75-84} + A1_{85+}}{2013 \text{ to } 2015 \text{ Population Estimate average}} \quad (C)$$

These are the age-specific admission rates for the 3 year average.

2 – Projected Population

2.1 Apply NRS projected populations (using the projected population estimates shown on the “Orkney population” tab of the provided tables) to the 3-year crude admission rates at each age / admission type / specialty category for the model years 2020 and 2030 as;

$$\frac{B}{1,000} * \text{Projected Population} \quad (D)$$

2.2 Calculate total estimated admissions against the projected population (across all ages) for each admission type / specialty category

$$D_{0-14} + D_{15-24} + D_{25-44} + D_{45-64} + D_{65-74} + D_{75-84} + D_{85+} \quad (E)$$

This is the projected age-specific admission rate for the model years 2022 to 2037.

3 – average length of stay (ALOS)

3.1 For each of the inpatient admissions extracted from national data (see 1.1), calculate the total number of bed days in hospital for the period 2010 to 2015.

⇒ Break this down to specialty, admission type and age group categories as in step 1.1

3.2 Calculate the three year average total bed days for each category

$$\frac{\text{Bed days}_{13} + \text{Bed days}_{14} + \text{Bed days}_{15}}{\text{No.Years}} \quad (F1)$$

3.3 Calculate total bed days (across all ages) for each admission type / specialty category as;

$$F1_{0-14} + F1_{15-24} + F1_{25-44} + F1_{45-64} + F1_{65-74} + F1_{75-84} + F1_{85+} \quad (F2)$$

This is the second table on the “Stays (consec eps) Bed days-jv” tab

3.3 Calculate ALOS over 3 year period for stays greater than 0 days and for each specialty and admission type as;

$$\frac{F2}{A2} \quad (G)$$

This is shown on the “Beds Template” tab cells B23 to E30

The calculations above provide the basis for the template to operate. Next these figures are supplemented by user input to generate the final bed estimates

4 – Occupancy level

4.1 User enters desired occupancy level in “**Beds Template**” tab cell B47. This defaults to 85% as a recognised optimum value.

5 – Planning Scenarios

5.1 **Scenario 1** – Estimated bed numbers based on user defined ALOS (observed 3 year average - “**Beds Template**” tab cell B29 to E29) and user defined occupancy (default to 85%).

5.1.1 Calculate total projected bed days for target years at each specialty group and admission type by multiplying projected age specific admission rate (admissions with LOS 1 or more days only) by ALOS

$$E * G \quad (H)$$

5.1.2 Calculate total projected bed days for target years across all specialty groups and admission types (admissions with LOS 1 or more days only) as;

$$H_{Med\ El1} + H_{Med\ NE11} + H_{Surg\ El1} + H_{Surg\ NE11} \quad (I)$$

5.1.3 Adjust total projected bed days for target years by user entered occupancy level as;

$$\frac{I}{0.85} \quad (J)$$

5.1.4 Estimate beds required for overnight stays in each target year as;

$$\frac{J}{365} \quad (K)$$

5.1.5 Estimate beds required for inpatient stays with LOS=0 in each target year as;

$$\frac{E_{Med\ El0} + E_{Med\ NE10} + E_{Surg\ El0} + E_{Surg\ NE10}}{365} \quad (L)$$

5.1.6 Calculate total estimated beds for modelled years as sum of Inpatient LOS>0 beds, Inpatient LOS=0 beds and obstetric bed requirement (provided by health board)

$$K + L + \text{Obstetric Beds} \quad (\text{M})$$

5.2 Scenario 2 – Estimated bed numbers based on user defined additional change in observed admission rates (over and above the impact of population growth) and default (85%) occupancy.

5.2.1 User enters desired admission rate correction factor in “**Beds Template**” tab cell G9. “ Adm_{growth} ”

5.2.1 Calculate total projected bed days for target years at each specialty group and admission type by multiplying projected age specific admission rate (admissions with LOS 1 or more days only) by ALOS by Adm_{growth}

$$E * G * \left(1 + \frac{Adm_{growth}}{100}\right) \quad (\text{N})$$

5.2.2 Estimate beds required for overnight stays in each target year by applying N in place of H in calculations 5.1.2 to 5.1.4

5.2.3 Estimate beds required for inpatient stays with LOS=0 in each target year accounting for additional growth as;

$$\frac{(E_{Med\ ELo} + E_{Med\ NELo} + E_{Sur\ ELo} + E_{Sur\ NELo}) * \left(1 + \frac{Adm_{growth}}{100}\right)}{365} \quad (\text{O})$$

5.2.6 Calculate total estimated beds for target years by applying O in place of L in calculation 5.1.6

5.3 Scenario 3 – Estimated bed numbers based on user defined reduction in observed ALOS (default to 10% - “**Beds Template**” tab cell M22) and user defined occupancy (default to 85%).

5.3.1 User enters desired ALOS reduction factor in “**Beds Template**” tab cell M22. “ $ALOS_{reduction}$ ”

5.3.2 Calculate total projected bed days for target years at each specialty group and admission type by multiplying projected age specific admission rate (admissions with LOS 1 or more days only) by ALOS by ALOS reduction factor

$$E * G * \left(1 - \frac{ALOS_{reduction}}{100}\right) \quad (\text{P})$$

5.3.3 Estimate beds required for overnight stays in each target year by applying P in place of H in calculations 5.1.2 to 5.1.6

5.4 **Scenario 4** – Estimated bed numbers based on user defined maximum LOS (default to 90 days - “**Beds Template**” tab cell S22) and user defined occupancy (default to 85%).

5.4.1 User enters desired maximum LOS in “**Beds Template**” tab cell S22. “ LOS_{trim} ”

5.4.2 For each inpatient admission whose bed days calculated in 3.1 is greater than LOS_{trim} reset bed days to LOS_{trim} .
$$\text{If } LOS > LOS_{trim} \text{ then } LOS = LOS_{trim} \quad (Q)$$

5.4.3 Recalculate the three year average total bed days for each category and the corresponding $ALOS_{trim}$ as in steps 3.2 and 3.3.
(R)

This is shown on the “Beds Template” tab cells B29 to E29

5.1.1 Calculate total projected bed days for target years at each specialty group and admission type by multiplying projected age specific admission rate (admissions with LOS 1 or more days only) by $ALOS_{trim}$
$$E * R \quad (S)$$

5.4.4 Estimate beds required for overnight stays in each target year by applying S in place of H in calculations 5.1.1 to 5.1.6

Note

Glossary

Acute Inpatient Admissions – Hospital admission to an inpatient bed (regardless of how long patient stays) in an acute (non-obstetric, Non-psychiatric hospital)

Admission type – whether the admission related to a planned (elective) episode of care or an unplanned or emergency (non-elective) episode of care.

Age specific admission rates - Numbers of admissions in a given time period calculated to reflect the population structure across age groupings

Average Length of Stay (ALOS) – the average time (measured in days) between admission and discharge of all individual episodes of inpatient care in the sample cohort.

Bed occupancy – The percentage of available staffed beds occupied by inpatients within a specialty over a given period of time.

Length of stay (LOS) – the time (measured in days) between admission and discharge of an individual episode of inpatient care. Also known as bed days

Obstetric beds – Activity in these beds is not available in the national data extract so count assumed to be constant. Baseline confirmed by health board.

Population estimate – National Records of Scotland mid-year population estimate

Projected population - National Records of Scotland population projections

Specialty – the clinical specialism of the consultant responsible for the patient's care

New Hospital and Healthcare Services Project Design Solution Summary

Introduction

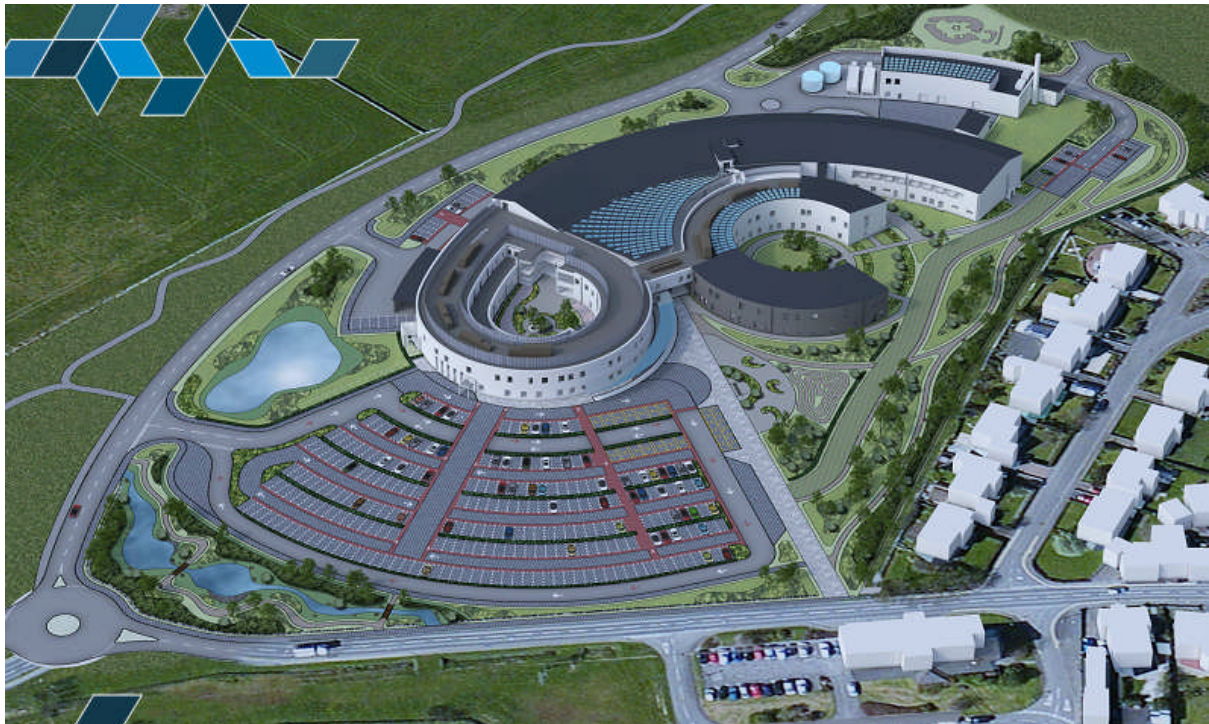
This document summarises the principal features of the Preferred Bidder design solution to deliver NHS Orkney's new hospital and healthcare facilities.

Setting

NHS Orkney has acquired a greenfield site to the south of Kirkwall. The site benefits from a newly completed road built by Orkney Islands Council and named Foreland Road. This new road provides a connection from New Scapa Road (the main road into Kirkwall, connecting East and West Mainland) to Hatston and Orphir, avoiding the centre of Kirkwall.

The Preferred Bidder design orientates the hospital and healthcare facilities building to connect to the town of Kirkwall, creating a direct and clear axis. The form of the building and site arrangement creates a welcoming gateway to the site and the southern edge of the town, with vehicle and pedestrian access clearly located and signed to reduce stress for visitors on approach.

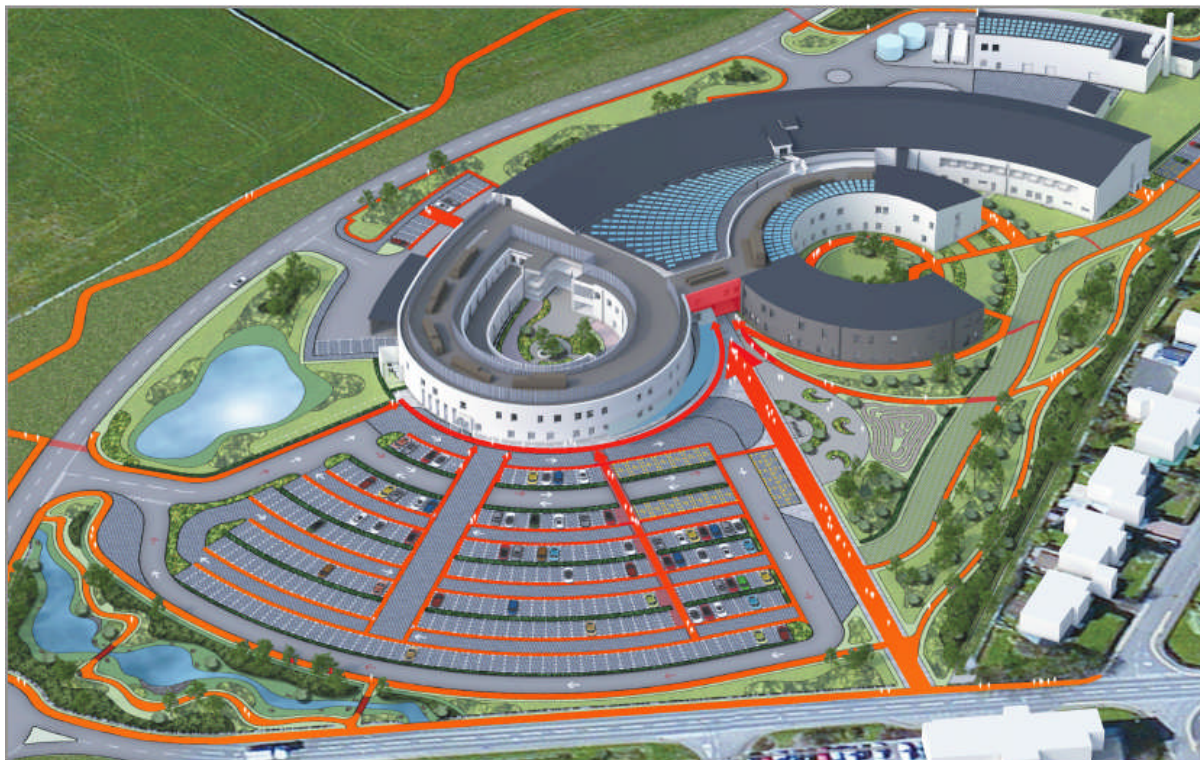
The landscaping proposals support the provision of safe and pleasant walking routes both through the site and connecting into existing networks beyond the site, including the Crantit trail



Artist's Impression, Aerial View

Site Access Arrangements

Pedestrians and Cyclists



Pedestrian and Cycle Arrangements

The main entrance to the new facilities will be accessible by pedestrians and cyclists from two points. The primary pedestrian access point is from New Scapa Road via a straight boulevard to the building's main entrance, with a secondary access point from Foreland Road. The site design and layout recognises the positive benefits both for the general public as well as NHS Orkney staff and building users, in creating pathways and circuit routes around the building and immediately adjacent to the site.

The site strategy and traffic plan prioritises pedestrians and cyclists over cars with the main pedestrian route linking the main pedestrian access point of the site to the main entrance. This route gives direct visual connection to the main entrance and will create a defined and important axis on the site. There are also safe, easily accessible cycle and footpath routes around the site leading to the hospital that follow desire lines, as well as access to existing footpaths such as the Crantit Trail. Bus, car and taxi drop-off points are close to the Main Entrance.

Vehicle Access



Vehicle Access from Foreland Road

All vehicles will enter the site from Foreland Road along the southern edge of the site via the entrances marked A, B and C on the site plan above. The principal public car parking zone is accessed off entrance A. The car park layout follows the curve of the hospital and is clearly visible from both Foreland Road and New Scapa Road.

Entrance B provides access to the Emergency Department for “blue light” vehicles with a dedicated sheltered drop-off and parking for emergency vehicles. Patients arriving by car and self presenting at the Emergency Department will also be directed to this entrance. There is a separate “walking wounded” entrance to the Emergency Department, with adjacent dedicated parking.

This site entrance also provides access to the Cancer and Palliative Care Unit for patients and visitors, with a dedicated parking area for the Unit.

Entrance C will predominantly be used by Facilities Management (FM) vehicles travelling to the main FM department and Energy Centre. The Mortuary is also accessed via this entrance, with dedicated visitor parking spaces and a drop-off for mortuary vehicles immediately adjacent to the department entrance.

Entrance to the Building

Movement from the outside to the inside of the building is phased and gradual. Curved sliding main entrance doors at the main entrance to the building open into a hub space, a light colourful and relaxed area. There is an immediate visual connection to both the reception and self check in spaces and to the GPs, Dental, Radiology and OPD departments.

From this central hub space the users can also see and access external space in the form of the internal courtyard, or choose to move further round in to the hub to make use of the restaurant, multifaith area and other public amenities within the building. The main hub space creates a relaxed atmosphere for users reducing stress and anxiety.



Artist's Impression, Main Entrance

The hub provides direct links to all clinical areas on the ground and first floor. Wayfinding is logical and the hub arrangement supports orientation and communication for patients and visitors while supporting service provision



Artist's Impression. Internal Hub

Court Yards

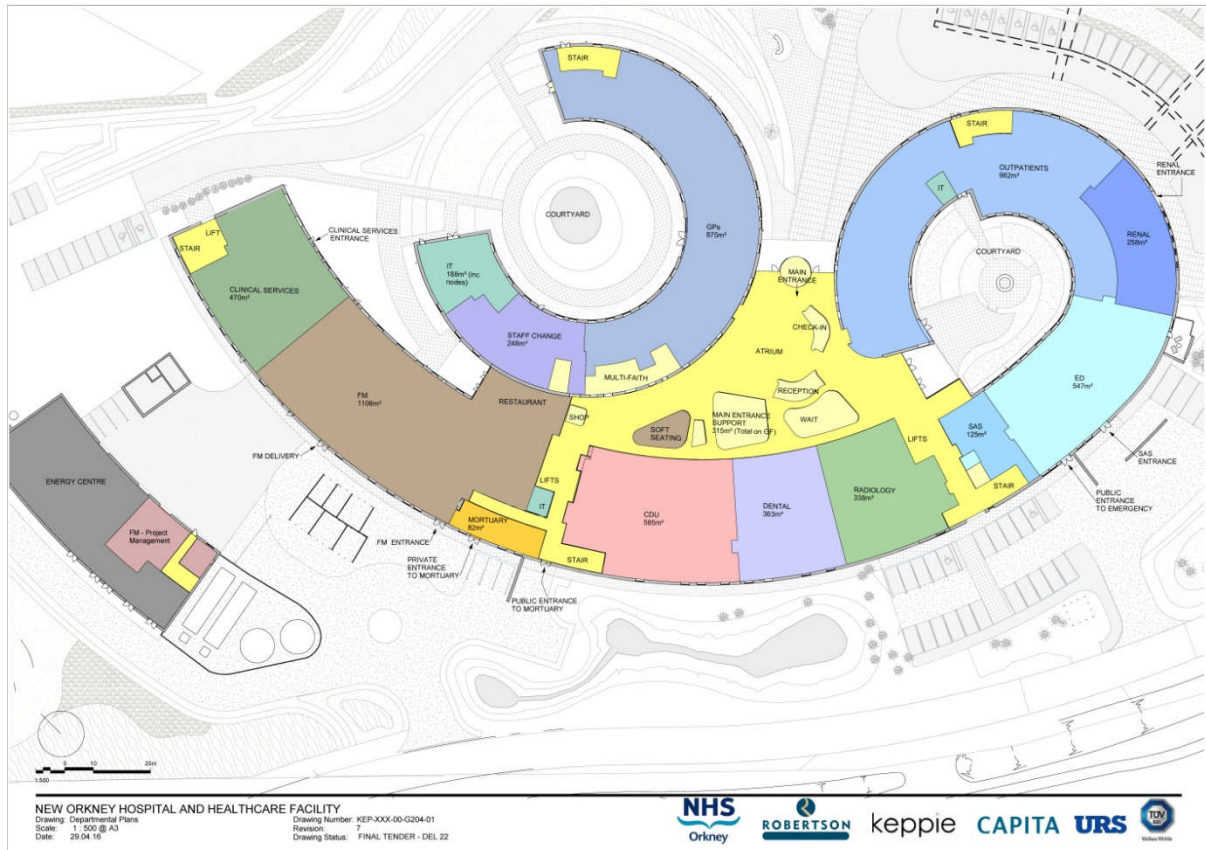
The south courtyard is a key area providing access to a large sheltered external space for all building users. Visible and accessible from the main entrance the hub space has been developed to introduce different usable zones;

- the main waiting area which overlooks the Main Entrance door also benefits from direct views out to this courtyard and people can access the landscape from the adjacent circulation space. The area immediately outside can accommodate a seating area to be used in good weather;
- there is Therapy and Sensory Garden with access from the AHP treatment waiting area, extending and enhancing the available treatment space and environment when appropriate, for both inpatients and outpatients;
- the space is a balance of structured zones for particular use whilst also providing a natural and more relaxed element of planting which provides visual interest and softness such as the wildflower boundary.

The north courtyard can be viewed from the consulting/ treatment spaces of Skerryvore and Heilendi GP practices. It is also directly accessible from the clinical support facility for staff to enjoy in good weather but will still ensure no visual privacy issues in terms of the adjacent consulting rooms.

Internal Arrangements (Clinical Areas)

The internal planning of the building has been subject to a rigorous process of design development. The design delivers all the adjacencies and clinical and operational flows mandated by NHS Orkney and responds to the Board's Design Statement in terms of environment and patient and staff experience.



Ground Floor Block Diagram

General Practice

The two General Practices within the healthcare facility, Heilendi and Skerryvore, benefit from a strong relationship with the central hub. The layout of the area maintains practice identity for both practices whilst offering future flexibility. Located on the ground floor adjacent to the main entrance, the two General Practices are immediately visible upon entry to the building, giving the practices a presence within the entrance Hub. Patients can enter and leave the practices quickly, without feeling they have been at the Hospital, with minimal disruption to other services but also have the opportunity to use the amenities in the hub space, including the restaurant and soft seating and waiting areas.

Dental Unit

The Dental Unit is accessed directly from the main entrance Hub, with direct line of sight from the main entrance door. The unit reception, waiting areas and overflow

waiting is located just inside the department entrance, with the waiting area directly in front of reception so the staff can undertake passive monitoring of the waiting area. The dental administration area is adjacent to reception to enable good communication. The dental recovery area is located directly opposite the special care and oral surgery treatment rooms.



Artist's Impression. Waiting Area

Outpatients and Ambulatory Care

The Outpatients and Therapy Department is located on the ground floor. The main public entrance to the department is adjacent to the main building entrance for easy access. There is a strong relationship with the central hub which supports check-in for appointments and wayfinding. There are external courtyard views from clinical spaces and waiting areas, within the Department.

The outpatient consulting area is adjacent to the Emergency Department treatment rooms to allow flexibility between departments in the event of clinical demands changing in the future or to cope with short term peaks in demand in either department.

Renal Unit

The Renal Dialysis Unit has its own dedicated external entrance located next to dedicated parking spaces. There is an alternative entrance, through Outpatients, which can be secured out-of-hours. The Renal Unit staff base is located directly opposite the dedicated entrance to the Unit and close to the entrance from Outpatients. This makes it highly visible to patients and visitors entering the unit and enables staff to monitor access to the area effectively. The staff base is also close to

the isolation treatment room and has an overview of the dialysis cubicles for observation of these areas.

Radiology

Radiology is situated centrally but not embedded within a deep footprint, thereby allowing for future expansion. It benefits from adjacencies to the lift core, the Outpatients area, Emergency Department and the main hub area, where it is visible from the main entrance door. It also delivers an excellent adjacency to the Dental Unit to the support out-of-hours activity of that Unit

Emergency Department

The Emergency Department (ED) is accessed from Foreland Road (Entrance B) by both ambulances and self presenting patients. The location of the department within the building enables efficient movement to and from diagnostic services and transfer to inpatient wards, while maintaining patient privacy and dignity. The ED waiting area benefits from views to the outside to improve the patient experience and provide a calming environment.

The Department also accommodates the Mental Health Transfer Bed and associated external garden area.

The ED entrance will be the only entrance to the building for patients, relatives and staff in the overnight period. Whilst there are parking spaces allocated both for ED, on call staff and SAS ambulance parking there will also be a connecting path from the main parking area to enable ease of access to and from the car park.

External to ED is the decontamination area for the erection of the decontamination tent in the event of a chemical contamination or other major contamination incident. This area is provided with the appropriate power and water services and containment facilities.

The Scottish Ambulance Service, NHS24 and the GP out of hours service are all co-located with the Emergency Department to form the Emergency Care Centre (ECC).

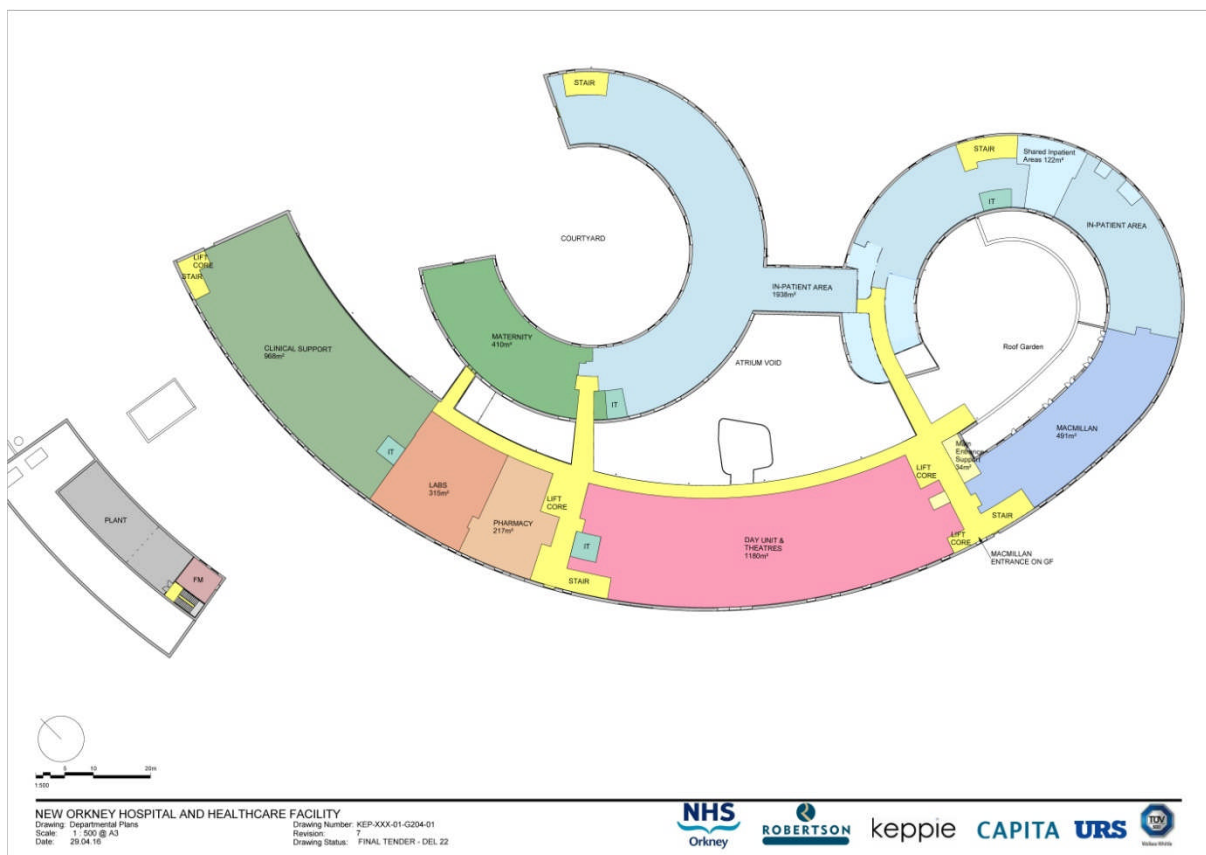
In Patient Areas

The public entrances to the inpatient areas are visible across the entrance hub void from the arrival points at the top of the main public stair and the public lift, to help orientate visitors. Public access to the inpatient areas is controlled by the ward reception area. Public, patient and FM flows are segregated by means of link bridges between the inpatient areas, theatre suite and FM routes.

The inpatient areas have been designed to provide a modern, calming environment that improves the patient experience and adds therapeutic value, thus aiding the healing process. The arrangement of the inpatient areas allows a flexible approach to bed utilisation, able to respond to changing clinical demand.

The inpatient single bedrooms will deliver a high level of privacy and dignity, enabling patients to be alone when they feel like it and to have a private conversation with a clinician or a visitor. Patients can choose to have visual privacy by closing the interstitial blinds in the observation window to the corridor and by closing the vistamatic vision panel in the door. Visibility from the bedrooms into the corridor is facilitated by large observation windows in each room, preventing patients in single rooms from feeling isolated.

Staff bases and touchdown spaces for each cluster of bedrooms has been provided with two touchdown spaces, one on each side of the central corridor, to ensure good observation of all bedrooms. These spaces are supported by centrally located staff bases.



First Floor Block Diagram

The inpatient therapy area is located to maximise the rehabilitation aspect of an inpatient stay. This includes an inpatient therapy area and an activities of daily living kitchen area for kitchen practice, where it is not possible to do this in a patient's own home in the initial stages of the patient journey. The therapy area is supported by views to an external garden deck area to improve patient experience and environment. Patients can also be escorted to the ground floor therapy garden area to enjoy the change in environment or for active rehabilitation.



Artist's Impression. In Patient Bedroom

Maternity Unit

Public access to the Maternity Unit is via a bridge link which is a short distance from the lift core. The link bridge arrives in the heart of the ward, with the entrance to the inpatient area monitored and controlled by the midwives' base. A separate private bridge offers a discreet route between the Maternity Unit and the Theatres. Access from this bridge will be via a secure door to prevent unauthorised entry to the Maternity Unit. Newborn infants will be cared for in a secure environment with restricted access to neonatal areas and the delivery suite. Maternity day treatment spaces and inpatient areas are segregated to minimise cross flow of patient types and to reinforce security.

The single rooms in maternity are positioned so they can be used by the inpatients area in periods of peak demand whilst still ensuring the remainder of the Maternity Unit is zoned and kept secure to maintain the security and privacy of mothers and babies.

Cancer and Palliative Care Unit

The Cancer and Palliative Care Unit is adjacent to the inpatient unit. This arrangement of the inpatient areas allows a flexible approach to bed utilisation. The Cancer and Palliative Care Unit is provided with its own dedicated, private entrance at ground level with dedicated parking spaces. This external entrance accesses into a dedicated lobby. From here patients and/ or visitors to the unit can take the lift or the stairs up to the Unit. On arrival from the stair or lift, the entrance to the Unit is immediately accessible.

All four of the Unit's bedrooms have direct access, via patio doors, to external balcony space. The external area will be finished in timber decking or paving units. Garden planters will provide visual and olfactory stimulation as well as screening and privacy for patients, while the orientation of the space will provide shelter from the elements

Theatre and Day Unit

The integrated Theatre and Day Unit suite is provided in well ordered accommodation. The departmental arrangement facilitates pre and post-operative and inpatient and day case patient flow segregation as well as the segregation of clean and dirty FM flows. The design has a robust 'red line' system, bringing staff in through the private corridor to the changing rooms and boot change/ footwear wash before entering the main theatre corridor. The staff rest room, within the theatre complex, is located centrally to allow staff to return quickly to the theatres in case of emergency

High Dependency Unit (HDU)

The High Dependency Unit has been planned to provide excellent visibility and observation of the two HDU bedrooms with support accommodation nearby. The location within the building ensures a high level of privacy for patients while maintaining integration with the main inpatient area. The dedicated HDU staff base is located opposite the HDU bedrooms with sight lines into each room via a glazed screen. This location offers excellent observation of the bedrooms

Pharmacy

The Pharmacy Department is located on the first floor, next to a lift core and stairwell. This location ensures that it is able to be secured whilst offering a robust service across Primary and Secondary Care with easy access to inpatient and Theatre areas. In order to meet emerging guidance a Consulting Booth has been included so patients can receive confidential advice on their medication.

An Emergency Drug store will be located in the Inpatient area to provide secure storage for medicines to meet the clinical needs of the hospital out with normal hours.

Laboratory

The laboratory offers accommodation which will ensure the delivery of a specified range of biochemistry, haematology, microbiology and blood transfusion services from a single secured area. Staff, patients or public dropping off samples will report to a sample reception area off the external corridor.

A separate Point of Care Test area will be located in the Emergency Department and provide out of hours access for clinicians wishing to run tests within the agreed scope delegated to them.

Clinical Support

An open plan shared working space within the clinical support area of the building will allow for the co-location of a variety of office based staff as well as hospital and community care teams who often provide care or services to the same patient or group of patients. This co-location will, for example, encourage and enhance the sharing of information to support care and service delivery across and between teams. A range of spaces for confidential meetings and work are provided within this area which is on the first floor of the building. The ground floor accommodates more office space and a range of meeting and conference facilities which can also be used by health related and other community groups after hours and at weekends. There is limited parking adjacent to the building to support ease of access by public either reporting to meet with staff who are based in the area or for out of hours access to the meeting rooms. The Boards Major Emergency Response Centre is located in the main conference room.

Information and Communication Technology (ICT)

ICT provision incorporates a strong ICT backbone which includes full Wi-Fi coverage, Cat 6A cabling infrastructure and additional allowances of blown fibre optic cabling. Resilience is provided by feeding data points from two separate network nodes. This strong spine will be capable of accommodating the implementation of healthcare ICT innovation such as asset and people tracking together with any future expansion of the system. Server and node rooms are appropriately located to ensure overall coverage of the building.

Central Decontamination Unit (CDU); Endoscopy Decontamination Unit (EDU)

The CDU/EDU design, layout and flows have benefited from detailed review by Health Facilities Scotland. NHS Orkney's activity and throughput levels within the CDU/EDU are low when compared to a mainland Board but its isolation renders transport of clean and dirty instruments from and to an out of Board area facility impracticable. The flows of both clean and dirty instruments and endoscopes have been mapped to ensure limited cross-over of clean and dirty flows and with public flows.

Facilities Management (FM)

Soft FM services provided by NHS Orkney include domestic, portering, stores, grounds maintenance, waste collection, medical physics, laundry and other in house FM services all of which will be provided and managed from FM offices within the FM suite on the ground floor of the building. The provision of patient meals and catering for the restaurant will be provided from a bespoke kitchen designed to support the catering provision required for an island facility, which for Orkney is predominantly 'cook and serve'. Food will be decanted and served at ward and department levels from bulk food service trolleys. The ground floor restaurant will serve staff and visitors and the soft seating area will have vending machines.

External Areas

External to the main FM area are waste compounds, grounds storage and the piped medical gases and vacuum compound. .

Energy Centre

The Energy Centre is external to the main building The primary power source for the new facilities is electricity, powering heat pumps, with oil fired boiler plant as the backup system to provide resilience and to ease any operational spikes. The main plant is twin air to water heat pumps which are externally mounted and in essence extract heat from the air and using electrical heat pump technology, transfer that heat to circulating water. Each of the external units is connected to internally mounted water to water heat pumps which distributes the heated water through a second heat pump cycle. This increases the temperature of the circulating water to normal heating system levels which then feeds the heating and hot water demands of the building.

Future Expansion Zones

The design solution addresses the briefed requirement for expansion.



Artist's Impression Expansion Zones

Both GP practices are located in the 'Horseshoe' element of the building which has been left open. The form could be extended towards its opposite end to provide additional accommodation. This accommodation would provide good views, orientation and outlook for the rooms within. The staff changing, multi Faith and IT

areas make up the other section of the ground floor horseshoe and as with the GP's accommodation, could expand with the regular structural grid pattern being extended. This zone of the building also offers adaptability and flexibility without expansion, as the staff changing area has the ability to be re-provided elsewhere, to allow overall development of the area for more clinical services to be provided.

The 'Hoop' and 'Tail' sections of the building also offer flexibility at the ground floor. The facade and edge of the building can be expanded and 'pushed' out to increase capacity.

The flexibility of extending the accommodation beyond the current building line to the south elevation could be utilised in the future to support the expansion in departments such as Radiology, where continual and rapid development of technology and services require flexibility across the building. Other areas on the 'hoop' and 'tail' can be treated in the same way, extending the accommodation outwards to provide rooms with light and view, moving the support accommodation, where required, to the inner line of the building.

NHSO Hospital PROCUREMENT Internal Risk Register

Ref.	Date Entered / (Removed)	Risk Description	Type	Current Likelihood	Current Consequence	Risk Rating	Action Plan Completed?	Time/Cost Impact	Mitigation	Target Likelihood	Target Consequence	Risk Rating	Action Status	Action Owner	Due Date
1b	1 April 2014	Failing to capture efficiency from community based services thus reducing the efficiency of the building	Development	2	5	10	No	C	Room audits to be undertaken to better allocate and schedule group room activity and sessions. Health Care Planner undertook capacity modelling against busiest weeks. Service development plans will reflect individual services change required to maximise service delivery. Undertake Risk Assessment Review. Preliminary discussions with C Bichan regarding any plans being developed in the Community. Update June 2016 - IJB planning now in development phase, Project Director to maintain contact at various levels to gauge how developments support Project objectives.	1	5	5	Ongoing	RW	Dec-2016
1c	1 April 2014	Failing to capture efficiency from flexibility within the services model	Service	1	5	5	Yes	C	Adjacency matrix and evaluation criteria reflect the flexibility and integration of the departments and rooms required. Both Bidders have met the Adjacency Requirements within their Draft Final Tenders	1	5	5	Complete	RW	Sep-2016
1d	1 April 2014	Day lighting requirements - resulting in net to gross areas inefficiency	Development	2	3	6	Yes	C	Development of design solution as part of reference design and part of design process during CD period. Update June 2016 - Preferred Bidder (PB) plans show 4 areas where day lighting needs to be resolved. These have been included in PB letter.	1	3	3	Ongoing	RW	Aug-2016
1e	5 December 2014	Inadequate space to maximise service flexibility within the new facility	Development	1	3	3	Yes	T&C	Adjacency matrix and evaluation criteria reflect the flexibility and integration of the departments and rooms required Adjacency Matrix is a mandated requirement within ITPD. Adjacency Matrix met by both Bidders, require flexibility achieved within both designs	1	3	3	Complete	RW	Sep-2016
4	1 April 2014	Business Risk - Failure to engage with Stakeholders impacting on design and requirements	Non Financial	2	3	6	Yes	T	Engagement and communication plan in place for project with regular review and stakeholder analysis. To review communication plan and stake holder process prior to Preferred Bidder. Refreshing Communication Plan which will incorporate all stakeholders engagement.	1	3	3	Ongoing	AMc	Aug-2016
4a	1 March 2015	Risk that top soil strip/construction activity will contaminate or foul the source of water supplying Highland Park distillery.	Development	2	3	6	Yes	T&C	All constructions should have constraining outflows from the site. No work will commence until details of containment measures are agreed with top soil contractor and subsequently PB. Risk now being passed to PB via Project Agreement. Note June 2016 - New Link Road construction completed without incident. Further culverting in place that should also mitigate risk of run off from site.	2	3	6	To be kept under review	AMc/AT	Feb-2017
7	1 April 2014	Strategic - failing to comply with ethos of national and local strategies such as 20/20 vision etc	Non Financial	1	4	4	Yes	T	Strategic Case outlines alignment with policies. Impact of Health and Social integration included in ITPD documentation.	1	4	4	Complete	AMc	Nov-2016
13	1 April 2014	Procurement Risk - Change to Legislation before FC	Development	1	3	3	No	T&C	New Building Regulations from 01/10/15. Advice re: impact provided by HFS and Tech Advisors, to be incorporated into ACRs via CD period Bulletin post down selection. T&T appointed as advisors to Principal Designer as of 1st October 2015	1	3	3	To be kept under review	BB	Aug-2016
14	1 April 2014	Procurement Risk - Change to Legislation before FC	Non Financial	1	3	3	No	T	Post FC by Scottish Government	1	3	3	To be kept under review	AT/AMc	Aug-2016
16	1 April 2014	Procurement Risk - Failing to pass KSR at any stage - delaying programme	Development	2	4	8	No	T	Pre OJEU and Pre ITPD KSRs approved. Ongoing review of all recommendations to ensure compliance at following stages. Pre OJEU, Pre ITPD & Pre Close of Dialogue KSRs approved	2	4	8	To be kept under review	AMc	Aug-2016
17	1 April 2014	Business Risk - loss of key member of the Project Team	Non Financial	3	4	12	Yes	T	Succession policy being developed. Record keeping and traceability of project processes kept up to date and in G drive to ensure information is not held by one individual. Maintenance of Project Fact File - reviewed on a monthly basis	2	4	8	To be kept under review	AMc	Oct-2016
18	1 April 2014	Commercial/Pricing Risks - Failing to adequately allow for location factor adjustments	Development	2	4	8	Yes	C	Local benchmarking from Schools obtained. Potential to be out by 5% either side. Agreement from IDR team and SFT and CiG. Risk Rating has increased due to both remaining Bidders identifying increased costs and in particular in respect of locally/regionally sourced M&E packages. Position notified to SFT and SG Capital Div and under review with Bidders. June 2016 Update: PB Capital Costs identified and resource availability confirmed via email exchanges with Scottish Govt. Formal confirmation by letter now being sought	2	4	8	To be kept under review	AT	Dec-2016
19	1 April 2014	Commercial/Pricing Risks - The projected BCIS indices (set out in the OBC for the period Q1 2014 to Q2 2017) exceeding the projected level	Development	2	4	8	Yes	T&C	TPI and BCIS indices reviewed on at least a quarterly basis and trends reviewed by Advisors and SFT.	2	4	8	To be kept under review	BB	Aug-2016
20	1 April 2014	Changes introduced as required by National Shared Services Strategy/Agenda	Service	3	2	6	Yes	T	Work ongoing in line with national strategy which is being continually monitored by MC.	1	2	2	To be kept under review	MC	Sep-2016
21	1 April 2014	Commercial/Pricing Risks - Failing to forecast operational costs of clinical staff	Service	2	3	6	Yes	T&C	Workforce plan for new facility developed in line with COS, SoA and operational policies - led by Head of OD (to be confirmed)	1	3	3	To be kept under review	JN	Sep-2016
22	1 April 2014	Commercial/Pricing Risks - Failing to accurately forecast costs for Non Clinical operations and staff	Service	2	3	6	Yes	T&C	FM and Life Cycle costs benchmarked against NHS Scotland norms. Location factors benchmarked against schools project. Led by Head of OD (to be confirmed)	1	3	3	To be kept under review	MC	Sep-2016
23	10 December 2014	Risk that construction activity will contaminate or foul the source of the water supplying Highland Park distillery		2	5	10	No	T&C	All constructions should have constraining outflows from the site. No work will commence until details of containment measures are agreed with top soil contractor and subsequently PB. Top soil strip will now be the responsibility of the PB and they will require to risk assess the works involved and agree certain measures with OIC planning department if works are carried out prior to full planning consent. Similar considerations will apply to bidders when seeking full planning consents for the construction works	1	5	5	To be kept under review	BB	Sep-2016
24	1 April 2014	Commercial / Pricing Risks - Failing to forecast recurring costs for energy	Service	2	2	4	Yes	T&C	Volume and Tariffs for energy to be calculated by H&K, monitoring on going through project period.	1	2	2	Ongoing	MC	Sep-2016
25	1 April 2014	Commercial / Pricing Risks - Failing to forecast recurring costs for retained maintenance or specialist activity not part of the NPD	Service	3	1	3	Yes	T&C	All services to be retained identified, scoped and priced in OBC and reflected in ITPD. OBC and ITPD states no TUPE of staff.	2	1	2	To be kept under review	AMc	Feb-2017
26	1 April 2014	Operational Risks - Failing to clearly define operational policies for the whole hospital	Service	3	3	9	Yes	T	Whole Hospital Policy developed, operational policies identified and being reviewed as required.	2	3	6	To be kept under review	RW	Aug-2016

27	1 April 2014	Commercial / Pricing Risks -equipping budget being exceeded including IT	Development	3	2	6	Yes	T&C	HFS involvement in assessing equipment needs in line with COS. Risk Rating increased due to unfiltered Equipment and initial IT review currently indicating requirement in excess of budget. As consequence of Project delay revenue and equipment Budgets require to be re-profiled.	1	2	2	Ongoing	AT	Sep-2016
28	1 April 2014	Failing to obtain innovative solutions, that reduce LCC but increase Capital	Development	2	2	4	Yes	C	Managed within ITPD and Evaluation process.	1	2	2	To be kept under review	RW	Nov-2016
30	1 April 2014	Complexity of hospital commissioning programming resulting in poor transition and increased decanting costs	Service	2	5	10	No	T&C	Out line commissioning programme identified.	1	5	5	To be developed	AMc/RW	Nov-2016
31	1 April 2014	Failing to resource and implement training	Non Financial	2	3	6	No	T&C	Training programmes for new facilities/equipment joint NHSO /Project Co responsibility. Commissioning programmes to identify training requirements and timetables. Resource planning required to incorporate this into Business as Usual commissioning process.	1	3	3	To be developed	MC	Nov-2016
32	1 April 2014	Failing to obtain appropriate L8 testing for Legionella etc.	Development	2	5	10	No	T&C	Project Co. Test failure will delay completion, operationally requires to be dealt with in QM and Method Statements by FM Provider - e.g. flushing regime etc.	1	5	5	Included in ITPD	RW/MC	Nov-2016
33	1 April 2014	Operational Risks - HAI - fail to meet requirements	Service	2	4	8	No	T&C	Implement HAI Scribe at each appropriate stage. FM cleaning regime by NHS. Needs done for each of the options, Stage 1 for each. Post site selection Stage 2 Report. Stage 2 Report completed	1	4	4	Included in ITPD	MC	Sep-2016
34	1 April 2014	Failing to provide appropriate resilience in systems to protect against critical services failure	Development	2	5	10	Yes	T&C	Critical services and disaster management planning to be developed by PB- requirements included in ITPD. Risk retained by Project Co re resilience of services. Paymech reflects critical areas.	1	5	5	Included in ITPD	AT	Dec-2016
35	1 April 2014	Archaeological finds pre construction and post construction resulting in delay to project	Development	5	2	10	Yes	T&C	Site archaeological report included in data room, Project C will not have access to identified site. Ongoing issue meantime Agreement with PIB to pursue top soil strip prior to selection of preferred bidder. Preferred Bidder will carry out Top Soil Strip. Risk managed under commercial workstream via PA	4	2	8	To be kept under review	BB	Aug-2016
36	1 April 2014	Construction/Site Risks - Ecology/Environment causing delay or cost	Development	2	2	4	Yes	T&C	Phase 1 ecology surveys complete . No real issues identified but to be kept under watching brief.	1	2	2	To be kept under review	AT/AMc	Nov-2016
37a	1 April 2014	Failing to obtain BREEAM Target under New Construction Regulations	Development	2	4	8	No	T	BREEAM requirements set out in ITPD, solution to be developed by Project Co. Advice re: impact of new regs from 01/10/15 provided by HFS and Tech Advisors, to be incorporated into ACRs via CD period Bulletin post down selection. (see also Risk No 13)	2	4	8	To be kept under review	BB	Nov-2016
38	1 April 2014	Off Site Flood requiring to be mitigated	Development	2	4	8	No	T&C	This risk lies with OIC- but, for example providing culverts at the time of the new road construction would alleviate the risk for the local area overall. Discussion with OIC Planners is ongoing around this aspect of the road construction. Under active discussion with OIC prior to Preferred Bidder. Risk Rating reduced as link road construction has commenced. OIC engineers have been provided with tech details by both remaining Bidders to inform culvert construction. PB to confirm culvert position of new link road as pare to site investigation	1	4	4	To be kept under review	AMc	Nov-2016
39	1 April 2014	Ground Conditions e.g. Geology and Rock, resulting in increased cost or Programme	Development	2	4	8	Yes	T&C	Site Investigation report included in ITPD. All bidders to consider what additional reports they may require. Update June 2016 - PB to undertake their own site surveys.	2	4	8	in ITPD	AT	Aug-2016
40	1 April 2014	Crantit Basin and local watercourse revealing spring water during construction	Development	2	2	4	Yes	C	Site Investigation complete and included in ITPD - Bidders to consider what further investigation may be required for their own purposes.	1	2	2	in ITPD	AT	Dec-2016
41	1 April 2014	Mains Water insufficient pressure or availability	Development	2	1	2	No	T&C	Bidders to confirm by their own investigations during CD period. Link road construction has commenced, OIC engineers have been provided with tech details by both remaining Bidders to inform culvert construction.	1	1	1	in ITPD	AMc	Aug-2016
42	1 April 2014	Drainage Impact (Surface / Foul Drainage) - unforeseen reliance on pumping requirements	Development	2	4	8	No	T&C	DIA complete - design to Stage C to reflect. SEPA to be consulted re surface water. Risk Rating reduced as both remaining Bidders drainage schemes evaluated to be appropriate to site.	1	4	4	in ITPD	AMc	Dec-2016
43	1 April 2014	Unforeseen utilities diversions on site	Development	3	3	9	No	T&C	Searches complete and results included in data room. PB to undertake further confirmation with SSE.	2	3	6	To be kept under review	AMc	Dec-2016
44	1 April 2014	Need for upgrading and re-enforcement of power supplies	Development	4	2	8	Yes	C	Works and Cost built into Stage C Design / Cost Plan. For Bidders to confirm with SE.	3	2	6	To be kept under review	AMc	Sep-2016
45	1 April 2014	Open watercourses bringing need for CAR License, realignment of culverts or delay	Development	3	3	9	No	T&C	Review of watercourses at new roundabout and on adjacent fields undertaken. As noted at Risk No. 38 providing culverts at the time of the new road construction would alleviate the risk for the local area overall. Discussion with OIC Planners is ongoing around this aspect of the road construction. Under active discussion with OIC prior to Preferred Bidder In PB letter	1	3	3	To be kept under review	AT	Feb-2017
46	1 April 2014	Site traffic movement, swept path analysis and TA reveal greater road network, widths, splays etc. e.g. for biomass	Development	1	5	5	No	C	Swept path analysis undertaken. However as at March 2015 Biomass unlikely to be energy solution. This risk now lies with the 2 Bidders who have both undertaken appropriate analysis in respect of their design solutions. Update June 2016 - PB to include anylysis as part of full planning submission.	1	5	5	To be kept under review	RW/MR	Oct-2016
47	1 April 2014	Poor operational flows and function leading to increased travel distances and staffing costs	Service	1	4	4	Yes	C	Operational flows identified in Ref design - ITPD seeks improvement from Bidders. Post Down Selection 2 remaining Bidders have demonstrated improvements on the ITPD flows during the CD process All mandated adjacencies met and flows are included in evaluations	1	4	4	Included in ITPD	RW	Sep-2016
55	1 April 2014	With single hospital facility in Orkney fire safety requirements may require to be over engineered with resultant increased capital expenditure	Development	2	4	8	Yes	T&C	Provision of sprinkler system confirmed as requirement in ITPD and costed within OBC. Other fire issues to be reviewed at PB including Atrium, Fire Treatment & Swing Doors etc. June 2016 Update . PB design reviewed by HFS and issues addressed as part of NDAP process. Atrium fire solution will be further reviewed by HFS and NHSO Fire Advisor is currently reviewing all PB fire plans and drawings.	2	4	8	Included in ITPD	MC	Sep-2016
55a	1 April 2014	Design Risks - Failure to coordinate with Fire officer, compromising effective escape strategy leading to increased staffing	Service	2	4	8	No	T&C	Fire meetings to be reinstated post down selection. Close scrutiny of fire proposals continues through Dialogue period . Sign of to Fire Strategy by FO. June 2016 Update . PB design intially reviewed by HFS and issues addressed as part of NDAP process. Atrium fire solution will be further reviewed by HFS and NHSO Fire Advisor is currently reviewing all PB fire plans and drawings.	1	4	4	To be kept under review	AMc	Oct-2016

56	1 April 2014	Design Risks - Failing to agree design fundamentals with A&DS	Development	2	3	6	Yes	T	A&DS Panel Review of all 3 Bid proposals held at Interim Bid stage to inform down selection process. Further A&DS review to be held pre PB. On going contact meantime. After pre PB - further panel review held 29/6/15, feedback provided to both Bidders - awaiting Bidder response. Bidders responses received and will be returned to AD&S with comments from NHS Orkney. June 2016 update. - A&DS informed of PB appointment. PB to provide A&DS with detailed drawings, plans and elevations within same timescale of planning submission for further review and comment.	1	2	2	Ongoing	AMc	Sep-2016
57	1 April 2014	Design Risks - AEDET Review resulting in change at later date	Development	2	4	8	No	T&C	Advice being sought re: AEDET requirements prior to appointment of PB.	1	4	4	To be kept under review	AMc	Nov-2016
59	1 April 2014	Acoustic treatment requiring enhancement to satisfy local objection	Development	1	3	3	Yes	T&C	Acoustic requirements included in ITPD. Bidders to confirm compliance with SHTMs etc. and seek permission for any derogation from regs and/or NHSO requirements.	1	3	3	Included in ITPD	AMc	Aug-2016
60	1 April 2014	Failure to review and incorporate requirements of Equality Act and DDA could result in a change to requirements at a later date	Development	2	5	10	No	T&C	Arrangements underway for Equality Manager and Access Panel to input with PB as part of 1:50 programme.	1	5	5	Ongoing	RW	Feb-2017
62	1 April 2014	Emerging changes to Building Regulations	Development	2	4	8	No	T&C	New Building Regulations from 01/10/15. Advice re: impact provided by HFS and Tech Advisors, to be incorporated into ACRs via CD Period Bulletin post down selection. (Also see Risks Nos 13 and 37a)	2	4	8	Ongoing	AMc	Mar-2017
63	1 April 2014	Building energy modelling and energy studies requiring additional mechanical venting or comfort cooling	Development	1	3	3	Yes	T&C	Energy modelling carried out as part of Section 6 compliance report for Stage C. Now with Bidders to run energy models to prove compliance with BREEAM and other requirements within capital costs.	1	3	3	To be kept under review	BB	Nov-2016
65	1 April 2014	Failing to develop robust technical (ACR) PQQ & ITPD documents leading to delay to PB and FC	Development	2	2	4	Yes	T&C	Process completed. Evidence from other NPDs shared to maximise efficiency. Rights to use other NHS docs obtained. June 2016 Update. PB successfully appointed.	1	2	2	Completed	AMc	Sep-2016
68	1 April 2014	Design Risk - Failing to obtain site investigation and warranties	Development	2	4	8	Yes	T&C	Warranties obtained to be passed to Bidders without prejudice. Warranties and all equivalents now passed to Bidders without prejudice	1	4	4	Completed	AMc	Aug-2016
71	1 April 2014	Specific requirements for Art and requirement for Contractor to provide interface and resources	Development	1	1	1	Yes	T	Art Strategy included in ITPD.	1	1	1	Included in ITPD	AMc	Aug-2016
72	1 April 2014	Lack of resource to commit to project leading to delays to FC	Development	2	4	8	Yes	T	Project Director, Project Team, Project Manager and all Advisors appointed.	1	4	4	Completed	AMc	Aug-2016
73	20 May 2014	Detailed Planning Risks - Failing to obtain planning on time	Development	2	5	10	No	T&C	PIP in place. Full Planning risk lies with PB, however NHSO remains in dialogue with OIC Planners to facilitate planning meetings with PB. A Planning Process Agreement is in place. Full Planning application submitted 04/07/16 on programme, verified by OIC planners 08/07/16.	1	5	5	To be kept under review	AMc	Aug-2016
74	20 May 2014	Weather Risks delaying construction activity	Development	2	3	6	No	T&C	Project Co to plan operations effectively and include suitable methodologies and planning to mitigate adverse weather impacts on construction programme. Will review once revised construction timetable available	2	3	6	Included in ITPD	BB	Sep-2016
75	20 May 2014	Fail to adequately provide for third party opportunities	Service	1	2	2	Yes	T&C	Community Benefits including use of local SMEs, Social Enterprises and 3rd Sector included in ITPD along with targets for Apprentices both during construction and in Operational phase.	1	2	2	Included in ITPD	AT	Nov-2016
76	20 May 2014	Failure to obtain appropriate skilled personnel when required on site	Development	2	4	8	No	T&C	Bidders to include proposals to mitigate any shortages in construction methods i.e. pre fabrication, letting of works packages. All Bidders have been encouraged to explore local market and specialist trades. Local panel including reps from local business, Education and 3rd sector set up and all Bidders have had the opportunity to meet with them.	2	4	8	To be kept under review	BB	Sep-2016
77	20 May 2014	Reputation / Procurement Risk - may fail to properly address community benefits causing delay and additional cost	Non Financial	2	2	4	No	T&C	Community Benefit plan in ITPD - reflects national guidance and benchmarks. Engagement with Orkney Community infrastructure in hand. Advice received from Orkney collage re: minimum targets. Both Bidders have provided strong cases in respect of community benefits	1	2	2	Included in ITPD	AT	Sep-2016
78	20 May 2014	Failure of Orkney Health and Care community based services to deliver the defined model of care - thus not keeping people out of hospital	Service	2	4	8	No	T&C	To be addressed within integration planning via Joint Integration Board as part of Health and Social Integration agenda..	1	4	4	Ongoing	AMc	Aug-2016
79	20 May 2014	Construction - lack of available accommodation for workforce during construction leading to higher location factor and preliminaries costs	Development	1	3	3	No	T&C	PB has identified mitigation strategies e.g. off site fabrication etc.	2	3	6	Included in ITPD	AMc	Oct-2016
80	20 May 2014	Design - Failure to allow for future flexibility resulting in high cost of change pre FC	Service	2	2	4	No	T	CoS include identified areas of flexibility and "soft" areas of expansion. Evaluation criteria includes identification of expansion areas.	1	2	2	Included in ITPD	RW	Aug-2016
81	20 May 2014	Specification of External Fabric increases due to requirement for enhancements to air testing	Development	3	4	12	No	C	Proposed external finishes reviewed by H&K as part of technical review and potential issues identified in PB letter.	2	4	8	To be kept under review	BB	Aug-2016
82	20 May 2014	Risk of cost overrun on enabling costs (equipment costs)	Development	3	4	12	No	C	Enabling programme to be defined and developed.	2	3	6	Included in ITPD	BB	Sep-2016
83	13th October 2014	The risk that revenue costs are underestimated.	Service	3	4	12	No	C	Operational Risk Register created to capture and manage key TCS dependencies including revenue impacts on not achieving envisaged efficiencies from new models and ways of working.	3	3	9	To be kept under review	AMc	Sep-2016
84	13th October 2014	The risk that the Project is not affordable in the longer term.	Service	3	4	12	No	C	The NHSO LDP 2014-19 demonstrates NHS Orkney moving into recurring surplus for the period 2014 - 2019, as the new facility comes online, the Board will move back into recurring balance as the cost pressures associated with the new facility come online.	3	4	12	To be kept under review	AT	Aug-2016
85	13th October 2014	The risk to the Project timetable and interface risks associated with enabling works	Development	2	4	8	Yes	T&C	Works programme to be provided by OIC. NHSO Project Team in on going dialogue with OIC. Planning permission for New Link Road passed 18/03/2015. OIC works programme now confirmed, will be completed by March 2016. Once road is completed this risk will be closed.	2	4	8	To be kept under review	AMc	Aug-2016
89	29th October 2014	There is a risk that equipment costs are underestimated	Procurement	2	5	10	No	T&C	Group 1 and Group 2 equipment list completed and provided to Bidders. Detailed responsibility matrix and a range of room data sheets completed	1	5	5	To be kept under review	AMc	Oct-2016

90	29th October 2014	External Influences - Clinical & Non Clinical External Influences cause significant changes to the scope of the services provided within the project during procurement. For example outcomes from Regional Planning and / or Scottish Govt decisions.	Factor outside the scope of the Project Team	3	3	9	No		Maintain awareness of Regional Planning and SG future planning. Measure any changes against plans for new build.	2	2	4	To be kept under review	AMc	Nov-2016
92	3rd March 2015	Migration with ICT Unable to achieve beneficial access to install ICT prior to handover		1	5	5	No		Negotiation and agreement for beneficial access prior to preferred bidder. PA drafting on Beneficial Access agreed with both remaining Bidders.	2	4	8	Complete	TG	Nov-2016
93	24th August 2015	Migration Risk - General Equipment There is a risk that insufficient planning and/or budget for equipping the new facilities will result in a lack of suitable equipment being available in the new building due to the transfer of unsuitable equipment, or equipment being at the end of its useful life and/or insufficient quantities of equipment being available to support clinical and operational service delivery in a safe and efficient manner.	Procurement	2	4	8	No	T&C	Planning and work underway to identify the clinical equipment required for the safe and efficient operation of the new hospital. Reviewing and prioritising the most effective use of the budget provision available for the total equipment requirements. Mitigation Update March 2016 - Baseline equipment audit complete and Planet FM equipment database being updated with audit data on condition/transfer status/location in new facility.	2	3	6	Ongoing	RW	Nov-2016
94	24th August 2015	Migration Risk - ICT Equipment There is a risk that insufficient planning and/or budget for the provision of ICT equipment for the new facilities will result in a lack of suitable equipment being available in the new building due to the transfer of redundant or unsuitable equipment, or equipment being at the end of its useful life and/or insufficient quantities of ICT equipment being available to support clinical and operational systems within the new facilities.	Procurement	2	4	8	No	T&C	Planning and work underway to identify the ICT equipment required for the safe and efficient operation of the new hospital. Reviewing and prioritising the most effective use of the budget provision available for the total equipment requirements. ICT fileserver equipment purchased in 2015/16 to strengthen Business Continuity which will assist in the migration of ICT to the new hospital. Further budget in 2016/17, 17/18, 18/19 and 19/20 allocated. Mitigation Update March 2016 - ITC audit has recorded all extant equipment but requires refinement re: location, condition etc.- ongoing.. Meetings with suppliers being setup to enable indicative requirements and costs to be determined.	2	3	6	Ongoing	TG	Nov-2016
95	24th August 2015	Migration Risk - Specialist Equipment CT Scanner/Endoscopy/ Radiology There is a risk that insufficient time and/or budget will be identified to plan (including contingency planning for service downtime) with specialist removers the decommissioning, transfer and re-commissioning of specialist equipment in the new building resulting in an extended period when these services are not available leading to delays and disruption to diagnostic and other services	Service	2	5	10	No	T&C	The development of a full Project Plan for the migration of patients, equipment and staff. Plan to incorporate best value options and experience from other projects	1	5	5	To be developed	AMc	Nov-2016
96	24th August 2015	Procurement/Migration Risk - Labs There is a risk that the timing of the procurement of new Labs equipment will make more complex the planning for the transfer of the service to the new building resulting in poor service planning, delays in the Labs procurement and/or additional revenue or capital costs and an extended period of compromised service levels.	Procurement/Service	2	4	8	No	T&C	Review transfer arrangements as per the new managed service contract for the labs - Work Ongoing	1	4	4	Ongoing	RW	Dec-2016
98	29th September 2015	There is a risk that clinical/operational teams may request changes to room or department layouts post PB to accommodate new or different service delivery models resulting in delay to programme and additional costs	Project	3	3	9	No	T&C	All service leads and service managers have been asked to review the Output Specification and Room Data Sheet details and advise the project team of any further changes required. All service leads met with on individual basis as well as attendance at team and advisory group meetings to recap on the need for as much detail to be updated at this stage as services identify as required.	2	3	6	Ongoing	RW	Dec-2016
99	29th September 2015	Integrated Joint Board There is a risk that the implementation of the IJB will result in change to service, delivery models impacting on the design or functionality of the new facilities in additional design, capital, operational costs	Project	2	3	6	No	T&C	Project Implementation Board (PIB) & Integrated Joint Board (IJB) Communication	2	2	4	To be kept under review	AMc	Dec-2016
100	8th October 2015	There is a risk that the FBC may not be supported by HFS/A&DS (NDAP) for approval by CiG resulting in delay and/or changes to the PB design resulting in additional costs to the Board.	Procurement	3	4	12	No	T&C	2 NDAP Panel Reviews completed and feedback shared with bidders. PB has responded to Panel Review feedback. Dialogue continuing with A&DS(and OIC Planners) and HFS.	2	3	6	Ongoing	AMc	Oct-2016
101	8th October 2015	Judicial Review Risk There is a risk that a third party may challenge the process followed by OIC in determining the Detailed Planning Permission awarded to Project Co. If the challenge is successful there is the potential for the project to be delayed or even cancelled post Financial Close. It is generally accepted that for the first 12 weeks from planning permission being granted, this risk would sit with the Authority.	Procurement	1	5	5	No	T&C	Only mitigation available within the control of the Authority is to wait 12 weeks from planning consent being granted before reaching Financial Close.	1	5	5	To be kept under review	AMc/RW	Nov-2016
102	9th December 2015	There is a risk that the bed numbers identified in the Outline Business Case are changed in the period up to or after Financial Close resulting in a change of scope and consequent additional design fees and increased capital and revenue costs.	Development	2	4	8	No	T&C	The OBC bed numbers are based on ISD projections in relation to demographics and population changes which in turn are informed by forecast changes in clinical practice and the improved pt flow and bed flexibility designed within the new facilities, including additional day surgical and treatment space, improved triage and observation space in maternity, improved access to theatre and endoscopy facilities and improved cancer and palliative care consulting and treatment areas. The bed numbers will be re-validated prior to Full Business Case stage by the use of improvement and management of change methodologies to test and implement new ways of working and new practices across community care, primary care, outpatients and inpatients, as far as that is practicable within current building footprints, supported by the development of operational policies and processes. For areas where physical change is not an option policies and processes based on evidence based practice within similar systems will be developed.	1	4	4	Ongoing	CB	Aug-2016
103	9th February 2016	There is a risk that, as a result of project delay due to the ESA10 issue, internal and/or external communications do not provide sufficient information to staff and the public leading to speculation and/or adverse comment on the status, viability or other aspect of the project going forward.	Procurement	1	3	3	No	T	Provide updated info on project progress via TOC, newsletters and other communications media as appropriate to project position, recognising such things as "purdah" periods, local and national political sensitivities, as and when they arise.	1	3	3	Ongoing	AMc	Aug-2016
104	9th February 2016	There is a risk that project delay due to the ESA10 issue may result in a negative impact on NHSOs local reputation with adverse comment in local media etc.	Board & Project Risk	3	3	9	No	T	Provide updated info on project progress as appropriate to project position, recognising such things as "purdah" periods, local and national political sensitivities, as and when they arise.	1	3	3	Ongoing	AMc	Aug-2016

106	9th February 2016	There is a risk that the issue of the Market Notification of Change to Source of Funding to inform the market of additional information to the original Contract Notice re change in financial structure may attract a procurement challenge or other adverse reaction.	Procurement	1	2	2	Yes	T	The Market Notification of Change to Source of Funding concerns a change permitted under the OJEU and has been carefully drafted by the Board's legal advisors to ensure the appropriate level of information is included to avoid challenge. This is a short term risk which will expire 30 days after the issue of the notice.	1	1	1	Ongoing	AMc	Oct-2016
107	23rd March 2016	There is a risk that the Revised Timetable may slip and as a consequence further delay Financial Close and start on site and as a result compromise the project Vfm position	Procurement	3	4	12	Yes	T&C	Revised timetable with 4th Oct 2016 Planning Committee date has been agreed with and issued to Bidders. PT and Advisors working to achieve this timetable which is being kept under close review by the Project Director, Project Manager and SFT.	2	4	8	Ongoing	AMc	Oct-2016
108	23rd March 2016	There is a risk that the delay to the Procurement Programme may result in Practical Completion of the new facilities occurring in the winter months with consequences in respect of transition and migration timetables	Procurement	4	3	12	No	T&C	At appointment of PB and confirmation of construction programme PT to review with clinical colleagues likely impacts and risk associated with service migration in winter months and develop mitigation programme.	3	4	12	Ongoing	RW	Dec-2016
109	23rd March 2016	Labs Managed Service Contract (MSC) There is a risk that the specifications, sizes and location of labs equipment to be provided under the Labs MSC will not be made available prior to the appointment of the PB resulting in changes to room layouts and services (water, power and data) in the post PB period, which will incur additional costs to the Board.	Procurement	3	3	9	No	T&C	Specification, sizes and layouts to be provided by Labs contractor as soon as practicably possible. Specifications and sizes now available	2	3	6	To be kept under review	RW	Dec-2016
110	23rd March 2016	Labs Managed Service Contract (MSC) There is a risk that the Labs MSC contractor will not provide detail on transfer costs to the new building until 3 weeks prior to the date of transfer, resulting in insufficient funding being identified within the migration budget which leads to additional unbudgeted costs being incurred by the Board and/or compromises other elements of the migration budget/plan.		3	2	6	No	T&C	Obligation for Labs contractor to provide estimate of transfer costs to be included in contract (or subsequent addendum). Actual costs to be formally agreed between Board and Labs contractor prior to commencement of migration planning. Transfer costs will not exceed £100k	2	3	6	To be kept under review	RW	Dec-2016
111	23rd March 2016	Labs Managed Service Contract (MSC) There is a risk that details of the physical transfer of Labs MSC equipment transfer to the new building are not included in the MSC contract and/or not agreed in sufficient time prior to the equipment transfer that the service experiences a lengthy period of downtime, compromising the Boards clinical services		3	2	6	No	T&C	Obligation to engage with the Board's migration planning process at an early stage to be included in contract (or subsequent addendum). Board and contractor contacts and lines of communication to be agreed as soon as possible. Given the equipment we are procuring and the level of service delivery, the risk of disruption is minor. We have backup machines for all the main analysers and point of care testing capability, virtually all tests can be provided by POCT therefore there is a double redundancy in the service set up. Team working on detailed plan for transition to the new service.	2	3	6	To be kept under review	AMc	Dec-2016
112	10th May 2016	There is a risk that due to the short timescale between appointment of PB and Financial Close the Board will have insufficient resource/capacity to address the range of specialist legal input required to conclude the PPA drafting and clarification of the principles with the PB.	Procurement	3	4	12	No	T&C	The PT will confirm with MacRoberts the resource strategy, including named resources and a timetable to deliver the Draft PPA and the final PPA in the PB appointment and post PB period	2	4	8	Ongoing	AMc	Aug-2016
113	10th May 2016	There is a risk that due to the short timescale between appointment of PB and Financial Close the Board will have insufficient resource/capacity to manage the design review and RDD process to be completed in the period and/or staff are inappropriately diverted from day to day responsibilities.	Procurement	3	4	12	No	T&C	Clinical and non clinical User Groups and memberships have been identified. A pre PB equipment W/S has been arranged with input from HFS and an outline programme of User Group meetings has been developed and accommodation booked in advance of PB appointment. The programme will be finalised with the PB. Sufficient flexibility will be built in to accommodate staff commitments and/or alternative methods of information consultation will be employed (i.e one to one sessions) as required to achieve the programme. Pre PB equipment W/S held with input from HFS.	1	4	4	Ongoing	RW	Aug-2016
114	10th May 2016	There is a risk that HMRC may rule that due to the change in the NPD financial structure VAT is not recoverable for project purposes.	Procurement	2	4	8	No	T&C	Two VAT advisor opinions have been sought and both indicate a favourable project VAT position. A ruling is being sought from HMRC to be provided prior to Financial Close. S Govt Health Finance sighted on the risk.	2	4	8	Ongoing	HR	Aug-2016

Key to Risk Owners		
AMc	Ann McCarlie	Project Director
AT	Albert Tait	Commercial Lead
BB	Bruce Barron	Project Manager
EP	Elaine Peace	Director of Nursing
CB	Christina Bichan	Head of Transformational Change and Improvement
JN	Julie Nicol	Head of OD and Learning
HR	Hazel Robertson	Director of Finance
MC	Malcolm Colquhoun	Head of Estates /Acting Hospital Manager
TG	Tom Gilmore	Head of IT
MR	Marthinus Roos	Medical Director
RW	Rhoda Walker	Clinical Programme Lead

NHSO Hospital OPERATIONAL Internal Risk Register

29th October 2014

Ref.	Date Entered / (Removed)	Risk Description	Type	Current Likelihood	Current Consequence	Risk Rating	Action Plan Completed?	Time/Cost Impact	Mitigation	Target Likelihood	Target Consequence	Risk Rating	Action Status	Action Owner	Review Date
1	29th October 2014	Loss of key personnel Loss of key personnel from the project team and advisers during the project. This could lead to a loss of project specific knowledge. New team members would have to be trained.	Project Management	2	4	8	Yes	T	1. Now at the stage where most project specific knowledge is captured in the Authority Requirements as issued to bidders. 2. 4Projects provides an audit trail of all information to bidders 3. Use of a shared drive within NHSO for information 4. Potential to provide personnel space on 4projects to supplement 3. 5. Full minutes from PIB recording all decisions to date. Points 2-5 would assist in the replacement of members of the project team and advisers as required.	1	4	4	Ongoing	AMc	Aug-2016
2	29th October 2014	Sustainability of Healthcare Provision Failure to maintain services during course of reconfiguration, for example, by inappropriate phasing of service relocation.	Project Management	3	5	15	No	T&C	1. Develop detailed project plan 2. Planning of all moves to ensure services continue to be provided on/off islands depending on timescales and duplication of equipment. 3. Cancel leave during above period to assist with resources. 4. IT equipment to be new to ensure no down time 5. Undertake full equipment audit to ascertain retention and new purchases and lead times for delivery. 6. Identify storage requirements to assist in transition requirements. Transfer plan will need to be agreed in detail with services and PIB prior to migration to the new build engagement with all departments/services crucial.	1	5	5	Ongoing	RW	Dec-2016
3	29th October 2014	Office Accommodation NHSO unable to consistently implement the agreed strategy for office accommodation.	Project Management	2	3	6	No	T	Brief fully consulted on. Significant staff input to this issue. Wiseman Workload measure has been used to assess percentage of time community staff should spend office bound and hot desks allocated accordingly. further Team meeting to be planned discuss office issues re new ways of working. Consider re-establishment of small working group.	1	3	3	Ongoing	RW	Sep-2016
4	29th October 2014	Design Over the lifetime of the project the development of new clinical or service delivery models render clinical design assumptions obsolete.	Clinical Planning	4	3	12	No	T&C	ITPD includes requirement for future expansion in new building, including "soft" expansion space internally and the ability to expand the building footprint to provide additional clinical space.	2	3	6	Ongoing	RW	Aug-16
5	29th October 2014	Medical Records Medical records of Hospital patients not completely electronic, thus requiring space for paper records	Organisational Risk	4	3	12	No	T&C	Scoping paper for realisation of NHSO's paper light vision reviewed at PIB and discussed at CMT. Risk to be escalated to Organisational Risk Register and Business Case being drafted for June PIB and included in NSS review of e-health. Risk Assessment to be taken to June NHSO Risk Management Steering Group. Risk now incorporated in Corporate Management Risk Register, PIB & CMT have agreed the high level programme and next steps programme. Short Life Working Group established including Finance.	2	3	6	Ongoing	AMc	Sep-2016
6	29th October 2014	Medical Records If records are not adequately integrated by the time services relocate Clinicians may not have access to all of the information relating to a patient in a single record, therefore increasing clinical risk. No different from current risk.(Related to Risk No.5)	Factor outside the scope of the Project Team	4	4	16	No	T&C	Scoping paper for realisation of NHSO's paper light vision reviewed at PIB and discussed at CMT. Risk to be escalated to Organisational Risk Register and Business Case being drafted for June PIB and included in NSS review of e-health. Risk Assessment to be taken to June NHSO Risk Management Steering Group. Risk now incorporated in Corporate Management Risk Register, PIB & CMT have agreed the high level programme and next steps programme including the appointment of an EPR Project Manager, taking up post on 1st Sept 2015. Short Life Working Group established including Finance.	1	4	4	Ongoing	AMc	Sep-2016
7	29th October 2014	Paper Records Community Care paper Health records, held by each service, require the use of clinical accommodation and restrict the development of optimum clinical advances, co-locations and/or pt flows.	Factor outside the scope of the Project Team	5	3	15	No	T&C	Scoping paper for realisation of NHSO's paper light vision reviewed at PIB and discussed at CMT. Risk to be escalated to Organisational Risk Register and Business Case being drafted for June PIB and included in NSS review of e-health. Risk Assessment to be taken to June NHSO Risk Management Steering Group. Risk now incorporated in Corporate Management Risk Register, PIB & CMT have agreed the high level programme and next steps programme. Short Life Working Group established including Finance.	2	3	6	Ongoing	AMc	Sep-2016
8	29th October 2014	Ability of Project to meet latest clinical standards Ability of Project to meet latest clinical standards.	Clinical Planning	2	3	6	No	T&C	ACR requirements reflect latest clinical standards. All Bidders will be evaluated on ability to achieve and sustain these and future adaptability criteria to facilitate meeting future changes.	2	3	6	Ongoing	MR	Aug-16
8a	29th October 2014	Legislative change impacting on Project. Time & Cost Impact.	External Factors	2	3	6	Yes	T&C	This is a risk outside the scope of the Project Team to influence - accept as a standing risk.	2	3	6	Accept	AMc	Aug-16
9	29th October 2014	Archeological Discoveries Possible delays due to archeological discoveries during construction	External Factors	3	4	12	No	T&C	Project Team scoping top soil strip of site, as recommended in OARC report, in advance of appointment of PB. Timing of top soil strip being reconsidered following discussion with OIC, alternative approach on undertaking top soil strip being revised with advisors. Risk now being passed to PB via Project Agreement	2	4	8	Ongoing	AMc	Dec-16
10	29th October 2014	Flooding of Site Risk of flooding of site	Project Co Risk	3	4	12	No	T	Project co must provide suitable SUDs and related water management schemes to prevent site flooding. Part of ITPD evaluation.	1	4	4	Ongoing	BB	Jan-2017
13	29th October 2014	Lack of Clarity or Inadequacy in Brief Lack of Clarity or Inadequacy in Brief leads to a delay in the project and increased costs.	Project Management	2	4	8	Yes	T&C	Process developed via dialogue to identify inadequacies in the brief and make amendments as required. Significant input to clinical outcome specifications and NPD process encourages clarifications on brief. Process agreed and implemented and working effectively.	1	4	4	Ongoing	RW	Aug-2016
14	29th October 2014	Management of Expectations Planned facilities do not meet expectations of public, staff, clinicians etc. Basic needs are met but quality could be lower than optimal. Could lead to lower staff morale, recruitment issues.	Project Management	3	3	9	No	T&C	Requires review and further development of communication and engagement plan to ensure appropriate focus and involvement as the project develops and consider greater involvement in the project by stakeholders post appointment of preferred bidder. Maintain effective communication links	2	4	8	Ongoing	RW	Aug-2016
17	29th October 2014	Wider change management project - wider change management processes not progressed in keeping with the steps and timescales identified in the Outcome Specifications	Factor outside the scope of the Project Team	2	4	8	No	T&C	To be incorporated into wider Transforming Clinical Services Programme. Undertake Risk Assessment Review. Preliminary discussion with C Bichan regarding any plans being developed in the Community	1	4	4	Ongoing	JN	Oct-2016
21	29th October 2014	Operational Risk Lack of finalised operational briefs for clinical services and non clinical services resulting in additional running costs	Development	3	5	15	No	C	Engagement with services and teams ongoing to ensure changes to ways of working are implemented prior to move to new build. Operational policies to be developed and aligned with service delivery plans and workforce planning strategy	2	5	10	Ongoing	RW	01/082016
24	10 December 2014	ICT Disaster Recovery Plans - Identification of off site DR location incurs additional planning, implementation or other costs not yet quantified or captured in project financial profile	Factor outside the scope of the Project Team	1	4	4	No	T&C	Graham House identified as interim DR location. Discussions held with OIC with regards to a joint DR facility however OIC timescales appear to differ from NHSO timescales DR premises identified with a view of being operational by April 2016	2	4	8	Ongoing	TG	Aug-2016
25	30 July 2015	Management of Expectations - Equipment and Furnishings There is a risk that staff and the public will expect all equipment and furnishings in the new building will be newly purchased rather than the more realistic position that much of it will be transferred from existing facilities (subject to H&S and other clinical and service criteria). This may lead to lower staff morale and adverse comment.	Project Management	3	3	9	No	C	All staff being informed at regular team meetings about likely equipment	1	3	3	Ongoing	RW	Jan-2017
26	24th August 2015	Management of Expectations - Systems There is a risk that staff and the public will expect that new systems, particularly in respect of the such things as an Electronic Patient Record, integration of acute and community systems and ecommunication systems will be in place and functioning when the new building becomes operational. The actual experience is more likely to be that such systems are either still being developed or that implementation is at a very early stage. This may lead to critical comment, adverse reaction and/ or lower staff morale.	Transforming Change	2	4	8	No	T&C	Separate Project Team and development plan and communication strategy being progressed with a view to some systems being embedded prior to service transfer to new build. However not all systems will be in place by that time and an ongoing programme will require to be developed for the period beyond occupation of the new facilities. Mitigation of this risk should include a robust communication and engagement plan.	2	3	6	Ongoing	CB	Aug-2016
27	19th November 2015	Contract Management There is a risk that failure to recognise the requirements of managing the contract with Project Co, within the plans for the new integration agenda restructure, creates operational difficulties in the management of the new facility going forward.	Operational Contract Management	3	4	12	No	T&C	Contract management responsibilities to be included within the appropriate job description within the new structure. Project Director to raise with Chief Executive.	2	3	6	Ongoing	AMc	Aug-2016

28	9th February 2016	Operational Risk - Failure to adjust staffing levels and structures appropriate to new ways of working within the new facilities.	Non Financial	3	3	9	No	T&C	Staffing levels and structures have been reviewed. Plans developed to recruit to and train for the required staffing mix in advance of new build becoming operational .	2	3	6	Ongoing	EP	Aug-2016

Key to Risk Owners		
AMc	Ann McCarlie	Project Director
AT	Albert Tait	Commercial Lead
BB	Bruce Barron	Project Manager
CB	Christina Bichan	Head of Transformational Change and Improvement
EP	Elaine Peace	Director of Nursing
JN	Julie Nicol	Head of OD and Learning
HR	Hazel Robertson	Director of Finance
MC	Malcolm Colquhoun	Head of Estates /Acting Hospital Manager
TG	Tom Gilmore	Head of IT
MR	Marthinus Roos	Medical Director
RW	Rhoda Walker	Clinical Programme Lead

COMPARISON OF VFM AND RELATED MATTERS IN RESPECT OF PROGRESSING THE NEW HOSPITAL AND HEALTHCARE FACILITIES PROJECT BY MEANS OF AN AMENDED NPD MODEL VS A D&B DELAYED CAPITAL PROCUREMENT MODEL

HEADLINE MESSAGES

1. Timetable Impact

- Continuing with an amended NPD model will deliver the project at least 18 months (possibly 24 months) earlier than stopping the existing procurement process and moving to a D&B procurement.

2. Cost Impact

- Under the revised NPD model a sum estimated at circa [REDACTED] NPV over the length of the 25 year contract would require to be met as a means of retaining fundamental aspects of that model such as the SPV equity capital investment and risk transfer retained by the SPV throughout the contract period. Significant levels of community benefits (apprenticeships, local employment and training already negotiated) will not be realised if the current procurements is moved to a D&B procurement model.
- Under the D&B option, the inflationary costs for delaying the procurement are likely to be at least [REDACTED] (possibly [REDACTED]). Additional project team costs and advisers fees could add a further [REDACTED] with up to a further [REDACTED] being required to address the delayed infrastructure, equipment and IT requirements which would need to be undertaken if the procurement of the new build was delayed by a further 18/24 months. All of these costs amount to circa [REDACTED] to [REDACTED]

3. Sunk Costs

- Project team and advisor costs to date are estimated at circa [REDACTED] with bidders probably having expended a similar if not greater sum of [REDACTED]. These costs will not be sunk if as agreed with bidders there is a commitment to seeing the present procurement (as amended) through to its conclusion.

4. Ability to Maintain Market Confidence

- The existing procurement has already encountered a number of changes and delays such as down-selection of one bidder half way through the procurement process, requirement for fully funded bids, affordability and ESA10 issues. To date the bidders have accepted and dealt with these various issues, incurred additional costs, and still remain willing to see the amended process to a conclusion. A move to stop the process and begin again with a D&B procurement will not be welcomed by these two bidders and

is also likely to undermine market confidence for the range of reasons set out in the body of this note. Such a change of direction in procuring the project with the delays noted above will carry a huge level of reputational risk for the Board and other parties involved in the decision making process.

5. Risk Considerations

- Based on the various risk factors identified within the body of this note significantly greater risks rest with moving to a D&B procurement rather than progressing with an amended NPD model based on a capital contribution being used to make an advance payment of the unitary charge. Some of the risks identified and where the greater risks lie are as follows:-

<u>Risk(s)</u>	<u>Model with Greater Risk</u>
Procurement Challenge	Amended NPD (although can be mitigated with VEAT notice)
Patient Safety – clinical and operational	D&B
No or limited risk transfer	D&B
Market confidence	D&B
Higher overall costs	D&B
Quality and resilience of build and maintaining maintenance standards	D&B
Reputational Risk	D&B

6. VFM/Cash Summary

NPD VFM

- NPV over 25 years (to maintain the fundamental structure of the NPD model and to achieve significant benefits arising from risk transfer, community benefits etc).

D&B Cash

- inflationary costs
- PT and Advisory Fees
- to support ageing infrastructure etc
- Circa ■■■■-■■■■ in total

7. Time Impact

NPD- New facility operational Winter2018/Spring

D&B New facility operational - Best Case (18 months) – Summer 2020
Worst Case (24 months) – Winter 2020

2019

Note regarding VAT treatment:- Although it does not feature in this paper the present VAT advice from our appointed professional VAT advisor (which is being tested with a second VAT advisor) is that VAT would be recoverable under the amended NPD procurement model but is not recoverable under the D&B procurement model.

AMENDED NPD MODEL	DELAYED CAPITAL PROCUREMENT D&B MODEL																								
1. Impact of Delay on Timetable																									
<p>Based on the recently confirmed collective support of all parties involved the timetable for delivery of the project <u>remains generally in line with the revised timetable</u> resulting from affordability and ESA10 issues encountered towards the end of 2015.</p> <p><u>Headline Dates</u></p> <table border="0"> <tr> <td>Close</td> <td></td> <td>Dialogue</td> </tr> <tr> <td>March/April 2016</td> <td></td> <td></td> </tr> <tr> <td>Appoint</td> <td>Preferred</td> <td>Bidder</td> </tr> <tr> <td>May/June 2016</td> <td></td> <td></td> </tr> <tr> <td>Financial</td> <td>Close/Commence</td> <td>Construction</td> </tr> <tr> <td>Sept/Oct 2016</td> <td></td> <td></td> </tr> <tr> <td>Construction Period</td> <td></td> <td>24</td> </tr> <tr> <td>months</td> <td></td> <td></td> </tr> </table>	Close		Dialogue	March/April 2016			Appoint	Preferred	Bidder	May/June 2016			Financial	Close/Commence	Construction	Sept/Oct 2016			Construction Period		24	months			<p>Based on the most up to date market intelligence/information our external project manager has prepared, for comparative purposes, a programme timetable for delivery of our project by means of a D&B procurement if it was decided to stop the existing amended NPD procurement process. This work identifies that the delay involved will be between an additional 12/18 months and more likely nearer the 18 month period (and possibly up to 24 months) when factors such as the lack of market confidence/interest, which are commented upon later in this paper, are also taken into account. The 12/18 months delay period scenario as a minimum featured within our earlier discussion and deliberations with SFT when considering the alternative options for proceeding with the procurement given that a significant capital contribution had now been secured for the project. The impact of the delay on cost which features in the next section is therefore based on the 12/18 month delay period scenario.</p> <p>Total period before new hospital would be available 42 months at least.</p>
Close		Dialogue																							
March/April 2016																									
Appoint	Preferred	Bidder																							
May/June 2016																									
Financial	Close/Commence	Construction																							
Sept/Oct 2016																									
Construction Period		24																							
months																									
2. Impact of Delay on Costs																									
NPD	D&B																								

AMENDED NPD MODEL	DELAYED CAPITAL PROCUREMENT D&B MODEL
<p>As referred to above the introduction of a capital contribution into the existing procurement arrangements is unlikely to have any impact on delay costs beyond those that may have resulted from the setting of a revised timetable due to the earlier affordability and ESA10 issues. However under the proposed change to the procurement arrangements the capital contribution (in the form of an Advanced Unitary Payment) will remove the requirement to revenue fund/service the senior debt envisaged but there will remain the requirement to service the equity/junior debt over the 25 year period of the project. This is estimated at circa [REDACTED] (NPV).</p> <p>The retention of equity/junior debt within the amended NPD model is fundamental to the operation of the whole contract structure and payment arrangements underlying the transfer of risk for the design, finance, build and maintenance (DFBM) to the appointed preferred bidder/SPV. The 25 year contract with the preferred bidder/SPV has also enabled the Board to secure from both bidders (within their draft final tenders) very significant community benefits commitments which will become legally binding commitments if they are awarded the contract. These benefits include creating sizeable numbers of apprenticeships, graduates, employing local labour and placing contract work locally as well as engaging fully over the 25 year period within our whole community planning processes.</p>	<p>In line with those earlier discussions with SFT and taking into account the very recent construction indices the additional inflationary costs of a 12-18 month delay to re-procure the project is likely to be over [REDACTED] stretching to circa [REDACTED] if the delay extended to 24 months. There would also be the need to extend the roles and input of the Boards project team and advisors for similar lengths of time which could add a further <u>circa</u> [REDACTED] of costs. Only limited maintenance and improvement works to the existing facilities are being carried out at present on the basis of a new build hospital and healthcare facilities being available in about 2½ years time. Similar constraints are being applied to the purchase of equipment both clinical and non-clinical. If under the D&B procurement the new facilities would not be available for a further circa 1½ years making the new build 4 years away the present plans to minimise expenditure would require to be urgently revised. The requirement to upgrade or replace major parts of the building fabric, infrastructure (ICT, heating and hot water systems) and clinical and non-clinical equipment over that 4 year period would need to be addressed and funded at a much higher level than would otherwise have been the case. There are major concerns around ICT infra structure (servers, network switches, telephone system, fire walls and file servers) in particular which are ageing with a risk of failure and/or coming out of formal support within the next 4 years. The other related area of concern is physical space within the current building to route additional cables to support additional functions. These are just a few of the more immediate issues that would require to be addressed/financed within that 4 year period in order to make a start to dealing with the backlog maintenance requirements all of which are spelt out more fully within our past and present PAMS submissions.</p> <p>The estimated additional costs of the infrastructure investments identified above will be significant and could well exceed [REDACTED].</p>

AMENDED NPD MODEL	DELAYED CAPITAL PROCUREMENT D&B MODEL
	<p>Other likely cost implications are identified within the market confidence and risk functions section of this note, however the above mentioned costs taken together amount to circa [REDACTED] to [REDACTED].</p> <p>Any community benefits from a D&B contract are likely to be minimal.</p>
<p>3. Sunk Costs Already Invested</p>	
<p>To date the costs of the project team and advisers is of the order of [REDACTED]. Bidders will have incurred in the order of [REDACTED] each as bid costs to reach this stage of the procurement process. Costs were also incurred by a third bidder who was down-selected at an earlier stage in the process. Both remaining bidders are willing to work with the Board and expend even more costs and resources to see the existing procurement through to its conclusion. Both bidders have submitted compliant draft final tender design submissions and only some limited work is envisaged to finalise these with other work required to be completed on tender pricing and affordability.</p>	<p>Not applicable at present but as mentioned above the costs of stopping and restarting with a new procurement with no guarantee of success will not be insignificant in both time and costs. As well as the reduced level of market confidence (as set out below) this course of action will add considerably to patient safety, clinical and non-clinical risks.</p>
<p>4. Ability to Maintain Market Confidence</p>	
<p>Our project has now been known to the market for some considerable time (approaching 2 years since the OBC was approved). Our Bidders Day attracted a lot of potential candidates but at the end of the process only 3 candidates submitted PQQs. Following some measure of scrutiny all 3 candidates were invited to participate in dialogue. Following 3 rounds of dialogue one bidder was down selected in line with the</p>	<p>A D&B project may well attract a different range of bidders from those that operate more normally in the NPD/DFBM market place.</p> <p>However as referred to earlier, attracting bidders to what would be a previously aborted procurement process, is unlikely to be straight forward. All of the issues related to delivering a project within an Islands setting, securing skilled labour and materials locally or the costs of</p>

AMENDED NPD MODEL	DELAYED CAPITAL PROCUREMENT D&B MODEL
<p>conditions set out by the Board. The 2 remaining bidders have gone through further strenuous dialogue sessions as well as submitting draft final tenders. In addition they were also advised that fully funded bids should be submitted at draft final tender stage and both bidders have engaged with funders and incurred costs at a much earlier stage than would otherwise have been the case. Such additional work would normally have been carried out and costs incurred once a PB had been selected.</p> <p>The work and costs previously incurred by the bidders to achieve fully funded bids has now been overtaken by the availability of capital funding to replace senior debt. The timetable for delivery of the project has also been impacted from that originally signalled to bidders due to affordability and ESA10 issues.</p>	<p>bringing these to the Island will require to be addressed again with any potential bidders, as was the case for the current procurement. All of the above combined with an abortive NPD procurement is likely to lead potential bidders (if there are any) to seek a premium to reflect these factors within their bids.</p> <p>In addition, it is being found in other, more populated parts of Scotland that contractors are reluctant to bid for D&B contracts due to cost/benefit compared to alternative development opportunities. To this end, to achieve sufficient interest in D&B projects, procurement is required to be undertaken via a two stage process. Although this reduces costs for bidders, it does result in greater risk of escalating costs for the procuring authority post appointment of contractor.</p> <p>Given all the effort and costs already expended by the present bidders, the prospect of stopping and starting a new procurement is unlikely to be well received by them and the likelihood of them not ever bidding for projects in Orkney again is very real. In addition bidders internal market intelligence within Scotland is well recognised and honed. Therefore there must be some measure of uncertainty as to who would be interested in bidding in the future and at what cost (premium?) figure.</p> <p>A significant level of reputational risk will arise for the Board and other parties involved in the decision making process if there is a change in direction for procuring the project.</p>
<p>5. Risk Considerations</p>	
<p>While there may be a risk of <u>procurement challenge</u> in terms of altering the funding arrangements this will be mitigated by</p>	<p>From a purely procurement perspective starting a new <u>procurement</u> exercise is the most risk averse of the options considered for progressing</p>

AMENDED NPD MODEL	DELAYED CAPITAL PROCUREMENT D&B MODEL
<p>means of issuing a VEAT notice which is currently being finalised for issue.</p> <p>Progressing the present procurement incorporating the changes to the funding arrangements considerably reduces the <u>clinical and operational</u> risks referred to in more detail under the D&B option.</p> <p>Under the amended NPD procurement model the well established full <u>risk transfer</u> to the SPV remains in place covering such matters as planning consent, lifecycle, FM risks and hand back condition of the asset at the end of the 25 year contract period.</p> <p>The <u>quality of the build and fitting out of the asset</u> will be a major consideration for the successful bidder as FM risk and responsibility rests with the bidder.</p> <p>The <u>FM requirements</u> and associated Pay-Mech arrangements as an incentive to ensure that the maintenance standards are timeously met throughout the 25 year contract period have been fully explored and acknowledged by both bidders. The financial cap and affordability limit which have been set for the FM services involved have been met by bidders in their tender submissions. Both existing bidders are fully aware that unlike most other areas in Scotland if facilities within our hospital are out of action for whatever reason there are no other hospital facilities available within Orkney. Both bidders have acknowledged and addressed this factor within their designs by building in resilience and contingencies to address this matter so</p>	<p>with the project, however having considered the overall risk position the Board concluded that this was outweighed by the nature of a number of other significant risks as described below.</p> <p>As previously referred to delaying the procurement considerably increases the <u>risks to the Boards operational services in respect of patient care, maintaining clinical services</u> within ageing buildings, supported by ageing infrastructure for longer than anticipated and the need to incur additional revenue and capital costs. There is a risk to the stability of our staffing levels, particularly medical staffing, as clinical staff have been attracted to posts based on the prospect of a new hospital and healthcare facility. We have been repatriating services from Grampian, in preparation for the new models of care which will be in place with the new facility. Our ability to continue to improve services over an extended time period will be very constrained. There are financial risks associated with this including excessive agency and locum costs, and excess costs on our SLAs and patient travel budgets.</p> <p>Under the D&B procurement there is likely to be limited risk transfer to the successful bidder during the construction phase and no transfer of planning risk or operational risks thereafter.</p> <p>The possibility of being provided with a <u>reduced resilience/quality of facility</u> is required to be taken into account as following the agreed handover period the contractor will have no on-going responsibilities for maintaining the building and equipment etc. (At this stage it is not possible to assess how any of the above might be subsequently reflected in possible tender prices for the project.)</p> <p>Under the D&B arrangements the <u>FM requirements</u> as specified within the NPD model will require to be separately outsourced or most likely</p>

AMENDED NPD MODEL	DELAYED CAPITAL PROCUREMENT D&B MODEL
<p>that for example the recent flooding/water leakage that put our only theatre out of action for over 2 weeks could not happen again. The NPD model transfers the risk, incentive/penalties for such matters to the PB/SPV which does not happen within the D&B model.</p>	<p>provided in-house involving the recruitment and training of additional specialist staff with no guarantee that such staff could be recruited and retained within the service. The absence of risk transfer for this important part of the service would be a cause for concern going forward. The opportunity to retain one FM service for all of the Boards facilities is likely to be a challenging task at best and an additional cost factor at worst.</p>

Scope of Services

Facilities to be provided

Service Area	To be provided in new development
Acute Inpatient Beds	20
Acute Assessment	2
HDU	2
Mental Health Transfer Bed –	1
Rehabilitation	16
Obstetrics	4
MacMillan	4
Total Inpatient Beds	49
Day Case Unit trolleys/chairs	10 trolleys plus 10 chairs Plus 2 stage 1 recovery trolleys
Renal Dialysis Chairs	6 renal chairs
Maternity	1 bed 1 chair
Macmillan	4 chairs
ED treatment rooms	2 resus trolleys, plus 4 treatment room trolleys
Total trolleys/chairs	18 trolleys, 15 chairs, 1 bed, plus 6 Renal Dialysis Chairs
Therapy Rooms	11
Cardiology	2
Maternity Consulting	1
Macmillan Consulting	2
GP Consulting	12, 1 OoH
GP Treatment	3
Dental	5, plus oral health room
Total Consulting	38

SOA Summary	Department
Main Entrance, emergency and outpatient clinical facilities	HUB: waiting, patient amenities, sanitary facilities, support
	HUB: Reception, clinical administration, Switchboard
	HUB Consulting: , audiology and AHP Therapy
	HUB Consulting: Outpatients including cardiology
	Renal dialysis
	GP Services
	Radiology
	Emergency Department – including NHS 24 and GP OoH
	Mental Health Transfer Bed
	Dental services
Inpatient Clinical Facilities	Macmillan Unit integrated in-patient OP and day treatment areas
	HUB 2 Amenities-in-patient, day patient: reception, waiting, sanitary facilities, interview room
	HUB 2: overnight stay room and ensuite: relatives
	HUB 2: staff rest facilities
	In-patient acute, Assessment, HDU and rehabilitation beds
	Scenario Training Area
	Maternity integrated LDRP, clinic and day unit
	Day Unit
	Operating Theatres and Endoscopy
Clinical Support Facilities	Pharmacy
	Laboratory, with Point of Care Area in ED
	Offices: generic
	IM&T
	Staff changing

SOA Summary	Department
	Staff rest area
FM support	Estates and Medical physics, incl waste transfer
	Materials Management including portering
	FM: catering
	FM: laundry
	FM: domestic staff
	Central/Endoscope Decontamination Unit
	Mortuary
SAS	Ambulance Services
Clinical Support Building	<p>Open plan workspace incorporating 120 desks (95 fixed, 25"hot" desks), accommodating quiet space/private rooms, tea and printing/photocopying points, area for members of the public and/or visitors to report to on arrival</p> <p>Conference suite incorporating meeting /conference rooms/Emergency Response Centre and e-learning/training room and library function.</p> <p>Other functions to be accommodated:-</p> <p>Store Area; DSR; Shower/Changing; disposal/recycling; IT server room. Toilets.</p>

Services to be Provided

In addition to the accommodation outlined above the successful Bidder is required to provide a full range of Hard FM services (excluding grounds maintenance).

The successful Bidder will also maintain the fabric of the building including maintenance and replacement of plant and equipment within an agreed programme over the 25 contract period.

The contract also requires the building to be handed back in the pre-determined condition as stipulated in the ACRs and the eventual contract documentation.

NHS Orkney

New Hospital and Healthcare Facilities Project

Report for PIB

Revised NPD Contract Structure

1. Scope of Report

This Report is for the Project Implementation Board of NHS Orkney (**PIB**) and provides an update as to the current position of NHS Orkney's ongoing procurement to award a contract for the design, build, financing and maintenance of a hospital for Orkney (**the Project**), using the Non-Profit Distribution Model developed and supported by the Scottish Futures Trust (**the SFT**) (**the Procurement**).

As PIB know, NHS Orkney have committed to use the NPD Model as the contractual basis for the Procurement and the Project; in value for money terms, this was on the basis of the Stage 1 Programme Level Investment Review undertaken in preparing the Outline Business Case for the Project. NHS Orkney are in competitive dialogue for the Project which is being conducted in accordance with Regulation 18 of The Public Contracts (Scotland) Regulations 2012 (**the Regulations**) and wish to conclude that dialogue shortly and then invite Final Tenders, based on which the Board would appoint a preferred bidder to become 'Project Co' which would deliver the Project and provide new hospital facilities for Orkney, from Financial Close.

The issue of updated guidance on the application of ESA10 accounting standards gave rise to a concern that assets procured under the current project finance model for procuring public sector infrastructure projects in Scotland i.e. the NPD Model in its current form, require classification as public sector assets for national accounts. Taking cognisance of the changing European regulations and guidance, further information was published in the Scottish Government Spending Plans announced on 16 December 2015 and NHSO were subsequently advised of a significant level of Public Sector capital funding becoming available. Following discussions between NHSO and SFT, reviewing options available to it, NHSO is continuing with its

previously advertised procurement for a new Orkney Hospital and Healthcare Facilities with the revision that NHSO will prepay for Services to the value of approximately 100% of the 'Senior Debt' requirement, which otherwise would have been met under the NPD approach using private sector finance.

Project Co will not be required to repay to NHSO, amounts provided as pre-payments (as these payments will be made as an advanced payment for service and not a loan). Annual service payments (made during the operational phase) to Project Co will be reduced accordingly i.e. reduced to remove the amount paid as a pre-payment (compared to amounts due under the current NPD Model i.e. including repayment of Senior Debt).

It is an important component of the proposed approach that Project Co still will provide financing equivalent to typical junior or subordinated finance by Sponsors under the NPD Model (approximately 10% of the Senior Debt requirement). As previously considered by PIB, this approach is the most appropriate for the Project in value for money terms, in order to avoid significant re-procurement delay to the construction and delivery of the new hospital facilities and also given NHSO's clinical requirement to ensure replacement healthcare facilities are operational as soon as possible.

It is of prime importance that NHS Orkney is making no changes to the scope of its hospital and health care facilities requirements as a consequence of or in connection with the above change and in the Procurement, NHSO is not changing the overall economic balance of risks and rewards between the Authority and Project Co in relation to the Project. That being said, NHSO does require to make certain changes to the NPD Model to accommodate the proposed Pre-payment, however these have been developed on the basis that only the minimum necessary adjustments shall be made. This Report outlines the adjustments to be made and the reasons these adjustments are required and includes details of: the Pre-payment Agreement, Security for NHSO in relation to Pre-paid monies, priority for NHSO over the interests of Sponsors through 'Subordination', (which will protect NHSO's interests and be in lieu of Senior Funding arrangements), as well as incidental changes to the Project Agreement.

2. Adjustments to be made

Structure charts and an accompanying glossary are appended to this paper. The structure charts provide an indication of the structure of a normal NPD project and an indication of the revised structure of this Project. Below we summarise the position based on the current dialogue documentation (which is to be finalised prior to close of dialogue).

Pre-Payment Agreement

As noted above NHS Orkney will substitute 100% of the Senior Debt requirement with capital funds. NHS Orkney therefore intends to apply funds (**“Pre-Payments”**) to pre-pay amounts of Annual Service Payments that otherwise would be payable by way of the ‘Unitary Payment’ over the contract life by the Authority to Project Co, for payment of the services required and also to fund the long term repayment of Senior Debt.

It is therefore not necessary for Senior funding documentation to be in place for the Project and instead the Project will include a pre-payment agreement. This pre-payment agreement will govern the terms of the pre-payments of the unitary charge. To assist in finalising the commercial points for the pre-payment agreement NHS Orkney has drafted pre-payment heads of terms (the **“Heads of Terms”**) and is currently in dialogue with the Bidders and the SFT to finalise acceptability of these Heads of Terms.

NHS Orkney requires to ensure that it secures performance and value in return for its payments (including the pre-payment) of Unitary Payment for services under the Project Agreement. The Heads of Terms therefore sets out principles which seek to ensure that Project Co applies Pre-payments, and other Unitary Payments for the purpose of being able to deliver the Services within familiar strictures that reflect fundamental NPD structural and commercial principles.

The Heads of Terms, in part, replicate rights exercisable by Senior Funders (in this instance rights to be exercised by NHS Orkney) under the standard NPD structure to ensure operational robustness for the Project Term: for example, by controlling

payments to 'subordinated debt' holders¹ and the application of lifecycle monies through the FM subcontract using an independent technical adviser. The Project Agreement and Heads of Terms require to address the risk of breach or default during the Construction Phase and failure to achieve Service Commencement and the ability of Project Co to continue to provide the Services at the Hospital during the Project Term and indeed to address any default during the operational phase.

Pre-payment as proposed puts a slightly different perspective on the risk of partial performance of design and construction obligations (which the NPD Model dictates are passed down to the Contractor under the D&B Contract). In a standard NPD Project, Project Co's losses in such circumstances are well understood: The structure allows for Project Co to recover such losses and also normally allows Senior Funders to take steps to protect their interests in repayment of debt. The Board requires to be able to take similar steps to those of a Senior Funder, (for different reasons) and to be able to protect the public interest in relation to Pre-payment sums. However, it is for Project Co, not the Board, principally to manage Construction Phase risks (although under the NPD Model, an Independent Tester is appointed under the Project Agreement and serves to check and ensure that the Works are properly completed). It is important to note however that although the Heads of Terms contain the protections describe here, NHS Orkney is not seeking to control and interfere with Project Co's operations and delivery of the Services i.e. NHS Orkney is paying for Services which include the running of and management of the Project Company.

Security

NHS Orkney requires the ability in the event of Project Co default on the Project, to exercise rights appropriate in the circumstances then prevailing, to reflect the Board's priority rights to receive service provision or to be able to take steps to enable the provision of Services to continue.

Accordingly it is expected that Project Co will grant a full suite of legal securities in

¹ The Project will include a certain level of debt provided by Sponsors (parties in the Project Company consortium). This will amount to between 8-10% of the capital cost of the construction of the hospital. This debt in a usual NPD structure would be subordinate to senior debt and as such is often referred to as subordinated debt.

favour of NHS Orkney in order to secure performance of its obligations to NHS Orkney, including an entitlement to compensation following default by Project Co, in respect of failure to deliver the Services.

NHSO's security package from Project Co is to include:

- (i) a first and only floating charge;
- (ii) assignments of each parent company guarantee granted to Project Co in respect of (a) the D&B Contract and (b) the Service Provider Contract; together with
- (iii) Collateral Agreements as are provided under the standard NPD structure.

Floating Charge

A floating charge in this instance will be a charge taken over a class of assets owned by Project Co as security (to protect pre-payments). In the case of Project Co becoming insolvent, the floating charge will crystallise and will be converted to a fixed charge over the assets which it covers at that time. The advantage of having a floating charge as opposed to a fixed charge at the outset is that before insolvency a floating charge will allow the charged assets to be bought and sold during the course of Project Co's business without reference to the charge holder (NHS Orkney).

Collateral Agreements

Collateral agreements will be entered into between NHS Orkney and the contractors which contract with Project Co i.e. the Construction Contractor and the Service Contractor. Should Project Co default on its responsibilities under the Project Agreement, NHS Orkney can ensure that the project is completed by taking over the relevant contract i.e. during the construction phase NHS Orkney can step into the Construction Contract and during the operational phase NHS Orkney can step into the Services Contract.

The shares in Project Co are to be pledged to NHS Orkney, enabling NHSO to take control over Project Co itself and NHS Orkney will retain the right to require additional fixed security during the Project term (such as over Project Co bank accounts) should that be considered necessary to protect NHSO. Project Co will be prohibited from granting any security, fixed or floating, to any party other than NHSO. Subject to tax and accounting advice, the Board may consider mandating Project Co

to make certain payments by the Board direct to the end payee.

During the Construction Phase Project Co's interests are closely aligned with those of the Board in relation to Pre-payment, namely to ensure the Works are completed so as to allow timely Service Commencement. The fixed price nature of the D&B Contract protects Project Co from construction cost risks. It is of prime importance, however, that Sponsors interests remain so aligned and the unconditional injection of Sponsor Debt, at the contracted time and as accelerated in case of default, backed by on demand Letters of Credit in respect of Sponsor Debt, will serve to retain that alignment. These Letters of Credit are provided by a bank of each Sponsor, requiring that bank to pay an agreed amount to Project Co on demand, and this provides confidence that Project Co will be financed as required.

During the Operational Phase, the Board receives Services in return for the Unitary Payment (including the Pre-payments that shall have already been made). The Project Agreement primarily regulates the provision of the Services to meet the Service Level Specification and the Payment Mechanism plays an integral role in assessing performance at the Hospital.

There are other critical protections: for example, the Handback provisions of the NPD Project Agreement (Part 19 of the Schedule) protect the Board in respect of the condition of the Hospital at the expiry of the Project Term. These will remain in place.

It is not intended to change the way those protections operate. However additional protection, for example by way of increased oversight of key operational concerns such as lifecycle planning and forecasting, will be essential to ensuring that the Board secures full value in return for its payment (including the Prepayment) for services under the Project Agreement and ensuring that the funds are held within Project Co and released for their specified and intended purposes.

On early termination, Project Co may receive compensation under the Project Agreement, depending on the grounds and level of performance prior to termination. In the absence of Senior Debt, the compensation provisions will reflect the Board's

entitlement to be put in the same position as it would have been, had there been full performance under the Project Agreement and to access both the subcontract and funds held in Project Co through the security arrangements.

Thus, in some instances, Project Co will owe the Authority money on termination of the Project Agreement. That obligation will be enhanced by the security package in favour of the Authority and ensure that other creditors (e.g. Sponsors Debt) is effectively subordinated.

Subordination of Sponsor Debt

NHSO has accepted as part of the NPD Model, the need for Sponsors to be able to transfer/ assign their interests to third parties and, in principle, this is acceptable. However, subordination arrangements with the Sponsors similar to those usually expected by Senior Funders will be required, including:

1. The Sponsors will not be able to assign earlier than permitted under the Project Agreement and not before the actual injection of all Sponsor Debt into the Project Co;
2. No amendments to the Sponsors' loan notes and equity instruments may be made other than such of a purely administrative nature;
3. No sums may be demanded or paid nor sued for, accelerated, set off or secured except as expressly provided for in the Project Agreement;
4. The Sponsor notes and instruments may not be terminated prematurely;
5. The Sponsors may not enter into any composition, compromise or other arrangement;
6. No payments may be received by a Sponsor beyond those specified in the Project Agreement but if received in error will be held in trust to be repaid to Project Co;
7. The notes and instruments will be ranked in right of payment and priority postponed and subordinated to the Secured Liabilities;
8. Standard provisions in respect of insolvency will operate.

Project Agreement

NHS Orkney are committed to ensuring that only minimum necessary adjustments are made to the Project to protect the integrity of the Procurement and to maintain

Bidder involvement. NHS Orkney therefore is only making the minimum necessary adjustments to the Project Agreement and as such the amendments are strictly consequential amendments arising from the adjusted structure. The principal adjustments to the Project Agreement are as follows:

1. Events of Default –the Authority Events of Default and the Project Co Events of Default in the Project Agreement will be amended to entitle termination through ‘cross default’ i.e. where there is a default under the Pre-payment Agreement this will trigger default under the Project Agreement.
2. Set-Off – This provision allows for sums payable under the Project Agreement by Project Co to be set off as against sums due by the Authority. This has been widened to include sums payable both under the Project Agreement and under the Pre-payment Agreement.
3. Compensation on Termination – The Compensation on Termination provisions in a normal NPD project provide protection for: 1) Senior Debt (Senior Funders offer lower interest rates for lending on the basis that there is a low risk of failure to be repaid indebtedness and related costs); and 2) Sponsors/Junior funders (Depending on which party is at fault in case of termination, junior funders are entitled compensation on termination under the NPD Model). The Compensation on Termination provisions provide a mechanism to calculate how much compensation is to be paid. As the revised Project structure does not include Senior funders but instead includes pre-payments of the Unitary Payment, these calculations are being reconfigured to ensure no higher (or lower) payments to junior funders and that there are protections for NHS Orkney’s pre-payments should the Project Agreement be terminated. Participants take into account the likelihood of termination and the anticipated compensation payment to Sponsors (if any), both in respect of their own interests in the Project and also any impact on the future investment value of these interests, which may be disposed of during the term of the Project (after an initial period has passed).
4. Refinancing – This Schedule will be removed as there are no Senior Funders, as such no senior lending to refinance (and Subordinated Debt refinancing is exempt under the NPD Model).

MacRoberts LLP

26 April 2016

APPROACH TO DELIVERING COMMUNITY BENEFITS

Introduction

This appendix provides a summary of the Robertson Capital Projects (RCP) approach to the delivery of community benefits in Orkney.

Local Commitment

RCP have committed in their final tender submission to focus on local delivery and in particular to ensuring that 80% of construction work packages will be offered to businesses on Orkney and up to 70% of the construction workforce will be from Orkney.

RCP will pass down the requirement for local supply chain use through subcontractor terms and will closely monitor their activity.

To maximise benefit across Orkney RCP have met with a number of local organisations and stakeholders in order to understand their requirements. That input has informed the development of the community benefits proposals and RCP continue to engage with them and other community organisations during the preferred bidder stage.

Education and Learning

During the construction period RCP will have a dedicated on site or near site training area and classroom and will deliver curriculum engagement opportunities and training for school pupils and students. A robust community engagement plan will be developed with primary, secondary and further education provision.

RCP will work with schools in the isles and local schools, including Kirkwall Grammar and Stromness Academy, to deliver curriculum support activities, engage with pupils and encourage an interest in the construction industry. The construction project team will be trained Construction Ambassadors who understand the STEM Agenda within schools. Activities will be designed to complement the Curriculum for Excellence agenda and the core learning themes.

During the CD period RCP engaged with the Orkney Training Group and Orkney College and will use these local training providers to up skill and deliver training. Any vocational training being delivered through the project will also be offered to local businesses to maximise learning potential.

Delivery of Commitments

RCP will develop and agree a community engagement plan tailored to local circumstances and based on consultation. This will include a programme of activities and initiatives that work towards achieving community development. The community engagement programme will:-

- be based on best practice standards;
- work in ways that balance social, economic and environmental impact;
- provide training and employment opportunities
- operate in ways that minimise any adverse impact on local communities;
- be led by a Community Benefit Co-ordinator for the project

Community Benefit Targets included in Project Agreement

- Take on 10 work experience placements (16 - 19 years) in the first 12 months of construction and 10 experience placements (16 - 19 years) in the 2nd 12 months of construction.
- Take on 4 work experience placements (14 - 16 years) in the first 12 months of construction and 4 experience placements (14 - 16 years) in the 2nd 12 months of construction
- Engage in 12 educational activities during the construction phase
- Recruit 1 graduate within the first year of construction.
- Recruit 5 New Apprentices during each year of construction
- 5 existing Apprentices to work on site during each year of construction
- 5 new jobs created by the Project.
- Subcontractors secure 8 S/NVQ starts in year one.
- Subcontractors complete 7 S/NVQs during the Construction Phase.
- 4 people from the subcontractor companies receive Supervisor Training for Subcontractors within year one of the construction start.
- All subcontractors on site develop a Training Plan via Construction Skills, aligned to the Project Training Plan.
- 2 people from subcontractor companies receive Leadership and Management Training for Subcontractors within one year of the construction start.
- 3 people from subcontractor companies receive Advanced Health and Safety Training for Subcontractors within year one of construction start.
- Undertake a minimum of 2 Meet the Buyer events and 1 Get Ready for Tender programmes during the Construction Phase.3
- Provide time bank offer during the construction phase .
- Deliver all the agreed targets within the Employment and Skills Plan during the Operational Term per Contract Year.

- On an annual basis contractually secure participation from specialist suppliers and subcontractors in marketing appropriate tenders through agreed SME/SE tender databases.

Failure to achieve the targets outlined above will result in financial penalties for non compliance/delivery of the agreed benefits.



*Our community,
we care, you matter.*

Transforming Clinical Services Programme Implementation Board

Agenda Item 2

Date of Meeting 16th October 2014

Paper Number 2

Title PQQ Evaluation Results

Recommendations Based on the results from the overall assessment of the submissions provided by the three candidates as detailed in the attached report, PIB is invited to confirm to the Finance & Performance Committee, that the assessment process has been carried out in accordance with the previously agreed arrangements and to recommend that the following three candidates be invited to participate in dialogue.

List for Dialogue
Canmore
Farrans/Equitix
Robertson

Author Bruce Barron/Albert Tait/Ann McCarlie

Contact Details Albert.tait@nhs.net



New Hospital and Healthcare Facilities

**PQQ Qualification Assessment to Select
Candidates to Participate in Dialogue**

Appendices E to H are not included.

Contents

1	Introduction	1
2	Process	2
3	Assessment	9
4	Results	10
	Appendix A – Contract Notice	11
	Appendix B – Assessment Matrix	15
	Appendix C – Question Weightings	16
	Appendix D – Candidate’s PQQ Response	23
	<i>(Appendices E-H attached as separate spreadsheet documents)</i>	
	Appendix E - Compliance Assessment Record	
	Appendix F – Candidate’s Summary Assessment Sheets	
	Appendix G – Non Scored Questions	
	Appendix H – Candidates Scores	

1 Introduction

In Accordance with the Scottish Government's NPD initiative, NHS Orkney is seeking to appoint an "NPD Partner" who will enter into a DBFM agreement with NHS Orkney to Design, Build and Finance the new Hospital and Healthcare Facilities and provide Hard FM and lifecycle services over a 25 year period.

This report describes the first stage of the process which relates to assessing the PQQs submitted by Candidates for the purposes of determining which of those Candidates should be invited to participate in dialogue.

As a project which is in part publicly funded, the process for appointment has to comply with the European Procurement rules. The first stage of the process was the publication of a contract notice in the European Journal. A copy of this notice is enclosed at [Appendix A](#).

Applications were received from three candidates and these were assessed to determine whether or not they would all proceed to the next stage of being invited to participate in dialogue.

2 Process

2.1 Assessment Objective

The main objective of the assessment was to determine which candidates would be invited to participate in dialogue (IPD), the next stage of the NPD Partner selection process.

2.2 Assessment team

The following members of the project team participated in the assessment of the candidates submissions.

- NHS Orkney – Ann McCarlie, Albert Tait, Marthinus Roos, Rhoda Walker, John Trainor, Malcolm Colquhoun, Carla Tannous, Gary Mortimer, Tom Gilmour.
- Sweett Group – Alan Harrison, Iain Ferguson
- MacRoberts LLP – Duncan Osler, Laurie Anderson-Spratt
- Caledonian Economics with QMPF LLP – Martin Finnigan & Moray Watt
- Buchan & Associates – Iain Buchan
- Turner & Townsend (T&T) – Bruce Barron, John Ord & Robin Reid

A schedule detailing each person's/organisations involvement is included within [Appendix B](#).

2.3 Assessment Format

The assessment of submissions was undertaken in the following order:

Part 1 - Compliance

Following receipt of PQQ responses they were checked for completeness and compliance with the requirements of the invitation.

Each submission was also reviewed to confirm that completed Forms of Good Standing (Section F) for each PQQ response were included to determine whether any grounds for mandatory or discretionary rejection existed under Article 45 of Directive 2004/18/EC and Regulation 23 of the Public Contracts (Scotland) Regulations 2012.

Part 2 – Assessment of Pass/ Fail Questions

Following the conclusion of Part 1 the following Pass/ Fail sections of the PQQ were assessed.

- Section A – The Candidate
 - A10: Conflicts
 - A11: Raising Finance
 - A14: Minimum Turnover
 - A16: Key Financial Information
 - A20: CDM ACoP
- Section B – Construction Contractor
 - B7: Blacklisting
 - B8: Claims
 - B10: Quality Assurance
 - B11-B13: Health & Safety
 - B14: Environmental Policy
 - B15-B21: Employment
- Section C – FM Service Provider
 - C8: Claims
 - C10: Quality Assurance
 - C11-C13: Health & Safety
 - C14: Environmental Policy
 - C15-C21: Employment

A score of 5 or more was a pass and a score of 4 or less was a fail.

Part 3 – Technical assessment

Following the conclusion of Part 2 the following sections of the PQQ were assessed.

- Section A – The Candidate
 - A7: Key Persons Relevant Experience
 - A8: Capacity/ Resourcing
 - A9: Working Together
 - A17: Partnering and Collaboration

- A18: Design Quality and Sustainability
- A19: Community Benefits
- Section B – Construction Contractor
 - B4: Comparable Healthcare Experience PPP
 - B5: Comparable Healthcare Experience Non-PPP
 - B6: Comparable Remote, rural and geographically challenging Experience
- Section C – FM Service Provider
 - C4: Comparable Healthcare Experience PPP
 - C5: Comparable Healthcare Experience Non-PPP
 - C6: Comparable Remote, rural and geographically challenging Experience
 - C7: Interface Experience
- Section D - Each of the Designated Organisations as described in the Glossary were required to complete this section separately
 - D.1 Architects
 - D1.3: Comparable Healthcare Experience PPP
 - D1.4: Comparable Healthcare Experience Non-PPP
 - D1.5: Comparable Remote, Rural and Geographically Challenging Experience
 - D.2 Lead Structural and Civil Engineer
 - D2.3: Comparable Healthcare Experience PPP
 - D2.4: Comparable Healthcare Experience Non-PPP
 - D2.5: Comparable Remote, Rural and Geographically Challenging Experience
 - D.3 Lead Mechanical and Electrical Engineer
 - D3.3: Comparable Healthcare Experience PPP
 - D3.4: Comparable Healthcare Experience Non-PPP
 - D3.5: Comparable Remote, Rural and Geographically Challenging Experience

- D.4 Specialist Health Care Planner
 - D4.3: Comparable Healthcare Experience PPP
 - D4.4: Comparable Healthcare Experience Non-PPP
 - D4.5: Comparable Remote, Rural and Geographically Challenging Experience

Part 4 – Non Scored questions

- Section A – The Candidate
 - A1: Details of the Candidate
 - A2: Status of Candidate
 - A3: Where Candidate is already a limited company
 - A4: Candidate Members, Candidate’s Advisors & roles on the Project
 - A5: Organisation chart showing internal relationships between the Candidate and Candidate Members
 - A6: Resourcing
 - A12: Candidate Identity Information
 - A13: Candidate Parent Company
- Section B – Construction Contractor
 - B1: Details of Organisation
 - B2: Type of Organisation
 - B3: Parent or Holding Companies
 - B9: References
- Section C – FM Service Provider
 - C1: Details of Organisation
 - C2: Type of Organisation
 - C3: Parent or Holding Companies
 - C9: References
- Section D - Each of the Designated Organisations as described in the Glossary were required to complete this section separately

- D.1 Architects
 - D1.1: Details of Organisation
 - D1.2: Type of Organisation
 - D1.6: References
- D.2 Lead Structural and Civil Engineer
 - D2.1: Details of Organisation
 - D2.2: Type of Organisation
 - D2.6: References
- D.3 Lead Mechanical and Electrical Engineer
 - D3.1: Details of Organisation
 - D3.2: Type of Organisation
 - D3.6: References
- D.4 Specialist Health Care Planner
 - D4.1: Details of Organisation
 - D4.2: Type of Organisation
 - D4.6: References
- Section E – PQQ Declaration
- Section F – Statement of Good Standing

Part 5 – The Scoring

Each of the scored questions in Part 3 was awarded a consensus score out of 10 in accordance with the following scoring criteria:

9-10) Excellent

- A response that covers **all factors** within the Evaluation Guidance in an **outstanding** way; and
- As appropriate/relevant to the question:
 - Demonstrates **excellent** understanding of all the issues;

- Provides **excellent** examples of relevant experience

7-8) Good

- A response that covers **most or all factors** within the Evaluation Guidance in a **good** way; and
- As appropriate/relevant to the question:
 - Demonstrates a **good** understanding of all the issues;
 - Provides **good** examples of relevant experience

5-6) Satisfactory

- A response that covers **some but not necessarily all factors** within the Evaluation Guidance in a **satisfactory** way; and
- As appropriate/relevant to the question:
 - Demonstrates **some** understanding of all the issues;
 - Provides **some** examples of relevant experience

2-4 Poor

- A response that addresses **some but not necessarily all factors** within the Evaluation Guidance; and
- As appropriate / relevant to the question:
 - Demonstrates a **poor** understating of all the issues;
 - Provides **some** examples / **basic** examples of relevant experience

0-1 Very Poor

- A response that **fails to address the factors** within the Evaluation Guidance; and
- As appropriate/relevant to the question:
 - Demonstrates a **very poor** understanding of all the issues;
 - Provides **some examples / basic examples** of relevant experience

Questions B8 and C8 are pass/fail questions and were scored using the following mechanism. A score of 5 or more is a pass and a score of 4 or less is a fail.

10 = no claims

9 = 1 claim
8 = 2 claims
7 = 3 claims
6 = 4 claims
5 = 5 claims
4 = 6 claims
3 = 7 claims
2 = 8 claims
1 = 9 claims
0 = 10 or more

All three candidates provided testimonials and in addition references were taken up to facilitate the scoring of Part 3.

Following the completion of the above scoring, each awarded score was weighted in accordance with the question Weighting & Sub weighting set out within Appendix 2 of the Information Memorandum and ranked accordingly. A copy of these weightings is included within Appendix C.

3 Assessment

3.1 Response

In response to the Contract Notice, NHS Orkney received three formal responses expressing their interest in the project and submitting the relevant pre-qualification documentation.

The three candidate teams who responded are listed within [Appendix D](#).

3.2 Formal Assessment

The formal assessment took place between Friday 5th September 2014 and Friday 10th October 2014. The submissions were scored as set out in section 2.3.

Part 1 – Completeness and Compliance check

A compliance check was undertaken on all three Submissions received. Following a series of clarifications all three submissions were deemed compliant.

Details on this can be found in [Appendix E](#) – Compliance sheet.

Part 2 – Preliminary Evaluation: Pass/ Fail Questions

An assessment of questions A10, A11, A14, A16, A20, B7, B8, B10-B21, C8, C10-21 was undertaken on all three submissions received.

All three submissions achieved a “pass” on all questions assessed.

Details of this can be found in [Appendix F](#) – Summary Assessment sheets.

Part 3 – Technical assessment

An assessment of questions A7-A9, A17-19, B4-B6, C4-C7, D1.2-1.5, D2.2-2.5, D3.2-3.5 and D4.2-4.5 was undertaken on all three submissions received.

Details of this can be found in [Appendix G](#) – Summary Assessment sheets

Part 4 – Non Scored questions

An assessment of questions A1-A6, A12-13, B1-B3, B9, C1-C3, C9, D1.1-1.2, D1.6, D2.1-2.2, D2.6, D3.1-3.2, D3.6, D4.1-4.2 and D4.6 was undertaken on all three submissions received.

Details of this can be found in [Appendix E](#) – Non scored questions

3.3 Scoring Detail

Detailed notes underlying the pass/fail assessments and scoring of the Candidate’s PQQs are not contained within the appendices but are being retained on file and available to respond to any queries by them.

4 Results

4.1 Candidates Scores

The overall evaluation process of the Pre Qualification Questionnaire has resulted in the following scores being awarded to the submissions from the three candidates as per Appendix H.

Candidate	Provisional Score Awarded
Canmore	████
Farrans/Equitix	████
Robertson	████

4.2 Proposed List for Dialogue

Based on the results from the overall assessment of the submissions provided by the three candidates as detailed in this report, PIB is invited to confirm to the Finance & Performance Committee, that the assessment process has been carried out in accordance with the previously agreed arrangements and to recommend that all three candidates be invited to participate in dialogue.

List for Dialogue
Canmore
Farrans/Equitix
Robertson

Consortia Name	Canmore	Farrans/ Equitix	Robertson
Consortia Lead	Canmore Partnership Ltd	Equitix Ltd	Robertson Capital Projects
Main Contractor	JV McLaughlin and Harvey & FES	Farrans Construction	Robertson Construction Group
Architect	Reiach and Hall Ltd	IBI Group (UK) Ltd	Keppie Design
M&E Engineer	DSSR	WSP UK Ltd Mercury Engineering	TUV SUD Wallace Whittle
C&S Engineer	Jacobs UK Ltd	Mott MacDonald Ltd	URS Infrastructure & Environment UK Ltd
FM Provider	FES FM Ltd	ISS Mediclean Ltd	Robertson Facilities Management
Health Care Planner	Healthcare Partnering Ltd	IBI Group (UK) Ltd	Capita

Appendix A - Contract Notice

United Kingdom-Kirkwall: Construction work for buildings relating to health

2014/S 138-246970

Contract notice

Works

Directive 2004/18/EC

Section I: Contracting authority

I.1) Name, addresses and contact point(s)

NHS Orkney
Project Offices, Balfour Hospital, New Scapa Road, Orkney
Contact point(s): Albert Tait
KW15 1BH Kirkwall
UNITED KINGDOM
Telephone: +44 1856888103
E-mail: albert.tait@nhs.net

Internet address(es):

General address of the contracting authority: <http://www.ohb.scot.nhs.uk/>

Address of the buyer profile: http://www.publiccontractsscotland.gov.uk/search/Search_AuthProfile.aspx?ID=AA00368

Further information can be obtained from: The above mentioned contact point(s)

Specifications and additional documents (including documents for competitive dialogue and a dynamic purchasing system) can be obtained from: The above mentioned contact point(s)

Tenders or requests to participate must be sent to: The above mentioned contact point(s)

I.2) Type of the contracting authority

Body governed by public law

I.3) Main activity

Health

I.4) Contract award on behalf of other contracting authorities

The contracting authority is purchasing on behalf of other contracting authorities: no

Section II: Object of the contract

II.1) Description

II.1.1) Title attributed to the contract by the contracting authority:

New Orkney Hospital and Healthcare Facilities.

II.1.2) Type of contract and location of works, place of delivery or of performance

Works

Main site or location of works, place of delivery or of performance: The new Orkney Hospital and Health Care Facility will be constructed on a site at New Scapa Road, Orkney. The contract is for the design, build, finance and maintenance of a new Hospital and Health Care Facility.

NUTS code

II.1.3) Information about a public contract, a framework agreement or a dynamic purchasing system (DPS)

The notice involves a public contract

II.1.4) Information on framework agreement

II.1.5) Short description of the contract or purchase(s)

NHS Orkney are seeking a Private Sector Partner to participate and invest in a new Orkney Hospital and Healthcare Facility ("the Project") The Project will involve the design, build, finance and maintenance of a new hospital on a site in Orkney with an estimated cost range of between [GBP 180 m and GBP 220 m] over a 25 year operational period. The capital cost of the construction works is estimated as [GBP 59 m]. This is to be delivered under the Scottish Futures Trust's Non-Profit Distributing (NPD) model which is in the form of public-private partnership preferred by the Scottish Government.

The objective of the Project is to provide NHS Orkney with a new hospital and health care facility to service the needs of patients in the Orkney area. Further information will be provided in the ITPD and contract documents.

II.1.6) Common procurement vocabulary (CPV)

45215100, 98341000, 79993000, 31625200, 32520000, 35120000, 45314300, 50330000, 50700000, 51410000, 66515200, 71314200, 72253000, 77314000, 90911300, 90922000

II.1.7) Information about Government Procurement Agreement (GPA)

The contract is covered by the Government Procurement Agreement (GPA): yes

II.1.8) Lots

This contract is divided into lots: no

II.1.9) Information about variants

Variants will be accepted: yes

II.2) Quantity or scope of the contract

II.2.1) Total quantity or scope:

Estimated value excluding VAT:

Range: between 180 000 000 and 220 000 000 GBP

II.2.2) Information about options

Options: no

II.2.3) Information about renewals

This contract is subject to renewal: no

II.3) Duration of the contract or time limit for completion

Duration in months: 324 (from the award of the contract)

Section III: Legal, economic, financial and technical information

III.1) Conditions relating to the contract

III.1.1) Deposits and guarantees required:

Parent company or other guarantees may be required in certain circumstances. Full details to be set out in the information Memorandum/Pre-Qualification Questionnaire.

III.1.2) Main financing conditions and payment arrangements and/or reference to the relevant provisions governing them:

Finance to be provided by the Private Sector Partner in accordance with the Scottish Government's NPD Initiative. Full details to be set out in the ITPD and contract documents. The contracting authority reserves the right to consider alternative funding, financing and/or contractual arrangements to support the delivery of the Project.

III.1.3) Legal form to be taken by the group of economic operators to whom the contract is to be awarded:

An NPD company as per the Scottish Government's NPD Initiative. Full details to be set out in the ITPD and contract documents.

III.1.4) Other particular conditions

The performance of the contract is subject to particular conditions: yes

Description of particular conditions: The successful Private Sector Partner may be required to actively participate in the achievement of social and/or environmental objectives in the delivery of the Project. Accordingly, contract performance conditions may relate in particular, to social, environmental or other corporate social responsibility considerations. Further details of any conditions or specific requirements will be set out in the ITPD and contract documents.

III.2) Conditions for participation

III.2.1) Personal situation of economic operators, including requirements relating to enrolment on professional or trade registers

Information and formalities necessary for evaluating if the requirements are met: Full details to be set out in the Information Memorandum / Pre-Qualification Questionnaire.

III.2.2) Economic and financial ability

Information and formalities necessary for evaluating if the requirements are met: Parties expressing an interest in the Project will be required to complete a Pre-Qualification Questionnaire to evaluate and verify economic and financial standing and professional and technical capacity in accordance with Regulations 23 to 26 of the Public Contracts (Scotland) Regulations 2012. Full details to be set out in the information Memorandum / Pre-Qualification Questionnaire.

Minimum level(s) of standards possibly required: Certain minimum standards will apply. Full details set out in the Information Memorandum / Pre-Qualification Questionnaire.

III.2.3) Technical capacity

Information and formalities necessary for evaluating if the requirements are met:

Parties expressing an interest in the Project will be required to complete a Pre-Qualification Questionnaire to evaluate and verify economic and financial standing and professional and technical capacity in accordance with Regulations 23 to 26 of the Public Contracts

(Scotland) Regulations 2012. Full details to be set out in the information Memorandum / Pre-Qualification Questionnaire.
Minimum level(s) of standards possibly required:
Certain minimum standards will apply. Full details set out in the Information Memorandum / Pre-Qualification Questionnaire.

- III.2.4) **Information about reserved contracts**
- III.3) **Conditions specific to services contracts**
- III.3.1) **Information about a particular profession**
- III.3.2) **Staff responsible for the execution of the service**

Section IV: Procedure

IV.1) Type of procedure

IV.1.1) **Type of procedure**
competitive dialogue

IV.1.2) Limitations on the number of operators who will be invited to tender or to participate

Envisaged number of operators: 3

IV.1.3) Reduction of the number of operators during the negotiation or dialogue

Recourse to staged procedure to gradually reduce the number of solutions to be discussed or tenders to be negotiated yes

IV.2) Award criteria

IV.2.1) Award criteria

The most economically advantageous tender in terms of the criteria stated in the specifications, in the invitation to tender or to negotiate or in the descriptive document

IV.2.2) Information about electronic auction

An electronic auction will be used: no

IV.3) Administrative information

IV.3.1) File reference number attributed by the contracting authority:

IV.3.2) Previous publication(s) concerning the same contract

Prior information notice

Notice number in the OJEU: [2014/S 116-203797](#) of 19.6.2014

IV.3.3) Conditions for obtaining specifications and additional documents or descriptive document

Time limit for receipt of requests for documents or for accessing documents: 22.8.2014

Payable documents: no

IV.3.4) Time limit for receipt of tenders or requests to participate

5.9.2014 - 12:00

IV.3.5) Date of dispatch of invitations to tender or to participate to selected candidates

31.10.2014

IV.3.6) Language(s) in which tenders or requests to participate may be drawn up

English.

IV.3.7) Minimum time frame during which the tenderer must maintain the tender

IV.3.8) Conditions for opening of tenders

Section VI: Complementary information

VI.1) Information about recurrence

This is a recurrent procurement: no

VI.2) Information about European Union funds

The contract is related to a project and/or programme financed by European Union funds: no

VI.3) Additional information

1. Interested parties should express interest, receive and submit Pre-Qualification Questionnaire submissions via the contracting authority in line with the details contained in the Information Memorandum/ Pre-Qualification Questionnaire documentation. The Information Memorandum / Pre-Qualification Questionnaire can be obtained by contacting the Board via the project team at Ork-hb.projectteam@nhs.net.

2. NHS Orkney will hold a Bidders' Open Day on 14.8.2014 for those parties interested in the Project. The Bidders' Open Day will be held in Orkney. Interested parties wishing to attend the Bidders' Open Day should register as soon as possible to attend this event by either emailing Albert Tait at E-mail: Ork-hb.projectteam@nhs.net, or by writing to

Project Office, NHS Orkney, Balfour Hospital, New Scapa Road, Kirkwall, Orkney, KW15 1BH. All correspondence should be clearly marked - NHS Orkney New Hospital and Healthcare Facilities Attendance at Bidders' Open Day. All correspondence should also confirm if the parties wish to request a short private meeting on the day. Private meetings will be restricted to consortia only, and NHS Orkney reserves the right to limit the duration of private meetings.

Further details will be provided upon registration.

3. Further to Section II.3 the anticipated duration shall be 300 months (or 25 years) operational plus the period of construction. The total anticipated duration is therefore 324 months (or circa 27 years) from the award of the contract.

4. Further to Section II.1.9 variants may be accepted by the contracting authority. However, interested parties should note that the contracting authority will seek to limit or restrict the requirements on which variants will be accepted and evaluated. Full details will be set out in the ITPD and contract documents.

5. Further to Section IV.1.3 the process is detailed in the Information Memorandum/ Pre-Qualification Questionnaire. This will be updated in the ITPD and contract documents.

6. Further to Section IV.3.3 the Information Memorandum/ Pre-Qualification Questionnaire available from the contracting authority describes the process for obtaining specifications and additional documents.

VI.4)Procedures for appeal

VI.4.1)Body responsible for appeal procedures

NHS Orkney
Balfour Hospital, New Scapa Road, Kirkwall,
KW15 1BH Orkney
UNITED KINGDOM
E-mail: albert.tait@nhs.net
Telephone: +44 1856888103
Internet address: <http://www.ohb.scot.nhs.uk/>

VI.4.2)Lodging of appeals

Precise information on deadline(s) for lodging appeals: The contracting authority will incorporate a minimum of a 10 calendar day standstill period at the point information on the award of the contract is communicated to tenderers. This period allows unsuccessful tenderers to seek further debriefing from the contracting authority before the contract is entered into. Applicants can make a written request for de-brief information and this information must be provided within 15 days of this written request being received. Such additional information should be requested from the address in I.1. If an appeal regarding the award of a contract has not been successfully resolved, The Public Contracts (Scotland) Regulations 2012 (SSI 2012/88) provide for aggrieved parties who have been harmed or are at risk of harm by breach of the rules to take action in the Sheriff Court or Court of Session. Any such action must be brought promptly (generally within 30 days).

VI.4.3)Service from which information about the lodging of appeals may be obtained

VI.5)Date of dispatch of this notice:

17.7.2014

Appendix B - Assessment Matrix

Group	Members	Questions
Core Evaluation Team	Ann McCarlie(Chair), Albert Tait, Marthinus Roos, Rhoda Walker, Bruce Barron Advisers-, Martin Finnigan, Duncan Osler, Alan Harrison Admin Assistance– Sharon Smith Robin Reid (A20 B11-B13 & C11-C13)	Leadership of the PQQ evaluation process. Preparation of shortlist report for Project Implementation Board approval All questions– compliance & completeness. Pass/Fail questions A10,A20,B7,B10-B16,B19-B21,C10-C16,C19-C21
Technical and Experience	Ann McCarlie(Chair), Rhoda Walker, Marthinus Roos, Malcolm Colquhoun, John Trainor, John Ord, Gary Mortimer, Tom Gilmour Advisers– Alan Harrison + other Sweett Group, Iain Buchan Admin Assistance– Sharon Smith	A7,A8,A9,A17 A19,B4,B5B6,C4-C7 D1.3-D1.5, D2.3-D2.5,D3.3-3.5,D4.3-D4.5
Commercial	Albert Tait(Chair) Bruce Barron, Carla Tannous, Advisers– Martin Finnigan, Duncan Osler, Sweett Group Admin Assistance– Sharon Smith	A11,A14,A16,B8,B17,B18,C8, C17,C18

Note: Robin Reid is the CDM Co-ordinator

Appendix C - Question Weightings

SECTION	QUESTION NUMBER	SUBJECT	STATUS	QU-SUB WEIGHTING	SECTION WEIGHTING
A		The Candidate			
	A1-A6	General Information	N/S		
	A7	Key Persons Relevant Experience	Scored	25%	
	A8	Resourcing	Scored	15%	
	A9	Working Together	Scored	15%	
	A10	Conflicts	Pass/Fail		
	A11	Raising Finance	Pass/Fail		
	A12	Candidate Identity Information	N/S		
	A13	Candidate Parent Company	N/S		
	A14	Minimum Turnover	Pass/Fail		
	A16	Key Financial Information	Pass/fail		
	A17	Partnering and Collaboration	Scored	10%	
	A18	Design Quality and	Scored	25%	

SECTION	QUESTION NUMBER	SUBJECT	STATUS	QU-SUB WEIGHTING	SECTION WEIGHTING
		Sustainability			
	A19	Community Benefits	Scored	10%	
	A20	CDM ACoP	Pass/Fail		
				100%	30%
B		Construction Contractor			
	B1-B3	General Information	N/S		
	B4	Healthcare Experience PPP	Scored	40%	
	B5	Healthcare Experience Non-PPP	Scored	25%	
	B6	Remote, rural and geographically challenging	Scored	35%	
	B7	Blacklisting	Pass/Fail		
	B8	Claims	Pass/Fail		
	B9	Testimonials / References	N/S		

SECTION	QUESTION NUMBER	SUBJECT	STATUS	QU-SUB WEIGHTING	SECTION WEIGHTING
	B10	Quality Assurance	Pass/Fail		
	B11-B13	Health & Safety	Pass/Fail		
	B14	Environmental	Pass/Fail		
	B15-B16	Employment	Pass/Fail		
	B17	Employment	Pass/Fail		
	B18	Employment	Pass/Fail		
	B19-B22	Employment	Pass/Fail		
				100%	30%
C		FM Service Provider			
	C1-C3	General Information	N/S		
	C4	Healthcare Experience PPP	Scored	40%	
	C5	Healthcare Experience Non-PPP	Scored	20%	
	C6	Remote, rural and geographically challenging	Scored	30%	

SECTION	QUESTION NUMBER	SUBJECT	STATUS	QU-SUB WEIGHTING	SECTION WEIGHTING
	C7	Interface Experience	Scored	10%	
	C8	Claims	Pass/Fail		
	C9	Testimonials / References	N/S		
	C10	Quality	Pass/Fail		
	C11-C13	Health & Safety	Pass/Fail		
	C14	Environmental	Pass/Fail		
	C15 – C16	Employment	Pass/Fail		
	C17	Employment	Pass/Fail		
	C18	Employment	Pass/Fail		
	C19-C21	Employment	Pass/Fail		
				100%	15%
D		Designated Organisations D1 – Architect D2 – Lead Structural and Civil Engineer D3 – Lead Mechanical and Electrical Engineer D4 – Specialist			

SECTION	QUESTION NUMBER	SUBJECT	STATUS	QU-SUB WEIGHTING	SECTION WEIGHTING
		Health Care Planner			
		Architect: D1			
	D1.1	General Introduction	N/S		
	D1.2	General Introduction	N/S		
	D1.3	Healthcare Experience PPP	Scored	40%	
	D1.4	Healthcare Experience Non-PPP	Scored	30%	
	D1.5	Remote, rural and geographically challenging	Scored	30%	
	D1.6	References	N/S		
				Sub – Total	35%
		Lead Structural and Civil Engineer: D2			
	D2.1	General Information	N/S		
	D2.2	General Information	N/S		
	D2.3	Healthcare	Scored	40%	

SECTION	QUESTION NUMBER	SUBJECT	STATUS	QU-SUB WEIGHTING	SECTION WEIGHTING
		Experience PPP			
	D2.4	Healthcare Experience Non-PPP	Scored	35%	
	D2.5	Remote, rural and geographically challenging	Scored	25%	
	D2.6	References	N/S		
				Sub-Total	15%
		Lead Mechanical and Electrical Engineer: D3			
	D3.1	General Information	N/S		
	D3.3	Healthcare Experience PPP	Scored	40%	
	D3.4	Healthcare Experience Non-PPP	Scored	35%	
	D3.5	Remote, Rural and Geographically Challenging	Scored	25%	
	D3.6	References	N/S		
				Sub-Total	30%
		Specialist Health Care Planner: D4			
	D4.1	General Information	N/S		

SECTION	QUESTION NUMBER	SUBJECT	STATUS	QU-SUB WEIGHTING	SECTION WEIGHTING
	D4.3	Healthcare Experience PPP	Scored	40%	
	D4.4	Healthcare Experience Non-PPP	Scored	30%	
	D4.5	Remote, Rural and Geographically Challenging	Scored	30%	
	D4.6	References	N/S	Sub-Total	
					20%
				Total	100%
E		PQQ Declaration			
F		Statement of Good Standing			

Appendix D – Candidate’s PQQ Responses

Consortia Name	Canmore	Equitix/Farrans	Roberston
Consortia Lead	Canmore Partnership Ltd	Equitix Ltd	Robertson Capital Projects
Main Contractor	JV McLaughlin & Harvey & FES	Farrans Construction	Robertson Construction Group
Architect	Reiach and Hall Ltd	IBI Group (UK) Ltd	Keppie Design
M&E Engineer	DSSR	WSP UK Ltd Mercury Engineering	TUV SUD Wallace Whittle
Civil & Structural Engineer	FES FM Ltd	Mott MacDonald Ltd	URS Infrastructure & Environment UK Ltd
FM Provider	FES FM Ltd	ISS Mediclean Ltd	Robertson Facilities Management
Health Care Planner	Healthcare Partnership Ltd	IBI Group (UK) Ltd	Capita

NHS Orkney New Hospital and Healthcare Facilities Project

Assessment of Final Tender Submissions

Appointment of Preferred Bidder Report

Appendices are not included.

Executive Summary	3
1 Introduction	4
2 Process	6
2.1 Structure and Format of Final Tenders	6
2.2 Overview of Bid Evaluation Process	6
3 Non-Price Evaluation and Results	7
3.1 Completeness Results	7
3.2 Compliance	7
3.2.1 Compliance Results	7
3.3 Clinical/Technical Evaluation Criteria	8
3.3.1 Quality Evaluation Criteria for Final Tender Bid Response Requirements	8
3.3.2 Quality	10
4 Price Evaluation and Results	11
4.1 Economic Cost	11
4.2 Final Tender	12
4.3 Price Evaluation Matrix	12
4.4 Price Evaluation Results	12
5 Affordability	13
5.1 Comparison with Authority Affordability Figures	13
5.1.1 Price – Comparison with Capex	13
5.1.2 Price for Lifecycle Costs (25 years)	13
5.1.3 Price for Facilities Management (FM) Services (25 years)	13
5.1.4 Comparison of Total Cost	13
5.1.5 Price per Square Metre	14
5.2 Comparison Outcome	14
6 Final Tender Submission Scores	15
6.1 Combining Non Price and Price Scores	15
6.2 Final Scores	15
6.3 Most Economically Advantageous Tender	15
Appendix 1 – Detail of Quality Evaluation Scores	
Appendix 2 – Financial Evaluation of Final Tenders	
Appendix 3 – Assessment and Evaluation of Legal Tender Submissions	
Appendix 4 – Final Tender Construction and Operational Cost Analysis Cost Report	
Appendix 5 – Update on the Status of the Recommendations Arising from the Close of Dialogue KSR	
Appendix 6 – Risk Scores and Mitigation Actions	

Executive Summary

Invitation to Submit Final Tenders (ISFT)

1. The ISFT documents were issued on 13 May 2016 to the two remaining Bidders following down selection of a third Bidder earlier in the process.
2. For the purposes of this report and to preserve Bidder anonymity these are referred to as Bidder 1 and Bidder 2 throughout the remainder of this report.
3. In relation to the requirements set out in the ISFT both Bidders submitted Final Tenders by the required deadline of 24 May 2016.
4. Not unexpectedly from what was submitted at Draft Final Tender stage both Bidders have submitted tenders which exceed the approved Capex level in the OBC while one of the tenders has also exceeded the capped level for lifecycle and for FM costs.
5. Both tender submissions were evaluated for completeness, compliance, quality and price assessment scores.
6. From the outset of the project the scoring for the various sections of the tender submission had been notified to Bidders as being as follows:-

Technical/Quality – 40%
 Financial/Cost – 60% (net present value NPV)
 Legal – pass/fail

7. The results of the evaluation are set out below:-

Ranking	Quality Score	Price	Overall Score
Bidder 2	████	████	████
Bidder 1	████	████	████

8. On the basis of the above evaluation, Bidder 2 who has achieved the highest overall score and has submitted the most economically advantageous tender is recommended for appointment as Preferred Bidder.
9. As their Capex level for the project exceeds the Capex level presently approved confirmation will be required from SFT/SG that the PB appointment can take place having regard to that situation which is broadly in line with SG expectations.

1 Introduction

- 1.1 This report describes the evaluation process and provides a summary of the key outcomes informing the scoring of the two Final Tender Submissions. That process has led to the recommendation that Bidder 2 should be appointed as the Preferred Bidder to deliver the NHS Orkney New Hospital and Healthcare Facilities Project.
- 1.2 The NHS Orkney project will be delivered using the Non Profit Distributing (NPD) procurement model incorporating a variation to the funding arrangement whereby the Authority will be making a significant level of pre-payment in respect of the Annual Service Payment (ASP).
- 1.3 The procurement process commenced when a notice was published in the Official Journal of the European Union on 17th July 2014. The Notice invited expressions of interest from multidisciplinary teams (Candidates) to provide the new hospital and healthcare facilities using the Competitive Dialogue method of procurement under a Non Profit Distributing Model (NPD). Expressions of interest were received and Pre Qualification Questionnaire's were issued accordingly.
- 1.4 Completed Pre Qualification Questionnaires were received before the deadline of 5th September 2014 and thereafter a formal completion and compliance evaluation process was undertaken by the Project Team and their professional advisers. At the conclusion of that process three Candidates (Bidders) were invited to participate in Phase 1 of CD on 31st October 2014.
- 1.5 The three Bidders were required to provide interim bids following close of dialogue phase 1. In accordance with the previously predetermined arrangements all interim bids were evaluated to establish which two bidder would progress sot phase 2 of the CD process with the other bidder being down selected.
- 1.6 That down selection process took place during April 2015 and was approved by PIB and the NHSO Board.
- 1.7 The two retained Bidders (Bidders 1 and 2) have subsequently continued in competitive dialogue and submitted Draft Final Tenders during July 2015.
- 1.8 Feedback from the Draft Final Tenders was provided in writing to Bidders and discussed with them at a series of dialogue meetings. These were supplemented by further written submissions to allow the Authority to be confident that compliant Final Tenders would be submitted.
- 1.9 An Invitation to Submit Final Tenders (ISFT) was issued on 13 May 2016 and Final Tenders were received on 24 May 2016.

- 1.10 The remainder of this report details how the Final Tender Bids have been evaluated and the recommendation reached on which of the two Bidders should be appointed as Preferred Bidder.

CONFIDENTIAL

2 Process

2.1 Structure and Format of Final Tenders

The Final Tenders submitted by each Bidder were split into clinical/technical, financial and legal sections. Those scoring the technical sections did not receive details on price and vice versa.

2.2 Overview of Bid Evaluation Process

The Bid Evaluation for each Bid comprised the following steps:

- Completeness and compliance checks (carried out by the project team and advisers)
- Non-price Evaluation and calculation of the Quality Scores (undertaken by specific members of the project team, on a consensus approach to confirm final scores with relevant input from advisers)
- Evaluation of the Financial Models provided, checking Capital, FM and Lifecycle costs used in the models (carried out by specific advisers and members of the project team)

Project Team – Project Director, Project Manager, Commercial Lead, Clinical Leads, Hospital Manager, NHSO Healthcare Planner, Estates & FM Leads, IT Lead

Technical Advisers – Sweett Group, Turner and Townsend (CDM)

Healthcare Planners – Buchan & Associates

Financial Advisers – Caledonian Economics with QMPF

Legal Advisers – MacRoberts

Insurance Advisers – Willis

3 Non-Price Evaluation and Results

3.1 Completeness Results

Neither Bid was rejected on the grounds of being incomplete.

3.2 Compliance

The Final Bids were only considered “Compliant” if they:-

- Were complete and met the Bid Submission Requirements;
- Had fully accepted, and priced on the basis of, the Authority Requirements and Service Level Specification, all as set out in Volume 3 of the ITPD without any amendments;
- Confirmed no amendments or qualifications to the NPD Documents other than as discussed with the Authority during dialogue; and/or notified in Dialogue Period Bulletins and Clarifications.

3.2.1 Compliance Results

There were aspects of each Bid that initially required further clarification. Following appropriate clarification queries from the Authority these were resolved/rectified and on that basis both Bids were treated as compliant. This included the need to seek some further clarifications towards the end of the financial evaluation process about specific aspects of each of the Bidders financial model submissions.

3.3 Clinical/Technical Evaluation Criteria

3.3.1 Quality Evaluation Criteria for Final Tender Bid Response Requirements

For the Quality Evaluation Score (QES) each requirement to be scored was given a score out of 10 in accordance with the scoring system set out in the following table. The score for each QES was multiplied by the QES Weighting and divided by 10 to give a weighted score. The weighted score for each QES was added up to give a total score for quality out of 40.

Scoring Range 0 – 10	Categorisation	Description
0-1	Very Poor	The Bidder's approach: <ul style="list-style-type: none"> • fails to demonstrate any understanding of all or most of the Authority's requirements; and/or • proposes a Solution which performs poorly in complying with all or most of the Authority's requirements.
2-4	Poor	The Bidder's approach: <ul style="list-style-type: none"> • fails to demonstrate a satisfactory understanding of some aspects of the Authority's requirements; and/or • proposes a Solution which performs poorly in complying with some of the Authority's requirements.
5	Satisfactory	The Bidder's approach: <ul style="list-style-type: none"> • demonstrates a satisfactory understanding of all aspects of the Authority's requirements; and/or • proposes a Solution which performs satisfactorily in complying with the Authority's requirements.
6-7	Good	The Bidder's approach: <ul style="list-style-type: none"> • demonstrates a satisfactory understanding of all aspects of the Authority's requirements and a good understanding of most aspects of the Authority's requirements; and/or • proposes a Solution which performs well against the Authority's requirements.
8-9	Very Good	The Bidder's approach: <ul style="list-style-type: none"> • demonstrates a good understanding of all aspects of the Authority's requirements and a very good understanding of most aspects of the Authority's requirements; and/or • proposes a Solution which performs very well against the Authority's requirements.

Scoring Range 0 – 10	Categorisation	Description
10	Excellent	<p>The Bidder's approach:</p> <ul style="list-style-type: none"> • demonstrates a very good understanding of all aspects of the Authority's requirements and an excellent understanding of some aspects of the Authority's requirements; and/or • proposes a Solution which performs very well in complying with the Authority's requirements and excels in complying with some of the Authority's requirements.

CONFIDENTIAL

3.3.2 Quality

Neither Bidder scored zero for any of the Clinical/Technical Evaluation sub-criteria specified. The Bidders scored the following:

B – Strategic and Management Approach

Bidder 1	Bidder 2	Maximum Weighted Score
████	████	████

C – Design and Construction

Bidder 1	Bidder 2	Maximum Weighted Score
████	████	████

D – Facilities and Management

Bidder 1	Bidder 2	Maximum Weighted Score
████	████	████

Total Score B+C+D

Bidder 1	Bidder 2	Maximum Weighted Score
████	████	████

Further details on the above evaluation are contained in [Appendix 1](#).

4 Price Evaluation and Results

4.1 Economic Cost

The Economic Cost of the Final Tender will be determined by calculating the NPV of each Submission to the Authority over the period of the NPD Project Agreement using the following components:

- a) NPV of Annual Service Payment - The proposed total Annual Service Payment stream over the operational period in the Bidder's Financial Model, prepared using the assumptions and specifications set out in Appendix B. The NPV will be calculated using the Treasury nominal 6.0875% discount rate; plus,
- b) NPV of Advance ASP Payments - The proposed total Advance Annual Service Payment stream in the Bidder's Financial Model, prepared using the assumptions and specifications set out in Appendix B. The NPV will be calculated using the Treasury nominal 6.0875% discount rate; less,
- c) NPV of Surpluses - The forecast level of surpluses in the Bidder's Financial Model deducted from the NPV of the total Annual Service Payment. Due to the more uncertain nature of the surplus payments the NPV will be calculated using a nominal discount rate of 9.0% as indicated in DPB031; plus,
- d) Equalisation Adjustment - The additional material related costs and revenues to be borne by the Authority as a result of any Final Tender, including energy and utilities, rates and insurance costs [as set out below]. The impact of such costs will be estimated by the Authority and expressed as an NPV of the adjustments made, discounted on the same basis as the Annual Service Payment. The result will be added to the NPV of the Final Tender Submission (an 'Equalisation Adjustment'); and plus
- e) Quantifiable Bidder Amendments - The Economic Cost will include an amount that reflects the deemed value (whether positive or negative) of any a) amendments, caveats or qualifications to the contract or specification that affect the risk profile of the Project or b) elements of the response to the Financial Submission Requirements, that have or, in the reasonable opinion of the Authority may have, a significant and quantifiable financial impact on the Authority (a 'Quantifiable Bidder Amendment').

4.2 Final Tender

The Financial Model identifies the net present value of each of the Bidders proposals.

4.3 Price Evaluation Matrix

The Economic Cost of each bid derived from the components described in Volume 1 of the ITPD documentation was assigned a score (the **Price Evaluation mark**). The Bidder with the lowest Economic Cost scored 60 marks which is the maximum possible. The Economic Cost of the other Submission(s) were assigned a score relative to the difference in price from the lowest according to the formula below.

$$y = 60 \times (1 - (x/z))$$

where:

y = Price Evaluation Mark of the Bid under consideration

x = the difference between the Economic Cost of the Bid under consideration from the Economic Cost of the Bid with the lowest Economic Cost expressed in pounds

z = the Economic Cost of the Bid with the lowest Economic Cost expressed in pounds

4.4 Price Evaluation Results

Bidder	NPV Annual Service Payments £'000	NPV Advanced Service Payments £'000	Surpluses NPV £'000	NPV Utilities Equalisation £'000	Adjusted NPV £'000	Score
Bidder 1	██████	██████	████	██████	██████	██████
Bidder 2	██████	██████	██████	██████	██████	██████

Further details on the above evaluation are contained in [Appendix 2](#).

5 Affordability

5.1 Comparison with Authority Affordability Figures

The following tables provide a comparison of the Bidders submissions with the Authority's affordability figures included within the Outline Business Case (OBC) and the ITPD/ISFT documentation.

5.1.1 Price – Comparison with Capex

	Bidder 1	Bidder 2	OBC/ITPD Figures
Capex	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]
Ranking	2	1	-

5.1.2 Price for Lifecycle Costs (25 years)

	Bidder 1	Bidder 2	OBC/ITPD Figures
Price	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]
Ranking	2	1	-

5.1.3 Price for Facilities Management (FM) Services (25 years)

	Bidder 1	Bidder 2	OBC/ITPD Figures
Price	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]
Ranking	2	1	-

5.1.4 Comparison of Total Cost

	GIFA	Capital Expenditure	Lifecycle	FM	Total
Bidder 1	[REDACTED]	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]
Bidder 2	[REDACTED]	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]
OBC/ISFT Figures	[REDACTED]	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]	£ [REDACTED]

5.1.5 Price per Square Metre

	Bidder 1	Bidder 2	OBC/ITPD Figures
Square meterage	██████	██████	██████
Capex	£██████	£██████	£██████
Lifecycle	£██████	£██████	£██████
FM	£██████	£██████	£██████

5.2 Comparison Outcome

Both Bidders have submitted bids which exceed the overall agreed Capex. There are however large variations in the makeup of the respective bids that have been submitted for construction costs.

With regard to the 25 year lifecycle costs (50% of which is borne by NHSO) only Bidder 1 has exceeded the affordability figure by £██████ approximately £██████ per annum.

In relation to the 25 year costs for FM services only Bidder 1 has exceeded the affordability figure identified by £██████ approximately £██████ per annum.

6 Final Tender Submission Scores

6.1 Combining Non Price and Price Scores

The Overall Score for Final Bid evaluation is the sum of:-

- The Weighted Price Score, being the Price Score multiplied by the Price Weighting of 60%; and
- The Weighted Non-Price Score, being the total of:

The Weighted Strategic and Management Approach

The Weighted Design and Construction Score

The Weighted Facilities Management Deliverability Score

Multiplied by the non-price Weighting of 40%.

6.2 Final Scores

The results of the assessment are set out in the table below. Please note that the scores awarded were out of a possible 100 Marks.

Ranking		Overall Weighted Score
1	Bidder 2	██████
2	Bidder 1	██████

6.3 Most Economically Advantageous Tender

The Most Economically Advantageous Tender is defined as the highest scoring tender submission, following assessment against the pre determined evaluation criteria. The criteria assessed in this case were price and quality with the latter encompassing deliverability.

In accordance with the arrangements stated in the ITPD Volume 1, the Bidder with the highest overall score should be selected as the Preferred Bidder to deliver NHS Orkney's New Hospital and Healthcare Facilities.



Ernst & Young LLP
City Gate
St James' Boulevard
Newcastle upon Tyne
NE1 4JD

Tel: + 44 191 247 2500
Fax: + 44 191 247 2501
ey.com



HM Revenue & Customs
Public Bodies Enquiries S0927
Newcastle upon Tyne
NE98 1ZZ
United Kingdom

3 June 2016

Ref: SM/SA/RM/HS
Direct line: 0131 777 2400
Email: smathieson@uk.ey.com

Dear Sirs

**NHS Orkney ("Board")
VAT Registration Number: 654 8512 20
Prepayment of the Unitary Charge**

We are writing on behalf of the above named client in order to establish its entitlement to recover VAT incurred in relation to the pre-payment of a significant part of the Unitary Charge for a new hospital and healthcare facility in Kirkwall, Orkney.

A non-statutory ruling request is required due to the uncertainty created by the pre-payment of the Unitary Charge which differs from the monthly payments typically made under a non-profit distributing ("NPD") procurement model.

1. Applicant Details

This request for a ruling is made on behalf of NHS Orkney registered at Garden House, New Scapa Road, Kirkwall, Orkney, KW15 1BQ with VAT registration number 654 8512 20.

EY is writing on behalf of the Board in its capacity as agent and there is a 64-8 on file. A copy has also been attached for your reference.

The Board is seeking a ruling in respect of its entitlement to recover VAT incurred in relation to the pre-payment of a significant part of the Unitary Charge from funding it has received from Scottish Government and the resultant lower level of the ongoing annual Unitary Charge for a new hospital and healthcare facility in Kirkwall, Orkney.

2. Background

The Board is in the process of contracting for the design, build, financing and maintenance of a new hospital in Kirkwall which will replace the current Balfour Hospital. The plans concern a two storey rural general hospital that will provide a mix of surgical, medical, anaesthetic, obstetric, diagnostic, nursing, midwifery and Allied Health Profession services on an outpatient, day or inpatient basis. It is expected that financial close for the project will be achieved by mid October 2016, work starting shortly thereafter with services from the facilities being available from Spring/Summer 2019. The Board is

carrying out the procurement by means of the well developed and extensively used NPD model in Scotland whereby the successful bidder designs, builds, finances and maintains the facilities.

As part of the contract arrangements the Board will be making a pre-payment of the Unitary Charge for services of circa [REDACTED] and there will also be a further private sector investment of circa [REDACTED]. This meets the requirement under the NPD model to have private sector risk investment. The pre-payment of the service charge removes the requirement for the successful bidder to secure senior debt investment. The pre-payment of the Unitary Charge means that taking account of the pre-payment arrangement there will be an annual level of Unitary Charge of circa [REDACTED] per year which includes life cycle and facilities management costs. Without the pre-payment the full monthly Unitary Charge would be circa [REDACTED].

While the pre-payment represents a change to the normal monthly payment funding arrangement, all other aspects of the NPD procurement model are preserved. As such, the Board is seeking confirmation that the VAT incurred on the pre-payment of the Unitary Charge is recoverable under COS Heading 45 - Operation of hospitals, health care establishments and health care facilities and the provision of related services. For ease, we have included a diagram illustrating a 'normal' NPD project and the arrangements proposed by the Board in Appendix 1.

3. Legislative basis

COS Heading 45 - Operation of hospitals, health care establishments and health care facilities and the provision of related services allows VAT recovery where the Board receives a building or facilities which enables it to treat and care for patients. This includes:

- An entire hospital complex of buildings
- Part of a hospital complex of buildings
- A discrete part of a hospital, such as a ward, a theatre suite, a radiology department, a renal dialysis suite, a diagnostic suite or an MRI unit
- An off-site facility that provides services which would normally be carried out in a hospital or health care establishment, for example an off-site facility for renal dialysis or diagnostic purposes
- Non-residential mental health facilities which are part of the healthcare offered by the NHS body

This allows NHS bodies to obtain VAT recovery on NPD/PFI arrangements where the contractor provides a sufficient level of services and support within the facility to allow the body to treat its patients.

4. VAT Treatment

The Board considers that it will be in receipt of a fully functioning healthcare facility from the Project Co and that the change in the payment arrangements do not affect the underlying supply.

Clause 2 of the Draft Pre-Payment Agreement Heads of Terms states:

*The Authority is in an ongoing procurement to award a contract for the design, build, financing and maintenance of a hospital for Orkney (**the Project**), using the Non-Profit Distribution Model (**the Project**). The Authority intends to apply funds ("**Pre-Payments**") to pre-pay amounts of Annual Service Payments that otherwise would be payable by way of Unitary Payment over the contract life by the Authority to Project Co for payment of an element of the services required for the full and effective delivery of the Project. These Heads of Terms outline the terms and conditions that will attach to such Pre-Payments. The Sponsor(s) will invest / subscribe for Sponsor Debt as specified in the Preferred Bidder Letter and the Sponsor(s) will be required to be a party to the Subordination Agreement. These Heads of Terms reflect restrictions in Project Co's Articles in relation to its operations, including Article 3 (Application of Revenues) and Article 5 (Proceedings of Directors) including decisions in relation to Reserved Matters.*

As HMRC will be aware, COS Heading 45 does not specify the level or frequency of payments that must be made. The focus of the guidance is on the nature of the supply rather than the payment mechanisms. In light of the lack of guidance from HMRC around the impact that the frequency or nature of the payment has on the VAT treatment, the Board is uncertain as to the correct treatment and is seeking confirmation that it is correct to treat the pre-payment of the Unitary Charge in the same way as it would treat normal monthly Unitary Charge payments - as recoverable under COS Heading 45.

As evidenced by the (25 year) ongoing annual Unitary Charge of circa [REDACTED] per year, the Project Co will be charging the Board for ongoing facilities management services and these do form an integral component of the supply. We have outlined below those clauses of Project Agreement which make it clear that the essential nature of the project is to provide 'a fully functioning building':

- Clause 5 - requires that both parties liaise to ensure that the requirements of the Board in respect of the operation of the facilities are met
- Clause 9 - provides that the Board will grant the necessary land/site access to the Project Co to allow it to construct, operate and maintain the hospital
- Clause 22 - requires that the Project Co provides the services in accordance with the service level specification
- Clause 23 - requires that the Project Co draws up an annual and five-yearly schedule of programmed maintenance and lifecycle replacement of facilities. Also ensures that plastering, carpets etc. will be renewed in a timely manner.

We can provide a copy of the contractual documentation via email on request - given the size of the documentation it is not possible to post copies with this correspondence.

In summary, the contractual documentation and agreements support the treatment of the project as a 'typical' NPD where the VAT would be recoverable under COS Heading 45 (with the only change being

made relating to a substantial pre-payment funding arrangement). Given that the pre-payment does not alter the nature of the supply and the pre-payment is only being made as a result of the significant level of funding being made available to the Board by Scottish Government, the Board considers that the VAT is recoverable under COS Heading 45.

5. Conclusion

As you can see from the details outlined above, the Board is of the opinion that it will be in receipt of a fully functioning facility which allows medical professionals to provide the care their patients require.

Therefore, the Board is looking for clarity around any impact that the nature of the pre-payment may have on the VAT treatment because HMRC's guidance is unclear. Ultimately, the Board is looking to confirm that the VAT incurred on both the pre-payment of the Unitary Charge and the annual Unitary Charge will be recoverable in full under COS Heading 45.

6. Tax Avoidance Schemes

The Board can confirm that this transaction does not fall to be covered at all or in part by any tax avoidance schemes.

I trust the information provided is sufficient for you to confirm that this treatment is acceptable. If you need any further information please do not hesitate to contact me on 0131 777 2400.

Yours faithfully,



Stewart Mathieson
Partner
Indirect Tax

Enc.

Appendix 1

Diagram 1. A typical NPD structure is set out below.

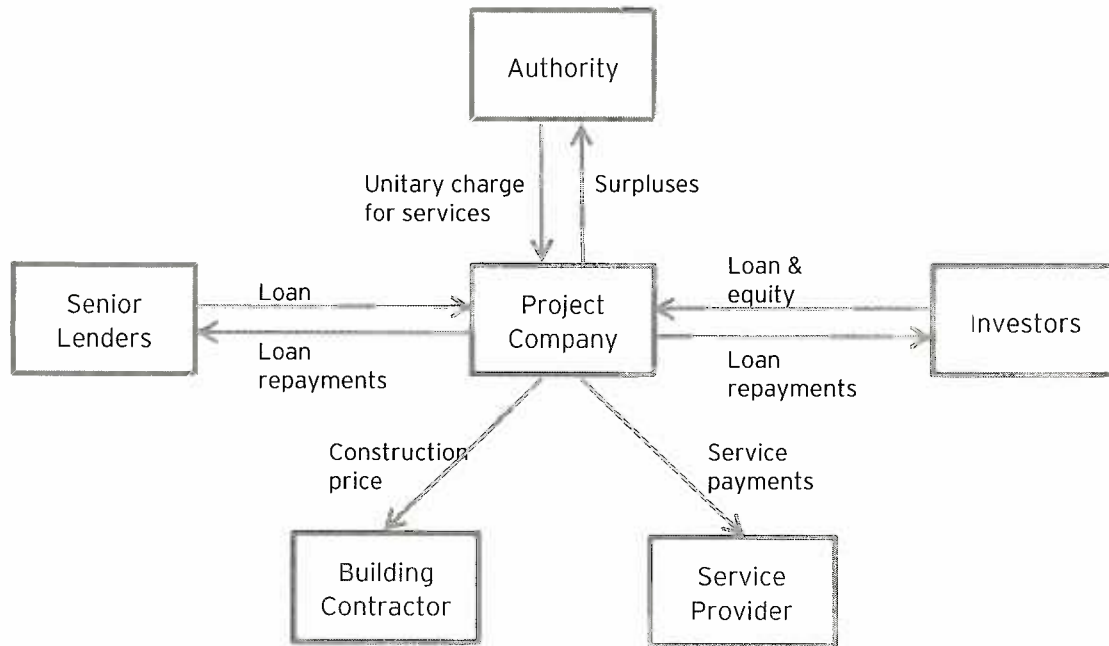
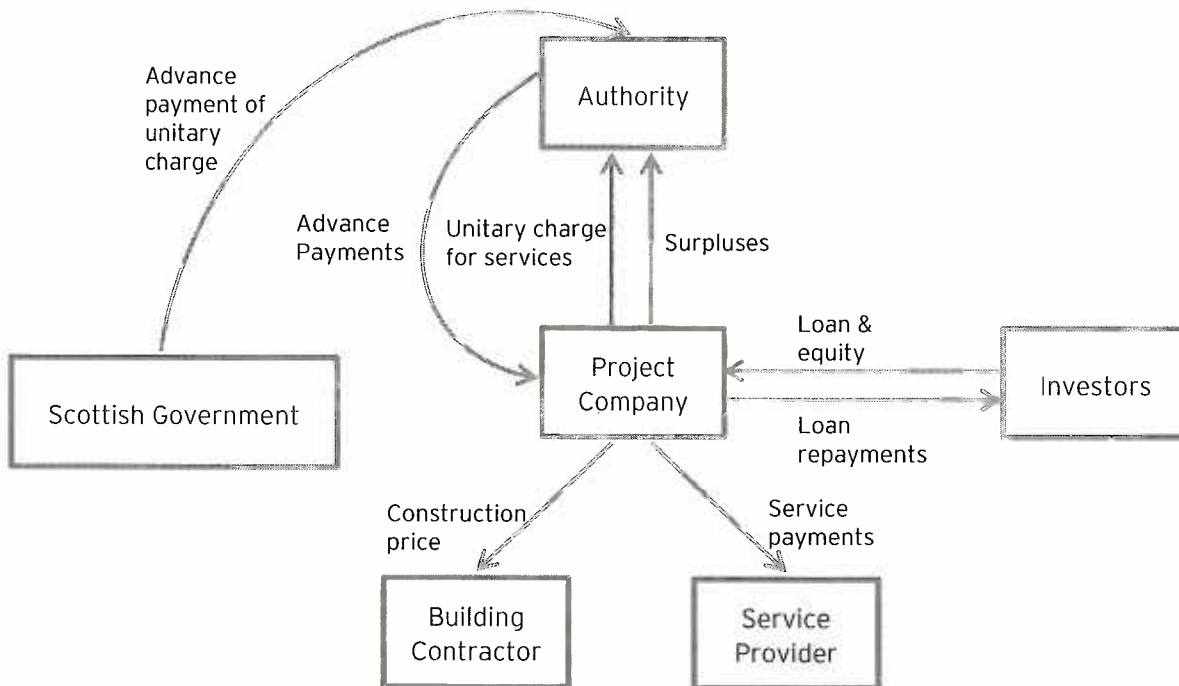
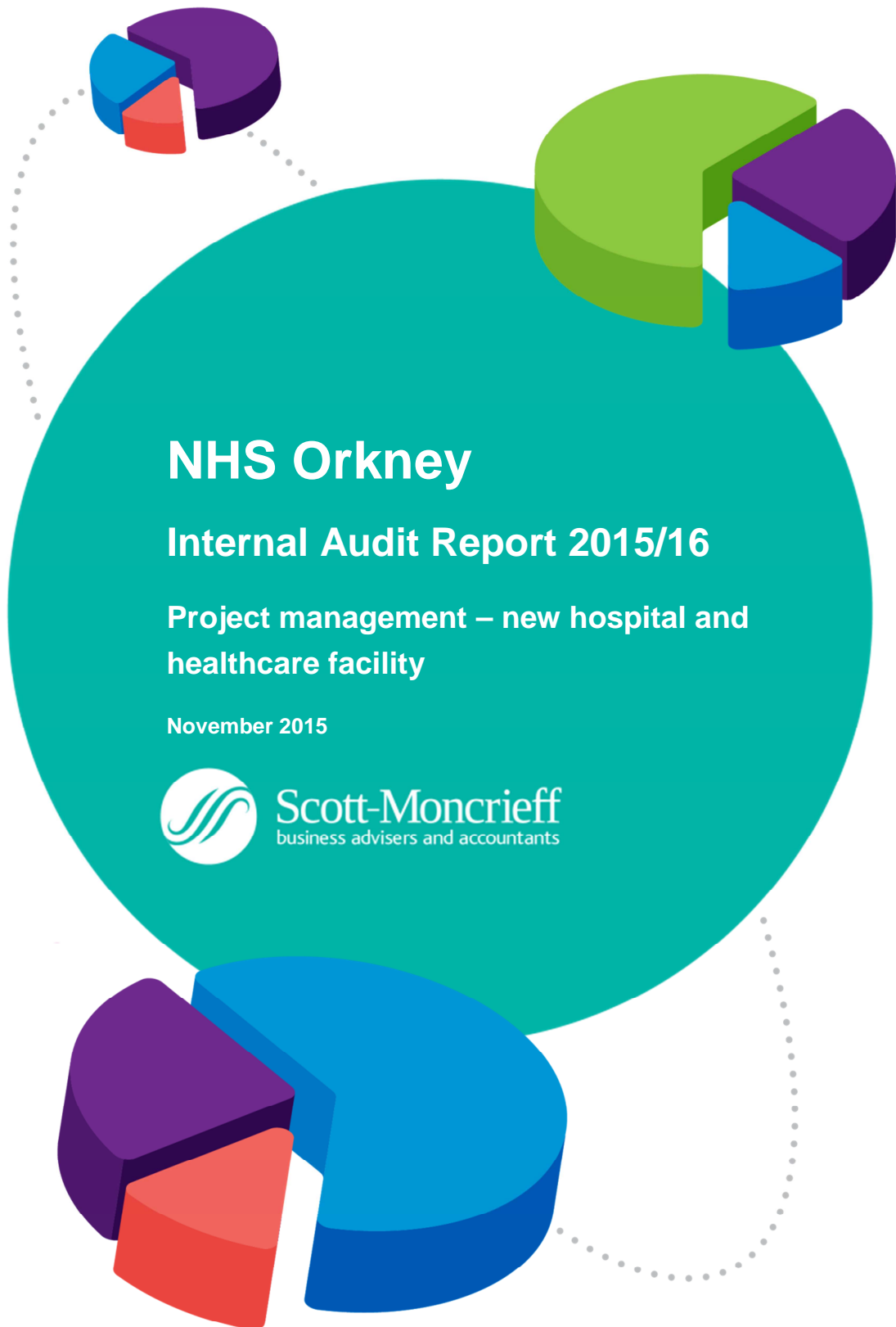


Diagram 2. Orkney NPD structure is set out below.





NHS Orkney

Internal Audit Report 2015/16

Project management – new hospital and healthcare facility

November 2015



Scott-Moncrieff
business advisers and accountants

NHS Orkney

Internal Audit Report 2015/16

Project management – new hospital and healthcare facility

Introduction	1
Summary of findings	2
Conclusion	3
Management Action Plan	5

Introduction

Background

In 2014, the Scottish Government approved the outline business case for the new hospital and healthcare facility in Orkney, which is to replace the existing Balfour Hospital. It is anticipated that the project will cost approximately £60m and be completed during 2018.

It is essential that robust project management arrangements are in place throughout the project to ensure its successful delivery within timescales and budget.

Scope

We assessed the effectiveness of NHS Orkney's project management arrangements for the new hospital and healthcare facility.

The control objectives for this audit, along with our assessment of the controls in place to meet each objective, are set out in the Summary of Findings.

Acknowledgements

We would like to thank all staff consulted during this review for their assistance and co-operation.

Summary of findings

The table below summarises our assessment of the adequacy and effectiveness of the controls in place to meet each of the objectives agreed for this audit. Further details, along with any improvement actions, are set out in the Management Action Plan.

No	Control Objective	Control objective assessment	Action rating				
			5	4	3	2	1
1	There is a comprehensive approved business case in place which covers all aspects of the project and is aligned with best practice.	GREEN	-	-	-	-	-
2	Roles and responsibilities in relation to the project have been clearly defined and delegated to responsible staff.	GREEN	-	-	-	-	-
3	Risks and issues logs are in place and these are actively managed throughout the duration of the project.	GREEN	-	-	-	-	-
4	There is regular reporting on progress with the project, including comprehensive explanations and action plans where delays have been incurred.	GREEN	-	-	-	-	-
5	Robust financial reporting is in place to promptly identify areas where there may be potential over or underspends.	GREEN	-	-	-	-	-

Assessment	Definition
BLACK	Fundamental absence or failure of key control procedures - immediate action required.
RED	The control procedures in place are not effective - inadequate management of key risks.
YELLOW	No major weaknesses in control but scope for improvement.
GREEN	Adequate and effective controls which are operating satisfactorily.

Conclusion

We confirmed that NHS Orkney has robust controls in place for managing the new hospital and healthcare facility project and these are operating effectively.

The new hospital and healthcare facility, which is being procured using a Non Profit Distribution (NPD) model, is at a crucial stage when competitive dialogue is due to end and a preferred bidder will be appointed. However, the project has encountered delays due to the European Statement of Accounts 2010 (ESA 10) payment mechanism changes and affordability in relation to the capital expenditure budget. The ESA 10 has changed the accounting rules that determine whether projects, such as the new hospital and healthcare facility, should be classified to public or private sector. This has led to delays on a number of Hub and NPD projects while the Office of National Statistics reached a decision on how the Aberdeen Roads NPD project should be classified and provided a view on the proposed Hub model. The Scottish Government and SFT will then have to decide on whether changes will be necessary to the project structure that delivers a value for money project whilst ensuring conformance to current accounting requirements. While discussions are ongoing, NHS Orkney is unable to reach a close on the competitive dialogue stage of the project and there is a risk captured in the risk register that the procurement phase is extended and thus the opening date for the hospital and healthcare facility is significantly delayed. NHS Orkney has engaged with the SFT to identify potential solutions to this problem but at the time of conducting this review no decision had been made. The Board has been kept fully up-to-date with the situation and the potential risks that delays to the project will bring.

Addendum to original report conclusion as at 28 January 2016

It should be noted that in the period since this audit was conducted and the report drafted, the Scottish Government budget has provided explicit budget allocation for this project and the Chief Executive is working closely with the Project Director and key stakeholders to actively pursue solutions to minimise any delay to the procurement timetable.

Main Findings

The Outline Business Case (OBC) sets out NHS Orkney's vision for delivering the new hospital and healthcare facility. The OBC was prepared in line with Scottish Government's Capital Investment Manual and supporting guidance. The OBC clearly defines NHS Orkney's Strategic, Economic, Commercial, Financial and Management Cases for the development of the new hospital and healthcare facility. The NHS Orkney Board approved the OBC in February 2014 and the OBC was subsequently approved by the Scottish Government in July 2014.

A clear governance structure is in place for the management of the project. A Programme Implementation Board (PIB), chaired by the Chief Executive, has been established and includes representation from the NHS Orkney Corporate Management Team, the Project Director and Team, the Scottish Futures Trust (SFT) and the Deputy Director of Capital & Facilities from Scottish Government. The PIB is accountable to the NHS Orkney Board directly; however the NHS Orkney Finance & Performance Committee is responsible for maintaining scrutiny of the project and making recommendations to the Board on key decisions, such as approval of the OBC and tender exercises. The minutes of the PIB (which meets monthly) are provided to the NHS Orkney Board, along with a regular update report. The minutes are also made available in the public domain.

The Project Team maintains risk registers, action logs and issues logs for the project to ensure there is comprehensive consideration of all factors that may impact on the delivery of the project. This also ensures a

clear audit trail is in place to monitor actions taken to date. The PIB receives monthly updates from the Project Director on the risk register and work to date on delivering the project. Additionally, the PIB maintains an action log from each meeting; work to complete actions identified from previous meetings will be discussed at the beginning of the next meeting.

There is regular reporting on progress of the project. The Project Team meets on a weekly basis to review progress. A formal progress report is then presented monthly to the PIB and as noted above, regular updates are given to the NHS Orkney Board and to the Finance & Performance Committee at key stages of the project. There is also detailed budget monitoring and reporting to ensure costs are controlled.

Further details of the points noted above are included in the Management Action Plan.

Management Action Plan

All actions are given a risk rating as follows:

Risk Rating	Definition
5	Very high risk exposure – Major concerns requiring immediate Board attention.
4	High risk exposure – Absence / failure of significant key controls.
3	Moderate risk exposure – Not all key control procedures are working effectively.
2	Limited risk exposure – Minor control procedures are not in place / not working effectively.
1	Efficiency / housekeeping point.

1. Control objective: There is a comprehensive approved business case in place which covers all aspects of the project and is aligned with best practice.

We have not identified any issues in relation to this control objective.

The Outline Business Case (OBC) was developed in line with guidance issued by the Scottish Government's Capital Investment Manual. This included adopting the 'Five case' approach where the Strategic Case, Economic Case, Commercial Case, Financial Case and Management Case were clearly outlined and justified. The OBC was approved by the Board, following recommendation by the Finance & Performance Committee, in February 2014 and by the Scottish Government's Capital Investment Group in July 2014.

2. Control objective: Roles and responsibilities in relation to the project have been clearly defined and delegated to responsible staff.

We have not identified any issues in relation to this control objective.

The OBC clearly outlines the project management arrangements. The project structure is clearly outlined and roles and responsibilities are defined for each individual, team and group within the project structure. This includes the key individual project staff, such as the Project Owner and Director, as well as the project's technical advisors.

A clear governance structure is in place for managing the project. A Programme Implementation Board (PIB) has been established and includes representation from the NHS Orkney Corporate Management Team, Project Team, the SFT and the Deputy Director of Capital & Facilities from Scottish Government. The PIB meets monthly and it has a comprehensive Terms of Reference. This includes monitoring the project risk registers and receiving updates from the Project Director at each meeting.

The PIB is accountable to the NHS Orkney Board, while the Finance & Performance Committee is responsible for maintaining scrutiny of the project and making recommendations to the Board on key decisions, such as approval of the OBC and tender exercises. The Finance & Performance Committee receives progress reports at each meeting, including minutes of the PIB meetings. The Board also receives regular updates and is consulted when key decisions need to be made or if there are any significant risks or issues identified in relation to the project.

3. Control objective: Risks and issues logs are in place and these are actively managed throughout the duration of the project.

We have not identified any issues in relation to this control objective.

The Project Team meets on a weekly basis to discuss the project's progress, highlight any issues that have arisen and also highlight any risks that may impact the delivery of the project. An issues log and action plan is maintained by the Project Team and reviewed during the weekly meetings. The structure of both documents ensures that each issue or action is allocated an owner and a target completion date. Progress with completing the actions is clearly documented on the log, ensuring an audit trail of work performed to date is maintained.

Two project-specific risk registers are in place: a Procurement Risk Register and an Operational Risk Register. The format of the risk registers requires each risk to be assigned a control and/or planned actions to mitigate each risk. Each risk has been allocated to the most relevant member of the Project Team, who is then responsible for implementing the agreed actions to manage and mitigate the risk. Deadlines are also set for when actions should be taken and when risks should be reviewed. Where project risks relate to NHS Orkney as a whole, these will be escalated to the Corporate Management Team for inclusion on the Corporate Risk Register.

The PIB also maintains an action log from each meeting. Progress against identified issues is reviewed and updated at the beginning of each PIB meeting.

4. Control objective: There is regular reporting on progress with the project, including comprehensive explanations and action plans where delays have been incurred.

We have not identified any issues in relation to this control objective.

As stated under Control Objective 2, a clear governance structure has been identified within the OBC and is fully operational. The PIB, Finance & Performance Committee and the Board all receive regular progress reports. Progress is reported against each key project milestone from the OBC.

Where issues have arisen, such as the ESA 10 issue, all governance groups have been kept fully informed on the issues and the actions that NHS Orkney has taken and plans to take to address the risks.

The Project Team is in regular communication with the SFT to ensure NHS Orkney is kept updated with progress on the project. In addition, by having a representative on the PIB, the SFT is fully aware of work undertaken by NHS Orkney to date and progress in addressing any emerging issues.

5. Control objective: Robust financial reporting is in place to promptly identify areas where there may be potential over or underspends.

We have not identified any issues in relation to this control objective.

The Project Team receives monthly budget reports from the NHS Orkney Finance Team. Reports show spend-to-date against budgeted spend. In addition, detail is provided of spend against each account code to ensure the Project Team has sufficient financial information to make informed decisions.

The Finance & Performance Committee and the Board receive regular financial reports setting out NHS Orkney's current financial position, including details of any over or underspends.

© Scott-Moncrieff Chartered Accountants 2016. All rights reserved. "Scott-Moncrieff" refers to Scott-Moncrieff Chartered Accountants, a member of Moore Stephens International Limited, a worldwide network of independent firms.

Scott-Moncrieff Chartered Accountants is registered to carry on audit work and regulated for a range of investment business activities by the Institute of Chartered Accountants of Scotland.

NEW HOSPITAL & HEALTHCARE FACILITY PROJECT OBJECTIVES

Ref No	Investment Objective	Benefit (For features see Benefit Criteria section below)	Measure including baseline	Who benefits?	Who's responsible?	Dependencies	Timescale
1	To improve capacity and access to healthcare services – ensuring the health needs of the population are met	Wellbeing and patient experience	Improved flexibility in room usage – 100% single room, outpatients, and generic therapy spaces.	Patients	Project Director (PD)	Delivery of planned design	On handover
			Enhanced access to VC through enabling of all areas	Patients	PD	Delivery of planned design	On handover
			Reduction in off island travel associated with repatriated services	Patients	Head of Transformational Change & Improvement (HoTCI)	Ability of workforce & facilities to support change	1 year post commissioning
			Increased access to private spaces – improved privacy and dignity	Patients and staff	PD	Delivery of planned design	1 month post commissioning
			Reduction in number of complaints regarding noise and other environmental factors	Patients	Head of Hospital and Support Services (HoHSS)	Delivery of planned design	1 year post commissioning
2	To improve capacity and	Timely access to services	Continue to achieve A&E 4 hour standard	Patients	HoHSS	Delivery of planned design	3 months post commissioning

	access to healthcare services – ensuring the health needs of the population are met	(transport, visibility, location)	<p>Increase in outpatient appointments delivered via VC</p> <p>Improved capacity – increased consulting & treatment space, increased number of potential clinics, increased theatre session time</p> <p>Increased primary care consulting capacity</p>	<p>Patients</p> <p>Patients</p> <p>Patients</p>	<p>HoTCHI</p> <p>PD</p> <p>PD</p>	<p>Stakeholder cooperation</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p>	<p>1 year post commissioning</p> <p>On handover</p> <p>On handover</p>
3	<p>To provide facilities/services that are:</p> <p>1. 'fit for purpose'</p> <p>2. support safe and effective clinical working</p> <p>3. improve clinical and functional relationships</p> <p>4. Enable the provision of modern NHS care</p> <p>5. Provide</p>	Attract and retain staff	<p>1. Increased % of Estate classed as quality category B or above in PAMS</p> <p>Statutory compliance – HAI and DDA</p> <p>Clear direction and easy way finding via aural, visual and tactile contrasts as well as clear signage (Ref: NHSO Design Statement, June 2013)</p> <p>Waiting areas within</p>	<p>Board of NHS Orkney</p> <p>Board of NHS Orkney</p> <p>Patients and staff</p> <p>Patients and staff</p>	<p>HoHSS</p> <p>PD</p> <p>PD</p> <p>PD</p>	<p>Delivery of planned design</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p>	<p>1 month post commissioning</p> <p>Handover</p> <p>Handover</p> <p>Handover</p>

sufficient flexibility for future changes to service provision	20m of the consult/treatment area and must be comfortable (Ref: NHSO Design Statement, June 2013)	Board of NHS Orkney	PD	Delivery of planned design	1 year post commissioning
	2. Compliance with Guidelines – improved performance against appropriate criteria	Patients & staff	PD	Delivery of planned design	6 months post commissioning
	Improved communication between clinicians and between clinicians and patients	HoHSS	PD	Delivery of planned design	Handover
	Improved security – ability to lock down	HoHSS	PD	Delivery of planned design	Handover
	Reduction in number of entry and exit points	Staff	Service Managers	Operational policies	3 months post commissioning
	Reduction in lone working	Board of NHS Orkney	HoHSS	Delivery of planned design	1 year post commissioning
	Reduction in Datix incidents in relation to environment classifications	Board of NHS Orkney	HoHSS	Delivery of planned design	3 months post commissioning
		Staff and			

			Reduction in risks on corporate risk register in relation to hospital estate, security and environmental factors	patients	HoHSS	Delivery of planned design	3 months post commissioning
				Staff and patients	HoHSS	Delivery of planned design	3 months post commissioning
			Reduction in moving and handling associated with frequent bed moves	Patients	PD	Delivery of planned design	Handover
			Reduction in bed moves associated with infection control measures	Board of NHS Orkney	HoHSS	Delivery of planned design	Handover
			Availability of second theatre for emergency purposes	Members of the public	PD	Delivery of planned design	1 month post commissioning
			3. Increased % of accommodation scoring category B or above in PAMS functional suitability	Patients & staff	PD & HoHSS	Delivery of planned design	1 month post commissioning
				Patients and staff	PD	Delivery of planned design	Handover
			Improved access and way finding to A&E				
				Patients and staff	HoTCHI	Delivery of Digital Medical Record Project	1 year post commissioning
			Increased access to point of care testing				

			<p>4. 100% Single room with sufficient size and flexibility to allow provision of a range of care services</p> <p>Improved access to electronic patient information to support diagnosis and commencement of treatments and continuity of care</p> <p>Increased utilisation of telemedicine and electronic self check in</p> <p>All rooms occupied by staff for more than 2 hours per day continuously at one time have access to daylight and a view (Ref: NHSO Design Statement, June 2013)</p> <p>Access to staff facilities and rest room within 10 minutes walk of all departments</p> <p>5. % of single rooms increased to 100%</p>	<p>Patients and staff</p> <p>Staff</p> <p>Staff</p> <p>Patients</p> <p>Board of NHS Orkney</p> <p>Board of NHS Orkney</p>	<p>HoTCHI & HoHSS</p> <p>PD</p> <p>PD</p> <p>PD</p> <p>HoHSS</p> <p>PD</p>	<p>Delivery of transforming outpatients project</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p>	<p>3 months post commissioning</p> <p>3 months post commissioning</p> <p>Handover</p> <p>Handover</p> <p>Handover</p>
--	--	--	---	---	--	---	---

			<p>Increased flexibility in use of inpatient beds</p> <p>Standardisation of room types and sizes to provide future opportunity for change</p>				
4	To ensure that the hospital and services are developed in such a way as to maximise performance and efficiency	Right clinical/non clinical adjacencies and flows	<p>Increased admission on day of surgery/procedure</p> <p>Reduction in number of admissions from A&E</p> <p>Increase in day case and/or OPD procedures</p> <p>Reduction in CO2 emissions</p> <p>Reduction in energy costs</p>	<p>Patients</p> <p>Patients</p> <p>Patients</p> <p>Wider environmental benefit</p> <p>Board of NHS Orkney</p> <p>All statutory and voluntary health and</p>	<p>HoHSS & HoTCHI</p> <p>HoHSS & HoTCHI</p> <p>HoHSS & HoTCHI</p> <p>HoHSS</p> <p>PD</p> <p>PD</p>	<p>Delivery of service improvements</p> <p>Delivery of service improvements</p> <p>Delivery of service improvements</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p>	<p>6 months post commissioning</p> <p>1 year post commissioning</p> <p>6 months post commissioning</p> <p>6 months post commissioning</p> <p>6 months post commissioning</p> <p>3 months post commissioning</p>

			Improved communication between primary care, community services and third sector as a result of collocation	care providers.			
			Reduction in length of stay	Patients	HoHSS & HoTCHI	Delivery of service improvements	1 year post commissioning
			Decrease in cost per sq m of soft FM services - ability to meet national averages for catering, portering, laundry	Board of NHS Orkney	HoHSS	Delivery of planned design	3 months post commissioning
5	Maximise benefits of shared facilities	Multifunctional rooms and spaces	Improved patient experience	Patients	Director of Nursing	Delivery of planned design	6 months post commissioning
			Improved satisfaction with physical working environment – staff	Staff	Head of Organisational Development & Learning (HoODL)	Delivery of planned design	6 months post commissioning
			Increased flexibility in room use	Board of NHS Orkney	PD	Delivery of planned design	3 months post commissioning

			<p>Improved speed of access to diagnostics – increased access to near patient testing and collocation of primary care with imaging and labs</p> <p>Reduction in staff travel associated with collocation on one site and increased use of VC</p>	<p>Patients</p> <p>Staff</p>	<p>PD</p> <p>PD & HoTCHI</p>	<p>Delivery of planned design</p> <p>Delivery of planned design and service improvements in regards to VC utilisation</p>	<p>3 months post commissioning</p> <p>6 months post commissioning</p>
6	Maximise benefits of shared facilities	Shared plant and facilities	<p>Improved communication between clinicians in primary and secondary care</p> <p>Improved multi disciplinary working and communication</p> <p>Increased use of technology to support facilities management</p>	<p>Patients</p> <p>Patients and staff</p> <p>Staff</p>	<p>PD</p> <p>PD</p> <p>HoHSS</p>	<p>Delivery of planned design</p> <p>Delivery of planned design</p> <p>Delivery of planned design</p>	<p>3 months post commissioning</p> <p>3 months post commissioning</p> <p>3 months post commissioning</p>
7	To ensure that the hospital	BREEAM & Sustainability	Achievement of BREEAM very good	Board of NHS Orkney	PD	Delivery of planned design	Handover

	and services are developed in such a way as to maximise performance and efficiency		rating as a minimum				
			Reduction in energy costs	Board of NHS Orkney	PD	Delivery of planned design	1 year post commissioning
			Reduction in travel costs	Board of NHS Orkney	HoTCHI	Delivery of planned design	1 year post commissioning
			Community benefits associated with long term operation as well as construction	Wider Orkney population	PD	Delivery of planned design and agreed operating model	Handover and 6 months post commissioning
8	Enable innovative ways of working	Attract and retain staff	Increased telemedicine availability and utilisation	Patients	HoTCHI	Stakeholder cooperation	6 months post commissioning
			Decreased % of services utilising paper records	Patients and staff	HoTCHI	Delivery of Digital Medical Record project	6 months post commissioning
			Increased frequency of utilisation of clinical decision making support	Patients and staff	HoHSS & HoTCHI	Implementation of shared clinical pathways with partner Boards	6 months post commissioning
				Patients and staff	PD & HoHSS	Delivery of planned design	6 months post commissioning

			Increased access to and utilisation of near patient testing	Staff	Head of IT	Delivery of planned design	1 month post commissioning
			Increased access to mobile working through the availability of wifi and appropriate networks and equipment	Staff	HoODL	Delivery of planned design and new ways of working	3 months post commissioning
			Increased workforce agility in relation to hot desking and working from home	Staff	HoODL	Delivery of planned design	6 months post commissioning
			Increased staff satisfaction with working environment				

Benefit Criteria

Benefit	Features
Wellbeing & Patient Experience	<ul style="list-style-type: none"> • Appropriate range of accommodation to meet patient, staff and visitor needs • Seamless transition from hospital to care in the community • Improved privacy and dignity • Dementia and cognitive impairment friendly • Access to real time information regarding care and telehealth solutions to enable care at home/closer to home • Electronic self check in
Attract & Retain Staff	<ul style="list-style-type: none"> • Better employee experience • Ability to repatriate services and retain and attract employees • Sustains adequate numbers of staff and students • Appropriate access to training and development • Improving the working environment for staff • Ability to both recruit and retain staff • Makes best use of all available skills amongst the work force • Complies with clinical staffing standards • More flexible ways of working e.g. home working options and smarter offices • Increased technology enabled support – access to remote clinical decision making
Fit for purpose (legislation, standards, accreditation)	<ul style="list-style-type: none"> • Provides appropriate and safe service provision within and out with normal working hours • Improved disabled access • Environment that supports effective prevention and control of infection • Meets minimum size guidelines for clinical & non clinical accommodation • Ability to meet quality standards and other guidelines • Meets all clinical standards, guidelines and legislation
Right clinical/non-clinical adjacencies/flows	<ul style="list-style-type: none"> • Optimises use of staff resource • Supports standard care pathways • Supports effective communication across the healthcare team • Supports integrated team working • Minimises duplication

	<ul style="list-style-type: none"> • Improved quality of care through real time access and updates to care plans (which can be shared with primary and other specialists). • Direct data entry at the point of care.
Access to services (transport, visibility, location)	<ul style="list-style-type: none"> • Supports joint working with other providers • Improved integration with SAS • Improved way finding • Increased accessibility – Travel Plan
Provision of Multifunctional Rooms/Spaces	<ul style="list-style-type: none"> • Maximises usage and likelihood of accessing suitable space • Makes best use of expensive resources e.g. theatres, radiology, etc. • Allows flexibility in work base
Shared Plant & Facilities	<ul style="list-style-type: none"> • Collocation of clinical and non clinical services within one central site • Collocation with Primary Care, SAS, NHS24, Dental and some community services • Efficiency from rationalisation of plant and support services
BREEAM & Sustainability	<ul style="list-style-type: none"> • Achieves BREEAM very good rating as a minimum • Supports a reduction in CO² emissions

New Hospital and Healthcare Facilities Project Outline Evaluation Plan

Evaluation Plan Considerations and Issues	Process
Clarity on the Objectives and Purpose of the Evaluation	<p>The evaluation to be undertaken will inform the Board and the wider Orkney health and social care community as to how well the Project has met its objectives. It will also:</p> <ul style="list-style-type: none"> • Help inform the process for any future capital projects to be undertaken by NHS Orkney, including staff and public engagement and communications, project management arrangements and risk management. • An interim evaluation will ascertain whether the new facilities are operating as planned, delivering the clinical and operational objectives in terms of flows and adjacencies and that corrective actions are being taken where necessary • Improve accountability by demonstrating the efficient and effective use of resources.
Scope of the Evaluation	<p>The evaluation will include a Summative Evaluation</p> <p>The objectives contained within this FBC are the starting point for the evaluation. Out of these objectives a number of Benefit Criteria were developed and are included, in full in a separate Section of this FBC.</p> <p>A Formative Evaluation will use the following as headings:</p> <ul style="list-style-type: none"> • Review of the Competitive Procurement Phase • Robustness of Contract Negotiation and Management • Clarity of the Contract/Schedules and Level of Risk Remaining for the Board
Timing of the Evaluation	<p>The interim evaluation will be undertaken between 6 and 9 months of the new facilities becoming operational. The full evaluation will take place between 12 and 18 months of the facilities becoming operational.</p>
Success Criteria	<p>Success criteria for the Summative Evaluation are included within the Benefits Realisation Plan under the heading – “Impact”</p> <p>The Success Criteria for the Formative Evaluation are to be drafted and agreed by the Project Implementation Board. They will cover the period from Financial Close through to completion of the construction and will mirror the timeframe for the Formative Evaluation.</p>
Performance Indicators and Measures	<p>Performance Indicators and Measures for the Summative Evaluation are included within the Benefits Realisation Plan under the heading –</p>

	"Measurement"
Structural Context	The baseline situation from which improvements will be made are as contained in the Strategic Context section of this FBC.
Proposed Evaluation Team	The Project Director will lead the Evaluation process, with the Evaluation Team chaired by the Chief Executive of NHS Orkney The team for the formative evaluation will be the Project Implementation Board. The Head of Transformational Change & Improvement will lead the team for the summative evaluation, membership of which will be further considered nearer the time.
Resources Available	The New Hospital and Healthcare Services Project Team budget will be used to resource PPE. The exact requirements cannot be calculated at this stage; however NHS Orkney is committed to resourcing the PPE appropriately.
Learning Culture	The New Hospital and Healthcare Services Project is the largest project ever undertaken by the local health and social care community and therefore it is important that a process for disseminating both good and less good experiences is established. To ensure full advantage is taken it is proposed that the Project Implementation Board develops and then signs off a Lessons Learnt Document as part the formative and summative evaluations
Organisational Impact and Change Management	A key issue both to date and for the coming years is how effectively the Board can manage change. Appropriate training and organizational support will be made available during the coming years to support the change process and organizational communications will be key to success. Staff will be asked their view on how well change is being managed on a regular basis and the existing staff representative forums will continue to be good vehicles for gathering feedback for evaluation.
Need for Robustness and Objectivity	The Project implementation Board will consider options to provide robustness and objectivity to the process. Options available to the board include engaging with other NHS organizations who will have recently completed major capital projects (NHS Dumfries and Galloway, SNBTS) and /or its external auditors to support or undertake the PPE.
Methodologies	The methods for providing the information for the PPE will vary according to the different aspects of the evaluation.