Brighton and Sussex NHS University Hospitals

3Ts Hospital Redevelopment
Teaching • Trauma • Tertiary care

Minutes of RSCH Hospital Redevelopment Programme Board 17 October 2014
10.30-12.30 in Meeting Room A St Mary's Hall

Present:

Graham Dodge	Deputy Clinical Chief of 3Ts, BSUH
Amanda Fadero	Deputy Chief Executive (for Sandy Spencer)
Duane Passman	Director of 3Ts (Chair), BSUH (by speaker phone)
Spencer Prosser	Chief Financial Officer (BSUH) (by speaker phone)
Steve Woodward	Director, Turner & Townsend

In Attendance:

Anna Barnes	Associate Director, 3Ts Governance, BSUH
Rob Brown	Head of Capital Development, BSUH
Mark Frake	Project Accountant, BSUH
Nick Groves	Associate Director, 3Ts Service Modernisation, BSUH
Lorissa Page	Assistant Director HR (for Helen Weatherill)
Paresh Patel	Deputy Chief Financial Officer
Gary Speirs	3Ts Capital Project Manager, BSUH

Apologies:

Ian Arbuthnot	Director of Health Informatics, BSUH
Steve Lloyd	Commercial Leader, HealthCare Sector, LOR
Paul Maitland	Director, Turner and Townsend

Part 2- commercial in confidence

1.8 FBC- overview and Executive Summary

Duane explained that in summary the FBC remains unchanged in scope from OBC. He then outlined the structure of the FBC as per the 5 Case Model and spoke to each case as follows:

1.9 Strategic Case/Case for Change

3Ts is still aligned with local and regional strategies and does provide flexibility for future changes in service configuration. However scenarios are very sensitive to small increases in growth or non-delivery of demand management;

- Base case 2019/20: 142 "surplus" beds across the Trust – 92 at RSCH;
- Base case 2022/23: 120 "surplus" beds across the Trust – 79 beds at RSCH;
- Base case 2027/28: 68 "surplus" beds across the Trust – 42 beds at RSCH;
- Decant/operational resilience beds (one ward at each site) would reduce this by 50+ beds (depending on wards used) throughout;
- Existing estate compliance with current bed spacing removes 99 beds at RSCH and 110 at PRH reducing any surplus to a deficit.

The base case therefore makes some "brave assumptions" about the impact of demand management/Better Care Fund and efficiencies which, if not achieved, would leave BSUH with a shortage of capacity in the longer term. In general, the case is conservative in neither providing surplus capacity nor reducing beds too radically. However the building has been designed with considerable flexibility for future uses if these assumptions are not correct.

Duane asked PB to note the following:

- The Strategic Case remains as per the Outline Business Case approved by the Board in 2009 and 2012 and is unaltered and unchallenged;
- Although the name of the programme is '3Ts' (Teaching, Trauma and Tertiary Care), replacement of facilities for District General Hospital services accounts for 43% of the floor area of the new facilities;
- The FBC continues to align fully with national, regional and local policies and strategies;
- With regard to the Case for Change, the key environmental drivers relating to the patient experience, operational efficiency and capacity in our oldest estate remain extant but, if anything, the urgency has become more pressing in the intervening years;

1.10 Strategic Case: Consultation and Engagement

Duane continued by saying that in terms of stakeholder engagement, it can be seen to have had had the comprehensive involvement of staff, members of the public and patients in the design. Programme Board was asked to note that there has been:

- Considerable engagement with Clinical Commissioning Groups (CCGs) and NHS England (and their predecessor organisations) – CCG support letters have been appended;
- Considerable patient engagement, through workshops with patients and patient groups and the Patient & Public Design Panel (PPDP). In particular, PPDP has provided input to the Access Audit undertaken in partnership with the Fed. Centre for Independent Living (Brighton & Hove Federation of Disabled People), the 3Ts Public Arts Strategy and the subsequent design of the main reception area. The PPDP has also had significant input to the design of bathrooms and wayfinding (mainly from a disability perspective);
- Considerable engagement with the general public, e.g. through the process of seeking Full Planning Consent and through the ongoing 3Ts Communications & Engagement Programme;
- Considerable engagement with staff – over 200 frontline staff have been involved through 90 meetings to develop the design, and this will continue in the next stage of detailed design;
- Considerable engagement with local residents through 26 meetings (to date) of the Hospital Liaison Group;
- This engagement will continue through the next stage of development and throughout the implementation period;
- An independent Equality ('Due Regard') Impact Assessment undertaken into the decant and main scheme concluded that the Trust is "undertaking proper action as regards the proposals for the 3Ts development in line with the Equality Act 2010".

1.11. Economic Case

Duane introduced the Economic Case by saying that the OBC qualitative analysis showed little to choose between public funding and PFI; The PFI comparator was marginal, and the realisation of the financial and non-financial benefits would be compromised if the PFI2 route was pursued because of the need to factor in a time delay of a further 2 years. Therefore PF2 costs, although having improved, would still add to the affordability burden - £36.7m to CIPs over the period. He outlined the comparison between OBC and FBC:

- OBC quantitative analysis showed marginal benefit towards public funding (risk and benefit adjusted);
- FBC qualitative analysis still shows little to choose between public funding and PFI;
- FBC qualitative analysis shows PFI marginally better vfm on risk adjusted measure but public funding marginally better vfm when also benefit adjusted (as PFI adds two years delay in realising benefits);
- Narrowing of gap has come through better funding terms in PF market (since 2009) and decrease in corporation tax;

Therefore the PFI is less affordable in cash terms, a view supported by Ernst and Young. Moreover, the time delay could reduce affordability because of a possible further deterioration in market conditions. Programme Board was asked to note the following:

- There has been an increase in capital costs in the development since the OBC approval. The OBC set out a capital cost of £420m (including equipment, design and Trust fees, optimism bias, risk contingencies, inflation to outturn and VAT (including allowable abatements);
- There has been no change in the physical scope of the building or its functional content since the design was frozen in Sept 2011 in order to seek Full Planning Consent;
- There have been some *minor* changes in overall scope of works which have been included – some regulatory change, IM&T equipment, the requirement for air quality mitigation measures at helideck level and some additional electrical infrastructure capacity required. These have been accounted for in a commensurate reduction in the optimism bias allowance – which is present to deal with scope change;
- The construction market has changed over the last year or so, with the pace of construction price inflation beginning to pick up as the economy recovers;
- Our Independent Cost Advisers, Turner & Townsend (T&T), have updated the capital costs for the increase in construction price indices and applicable location factor. With no other changes, and including all the other factors (contingency etc.), this gave a projected capital cost of £516m;
- LOR submitted a revised works costs, which when the other factors were added to that, generated a capital cost of £517m;
- Further to discussions at the Board of Directors, the Trust team has entered into discussions with LOR and secured a reduction in their works cost which generates a capital cost of £485.577m. This has been done with no reduction in scope, but some assumptions have been made about specification which should not affect the overall quality of the scheme. LOR have also made some commercial adjustments – these are covered in the interim cost report from T&T (section 3 of that report);
- This reduction assumes that we are able to secure £1m of charitable funding from the County Air Ambulance Trust HELP Appeal, which has offered this previously. This is currently being pursued;
- An interim report from T&T has been circulated which sets out the process undertaken with LOR to secure a revised works cost, the reductions around that and the initial view of value for money of the capital cost based on benchmarking against other projects. The key output of that draft report is that the capital cost now in play compares well to other major health schemes and is therefore reasonable being only marginally above the average;
- A final report would be available in the week commencing 20 October which will examine the LOR offering in finer detail on a line by line basis. This will be presented to the Board of Directors (and Programme Board) for information subsequently, building on the discussion at the board on 20 October;
- The Trust team and T & T are now in discussion with the Independent Cost Adviser appointed by the TDA and DH who will take a view on the inflation allowances (inflation since OBC submission, increases in location factor and projected inflation

to the completion of the project) that we have made and advise his clients accordingly;

- A comparison has also been made with a Private Finance Initiative (PFI) (or PF2) funded alternative. At OBC stage, the value for money gap between the two was narrow. This has narrowed further as PF2 funding terms have improved over the last two years. The revised analysis shows that for the basic risk-adjusted net present values and equivalent annual costs, there is a 0.07% and 0.8% advantage in using PF2 – which is hardly material;
- When benefits are added to this, the public funding solution provides marginally better value for money (due to the earlier realisation of benefits) as was the case in the approved OBC;
- The qualitative analysis (PFI vs public funding) has not changed since the OBC and remains a balanced assessment;
- The PF2 alternative, although marginally less better value for money when adjusted for risk and benefit realisation is less affordable than the preferred publicly funded solution – and this has remained the case since OBC.

1.12 Commercial Case- The building

Duane outlined the process which had been undertaken to develop the preferred option:

- The Trust has undertaken over 30 site visits during the last six years to inform the planning of the new facilities and to learn lessons from elsewhere;
- The team have ensured that quality and safety have been part of the design principles of the building (this is reflected in the letter of support from the Trust Chief of Safety & Quality);
- Standardisation and repeatability have been applied where appropriate throughout the building;
- The building will have flexibility for future change as a result of its design;
- The development greatly improves the clinical adjacencies on the site to improve and enable effective team working, the development of innovative models of care, operational efficiencies and enhanced opportunities for teaching and research;
- Increased privacy and dignity for patients through the inclusion of an average 65% of the inpatient beds being in single, en-suite rooms, with the remainder in four-beds bays;
- The development meets sustainability targets;
- Patients, staff and the public have been extensively engaged in the proposals since the start of the process in 2008.

1.13 Commercial Case IM&T

Programme Board was asked to note the following:

- IM&T, based on the current Information Strategy, has been included in the design of the building;
- £4.1m has been included in the equipping and commissioning costs for IM&T – other expenditure on IM&T for the building is included in the capital programme as this would have to be expended whether 3Ts went ahead or not;
- The development does not include the cost of relocating the Data Centre (consistent with the OBC). A further option appraisal and Business Case for this will be presented to the Board in due course.

1.14 Commercial Case: Procurement and Equipping

Duane asked PB to note the following:

- The procurement of the building is being managed in accordance with the Board-approved Procurement Strategy for 3Ts, which involves an open-book approach to the tendering of works packages within the scheme;

- There is a further process of design refinement and detail to be undertaken whilst the FBC is being appraised by the approving bodies. This will allow the Trust to agree a final price and thereby enter into contract;
- Further work will be undertaken during this period to drive out any further capital cost efficiencies, to manage risk contingencies further and arrive at a final contingency sum for the scheme whilst construction is underway and the interplay between this and the works costs;
- Optimism bias is currently at a level which has been assessed as the cost of designing scope change into Stage 2;
- The legal opinion received from Michelmores LLP confirms the legality of the proposed approach;
- The key risk is that building price inflation continues during the period of the FBC approval and in the period thereafter before a contract is entered into and underlines the importance of a relatively speedy resolution to the approval process.

1.15 Financial Case - capital

Duane explained that although the capital costs of the scheme were now substantially higher than at OBC (an increase from £420m to £516m then reduced to £486m), they had been benchmarked against recent NHS capital developments and were in line with these comparators. The cost per square meter was marginally above average (with abnormals) or marginally below (excluding abnormals).

Duane then outlined some of the possible value engineering solutions which had been considered;

- Opportunities for savings through reduction in scope: "shell and core" area (non-clinical and ward areas);
- Omit helideck;
- Omit some or all of car parking.

However radical redesign could cause further delay which would compromise and therefore not release major savings, coupled with increased uncertainty if there was a need to reapply for planning consent, and the risk of a further increase in building price inflation during this period. There had therefore been no major compromises in the design but there would be further opportunities for detailed review during the next stage market testing phase.

Duane then explained that the subsequent £31m reduction in capital costs had been achieved through specification changes and commercial negotiations and was a considerable achievement. The Turner and Townsend Interim Report(cited in 1.11) provided a commentary on the reduction to £486m:

- Fee reduction;
- Charitable contribution to helideck;
- Improved buying gains;
- Specification (but not scope) changes;
- Risk review
- Inflation to out-turn based on cost consultants' average
- The scheme remains affordable – adding £15.6m to the Cost Improvement Programme (CIPs), which would have to be made over the next 10 years even if the scheme did not go ahead (which compares with £14.6m at OBC). This is mainly due to the increase in capital cost being offset by revised guidance from the District Valuer as to the valuation of the building and a lower projected level of capital charges;

- The Trust would be required to secure a higher level of CIPs to afford the PFI/PF2 alternative;
- The assumptions regarding activity and income have been shared with and supported by the CCGs. They have also been shared with NHS England (as specialist commissioner), who are progressing their own internal assurance and approvals;
- The letters of support already received account for more than 80% of Trust income from CCGs;
- Transitional costs overall (i.e. the costs of the project team, the costs of bringing the facilities into use and one-off costs associated with that) are currently estimated at £29m overall (£31.8m including sunk costs). These transitional costs were approved by the former Strategic Health Authority (SHA) and are currently being funded by NHS England as a legacy commitment. The continued funding of these will require NHS England approval;
- Based on the sunk costs expended to date (in developing the design and the decant schemes either underway or completed), plus the recent loan secured for further design development, the remaining capital required to complete the project (based on the £485.577m) is £412.8m. The base case in the FBC assumes that we are successful in securing Public Dividend Capital for the remainder;
- That the Trust's Tier 1 borrowing capacity will be a maximum taking account of existing loans and potential loans for the Radiotherapy Linked Units – additional loans will mean a reduction in expenditure elsewhere of a further increase in CIPs;
- Loan interest is currently at a relatively low level, but this is not guaranteed to remain the case over the construction period (as we would not draw down the entire amount in one loan);
- The Trust will score 2 on its Liquidity Ratio and 3 in its Capital Servicing Capacity Ratio over the Long-Term Financial Model (with a weighted average of 3), which should be acceptable to Monitor.

1.16 Financial case- affordability/revenue

Duane then moved on to a discussion about the revenue impacts and overall affordability. He made a comparison between the OBC and FBC as follows:

- OBC showed affordable position (at 13/14 prices) with CIPs of £251.7m to completion;
- FBC shows affordable position (at 14/15 prices) with CIPs of £257.6m;
- £15.6m of the £257.6m is driven by 3Ts – the rest would have to be achieved anyway;
- OBC assumed impairment on the buildings to be 25% (and capital charges were calculated on that);
- FBC assumes 40% (based on current advice from District Valuer);
- This will remain a risk until the building is finally assessed when open. However, this has improved the overall affordability of the scheme
- Considerable work undertaken with KPMG for next three years (including 14/15) to consolidate the work undertaken last year;
- Governance of CIPs programme through the Delivery Unit has added a further degree of assurance and rigour;
- The Trust would be required to secure a higher level of CIPs to afford the PFI/PF2 alternative;
- The assumptions regarding activity and income have been shared with and supported by the CCGs. They have also been shared with NHS England (as

specialist commissioner), who are progressing their own internal assurance and approvals;

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- The Trust will score 2 on its Liquidity Ratio and 3 in its Capital Servicing Capacity Ratio over the Long-Term Financial Model (with a weighted average of 3), which should be acceptable to Monitor.

1.17 Management Case/benefits realisation

Duane finished his presentation by outlining the systems and processes for delivering the scheme which were robust. The team to take the scheme forward was stable, and experienced. The systems and processes being used via the P21 Framework were sound and had been externally assured. He asked PB to note the following:

- There is a clear governance structure in place, which has been approved by the Board. This will need to be refreshed further once implementation commences;
- There is an appropriately skilled and resource internal team well placed to manage the process through to signing the contract and beyond;
- The Board of Directors receives assurance through the 3Ts Programme Board, the Internal Audit assessment of the risk assessment and management process and external Gateway Reviews (the next of which is in mid-November 2014);
- Risks and issues are clearly identified and actioned and this will continue.

Duane then moved onto a discussion about benefits realisation/post project evaluation where the following points were noted:

- The benefits of the programme are clearly described and plans are in place to realise them and to measure them;
- A plan is in place to undertake Post-Project Evaluation and funding for this is contained in the transitional costs of the scheme

1.18 Letters of support

Duane reported that letters of support for the FBC have been received from the following:

- Infection Prevention & Control;
- Chief Nurse;

- Medical Director;
- Chief of Safety and Quality;
- Deputy Clinical Chief of 3Ts;
- Operational Director of HR;
- Director of Education;
- Head of Research & Development;
- Head of Resilience, Emergency Planning and Business Continuity;
- Head of Chaplaincy;
- Head of Equality, Diversity and Human Rights;
- Medical Director, Chief Nurse and Chief of Safety & Quality (for the Quality Impact Assessment);
- Chair of Onward Arts;
- The Patient & Public Design Panel
- Brighton & Hove CCG;
- Coastal West Sussex CCG;
- Eastbourne, Hailsham and Seaford CCG;
- High Weald Lewes Havens CCG;
- Horsham and Mid-Sussex CCG

In addition, a letter from Brighton & Hove Health and Well-being Board is expected.

1.19 FBC Assurance and checklists

In summary Duane finished with the following points:

- The TDA Checklist for capital investments has been completed
- The NHS England Checklist for capital investments has been completed
- A new TDA Checklist for safety and quality was received on 10 October 2014 and is currently being completed. This will be brought to the attention of the Board at a future meeting and any key issues highlighted which might have an impact on this approval;
- A Quality Impact Assessment has been undertaken, which identifies positive benefits for patients.

He asked Programme Board for the following to be affirmed:

- The continued commitment to the provision of District General Hospital (DGH) services for the people of Brighton & Hove;
- The continued commitment to provide high quality DGH services from the Princess Royal Hospital, which will continue to play a key role in the overall service provision profile of the Trust;
- The commitment of the Trust to develop and strengthen its leadership role in the wider health system as the Teaching Hospital and tertiary centre;
- The commitment to continue to work with commissioners during the implementation phase of the project;
- That given the relative costs, benefits, risks and timescales for implementation of the preferred option using public funding or PF2, the Board's preferred position is to proceed with seeking public funding given this will deliver benefits 2 years earlier than PF2;
- The need for a detailed agenda item in the coming months to explore the eventual contractual position further and for the Board to understand its rights and obligations under the Contract. This should also be the subject of a Board Seminar for the Board of Directors
- That the preferred funding for the remainder of the project (£412.8m) is Public Dividend Capital, but there is recognition that further discussions will be required with the Trust Development Authority and the Independent Trust Financing Facility on this – the proposed final outcome will be brought back to the Programme Board at a suitable future meeting;

1.20 Questions

There were questions and comments as follows:

- Graham thanked the team for the production of the case, which he thought was robust and as future proofed as could be with regards to meeting the future health needs of the population.
- Amanda agreed. She acknowledged that there is room for improvement in the liaison with commissioners (CCGs) who have concerns about the impact of decant and construction on business continuity and further emphasised the need to undertake more work with the CCGs in order to provide the reassurance that was required.
- Spencer added that the Financial Case was robust and would stand up to external scrutiny, and that the PF2 option would not be affordable because of the increased revenue implications. He therefore fully endorsed the FBC.

1.21 Approval

The FBC was unanimously approved by Programme Board. Programme Board agreed to recommend approval to the Trust Board.

Thanks were recorded to members of the team who had worked tirelessly to complete the case including Mark Frake, Paresh Patel, Miles MacDonald, Anna Barnes, Nick Groves (and Duane Passman for co-ordinating it). Amanda also expressed gratitude to Michael Schofield within Brighton and Hove CCG for his support and coordinating role across the Local Health Economy. All agreed that this was a historic moment and the next challenges would be to make it happen in reality.

1.22 Date of the next meeting

The next meeting will be held on **Friday, 21st November from 10.30-12.30 Meeting Room A St. Mary's Hall.**