St George's Healthcare NHS
NHS Trust

Name and date of meeting: **TRUST BOARD** **30th January 2014**
Document Title: **Outline Business Case for a Private Patient Unit (PPU)**
Action for the Board: Approve the recommended option in the business case i.e to procure a design, build and operate solution for a PPU through a private sector partner. Agree that the Trust should prepare a Full Business Case for presentation in February 2014 demonstrating how the deal will be structure and how the proposed contracts will protect the Trust from any risk and maximise the returns available
Summary: This Outline Business Case (OBC) presents the strategic case for developing enhanced private patients services, assesses the private healthcare market opportunity both in a national and local context, summarises the delivery options that the Trust considered, describes the commercial approach and procurement strategy followed (including the key contractual issues), and presents the financial case to evidence how the Trust will optimise its risk and reward profile and achieve best Value for Money from an outsourced PPU solution
Author and Date: Graeme McConnell, Project Manager PPU Steve Bolam, Director of Finance, Performance & Informatics
Contact details: Tel: 020 8725 2187 E-mail: steve.bolam@stgeorges.nhs.uk

Outline Business Case
for the development of a

Private Patients Unit
at
St George's Hospital, Tooting, SW17

December 2013

Executive Summary

1.0 Background to the Trust and private patients services

1.1 St George's Healthcare NHS Trust ("St George's" or "the Trust") achieved a revenue surplus of £6.286m on income of £641.8m in 2012-13. The total savings challenge that the Trust faced in 2012-13 was £37.17m, against which it delivered £36.97m. The Trust faces a similar level of financial challenge in 2013/14, and needs to identify further savings of £37.1m. The delivery of savings of this magnitude is highly challenging and carries significant risk for the Trust.

1.2 Over 90% of the Trust's income comes from delivering NHS clinical activity, either through CCG's or NHSE England, and only around 5% of Trust income is generated from commercial activities. In its Commercial Strategy 2013 – 2016, the Trust has set out a strategic objective to seek to grow commercial income as a means of reducing the impact of savings requirements on NHS services.

1.3 A key element of the Trust's existing commercial income is the revenue that the Trust earns from treating private patients. In recent years this income stream has grown by around 40% from £2.6m in 2009-10 to £3.7m in 2012-13. However, despite commendable growth, the absolute quantum of income that the Trust earns from this income stream is considerably lower than other London NHS Trusts are achieving, as is evidenced by published research for 2009-10 set out in the table below.

1.4 Following a detailed review undertaken in 2011, the Trust identified that the main factor contributing to its underperformance relative to other trusts is that St George's is possibly unique amongst London hospitals in not having a dedicated private patients unit (PPU).

1.5 The Trust wishes to continue to grow income from private activity and aspires to achieve the level of financial returns consistent with its peer group. Therefore, as part of its Commercial Strategy, the Trust has determined to seek to develop a dedicated PPU.

1.6 An options appraisal was undertaken during 2011-12 to look at strategies and risks associated with different delivery models for developing PPU. Based on estates constraints, but also due to the lack of available capital to invest, the option to outsource and procure a private sector solution was selected as the preferred route.

1.7 In July 2011 the Trust launched an OJEU procurement to seek to appoint a private sector partner to design, build, finance and then to operate a full service, standalone

private hospital on the site of the existing Atkinson Morley Wing car park.

1.8 This Outline Business Case (OBC) presents the strategic case for developing enhanced private patients services, assesses the private healthcare market opportunity both in a national and local context, summarises the delivery options that the Trust considered, describes the commercial approach and procurement strategy followed (including the key contractual issues), and presents the financial case to evidence how the Trust will optimise its risk and reward profile and achieve best Value for Money from an outsourced PPU solution.

1.9 Final solutions continue to be developed with the shortlisted bidders. Final Interim bids are due to be received on 20th December 2013 and following a further short dialogue process in early January, the Trust expects to issue an Invitation to Submit Final Tenders for receipt of confirmed Final Bids before the end of January 2013.

1.10 A Full Business Case will be developed on receipt of Final Bids and to reflect the solution put forward and agreed with the Preferred Bidder.

1.11 This case demonstrates that the Trust will get maximum value through the procurement of a design, build and manage PPU through a private sector partner (option 3a). This minimises the financial and operational risks to the Trust and maximises the financial returns available to the Trust through greater scale of the business opportunity.

2.0 Strategic Case: St George's Commercial Strategy

2.1 As part of the development of the Trust's overall commercial strategy to diversify income streams and become less dependent on its dominant NHS income, a detailed review of private patients' services at St George's was undertaken during 2011.

2.2 The review found that private patients' services at St George's were very limited and that income had remained relatively static at around £3m, representing approximately 0.5% of total NHS income, since 2002. St George's was identified as unique amongst its peer group in not having a dedicated PPU facility, and as a consequence the magnitude of private patient income at St George's fell considerably short of other London NHS Trusts.

2.3 The review concluded that new facilities were required to develop the private patients' service, and that since the Trust's capital programme was already committed any development would require external investment.

2.4 In the interim period a number of objectives were set to aim to increase non-NHS funded income:

- to increase the private patients income within the Trust;
- to increase the activity and income from overseas sponsored patients;
- to increase returns by focussing on higher margin private patient activity with minimum margins of 40% unless agreed at a lower rate for strategic reasons;
- to achieve the 2011-12 target of £4.34m income for private patients, up from the £3.2m achieved in 2010-11; and

2.5 The strategies identified to deliver these objectives included:

- to identify services in which the Trust has a strong clinical reputation and develop the private practice within the current resources and facilities;
- to link with the medical insurance companies to encourage them to authorise more private patients to being treated at St. George's;
- to work with consultants to improve the administration service and patient experience of private patients in order to encourage them to treat more private patients at St. George's;
- to link with the Private Hospitals Association to gather market intelligence of the inner London NHS private market and pursue opportunities to access the overseas market; and
- to obtain agreement from Trust Board that the long term development of a dedicated private patients facility on the Trust site could take place subject to the development satisfying both financial and operational benefits.

2.6 Plans were developed for the short (0-6 months), medium (6-18 months) and long term (> 18 months) to implement the Private Patients Strategy.

Short Term

2.7 In order to deliver the objective of achieving the £4.34m of private patients' income target for 2011-12, specific action plans were developed and implemented for a number of clinical specialties. Furthermore, in response to feedback and recommendation from Trust consultants, a dedicated Private and Overseas Business Development Manager was recruited and appointed in February 2012.

Medium Term

2.8 A number of actions were identified that could take place within 6-18 months to continue to grow the private patients business whilst demonstrating to consultants the Trust's commitment to develop a long term solution.

Dedicated Private patient beds

2.9 The main challenge to developing the private patient's service was seen as the lack of dedicated beds. Discussions with clinicians suggested that additional private activity could be brought into the Trust if more dedicated private rooms were available.

2.10 A medium term option to close and refurbish a ward to become a dedicated private patients ward was considered a possibility, with a further option identified that the facility could be managed either by the Trust or by an external private sector provider. The cost to fit-out and refurbish a ward to provide 12 single en-suite rooms was estimated at £1.0m. The income generation opportunity was quantified at £4m but with incremental operating costs to deliver this service of £3m the surplus potential was estimated at £1m in year 1.

2.11 The key risk identified was whether consultants were fully committed to repatriate sufficient activity from established private facilities to support the Trust's £4m income assumptions, while the Trust was exposed to carrying the up front investment in capacity and resources and the significant risk that the activity would not materialise.

Improved Hotel Services

2.12 The review identified that there was no differentiation in hotel services between private and NHS patients. Evidence obtained from other NHS Trusts identified that simple improvements such as a better quality food offering and the provision of newspapers achieves immediate results.

Private Patient Prices

2.13 Although significant levels of work had been undertaken to rebase private patient tariffs and benchmark against other private providers, it was recognised that further work was required. Target margins on all new activity were set at 50%.

Long Term

2.14 In order to develop a long term, thriving PPU and to maximise financial returns, the Private Patients' Strategy identified that the minimum requirement involved significant capital investment to refurbish surplus ward accommodation in order to create a dedicated facility. However, since the Trust's capital programme was fully committed it was recognised that the capital resource required for large scale investment was unlikely to become freed up for a PPU development.

2.15 The Trust's estates strategy offered scope to make space available for development on the St George's site rather than refurbish existing accommodation. Therefore, an alternative option was identified to commission a new build dedicated PPU facility, albeit with recognition that the capital investment would require to come from a third party.

2.16 The Private Patients' Strategy recommended that the Trust explore the new build option further. The preferred commercial model, based on examples seen at NHS Trusts elsewhere, was to offer a long term lease over a plot of land to a private provider who would build and operate the PPU. In return the Trust could expect to receive:

- payment of rent under a ground lease for the land;

- a profit share for providing the land, access to consultants, clinical support and access to high specification services such as ITU;
- as a minimum these income streams would be set at a level torecover the current profit on the existing private patients services; and
- further income generated from the supply of support services and utilities.

2.17 Soft market testing was undertaken with a number of key private providers in the market during 2011, including HCA, Ramsey, Aspen, Spire and BMI. All responded positively to the development opportunity and the commercial model, and so with this confidence the Trust proceeded to place an OJEU advert to launch a formal procurement to be conducted using the competitive dialogue process and with the objective to appoint a private sector partner to design, build, finance and operate a new dedicated PPU facility.

Private healthcare market assessment

2.18 In order to satisfy itself on the sustainability of the market for private patients services, and to provide a benchmark estimate of the potential financial returns available from an outsourced PPU solution, the Trust commissioned a commercial review and market assessment from Capita Symonds in September 2012.

2.19 In addition, the shortlisted private sector bidders taken forward into competitive dialogue were asked to present an initial outline submission containing their assessment of the market for private patients services in south west London.

2.20 The market analysis and intelligence derived from the above supports the strategic case for investment in PPU services at St George's. The market assessment considered:

- the national context of trends in private medical insurance cover;
- a review of revenue performance of private hospitals and NHS PPU's nationally;
- the local context of an assessment of the London market for private hospital services; and
- a review of existing competitor facilities in south west London.

National context – trends in private medical insurance (PMI) cover

2.21 The main funding source for the UK's independently run hospitals and NHS PPU's are patients presenting with private medical insurance cover. This traditional market has been under pressure in recent years with declining policy sales, but there is evidence to suggest that demand has stabilised during 2012-13.

2.22 According to research published by Laing & Buisson, UK spending on (insured and self-insured) private medical cover increased during 2012 by 0.3% in real terms (taking into account inflation (RPI)) to reach £4.4bn, as the average price paid for private medical cover, estimated at £1,100 in 2012, was little changed in real terms over the year. This period of stability in 2012 followed a contraction of 2.9% in real terms during 2011, and overall spending on PMI remains significantly below the estimated total of £4.94 billion in 2009.

2.23 Demand for individual PMI cover continues to slide despite a modest pick up in the corporate market. The number of individual paid policies decreased by 1.5%(or 15,500 policies) in 2012 following similar falls of 4.2% and 4.6% in 2011 and 2010 respectively, and is now below one million policies.

2.24 Company-paid PMI policies experienced modest growth in 2012 with an increase of 2%, building on a similar small increase of 1.2% achieved in 2011. However, there has been a small contraction in the number of people covered by company-paid

medical policies in recent years suggesting some large employers may have tightened eligibility criteria in order to cut costs.

2.25 Overall penetration of the UK population by private medical insurance cover was estimated at 10.8%, or just under 4 million lives, at the start of 2013. This is the lowest rate in more than 20 years, and down from a peak of 12.8% in 2002.

2.26 Regional data is not routinely published, but Government data estimates for 2006 indicate that the South East of England had the highest penetration with 18.5% of the population in this region covered by PMI, while the equivalent figure was around 17.5% within London. The UK national average at that time (in 2006) was 12.2%, and so it is clear that the catchment populations for a PPU at St George's enjoy significantly higher levels of PMI penetration than other UK regions.

National context – review of private hospital revenues

2.27 As a consequence of declining PMI penetration, the proportion of private hospitals' revenue which is derived from insured patients has slipped consistently over the past five years, accounting for just 55% (£2.1bn) of total revenues generated in 2012 compared with 65% in 2005.

2.28 Helping to make up for some of this fall, NHS patients using private facilities have in recent years accounted for up to a quarter of private hospitals' revenue (compared to 14% in 2005) and generating £1bn of revenue across the UK. Latest analysis, though, suggest that this source of revenue, which has bolstered private hospitals' market fortunes in recent years, may have peaked.

2.29 Hospital operator groups such as Spire, Ramsay and Nuffield have all reported increases in self-pay patients who now provide around 15% of revenues (£500M) for private hospitals, up by 0.5-1% percentage point despite the recession.

2.30 Overall, the weak UK economy has prompted more employers to seek cost savings by restricting health cover under their PMI policies, and vulnerable household budgets have put pressure on individual demand for cover, such that insured private patient volumes have experienced a steady decline. There is evidence that the decline in insured patients has now bottomed out, and the impact for private hospital operators has been partially offset by more consumers electing to self-pay for private treatment when the need arises.

National context – review of NHS PPU revenues

2.31 Research published by Laing & Buisson in 2011 estimated that the total private patient income of NHS Trusts in the UK was £430m in 2009-10. This represented around 0.6% of the NHS' total income, but revenues were estimated to have declined by just over 2% from £439m in 2008-09. Overall, there was no evidence of growth in revenues of NHS PPU's since the levels achieved in 2006-07.

2.32 More recently, in response to a Freedom of Information request in September 2013, the Department of Health announced that income from private patient procedures in NHS hospitals in England had risen by 12% in 2012-13 to £434m, and that the same NHS hospitals were predicting that private patient income would grow by a further 10% to £480m in 2013-14.

2.33 According to the British Medical Journal (BMJ) in July 2013, one in six NHS Trusts has started to offer private patient services in the past year and it is now estimated that 90% of all Trusts now offer private treatment options. There is now widescale acceptance of the role that developing private patients services can play in helping to offset Trusts' savings targets.

Local context – the London market for private hospital services

2.34 The healthcare market in South and South West London reflects the general pattern across London as a whole, that of large, well equipped private hospitals operating in a small geographical area alongside similarly well equipped and successful NHS private patient units.

2.35 The clinical acuity of work carried out in London generally tends to be at the more complex end of the market and the providers within this market each have a particular range of specialties or complexities they focus on. This is driven by the highly specialist nature of services provided within the major teaching hospitals and the consultants they attract.

2.36 All of the stand-alone London private hospitals list many more consultant users than might be expected in a similarly sized provincial independent hospital. This reflects the opportunity to attract private patients in London but also the propensity of consultants to use more than one facility for their private practice.

2.37 Anecdotal evidence from providers across London suggests that underlying demand has not reduced for private healthcare despite the economic downturn. Indeed, some NHS private patient units are operating at 90% occupancy and demand, particularly from the non-UK market, continues to be strong. Incomes generated by NHS private patient units within the catchment area have increased (in some cases substantially) in recent years, in contrast with NHS private patient units elsewhere in the country.

2.38 Whilst private medical insurance continues to be an important driver for demand, the nature of London and the services provided means that the self-pay or overseas state paid market also remains buoyant. London is still seen as a primary destination for international healthcare with new regions such as Russia and the former Eastern Bloc countries attracted to the standard of healthcare provided and other factors such as perceived prestige and quality of other cultural and recreational opportunities in the capital.

2.39 The following hospitals are seen as the main beneficiaries of international healthcare services:

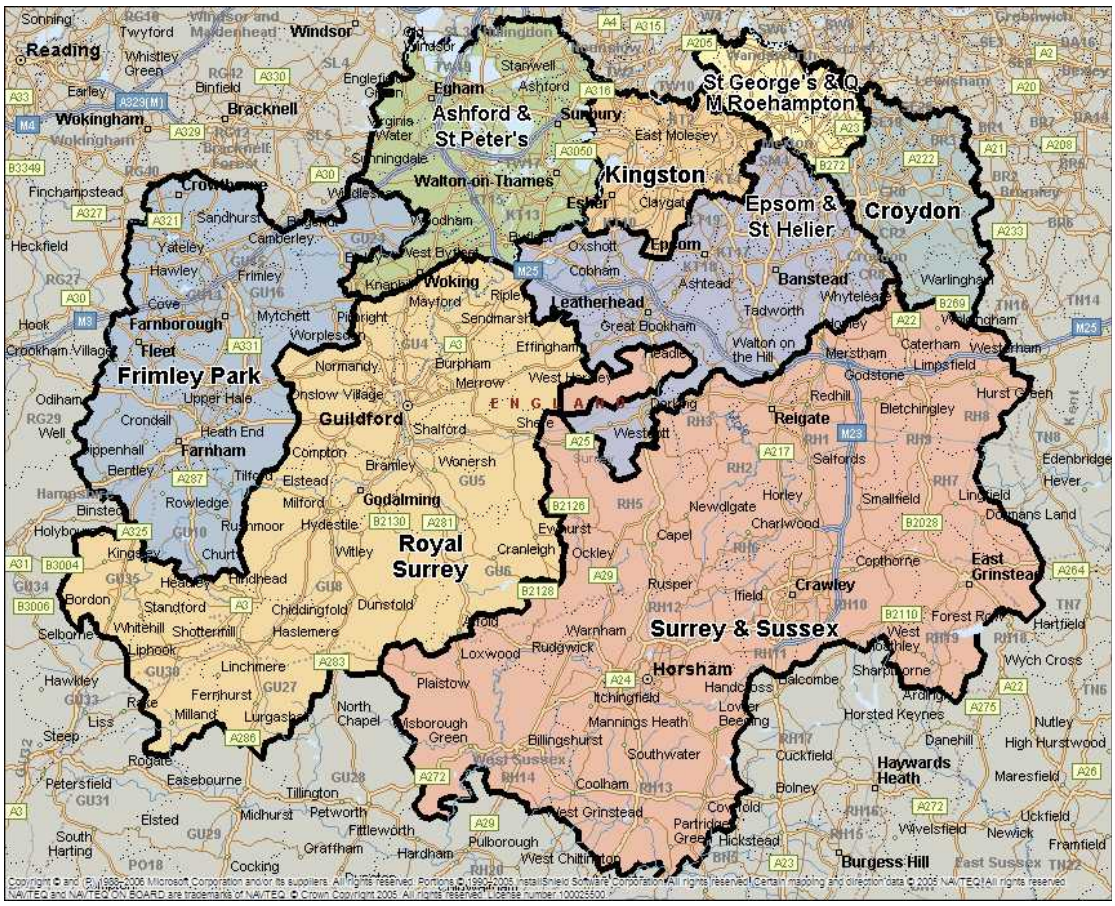
Private Hospitals	**NHS PPU's**
Bupa Cromwell	Royal Brompton & Harefield
The London Clinic	Royal Marsden
HCA – Wellington Hospital	Moorfields
HCA – London Bridge Hospital	Great Ormond Street
HCA – Harley Street Clinic	GSTS
HCA – Lister Hospital	Royal Free
HCA – Portland Hospital	Imperial College
	National Hospital Neurology & Neurosurgery

2.40 Capita Symonds estimate that excluding the value of the flights, accommodation and other expenditure by the patient and their relatives, the value of the international patient spend on medical treatment in London is approximately £250-300m a year.

2.41 It is estimated that there are over 7,000 international inpatients and over 100,000 outpatients' attendances a year. The average cost per treatment for an inpatient is over £20,000 and an average cost per treatment for an outpatient is £1,000. Accessing this market from a PPU at St George's presents a significant market opportunity.

Local context – south west London market assessment

2.42 St George's serves a local healthcare services population of approximately 1.3 million across South West London. For London, drive times alone may not be appropriate for defining local geographic markets due to the high use of public transport and the high volume of commuters. However, for a large number of Trust clinical services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, the Trust provides services to a regional population of around 3.1 million people from South West London, Surrey and Sussex.



2.43 The following table summarises the estimates of the populations living within the secondary and tertiary catchment areas, with St George's at the hub of the secondary catchments. PMI data by postcode district has been taken from estimates provided to us by bidders during the early stages of the PPU procurement and is sourced from CACI.

2.44 It suggests that on average 15% of adults in the St George's tertiary catchment area hold private medical insurance, representing almost 450,000 adult lives. Applying industry metrics of admission rates per insured head of population, and average hospital income per private admission, the local private patient market is estimated to be worth approximately £250M.

Territories	2012 Pop	5-Yr Growth	% PMI	PMI pop '000	Total market £'000s
St George's & Q M Roehampton	438,592	5%	15%	63,885	35,137
Epsom & St Helier	465,622	5%	14%	67,477	37,112
Surrey & Sussex	437,253	5%	14%	61,336	33,735

Ashford & St Peter's	367,827	5%	16%	57,762	31,769
Croydon	423,693	4%	13%	55,506	30,528
Kingston	339,416	7%	16%	54,106	29,758
Frimley Park	346,401	4%	14%	49,870	27,429
Royal Surrey	258,077	3%	15%	38,302	21,066
Grand Total	**3,076,881**	**5%**	**15%**	**448,244**	**246,534**

2.45 These estimates are substantiated and agreed by all of the bidders responding to the PPU procurement, and also by Capita Symonds who undertook a market assessment exercise for the Trust in September 2012. The estimates are for the domestic market opportunity and exclude international potential, which each of the bidders is seeking to develop.

Local context – review of existing competitor facilities in south west London

2.46 Capita Symonds undertook a review of local private and NHS hospitals within 5 miles and 25 minute drive time (off peak by fastest drive time) of St George's to help corroborate their estimate of a £250m market for south west London. The facilities identified are summarised in the table below.

Hospital	Provider	Location	Distance Miles (Mins)	Beds	Estimated Total Revenues
Parkside Hospital	Aspen	Wimbledon	3.4 (15)	69	£26m
The Chelsea Wing, Chelsea & Westminster	NHS	London	4 (20)	15	£9m
The Royal Brompton PPU	NHS	London	4.4 (20)	29	£18m
The Robert Tiffany Ward, Royal Marsden	NHS	London	4.4 (25)	25	£46m
The Lister Hospital	HCA	London	4.5 (25)	60	£36m
St Anthony's Hospital	Charitable Foundation	North Cheam	4.5 (25)	80	£19m
Bupa Cromwell Hospital	Bupa	London	4.8 (25)	116	£73m
New Victoria Hospital	The Victoria Foundation	Kingston on Thames	5 (25)	36	£12m
			TOTAL		**£239m**

2.47 **Parkside Hospital** is owned by Aspen Healthcare, which itself is owned by United Surgical Partners International. USPI has an excellent reputation for the quality of its surgical facilities and care in the US and this is reflected in the good reputation Aspen Healthcare enjoys in the UK. In addition to a wide range of elective surgical specialties, Parkside also concentrates on oncology, and provides an outpatient and day patient service in chemotherapy and radiotherapy at the nearby Parkside Oncology Clinic.

2.48 **The Robert Tiffany Ward, the Royal Marsden** is a small unit in terms of beds but is part of a substantial and growing private patient business within the Trust. The Trust is the highest earner from private patients within the NHS, with approaching 30% of total Trust revenues from fee paying sources. The Trust achieves high private patient incomes from diagnostic imaging and radiotherapy treatments rather than inpatient and day cases. The Trust has a strong international brand presence, and is likely to be amongst the first NHS Trusts to consider expanding overseas through franchising, or other commercial routes.

2.49 **The Lister Hospital** is owned by HCA and concentrates on a wide range of more general surgical and medical services. HCA has regularly invested in new services and facilities at the hospital, including the recent opening of a £1M endoscopy suite to complement its existing gastroenterology service. The hospital has just opened a new £3M critical care unit, the culmination of a four year programme of development, expansion and renewal of The Lister costing a total of £20M. In addition to the main hospital, the Lister has also invested in the Chelsea Outpatient Centre with 70 practising consultants and a private GP building on Kings Road, plus a private GP centre at Lower Sloane Street.

2.50 **St Anthony's Hospital**, Cheam is owned and run by a religious order and is a charitable foundation. It has eight Level 3 critical care beds supporting its strategy to carry out complex surgery, particularly cardiac procedures. Its' consultant users include many from St George's Hospital, and presently appears to cater well for their needs.

2.51 **Bupa Cromwell Hospital** was acquired by Bupa in 2008 and marked Bupa's re-entry into the private hospital provider market after the prior sale of their network to Spire. The Cromwell has over the last 30 years established itself as one of the leading private hospitals in the UK. It has invested heavily in emerging medical technologies, from diagnostic scanning through to the use of the gamma knife in surgery. It claims 400 consultant users and offers a range of complex specialties alongside more generalist work, including complex paediatric surgery. It continues to attract a high

proportion of non-UK patients alongside local referrals. Bupa has announced that the hospital will undergo a major redevelopment and reconfiguration, and it is understood that this will involve the provision of additional angiography operating theatres, upgraded diagnostic imaging, additional critical care capacity and further ward beds, and more. The extensive redevelopment may cost in the region of £100M, it is believed.

2.52 **The New Victoria Hospital** has had a chequered ownership history but appears to have now secured financial stability and is also about to invest in a new development. This will build an extension to the existing hospital in which it will provide four new operating theatres with ancillary accommodation and de-contamination unit, a 16 bedded day unit, a high dependency unit, a new pharmacy, an enlarged pathology laboratory, six additional Consulting rooms, and an enlarged diagnostic imaging department. Total bed numbers will increase to 47 and the existing building will also undergo a complete refurbishment and upgrade. The hospital sets out to cater for a local elective market in and around south west London and Surrey and concentrates on more general, rather than tertiary specialties, including cosmetic surgery.

Summary of Strategic Case

2.53 The Trust has a stated objective as part of its overall commercial strategy to diversify and grow its income streams to become less dependent on NHS income. A review of those commercial income streams identified that the Trust was under-performing on private patient revenues relative to peer group London NHS Trusts.

2.54 Market assessments, undertaken at both national and local levels, identified that many NHS Trusts are enjoying success in developing private services, that there is strong international interest in the London healthcare market and the specialist services that the major London teaching Trusts can offer, and that the St George's catchment population enjoys considerably larger penetration of private medical insurance cover than the UK national average.

2.55 Considerable interest from private providers in the proposal to invest in and run a dedicated PPU on the St George's site has also been confirmed.

3.0 Economic Case: Options explored for private patients income growth

3.1 This section of the OBC documents the range of options that were considered in response to the strategic decision to seek to develop enhanced PPU services. The process of appraisal is described including:

- identifying the critical success factors for the project;
- descriptions of the list of options considered;
- the economic appraisal; and
- the identification of the preferred option.

3.2 The economic case demonstrates that by outsourcing to the private sector to design, build, finance and operate a PPU and offering a long leasehold interest in the land the Trust has selected the best option to meet its objectives to maximise the financial returns whilst at the same time providing the best possible clinical outcomes for consultants and patients from a convenient, modern, high quality and professionally managed PPU.

Critical Success Factors

3.3 The critical success factors for this project are considered to be:

- Potential affordability and value for money – how well the option
  - matches the likely availability of funding, where the Trust ideally does not want to make any capital or debt funding contribution;
  - provides a level of guaranteed income for the Trust; and
  - provides a mechanism for the Trust to share in any upside in the financial performance of the PPU

- Clinical support – how well the option meets the clinical service requirements and engages the St George's consultant (and clinical) body to want to refer patients by providing a convenient, modern, high quality, and accessible, professionally managed facility;

- Patient service – the extent to which the option offers better patient services for private patients at St. George's through dedicated, high quality and sustainable facilities and equipment;

- Patient choice – the extent to which the option provides choice to private patients of where they would like to be treated and can offer a possible solution for patients who might not qualify for NHS treatment, such as overseas patients;

- Staff benefits – the extent to which the option is likely to contribute towards retention and recruitment of new consultants and clinical staff to the Trust;

- Estates strategy – how well the option meets the requirements to provide a sustainable facility that fits with the Trust's overall estates strategy and enhances the building environment at the St George's Hospital site; and

- Brand reputation – the extent to which the option enhances the reputation and brand of St. George's Healthcare NHS Trust.

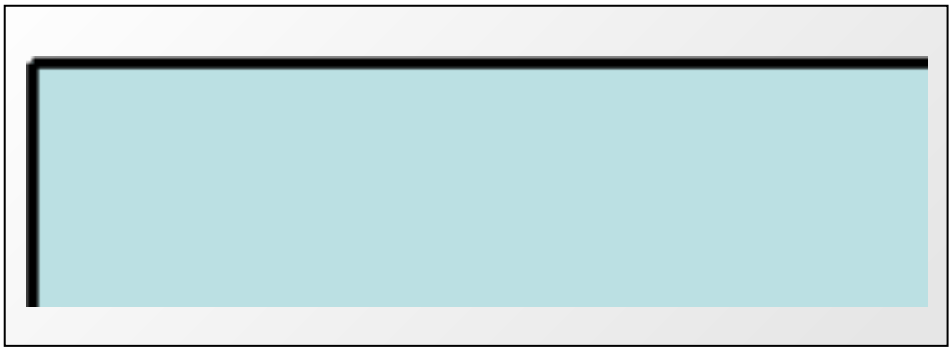
4.3 TBR (14) 3

List of options considered

3.4 Possible options for a 5 year strategic private patients plan were presented in a paper to the Trust's Commercial Board in May 2012. These options were based around three themes of

1. Incremental growth of existing business;
2. Dedicated build (by St George's); and
3. Stretched target (dedicated build by a private partner) with some variant scenarios presented under the dedicated build themes.

3.5 The diagram below pictorially explains the generic types of options considered in May 2012 with some high level financial estimates at that time.



3.6 Following discussions with providers, industry experts and clinicians it was considered under Option 3 that a building of less than 40 beds was unlikely to be commercially viable and that therefore the target for income generation would need to be greater than £20m.

3.7 **Long List of Options**

3.8 The following table submitted to Commercial Board in May 2012 sets out the long list of options and demonstrates the assessed pros and cons of each option plus brief details around the identified risks and financials.

Scenario 1:	***Incremental growth– creating sub units within the trust in specific areas.***		
Pros:	*Cons:*	*Risks:*	*Financials:*
Brings money quickly into the trust	Requires capital money for conversions	Business as normal capacity concerns means that the capacity could easily changed back to NHS use	Based on current financial modelling could bring in up to £8m in the next 2 years based on current activity assumptions. Profit from the current service is ~ 35% on average
	Unclear where NHS and PP stop and start		

Scenario 2a:	***Dedicated build offsite (potentially St. Anthony's site)***		
Pros:	Cons:	Risks:	Financials:
Offsite capacity already built	Already set-up to run PP	Unsure whether site will be sold or change of use occurs	TBC – would generate profit from the work, but need to remove our FM & estates elements from our costs and add in providers costs implication on profit would need to be investigated
Some consultants	Consultants would still		

already use the facility	remain offsite for their PP activity		

Scenario 2b:	***Dedicated build within St. George's Site funded by St. George's and run by SGH***		
Pros:	Cons:	Risks:	Financials:
Trust in control of the whole service and hence would get a better return on investment	Requires trust capital to build the unit	Trusts core business is NHS work not PP	Requires significant capital and resource, recent exploratory work shows modular build for 15 beds would cost £2m of capital plus cost of enabling works, theatres and imaging equipments and installation. (Modular build beds only for 50 beds ~ £10m)
	Consultants would not transfer their work (in the long term) unless the size of the unit was significant for expansion and the unit had it's own dedicated services.	Other NHS activities are seen as more important and therefore limited resource to implement the scheme.	Potential to bring in up to £16m average PP unit across London.

Scenario 2c:	***Dedicated build within St. George's Site funded by St. George's but run by a PP provider***		
Pros:	Cons:	Risks:	Financials:
Trust has more opportunity to generate surplus on same size of activity than option 3.	Requires capital for build	Trust does not have capital for such a scheme	Requires significant capital and resource, recent exploratory work shows modular build for 15 beds would cost £2m of capital plus cost of enabling works, theatres and imaging equipments and installation. (Modular build beds only for 50 beds ~ £10m)
Run by experts in PP	Continued maintenance and upgrade would be required by the trust.	Relationship with a provider relatively untested at SGH	

Scenario 3a:	***Dedicated build within St. George's Site funded and run by external provider***		
Pros:	Cons:	Risks:	Financials:
Unit built by external capital	Trust will receive less of profit from the work than options 1 & 2	Dependant on ability of PP provider to generate business	Model would be based on a lease, SLA for services provided and a profit share.
Run by experts in PP		Dependant on engagement by the clinicians	Trust would receive profit and not have to significantly invest for any return, rates for SLA items could all include at least 20% profit
Keeps consultants on site for their PP work			

Scenario 3b:	***Dedicated build within St. George's Site funded and run by external provider with consultants as a partner in the build***		
Pros:	Cons:	Risks:	Financials:

Unit built by external capital	Trust will receive less of profit from the work, than option 1 & 2	Dependant on ability of PP provider to generate business, reduced by consultant by in	Model would be based on a lease, SLA for services provided and a profit share.
Run by experts in PP		Oft review when completed may impact the ability to undertake this option.	Trust would receive profit and not have to significantly invest for the return
Consultants more actively associated with the PP service & trust			
Enhances trusts negotiating power in order receive a better return on the profit share than option 3a			

Scenario 4	***Do Nothing***		
This is not a viable option as it does not implement the St George's commercial strategy			

3.9 The key criteria used to determine which scenarios to shortlist for further appraisal were identified from the critical success factors. Particular emphasis was placed on the following requirements:

- **Capital availability** – due to the lack of Trust capital to invest, the selected options must provide a solution that does not require any significant capital or debt funding contribution from the Trust, or result in any debt funding being consolidated onto the Trust's balance sheet.

- **Clinical support** - selected options must meet the clinical service requirements and engage the St George's consultant (and clinical) body to want to refer patients by providing a convenient, modern, high quality, and accessible, professionally managed facility. Adjacency to their NHS practice was identified as a key selling point and critical success factor for the Trust's consultant body.

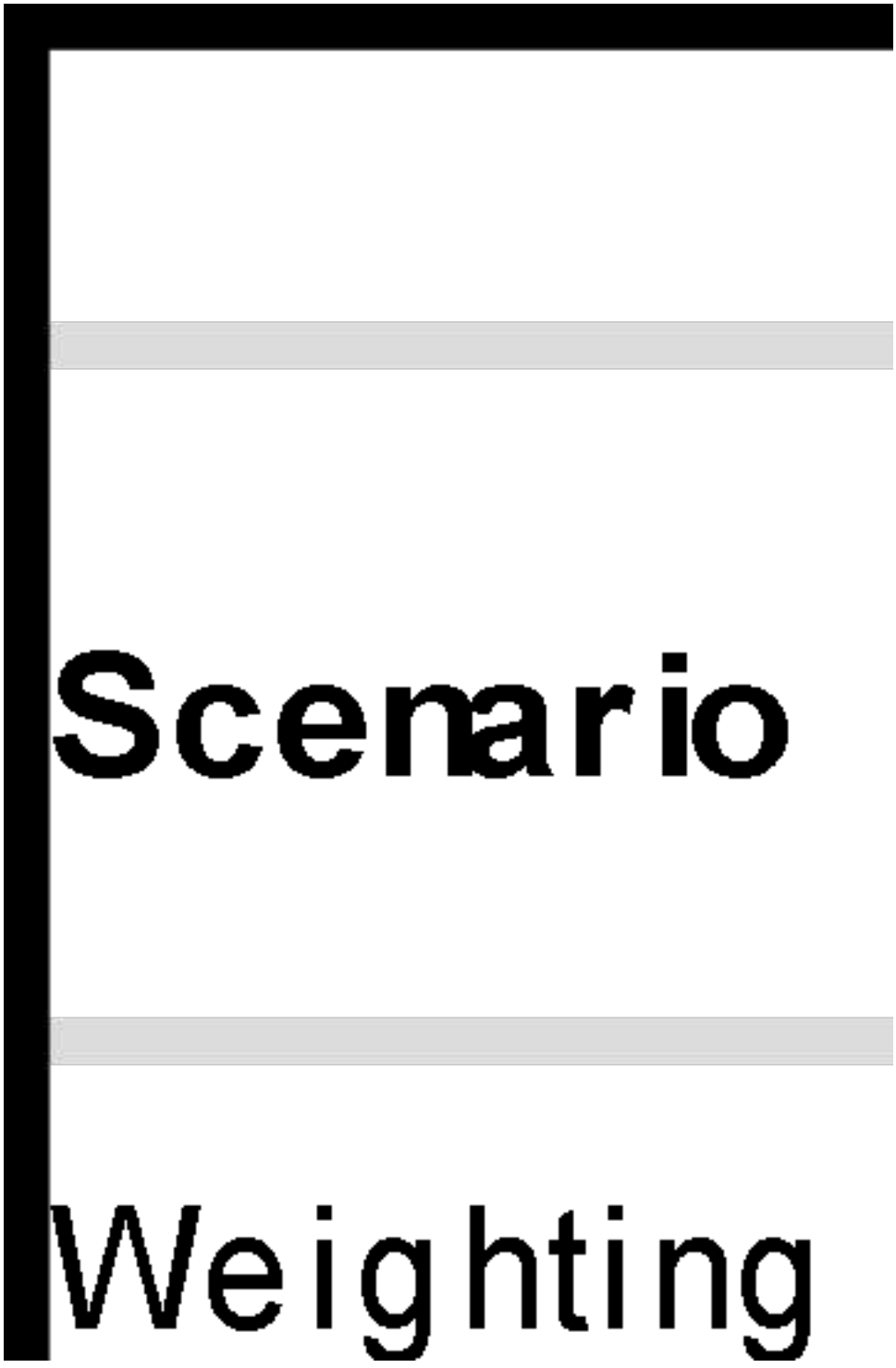
- **Management resource –** the recent appointment in February 2012 of a dedicated Private and Overseas Business Development Manager ensures that the Trust had the necessary management resource in place with which to pursue the incremental growth plan set out as Scenario 1. However, it was acknowledged that the Trust did not possess the depth of management resource and experience that would be required to pursue a strategy of managing a dedicated new build PPU. Feedback from consultants suggested that there was a lack of support for a Trust managed new build solution

- **Patient service and choice** – the extent to which the option offers more choice and better patient services for private patients at St. George's through dedicated, high quality and sustainable facilities and equipment was assessed and considered best met from a dedicated new build solution;

- **Estates strategy** – the requirement to provide a sustainable facility that fits with the Trust's overall estates strategy and enhances the building environment at the St George's Hospital site

3.10 The following table summarises the assessment of each of the scenario options

considered and the reasons for short-listing or rejecting when judged against the critical success factors. In some cases options were judged to meet the critical success factors but were similar and slightly inferior to other shortlisted options so were rejected too.



Short List of Options

3.11 Overall, when measured against the key criteria, the shortlisted options selected for detailed appraisal were as follows:

Option 1 - Incremental growth– creating sub units within the trust in specific areas.

3.12 This scenario is essentially an in-house model which seeks to build on the Trust's recent success in growing its existing private patients business through continued organic growth plans and through targeted business cases to capture incremental income growth opportunities.

3.13 Modest capital investment is required to refurbish and create dedicated private patient rooms within clinical specialty areas. Capital investment proposals will be evaluated against specific business cases carrying the support and commitment of the specialty group consultants to repatriate private activity into the Trust's facilities.

3.14 The model assumes a phased approach to development, with planned step changes to provide additional capacity. During Phase 1, diagnostics and theatre provision will initially continue to be met by accessing NHS facilities either out of hours or at the beginning or end of a NHS theatre list, and then subsequently from dedicated temporary solutions funded from revenue. Phase 2 involves capital investment to refurbish and extend an area of the St George's site to create permanent capacity for a ring-fenced dedicated PPU having its own theatre capacity and beds.

3.15 As capital is scarce and this option is Trust funded and as a number of St George's consultants may not fully support a Trust run facility, this option is by definition more limited in scale.

Option 3a – Dedicated build within St George's site funded and run by external provider

3.16 This option is the outsourced model procured from the private sector using the competitive dialogue procedure in accordance with the requirements of the Public Contracts Regulations 2006.

3.17 Under this model the successful independent sector bidder will design, build, finance and then operate a full service standalone private hospital.

3.18 The Trust will measure potential affordability and value for money by how well the solution

- meets the core requirement whereby the Trust does not want to make any capital or debt funding contribution to the project;
- provides a level of guaranteed financial surplus for the Trust that is at least equivalent to the financial benefits that the Trust achieves from the current private patients service; and
- provides a mechanism for the Trust to achieve additional financial returns by sharing in the upside financial performance of the PPU.

3.19 **Financial Risk Assessment**

Option 1

3.20 Under Scenario1 the Trust will assume the equity risks and rewards that will follow from the development an in-house PPU solution. Investment of both capital and revenue will be required to fund step-changes in the scale of business operations. These are described more fully in the Financial Case chapter, but the principal investment requirements are considered as follows:

- £1.2m initial capital investment to provide dedicated patient beds, and facilities for staff and visitors on the third floor of Atkinson Morley;
- additional WTE administrative support for the private patients team, and increased indirect allocation of corporate and divisional overheads;
- revenue investment to rent temporary operating theatre capacity during Phase 1;

- significant capital investment of estimated £4m (in 2013/14 prices) at Year 10 to fund the development of Phase 2; and
- recruitment of senior executive management resource to deliver Phase 2.

3.21 Under this option the Trust will also take all of the operating risks associated with maintaining and growing the scale of the business and securing Consultant commitment to operate at St George's.

3.22 In return for bearing the risks associated with operating an in-house PPU, and funding the capital and revenue investment required to create the necessary infrastructure, the projected annual surplus from increased private patients income will fully accrue to the Trust.

3.23 Appendix 1 shows how the Trusts current revenue position builds with the investments and additional capacity highlighted above to create the initial base model. This uses the current Private Patient workplan and the Project Initiation Document prepared as part of the Trusts detailed 2 year CIP plans to derive the income and cost assumptions. This is assumed to grow further from year 11 after the investment noted above to build bespoke capacity is factored in.

Option 3a

3.24 Under the outsourced model the Trust is transferring the equity risk of ownership to the private sector partner, who will be responsible for raising the capital required to build the infrastructure, and to subsequently develop the private patients' business. In return for assuming the financial and operational risks, the private sector partner will retain the net financial returns earned during the life of the Operating Agreement entered into between the private sector operator and the Trust.

3.25 In addition to the Operating Agreement, the Trust will grant a Lease over the land on which the PPU is to be constructed. The Trust will also supply certain clinical support services to the private sector operator under Service Level Agreements (SLA).

3.26 The cashflows to the Trust under option 3a will come from the following sources:

- one-off initial payment for the land from a property developer;
- fixed, guaranteed annual revenue share from the operator;
- fixed and indexed (non-guaranteed) overhead fee from the operator towards service charges and the maintenance of common parts;
- a variable (non-guaranteed) share of incremental revenue generated by the operator above a minimum threshold;
- profit from the supply of clinical support services under SLA's

3.27 By implementing option 3a, the Trust considers it is accessing a private sector partner's capital to deliver an off balance sheet solution for the Trust, and that this model will generate higher financial returns for the Trust whilst substantially transferring all of the financial and operating risk to the private sector partner.

3.28 **Economic Appraisal**

3.29 In this section, the economic returns of the project are evaluated over the whole life of the project. The economic appraisal follows the guidance set out in the HM Treasury Green Book and guidance on public sector business cases.

3.30 It is a means of determining the best value option – this is broadly the option with the highest net present value of future cashflows to the Trust, taking into account the

qualitative benefits determined by the non-financial appraisal. It compares the relevant cash flow of each option over the whole life of the project discounted to present day values.

3.31 The main principles and assumptions used for modelling were:

- the base year (ie Year 0) for the appraisal period is 2015/16, since this is the financial year in which the Trust would expect to award a contract and receive a developer payment for the land;
- cashflows for the relevant capital and revenue costs as described above;
- cashflows are index linked at 2.5% pa
- optimism bias is shown as a separate cashflow.
- the operating agreement with the successful bidder will be for 30 years and this forms the basis of the appraisal period;
- the rate of interest used to discount the cashflows is 3.5%;
- all cashflows are assumed to be exclusive of VAT
- sunk costs and ancillary costs, such as any cost of PFI variation or costs relating to the multi-storey car park and link structures into Atkinson Morley Wing are excluded

3.32 The results of the modelling for the two options are attached as an Appendix and summarised in the table below.

3.33 Appendix 2 shows the cashflows for option 1 over the full 30 year period. Appendix 3 shows the cashflows for option 3a over the full 30 year period.

Scenario 1	**Undiscounted £'000**	**Net Present Value £'000**
Capital investment	-6,195	-5,823
Annual PPU Surplus	102,677	56,070
Total projected cashflow	96,482	50,247
Risk adjustment	5%	-2,803
Risk adjusted NPV		47,444

Scenario 3a	**Undiscounted £'000**	**Net Present Value £'000**
Developer payment for Land	2,500	2,415
Guaranteed revenue share	15,000	9,196
Fixed overhead fee	10,537	6,064
Variable upside revenue share	131,797	67,440
Operator payments to Trust	**159,834**	**85,116**
Trust profit on SLA services	45,190	24,081
Total cashflow to Trust	**205,024**	**109,197**
Optimism bias	10%	- 9,152
Risk adjusted NPV		**100,045**

3.34 Substantially the entire cashflows under scenario 1 are at risk, since the Trust is bearing all of the business, operational and market-related risks in arriving at the annual surplus retained from PPU services. A risk adjustment of 5% of the net present value of Annual PPU Surplus is applied in the economic assessment, resulting in a risk adjusted NPV of £47.4m.

3.35 Under scenario 3a, the developer payment for the land (which is due on financial closure) and the guaranteed revenue share are fixed payments which are supported by parent company guarantees. The Trust considers that neither is at risk. The fixed overhead fee is not guaranteed, but it is an index-linked fixed annual payment which is not dependent on business activity levels.

3.36 The variable upside revenue share, and the Trust profit on SLA services, are at risk should the operator underperform relative to its business plan. A sensitivity analysis of 10% of the net present value of these cashflows has been applied as an Optimism bias resulting in a risk adjusted NPV of £100.04m.

3.37 **Economic appraisal - Preferred Option**

3.38 The conclusion drawn is that the shortlisted scenario options carry a markedly different level of risk, with Scenario 1 assessed as the riskiest option since the Trust is placing capital and revenue costs at risk in pursuit of developing a market opportunity where the Trust has limited presence and experience.

3.39 Scenario 3a offers the opportunity to access the skills and experience of established, successful private sector providers and to achieve greater financial returns for substantially no risk to the Trust.

3.40 The economic appraisal suggests that the private sector partner would require to underperform its business plan by nearly 50% over the initial 30 year term before the NPV of cashflows from a Trust-developed in-house solution might potentially become more attractive. Given the calibre and track record of the shortlisted bidders, such a level of sustained underperformance against plan is considered unlikely.

3.41 In the earlier years when the risks to the new build are more considerable as the PPU is established which is reflected in the submissions from the bidders through lower anticipated revenues and lower revenue shares and payments to the Trust, the private sector option (option 3a) still considerably outperforms the Trust option (option 1)

3.42 It is clear that the outsourced solution under Scenario 3a is the preferred option.

4.0 Commercial Case: Procurement strategy

4.1 This section describes the Trust's approach to the procurement strategy, the key procurement requirements, sets out the commercial structure that the Trust will enter into with the preferred bidder, and summarises the legal structure and key contractual protections for the Trust.

Approach to procurement strategy

4.2 The Trust's objective is to appoint a suitable private sector partner to undertake the design and construction of a new PPU facility at St George's hospital, and then to operate the PPU facility.

4.3 As such, the complexity of the procurement extends beyond a straightforward new build of facilities, design and construction project by adding the challenges of also entering into a contract for services with the successful operator. Identifying the operator solution within the procurement specification was considered vital to gaining the support of the Trust's consultant body for the project.

4.4 The Trust sought specialist legal advice from the procurement team at Capsticks, Solicitors before proceeding. For complex procurements, the Public Contracts Regulations 2006 (as amended) provide for four main procurement procedures.

1. Under the **Open** procedure any interested party is invited to tender and those who respond to the OJEU notice receive full contract documentation. There is no ability to shortlist candidates by undertaking a pre-qualification process and contract negotiations are not allowed.

   This option was assessed and discarded because the Trust had insufficient clarity of the procurement solution and the commercial model to be able to develop full contract documentation at the outset.

2. Under the **Restricted** procedure, Contracting Authorities undertake a pre-qualification process and invite only shortlisted candidates to tender. Contract negotiations are not allowed.

   This option was assessed and discarded for similar reasons around lack of clarity at the outset on the solution and commercial model, which implied a requirement to negotiate.

3. Under the **Competitive Dialogue** procedure, Contracting Authorities undertake a pre-qualification process and then invite short listed candidates to participate in a dialogue process during which any aspects of the project may be discussed and solutions developed. The Contracting Authority can continue the dialogue until it identifies one or more solutions that are capable of satisfying its requirements. It then closes the dialogue and invites final tenders. Only limited discussion and clarification is permitted once the dialogue stage has closed which does not amount to "negotiation".

   The Competitive Dialogue procedure can only be used for "particularly complex contracts" where at the outset the Contracting Authority:

   - is not objectively able to define the technical means capable of satisfying its needs or objectives; and/or
   - is not objectively able to specify the legal and/or financial make-up of the project.

   In addition the Contracting Authority must consider that the use of the Open or

Restricted procedure will not allow the award of the contract.

This procurement option was assessed as best suited to meeting the Trust's needs having regard to all circumstances, but in particular because of the flexibility it offered to develop and refine acceptable solutions during the dialogue process whilst also helping to ensure Value for Money by sustaining competitive tension throughout the procurement.

4. Under the **Competitive Negotiated** procedure, Contracting Authorities undertake a pre-qualification process and then issue an invitation to negotiate. There are no detailed rules as to how the negotiations should take place and unlike the Competitive Dialogue procedure there is no formal end to the negotiation phase before contract signature. In practice there has often been substantial negotiation following the appointment of a preferred bidder when competitive tension is no longer present.

   Treasury guidance states that any Contracting Authority considering using the Negotiated procedure should clearly set out the justification in writing after seeking advice from its commercial department, legal team and lawyers and/or external professionals as appropriate before advertising the Contract Notice in the OJEU. Contracting Authorities should be aware that the European Commission may scrutinise any use of the Negotiated procedure

   This option was considered and discarded due to the substantial risk of failing to achieve best value for money and the possibility of a subsequent procurement challenge.

4.5 The Trust decided to proceed using the Competitive Dialogue procurement process and an OJEU advert was placed in August 2011. Some 25 independent sector providers expressed an interest to receive a Pre-Qualification Questionnaire (PQQ), and 7 candidates submitting PQQ responses were shortlisted to progress into Dialogue.

4.6 Further soft market testing was undertaken with the shortlisted candidates prior to the commencement of the dialogue process, and the Trust used the opportunity to work with its legal advisers to develop an outline procurement specification, identify its preferred commercial structure, and to facilitate a structured engagement session for each bidder to meet with representatives of the Trust's consultant body.

4.7 Subsequently, an Invitation to Participate in Dialogue (ITPD) was issued to the 7 shortlisted candidates in January 2013 calling for initial outline submissions (ITPD Responses) by March 2013. The ITPD set out the basis for evaluation of the ITPD Responses and advised that a **maximum** of 4 candidates would be progressed into stage 2 dialogue.

4.8 On receipt of the ITPD, three peripheral candidates voluntarily chose to withdraw from the procurement. Of the subsequent ITPD Responses received, one submission was evaluated as being inadequate and therefore the Trust shortlisted 3 candidates to progress into stage 2. These were Aspen, HCA and Spire.

4.9 Almost immediately, Spire chose to withdraw from the procurement. They referenced a number of factors, none of which in isolation drove their decision, but when taken together caused Spire's executive management team to consider that the PPU project is too high risk relative to other strategic priorities.

4.10 The Trust has progressed a comprehensive Competitive Dialogue procurement

process with two remaining bidders – Aspen and HCA.

Key procurement requirements

4.11 As outlined above, the PPU project seeks to appoint a private sector partner to design, build, finance and then to operate a new, standalone private hospital facility on the site of the car park adjacent to Atkinson Morley Wing.

4.12 Decisions on the design of the building, the schedule of accommodation, the specification of clinical and diagnostic equipment, and the clinical treatments to be offered will be for the bidders to determine reflecting their assessment of the market opportunity and capturing the output from their discussions with the Trust's clinicians.

4.13 The Trust's key requirements are summarised below.

- *Financial requirements*

The key financial objective from the procurement is to maximise the recurring annual income accruing to the Trust.

The Trust will not make any financial contribution to the overall capital requirement of the project; nor will the Trust take any debt funding relating to the project onto its balance sheet.

- *Clinical services*

In their ITPD Responses, both bidders requested dedicated space within Lanesborough Wing to deliver private obstetrics and specialist paediatric inpatients services. The Trust has reviewed various options to try to meet this request, but concluded there is insufficient capacity within the built and planned estate to release space for private services without compromising front line NHS services.

A possible solution could become available once the outcome of the Better Services Better Value (BSBV) review of NHS services in south west London and the surrounding areas is published and the Trust has a clearer view of NHS estate requirements. Until then, and for the purposes of their final bid submissions, the bidders have been directed to exclude obstetrics and paediatric inpatients services from the initial phase of PPU development.

The bidders also have ambitions to invest in radiotherapy capability, but the business case appears dependent on NHS volumes to be commercially viable. The Trust has made clear this is a commercial decision for the bidders to consider, and that whilst it is acknowledged that some NHS patients could benefit from radiotherapy provision at St Georges, the Trust has no intention to proactively move away from its existing NHS partnerships.

- *NHS activity in the PPU*

The Trust outsources around £4m pa of NHS waiting list initiative activity to local private providers. The Trust will offer first refusal to the PPU to undertake this (and future outsourced NHS work) at sub tariff with the Trust retaining a small margin, but the Trust will not commit to volume guarantees.

The PPU operator will not be permitted to register for NHS Choose & Book activity.

Commercial Structure

4.3 TBR (14) 3

4.14 The commercial structure that the Trust is seeking to implement follows the principles of a landlord and tenant model, where the Trust will grant a long term leasehold interest in the land and enter into an operating agreement with the successful bidder.

4.15 In return, the Trust's financial reward will comprise a combination of:

- fixed and guaranteed rental payments due under the lease;
- variable royalty payments due under the operating agreement and based on a share of the PPU's revenue; and
- income from the supply of support services into the PPU under Service Level Agreements.

4.16 PricewaterhouseCoopers (PwC) advised the Trust on financial and commercial matters and led the dialogue sessions with bidders to explore lease structuring and funding options designed to drive out the best possible financial deal for the Trust.

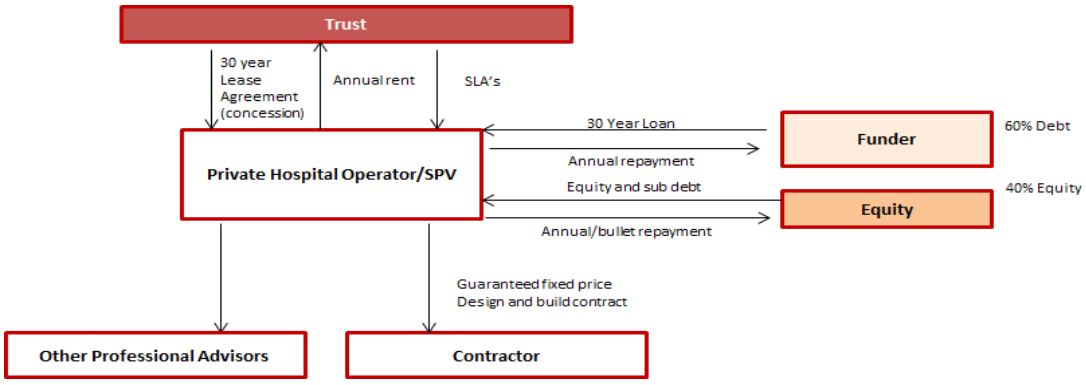
4.17 The models that the Trust assessed are described below.

4.18 ***Project Finance***

4.19 Project finance, or limited recourse finance, is the long-term financing of infrastructure and industrial projects based upon the projected cash flows of the project rather than the balance sheets of its sponsor, with the asset reverting to the procuring body at expiry.

4.20 Under this model funders are exposed to the performance risk of the PPU operator which means that they will only advance a proportion of the funds required for the project, typically not more than 60% of the total requirement, with the bidder required to fund the balance from equity or other means.

4.21 A diagrammatic summary of the model is set out below.



4.22 The Trust has ascertained that a number of banks are interested to follow this model and to lend to the PPU project, but that indicative loan to value ratios are around 60% with the debt priced at circa 300bps above base for a 25 year tenor. Combined with a requirement to achieve equity returns on the balance of the project funding, it is estimated that the weighted average cost of capital under the Project Finance model exceeds 8% pa.

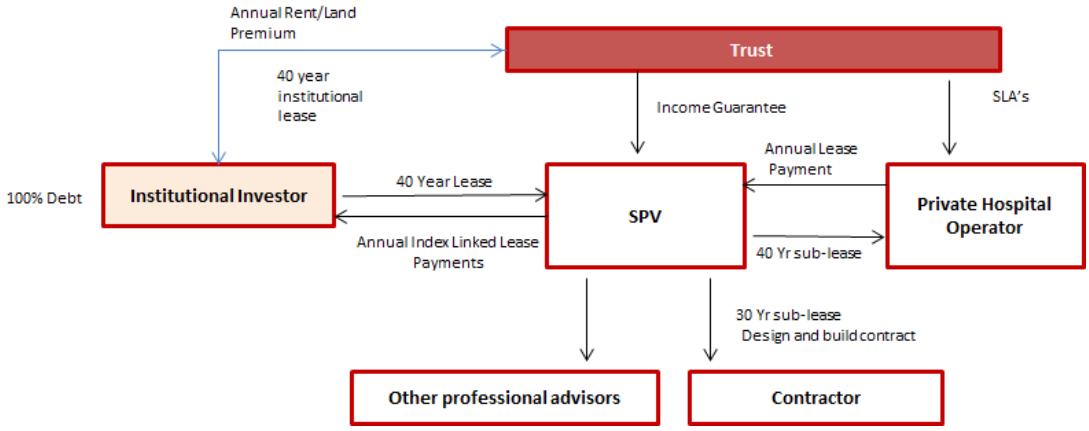
4.23 The Trust has assessed that the Project Finance model is the simplest to implement but results in a relatively expensive blended cost of finance.

4.24 ***Strip Income***

4.25 A strip income model is typically where an investor, such as a pension fund, forward funds a new development in conjunction with a property developer against a pre-commitment of the Trust to enter into a long term lease. The Trust would then enter into a back to back, or mirrored, sublease to the PPU operator.

4.26 The advantage of structuring a deal this way is that the institutional investor is looking to the strong covenant of the public sector body as its tenant, and will therefore fully fund the development at a competitive cost of funding.

4.27 A diagrammatic summary of the model is presented below.



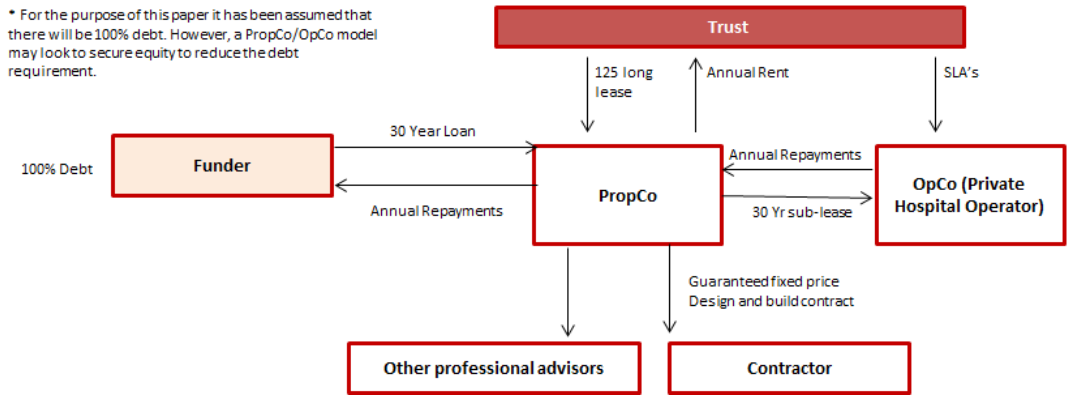
4.28 Indicative terms in the market for an income strip model for a 35 year term, with the facility reverting to Trust ownership and control at the end of 35 years, are an indexed linked yield of 4.5%.

4.29 However, whilst the strip income model offers a lower cost of capital, the structure requires the Trust to take the debt financing for the project onto its balance sheet. The Trust has determined that a key financial objective is to avoid this, and therefore the Trust has assessed that whilst the strip income offers the cheapest cost of finance, the balance sheet implications are probably not acceptable.

4.30 Quasi-freehold PropCo/OpCo

4.31 Under this model a funder/developer takes a long term interest in the land; a lease term in excess of 99 years is considered quasi-freehold and typically deals are being struck for 125 years. The funder/developer will fund the PPU construction costs against a pre-let tenancy agreement with the operator, for typically a 30 year term.

4.32 A diagrammatic summary is presented below.



4.33 A key commercial issue arising under this model is that funders require a risk mitigation strategy in the event of default by the operator. If the Trust commits to step into the lease obligation to pay rent to PropCo in the event of 1) a default by OpCo and 2) no suitable replacement tenant emerging following re-procurement, then the project will attract a more competitive cost of funding and tend towards the rates available under strip income.

4.34 Granting a long term lease will trigger a disposal of the land in the Trust's accounts and therefore this model will deliver an up front payment, which will be pitched at a level to ensure that the Trust does not require to recognise an accounting loss on disposal. Also, the structure creates a contingent liability for the Trust which will require to be disclosed in the notes to the Trust's statutory accounts.

4.35 The Trust has assessed that the contingent risk of requiring to step into the lease in an event of default is mitigated by the financial benefit achieved under this model. The Trust has concluded that the quasi-freehold model offers the optimum structure for the Trust to achieve its key financial objectives of maximising the financial return from the procurement, without capital contribution, whilst retaining the debt funding off balance sheet.

4.36 **Financial examples of each option**

4.37 The tables below illustrate some of the financial differences between the three models. The illustration can assume that the development has a capital cost of £50m.

Model	Term/ Years	Cost of development	Funding	Annual debt service	Assumed rental (p.a.)	Comments
Project Finance	30	£50m	Debt- £30m Equity- £20m	Debt- £2.483m Equity- £2.179m	Minimum £4.662m	Assumed rental dependent on repair and maintenance obligations/ life cycle costs.
PropCo/ OpCo	125	£50m	Debt- £50m	6.25%	Minimum £3.125m	Assumed rental on yield of 6.25%
Strip Income	40	£50m	Debt- £50m	5.75%	£2.875	Assumed rental on an assumed yield of 5.75%.

4.38 **Approach adopted to bid submissions**

4.39 The commercial position that has emerged during the latter stages of competitive dialogue is that one of the remaining bidders has been unable to differentiate a pricing advantage from the funding market for a strip income or quasi freehold structure (compared with traditional project finance, or limited recourse, structures) without compromising the Trust's stated commercial requirement for an off balance sheet solution.

4.40 The bidder has concluded that its only option to move forward and submit a fully funded proposal that meets with the Trust's commercial requirements is to bid on the basis of a project finance model. To sustain competition, the Trust has determined to issue contract documentation and call for final bid submissions reflecting the baseline project finance commercial model over a 30-year term.

4.41 The other bidder is progressing negotiations with funders and developers and has proposed a shortlist of options on commercial structures, including a baseline 30 year project finance model but also variant proposals which combine some of the features of strip income and the 125-year term of a quasi-freehold models. The Trust is in the process of seeking advice from PwC on the accounting treatment implications of the variant proposals, but provided that they meet the Trust's key requirement to have an off balance sheet solution then the request for final tenders will invite bidders to submit a variant 125-year model.

4.42 The structure envisages a 125-year head lease between St George's as Freeholder and an investor/developer as Landlord. The grant of a 125-year leasehold interest is accounted as a disposal of the land and the Trust will receive a market value payment, estimated at £2.5m on financial closure.

4.43 The Landlord will enter into a 30-year underlease with the operator, and the Trust will enter into an Operating Agreement with the operator. The Trust will have step-in rights whereby it can collapse the head lease with the Landlord and take control of the building in the event of a default by the operator. Upon expiry of the operator's 30-year underlease, the Trust will have the right to buy-out the head lease for nominal payment of £1. Thus, despite entering into a quasi-freehold 125-year lease structure, the Trust has essentially a break right to regain control over the asset after 30 years.

4.44 The rationale for pursuing a long-term 125-year structure is that the cheaper cost of finance will be substantially passed through to the Trust in the form of higher guaranteed payments under the revenue share mechanism.

4.45 PwC and Capsticks are working closely with the Trust to develop and shape the suite of legal documents that will be released to bidders for mark-up and return with the final bid submissions. The Trust will also draw on their support and advice during the process of evaluating the final bid submissions and selection of Preferred Bidder.

Key contractual protections

4.46 The suite of legal agreements to govern the PPU contract will comprise a Development Agreement for the construction of the PPU, the Lease relating to the interest in the land, and an Operating Agreement for the service contract to operate the PPU. There will be a number of Service Level Agreements sitting behind the Operating Agreement to govern the provision of support services.

4.47 The Development Agreement establishes certain Initial Conditions that must be satisfied by an agreed longstop date. These convey an obligation on the Trust to submit its strategic planning application for the St George's site, which includes outline planning for the PPU, and subsequently for the bidder to submit its detailed planning application for the PPU within a defined period after notification by the Trust. Both parties are obliged to agree the form of any PFI variation agreement and to achieve any necessary regulatory approvals. Failure to achieve the Initial Conditions

by the longstop date conveys the right to terminate by either party.

4.48 Subsequently, on satisfaction of the Initial Conditions, the Development Agreement obliges the bidder to proceed to undertake the construction works and establishes a second longstop date by which the bidder must achieve practical completion. Either party can terminate if the conditions have not been confirmed by this latter longstop.

4.49 The Lease is a standard form document framing the rights of occupancy and the obligations on the bidder to pay rent to the Trust. It includes the break protections referred to previously whereby the Trust can automatically take control over the asset on the expiry of the Operating Agreement, or earlier if the bidder defaults under either the lease or the Operating Agreement.

4.50 The Operating Agreement is essentially the service concession that establishes the basis on which the bidder is allowed to operate the PPU at St George's. The initial term is set at 30 years during which period the bidder has exclusive rights to provide the agreed, privately funded clinical treatments and services. The Trust has the right to terminate the Operating Agreement for non-performance and to take any necessary steps to protect its brand and reputation, including the right of veto over services or treatments offered from the PPU where the Trust determines a reputational risk.

5.0 Financial Case: Affordability appraisal

5.1 This chapter sets out the calculation of the affordability of an outsourced PPU solution at St George's.

5.2 The draft bid proposals received from the shortlisted PPU bidders have been reviewed and a hybrid estimated position taken of the likely cashflows accruing to the Trust over the term of the lease and the PPU Operating Agreement. The net present value of these cashflows is compared with an estimate of cashflows that the Trust could achieve over the same term, were the Trust to have access to the required capital to invest in developing an in-house PPU solution (a public sector comparable model).

5.3 The risk profile of the respective solutions is very different. Under the outsourced model the Trust is receiving guaranteed payments, with the third party provider bearing the market and operational risks. The contractual cashflow obligations of the operator to the Trust are backed up by parent company guarantees, so the Trust has effectively transferred all of the risks to the operator.

5.4 Under the in-house, public sector comparator model the Trust is adopting an equity risk profile whereby all of the upside financial performance theoretically accrues to the Trust, but equally the Trust is exposed and carries the downside risk of non-performance.

5.5 The financial case seeks to demonstrate that by following the outsourced PPU model and accessing the private operator's capital, the Trust can effectively access the financial rewards that could be achieved from an in-house solution whilst substantially transferring all of the risks to the operator.

5.6 **Public Sector Comparator (PSC) model**

5.7 The PSC model reflects two distinct phases of development. Phase 1 assumes investment of £1.2m to carve out space and create 8 dedicated private beds within Atkinson Morley Wing. The timescale to achieve this is assumed to be 12 months with the beds becoming available from the start of the 2015-16 financial year. The strategy to maximise occupancy and income from these beds would concentrate on the following immediate opportunities:

- consolidation of the Trust's existing private patients' business; and
- implementation of specific business development growth opportunities which are the subject of current and active discussions with Trust consultants.

5.8 The Trust would not have sufficient theatre capacity within its existing estate to offer the dedicated capacity required to support increased private activity volumes, and therefore the financial model for Phase 1 includes an allowance of 50% of the notional costs to rent a temporary mobile operating theatre. The working assumption is that repatriation of outsourced NHS elective activity would absorb the remaining 50% of additional capacity and cost of a temporary mobile theatre solution.

5.9 Phase 2 assumes a step change in operational scale and risk through the development of a ring-fenced, 12-bed PPU having its own dedicated theatre and cath lab in an extension of Atkinson Morley Wing. The capital requirement is estimated at £4m in 2013/14 prices to create and equip around 1,500 sqm. Given the scale of investment and step change in risk, it is considered that implementation of Phase 2 would be deferred until a sustained and demonstrably successful track record is proven for Phase 1. Therefore, the model assumes that Phase 2 would be

implemented in Year 10.

5.10 The business plan and strategy for Phase 2 would aspire to replicate the in-house private patient units of peer group London teaching hospitals such as Royal Free, which earned £21.7m of income from private patient services in 2012-13 from a dedicated area on the 12th floor of the hospital.

Phase 1 – Part 1 -Existing Private Patients Business

5.11 During financial year 2012-13 the Trust earned £3.7m of revenue from private and overseas patients. Some £3.4m came from inpatients and day case procedures and two-thirds of this activity was comprised of premium margin cardiology and neurosurgery procedures. The remaining £0.3m of private income was derived from diagnostics, drugs, and outpatients. It is assumed there is no mark-up on this income.

5.12 The inpatients and day case activity has been mapped to average HRG reference costs from which it is estimated that the Trust's direct costs incurred in the delivery of private patients activity were £2.3m. This estimate includes £0.5m of allowances to cover the medical consultant and anaesthetist; adjusting for these, the estimated hospital cost to deliver the private patients activity is £1.8m.

5.13 Therefore, the Trust estimates that it achieves a gross margin on its existing private and overseas patients business of £1.6m, or 44%.

5.14 Budgeted pay and non-pay costs for the private patients' administration team are £0.2m, and an additional allowance of £0.1m is apportioned for corporate and divisional overheads.

5.15 Overall, this leads to an estimate that the existing private and overseas patients business is generating a surplus of £1.3m.

Private and overseas patients Estimated 2012-13 I&E	**£'000**
Inpatients and day case income	3,394
Other income	287
Total private patients revenue	**3,681**
HRG average reference costs	2,284
Medical staff costs	(345)
Anaesthetic rebate	(173)
Costs to deliver other income	287
Total hospital costs	**2,052**
Hospital gross profit	**1,629**
%	44.2%
PP Administration budgets	(240)
Corporate & divisional overhead	(100)
Surplus	**1,289**
%	35.0%

5.16 During 2013/14 the Trust invested £90,000 to create 2 dedicated private patients' bedrooms in its Belgrave cardiology ward. A business case has been approved to invest a further £120,000 to create 2 dedicated neurology private patients bedrooms, 1 each in Kent and McKissick wards. As a result of this investment, the Trust considers that the financial performance set out in the table above is recurring.

Phase 1 –Part 2 – Incremental business development growth opportunities

5.17 As a result of targetted discussions with various Trust consultants over several

months, a number of business development opportunities have been identified to further grow private patient income streams. These are assumed to be deliverable within 12 months for the purposes of Phase 1 of the PSC model and are described below.

- Approximately £1.6m of the Trust's existing private patients' income is generated from cardiology. Income generation has historically been constrained by an absence of dedicated private cardiology bedrooms. As a result of the 2013/14 investment in Belgrave rooms, the annual revenue potential from cardiology is now estimated at £2.5m. The Trust's cardiologists have committed to undertake additional private outpatient clinics to generate further private activity. Assuming conversion to additional procedures, the incremental revenue potential is estimated at £0.2m at 45% gross margin. Taken together these opportunities are worth £0.624m.

- Some £0.4m of existing private patients' income is generated from neurology. Capacity is constrained by lack of dedicated private bedrooms. A business case has been developed to provide 2 refurbished and equipped dedicated private bedrooms at a cost of £120,000. The income potential is estimated at £1.0m pa, and the incremental opportunity is quantified at £0.6m of income at 40% gross margin.

- The NHS bowel cancer screening programme is expected to result in £0.43m from private gastroenterology treatments at 33% gross margin.

- The Trust's neurosurgeons have identified £0.33m income potential from paediatric scoliosis cases at a conservative 22% gross margin.

- Initiatives to look at private opportunities in renal transplants and bone marrow treatment have quantified near-term opportunities at £0.2m of annual income and 25% gross margin.

5.18 Overall, the sum of these and other smaller planned business development growth opportunities adds £3.174m of incremental income from 2014/15 through to 2016/17.

5.19 In addition to the existing £120,000 capital commitment to create 2 dedicated neurology rooms, the Trust has identified an area within Third Floor Atkinson Morley Wing which would be suitable for conversion to provide an additional 4 dedicated private patients' bedrooms, together with dedicated staff and visitor facilities to support such a step change in private patients' activity. The capital investment required is estimated at £1.2m, resulting in annual capital charges and depreciation of c£0.1m

5.20 The estimated cost to rent temporary operating theatre capacity is £0.5m per annum.

5.21 Additional overhead is assumed with £0.1m allowed for additional administrative resource in the private patients' business office and £0.1m for incremental corporate and divisional overheads.

5.22 Based on all of the above, Phase 1 of the PSC model is forecast to achieve £7.1m of revenue and generate a recurring annual surplus of £1.8m from Year 1 onwards. The pro forma income and expenditure account for Phase 1 is represented in the table below.

5.23 It is assumed that further growth during Phase 1 is constrained by an absence of theatre and bed capacity, such that the financial returns to the Trust are capped at £1.8m per annum, index-linked.

Phase 2 PSC model

5.24 The working assumption for Phase 2 is that an investment of £4m (at 2013/14 prices) will create a dedicated PPU with an integrated theatre, diagnostics and additional ensuite private beds, the Trust can target to double its private patient revenues to £12.5m, and that the incremental revenue would be priced at 40% gross margin. This would position the revenue performance of an in-house PPU at St Georges at a level consistent with that of an established, mid-sized, provincial private hospital.

5.25 Capital charges and depreciation on the new investment are approximately £0.37m per annum

5.26 Recruitment of additional and dedicated senior executive resource in the areas of business development and clinical management would be required, and the PPU would require additional corporate and divisional support from the Trust.

5.27 Once it has reached maturity, the model assumes that Phase 2 will result in an enlarged PPU generating an operating surplus of £2.9m per annum on £14m revenue. The detailed financial model is included as appendix 2.

5.28 **Outsourced PPU model**

5.29 Draft financial models containing revenue payment proposals to the Trust were received from the PPU bidders in November 2013. These reflect the commercial due diligence that the bidders have undertaken to assess the market opportunity and their specific discussions with the St George's consultant body.

5.30 Both bidders are forecasting that a PPU built adjacent to Atkinson Morley Wing will achieve income of approximately £30m by the time the facility has matured in Year 5.

5.31 The Trust will achieve its financial returns from an outsourced PPU solution from a combination of income streams:

- fixed and guaranteed rental payments under a lease for the land;
- variable royalty payments under an operating agreement based on the Trust receiving a share of the PPU's revenue; and
- income from the supply of support services into the PPU under Service Level Agreements.

5.32 Based on the draft models received from the bidders in November 2013, the Trust has made the following assessment of the financial returns it expects to achieve:

- an initial one-off payment from a developer in lieu of the Trust granting a long term leasehold interest in the land. The payment will at least equate to the net book value of the land in the Trust's accounts;
- fixed and guaranteed payments of at least £1.25m per annum, which compensate for the surplus achieved by the Trust on its existing private patient business;
- a percentage revenue share applied to all PPU revenues achieved by the operator above a baseline hurdle. This amount will be variable, uncapped, but is not guaranteed. When added to the fixed and guaranteed payment, the Trust expects to receive circa £2.6m in Year 5. This amount exceeds the profit potential of the Phase 1 PSC model;
- the Trust will receive circa £1m per annum to provide specialist clinical support such as junior doctor cover, allied health professionals, and specialist advisory services. A conservative assumption has been made that the costs incurred in delivery will equate to the revenue received such that Trust benefits are intangible. The contractual mechanisms will ensure that excess costs incurred by the Trust are recoverable;
- variable income will be received from the provision of pathology, sterile services and drugs. The Trust estimates that it will receive £3m from these income streams in Year 5 with incremental contribution to the Trust of £0.8m.

5.33 By year 10, when the Trust might otherwise implement Phase 2 of the PSC model, the bidders are forecasting that the PPU will be achieving £40m revenue. The Trust estimates that its (fixed guaranteed and variable) revenue share will be £3.6m with a further £5m of income for SLA support services generating £1.0m profit contribution.

5.34 Thus, the Trust considers that the outsourced PPU model will deliver higher financial returns than the PSC model at all times during the lifetime of the procurement.

5.35 **Affordability – Conclusion**

5.36 Based on the net present value of discounted future cashflows, and other assumptions described in this Outline Business Case, the preferred option of an outsourced solution is affordable in the context of delivering higher financial returns than the Trust could otherwise aspire to achieve whilst at the same time transferring substantially all of the risks to the private sector operator.

6.0 Management Case

6.1 Project Management and Organisation

6.2 The diagram below explains the current project structure with the executive sponsor reporting to EMT on an exceptional basis. The PPU project is a standing item on the Commercial Board agenda to receive regular updates, while position papers and OBC/FBC are taken to Trust Board for approval.

6.3 Two working groups are established to manage the project, both of which involve key stakeholders. The Clinical Reference group is made up of clinicians with management support provided by the Project Manager. The chair of this group (Dr O Foster) is also part of the Steering group.

6.4 The Steering group is chaired by the Director of Finance, who is also the project's Executive Sponsor. It meets monthly to receive reports from the Project Manager and to discuss and agree operational matters and issues arising under the project, and is attended by a broad spread of clinicians and Trust general managers.

6.5 The Steering group has supported a proposal for new governance arrangements for the implementation phase of the PPU project. This will be presented to the Steering group in January 2014 and will come into effect in March 2014. The composition and constitution of the various groups and their interactions will be developed and explained in the Full Business Case. The Steering group will develop an Integrated Implementation Plan

6.6 Introduction to Trust Project Management

6.7 The PPU development project involves construction of a new building within a busy teaching hospital site that will continue to be fully operational throughout the construction period. The PPU will be developed in parallel with other strategic Trust initiatives including the development of a new multi storey car park (MSCP) and reprovisioning of temporary parking facilities. Careful thought has therefore been given to the construction phasing, traffic management, project organisation and management structure to ensure safety, smooth running, close control and minimal disruption.

6.8 This section sets out how the Trust will manage the project implementation through to

commissioning and opening, into the operational and post-project evaluation phases. It describes:

- main roles and responsibilities;
- project implementation structure, including membership and terms of reference of the implementation groups;
- the project costs of the implementation phases;
- the management of the interface with the bidder throughout this period;
- the management of the interface with Trust staff throughout this period;
- liaison with both internal and external stakeholders.

6.9 **Project Governance Roles**

6.10 The following roles will be maintained throughout the construction and operation phases of the project:

- **Investment Decision Maker -** This role is occupied corporately by the St George's Trust Board, sitting quorate, as a statutory public body. The Trust Board has a scheme of delegation permitting, within defined limits, the Chairman and Chief Executive together to authorise urgent actions in order to progress the project within planned timescales. There is further limited delegation for this purpose to the Director of Finance and the Director of Estates.

- **Project Owner –** the Director of Finance, as senior responsible officer, retains personal accountability for the project.

Decision Making: Construction phase

6.11 The Deputy Director of Estates will be the decision-maker on behalf of the Trust regarding the progress of the phases of the construction programme. Any matters with significant implications regarding the project objectives, beyond resolution by the Deputy Director, will be referred first to the Director through weekly supervision, or immediate intervention if necessary; [and secondly by reference to the monthly EMT]

6.12 The Deputy Director of Estates will have delegated authority to act as the Trust Representative and point of contact in all bidder dealings and with their professional advisors and contractors.

Project Implementation Programme

6.13 The project is an outsourced solution to design, build, finance and operate a PPU facility. The key milestones for the programme are as follows:

6.14 The costs to the Trust associated with project implementation are considered to be nominal since the preferred bidder will be bearing the implementation costs.

Milestone	Expected Date
OBC submission and approval	December 2013
Receipt of Final Bids	January 2013
FBC approval with recommendation of Preferred Bidder	February 2014
Award of Contract	April 2014
Detailed planning consent	September 2014
Construction work commences	October 2014
Construction work completed	March 2016
Service commencement	April 2016

Communications

6.15 Communications both with internal and external stakeholders will be vital both in terms of reinforcing the key project objectives and in providing advance warnings and regular updates on possible site disruptions arising out of a major construction project on a busy operational acute hospital site.

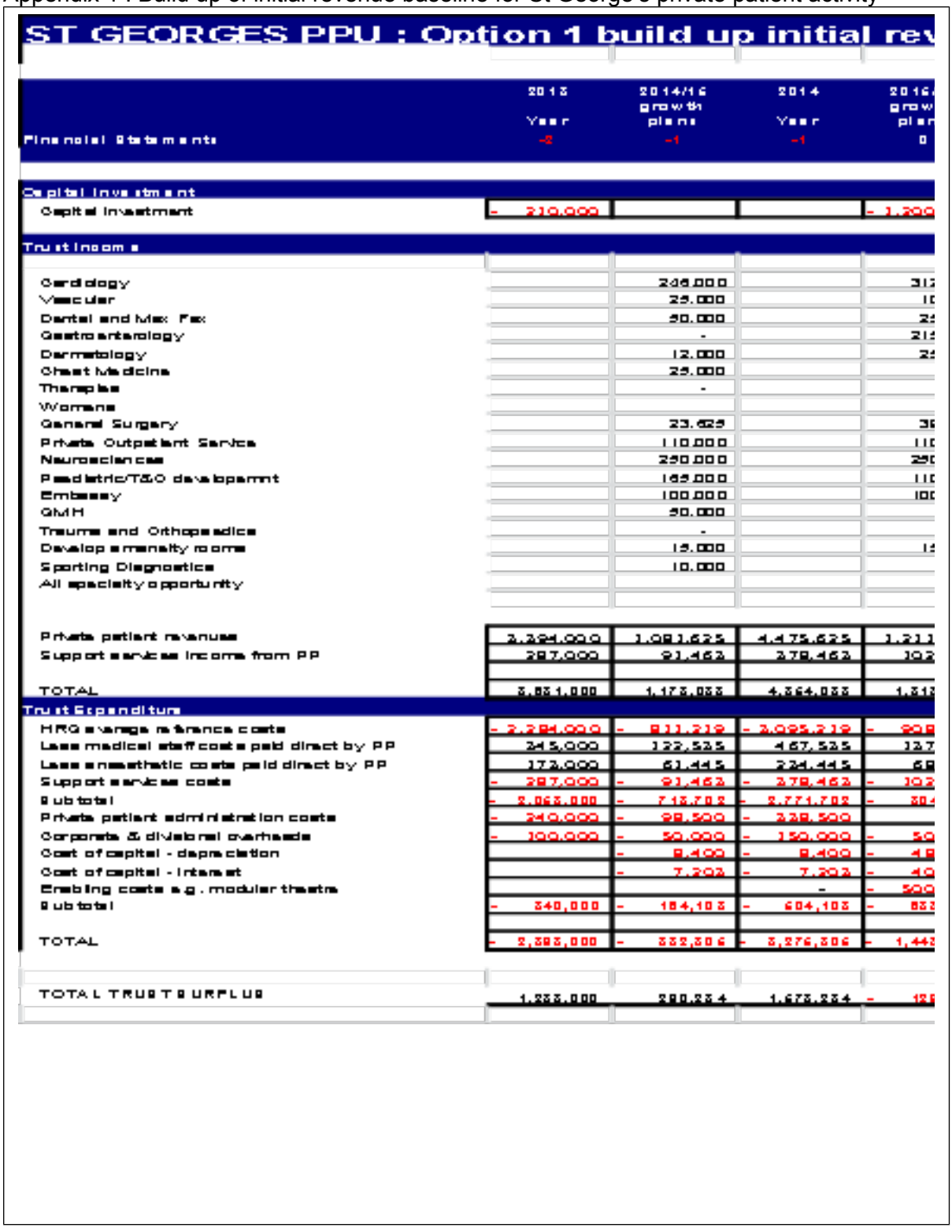
Risk and Value Management

6.16 The Trust is not making any financial contribution to the project. The project is an outsourced solution to design, build, finance and operate and as such the construction and operational risks rest with the preferred bidder.

6.17 The Trust assesses that its risk potential is low risk and does not consider that Office of Government Commerce (OGC) Gateway Review Process is required in this instance.

4.3 TBR (14) 3

Appendix 1 : Build up of initial revenue baseline for St George's private patient activity

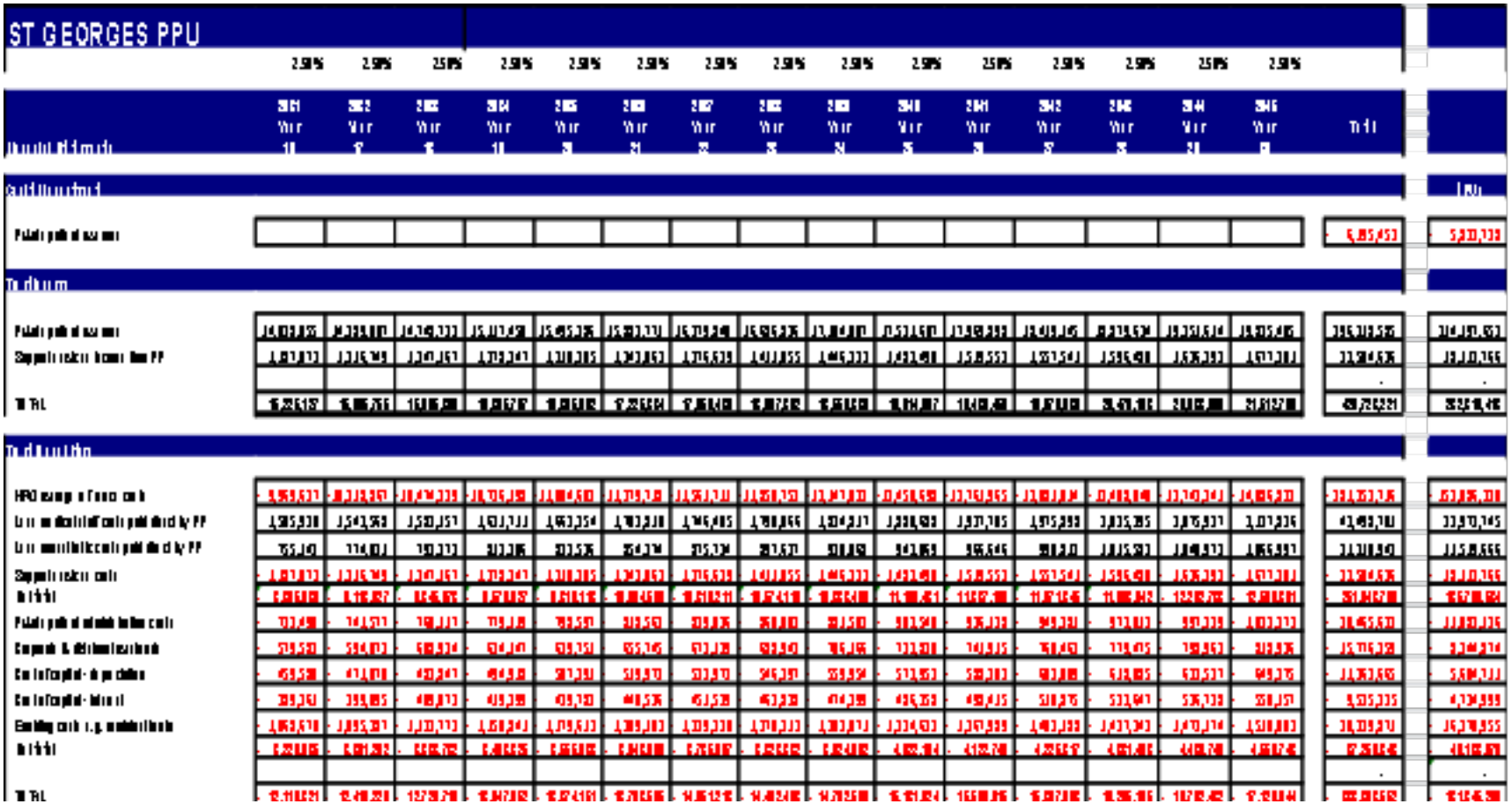


ST GEORGES PPU : Option 1 build up initial rev

Financial Statements	2013 Year -2	2014/15 growth plans -1	2014 Year -1	2015/ growth plan 0
Capital Investment				
Capital Investment	- 210,000			- 1,200
Trust Income				
Cardiology		246,000		312
Vascular		25,000		1
Dental and Max Fax		50,000		2
Gastroenterology		-		21
Dermatology		12,000		2
Chest Medicine		25,000		
Therapies		-		
Womens				
General Surgery		23,625		3
Private Outpatient Service		110,000		11
Neurosciences		250,000		25
Paediatric/T&O development		165,000		11
Embassy		100,000		10
GMH		50,000		
Trauma and Orthopaedics		-		
Development rooms		15,000		1
Sporting Diagnostics		10,000		
All speciality opportunity				
Private patient revenues	2,294,000	1,081,625	4,475,625	1,211
Support services income from PP	287,000	91,462	378,462	102
TOTAL	2,581,000	1,173,088	4,854,088	1,313
Trust Expenditure				
HRG average reference costs	- 2,294,000	- 811,219	- 3,095,219	- 908
Less medical staff costs paid direct by PP	245,000	122,525	467,525	127
Less anaesthetic costs paid direct by PP	173,000	61,445	234,445	68
Support services costs	- 287,000	- 91,462	- 378,462	- 102
Subtotal	- 2,063,000	- 718,708	- 2,771,708	- 804
Private patient administration costs	- 240,000	- 98,500	- 338,500	
Corporate & divisional overheads	- 100,000	- 50,000	- 150,000	- 50
Cost of capital - depreciation		- 8,400	- 8,400	- 40
Cost of capital - interest		- 7,202	- 7,202	- 40
Enabling costs e.g. modular theatre			-	- 500
Subtotal	- 340,000	- 184,103	- 524,103	- 833
TOTAL	- 2,383,000	- 332,306	- 3,276,306	- 1,443
TOTAL TRUST SURPLUS	1,233,000	280,234	1,678,234	- 129

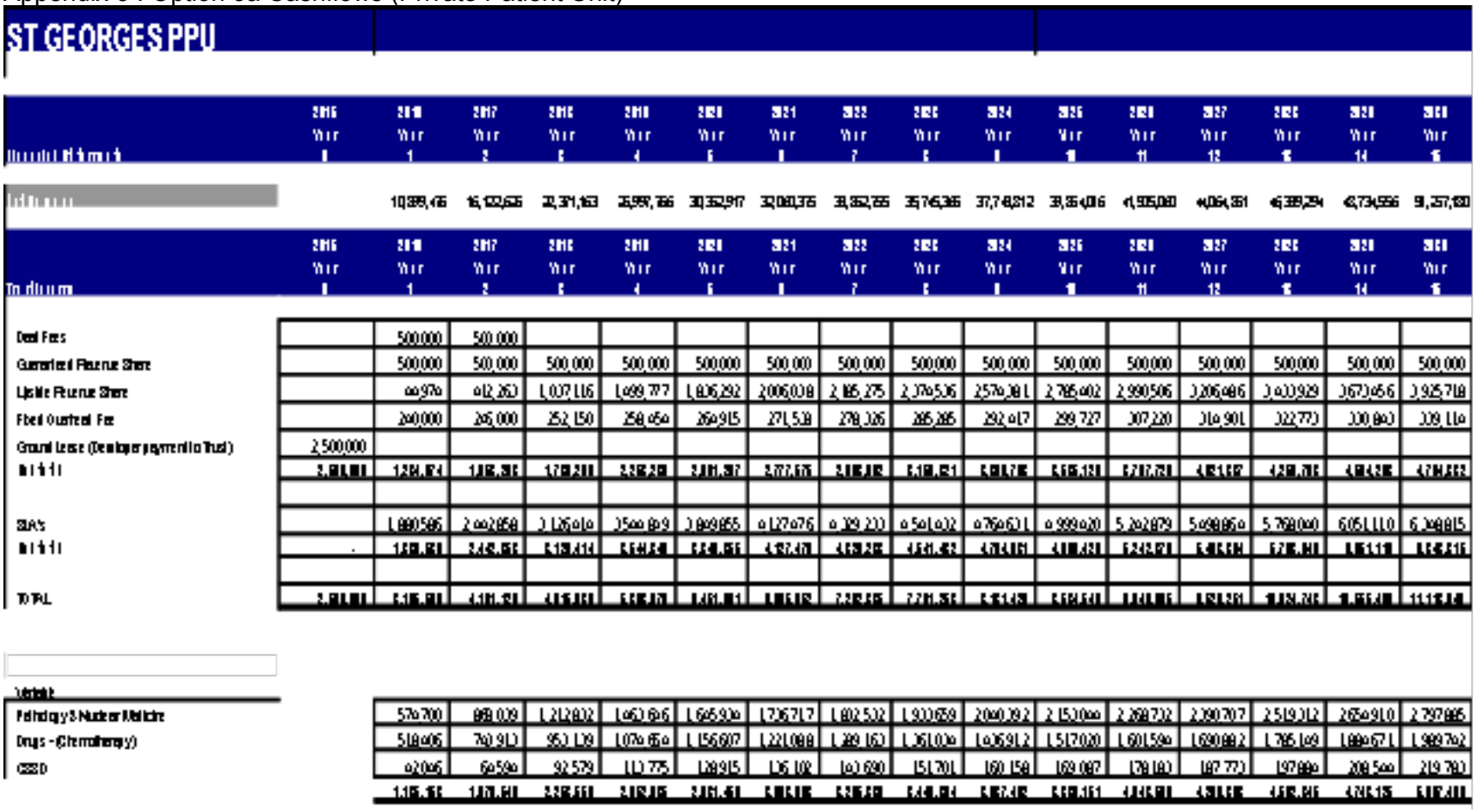
Appendix 2 : Option 1 Cashflows (St George's PSC)

4.3 TBR (14) 3



4.3 TBR (14) 3

Appendix 3 : Option 3a Cashflows (Private Patient Unit)



4.3 TBR (14) 3