

Capital Costs of 2012/13 Interim Configuration Options

Supplementary Report: 16th October 2009

1 Introduction

The Provex Consultancy Limited / Strategic Healthcare Planning Limited team has been asked to provide a Supplementary Report on the Capital Costs for the 2012/13 Interim Configuration Options in the light of various queries and comments that have arisen on the report produced for the Programme Board.

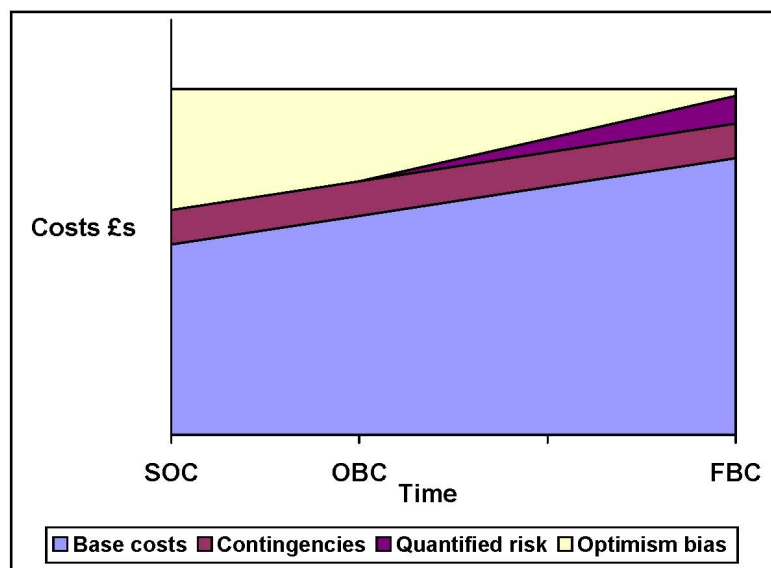
This paper responds to the specific questions raised in Terry James e-mail dated 15th October 2009.

2 Interpretation of Capital Costs

We can confirm that your interpretation of the level of capital costs for the 4 Options specified by the Programme is correct.

It is important to emphasise three points in relation to **all** of the Options:

- ❖ Firstly, the approach to capital costing is in accordance with established NHS capital cost guidance, the NHS Departmental Cost Allowance Guide and the Treasury 'Green Book';
- ❖ Secondly, the level of forecast cost includes a significant "contingency" in the form of an Optimism Bias adjustment, given the high-level nature of the work undertaken to date. The calculation includes Optimism Bias at 31% for each Option. It is, of course, possible that this level of Optimism Bias is not required once the detailed work is undertaken to develop the chosen solution, but experience shows that it is a very useful indicator of how costs change as projects progress. We repeat here, for ease of reference, the graphical illustration of how capital costs change over the life of a project:



- ❖ Thirdly, the principal driver in relation to the capital costs of the options is the nature of the space required to deliver the functional requirements. Clearly, different clinical requirements

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would lead to different judgements in relation to both the solution and therefore the capital costs.

3 Option 2 Capital Costs

The major differentiator of the capital costs between options 1 and 2 is the provision of an Obstetric facility. This facility would include:

- ❖ Ante natal clinics;
- ❖ Consultant led delivery suite;
- ❖ Midwifery led birthing suite;
- ❖ Obstetric in patient beds;
- ❖ Early Pregnancy Assessment Unit;
- ❖ Neonatal Intensive care unit;
- ❖ Special care baby unit; and
- ❖ Transitional care unit.

It is assumed that it would be designed to the latest spatial standards and takes the schedules of accommodation for 2020 vision project as the design basis. The costing of the facility in option 2 is based on a combination of converting the existing midwifery unit and adding a substantial new build extension. The analysis of this is shown in Table 1 below:

Table 1: Obstetric Facility Spatial Requirement

Heading	Floor Area m ²
Conversion / Major Refurbishment	1,250
New Build	2,850
Total	4,100

If the new build component were to be created by conversion of existing facilities, there would be a requirement of at least that set out in Table 2 below:

Table 2: Alternative Spatial Requirement

Heading	Floor Area m ²
Conversion / Major Refurbishment (as above)	1,250
Conversion / Major Refurbishment (in lieu of new build)	2,850
Total	4,100

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In addition, it is highly likely that capital cost will be required to deliver an alternative solution for the displaced accommodation (2,850m²).

The costs of the requirements set out in Table 1 have been assessed based on the NHS Departmental Cost Allowance Guide and the Treasury 'Green Book'.

It is not possible to assess the capital cost of the alternative to the same degree of certainty without determining what will be displaced, and how and where it will be re-provided. What can be said however is:

- ❖ The conversion of existing facilities instead of building new would be budgeted at a level in the order of 70-75% of the cost of building new. This is based on an established NHS methodology known as the 'Needleman Formula' (and reflects the need for engineering services to be addressed as part of the solution); and
- ❖ The cost of replacing the displaced accommodation could be a similar order of cost to the new build obstetric facility, depending on what functions are displaced and how it needs to be re-provided.

From the above it can be seen that the conversion option could cost considerably more than the new build extension, and is unlikely to be significantly cheaper.

4 Option 1 Capital Costs

Option 1 largely comprises additional paediatric beds and dedicated theatre suite, expansion of critical care, expansion of A and E and re-designation of urology beds for emergency and complex surgery at RSH.

Clearly, the same potential questions arise in relation to alternative ways of delivering the Option 1 requirements. In exactly the same way as for Option 2, there may be different ways of delivering the requirement by displacing other services, but the same arguments apply in relation to the impact this would have on capital costs.

5 Conclusion

We can confirm that in our professional opinion, the high level solutions offered for options 1 and 2 are optimal based on the clinical brief provided by the Trust, our knowledge of the sites, the need for the solutions to focus on achieving the short term objectives and the brief to minimise capital expenditure.

There **may** be scope to reduce these costs through Value Engineering at the next stage. For example one of the drivers of the new build and remodelling costs is the spatial standards for the proposed accommodation. The current costs assume that the latest standards prescribed by the Department of Health will be adopted. The Programme may wish to consider adopting lower standards for some of the accommodation, which could lead to capital cost savings.

Having said this, such opportunities exist for each of the Options, and would have a similar proportional impact on each, thus maintaining the broad differences in capital cost between the Options.