ESTATE AND FACILITIES MANAGEMENT POLICY

Version 2.1

Name of responsible (ratifying) committee Senior Management Team

Date ratified 7 October 2019

Document Manager (job title) Director of Estates, Facilities, PFI and Capital Development

Date issued 29 November 2019

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Electronic location Management Policies

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- Fire Safety Policy;
- Physical Security Management Policy;
- Parking Control – Security Policy;
- Asbestos Management Policy;
- Waste Handling Policy;
- Control and Prevention of Legionnaires Policy;
- Environmental Policy;
- Energy Policy.

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- Assurance;
- NHS PAM;
- Patients;
- PFI;
- Professional Structure;
- PLACE;
- Governance Structure;
- PEPG;
- Project Agreement.

Version Tracking

<table>
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<th>Date Ratified</th>
<th>Brief Summary of Changes</th>
<th>Author</th>
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<td>2.1</td>
<td>01/02/2021</td>
<td>Due to the second wave of the Coronavirus pandemic and continuing exceptional circumstances, the Trust Board have agreed to further extend all policies currently over their review date to 1st July 2021</td>
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<td>2</td>
<td>7/10/2019</td>
<td>Refresh of policy to reflect changes following the appointment of Engie as PFI contractor and to the Estates Team structure</td>
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<td>1</td>
<td>21/01/2015</td>
<td>Completely revised Policy to reflect up-to-date NHS Regulatory and Assurance framework for Estates and Redevelopment</td>
<td>Director of Redevelopment</td>
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QUICK REFERENCE GUIDE
This policy must be followed in full when developing or reviewing and amending Trust procedural documents. For quick reference the guide below is a summary of actions required. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy.

1. The objective of this Policy is to outline the estate and facility management governance, regulatory and assurance framework which will ensure the Estate and Facility service remains compliant, minimises risk arising from occupation of the built environment and remains in good repair.

2. The Trust Board, Chief Executive and Chief Finance Officer hold accountability and responsibility for management and maintenance of the Trust’s estate.

3. Responsibility is devolved in line with delegated authority to the Director of Estates, Facilities, PFI and Development.

4. The Director of Estates, Facilities, PFI and Development leads the Trust’s Estates and Facilities Team and is supported by the Deputy Director of Facilities and Estates, Head of Capital and Property, Head of Estates and Head of Soft FM.

5. The Trust will utilise the NHS Premises Assurance Model (NHS PAM) to provide assurance for the healthcare environment and to ensure patients, staff and visitors are protected against risks associated with hazards such as unsafe premises.

6. The Estates and Facilities Team will undertake an informed client role to monitor the delivery of the estate and facilities management service at Queen Alexandra Hospital via the PFI arrangement. An informed client role will also be adopted as appropriate where facilities used by the Trust are provided by other NHS organisations.

7. The recognised Professional structure as summarised below will be adopted for the delivery of high risk impact specialist services within the Trust (e.g. high voltage electricity, decontamination, medical gas pipelines, lifts etc).

8. The NHS Regulatory and Assurance framework for Estates and Facilities is provided at Appendix A

9. An overview of the PFI arrangements, including contract management is provided at Appendix B

Estate and Facilities Management Policy
Version: 2.1
Issue Date: 29 November 2019
Review Date: 01 July 2021 (unless requirements change)
1. INTRODUCTION

Portsmouth Hospitals NHS Trust is committed to ensure a high quality Estates and Facility service and effective estate maintenance system is in place that ensures:

- The continuous provision of functionally suitable facilities for healthcare provision creating a safe pleasant environment internally and externally;

- Maintenance of the integrity of the building fabric and building services, public health and utility systems, equipment and site infrastructure which comprises the Facilities;

- Minimal disruption to the Trust’s operations in the delivery of the Estate Service;

- Compliance with codes and policies of good practice and industry and statutory standards;

- All plant, equipment, buildings, utility services and site infrastructure do not cause or create any hazard to the environment and / or any person on the Trust site(s); and

- A safe environment and safe working practices including the use of recognised risk assessment / management systems to ensure the standards stay high, and that any slippage is recognised and corrected;

- Fire safety is maintained incorporating continual fire training, fire risk assessment and review;

- Patients, staff and visitors perceive that the cleanliness, condition, appearance, maintenance and privacy and dignity of the estate are satisfactory;

- Facilities, equipment, staff, patients and visitors are secure and protected within a safe environment in line with the principles of NHS PROTECT, underpinned by use of an accredited trained Local Security Management Specialist (LSMS);

- NHS catering services provide adequate nutrition and hydration through the choice of food and drinks for people to meet their diverse needs;

- Access and car parking arrangements meet the reasonable needs of patients, staff and visitors and are effectively managed at all times;

- An effective management of accommodation including occupancy, utilisation, leasing and licensing where appropriate and staff residences;

- A safe, effective portering services are provided that meet the need of patients, staff and visitors and the Trust, consistent with all relevant guidance and legislation;

- The telephony and switchboard service is provided efficiently, professionally and courteously within agreed target response times;

- There is a continual drive for improvements in our environmental performance, in particular energy and water consumption, waste production and non-patient transport and the impact they have on the Trust’s carbon ‘footprint’;
• Compliance in the development, occupation and management of all land and property, including acquisitions and disposals of freehold and leasehold land and premises.

• There is an effective estate and facilities risk management process that reflects the principles within the Trust's risk management strategy and gives assurance that Estates and Facilities risks are being identified, proactively controlled and mitigated.

2. PURPOSE

The objective of this Policy is to outline the estate and facility management governance, regulatory and assurance framework which will ensure the Estate and Facility service, as far as reasonably practicable:

• Remains compliant with legislation;

• Minimises the risk arising from occupation and use of the built environment;

• Ensures the structure, fabric, and finishes remain in good repair and fit for purpose;

• Ensures that environmental conditions remain appropriate and conducive to allow the Trust to safely and effectively deliver its services; and

• Performance of the estate is benchmarked against local and national organisations of a similar size and clinical case mix to assess how continual improvements to the estate performance can be achieved.

An overview of the NHS Regulatory and Assurance framework for estates and facilities is provided at Appendix A. The Trust will utilise the NHS Premises Assurance Model (NHS PAM) to provide assurance for the healthcare environment and to ensure patients, staff and visitors are protected against risks associated with hazards such as unsafe premises. The Trust's services will be subject to the annual assessment undertaken by the Patient-Led Assessments of the Care Environment (PLACE).

‘In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety’

3. SCOPE

This policy applies across all estate and facilities provided by the Trust (including facilities occupied and used by other NHS organisations or third parties). The policy also applies to all other facilities, not provided by the Trust but used to deliver Trust operational service.

The facilities at the Trust’s main site, Queen Alexandra Hospital, are provided under a comprehensive whole-site Private Finance Initiative (PFI) arrangement. The PFI Project Agreement identifies the obligations and responsibilities of Project Co. and its sub-contractor Engie. The Trust has robust PFI contract management arrangements in place.

The management, maintenance and purchase of medical devices is covered under a separate Trust Policy.
4. DEFINITIONS

NHS Regulatory and Assurance framework for Estates and Facilities - an overview is provided at Appendix A. This includes:

- NHS Constitution which sets out the rights to which patients, public and staff are entitled.
- Care Quality Commission (CQC) regulates all providers of regulated health and adult social care activities in England.
- NHS Premises Assurance Model (NHS PAM) provides assurance for the healthcare environment and to ensure patients, staff and visitors are protected against risks associated with hazards such as unsafe premises.
- Health and Safety legislation places legal duties on various duty holders. The Health and Safety Executive (HSE) is the national regulator for workplace health and safety.
- Health Technical Memorandum (HTM) are the main source of specific healthcare-related guidance for estates and facilities.
- Health Building Notes (HBN) give best practice guidance on the design and planning of healthcare buildings and on the adaption / extension of existing facilities.
- Patient-led assessment of the care environment (PLACE) is the system for assessing the quality of the hospital environment.
- Patient Environment Partnership Group (PEPG) provides an operational overview of the facilities and environment, which supports the delivery of the Trust objective “Best Hospital”.

Private Finance Initiative (PFI) – The Trust contracts directly with The Hospital Company (QAH Portsmouth) Ltd (THC), the PFI Special Purpose Company (Project Co.), for the provision of all estates and facility services at Queen Alexandra Hospital. The PFI Project Agreement is for a period of 35 years which commenced at the date of the Project Agreement, 15 December 2005. Engie provides all the facility management services at Queen Alexandra Hospital on behalf of THC.

5. DUTIES AND RESPONSIBILITIES

Healthcare organisations have a duty of care to patients, visitors and staff to ensure a safe and appropriate environment for healthcare. This requirement is identified in a wide range of legislation and common law.

At the most senior level within an organisation, this responsibility does not need to include technical, professional or operational duties, but the “accountable officer” should have access to a structure that delivers governance, assurance and compliance through a formal reporting mechanism.
**Trust Board**
The Trust Board has overall accountability for all the activities of the organisation, which includes the management and maintenance of the Trusts estate. This includes the following:-

- Land and property matters;
- Planning strategic investment in the estate;
- Land and property appraisal;
- Asset management;
- Building maintenance;
- Engineering maintenance;
- Energy management.

The Trust Board delegates the responsibility for the management and maintenance of the estate to the Chief Executive.

**Chief Executive**
The Chief Executive has the ultimate managerial responsibility for the management and maintenance of the estate and delegates the operational day to day responsibility and authority to the Director of Estates, Facilities, PFI and Capital Developement (via the Chief Financial Officer) who will manage, maintain and control the estate as set out in this policy and other related policies.

**Director of Estates, Facilities, PFI and Capital Development**
The Director of Estates, Facilities, PFI and Capital Development will operate the management and control systems outlined in this policy and procedure document. The Director of Estates, Facilities, PFI and Capital Developement leads the Trust's Estates and Facilities `Team and is supported by the Deputy Director of Estates and Facilities, the Head of Capital and Property, Head of Estates and Head of Soft FM

The Estates and Facilities Team will undertake an informed client role to monitor the delivery of the estate and facilities management service at Queen Alexandra Hospital via the PFI arrangement. An informed client role will also be adopted as appropriate where facilities used by the Trust are provided by other NHS organisations.

The Estates and Facilities Team will also ensure robust project management, including initial feasibility of proposed new developments and reconfigurations to the estate.

The PFI Project Agreement identifies the obligations and responsibilities of Project Co. and its sub-contractor Engie. The Trust has robust PFI contract management arrangements in place. An overview of the PFI arrangement is provided at Appendix B(i). It is through the Liaison Committee and supporting sub-groups / meeting structure that the PFI is monitored and managed.

An overview of the PFI contractual agreement is also provided at Appendix B(ii) for information.
All Staff

It is the responsibility of all Trust employees and other staff using the Trust’s premises to:

- Recognise their duty under legislation to take reasonable care for their own safety and the safety of others at all times;
- Be familiar with the contents of this policy, but in particular the supporting policies where relevant, e.g. Fire Safety, Security etc.

Professional Structure

While the Chief Executive and the Trust Board carry ultimate responsibility for the safe and secure healthcare environment the structure below represents the professional adopted approach to the delivery of high risk impact specialist services within the Trust. These include the management of high voltage electricity, low voltage electricity, decontamination, medical gas pipelines, asbestos, water safety and quality, ventilation systems, lifts, pressure systems etc.

Designated Person (DP)

This person provides the essential senior management link between the organisation and professional support, which also provides independence of the audit-reporting process. The DP will also provide an informed position at board level. The DP will work closely with the Senior Operational Manager (SOM) to ensure that provision is made to adequately support the specialist service.
Trust Senior Operational Manager (SOM)
The SOM may have operational and professional responsibility for a wide range of specialist services. It is important that the SOM has access to robust, service-specific professional support which can promote and maintain the role of the “informed client” within the healthcare organisation. This will embrace both the maintenance and development of service-specific improvements, support the provision of the intelligent customer role and give assurance of service quality.

Authorising Engineer (AE)
The AE will act as an independent professional adviser to the healthcare organisation. The AE should be appointed by the organisation with a brief to provide services in accordance with the relevant HTM. The professional status and role required may vary in accordance with the specialist service being supported.

The AE will act as assessor and make recommendations for the appointment of Authorised Persons (APs), monitor the performance of the service, and provide an annual audit to the DP. The AE, to effectively carry out this role, particularly with regard to audit, should remain independent of the operational structure of the healthcare organisation.

Appointment of AE’s is discipline-specific and in some cases an AE for a site may be a Trust appointment, a PFI appointment or a joint appointment, dependant upon the circumstances of the particular discipline and site.

Authorised Person (AP)
The AP has the key operational responsibility for the specialist service. This person will be qualified and sufficiently experienced and skilled to fully operate the specialist service. They will be nominated by the AE, appointed by the healthcare organisation and be able to demonstrate:

- Their understanding through familiarisation with the system and attendance at an appropriate professional course;
- Competency;
- A level of experience; and
- Evidence of knowledge and skills.

An important element of this role is the maintenance of records, quality of service and maintenance of system safety (integrity).

The AP will also be responsible for establishing and maintaining the validation of Competent Persons (CPs), who may be employees of the organisation or appointed contractors.

Larger sites may need more than one AP for a particular service. Administrative duties such as record-keeping should be assigned to a specific AP and recorded in the operational policies.

Competent Person (CP)
This person provides skilled installation and/or maintenance of the specialist service. The CP will be appointed, or authorised to work (if a contractor), by the AP. They will demonstrate a sound trade background and specific skill in the specialist service. They will work under the direction of the AP and in accordance with operating procedures, policies and standards of the service.
6. PROCESS

Details of the processes to be followed are set out within supporting Trust Policies which include:

- Fire Safety Policy;
- Security Policy for controlling car parking;
- Asbestos Management Policy;
- Waste Handling Policy;

7. TRAINING REQUIREMENTS

Detail of the specific training requirements are contained within the supporting separate Trust Policies which include:

- Fire Safety Policy;
- Security Policy for controlling car parking;
- Asbestos Management Policy;
- Waste Handling Policy;

Regular reviews of training needs will be used to inform requirements for the forthcoming financial year.

8. REFERENCES AND ASSOCIATED DOCUMENTATION

See Appendix A for an overview of the NHS Regulatory and Assurance framework for Estates and Facilities.

9. EQUALITY IMPACT STATEMENT

Portsmouth Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly

Our values are the core of what Portsmouth Hospitals NHS Trust is and what we cherish. They are beliefs that manifest in the behaviours our employees display in the workplace.

Our Values were developed after listening to our staff. They bring the Trust closer to its vision to be the best hospital, providing the best care by the best people and ensure that our patients are at the centre of all we do.

We are committed to promoting a culture founded on these values which form the ‘heart’ of our Trust:

**Working together……**

- for Patients
- with Compassion
- as One Team
- Always improving

This policy should be read and implemented with the Trust Values in mind at all times.
10. MONITORING COMPLIANCE WITH PROCEDURAL DOCUMENTS

This document will be monitored to ensure it is effective and to assure compliance.

The effectiveness in practice of all procedural documents should be routinely monitored (audited) to ensure the document objectives are being achieved.
The process for how the monitoring will be performed should be included in the procedural document, using the template above.

The details of the monitoring to be considered include:

- The aspects of the procedural document to be monitored: identify standards or key performance indicators (KPIs);
- The lead for ensuring the audit is undertaken
- The tool to be used for monitoring e.g. spot checks, observation audit, data collection;
- Frequency of the monitoring e.g. quarterly, annually;
- The reporting arrangements i.e. the committee or group who will be responsible for receiving the results and taking action as required. In most circumstances this will be the committee which ratified the document. The template for the policy audit report can be found on the Trust Intranet Trust Intranet -> Policies -> Policy Documentation
- The lead(s) for acting on any recommendations necessary

<table>
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<th>Minimum requirement to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency of Report of Compliance</th>
<th>Reporting arrangements</th>
<th>Lead(s) for acting on Recommendations</th>
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<td>Director of Estates, Facilities, PFI and Capital Development</td>
<td>NHS Premises Assurance Model (NHS PAM)</td>
<td>Annual</td>
<td>Annual Estates Report to: • SMT / Trust Board</td>
<td>Director of Estates, Facilities, PFI and Capital Development.</td>
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<td>Head of Internal Audit</td>
<td>Internal Audit</td>
<td>Annual or in line with the Audit Plan</td>
<td>Policy audit report to: • Audit Committee</td>
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Appendix A

NHS Regulatory and Assurance framework for Estates and Facilities

Assurance of estates and facilities

One of the government’s key priorities is delivering better health outcomes for patients. The quality and fitness-for-purpose of the healthcare estate is vital for the delivery of high quality, safe and efficient healthcare. Quality and fitness-for-purpose of the estate are assessed against a set of legal requirements, standards and best practice guidance. This Policy adheres to the guidance outlined in the relevant Health Technical Memorandum (HTM) and will be taken into account as evidence towards compliance with these legal requirements and standards.

Regulator requirements: standards of quality and safety

The Care Quality Commission (CQC) regulates all providers of regulated health and adult social care activities in England. The CQC’s role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

At the time of preparing this document, registration requirements are set out in the Care Quality Commission (Registration) Regulations 2009 (CQC Regulations) and include requirements relating to:

- Safety and suitability of premises;
- Safety, availability and suitability of equipment; and
- Cleanliness and infection control.

The CQC is responsible for assessing whether providers are meeting the registration requirements. Failure to comply with the CQC Regulations is an offence and, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, CQC has a wide range of enforcement powers that it can use if the provider is not compliant. The regulations stipulate that all premises and equipment used must be safe, clean, secure and suitable for the purpose for which they are being used, and properly used and maintained.

NHS Constitution

The NHS Constitution sets out the rights to which patients, public and staff are entitled. It also outlines the pledges that the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All healthcare organisations are required by law to take account of this Constitution in their decisions and actions.

Healthcare organisations need to “ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice” [pledge].

In order to deliver on this pledge, it specifically advises NHS organisations to take account of:

- National best-practice guidance for the design and operation of healthcare facilities;
- The NHS Premises Assurance Model (NHS PAM).
NHS Premises Assurance Model
The NHS has developed, with the support of DHSC, the NHS Premises Assurance Model (NHS PAM), whose remit is to provide assurance for the healthcare environment and to ensure patients, staff and visitors are protected against risks associated with hazards such as unsafe premises.

Primarily aimed at providing governance and assurance to boards of organisations, it allows organisations that provide NHS-funded care and services to better understand the effectiveness, quality and safety with which they manage their estate and facilities services and how that links to patient experience and patient safety.

Key questions are underpinned by prompt questions which require the production of evidence. Healthcare organisations should prepare and access this evidence to support their assessment of the NHS PAM.

The model also includes reference to evidence and guidance as a helpful aide-memoir to assist in deciding the level of NHS PAM assurance applicable to a particular healthcare site or organisation.

NHS PAM is designed to be available as a universal model to apply across a range of estates and facilities management services.

Health and safety legislation
The Health & Safety Executive (HSE) is the national regulator for workplace health and safety. The following legislation places legal duties on various duty holders:

- Workplace (Health, Safety and Welfare) Regulations
- Health and Safety at Work etc Act 1974, section 3
- Management of Health and Safety at Work Regulations, regulation 3
- Construction (Design and Management) Regulations
- Manual Handling Operations Regulations
- Pressure Equipment Regulations
- Pressure Systems Safety Regulations
- Confined Space Regulations

Health Technical Memorandum (HTM)
HTMs are the main source of specific healthcare-related guidance for estates and facilities professionals. They give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

HTM 00 is supported by the HTM suite of guidance (see diagram below). The aim of HTM 00 is to ensure that everyone concerned with the managing, design, procurement and use of the healthcare facility understands the requirements (including regulatory) of the specialist, critical building and engineering technology involved. The core guidance (including professional support) is applicable to all building engineering services including those not covered by HTMs (for example, steam, gas and pressurised hot water services).
HTM 00 addresses the general principles, key policies and factors common to all engineering services within a healthcare organisation. Key issues include:

- Compliance with policy and relevant legislation;
- Professional support and operational policy;
- Design and installation;
- Maintenance;
- Training requirements.
**Principles of healthcare engineering**

Patients and staff have a right to expect that engineering systems and equipment will be designed, installed, operated and maintained to standards that will enable them to function efficiently, reliably and safely. Compliance with the guidance in the HTMs will help to meet these goals.

Healthcare providers have a duty under the Health and Safety at Work etc. Act to ensure that appropriate engineering governance arrangements are in place and are managed effectively. HTMs provide best practice engineering standards and policy to enable management of this duty of care. The special nature of healthcare premises and dependency of patients on the provision of effective and efficient engineering services (in most cases 24 hours a day, seven days a week) requires that engineering staff and systems must be resilient in order to maintain the continuity of health services and ensure the ongoing safety of patients, visitors and staff.

**Engineering governance**

Engineering governance is concerned with how an organisation directs, manages and monitors its engineering activities to ensure compliance with statutory and legislative requirements whilst ensuring the safety of patients, visitors and staff is not compromised. Healthcare organisations need to ensure that sound policies are approved by the board of directors. These should:

- Ensure safe processes, working practices and risk management strategies are in place to safeguard all their stakeholders and assets in order to prevent and reduce harm or loss; and
- Be backed up with adequate resources and suitably qualified, competent and trained staff.

Responsibility and, more specifically, the duty of care within a healthcare organisation are vested in the board of directors and its supporting structure.

**Health Building Notes (HBN)**

Health Building Notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation / extension of existing facilities.

The HBNs provide information to support the briefing and design processes for individual projects in the NHS building programme.

All Health Technical Memoranda should be read in conjunction with the relevant parts of the Health Building Note series.

**Activity Database (ADB)**

The Activity DataBase (ADB) data and software assists project teams with the briefing and design of the healthcare environment. Data is based on guidance given in the Health Building Notes and Health Technical Memoranda.
HTMs and the Legislative Framework
Patient-Led Assessments of the Care Environment (PLACE)

Patient-led assessments of the care environment, (PLACE) is the system for assessing the quality of the hospital environment, which replaced Patient Environment Action Team (PEAT) inspections from April 2013. PLACE assessments apply to all hospitals delivering NHS-funded care, including day treatment centres and hospices.

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviours.

The assessment is undertaken annually, and results are reported publicly to help drive improvements in the care environment. The results will show how hospitals are performing nationally.

Most importantly, patients and their representatives will make up at least 50 per cent of the assessment team, which will give them the opportunity to drive developments in the health services they receive locally.

Trust Standing Orders (SOs) & Trust Standing Financial Instructions (SFIs)

In line with the Trust’s Standing Orders and the Trust’s Standing Financial Instructions, the Trust shall comply as far as is practicable with the requirements of the Department of Health “Capital Investment Manual” and “Estatecode” and shall consider guidance “Best Practice in making Investments for NHS foundation Trusts” and other such guidance as may be issued by the Independent Regulator from time to time in respect of capital investment and estate and property transactions.

The Chief Executive and the Director of Finance and Investment shall ensure that the arrangements for financial control and financial audit of buildings and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

Estate Return Information Collection (ERIC)

ERIC data enables the analysis of estates and facilities information from Foundation Trusts and NHS Trusts in England. It is a mandatory requirement that returns are submitted, which in turn becomes part of the national statistics. Statistics taken from the organisation’s annual ERIC returns are a good basis for assessment and can be used to indicate its performance relative to its peers. Most importantly, ERIC should be treated as the standard first step when analysing estate data. It is important that accurate figures to address critical infrastructure and longer term risks are presented at local and national level via ERIC in order to monitor condition of the estate assets.
PFI Governance Structure (B(i)) and PFI Contract Framework (Overview) (B(ii))

The Trust contracts directly with The Hospital Company (QAH Portsmouth) Limited, the Special Purpose Company (SPC), for the provision of all services related to the PFI Project. The Project Agreement is for a period of 35 years, including a 3.5 year construction phase. The contract commenced at the date of the Project Agreement, 15 December 2005 and is subject to rights of early determination, including in the event of there being poor performance by THC of the services.

The Project includes a number of types of contractual agreements, which are summarised diagrammatically below:
An overview of the PFI (QAH) Project Governance Structure is shown below:
PFI Liaison Committee
This is chaired by the Trust and has joint membership from the Trust and The Hospital Company, including Engie. The Liaison Committee provides a means for joint review of issues relating to all day to day aspects of the performance of the Agreement. It also provides a forum for joint strategic discussion, considering actual and anticipated changes in the business of the Trust, and possible variations to the Agreement to reflect those changes or for more efficient performance of the Agreement.

Combined Contract Reporting Group (CCRG)
The Facilities Management (FM) Combined Contract Reporting Group reviews and discusses on a monthly basis the content of the monthly FM monitoring report provided by The Hospital Company to the Trust. The report details information required monthly from Project Co. as set out within the PFI Agreement in respect of all FM services. The review and discussion at this meeting ensures the contract is delivering quality services that represent value for money and to jointly highlight areas where the FM services can be improved to the benefit of patients and the delivery of the Trust's services.

Patient Environment Partnership Group (PEPG)
The Patient Environment Partnership Group is commissioned by the Patient Experience Steering Group (PESG) to provide an operational overview of the facilities and environment, which supports the delivery of the Trust objectives "Best Hospital". It has no executive powers, other than those outlined in it terms of reference:

- Ensure the Trust considers all aspects of the patient environment in the delivery of high quality patient care and the achievement of the organisation’s objectives;
- Ensure the provision of an environment and food which promotes healing and well being as defined by national standards;
- Ensure the facilities management services, provided by Engie, meet the patient and organisations required standards; and
- Ensure collaboration and partnership working with members of the public, Engie and the Trust in all environment and facilities matters, contribution to Trust objectives.

Client Contract Group
The Client Contract Group reviews and discusses, on a monthly basis, the operational management of the contract for the monthly Facility Management Services provided to the Trust by The Hospital Company through Engie.

Technical Meeting Group
The Technical Meeting Group meets every two weeks to review and discuss technical and compliance issues in respect of the design, construction and maintenance of the estate and facilities at QAH.

Utility Working Group
The Utility Working Group jointly reviews, discusses and agrees an energy and conservation policy which establishes consumption targets and measures performance against these, in accordance with the requirements of the PFI Agreement.
Human Resource (HR) Monitoring
The HR Monitoring Group reviews and discusses, on a monthly basis, the content of the monthly report provided by Project Co. in respect of all Retained Staff Members as set out within the Agreement.

Appendix B(ii)

PFI Governance Structure (B(i)) and PFI Contract Framework (Overview) (B(ii)

The Project Agreement is in the standard form for NHS Project Agreements as issued by the Department of Health. The version that has been used for this Project is the version that was issued in September 2003 – Standard Form 3 (SF3) together with subsequent changes to SF3 issued in July 2004.

The Hospital Company (THC)

Land Interests
THC does not have a land interest in the hospital, subject to various exceptions that are set out below. THC was given an exclusive licence to carry out the construction works (the Works), including works to the existing estate (the Retained Estate), in those areas where the construction works took place. The Trust has also granted to THC a non-exclusive licence to perform and manage the FM services in respect of those areas where the services are to be provided. The FM services were provided, in part, in advance of the completion of the construction of the new buildings during the interim period and the non-exclusive licence operates for the relevant areas at the commencement of the provision of the FM services.

The Trust has granted individual leases to THC of small areas within the hospital, which are required as exclusive office space for the service providers and a further area, which is used by the service providers for provision of the patient catering and non-patient catering service. The leases were granted at the time the services that they relate commenced. The leases are co-terminous with the Project Agreement.

The Trust has leased to THC two areas (a retail area and a café area) in the newly constructed building. The leases commenced on completion of the new facility and otherwise will be co-terminous with the Project Agreement. THC has sub-let each of the areas to individual retailers and in the case of the retail area; this may be sub-let to up to three different retailers at any given time. In the event of early determination of the Project Agreement the leases will terminate but the Trust will enter into new leases of an equivalent term with the tenants.

Sub-Contracts
THC had sub-contracted its obligations to design and construct the Works at QAH to Carillion [now insolvent] and its responsibilities for the provision of FM services to the whole of the site to Engie.

Engie will in turn be entitled to further sub-contract service provision responsibility to specialist sub-contractors. At the commencement of the contract three specialist sub-contractors were identified, Sunlight Service Group Limited to provide the linen and laundry service, Dalkia PLC operate the energy centre and White Rose Environmental Limited deal with clinical waste disposal. Engie now operate the
Energy Centre, Berendesbn operate the Laundry service and SRCL Limited provides the clinical waste disposal service.

The provision of these services are supported by detailed service level specifications (SLS) drawn up by the Trust and agreed to by THC. These SLSs are included in Schedule 14 of the Project Agreement.

The parent company of the Engie Services, has provided performance guarantees to THC.

Since the insolvency of Carillion responsibility and liability for construction design, works and defects has been retained by THC.

**Direct Agreement**

A direct agreement between the Trust, THC and the Law Debenture Trust plc., as Security Trustee, for the providers of the senior debt was entered into contemporaneously with the Project Agreement. The Security Trustee will have the right temporarily to step into THC’s rights and obligations under the Project Agreement if THC is in serious breach of its funding arrangements or is in serious default under the Project Agreement. The Direct Agreement also deals with the order of priority of claims in respect of default of the building sub-contractor or the services sub-contractor.

**Funding Agreements**

Financial Security Assurance (UK) Limited, the Department of Health and The Law Debenture Trust Corporation plc. (as Security Trustee) in respect of the provision of senior debt, and Royal Bank Project Investments Limited providing subordinate debt and ordinary share capital, entered into appropriate funding agreements with THC at the date of the Project Agreement under which they committed to advance the relevant funds to THC on the terms set out in those agreements.

The Department of Health's provision of senior debt was provided in the form of Credit Guarantee Finance (CGF) and is guaranteed by Financial Security Assurance (UK) Limited.

**Performance of Services**

THC has the primary responsibility for monitoring the performance of the services. The Service Level Specifications are contained within Schedule 14 of the PFI Agreement. The Trust will have an ability to monitor performance of services and if the service deteriorates the Trust will be entitled to increase its monitoring. Continued poor performance will allow the Trust to step into a specific service and ultimately to require THC to replace a particular service provider. In the case of extreme poor performance it would be possible for the Trust to terminate the Project Agreement entirely, although not individual services.

**Project Specific Issues in respect of the Project Agreement**

**Phasing**

The construction aspects of the project comprised three phases for the Works. Phase 1 of the works was completed on the actual completion of the Rehabilitation, Pathology and Mortuary building (the Phase 1 Actual Completion Date – 16 August 2007). Phase 2 of the works completed on the actual completion of the new main
hospital facility (the Phase 2 Actual Completion Date – 19 June 2009). Phase 3 of
the works completed on the actual completion of the reconfiguration works in the
main hospital building and any outstanding back-log maintenance works to the
Retained Estate (the Phase 3 Actual Completion Date – 24 June 2010). All three
phases ran in parallel.

The payment by the Trust to THC of the Service Payment commenced after the
Phase 2 Actual Completion Date at approximately 98% of the total Service Payment,
with 100% becoming payable after the Phase 3 Actual Completion Date.

Works of backlog maintenance to the Retained Estate
As part of the services element of the contract, THC has taken lifecycle responsibility
for maintaining the whole of the Queen Alexandra Hospital site, including the existing
buildings. A schedule of backlog maintenance works required to bring the Retained
Estate up to a satisfactory condition was agreed with THC and was derived from a
survey carried out by a firm of local surveyors, Ridge. The nature of the works was
intended to bring the Retained Estate up to a condition that would satisfy the
elements of NHS Estatecode Conditions relating to physical condition, fire and health
and safety. The works were largely carried out during the period of construction of
the new facility but some works are scheduled to be carried out after completion of
the new facility. The Works were programmed in a way that reduced the possibility
that a delay to the Retained Estate works could impact on the programme for the
completion of the new facility in order to minimise the risk that the interaction
between the Trust and THC in respect of the maintenance works, particularly in
respect of decanting arrangements, causes delay to the build programme for the new
facilities. During the construction phase, where THC was carrying out works in areas
of the Retained Estate - Retained Estate Works - in accordance with the agreed
construction sub-plan Excusing Cause protection was available to THC so that it was
not penalised via the payment mechanism for the fact that works are ongoing.

Excluded Items
As part of the agreement of the scope of the works to the Retained Estate the Trust
agreed with THC that THC would not carry out certain works. These are defined in
the Project Agreement as Excluded Items and include certain works related to the
Disability Discrimination Act and to Fire Regulations. The Trust excluded these items
as the Trust was of the view that the relevant legislation did not require those works
to be done and that if it were itself carrying out the Retained Estate Works, it would
not itself carry out such works. The agreement provides that if the Excluded Items
are in fact required by law then such items will be included within the scope of works
to be carried out by THC to the Retained Estate by way of a variation to the Project
Agreement. The Trust will, therefore, take the risk in respect of a Change of Law, as
defined in the Project Agreement, requiring that any of these items of work be carried
out.

Asbestos
THC were responsible for the removal or encapsulation of specific asbestos in the
Retained Estate and all areas within buildings demolished where identified in the
agreed asbestos register or in the case of areas which had been sampled, where
asbestos should have been identified by a properly carried out Type 2 survey. In
relation to asbestos discovered in the Retained Estate but not identified in the
asbestos register the Trust retain the risk of such discovery of asbestos throughout
the term of the Project Agreement, except in the case of the areas where significant
work is being carried out (the Reconfiguration Works Areas) where the Trust were only responsible for asbestos discovered before the completion of Phase 3. In the Reconfiguration Works Areas, THC will be responsible after the Phase 3 Actual Completion Date.

Additional Works
In addition to the works that have been agreed between the Trust and THC in respect of the Retained Estate, THC have identified a possibility that further works – Additional Works - may have been needed in order to bring the Retained Estate up to the proper level of condition and that these would only have become evident when the backlog maintenance was actually carried out. THC accepted the risk of those works and passed the risk to the building sub-contractor.

Trust Maintenance Obligations
Prior to the transfer of the Trust's estate maintenance team to THC, the Trust continued to be responsible for the maintenance of the retained estate.

Decanting
There were four subsets of decant moves:
- The old South Block decants whereby occupants were required to move out of areas that were to be demolished.
- Interim moves (during the main construction period, including and consequent on the move of pathology and rehabilitation into their new accommodation).
- The main moves into the new build; including relocating staff and patients from the St. Mary's site and Royal Hospital, Haslar to QAH.
- In addition, there were moves consequent on the carrying out of any reconfiguration works and the condition B backlog maintenance in the existing estate.

Driven by the construction programme and its phasing, all moves needed careful timetabling, and involved both the Trust and THC delivering on agreed responsibilities to avoid time delays and claims for additional costs. THC was responsible for the physical transfers, with the Trust retaining the clinical risks.

Advance Works
In order to achieve the completion date of the construction element of the project, and to enable THC to begin the main phase of the construction programme immediately after Financial Close, the Trust entered into an Advance Works agreement. The agreement for the works was between the Trust and Engie, because THC did not become a legal entity until Financial Close. The works were transferred and warranted to THC at Financial Close. Early Works are not covered by the Standard Form contract. However, there was precedent in the Oxford (John Radcliffe) scheme, and the legal documentation from that scheme was being used as a standard by the PFU. The aim was that the carrying out of these works was not at the Trust’s risk although if the project were not to proceed the Trust would be required to pay an agreed value for the works carried out.

Interim Services
THC provided interim services to the Trust on both the QAH site and the SMH site up to the Phase 2 Actual Completion Date when the services required in the main operational period (defined in the Project Agreement as the Operational Term) commenced. The payment for the services was subject to the application of the payment mechanism, although the standard of service required were reduced in
certain limited cases from the standard of service set for the Operational Term and the deductions were fixed amounts for certain specific failures where the standard of service is considered particularly important to the Trust. The performance regime could have led to termination of a subcontractor but during the interim services would not have led to termination of the Project Agreement. Service Failure Points accrued did not roll over into the Operational Term. Instead, points awarded over the last six months of the interim services period were awarded a monetary value (equivalent to double the value of the deductions accrued in that period) for which THC was liable to the Trust.

THC and the Trust worked together to implement an agreed HR Plan during the interim services period. When certain key events occurred within a defined period the Trust agreed that THC was entitled to a temporary “bedding in” period in respect of which deductions were reduced. The Interim Services was provided on a phased basis. There was planned to be a first phase shortly after financial close comprising the transfer of the estates management service and the Helpdesk, followed by a second phase with all other services transferring other than linen and laundry. There was a third phase, in 2008, with the transfer of the linen and laundry service. Due to the delay experienced in reaching Financial Close the first and second phases occurred simultaneously.

Energy
The provision of energy on a whole site basis was a required deliverable of the project. The underlying principle is that the Trust takes the price risk, and THC the volume risk (thus incentivising the delivery and maintenance of energy efficient facilities). THC constructed the Energy Centre - and an element of the Trust's energy requirements is from the output from the CHP. THC is responsible for procuring the energy supply contracts.

Equipment
The Trust agreed that with the exception of, essentially, medical equipment, THC is responsible for the maintenance of all equipment, including FM Services Equipment. The allocation of the responsibility for each item of equipment (including FM Services Equipment) including responsibility for supplying, installing replacing and disposing of it will be set out in an Equipment Responsibility Matrix.

To the extent that there was a difference between the assumptions recorded in the base-line matrix regarding the numbers of items which were expected to be suitable for transfer and those that were actually determined to be suitable for transfer there was a deemed variation to the Project Agreement in accordance with the contractual variation procedure. THC and the Trust agreed which items of FM Services Equipment transferred from the Trust's existing resources.

THC is responsible for the replacement of all “category A” equipment and the state of that equipment when it is handed back at the end of the Project is to be in a Handback Condition (defined as being of sufficient continuing utility to continue to be used for the purposes of the Trust).

The Annual Service Payment reflected an agreed baseline of equipment at Financial Close. The Trust was to ensure that this baseline was consistent with the development of the design agreed at Financial Close and the very detailed Equipment Responsibility Matrix.
Independent Tester
Included in the Standard Form contract, the role of the Independent Tester (IT) was to certify, on behalf of both parties, that the construction of the new facilities had been completed to the agreed design and other standards. The appointment of the IT was a joint appointment. For the purposes of this Project the IT was also be required to certify that the Reconfiguration Works and the Retained Estate Works had been completed. The IT also certified the Advance Works, which were not certified by a statutory body.

Latent Defects
A latent defect comprises “a hidden or dormant defect or use of deleterious materials in the Sub-Structure, Frame, Upper Floors, Roof Structure, Stair Structure or External Walls of the Retained Estate attributable to (a) defective design and workmanship or (b) the use of defective or deleterious materials (in each case other than by Project Co) having regard to good industry practice and to the appropriate British Standards current at the date of this Agreement and to which Clause 5.2B [Asbestos] does not apply and which is not within the knowledge of Project Co at the date of the Agreement provided that an absence of insulation shall not constitute a Latent Defect”.

THC has taken the risk of latent defects in the new build part of the facilities, but would not do so for the Retained Estate. Insurance was not a cost effective option. The Trust is effectively self-insuring this risk. The Trust therefore retains the risk of a latent defect occurring in the Retained Estate.

Should a latent defect occur, the Trust would be obliged to seek to address it by variation to the scope of the Project. Where it transpires that a variation is not possible and the works required amount to more than £10 million the Trust has the option to terminate the Project, in which case, compensation will be payable on a force majeure basis.

Pending any variation taking effect, the existence of a latent defect would constitute a Delay Event and a Compensation Event and/or an Excusing Cause. Additionally, if a latent defect causes THC to lose income in respect of the Non-Patient Catering Service, the Car Parking Service or the rental income of the area under the Retail Lease then subject to a test of materiality the Trust would be liable to pay such lost income up to a pre-agreed level in respect of the relevant affected services. The capped level is equivalent to the amount by which THC has reduced the Annual Service Payment in respect of its projection of income from those services.

Unforeseen Ground Conditions/Contamination
Where THC was unable to survey an area under existing buildings the Trust took the risk of unforeseen ground conditions/contamination in line with SF3. Certain caveats, however, applied:

- Once a building had been demolished and THC had therefore had the opportunity to conduct any surveys deemed necessary, any risk associated with the ground conditions or contamination under that building reverted to THC;
- Risk of unforeseen ground conditions and/or contamination would not lie with the Trust if they were revealed or evident from other surveys disclosed to THC by the Trust prior to the date of the Agreement or carried out by or on behalf of THC or Engie. or the Service Providers before the Agreement which
should reasonably have been extrapolated from those surveys, except in cases of contamination of materially higher levels or materially different in type and/or level to that revealed by such surveys.

Third Party income generation
THC has assumed a level of income from third parties (mainly through Car Parking, Non-Patient Catering Services and retail activity) in calculating their proposed Service Payment. THC has an exclusive right to carry out those activities. During the interim services period THC received the income generated from the Non-Patient Catering Service and the Trust retained the income generated by the Car-Parking Service.

In addition, the Trust imposed restrictions that may be required on the types of income generating activities, which it would allow on the site (i.e. only allowing those consistent with an NHS ‘ethos’).
To the extent that THC's ability to earn third party income from Non-Patient Catering, Car-Parking or retail services is affected by an Excusing Cause or Compensation Event, THC will be able to claim lost revenue up to a specified level of underwriting. THC's ability to make such a claim will be subject to mitigation and a materiality test. This broadly mirrors the situation set out above for Latent Defects.

Indemnities and Insurance
No construction work was being undertaken by THC at SMH and no services were to be provided from the Site by THC once the Operational Term commenced. The Trust agreed that should damage have occurred to SMH buildings on the Site (and identified within the Project Agreement) it would not have required THC to indemnify it for reinstatement of those buildings, although it would have required it to provide alternative accommodation to allow the Trust (approval of which the Trust would not unreasonably withhold or delay) to continue to provide clinical services for a period of three months from the last to occur of the Phase 1 Actual Completion Date or Phase 2 Actual Completion Date (to allow for any practical aspects of the transition). At QAH the Trust agreed to continue to insure the Social Club and the Swimming Pool under the NHS Pool. Accordingly, liability for any damage to these buildings was excluded from the indemnity for damage to Trust Assets given by THC in the Project Agreement.

Real Estate
Historically, there were a number of third party interests on the QAH Site, which may or may not have continued to subsist as a matter of law. If third party interests were to be exercised in a way that caused THC to suffer a delay to the works or detriment to providing the services, THC would have been entitled to claim a Delay Event and a Compensation Event during the construction period and will be entitled to claim an Excusing Cause during the operational period. It will also be entitled to compensation for loss of third party income.

Within the existing hospital building there was a retail unit, which needed to be vacated in order for the construction of the new facility to be completed. If it was not possible to obtain vacant possession within 18 months of the date of the Agreement the Trust would have needed to issue a Works Variation to work around the unit and it was agreed with THC that there will be no impact in terms of time or money in this
respect although it will be necessary to issue a subsequent Variation to go back and work in the area once vacated. There would also have been an impact on the third party revenue which THC or the Service Provider would lose because the previous existing lease contained non-compete provisions or failure of the Trust to procure vacant possession. The Trust indemnified Project Co in these circumstances subject to the agreed caps and subject to an obligation to mitigate loss.

Payment Mechanism and Payment Arrangements
The payment mechanism follows the standard form for PFI Projects. Payment of the full Service Payment commenced when the Facilities were fully commissioned, in accordance with the NHS Standard Form Contract, i.e. construction/final site works had been completed, equipment installed, facilities provided by THC were available and fully operational. The Service Payment is based upon the services performed by THC across the entire QAH Site.

The Trust pays THC for services rendered to it on a monthly basis, in arrears. Charges levied by THC are calculated in accordance with the payment mechanism included within the Project Agreement. There is a single Service Payment. All payments are reviewed annually and revisions are linked to annual movements in the retail prices (all items) index (except for the element of the service payment attributable to the retention of employment FM staff, which attracts, in effect, indexation at the level of NHS pay wards).

If services are not provided to an acceptable standard or the service level specifications are not met in any other way, appropriate deductions are made from the Service Payment in accordance with formulae set out in the payment mechanism relating to Quality Failures and Failure Events. Quality Failures and Failure Events also attract a number of service failure points. The level of deductions from the Service Payment and the number of service failure points are dependent on the seriousness of the default and the importance to the Trust of the area of the hospital that is affected by poor performance. There is no distinction between the new facility and the existing facilities in this respect.

THC has an obligation to ensure that the services that it provides, other than the maintenance of the facilities, remain competitive throughout the period of the Project Agreement. The method to be employed in order to achieve this is periodic market testing and benchmarking exercises, which take place regularly, at five yearly intervals.

Where recyclable waste becomes subject to a charge at any time up to six months before the first market testing date, the Trust will meet the additional costs incurred in dealing with it.

Volume Adjustments
The payment mechanism contains an element of volume adjustment, which is calculated for a contract month and added to the service payment for that month. Volume adjustments will apply to the following services:

- Laundry
- Waste
- Catering
- Energy
THC is responsible for the delivery of energy efficient facilities (new and reconfigured buildings) over the term of the concession period. The facilities have been designed and will be constructed in order that they meet appropriate standards, which will be based upon a 20-year degree day average for all space heating loads. This was subject to independent review on commissioning and throughout the Project Term for the purposes of determining appropriate volume limits. The variations in volumes, which are linked to the deterioration in the energy efficiency of building, is the responsibility of THC. The risk in relation to changes to utility tariffs throughout the concession period is borne by the Trust, although until the commencement of the Energy Centre the Trust simply paid the actual cost of the energy consumed as a pass through cost.

The Trust pays THC for the electricity, gas and water consumed at the facilities (excluding THC areas) each month, through the Service Payment, subject to agreed volume limits in any 12 month rolling period. The Trust and THC seek to mitigate and minimise their use of energy at all times and follow an agreed Energy Protocol.

Indexation
The Service Payment is indexed on 1 April, for each Contract Year, by reference to RPI published or determined with respect to the month of February most recently preceding the date when the provision in question is to be given effect. The only exception to this being the staff costs associated with the Retention of Employment model, which will be treated as a pass through cost, with the risk retained by the Trust (i.e. NHS pay awards).

Agenda for Change
The Project Agreement was adapted to reflect the fact that the transfer of staff took place during or before the staff members were assimilated onto the Agenda for Change arrangements. The effect of Agenda for Change was that the costs of the employment of staff increased and that cost increase needed to be identified and allocated within the employment provisions of the agreement. The Trust is responsible for meeting this cost increase.