STRATEGIC OUTLINE CASE FOR
THE REPROVISION OF
MENTAL HEALTH IN-PATIENT SERVICES
ACROSS THE
NORTHERN HEALTH & SOCIAL CARE TRUST

V17 30 MARCH 2012
Project Overview

1.0.1 The Northern Health and Social Care Trust is one of five health trusts in Northern Ireland which were established on 1 April 2007. The Trust provides an extensive range of health and social care services for people across the local council areas of Antrim, Ballymena, Ballymoney, Carrickfergus, Coleraine, Cookstown, Larne, Magherafelt, Moyle and Newtownabbey. Services are provided from nine different local, community and acute hospitals and a large number of community based settings including people’s own homes.

1.0.2 The Trust has one of the biggest geographical locations to cover within Northern Ireland with a population of over 457,000.

1.0.3 Holywell Hospital was opened in 1901. The main hospital building houses the Intensive care, Rehabilitation, Challenging Behaviour, Continuing Care, and Addiction wards.

1.0.4 The 3 acute admission Tobernaveen wards were constructed in 1952 (although refurbishments were carried out in 2003) and Tardree, the Dementia assessment ward was opened in 1984.

1.0.5 There is a 32 bedded acute psychiatric admission ward, Ross Thompson, attached to Causeway Area Hospital. The bed numbers have recently been reduced to 25 as a result of health and safety recommendations. Although the hospital is less than 20 years old, the ward is based on a general hospital design and there are problems with the ward layout.

1.0.6 The inpatient provision is not fit for purpose on either site and the physical condition, security, function and suitability of the various in-patient wards is deemed to be below acceptable standards.

1.1 The Northern Trust, and legacy Trusts, have undertaken substantial service modernisation programmes for mental health services across both hospital and community settings. This has been driven by the Bamford Strategic Reviews, Commissioner and Trust strategies; the ATM Consulting Report on the Implementation of Change Management Programme; legacy Homefirst Trust Business Case for the Re-provision of Mental Health Services (December 2002) and Trust strategy developed through local consultation “Adding life to Years” (April 2007).

1.1.1 The changes made reflect a key Bamford principle to reduce reliance on inpatient and institutional services and provide more treatment and care in the community. A series of initiatives have been implemented to extend capacity to provide appropriate services within community settings and to enhance pathways for patients across community and hospital services including the:

- strengthening of Community Mental Health Teams (CMHT)
- establishing a Crisis Response Service
- development of a Home Treatment Service
- restructuring following the amalgamation of Trusts
- development of a Recovery ethos within mental health services
- introduction of “New Ways of Working” and
- further development of supported living services to facilitate the resettlement of long stay patients
1.1.2 This approach has resulted in a significant reduction across the range of inpatient beds, reducing from 384 beds in 2001 to 220 beds by 2011. This was facilitated by the development of innovative community based services, by improved efficiency through restructuring and by the application of best practice models.

1.2 Strategic Reform

1.2.1 The focus of reform of Mental Health services within the Trust is to ensure an appropriate range of health and social care services to support patients and their families, to allow them to live as full a life as possible and to promote a recovery ethos as integral to their treatment. The “centre of gravity” for services continues to shift towards community based services and away from an over reliance on hospital services. Providing care and support to people in such a way as to allow them to remain in their own home should be regarded as the norm.

1.2.2 The Trust had established a “New Ways of Working” Project Team which has produced the report entitled: “A Proposal for the Implementation of New Ways of Working in Acute General Adult Psychiatric Services” (September 2010). The group suggested the following:-

- the reorganisation of the existing Community Mental Health Teams (CMHT’s) from 8 teams to 9.
- the categorisation of the CMHT caseloads into 3 broad groups - primary care facing, secondary care acute and recovery; and
- the creation of inpatient acute care teams based in acute wards with dedicated inpatient consultants acting as joint clinical leads along with ward managers and administrative support.

1.2.3 The next phase of improvement and efficiency is to consolidate these improvements within a modernised estate providing a tightly focused inpatient service fully integrated with community services which can respond to the rising levels of acuity across inpatients. A consistent medical presence on the ward (with dedicated ward based consultants) will improve quality and management of the patient pathway. It is envisaged that further reduction of inpatient beds will occur over the next 2 to 3 years facilitated by the continued implementation of the “New Ways of Working” project.

1.2.4 Further changes to bed numbers will be achieved through resettlement of the remaining long stay patients and regionally driven initiatives for cross-Trust service provision with future plans for beds within the NH SCT incorporating proposals for regional or cross Trust service provision. Additional investment in the community services along with improved quality of inpatient care will also lead to further bed reductions.

1.2.5 The bed compliment for the Trust will be 166 beds of which 100 are acute, 28 non-acute and 38 for people with dementia. With a population of around 457,000 (NISRA, 2009 levels) this will give the NH SCT a ratio of 36 beds per 100,000 people. Taking account of the projected population increase to 474,605 by 2015 the ratio would reduce to 35 beds per 100,000 population.** (See Appendix 1)

1.2.6 With a population of 457,000, the Northern Trust represents almost 26% of the NI population of 1.7 million. At current levels, the planned 166 beds are just 20% of the regional planned provision of 825 beds (or 22% of the planned 758 beds excluding the 67 specialist beds).
1.2.7 A major emphasis of future inpatient service provision will be to respond to increasing levels of acuity, co-morbidity and complex needs with more sophisticated therapeutic interventions facilitated within a specialty designed and focussed estate.

Table 1 Current and proposed inpatient bed numbers for the NHSCT

<table>
<thead>
<tr>
<th>Inpatient service bed complement</th>
<th>Current Beds @ 31/3/2011</th>
<th>Proposed Beds</th>
<th>Ratio per 100,000 pop**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non - Acute beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>14</td>
<td>10*</td>
<td>2.2</td>
</tr>
<tr>
<td>Low Secure</td>
<td>0</td>
<td>8</td>
<td>1.8</td>
</tr>
<tr>
<td>Addictions</td>
<td>10</td>
<td>10</td>
<td>2.2</td>
</tr>
<tr>
<td>Intensive Challenging Behaviour</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing Care</td>
<td>16</td>
<td>0***</td>
<td></td>
</tr>
<tr>
<td>** NON-ACUTE TOTAL</td>
<td>52</td>
<td>28</td>
<td>6.2</td>
</tr>
<tr>
<td>Acute beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute inc Functionally Mentally ill (FMI)</td>
<td>104</td>
<td>88</td>
<td>19.3</td>
</tr>
<tr>
<td>Intensive Care (PICU)</td>
<td>18</td>
<td>12</td>
<td>2.6</td>
</tr>
<tr>
<td>** ACUTE TOTAL</td>
<td>120</td>
<td>100</td>
<td>21.9</td>
</tr>
<tr>
<td>Beds for Older People</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia Assessment</td>
<td>24</td>
<td>24</td>
<td>5.3</td>
</tr>
<tr>
<td>Intermediate Treatment - Elderly Mentally Infirm (EMI)</td>
<td>22</td>
<td>14</td>
<td>3.1</td>
</tr>
<tr>
<td>** BEDS FOR OLDER PEOPLE TOTAL</td>
<td>38</td>
<td></td>
<td>8.3</td>
</tr>
<tr>
<td>** OVERALL TOTAL</td>
<td>220</td>
<td>166</td>
<td>36.3</td>
</tr>
</tbody>
</table>

* The Trust is committed to working regionally with the Commissioner and other Trusts to explore effective and efficient models which reduce and potentially remove hospitalisation from the model of service for these particular remaining clients (see paragraph 1.3.14)

** (NISRA 2015 figures http://www.nisra.gov.uk/demography/default.asp47.htm)

*** In line with Regional Policy it is anticipated that continuing care patients will be resettled to appropriate community placements.

1.3 Outline of Proposals by Specialty

Acute Provision

1.3.1 Acute care has been the focus of reform and modernisation for many years and this continuing focus will facilitate the reduction of a further 15 beds. The planned provision of 88 beds (excluding PICU) gives 19 beds per 100,000 population (based on NISRA 2009 levels for a population of 457,000) which is under the overall regional projection of 20 beds per 100,000. With the population rising to 474,605 over the coming 4 years (NISRA 2015 figures) the ratio becomes 18.5 beds per 100,000 people.

1.3.2 The acute beds will cater for a wide range of needs including 2 crisis beds and will include provision for people with eating disorders. Children are also occasionally admitted to adult wards and the Trust is working with the Region to reduce and eventually eliminate the number of under 18 admissions to adult wards. Within the acute setting inpatient beds will be used to facilitate a range of quality and efficiency improvements based on the learning from the innovative approaches
piloted in the Ross Thompson Hospital. This will provide a more focussed approach to the use of medical and nursing time as the allocation of a dedicated acute care medical consultant to each inpatient ward will increase efficiency by reducing the number of ward rounds and team meetings. A dedicated medical presence on the wards will improve quality and speed of decision-making. It will allow for the development of a consistent approach to the management of inpatients and drive up clinical and therapeutic standards in wards. By developing a team culture there will be opportunities to improve clinical standards and foster innovative practice.

1.3.3 The Trust recognises the need to change the model of service delivery within the acute inpatient units to take into account of the:

- reduction in the number of admissions as a result of enhanced community based services;
- probability that the overall level of severity of illness’ of admitted patients will increase;
- changing expectations of patients and carers; and
- the need to optimise the use of scarce and expensive inpatient beds.

Psychiatric Intensive Care Provision

1.3.4 The primary function of a Psychiatric Intensive Care Unit (PICU) is the rapid assessment and intensive management of acute mental illness and behavioural disturbance within an integrated pathway. Patients will present with increased vulnerability and pose a level of risk that means that they are unable to be safely managed in an acute ward setting. The treatment provided in PICU will have a direct impact on reducing risk. The multi-disciplinary team takes an active, treatment focussed approach aimed at rapid stabilisation, crisis resolution and risk reduction and prevention of relapse and promotion of recovery. With the development of home treatment, the acuity of patients being admitted to hospital has increased and this is reflected in the nature of patients being transferred to PICU. This experience has been reflected elsewhere; in Scotland there is a planned increase in the number of PICU beds due to the changing levels of acuity of patients admitted to psychiatric units.

1.3.5 A review was undertaken of patients admitted to PICU between October 2011 and February 2012. There were 41 admissions during this period, 28 male and 13 female. Four patients were directly admitted following detention under the Mental Health Order. Three patients had a second admission during this period. Eighteen patients had a forensic history. None of the patients would have been considered suitable to remain on an acute ward. The average length of stay for the male patients was 37.4 days and 59 days for female patients (28 days if an outlier is excluded).

1.3.6 The Trust held a PICU workshop in January 2012 at which the nature and function of psychiatric intensive care was explored. It was agreed that the service provided by the trust was appropriate and proportionate, however a purpose built unit would allow for more flexible use of beds through ‘swing’ beds for males and females. This would create greater flexibility in the use of beds and consequently the number of beds required could be reduced. The development of specialist Low Secure facilities in N Ireland could also impact on PICU usage, so it was agreed that the bed numbers should be further reviewed once the regional Low Secure provision is in place.
1.3.7 The plan currently is to reduce PICU beds from the existing level of 18 to 12 beds. This recognises the factors outlined above coupled with the increasing acuity of inpatients and the requirement to have an adequate facility to meet the needs of very disturbed patients in an appropriate environment. Good practice also recommends an 85% bed occupancy within Intensive Care Units. This complies with the recommended size of 12 – 15 required for an operationally viable unit. It should be co-located with the acute admissions units but be separate from them. This will enable the PICU to be designed according to the National Association of Psychiatric Intensive Care unit standards and ensure that a therapeutic milieu is maintained.

Inpatient Addictions Service

1.3.8 Considerable work has already been done within the NHSCT in line with Bamford to review and refocus addictions services across community and hospital settings. To maintain operational viability the current level of 10 beds will be maintained by providing three beds for use by other Trusts. The nature and number of beds may change following the outcome of the regional commissioning review of addiction services.

Dementia Services

1.3.9 Modernisation of dementia services in recent years including the development of specialist mental health services for older people teams and dementia behavioural support services, has enabled the reduction of inpatient dementia assessment beds from 48 to 24 beds in line with the Trust’s Adding Life to Years Strategy (2007). Currently the Trust has reduced dementia intermediate treatment beds from 24 to 22 and would envisage a further reduction to 14 beds with the development of improved capacity to manage more complex needs within the independent EMI nursing sector.

Functionally Mentally Ill provision for Older People

1.3.10 The Trust’s strategy, Adding Life to Years (2007) recommended the reduction of the then 22 bedded usage to 18 beds. The need for 18 beds was based on a shift from hospital to community based treatment including day hospital and home treatment provision. While home treatment has been implemented there was no available investment to develop a day hospital service and demographic pressure continues. Despite this the projected need has been revised down to 14 beds due to the success of home treatment services in ensuring greater numbers are being treated in the community.

Rehabilitation Services

1.3.11 The Trust is undertaking a programme of reform for rehabilitation services focusing on delivering a community based service in line with a recovery model ethos. Community Mental Health Teams have been re-designed and under “New Ways of Working” provide an enhanced role in the rehabilitation of clients. Supported living and community based services are being expanded to provide additional residential capacity using both housing and peripatetic support models. This enhances provision across the range of high, medium and low needs as people progress through the system. In addition the re-location of existing statutory supported living services to new premises in both Ballymena and Antrim will enable a more independent living model to be developed. Links between hospital and community
services have been enhanced with policies introduced which strengthen the stakeholder role in decisions over resettlement into the community. Closer working with independent sector providers and the tracking of clients across the whole system ensures opportunities for “move-on” are maximised and a community based service which minimises admissions to, and lengths of stay in, hospital.

1.3.12 The progression of this programme will deliver further reduction of rehabilitation beds, from 26 beds (including intensive challenging behaviour) in March 2011 to 10 beds. The Trust is committed to the on-going development of community based rehabilitation and has successfully progressed this model for a range of clients including many with challenging needs.

1.3.13 There remain a small number of clients, typically with conditions such as Korsokoffs syndrome and severe schizophrenia, for whom the service model requires both community placement and inpatient provision to ensure a safe and effective service.

1.3.14 The Trust is therefore of the view that inpatient rehabilitation beds are required, alongside enhanced community services, as part of the overall model of provision. The evidence indicates that an exclusively community based model works for most but not all clients in the long term. The Trust is committed to working with the Commissioner and other Trusts to explore effective and efficient models which reduce and potentially remove hospitalisation from the model of service for the clients referred to at 1.3.13. The overall provision of beds required by the Trust reflects this approach and maintains sufficient flexibility to respond to an effective model of provision which is entirely community based.

Low Secure Provision

1.3.15 The Trust has identified the need for 8 low secure beds for the Northern Area population with future provision for low secure services being taken forward by a regional group. Carrick 2 is currently being refurbished to provide for existing low secure needs in the interim.

1.4 Key Drivers for Change:

1.4.1 A number of drivers for change have been identified that endorse the Trust strategic direction for mental health services. These include:

- NHSCT Mental Health Bed Requirements paper, January 2012
- Transforming Your Care, December 2011
- Improving Dementia Services in N Ireland - A Regional Strategy 2011
- The National Health Service Framework for Mental Health (DOH, 1999)
- Modernising Mental Health Services (DOH, 1999)
- Mental Health Policy Implementation Guide: National minimum standards for general adult services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments (DOH, 2002)
- “Adding Life to Years” – Dementia and Mental Health Services for Older People – A Service Strategy for the Northern Area (April 2007)
- Low Secure Report (June 2010) a regional working group established and chaired by Dr Ian McMaster
2.0 Aims, Needs, Objectives & Constraints

2.0.1 Holywell Hospital is a 195 bedded Trust owned psychiatric hospital located in Antrim. It is a Category C listed building which was opened in 1901. The physical condition, security and functional suitability of the various in-patient wards is deemed to be below statutory standard.

2.0.2 Asset condition surveys indicate that the inpatient units at Holywell hospital and the Ross Thomson unit at Causeway hospital do not meet contemporary standards for accommodation. Whilst capital investments to improve patient environments have been made to both units in recent years, these are greatly limited by the constraints imposed by existing buildings.

Overall the accommodation of patients within a large Victorian asylum building is incompatible with providing mental health care within a non-stigmatising and therapeutic environment and is by definition wholly unacceptable for 21st century service provision.

Within wards the current accommodation does not meet modern standards for therapeutic mental health care as patients do not have single ensuite bedrooms, there is inadequate levels of clinical, occupational and recreational space. Staff and visitor accommodation is cramped and inadequate. It is impossible within the existing design and construction of buildings to ensure best design practice in critical areas of patient safety including observation of access/egress from wards and elimination of potential points of ligature.

2.1 Objectives

2.1.1 The main aim of this project is to provide a modern fit for purpose Mental Health In-Patient facility that:-

- provides services that are both clinically effective and safe, and allow for the provision of individualised therapeutic care;
- provides services which meet the strategic direction of the DHSSPS, HSCB and the Trust’s Corporate and Service Delivery Plans;
- provides in-patient services which are fully integrated with and provide support to, community mental health and social service;
- ensures compliance with the requirements for gender separation within in-patient facilities and ensures patient dignity, privacy and safety is maintained at all times;
- provide facilities designed for psychiatric care that are “fit for purpose” in line with current HBN 35: Accommodation for People with Mental Illness, including
the creation of a therapeutic and flexible environment from which high quality patient care can be delivered;
- provides a centre of excellence in patient care; and
- improves accessibility to services for patients and service users.

Constraints

- This project is dependant upon capital funding being made available by the DHSSPSNI.
- The revenue costs of this project have to be funded from within existing resources.
- Services must remain operational at all times with minimal disruption to staff, patients and clients during the construction period.
- The proposed new build must be provided on the Trust owned site to ensure we are using Trust Estate efficiently.

2.1.2 Table 1 on page 4 sets out the specialty related bed complement based on the current assessment of need. The design of wards in each category has specific requirements suited to the patient condition and this restricts the overall bed configuration. The accommodation design is being developed in conjunction with the Health Estates Investment Group (HEIG) and in line with identified “Best Practice” guidelines e.g. single room and male/female segregation. The ward design will be flexible enough to allow for redesign to meet changing needs in future.

3.0 Stakeholder Issues

3.0.1 Full stakeholder engagement will be carried out as the scheme progresses. This will involve all relevant parties, including, but not limited to the trust Senior Management Team (SMT), staff, patients, carers, professional bodies, GP’s, the Trust Advocacy Service, Local MLA’s and councillors, statutory hostels, local residential homes, and the PSNI.

4.0 Management & Implementation

4.0.1 A comprehensive project structure has been established within the NHSCT to ensure that, subject to business case approval, the development of the new Mental Health In-patient Unit will be strongly led and implemented within the required timescales. The Trust’s Chief Executive will be the project owner. The Trust’s Capital Development Steering Group comprising of membership from the Trust Directors, HSC Board and Health Estates Investment Group will provide strategic leadership and direction. A Project Team will be established including members from the Mental Health and Disability Directorate, Finance, Human Resources, Capital Development, Estate Services, ICT, Infection Prevention and Control and Support Services. A project manager will be appointed to work as a single point of responsibility for the day-to-day oversight of the project. For the proposed management structure and key personnel (see Appendix 2).

5.0 Consideration of Options

5.0.1 A number of options to deliver this new service model have been considered and will be examined in more detail in the outline business case. For the purposes of the SOC the six following options will be examined:-

1. Option 1 Status Quo / Do Minimum
This option requires investment to improve the standards of the current Mental Health In-Patient facilities. Whilst the status quo option is not an adequate or acceptable solution it provides a baseline against which to compare other do-something options.

2. **Option 2 Build a Standalone Mental Health In-Patient Facility on the Antrim Area Hospital site**

This option will deliver a standalone permanent Mental Health In-Patient (MHIP) facility on the Antrim Area Hospital site providing 88 acute beds including FMI, 12 Intensive Care (PICU), 28 Non-Acute beds for rehabilitation, low secure and addictions services, and 38 beds for older people in the form of Dementia Assessment and Intermediate Treatment EMI beds.

3. **Option 3 Build a Standalone Mental Health In-Patient Facility on the Holywell Hospital site**

As with option 2, this option will deliver a standalone permanent Mental Health In-Patient (MHIP) facility, this time on the Holywell Hospital site, providing 88 acute beds including FMI, 12 Intensive Care (PICU), 28 Non-Acute beds for rehabilitation, low secure and addictions services, and 38 beds for older people in the form of Dementia Assessment and Intermediate Treatment EMI beds.

4. **Option 4 Build a new Mental Health In-Patient Facility across two sites with provision split between the Antrim and Holywell Hospital sites**

This option involves developing a 2 site Mental Health In-Patient new build to re-provide Acute Assessment Beds; PICU and Dementia Assessment on Antrim Area Hospital site and Low Secure Beds, Intermediate Treatment EMI, Rehabilitation and Addictions on Holywell Hospital site.

5. **Option 5 Build Mental Health Inpatient Facilities on two sites with provision split across Antrim Hospital site and Coleraine Hospital site**

This option involves developing a 2 site Mental Health In Patient new build to re-provide Acute Assessment Beds; PICU and Dementia Assessment on Antrim Area Hospital site and Low Secure Beds, Intermediate Treatment EMI, Rehabilitation and Addictions on the Causeway Hospital site.

6. **Option 6 Build Mental Health Inpatient Facilities on two sites with provision split across Holywell Hospital site and Coleraine Hospital site**

This option involves developing a 2 site Mental Health In Patient new build to re-provide Acute Assessment Beds; PICU and Dementia Assessment on the Causeway Hospital site and Low Secure Beds, Intermediate Treatment EMI, Rehabilitation and Addictions on Holywell Hospital site.
The Trust is planning to manage the project and its complexities within existing resources which are dependent on the options around releasing the current resources from the Holywell Hospital site when its future is clearer.

6.0 Costs, Benefits & Risks

6.0.1 The estimated capital costs of the project are £49-52 million as outlined in the table above. (Provided by Health Estates Investment Group).

6.0.2 The revenue costs in relation to Mental Health services are expected to remain neutral. This is dependent upon final confirmation of the service models developed and on the best practice guidance at the time of finalisation as regards to staffing ratios and skill mix.

6.0.3 It is the intention of the Trust at this stage to proceed in the planning of the development with the aim that the infrastructure associated revenue costs will be kept as revenue neutral as possible. There are complexities surrounding the current Holywell Site that may affect the potential to fully release the revenue resources committed there, which would be required to enable the project to remain revenue neutral. Further detailed work is required on the options that would seek to enable full release of the revenue resources in Holywell so as to not require any additional recurring revenue.

6.0.4 It is considered however, that these matters do not prevent the Strategic Outline Case proceeding to Outline Business Case at which stage the issues would be worked through in significant detail.

6.0.5 Given the uncertainties about the revenue consequences of the project, especially around the infrastructural revenue, at this stage savings are not anticipated. The benefits are considered to be non-financial.

7.0 Key Risks

- This project is dependant upon the availability of capital funding from the DHSSPSNI.
- The revenue costs of this project have to be funded from within existing resources and both the Commissioner and the Trust finance are represented on the Project Team.
• Services must remain operational at all times with minimal disruption to staff, patients and clients during the construction period.
• The proposed new build must be provided on a Trust owned site and possible options have been identified.
• Sufficient resources being available to develop and implement the new service model.
• Holywell Hospital buildings continue to deteriorate until approval for this scheme is obtained meaning that services continue to be provided from a building that is approximately 110 years old, is not fit for purpose, does not provide a suitable environment for patients or staff and does not meet statutory standards

8.0 Funding & Affordability

8.0.1 This project is one of the key capital projects within the NHSCT. There are complexities surrounding the current Holywell Hospital site that may affect the potential to fully release the revenue resources committed there which will affect the revenue impact of the project. Further detailed work is required on the options that would seek to enable full release of the revenue resources across the Holywell Hospital site.

8.0.2 At this stage, the high level estimated capital cost for the project is £49-52 million with no revenue implications. Full capital funding is being sought from the DHSSPSNI.

8.0.3 The potential for capital and/or equipment requirements to be funded by either a traditionally funded or PFI route will be fully tested in the business case in accordance with the most recent DHSSPS guidance.

8.0.4 The proposed timeline for delivery of the scheme is:

- SOC submitted to the HSCB in April and the DHSSPSNI in May 2012
- SOC approved by June 2012
- Estimated Business Case submission date of December 2012
- Assuming 6 months to approve – June 2013

From time of OBC approval:

- Design Team Procurement and development of brief - 6 months
- Design period - 12 months
- Construction phase 30-36 months.