

Public Private Partnerships in the National Health Service: The Private Finance Initiative

Good Practice

Section 1: The Selection and Preparation of Schemes

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1. Introduction

1.1 This section of the guidance sets out the basis on which schemes in the NHS should be selected to procure under the Private Finance Initiative (PFI), and what preparations the public sector should undertake prior to commencing the formal procurement process.

1.2 The practical guidance in this section covers:

- the importance of setting the strategic context within which a scheme should be developed;
- what information is required for approvals by the NHS Executive prior to commencing the formal procurement;
- public sector roles and responsibilities;
- the engagement and management of advisers;
- openness and consultation.

2. Overview of the pre-procurement process

Introduction

2.1 This guidance is concerned with schemes which are subsequently procured through the PFI. It must be read in conjunction with the *Capital Investment Manual*, particularly the *Business Case Guide* which sets out the process for appraising and developing proposals for capital investment in the NHS whether publicly or privately funded. The *Capital Investment Manual* is currently being revised.

Overview

2.2 The strategic context for any scheme must be established at the outset through the appropriate Health Improvement Programme and should be consistent with its overarching objectives. This should be agreed with the NHS Executive Regional Office as appropriate. Guidance on establishing the strategic context is set out in the *Business Case Guide*. The objectives at this point are to:

- identify the current provision of health services;
- identify the required provision;
- make the case for change.

2.3 For schemes with an expected capital value of £25 million or more the strategic context should be documented in a Strategic Outline Case (SOC). Proposals for investment need to be fully consistent with local health needs, business and health care strategies, and local resources as identified within the Health Improvement Programme. The SOC should be prepared jointly by the NHS Trust, the main commissioning Health Authorities (HAs) or Primary Care Groups (PCGs) and the Regional Office (RO).

2.4 Strategic Outline Cases are considered by the NHS Capital Prioritisation Advisory Group (CPAG) and Ministers, and for those chosen to proceed the next step is the preparation of the Outline Business Case (OBC).

2.5 For a prospective PFI procurement, a key objective of the OBC is to produce a preferred option against which the best PFI solution may subsequently be assessed and (for major schemes) to validate the scheme proposals set out in the SOC, particularly in terms of health service need, local strategic context and affordability.

2.6 At the same time that the OBC is being developed, the NHS Trust and commissioning HAs or PCGs should be preparing fully for the PFI procurement itself. This will include establishing the roles and responsibilities of the public sector team, undertaking consultation, appointing advisers, developing output specifications for the scheme and drawing up the Invitation To Negotiate.

2.7 Proposals for schemes with an expected capital value of less than £25 million are not considered by CPAG, and for such schemes a SOC is not required. However, the strategic context should always be established involving commissioning HAs or PCGs and Regional Offices before preparing an OBC, and it is recommended that the broad principles for SOCs are followed in developing proposals for smaller schemes. Such schemes should proceed directly to preparing an OBC, involving commissioning HAs or PCGs as appropriate, and in preparing for the procurement. Regional Offices should also be involved before an NHS Trust starts work on any OBC which will be outside the NHS Trust's delegated limits. Delegated limits for PFI schemes for NHS Trusts are set out in Appendix 1.

Definition of the capital value of schemes

2.8 SOCs are required for all schemes with an expected capital cost of £25m or more. The capital cost of a scheme includes the following:

- land costs
- building costs – including building and engineering
- equipment costs
- professional fees – including legal fees
- planning and building fees
- planning contingency

The requirement to consider PFI

2.9 All procurement in the NHS which would involve capital expenditure should normally consider PFI. Where an NHS Trust considers that a project has little chance of attracting private finance, and that the interests of the NHS would not be served by testing for PFI, the NHS Trust should put its case in writing to the relevant NHS Executive Regional Office. The Regional Office will determine whether or not the project should be exempt from the requirement to consider PFI. Each project will be considered on its own merits and will not necessarily set a precedent for later schemes. Even where it is demonstrated that a failed PFI scheme is value for money using public procurement, there is of course no guarantee that public capital will be available to fund it.

2.10 Where the OBC shows that the project is within the NHS Trust's approval threshold (see also Appendix 1), there is no requirement to consult the Regional Office. NHS Trusts may determine for themselves whether or not to consider these projects for PFI but ought to be able to justify their decisions, particularly in the context of their duty to achieve value for money.

Further information

Capital Investment Manual, Business Case Guide, NHS Executive, 1994

~~3. The Strategic Outline Case~~

~~Introduction~~

~~3.1 The purpose of the Strategic Outline Case (SOC) is to provide the necessary information in a format which will enable the NHS Capital Prioritisation Advisory Group (CPAG) to assess major (£25m or more) capital investments in both the acute and non-acute sectors and report to Ministers. An outline of CPAG's role and responsibilities is given in Chapter 4.~~

~~3.2 The SOC is a collaborative document produced by the NHS Trust, its commissioning HAs or PCGs, and the appropriate NHS Executive Regional Office. It draws on existing guidance in the *Capital Investment Manual* with greater emphasis on the NHS Trust and commissioning HAs or PCGs working together throughout the process. The information that is required in a SOC is closely defined to enable schemes to be prioritised nationally based on health service need.~~

~~3.3 Regional Offices are told how many schemes they may submit to CPAG for each tranche of schemes under consideration, and are responsible for determining which SOCs should be prepared on the basis of regional priorities.~~

~~3.4 The system for prioritising and selecting schemes applies to all capital investments of £25m or more proposed by the NHS, whether publicly or privately funded.~~

~~Strategic Outline Case guidance~~

~~3.5 The latest guidance on the preparation of SOCs for consideration by CPAG was issued to the NHS in June 1998. NHS Trusts and commissioning HAs or PCGs who may be considering proposals to put forward to CPAG in future years should consider this guidance from an early stage as much of the work that goes into a SOC should be started well in advance. In particular, they will need to ensure that they have a healthcare strategy in place which can be reflected in the SOC. NHS Trusts and commissioning HAs or PCGs considering a scheme which falls below the capital value threshold (£25m) for consideration by CPAG are recommended to consider the SOC guidance, as many of the issues identified are applicable to schemes of all sizes.~~

~~3.6 The SOC guidance highlights a number of areas which should be considered in the preparation of a SOC. These are:~~

- ~~● strategic context~~
- ~~● health service need~~
- ~~● formulation of options~~
- ~~● affordability~~
- ~~● timetable and deliverability~~

Strategic context

3.7 Both the NHS Trust and commissioning HAs or PCCs should set out their strategy for health service provision and demonstrate how the proposed scheme is consistent with this. In particular, the commissioning HA or PCC should ensure that it accounts for all its services within the local healthcare context, not just those to be covered by the proposed scheme. Proposals should have been discussed in outline with wider stakeholders, eg local authorities.

Health service need

3.8 The service need for the proposed scheme should be demonstrated by detailing the service problems which the scheme is intended to address.

Formulation of options

3.9 A shortlist of options which satisfy health service need, are within the strategic context, and are affordable, should be developed. If the analysis establishes a clear preference for a particular option, this should be identified.

Affordability

3.10 The affordability ceiling below which any proposals for a scheme are to be developed should be clearly defined and accepted by the NHS Trust and commissioning HAs or PCCs. Commissioners are expected to take account of any changes in costs elsewhere in the local health economy resulting from the scheme.

Timetable and deliverability

3.11 The proposed project timetable for achieving contract signature should be set out. For PFI schemes, key milestones which must be reached before a scheme can be formally advertised in the Official Journal of the European Communities (OJEC) include the completion by the Health Authority of any necessary formal public consultation, and where possible and appropriate outline planning permission for the site likely to be developed.

Approval and publication

3.12 SOCs must be made publicly available within a month of the announcement of the results of each national prioritisation exercise. This is discussed further in Chapter 12.

3.13 Once a scheme has been prioritised by CPAG, an OBC should be developed. Approval for the OBC is required from the relevant NHS Executive Regional Office, and will be subject to rigorous testing. Approval of the draft Invitation To Negotiate is also required from the NHS Executive headquarters before a scheme can commence the formal procurement process by advertising in OJEC.

Further information

Capital Investment Manual, Business Case Guide, NHS Executive, 1994

The Strategic Outline Case, NHS Executive Private Finance Unit, June 1998

~~4. The Capital Prioritisation Advisory Group~~

~~Introduction~~

~~4.1 The NHS Capital Prioritisation Advisory Group (CPAG) was established in 1997. Its role is to consider proposals for both publicly and privately financed schemes with a capital cost over £25m and to report to Ministers.~~

~~4.2 CPAG was established to help Ministers prioritise schemes on the basis of national health service need. It is responsible for developing the criteria against which this will be assessed. It also considers the affordability and deliverability of schemes.~~

~~The prioritisation process~~

~~4.3 CPAG assesses schemes on the basis of information contained in the Strategic Outline Case (SOC). The SOC is produced before the Outline Business Case (OBC) and should contain sufficient information to enable CPAG to consider the health service need for a scheme. All schemes prioritised for development subsequently require OBC and Full Business Case (FBC) approval.~~

~~4.4 Regional Offices are responsible for deciding, based on national and regional priorities, which schemes should prepare a SOC. Those schemes demonstrating the highest health service need within the region are then forwarded to CPAG for consideration.~~

~~4.5 CPAG is assisted by a technical sub-committee (TSC). Details of the terms of reference of both CPAG and the TSC are set out below.~~

~~4.6 The prioritisation process can be summarised as follows:~~

~~Step One Regional Offices select and prioritise schemes for consideration by CPAG.~~

~~Step Two Regional Offices submit the SOC's for their selected schemes for scrutiny by the TSC indicating an order of priority between them.~~

~~Step Three The TSC scrutinises the schemes submitted, consulting with Regional Offices and HM Treasury.~~

~~Step Four The TSC advises CPAG on the schemes submitted.~~

~~Step Five CPAG considers the schemes submitted and reports to the NHS Executive Board and subsequently to Ministers.~~

4.7 CPAG determines the number of schemes that it will consider from Regional Offices for each prioritisation exercise. For example, in 1997/98 and 1998/99 Regional Offices were instructed to put forward no more than two schemes each.

4.8 Figure 4.1 below summarises the roles and responsibilities of CPAG and the TSC.

Figure 4.1: Roles and responsibilities within CPAG

The Capital Prioritisation Advisory Group

- reports to Ministers on schemes with a capital cost of £25m or more which satisfy the demands of health service need;
- agrees the criteria against which health service need will be assessed by the Regional Offices;
- ensures that schemes are only developed if they are affordable nationally without adversely affecting higher priorities and/or if there is sufficient private sector market capacity.

The Technical Sub-Committee to CPAG:

- scrutinises schemes to ensure that the criteria for selection have been applied in a fair and consistent manner;
- quality assures the Regional Office submissions supporting the schemes selected;
- assesses the level of capital investment that can be afforded and sustained by the market (for PFI schemes).

5. The Outline Business Case

Introduction

5.1 The objective of the Outline Business Case (OBC) is to:

- identify and develop the preferred option for the proposed scheme;
- show that this has been achieved through a rigorous investment appraisal process;
- show that it is in response to a robust case for change and is in line with national and local strategies and priorities; and
- demonstrate that key stakeholders have been involved in formulating, and are committed to, the proposals.

5.2 The preferred option provides a basis for the Public Sector Comparator for evaluating whether the best PFI option which emerges at the Full Business Case stage provides value for money. The Public Sector Comparator is discussed in more detail in *Technical Issues*.

5.3 At the same time that the NHS Trust is developing its OBC, it should be preparing the output specifications and the content of the Invitation To Negotiate that will be used when the scheme proposals are developed under PFI. Output specifications are discussed further in Chapter 10. The Invitation To Negotiate is detailed further in the *PFI Procurement Process*.

Developing the Outline Business Case

5.4 It is important for the OBC to be developed in close collaboration with commissioning HAs or PCGs, key clinical and other staff affected by the proposals, and the Regional Office. It should adhere closely to the guidance in the *Capital Investment Manual*, particularly stages 1 and 2 of the *Business Case Guide*.

5.5 Where a Strategic Outline Case (SOC) has already been prepared, the preferred option that is developed in the OBC should be used to validate the scheme proposals set out in the SOC both in terms of value for money and affordability. Any proposals in the OBC that are materially different from and/or cost significantly more than the solution outlined in the SOC may be reconsidered by CPAG. Consideration needs to be given to the most appropriate source of finance and the project's deliverability in terms of PFI, and/or public sector capital. It is good practice to take soundings within the market as to whether the scheme proposals are likely to be feasible under PFI. Schemes which have not been through the SOC process must involve the Regional Office in their market sounding exercise.

5.6 The NHS Trust, Regional Office and the main commissioning HAs or PCGs should ensure that the preferred option identified in the OBC fully satisfies the strategic and health service objectives underlying the proposed scheme.

5.7 This will include a demonstration that:

- the proposals have been signed off by relevant clinical stakeholders;
- appropriate capacity modelling techniques have been used in determining the scope and size of the investment proposals;
- due regard has been given to the optimal utilisation of any existing facilities that will be retained;
- the proposals take account of current models of care, good practice, relevant national service frameworks, etc.

5.8 The costs, benefits and risks associated with this option should be rigorously assessed over the full life of the project using:

- an economic appraisal (or value for money analysis);
- an assessment of the non-financial benefits and factors (eg using a scoring and weighting analysis); and
- a cost benefit analysis that brings together the economic and non-financial factors.

The preferred option will normally be the one which meets the project objectives and delivers the greatest ratio of benefits to costs.

5.9 The NHS Trust should also undertake a financial appraisal to demonstrate the affordability of the preferred investment decision over its life span. Sensitivity analyses should be undertaken on the key assumptions underlying the cost of the preferred option (for both the economic and financial appraisals).

5.10 The variables tested in the sensitivity analysis should include changes in capital costs and revenue costs, delays in timing for construction of the scheme, changes in commissioning or NHS Trust strategy which may affect assumptions about activity levels (hence the size of the facility, income due to the NHS Trust, revenue cost of services, and the capital cost of the scheme), assumptions about savings on capital charges, and any other factors which could materially affect the affordability of the scheme. It is important to look at variables covering both the construction and operational phases of the scheme.

5.11 Different scenarios should be modelled, including optimistic, neutral and pessimistic scenarios. The financial analysis should also make explicit allowance for the cost of risks, whether these are expected to be transferred to the private sector or retained by the public sector under PFI.

5.12 The options appraised as part of the process of identifying the preferred option will normally include a “do minimum” option. This option should be retained to serve as a baseline for gauging the extra costs and benefits of the preferred Public Sector Comparator and the best PFI option which is likely to emerge from the

procurement process. It should include a financial/affordability analysis. The do minimum option should be the minimum that is required to deliver the core clinical services whilst complying with statutory requirements. Any assumptions about the sustainability or otherwise of the do minimum option should be recorded.

5.13 It is important to define the do minimum option clearly and realistically. This should take into account the whole-life costs of maintaining and providing the current level of service. Buildings and equipment may need to be replaced or upgraded. Additional running costs may be incurred to maintain the status quo if throughput of patients is increasing. The risks associated with the do minimum option should also be assessed and reflected in its cost. Further commentary on the issues to consider in drawing up a do minimum option, based on the experience of a first wave scheme, is at Appendix 3.

5.14 Appendix 2 provides a checklist of the issues which should be considered in an OBC. NHS Trusts should also develop a comprehensive risk allocation matrix, output specifications, draft Invitation To Negotiate and contract to reflect the nature of their particular project before they begin negotiations with the private sector.

5.15 For schemes which have been prioritised the OBC should confirm that the scheme is still below the affordability ceiling which was agreed with commissioning HAs or PCGs and set out in the Strategic Outline Case. Also, the OBC should state progress against any milestones and timetable agreed upon prioritisation. There should also be a clear audit trail for any changes which have taken place since the SOC.

5.16 A scheme cannot commence the formal procurement process and issue a contract notice in the Official Journal of the European Communities (OJEC) until it has received OBC approval from the relevant Regional Office of the NHS Executive. For major schemes (with a capital value of £25m or over) the NHS Executive Regional Office and headquarters will also have to approve the Invitation To Negotiate and draft contract notice before commencing the formal procurement process.

Conditions for commissioner support – OBC stage

5.17 When the NHS Trust submits its Outline Business Case, it should include written evidence from the main commissioning HAs and/or PCGs to show that:

- it forms part of any Health Improvement Programme agreed by the commissioner;
- they support the strategic and corporate objectives of the business case;
- they are satisfied that the objectives of the business case are consistent with both their own and national priorities and initiatives;
- they support the “model” or “philosophy” of care where this will be circumscribed by the physical facilities;
- they understand the practical capacity and financial implications of the business case;

- they agree the cost and activity assumptions upon which the case is based;
- they can afford to pay for the services they require at the agreed price;
- they are satisfied that any conditions placed on previous statements of support have been fulfilled;
- the margins of leeway, beyond which support must be re-validated, have been agreed.

5.18 These conditions should be consistent with the support given by commissioning HAs or PCGs for the SOC for schemes (where relevant), and the support will need to be reconfirmed in the Full Business Case.

Publication

5.19 NHS Trusts are required to publish an OBC within a month of approval. This is discussed further in Chapter 12.

5.20 Some of the information in the OBC may be commercially sensitive. It is recommended that such information is, as far as possible, placed in appendices to the OBC which can be more easily taken out before publication. NHS Trusts should ensure that they comply with the Code of Openness in the NHS when classifying information as commercially sensitive.

Further information

Capital Investment Manual, Business Case Guide, NHS Executive, 1994

6. Affordability and value for money

Introduction

6.1 This chapter looks at issues which should be taken into account when the NHS Trust is assessing the affordability of a scheme and the value for money of options when preparing the Strategic Outline Case and/or the Outline Business Case. It also examines how the cost of risks associated with projects should be taken into account. Schemes should not proceed unless it can be demonstrated that they are affordable and value for money at every stage. If a preferred option does not have the lowest Net Present Cost (NPC), the scheme should not proceed any further without clear approval from Treasury.

Affordability

6.2 The affordability ceiling below which any scheme proposals are to be developed must be clearly defined and agreed by both the commissioning HAs or PCGs and NHS Trust from the outset. All assumptions underlying the affordability analysis should be made explicit. There should also be full agreement on these assumptions from the commissioning HAs or PCGs and the NHS Trust. The affordability of any proposed scheme is a critical constraint on the development of the Outline Business Case (and the Strategic Outline Case for major schemes).

6.3 The assessment of affordability of the scheme proposals should take into account the following:

- the revenue cost of existing services and associated cost of change (including savings due to efficiencies);
- the cost implications of the commitments required as part of the agreement;
- capital costs and the resultant implications for capital charges;
- equipment and IT costs;
- whole life costs;
- the cost of risks associated with the project;
- project costs (eg fees and decant costs);
- the full economic cost of land or other assets transferred into the scheme;
- VAT which cannot be recovered;

- any adjustments to be passed through the Trust's P&L account prior to the scheme's effective date;
- cost impact on the relevant health systems beyond the scheme directly under consideration;
- the impact of any price inflation on costs in excess of the assumed rate of general inflation.

6.4 Sensitivity analysis should be carried out on all key assumptions underlying the financial analysis. Where the financial and economic case for a scheme relies upon efficiency savings resulting from the project, the robustness of the assumptions underlying these should be demonstrated. It is good practice that where broad assumptions have been made across a whole range of an NHS Trust's services that the assumptions are validated by an exercise which estimates the efficiency savings based on a sample of specific services.

6.5 Whole life costs should include the cost of maintaining facilities over the full project appraisal period to the standards specified by the project sponsors (eg estates condition B).

6.6 The affordability analysis should take account of the costs of risks. Details on assessing the cost of risk are set out below. The assessment of risk should be initially considered as part of the consideration of options in the value for money appraisal of a scheme. However, the affordability assessment of the preferred option should also take account of the cost of risks attached to the construction and operating of all facilities which are relevant to the scheme.

6.7 The SOC/OBC should include the results of the financial appraisal conducted by the NHS Trust. Support for the results should be explicitly stated by the commissioning HAs or PCGs. Where a scheme will have an impact on other commissioning HAs or PCGs then the level and form of support from these organisations must be demonstrated and should be agreed in advance with the relevant Regional Office.

6.8 As well as being thoroughly vetted at an early stage, the assumptions underpinning the affordability analysis should be kept under continuous review as the project develops.

6.9 The NHS Trust's and commissioning HAs' or PCGs' strategic plans should demonstrate that the services will remain affordable over the lifetime of the project, consistent with prudent assumptions about future growth in NHS funding.

6.10 The affordability assessment of any proposed project should also take into account the cost of existing services, and the cost of the do minimum option if the project does not proceed.

Value for money

6.11 The factors which should be looked at in assessing the costs and benefits of shortlisted options as part of the value for money assessment in the OBC are set out in the Business Case Guide of the Capital Investment Manual.

6.12 The cost of risks associated with the project should also be considered as part of the value for money assessment as it may affect the overall ranking of options. It is acknowledged that the assessment of the cost of risks for each individual short listed option can significantly add to the cost of developing an OBC. The amount of effort devoted to the risk analysis at this stage should therefore be proportionate to the size of the scheme.

6.13 The Net Present Values (NPVs) of the options in the economic appraisal should be adjusted to include an assessment of the cost of risk if they have different risk profiles (for example rebuild versus a refurbishment). If no such adjustments are made, the reasoning behind this should be recorded. As a minimum, in all cases, the affordability assessment of the preferred option should look at the impact on costs both before and after the assessment of risks. Commissioner support must be given on the basis of the affordability assessment which takes account of the cost of risk.

The evaluation of risk

6.14 Any project, whether a PFI scheme or not, involves risks. The value of risk analysis is to ensure that the right value for money and affordability decisions are made at the appropriate stages of the procurement process. As part of the SOC/OBC, risks associated with the project should be identified and a suitable framework set in place for the management of risk throughout the lifetime of the project.

6.15 At the OBC stage, the aim of risk evaluation is to estimate the value and probability of occurrence of the risks that are likely to fall to the public sector through options involving public sector procurement. Risk analysis is a complex exercise, with a commensurate call on resources, and NHS Trusts are not expected at the OBC stage to go into the level of detail required at FBC. However, the level of work carried out should be sufficient to assure the NHS Trust that the preferred option is affordable and represents the optimum solution. Risk analysis is discussed fully in Chapter 2 of *Technical Issues*.

Further information

Information on the affordability and value for money assessment at OBC stage can be found in:

Capital Investment Manual, Business Case Guide, NHS Executive, 1994

7. Roles and responsibilities of the public sector team

Introduction

7.1 The best private sector bidders are likely to be highly organised and very purposeful. Public sector teams need to be at least as well prepared in order to negotiate effectively and arrive at an optimal solution. Project arrangements will have been considered and a shadow project team may have been set up for the drafting of the Strategic Outline Case (SOC). But to avoid unnecessary expenditure, preparation for procurement normally only begins in earnest once the SOC is approved. For schemes which do not require a SOC, preparations for procurement should begin while the OBC is under development.

7.2 The starting point is to be clear about tasks, roles and responsibilities: who is responsible for what between the members of the public sector team, including advisers? There may be some overlap in functions but specific responsibilities for performing tasks must be clearly allocated. Local circumstances will vary but typically, the roles and responsibilities for a major PFI procurement are broadly as described in Figure 7.1. One general rule is that advisers should advise, not lead or negotiate, except on very specific, closely bounded tasks.

7.3 NHS Trusts should also consider the guidance on Project Organisation in the Capital Investment Manual. Key members of the project team will be involved in negotiations with bidders, and the NHS Trust should consider whether training courses (such as negotiation skills) for individuals or for the team as a whole would be useful.

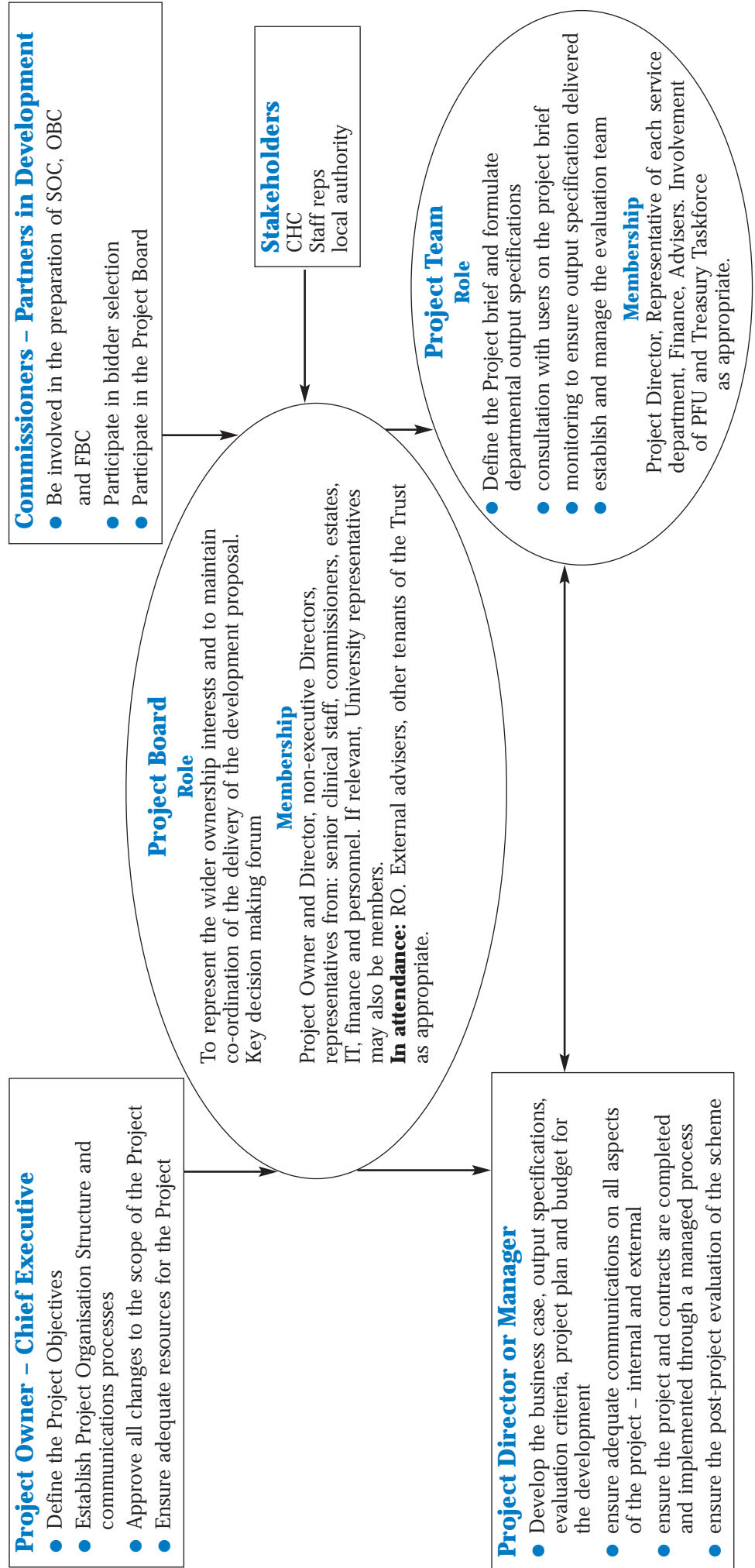
NHS Trust Chief Executive – project owner

7.4 It is possible to envisage different models of public private partnership, but for the purpose of this guidance the assumption is that most PFI procurements will continue to be NHS Trust-led. In these circumstances, the project owner and accountable officer for the transaction is the NHS Trust Chief Executive. The Chief Executive has ultimate responsibility for delivering the project, and as such owns the deal and must show the leadership and commitment necessary to keep the momentum up. S/he is an accountable officer (through the NHS Chief Executive to Parliament) and is therefore responsible for ensuring value for money and appropriate use of public funds.

7.5 The Chief Executive's role will usually involve:

- defining project objectives;
- recruiting a project director and agreeing their terms of reference;

Figure 7.1: Roles and responsibilities of the public sector



- establishing reporting procedures to determine project performance;
- approving any changes to the agreed scope of the scheme;
- ensuring adequate resources are available to the project director;
- key negotiations with bidders;
- ensuring all necessary approvals are secured;
- acting as accountable officer for all aspects of the transaction.

7.6 The relationship between Chief Executive and Project Director is pivotal, and the eventual success of the project may depend on the Chief Executive's ability to recruit the right Project Director and then delegate real responsibility to that individual. The Chief Executive must empower and support the authority of the Project Director to deliver in negotiations. If the Chief Executive is to remain in operational control of the NHS Trust, s/he will probably only be present at key project negotiating meetings. In these instances s/he needs to be very clear about roles during the meeting.

Commissioner – partner in procurement

7.7 The involvement of commissioning HAs or PCGs in the preparation of the SOC for major schemes emphasises the importance of wholehearted commissioner support for procurements. This close involvement should be maintained throughout the project and the main commissioning HAs or PCGs should have a place on the project board. Representatives of other commissioning HAs or PCGs should also be involved as appropriate.

7.8 Regional Offices can help to facilitate where there is no single main commissioning HA or PCG or where adequate commissioner representation is difficult to achieve. In some cases a "lead" commissioner may be appropriate, in others the involvement of separate commissioning HAs or PCGs may be necessary. For some schemes, a special purpose Strategic Group may need to be set up to speak for all commissioning HAs or PCGs. For smaller schemes the same procedure may be followed; as a minimum, commissioning HAs or PCGs should be kept informed throughout the procurement process and be involved in key decisions.

7.9 In addition to its overarching responsibility for determining the health need of the population and ensuring the need is met, the commissioning HA or PCG's role in the context of a PFI procurement should involve:

- joint preparation of the Strategic Outline Case and/or setting the strategic context for the project;
- participation on the project board for major schemes and involvement in other schemes where appropriate;
- participation in bidder selection;
- formal endorsement of the Outline and Full Business Cases.

7.10 The commissioning HA or PCG's understanding and support for the procurement is likely to be tested hard during the procurement stage and it is important that there should be "no surprises" from the NHS Trust at that stage. Joint preparation of the SOC will tease out many of the issues, and discussion of these is likely to continue in more detail as the project progresses. For schemes which do not require a SOC, the commissioning HAs or PCGs should be involved when the NHS Trust sets out the strategic context to ensure that the commissioning HAs or PCGs' and NHS Trust's strategic plans are consistent with each other.

7.11 The conditions for commissioner support at OBC stage, outlined in Chapter 5, set out the minimum areas in which both the commissioning HAs or PCGs and NHS Trust should be in clear agreement during the course of the project.

NHS Trust board

7.12 For a major scheme, the procurement will be the most important project the NHS Trust has ever undertaken, and is likely to absorb a considerable amount of the NHS Trust's management resource. It is a responsibility of the NHS Trust board to ensure not only that the Chief Executive has the board level support s/he needs, but also – in conjunction with the Chief Executive – that the NHS Trust continues to function effectively during procurement. Where the Chief Executive is required to spend a high proportion of their time on the project (for example at key stages of negotiation) the board will need to be satisfied that management arrangements are in place to deal with other operational matters. Consideration should be given to this issue as early as possible and certainly before procurement commences.

7.13 The NHS Trust board's role will usually involve:

- defining the Chief Executive's terms of reference;
- authorising the allocation of funds for project work;
- overseeing project performance;
- deciding the size/make up of the project board;
- ensuring the project board adequately represents work groups;
- ensuring the project board has time to fulfil its task;
- considering how to address timetable clashes between the project and the NHS Trust's normal operation;
- approving the scheme's commercial and service aspects prior to submission of the FBC.

7.14 An NHS Trust board has powers under the NHS Trusts (Membership and Procedure) Regulations 1990 to appoint committees to discharge its functions. It is recommended that the project board is constituted as such a committee to enable it to act directly on behalf of the NHS Trust and to be accountable to the NHS Trust board. Such a committee may include non-executive directors of the NHS Trust.

Project board

7.15 The project board should be given clear terms of reference and stated areas of delegated discretion from the NHS Trust board. The project board is likely to include:

- executive and non-executive members of the NHS Trust board;
- a representative of the commissioning HAs or PCGs;
- the project director;
- senior clinicians (eg the Director of Medicine, the Director of Nursing and the Clinical Director of any relevant specialities);

7.16 Membership of the project board is at the NHS Trust's discretion, since local circumstances may dictate different arrangements from one project to another. The NHS Trust may well decide to invite other members onto the project board from bodies not listed above, including advisers or other interested parties, subject to keeping its size manageable.

7.17 The project board's role will usually involve:

- representing wider ownership; maintaining co-ordination;
- setting out project controls and processes;
- agreeing an internal and external communications plan;
- ensuring the project achieves its objectives;
- signing off project documentation.

7.18 The project board should establish at the outset of each stage of the procurement process the resources required, timetable and objectives. The discipline of setting realistic and achievable goals builds confidence and momentum.

Project director and project team

7.19 The project director is a key appointment. S/he needs the full confidence and backing of the project and NHS Trust boards in order to negotiate effectively on the NHS Trust's behalf, and should therefore be given sufficient authority from the outset to develop and lead a team capable of successful procurement. It is recommended that the project director should be a direct employee of the NHS Trust, and ideally, for large transactions, be a full member of the Trust board. The project director has responsibilities across the entire span of the project. These include:

- developing the business cases and budget;
- preparing the overall output specification;
- producing progress reports, liaising with the NHS Trust board and communicating with stakeholders;

- managing the project team, including external advisers;
- taking the lead in negotiations with bidders;
- and co-ordinating the working of any technical sub-groups.

7.20 For a major scheme, the project director should be full time from a very early stage in the development of the scheme, and certainly well before the scheme is advertised in OJEC. The project director should not also retain day to day duties elsewhere within the NHS Trust, as these may hinder his/her ability to concentrate on the project. S/he may have to be recruited specifically, using appropriate techniques, to ensure that the holder of this key post is suitable.

7.21 The project team is likely to include:

- project director and/or project manager (larger schemes may have both);
- representatives of service directorates (eg estates, facilities management);
- representatives of clinical directorates;
- NHS Trust finance;
- Trust advisers and/or the NHS Executive's Private Finance Unit (PFU)/Treasury Taskforce (TTF).

7.22 Its responsibilities also cover the whole span of the project, and prior to advertising in OJEC will include:

- production of output specifications for individual departments;
- consultation with clinical/operational staff regarding brief;
- consultation with staff representatives and trades unions regarding proposed transfers under TUPE regulations.

7.23 The amount of work necessary to produce the output specifications for the scheme should not be underestimated. The production of the output specifications will clearly affect the timetable for progressing the scheme. The project team should also ensure that nominated stakeholders within the NHS Trust have ownership of given output specifications.

7.24 The project director and project team should give early consideration to the way in which they will relate to the NHS Trust and project boards, how they will keep these groups up to date with developments without submerging them in detail, and how urgent decisions will be obtained from the boards. The project team should set up sub-committees to deal with technical aspects of the scheme, eg clinical, facilities management, finance and contractual. Such sub-committees play a key role in evaluation and in "negotiating" the final scope of the scheme. They need to have clearly defined terms of reference and delegated discretion. The project director and team are also responsible for co-ordinating all aspects of the project. In particular, they should ensure that decisions made on one part of the scheme do not adversely affect other parts of the scheme.

7.25 The project director and team should also make arrangements for the storage of project documentation and establishment of a comprehensive audit trail throughout the procurement process.

7.26 The project team should also be responsible for ensuring that the NHS Trust's communications strategy both internally and externally is in place at the beginning of the process, for agreeing the reporting requirements with the project and NHS Trust boards, and for ensuring that there is a strong linkage with the public relations team in other parties such as the commissioning HA or PCG.

7.27 The NHS Trust should also set up a data/briefing room, where all the relevant information can be made available to bidders. The data/briefing room also provides an opportunity to display information using a variety of formats and media.

Internal audit

7.28 NHS Trusts are required to maintain a high standard of Corporate Governance in all matters, including PFI. This relates to the need to demonstrate:

- due process;
- value for money;
- legality;
- effective management and decision making.

7.29 Before commencing a procurement the NHS Trust should decide whether Internal Audit should:

- be represented on key decision making groups (in an advisory role only);
- attend project meetings, presentations and negotiations with bidders;
- review the selection process (including the development of review criteria and the evaluation of bids);
- review key documentation;
- participate in contract monitoring and post project evaluation after financial close.

External audit

7.30 External auditors will ultimately be responsible for agreeing ~~any off~~-balance sheet opinion the NHS Trust secures or provides for the project. This task cannot be completed "overnight" and the project team is responsible for ensuring that external auditors are regularly updated on progress and given the opportunity to appraise key documents as appropriate.

Experience from other schemes

7.31 Trusts should invite senior individuals who have been involved in completed major PFI schemes to sit on the project board of major schemes under procurement in a part time role, or to give specific advice directly to the project team on issues raised (for example, on the selection of advisers or preferred bidder).

7.32 This individual is most likely to be a member of the RO or PFU, but s/he may be an officer with high level experience of another project which has reached financial close. The NHS Executive headquarters or the Regional Office can help NHS Trusts find suitable individuals, whose role is to pass on general experience, to offer informal advice, and above all to ensure that hard-won lessons from one project are disseminated to others throughout the NHS.

7.33 The NHS Executive will also facilitate networking between schemes which have already reached financial close and schemes entering or continuing through the procurement process.

NHS Executive

7.34 For major schemes (with a capital value of £25m or over), the project director should ensure that the NHS Executive Regional Office and PFU are involved as appropriate throughout the procurement process. They should be kept regularly updated on progress of the scheme and should be present at decision meetings. In particular, the NHS Executive should be represented in an advisory role when key decisions on the selection of bidders are being made. The NHS Executive can give an overview of experiences and lessons from other relevant PFI schemes. However, the decision itself on the selection of bidders must ultimately remain the responsibility of the project board.

7.35 Major schemes will be given increasing levels of support from the NHS Executive in the latter stages of the deal, particularly during the period approaching financial close.

7.36 For other schemes, involvement of the Regional Office and headquarters as the scheme progresses should be agreed at a level appropriate to the size and nature of the scheme.

7.37 The NHS Executive Private Finance Unit is responsible for giving advice and support to Regional Offices and the NHS. It includes secondees from the private sector who have relevant experience in the types of issues raised by PFI schemes. The Private Finance Unit also works with the private sector to help facilitate the progress of schemes throughout the procurement process. The Private Finance Unit also liaises with the Treasury Taskforce on the ongoing development of PFI and to help produce best practice solutions for managing the procurement process and on financing and contractual issues.

HM Treasury

7.37 HM Treasury has two distinct roles in the PFI process. It is responsible for PFI policy across government, and in this capacity offers advice and guidance through the Treasury Taskforce. In addition, the Treasury's Health Spending Team has overall responsibility for approving PFI schemes. Some approvals are delegated wholly or partly to the NHS Executive, but all schemes that are novel or contentious require Treasury approval regardless of their capital value.

Further information

Project Organisation, Capital Investment Manual, NHS Executive, 1994

8. Skills, training, and where to turn for help

Introduction

8.1 PFI transactions can raise some unfamiliar and complex issues. Although the project team will be able to deal with many of them, they will probably not have the breadth of expertise to address them all. Relevant guidance, and advice from other public sector bodies, can help to fill the skills gap. In addition, the NHS Trust is likely to require the assistance of some external advisers, although the intention is that as PFI becomes more widespread in the NHS, more of the expertise should come from within the service.

8.2 One of the main lessons to emerge from the first wave of major projects is that it is important to “know thy team” – only with a good understanding of the project team’s strengths and weaknesses can Chief Executives and project directors make informed decisions about what additional expertise is required, and at what stage. For example some NHS Trusts will need more assistance with the evaluation of risks in the deal than others, and so on.

8.3 Having identified any skills gaps, the project leaders must decide how best to address them. The first port of call is to look elsewhere within the NHS Trust – for example, non-executive directors may have some skills and experience which can be of direct benefit.

Skills within the public sector team

8.4 NHS Trusts should consider the time that will be needed from employees as the scheme develops, for example in participating in evaluation teams. Suitable arrangements should be put in hand to provide cover for employees’ daily activities as appropriate.

8.5 NHS Trusts should carry out a skills analysis to identify strengths and weaknesses in their project team, and produce a plan to address the weak areas. The continued strength and viability of their team should be assessed on a regular basis. Teams should identify which skills are available in-house, and which skills are to be brought in from the private sector or elsewhere in the NHS.

8.6 Suggested skill requirements include:

- project management
- estates
- financial accounting
- management accounting

- corporate finance
- negotiating
- legal
- investment appraisal
- risk assessment and evaluation
- procurement
- preparing output specifications
- planning
- design
- communications
- public relations
- other relevant specialities (eg IT and equipment)
- management and use of advisers
- HR management
- negotiations with staff representatives.

Guidance and advice

8.7 NHS Trusts should also make use of the guidance now available on PFI procurement. In addition to the material in this guidance, the Capital Investment Manual offers general advice on procurement, eg business case preparation, output specification drafting etc. The vast majority of PFI issues are not unique to health but arise across the entire public sector. It follows that generic guidance on PFI applies to the NHS as it does to most other sectors. A series of topic specific PFI guidance booklets has been produced by HM Treasury; they are cross referenced in this guidance where appropriate, and new volumes are likely to be added in the future.

8.8 Advice is also available from NHS Executive headquarters and Regional Offices. Regional Offices in particular will have been closely involved in projects from the outset, having jointly prepared the SOC with both NHS Trust and commissioning HAs or PCGs. And headquarters retains consultants who can help with technical expertise – for example on legal issues, project finance etc – although this is intended to be a supporting role, not a substitute for NHS Trusts' own advisers.

Training

8.9 Training forms a key part of the preparation of the public sector team for the PFI procurement process. This can include both generalist courses such as

negotiation skills and investment appraisal, and PFI specific courses such as understanding the PFI procurement process and developing payment mechanisms.

8.10 The NHS Executive will arrange suitable training programmes for personnel who are to be involved in PFI schemes, led by experts from both the public and private sectors. Training will reflect this guidance and will include topics such as establishing the strategic context for schemes, preparing business cases, developing output specifications, risk assessment, payment mechanisms, etc. The purpose of this is to consider specific aspects of PFI in the NHS, with the emphasis on practical lessons learned from previous deals.

8.11 The Treasury Taskforce has developed a training programme for the public sector which covers the assessment of whether schemes are suitable for the PFI procurement route, the stages of the PFI procurement process, and which also includes specialist training courses on specific issues.

8.12 NHS staff should note that the most suitable training courses and conferences for them to attend are those which are accredited or supported by either the NHS Executive or HM Treasury.

9. The selection and management of advisers

Introduction

9.1 The proper use of high quality advisers can be a key factor in timely and successful PFI procurement. Failure to appoint the right advisers or to manage them correctly can have an adverse impact on a PFI scheme. External advisers are costly and poor selection/management of this resource could be extremely wasteful of public funds. It can lead to a deal that is not as good as it could have been, or worse, may cause it to fail altogether.

9.2 The purpose of this chapter is to provide a number of recommendations as to:

- the thought processes that an NHS Trust should go through in deciding whether to appoint advisers;
- the kind of advisers an NHS Trust should consider appointing at the different stages of the project;
- the most appropriate stage at which the appointments should be made;
- the management structures that should be put in place to ensure that the NHS Trust gets the best out of its advisers.

Is it appropriate to appoint an external adviser?

9.3 In deciding whether to appoint external advisers, NHS Trusts should consider :

- the skills already available in-house or those which may be developed through training/mentoring;
- the help available elsewhere within the public sector – eg from guidance, from the NHS Executive regions and headquarters, from NHS Estates, Treasury Taskforce etc;
- the complexity and technical requirements of the project.

9.4 For a PFI project, skills may be broadly subdivided into:

- technical expertise: legal, financial, design and construction, insurance, facilities management (FM), property or other technical skills;
- PFI expertise: knowledge of the process from other projects and experience of issues and their resolution;

- market knowledge: understanding of how to present the project, who would be interested, what issues the market will be prepared to negotiate on;
- sector knowledge: understanding of the health care environment and future developments, including knowledge of where risks and costs lie;
- presentation skills: assistance in the promotion of the project.

When to appoint advisers

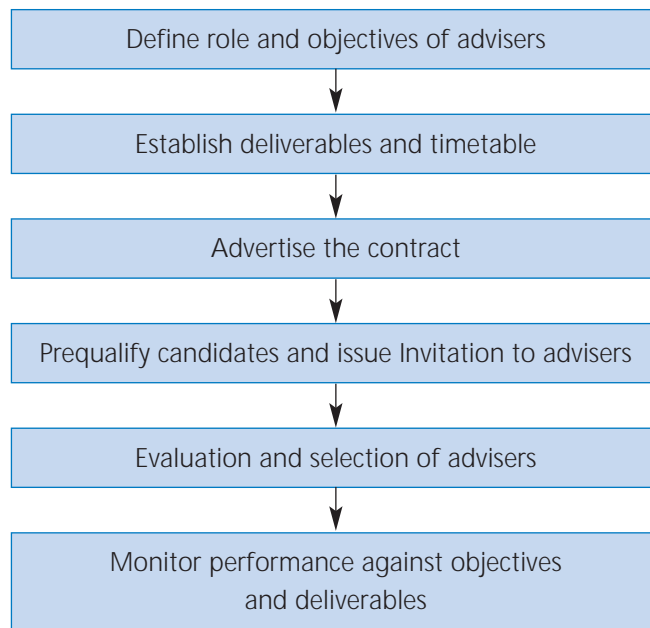
9.5 When there are gaps identified in the in-house expertise available, NHS Trusts consider using appropriate professional advisers. The stage at which advisers should be appointed and the nature of their involvement should always be determined by where their input and experience can add value to the procurement process, and in practice will vary from one project to another. Typically, advisers have been appointed at the following stages:

- healthcare advisers: when setting the strategic context for the scheme and where appropriate in the preparation of the Outline and Full Business Cases;
- legal and financial advisers: to assist in preparing the Invitation to Negotiate (ITN) before OJEC, and thereafter to work through to financial close;
- technical advisers: to assist in preparing the ITN and output specifications, in the evaluation of bids, costing and deliverability of bidders' design solutions, and in the monitoring and implementation of the contract.

It may be appropriate to appoint the legal and financial advisers to a scheme at the same time. NHS Trusts should also consider whether to invite bids from advisers working as joint teams, as this may produce financial savings from the bidders.

9.6 There is, inevitably, a balance to be struck in the timing of appointments. Early appointment of advisers increases their familiarity and involvement with the project and draws on PFI experience quickly. It may also provide opportunities for advisers to identify potential problems early and to avoid time being spent "firefighting" later on.

Figure 9.1: Steps in the appointment of advisers



9.7 Seeking appropriate advice early should not increase costs overall provided that advisers are properly managed. Indeed, it may well avoid time consuming and costly negotiation later in the process. Objectives for advisers being appointed when the scheme is at an embryonic stage should be as tightly defined as possible. For example, when scheme options are being considered, the NHS Trust may wish to obtain advice as to which of them is best suited to PFI. Under such circumstances, it may prove to be useful for a highly focused meeting to be arranged with advisers. This could be held at comparatively little cost.

9.8 Delaying the appointment of advisers until too late in the process can limit the extent to which the adviser can add value and lead to later expense and a sub optimal deal.

9.9 In cases of doubt, Regional Offices and headquarters can offer advice, and the experienced PFI practitioners appointed to each project will have first hand experience of this issue from their previous deals. The role of these individuals is discussed in Chapter 7.

9.10 However advisers are appointed, and regardless of their nominal role, the prime responsibility for scheme delivery remains with the NHS Trust. The NHS Trust can not abdicate this responsibility.

The selection of advisers

9.11 The competitive process for selecting advisers should aim to secure the best quality and value advice for the NHS Trust. Subject to the scope of advisory work required, the need to advertise in OJEC and the number of organisations expected to tender, the following gives an indication of the steps to follow. This process may be simplified for smaller scale projects.

Defining the role and objectives of advisers

9.12 Before procuring the services of advisers, the NHS Trust must decide what functions it wishes its advisers to perform based upon project requirements and skills already available to the project team. Both the role and objectives should be clearly specified to ensure both that the efforts of the advisers are well focused and that a clear understanding will exist between the NHS Trust and adviser.

Establishing deliverables and timetable

9.13 Many of the functions that could be provided by advisers result in clearly definable outputs, such as sections of the Invitation To Negotiate, draft contracts, or output specifications. These should be identified by the NHS Trust, together with the timetable within which they should be delivered.

9.14 It will also be necessary to identify where advisers will require support from the NHS Trust to deliver these outputs, to ensure that key NHS Trust personnel will be available to work with the advisers at the appropriate time.

9.15 Where it is not possible to define tangible outputs, the NHS Trust should ensure that potential advisers have a clear understanding of the range of issues and level of input expected from them.

Advertising the contract

9.16 The NHS Trust will need to consider certain legal issues before procuring advisory services. In particular, the Public Services Contracts Regulations 1993 may apply to the procurement of advisory services (other than legal services) that are expected to cost more than a threshold value. The current threshold for services is £104,435. Contracts for advisers will normally be advertised under the Restricted Procedure. Generally, all advisers other than legal advisers on which expenditure is expected to exceed the threshold should be procured under the public procurement regulations and advertised in OJEC. The public procurement regulations are discussed further in Appendix 2 of *The PFI Procurement Process*. NHS Trusts should also advertise the procurement of all advisers in Government Opportunities.

9.17 If the EU procurement regulations do not apply, the manner of advertising and procurement becomes subject to the NHS Trust's discretion and good practice within service-wide procurement policy guidelines. In these circumstances advertising the contract widely through trade journals and other contacts is recommended to ensure that the NHS Trust is able to select from a wide sample of candidates. NHS Trusts may also approach firms of advisers already known to them and draw to their attention the fact that they are advertising.

Prequalification and the Invitation To Tender

9.18 The steps following advertisement will also depend upon the size and complexity of the project. In larger scale projects where a great number of advisers are expected to tender or where there are issues which might disbar some advisers, such as conflicts of interest, the NHS Trust may wish to prequalify respondents to advertisements before asking for detailed bids.

9.19 Legitimate grounds for prequalification in EU regulated processes are outlined in the Public Services Contracts Regulations.

9.20 The prequalification document sent to potential bidders should provide them with sufficient information to understand the key issues surrounding the project and the expected role of the advisers, including:

- the strategic context and key objectives of the project;
- the timetable for the project;
- the timetable for selection of advisers;
- evaluation criteria that will be used to select advisers;
- input and resources expected of advisers;
- information that potential advisers are expected to supply for prequalification.

9.21 It may also be appropriate to make background information such as the Outline Business Case and/or Strategic Outline Case available to candidates.

9.22 Following evaluation of the prequalification responses or receipt of expressions of interest the NHS Trust should produce a short-list of advisers to whom it wishes to issue an Invitation To Tender. NHS Trusts should generally ask no more than four firms to prepare a full tender for a piece of work.

9.23 The Invitation To Tender (ITT) document will set out any additional information about the project which the NHS Trust considers it helpful to provide in addition to that set out in the Prequalification Questionnaire. The ITT will invite shortlisted advisers to describe how they would approach the NHS Trust's project and to provide full details of their experience on other projects. Information should also be sought as to the specific individuals who will be the key advisers for the project, their level of seniority and experience and their current commitment on other projects. Where legal services are being tendered for, the NHS Trust may also consider asking for information about IT, library and document production facilities.

9.24 The ITT should also set out how much work will be needed from the advisers to be appointed. This is particularly important where some or all for the intended fee for the advice is to be fixed at the outset. Alternatively, advisers may be first asked to conduct a scoping study including, for example, a review of previous work and existing data after which the extent of work can be more accurately assessed. Generally, all advisers should be asked to set out their procedures for rendering invoices and for keeping the NHS Trust fully apprised on the level of costs incurred. Advisers should be able to provide the NHS Trust with a clear audit trail so the NHS Trust can determine whether it is achieving value for money.

Evaluation and selection of advisers

9.25 Evaluation criteria used to select advisers should follow naturally from the definition of objectives and deliverables and should be established before advertising the contract. Cost of advice is a key criterion, but should not be the sole determinant.

The lowest bid may not mean best value for money. It may be an indication of an adviser who is seeking the instruction as a means of buying experience. It is unacceptable for NHS Trusts to have to pay advisers for “learning on the job”. This may ultimately increase costs and will result in the NHS Trust receiving sub optimal advice. The most experienced advisers may be more expensive, but may be able to apply their skills more efficiently than apparently cheaper alternatives. In making their choice, NHS Trusts should obtain commitments from bidders that the same people who make the bid presentation will also continue to be personally involved throughout the project, and not replaced by other individuals without good cause.

9.26 The evaluation criteria should also allow for consideration of potential advisers’:

- demonstrable ability to contribute to the delivery of the project and provide value for money;
- experience and expertise in relevant areas – not only corporately, but more importantly the individuals who are to work on the project;
- ability to supply the full resources necessary at peak periods of work during the procurement.

9.27 Responses to this Invitation To Tender in the form of priced bids, and presentations if required, should be evaluated against the criteria already established to select the best value for money and most skilled team. In particular, NHS Trusts should ensure that the selected advisers demonstrate a clear understanding of what is expected of them and the wider requirements of the NHS Trust in undertaking the project.

9.28 NHS Trusts should not confine their decision regarding appointment on the basis only of information provided to them by potential advisers. References given by bidding advisers should be taken up from other NHS Trusts who have had experience of the firms they are considering, and they should be asked for their views on the quality of service received, and more importantly the individuals who will be appointed to the project.

9.29 On major schemes (with a capital value of £25m or over), NHS Trusts should seek advice from the NHS Executive on the appointment of key legal and financial advisers. The NHS Executive will be able to give an overview of experience and lessons from other PFI schemes that are relevant. However, the decision on the selection of advisers must remain the responsibility of the project board.

9.30 It is good practice to offer a de-briefing to unsuccessful bidders.

Payment

9.31 Payment mechanisms and fee levels agreed with advisers must be carefully considered by NHS Trusts to ensure that best value is achieved and that the risks of cost overruns are strictly controlled. Experienced advisers should be able to offer terms that meet these requirements by focusing effort on areas of genuine added value and helping to control project cost overruns, for example by capping fees to an agreed level.

9.32 NHS Trusts should expect the most competitive arrangements on advisory services where there is already significant market experience (for example in the development of pre-qualification documents), which means that fixed price agreements are achievable, or where advisers are competing strongly for business. Confidence among advisers that the procurement process proposed by the NHS Trust is well-managed and that they can work with management will also reduce costs.

Fee structures

9.33 There is a variety of fee structures that may be used for PFI advice. Often advisers will accept payment for services on different terms for different phases of the work. NHS Trusts may ask for alternative bids which are based on different rates, eg an hourly rate, or a reduced rate to reflect the inclusion of a success fee. With the exception of advice on the feasibility stage of a project, procurers should consider at least some success fee element. This is because, in a straight fee basis arrangement, there is no explicit incentive to close the deal. Fee structures might also be agreed on the basis of:

Time

9.34 Although this allows the greatest flexibility, it does expose the NHS Trust to cost overruns. Advisers may prefer to be paid on this basis where there is uncertainty about the level of effort required, but should anticipate that the expected fee income from this structure could be less than that from a structure where they accept more risk – such as success fees.

9.35 In the event that NHS Trusts decide to accept a bid on a time basis, it is good practice to request the production of detailed estimates in advance for fees against discrete stages or deliverables for the project against which outturn fees can be compared and comparisons made. This will help show up where overruns are occurring.

Fixed fees

9.36 Fixed fee contracts are commonly offered by legal, financial and design advisers for PFI advice in the stages up to issue of the Invitation To Negotiate for the project, and sometimes beyond. Again, this will depend on the uncertainties in the project, the degree of precision in defining advisers' responsibilities in the terms of reference and confidence in the NHS Trust's project management team.

9.37 If a fixed fee contract is agreed the NHS Trust should agree in depth with the advisers the level of work that they will be providing under the contract. This should be in terms of the minimum specified hours to be worked at each stage of the procurement for a given output. This will also enable a clearer comparison of bids.

Capped fees

9.38 Variable fees capped to an agreed level provide NHS Trusts with a good mechanism to control costs, while sharing incentives to keep costs low once contracts have been signed. As with fixed fees, advisers may not be willing to cap fees where there is lack of clarity in their responsibilities and the resources they will be required to provide. In these circumstances it is unrealistic to expect advisers when bidding to commit to a cap, before they have had an opportunity adequately to scope the work in discussion with the NHS Trust's team.

9.39 For time and capped fees, NHS Trusts should ask for monthly billing and auditing so that problems with fees are signalled early.

Success fees

9.40 In some cases advisers are prepared to offer success-fee based contracts, or terms where an element of payment is dependent upon success. With the exception of advice on the feasibility stage of a project, NHS Trusts should consider at least some success-fee element, as open-ended fee-based payments do not incentivise advisers to close deals. While success fees provide shared incentives between the NHS Trust and its advisers, the extra risk for the advisers may result in their expectation of higher overall fees.

Management of advisers

9.41 NHS Trusts will not obtain value for money from advisers without managing them effectively. Key considerations include:

- making sure that relevant expertise is available at meetings (but NHS Trusts should always first consider whether the attendance of advisers is at all necessary);
- limiting of the numbers of advisers that attend meetings to key personnel;
- making sure that advisers have a clear picture about what is expected of them and the timescales within which they must operate;
- asking advisers to agree with one another which are to have prime responsibility in given areas so as to avoid duplication;
- ensuring that all advisers have equally effective systems in place to manage their own team;
- setting budgets with advisers for fees and monitoring their costs;
- ensuring that advisers have a clear client within the NHS Trust (eg the finance or project director);
- not being afraid to demand that poor performers be replaced, or not to pay for bad work or advice.

9.42 Regular monitoring of the performance of advisers as the project develops is essential. Concerns regarding performance should be raised with advisers as early as possible.

9.43 It is important to define the scope of work as clearly as possible before contracting with the adviser. However, changes in timetable or scope may develop through the course of the project and this may impact on advisers and their fees.

9.44 Changes in scope will always have to be confirmed to advisers, but the NHS Trust will need to avoid having to re-negotiate its terms of appointment with its advisers after every such change. Therefore, a key item in relation to selection will be the attitude of advisers to change and their willingness to be flexible.

Summary

9.45 Efficient use of external advisory services depends upon:

- recognising that the role of advisers depends on the NHS Trust's internal strengths, the nature of the project, the combination of advisers to be used and their ability to work as part of the public sector team;
- obtaining support from high-quality advisers and ensuring that contracts deliver value for money;
- obtaining advisers who are skilled in the relevant areas;
- obtaining support from the appropriate individuals who will be available when needed;
- controlling costs, particularly by being as specific as possible in setting terms of reference;
- avoiding conflicts of interest among advisers;
- NHS Trusts maintaining ownership of the project, understanding key procurement issues and providing clear directions to advisers;
- effective management structures being put in place.

Further information

PFI Technical Note No 2: *How to follow EC Procurement Procedure and Advertise in the OJEC*, Treasury Taskforce, June 1998

PFI Technical Note No 3: *How to Appoint and Manage Advisers*, Treasury Taskforce, September 1998

Public Works Contracts Regulations, SI 1991/2680

Public Services Contracts Regulations, SI 1993/3228

Guide to procedures for commissioning building and engineering consultants, NHS Estates, Concode, April 1994 and amendment November 1995

Government Opportunities, Business Information Publications, tel 0141 332 8247, fax 0141 331 2652.

HM Treasury guidance is also available on the Treasury's web site <http://www.hm-treasury.gov.uk>, under the section headed "Guidance".

10. Developing the scope of the project

Introduction

10.1 Whilst the NHS Trust is preparing the Outline Business Case for a scheme it should also be devoting resources to developing the scope of the project. This should be well advanced, if not complete, before the NHS Trust commences the formal procurement process by advertising in OJEC.

10.2 Key areas which should be addressed in determining the scope of, and the level of risk within, the project before OJEC are:

- the Invitation To Negotiate;
- output specifications for the facilities and services (sometimes referred to as the built environment).

The Invitation To Negotiate is discussed in Chapter 5 in *The PFI Procurement Process*. Output specifications are discussed below.

Developing output specifications

10.3 The output specifications for the facilities and services for which bidders are expected to submit proposals will cover the NHS Trust's requirements for objectives, outputs or outcomes. They will also cover the minimum quality and performance standards on which the Public Sector Comparator is based. Output specifications will also be required for services (both clinical and non-clinical) which will continue to be provided by the NHS Trust. Bidders will need these to be able to produce proposals for facilities which meet the NHS Trust's requirements.

10.4 The specifications should concentrate on what must be achieved, rather than how to achieve it. In that way, they should encourage innovation, performance in line with the NHS Trust's requirements and superior cost effectiveness. The responses from bidders may also exceed the NHS Trust's minimum requirements as stated in the specification. However, it is important that the specifications faithfully reflect the outputs delivered in the Public Sector Comparator. The output specifications will be extremely important in encouraging a response that provides high quality healthcare and meets the NHS Trust's business objectives.

Who should prepare output specifications?

10.5 It is good practice to include a wide range of interested parties when drawing up the output specifications. This should include representatives of the staff who depend on, or who are users of, the particular service. They will therefore be drawn from clinical and non-clinical staff, managers and those with a technical background

or who are directly responsible for providing the service now. Care should be taken not to re-specify what currently exists but to consider what may be required or be of benefit in the future. It is easier to do this by thinking in terms of outputs and outcomes. However, setting out the existing service specifications may provide a useful starting point although these should be subject to a critical analysis, for example to establish what is done, how and by whom.

10.6 Depending on the size and scope of the scheme, the NHS Trust may also need external advisers who have previous experience in drawing up output specifications for other projects – particularly if the specifications involve providing a new facility from which the NHS Trust will be delivering clinical services.

10.7 Output specifications are wholly different from input based specifications and the project team and its advisers will have to encourage everyone involved to think in terms of outputs rather than inputs. They will also have to co-ordinate the preparation of the specifications so that they are consistent across the services. A key area of importance is to specify the interfaces between services included and excluded from the PFI deal.

10.8 NHS Trusts should not underestimate the amount of work and the time involved in drawing up comprehensive output specifications for a project. The project team should manage their development and should also ensure that nominated stakeholders within the NHS Trust are responsible for, and have ownership of, given output specifications.

10.9 NHS Trusts should consider how best to interpret clinicians' requirements in a way that can be understood and acted upon by bidders and their design teams. One option chosen by a first wave PFI scheme was to employ a Quantity Surveyor to interpret the NHS Trust's requirements, and to manage the interface between clinical requirements and design throughout the procurement process.

Defining the NHS Trust's requirements

10.10 The facilities and services it is proposed will be provided under the project will need output specifications that outline the NHS Trust's requirements. Those requirements will include:

- facilities that both support the clinical and other services that will be offered there and meet the NHS Trust's investment objectives;
- support services (hard FM; and soft FM to the extent it is appropriate and value for money);
- other services (both clinical and non-clinical) that will continue to be provided by the NHS Trust.

10.11 The specification of the NHS Trust's requirements should not be too prescriptive. They should be outlined in terms of the performance standards which the NHS Trust will require. The output specifications should be based on the NHS Trust's needs not wants, and the NHS Trust should ensure that services are quantifiable and measurable. The private sector will then be given scope to decide how the services should be provided.

10.12 The steps involved in preparing output specifications are the same regardless of the size and nature of the project:

- stage 1 – define the scope;
- stage 2 – set objectives;
- stage 3 – define requirements and performance standards;
- stage 4 – identify the constraints;
- stage 5 – set out estimated activity levels and flows;
- stage 6 – develop a system for performance measurement.

Stage one – define the scope

10.13 The scope of the services or facilities covered by the output specifications must be quite precise in order to avoid any misunderstanding between the NHS Trust and contractors about their respective responsibilities.

10.14 Points to consider include:

- the services and activities that are included and the boundaries with other services excluded from the scope of the scheme;
- services that are specifically excluded;
- whether the services extend to all NHS Trust sites.

Stage two – set objectives

10.15 Overall objectives should be expressed in terms of outputs: what is the NHS Trust trying to achieve? Objectives must be consistent with the NHS Trust's business objectives and specific service requirements. When setting objectives, NHS Trusts should also consider how particular services or elements contribute to its overall model of care. Setting the objectives and defining the scope of the scheme should be an interactive process.

Stage three – define requirements and performance standards

10.16 The NHS Trust's requirements for facilities and services should be precise, quantifiable, and provide a means of objectively assessing the extent to which the standard has been achieved. Requirements should cover statutory requirements, Patient Charter requirements, NHS Trust policies, requirements of end users, good practice and NHS Trust defined standards.

10.17 The NHS Trust should also set out its proposed model of care. This should include the proposed departmental relationships for services.

Stage four – identify the constraints

10.18 Any constraints that will restrict the way in which bidders develop solutions should be disclosed. For example: the managerial and operational policies of the NHS Trust or known constraints imposed by the local planning authority or other statutory bodies.

Stage five – set out estimated activity levels and flows

10.19 An indication of the size of the service needed should be expressed in terms of measures of activity that best reflect demand, for example the number of inpatient days or day cases. This will enable bidders to form an opinion of the likely facilities needed. The NHS Trust should offer very clear guidance on the size of facilities it believes is appropriate. In particular, NHS Trusts should give very clear indications of bed numbers, theatres etc that they believe are required. But bidders are ultimately responsible for the decision based on their own assessment of the necessary inputs. The NHS Trust should not rule out opportunities for the private sector to make improvements through innovation.

10.20 The NHS Trust should also provide details of current levels of patient needs and identify any known or perceived issues which could impact on quantities.

Stage six – develop a system for performance measurement

10.21 There must be a system for measuring the performance of the private sector operator against the requirements and performance standards for the facility or service specified. The principles and the framework of the performance monitoring regime should be developed in consultation with the NHS Trust's advisers and the end users. The performance monitoring regime will need to be developed sufficiently so that details can be set out as part of the payment mechanism in the Invitation To Negotiate. Since the private sector operator and the NHS Trust must work in partnership, the performance monitoring system should be robust, challenging and fair, but not needlessly intrusive or excessive.

10.22 The NHS Trust should also consider whether monitoring systems should be led by the private sector operator, and supported by the NHS Trust's own systems. It is not necessary to fully develop systems which the operator will be asked to provide. However, the measures provide an important input into the payment mechanism. They should be developed sufficiently so that the NHS Trust has a clear idea of how the performance of services will be measured, and so that bidders have a clear idea of what is expected of them. The NHS Trust should retain the right to monitor performance directly, eg as an extreme measure in the event of default.

10.23 The main objectives for the measurement framework are:

- to provide an objective method of measuring performance;
- to minimise the time spent by the NHS Trust on monitoring;
- to provide incentives to meet the minimum requirements.

10.24 Bidding is costly and the NHS Trust must bear in mind that unless potential bidders have all the information they need about the output specifications, they may either not bid or may price bids higher which would adversely affect the value for money and affordability of the scheme. Therefore before prospective bidders undertake detailed work based on the output specification, they could be given an opportunity to comment on the proposed format and content and to seek clarification on any points. They could also be asked to suggest any amendments which they consider appropriate.

10.25 The nature of the output specifications and the performance measurement regime will need to be incorporated into the payment mechanism which the NHS

Trust will need to develop as part of the Invitation To Negotiate. Payment mechanisms are also discussed in *Technical Issues*.

10.26 A key area to consider is performance related risk for the operator and how this will be reflected in the payment mechanism to ensure both that the operator is incentivised to maintain high levels of performance and that suitable deductions are made to payments for poor or non-performance.

Infrastructure and facilities

10.27 The NHS Trust should not be too prescriptive about what facilities and infrastructure the private sector should provide. Although the NHS Trust should refer to the preferred option (for example new build on greenfield site) set out in the Outline Business Case, it should not prevent bidders putting forward alternative proposals that are consistent with the NHS Trust's business objectives. However, the parameters of any potential solution must be sufficiently specified to prevent bidders developing proposals which the NHS Trust could not consider – for example, facilities and services outside the scope of the project; or an unacceptable geographical location of the facilities.

10.28 Any constraints that will place restrictions on bidders when they are developing solutions should be stated. For example: restrictions on planning permission, access to the site during the construction phase, or the need to keep hospital services operational during the construction phase.

10.29 The NHS Trust should set out the minimum building design quality, facilities and services required in terms of outputs and outcomes that are needed to provide an appropriate environment to deliver health care services to patients in a manner that is consistent with the NHS Trust's objectives in terms of risk transfer and value for money.

10.30 Traditional procurement approaches allow a “trial and error” attitude during the development of the detailed design, with solutions being created and modified in an iterative process. This is appropriate for a client organisation where the detailed design comes before a contractual commitment to build. It is hazardous in the PFI environment, where increasing contractual commitments are being made with a private sector partner before the detailed design is complete. Some evolution in design is both inevitable and healthy, as different professionals discuss service needs and potential developments. But it should be possible to reduce uncertainty without stifling innovation, and PFI requires clearer thinking from the outset. Time and effort invested by the NHS Trust at this stage will greatly assist the PFI process and thereby improve potential value for money.

10.31 The requirements for the design should be defined by identifying the outcomes and outputs required. These requirements will set the framework for the design within which the more detailed requirements for the services to be provided as part of the scheme can be accommodated.

10.32 A good design makes the best use of valuable resources. It must also be achievable. A well designed building should do exactly what you need and will do it in an efficient manner. Within the basic cost of fulfilling the need, it will also provide as much extra added value to the lives of those who use it.

10.33 The output specifications should address issues of design and design quality that will be important to the scheme. One key area which should be addressed is the degree of flexibility and adaptability of buildings the NHS Trust requires to allow for changes in the operations of the NHS Trust throughout the contract period. These concepts can be very difficult for the NHS to articulate, given the potential for change in future patterns of service delivery, but factors to bear in mind include:

- flexibility – during a building’s lifetime its constituent parts may have to fulfil more than one function, due to technical advances and changes in medical treatment techniques. Flexibility should be an in built feature of the design, to allow for minor adaptations and alterations to be undertaken without the NHS Trust incurring excessive costs. The capacity for the building to respond to these changes will also assist in guarding against the risk of the structure becoming obsolete before the contract end;
- adaptability – the capacity for major change for any healthcare building in relation to either its expansion or contraction is a risk that should be estimated at the time of the initial design conception.

10.34 The NHS Trust should give examples of key factors which will be considered when assessing flexibility and adaptability such as growth, change or contraction which the design will have to demonstrate that it can fulfil.

10.35 Flexibility and adaptability are achieved at a cost. The NHS Trust should take the appropriate advice on the cost implications of requirements within the output specifications. The extent to which bidders are asked to include an allowance for flexibility and adaptability in their designs should also be reflected in the Public Sector Comparator.

10.36 The output specification for architectural and environmental standards will have to be set in consultation with specialist professional and technical advisers and with reference to statutory requirements, the NHS Trust’s overall design philosophy and NHS guidance. Guidance may include Health Facilities Notes, Health Guidance Notes and Health Technical Memoranda. Other issues to be covered include:

- operational issues;
- spacial and functional relationships;
- clinical adjacencies;
- the type of environment – the use of natural light, external views, de-institutionalised atmosphere etc;
- access arrangements for staff, patients, visitors, suppliers and disabled people;
- use of labour-saving technology and designs;
- rationalisation of resources by use of flexible facilities (multi-purpose rooms, operating theatres etc), the grouping of facilities and extending the working day;

- the provision of staff amenities;
- links with community care providers and potential scope for integrating the use of facilities;
- site master-planning to allow for the possible down-sizing and/or expansion of clinical departments;
- environmental standards including, for example, the NHS Trust's objectives in terms of energy efficiency and for reducing and recycling waste.

10.37 The NHS Trust should have a clear idea before it commences the procurement of the extent to which it will need to approve the clinical functionality of the designs provided by the private sector prior to financial close.

Support services

10.38 The NHS Trust should set out what services it expects to be provided by the private sector as part of the project. NHS Trusts will continue to be the employer of clinical staff. Services which can be included in PFI schemes are set out in Figure 10.1 overleaf.

10.39 It is no longer an automatic requirement for support staff to be transferred to the private sector consortium ~~in order to achieve an off-balance sheet audit opinion~~. The amendment to FRS 5, and new Treasury accounting guidance (Technical Note No.1 Revised) determine balance sheet treatment by assessing the impact of property risks, excluding separable service related risks from the analysis. The extent to which "soft" facilities management staff (eg catering, portering etc.) transfer will now depend solely on the individual NHS Trust's circumstances, and the achievement of value for money. NHS Trusts should contact the NHS Executive for advice.

10.40 Bidders will be responsible for developing the operational policies and identifying their requirement for the facilities for support services based on the output specifications for each service. In this way bidders will be able to put forward a solution that will maximise opportunities to deliver efficiencies in the provision of support services – for example, the use of the bidder's own commercial, organisational and management systems.

10.41 This new approach will apply to all future schemes and those which have not yet gone out to tender by placing a notice in the European Journal. The costs and delays in reopening decisions on the provision of support services at more advanced schemes cannot be justified.

Figure 10.1: Services which can be included in a PFI scheme

Services which <i>may</i> be provided by the private sector under a PFI agreement
Grounds and gardens maintenance
Property and building maintenance
Equipment maintenance
Domestic services
Catering
Laundry
Waste disposal
Pest control
Portering
Security
Non-emergency patient transport
Courier services
Information Management and Technology Systems
Financial services
Car parking
Telecommunications
Energy and utilities
Sterile Supply Services/SSDs
Stores
Reception
Postal services
Residential accommodation
Day nursery and creche services

10.42 Separate output specifications should be produced for each of the services for which the short-listed bidders will be invited to submit proposals. However, the NHS Trust should take care not to restrict service delivery to current patterns and should allow bidders to come up with innovative proposals. These specifications will define the nature of a partnership with the private sector operator which may run for many years and are therefore extremely important. Output specifications should also cover other non-clinical services for which the NHS Trust expects to remain responsible.

10.43 Advisers can be used to help the NHS Trust draw up the specifications but they should, at a very early stage, consult the end users and service managers who will have detailed knowledge of the standards and their relative importance. The NHS Trust should retain ownership of the specification and not rely entirely on its advisers.

10.44 The scope of the service covered by the output specification must be clearly defined, particularly in relation to the boundaries with other services both included and excluded from the scheme. This will avoid any misunderstandings between the NHS Trust and the bidder about their respective responsibilities. For example, questions over ownership of assets (bed linen, cutlery etc) and responsibility for laundry services. In addition, the NHS Trust should not introduce constraints on how the bidder organises the operatives, for example multi-skilling, unless such constraints are fundamental to the delivery of direct patient services. The NHS Trust may wish to list assets, other than those which will be provided by the private sector operator, that will be available for use in the delivery of support services.

10.45 The output specifications should also take account of the NHS Trust's operational policies, and service level issues such as response times and proposed monitoring arrangements. The NHS Trust should also consider what sorts of mechanisms will be used to cater for changes in the level and requirements of services during the contract period.

10.46 In cases where the service will continue to be provided on another hospital site, the NHS Trust should consider the potential benefits of extending the private sector service to all sites: for example, improved co-ordination, increased flexibility and the opportunity for greater efficiency.

10.47 NHS Trusts should also consider IT and equipment services they will require to be provided as part of the project. The provision of IT and equipment as part of larger PFI deals is discussed in *Technical Issues*.

Clinical services

10.48 So that the facility supports the delivery of the objectives of each of the clinical services, the NHS Trust must produce output specifications which define the functional relationships, the functional content and the key operational policies within it. This should take account of reasonable clinical working practices and performance standards, and also clinical adjacencies. The NHS Trust should make reference to both medical advances and the need to meet any change in demand.

10.49 The defining of the functional relationships between the clinical services will enable the bidder to produce a design that maximises efficiency. For example, the pharmacy may be best situated near to the out-patient department.

10.50 The broad specification of the functional content of the facility needed to support the services using it should consider:

- the indicative caseload and/or number of beds by speciality, including speciality performance targets (for example average length of stay, occupancy rates, etc);
- the notional number of beds per ward and proportion of single rooms required. This will be influenced by the NHS Trust's intentions about the delivery of patient care (for example, care philosophy) and any national imperatives such as single-sex wards;
- Patients Charter requirements;

- hygiene facilities required (for example, en-suite facilities to a proportional number of beds etc);
- types of patient to be treated (for example, in-patients, out-patients and high or low dependency);
- planned patient flows;
- planned patient activity by speciality;
- the continuous need for the facilities to cope with minor adaptations and alterations in response to service need, technical advances or statutory changes.

10.51 The solution for the building design and operation of the facilities has to support the delivery of the key operational policies. This should include details of how patient care is to be delivered and the operational policies needed to support it – for example, total patient care, the notional number of sessions per week in key facilities and the hospital working day.

Other tenants

10.52 Where other tenants of the NHS Trust's existing premises are to be included in a PFI project (eg GPs), the output specifications for the building and service requirements should make reference to the tenancy details.

Further information

Writing an Output Specification, HM Treasury/Private Finance Panel Executive, 1996

NHS Estates produce technical guidance providing information and advice relating to the planning, design and maintenance of buildings for health care. This guidance is produced for facilities managers, architects, builders, engineers, surveyors, capital planners and other contractors working in the health care estate field. NHS Estates is an executive agency of the Department of Health and can be contacted on 0113 254 7000.

11. Planning permission

11.1 As part of the preparation for PFI schemes, NHS Trusts are expected to obtain outline planning permission for the site to be developed prior to advertising the scheme in OJEC. Where outline planning permission is not appropriate, for example, where the site involves a listed building or buildings in a conservation area, and full planning consent is required instead by the planning authority, then NHS Trusts should discuss the requirements of the project with the NHS Executive Regional Office and, for major schemes (with a capital value of £25m or over), with headquarters.

11.2 It should also be made clear to bidders that obtaining outline planning permission before the project was advertised should not limit their scope for innovation in bids. If a bid was returned that advocated the use of a different site or required outline planning permission to be re-obtained then this, and any additional time delay, would be considered alongside any bids which were within the outline planning permission already obtained. The NHS Trust would need to compare the costs and benefits of the different bids.

11.3 Where an NHS Trust proposes that surplus land is to be included in a scheme, it is important not to restrict private sector innovation by seeking planning permission for any surplus land too early on in the procurement process. The value of a site may depend on the type of outline planning permission that can be obtained for it, which will affect the affordability parameters of the scheme. Professional advice should be taken, as it may be appropriate for the NHS Trust to develop a planning brief for the surplus land site rather than seek outline planning permission.

12. Openness and public involvement

Introduction

12.1 In the past PFI schemes have often been perceived as secretive and exclusive by the communities they serve. The degree of public involvement and openness has varied between schemes.

12.2 Openness and public involvement are key features of the new NHS. PFI schemes usually involve major changes to the provision and location of NHS services. Local people, staff and their representatives must be able to comment on and respond to options and proposals. Active communication and a continuing dialogue, including early discussion of any changes, should be a standard feature of all PFI schemes. The guidance in this chapter is intended to establish a more consistent approach to consultation, dialogue and the release of information.

Consultation and dialogue

12.3 A proposal for a major project requires the production of a Strategic Outline Case (SOC) to demonstrate the health service need for a major capital investment. In the SOC the Health Authority is required to set out its plans to communicate and explain its proposals to the local community throughout the process of developing the scheme, and to provide opportunities for views from the public to be expressed and considered. Under regulation 19(1) of the Community Health Councils Regulations 1996 Health Authorities have a duty to provide local Community Health Councils (CHCs) with information about the planning and operation of health services in their area.

12.4 Ministers prioritise SOC's. Prioritisation indicates that a SOC has identified a health service need which has to be met, that there are some viable options and that the NHS Trust should proceed to fully consider and develop all the options for meeting that need in an Outline Business Case (OBC).

12.5 Under regulation 18(1) of the Community Health Councils Regulations 1996 Health Authorities have a duty to consult CHCs on any proposals which the Health Authority may have under consideration for substantial developments or substantial variations in services in a Council's district. This consultation period should begin when proposals are reasonably well developed so that there can be meaningful consultation, but clearly the consultation has to be conducted before any final decisions are made. The precise timing will be decided upon by the Health Authority.

12.6 The NHS Trust board should set up the project board (see chapter 7) once preparation of the OBC starts. Among the project board's roles are representing the wider ownership of the project and agreeing an internal and external communication plan. Whatever local arrangements are agreed upon by the Health Authority in the

discharge of regulations 18(1) and 19(1) of the Community Health Councils Regulations 1996, the project board's external communication plan should ensure that there are clearly agreed arrangements and mechanisms to keep CHCs and other interested external parties informed and updated about the service options being considered in the OBC. The project team is responsible for ensuring that the external and internal communication plans are in place and are executed.

12.7 After the OBC has been approved the arrangements and mechanisms agreed under the external communication plan should remain in place throughout the PFI procurement period, ensuring a continuing dialogue between the NHS Trust and interested external parties as the NHS Trust selects a private sector partner and develops a PFI solution which meets the service requirements identified in the OBC. CHCs and other external parties must have the opportunity to express their opinions and views and seek answers to questions on behalf of those they represent during the PFI procurement period. They must have a genuine opportunity to influence decisions before they are taken.

12.8 In making documents and papers available for the continuing dialogue described in paragraph 12.7, NHS Trusts must observe the guidelines on access to information which are discussed under "Making information available" below. Certain information received from bidders or produced by the NHS Trust may be commercially sensitive and NHS Trusts must be clear about the exact nature and implications of any confidentiality or restricted access arrangements which they decide upon.

12.9 If the service element of a PFI solution differs significantly from that originally approved in the OBC, such that it is different from the proposals already consulted on, the Health Authority will need to extend the original consultation under regulation 18(1) of the Community Health Councils Regulations 1996.

12.10 The checklist at Figure 12.1 at the end of this chapter sets out the requirements for consultation under regulation 18(1), information release under regulation 19(1), and continuing dialogue, as discussed above. It also includes the requirements with respect to planning permission (see chapter 11), establishment orders (see chapter 13 of *Technical Issues*) and staff at the NHS Trust (see chapter 13 of this section). In order to reduce uncertainty for the private sector and thereby optimise value for money, all the statutory consultation exercises (apart from those under TUPE and the provision of information to CHC(s), which will be ongoing) must be completed wherever possible before a scheme proceeds to OJEC and the private sector becomes involved.

12.11 The OBC and FBC must include a discrete section which summarises the statutory consultation exercise and continuing dialogue. This must set out the major concerns and issues raised and how these were taken into account by the Health Authority and the NHS Trust. It will be a requirement of business case approval that the consultation, information and dialogue requirements set out above are observed.

Making information available

12.12 To be meaningful and effective the dialogue between an NHS Trust and interested external parties during the PFI procurement period must be based on valid and adequate information. A key requirement for managing the procurement process properly is a well prepared and widely understood strategy for the disclosure and dissemination of information.

12.13 The general principle to be followed by NHS Trusts is set out in the Code of Practice on access to Government Information which states that:

“the approach to the release of information should in all cases be based on the assumption that information should be released ...except where disclosure would not be in the public interest or would breach personal privacy or the confidences of a third party”.

This is also the approach taken in the NHS’s own guidance document Code of Practice on Openness in the NHS:

“There should always be a general presumption of openness and transparency on the part of an NHS organisation conducting a tendering process. Commercial good practice, while welcoming openness, demands some confidentiality to preserve the business interests of competing companies and to protect the position of the NHS organisation in current or future tendering activities. Nothing in the Code therefore requires NHS organisations to prejudice the legitimate commercial confidences of tenderers and contractors.”

12.14 The Code of Practice on Openness in the NHS states that competitive tendering should not lead to any loss of public accountability for public service, or loss of transparency in the spending of public money. The guidance lists the information which should normally be made public:

- the range of tender bids, where three or more are received;
- the identity of the successful tenderer (by agreement with tenderer);
- the nature of the job, service, or goods supplied;
- performance standards;
- the criteria for award of contract;
- the winning tender price (by agreement with tenderer);
- the general contract terms and conditions.

12.15 NHS Trusts must carefully consider the implications of these guidelines for the release of information for the continuing dialogue throughout the PFI procurement period. The application of these guidelines is a matter of judgement for individual NHS Trusts, but NHS Trusts should clearly set out their proposals for dialogue with external parties and their approach to making information available in the Memorandum of Information, which is sent to all those who respond to the contract notice placed in OJEC. As suggested in Chapter 5 of *The PFI Procurement Process*, the presentation is a good opportunity for the project team to discuss further with prequalified parties the NHS Trust’s external communication plan and access to information.

12.16 Most of the information which could be regarded as genuinely commercially sensitive, in that its release during the PFI procurement period might jeopardise the competitive process and achievement of value for money, is provided in response to the Preliminary and/or Final ITN. The different types of ITN are explained further in

Chaper 5 of *The PFI Procurement Process*. Information provided in response to the preliminary ITN in this category might include innovative design and construction points, methods of financing, risk allocation, treatment of surplus land or other specific features of the scheme. Information provided in response to the final ITN might include details of the financial model, the payment mechanism, the tariff and charging arrangements, methods of financing and sources of income.

12.17 To be transparent and fair, NHS Trusts should seek to ensure that, as far as possible, the same level of information should be available on each bidder during the dialogue with external parties. NHS Trusts should use the presentation to establish a consistent and fair approach to the release of information with all the remaining bidders. However, NHS Trusts should take care to avoid a level of information release which simply accepts the lowest common denominator. Variations in the commercial practices and conventions of bidders is inevitable and, in any case, it is likely that further discussions and clarifications will need to be undertaken as the details of bids are developed.

12.18 Trades Unions representing staff at NHS Trusts who are anticipated to transfer to a potential private sector partner should be invited to hold discussions with shortlisted bidders to discuss staff issues. The information requirements for this process are dealt with separately in the next chapter on “Fair treatment of staff”.

12.19 It should be noted that these guidelines on the release of information do not provide an option on the part of NHS Trusts to refuse to release information regarding the particular outputs to be purchased under the contract, or the general terms on which the NHS Trust initially proposes or subsequently has agreed to do business. This means that, unless a genuine commercial sensitivity can be demonstrated, the NHS Trust should make available during the PFI procurement period the contract notice placed in OJEC; the Memorandum of Information; the Prequalification Questionnaire; and the Preliminary and/or Final ITN.

Release of key project documents

12.20 The release of the key PFI project documents at each approval stage is to ensure that a full and final record is in the public domain of the decisions for which the NHS Trust is accountable. The key PFI project documents are the OBC, the FBC and the final contract between the NHS Trust and its private sector partner. The Strategic Outline Case (SOC), required for projects with a capital value of £25 million or over, must be made publicly available in the same manner as the other key project documents.

12.21 Publicly available is defined as providing one free copy of each of these project documents at the following locations:

- (i) the NHS Trust’s premises for staff and patients to see;
- (ii) with the Chairperson of the Trades Unions representing staff at the NHS Trust;
- (iii) with the local Community Health Council(s);
- (iv) with the local authority (only applies for schemes with a capital value of £1 million or greater);

- (v) at the local main public Library where it must be available for viewing (only applies for schemes with a capital value of £10 million or greater);
- (vi) in the libraries of the House of Commons and House of Lords (only applies for schemes with a capital value of £10 million or greater);
- (vii) in the PFI Treasury Taskforce Library at HM Treasury (only applies for schemes with a capital value of £25 million or greater).

12.22 The addresses for sending copies to the House of Commons and House of Lords Libraries and the PFI Treasury Taskforce Library at HM Treasury are as follows:

House of Commons Library	The Librarian
The Deposited Papers Clerk	The Library
Oriel Room	House of Lords
House of Commons	LONDON SW1A 0PW
LONDON SW1A 0AA	

Olga Morris
Treasury Taskforce (PFI Library)
Private Finance Policy Team
Room 19A/G
HM Treasury
Parliament Street
LONDON SW1P 3AG

12.23 One copy of each project document must also be lodged with the appropriate NHS Executive Regional Office.

12.24 Each project document should be made available in hard copy; NHS Trusts should also consider offering a CD-Rom version where possible. Business Cases should include the name and address of a contact point at the NHS Trust and the Regional Office who can respond to queries.

12.25 NHS Trusts should supply further copies of their project documents upon request from any person, but are entitled to make a reasonable charge for them to cover photocopying/postage costs. NHS Executive Regional Offices are responsible for supplying further copies of the SOCs upon request (charging is at Regional Offices' discretion).

12.26 For PFI projects with a capital value of £10m or greater NHS Trusts must place an advertisement in their local paper at the time of publishing the OBC and FBC. This must explain that these documents are now available for viewing and where they have been placed.

12.27 The OBC and FBC must be made publicly available within one month of their respective final approval (which could be by the NHS Executive, HM Treasury or Ministers, depending on value). The final contract must be made publicly available within a month of financial close.

12.28 SOCs must be made publicly available within a month after the results of each national prioritisation exercise are announced. SOCs must be released irrespective of whether they were prioritised or not. If following the production of the SOC there

were significant changes to the investment proposal considered by Ministers, an addendum should be added to the published SOC to show the changes.

12.29 As with the release of information for the dialogue during the PFI procurement period, information released in the business cases and the final contract is subject to the same guidelines on commercial sensitivity. NHS Trusts should observe the guidelines set out in Paragraphs 12.13 and 12.14 above. NHS Trusts and their private sector partners should explicitly agree on what information should be withheld from the project documents to be released and it must be clearly stated in these documents what information has been excluded on the grounds of commercial confidentiality. When the FBC is made publicly available the competitive element of the PFI procurement process will have been completed along with the value for money calculations and approvals. This means that certain information will no longer be regarded as commercially sensitive and should be included in the FBC.

12.30 NHS Trusts should be able to release their SOCs and OBCs virtually intact.

12.31 Information disclosed under the Arbitration and Conciliation Advisory Service (ACAS) code of practice for collective bargaining should be treated as being technically available in the public domain. It must be included in full in business cases made publicly available, unless by doing so it would allow readers to identify personal information about individuals.

12.32 An operational guidance note was issued in December 1998 by the NHS Executive which deals with the position of NHS Trusts which already have signed contracts and/or approved Business Cases. This made it plain that the same principles of openness apply to existing PFI Contracts, and is available from PFI contacts at NHS Executive Regional Offices.

Figure 12.1: Consultation, information and dialogue checklist

Stage of scheme	Statutory
Develop Strategic Outline Business Case and/or Outline Business Case and prepare for procurement	<p>Consultation on service change by Health Authority(s): CHC(s) consulted</p> <p>Health Authority(s) provide CHC(s) with information (continues throughout procurement process)</p> <p>Establishment Order consultation between Secretary of State (NHS Executive Regional Office may conduct consultation) and CHC</p> <p>Outline planning permission sought from Local Authority</p> <p>Staff representatives and trades unions should be consulted by the transferor and transferee employers on proposed transfers under TUPE regulations no later than when ITN is being prepared (consultation continues throughout procurement process)</p>
Stage of scheme	Non-Statutory
Develop Strategic context and Strategic Outline Business Case and/or Outline Business Case and prepare for procurement	<p>NHS Trust alerts CHC(s) to its intentions and possible need for change in the Establishment Order</p> <p>Preliminary discussions with Local Authority re planning permission</p> <p>Dialogue about the scheme with other NHS Trusts, commissioners and other NHS bodies in the local health economy, staff representatives and trade unions, general public, CHCs, tenants of the NHS Trust, local authorities and voluntary organisations</p>
Advertise project in OJEC, shortlist and select preferred bidder	Continuing dialogue with interested external parties, including CHCs: parties to be kept regularly informed and updated during the PFI procurement process and invited to present their views to project management
Develop Full Business Case	Outcome of formal consultation exercise and subsequent dialogue during PFI procurement process recorded in FBC
Award contract and implement scheme	Continuing dialogue with staff representatives and trade unions regarding ongoing human resource

Further information

Code of Practice on Openness in the NHS, EL (95) 42 NHS Executive, 1994

Your Right to Know: the Government's proposal for a Freedom of Information Act, The Stationery Office, December 1997

Code of Practice on Access to Government Information, Second Edition Cabinet Office 1997

Community Health Councils Regulations [SI 1996/640]

13. Fair treatment of staff

Introduction

13.1 NHS Trusts must involve staff and their representatives in a process of continuous dialogue during the PFI procurement period as outlined in the previous chapter on openness and public involvement. As with the external communication plan, the project board's internal communication plan should ensure that there are clearly agreed arrangements and mechanisms to keep all staff at the NHS Trust fully informed about developments. Staff at the NHS Trust, both individually and through their representatives, must have a genuine opportunity to express their opinions and views and to influence decisions.

13.2 NHS staff who are directly affected by a PFI scheme also have an interest in potential bidders as they may also become their future employers. The NHS needs to achieve the best service delivery and to secure value for money. Delivering value for money under the PFI is not a question of the lowest cost. As a good employer itself, the NHS has found from past experience that the private sector partners who get the best from their staff by means of good employment practices are most likely to achieve successful partnerships which offer value for money.

13.3 To ensure that these issues are properly addressed during the procurement period, NHS Trusts must follow the Code of Practice set out below. Representatives of professional organisations may be involved along with representatives of trade unions in this process, but for the purposes of this guidance the term trade unions (TUs) is used. The Code of Practice is followed by a section on the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE).

13.4 The measures below reflect and incorporate the Treasury Taskforce Policy Statement No.4 *Disclosure of Information and Consultation with Staff and other Interested Parties*. As the Treasury guidance makes clear, there are legal requirements and value for money criteria which all public sector procuring bodies should observe and take into account when awarding a contract. The measures also reflect the letter sent by the then Minister of State for Health, Alan Milburn, to UNISON and all other health sector TUs on 20th October 1998. This letter has been widely circulated and provides background to the Department of Health's policy for the process of involving the TUs.

13.5 This process should be handled by the NHS Trust with care and conducted in good faith. The role of TUs is important in informing an NHS Trust's decision. But the correct balance must be struck between an informed, constructive dialogue and observing the EU procurement regulations. NHS Trusts should take legal advice on these points at the outset and throughout the project. Once the legal parameters are understood, NHS Trusts should ensure that a framework is agreed with staff representatives from the outset on exactly what information will be made available to them, and when, and how the discussions and reporting requirements will be

handled. This framework should form the most important part of the project board's internal communications strategy.

13.6 The process must also be transparent and fair. Any representations the TUs wish to make about particular bidders during the process must be formally communicated in writing or at a minuted meeting. There should be someone present from the NHS Trust to make an official record of any such meeting. One of the objectives of this exercise is improving the quality of contractors working in the NHS. Therefore, for the market to respond to TUs' concerns, these concerns must be communicated back to individual bidders by the NHS Trust.

Legal considerations

13.7 TU input into the appointment of a preferred bidder by the NHS Trust must comply with the relevant procurement regulations. If not managed properly, this process may lay the NHS Trust open to legal challenge. Inappropriate use of information by the NHS Trust (including information which is not relevant to the criteria adopted by the NHS Trust for selection or appointment) or use of information at the incorrect stage in the procurement process could be challenged under the procurement regulations. The use of information supplied by the TUs that is not capable of being substantiated could also expose the NHS Trust.

13.8 NHS Trusts and their legal advisers must therefore ensure at all stages in the selection and appointment process, working in co-operation with their TUs, that the content of any written representations (including minutes of meetings and reports) made to the NHS Trust and containing the views of the TUs are capable of being substantiated and that the use of the reports complies with the relevant procurement legislation and is relevant to the selection of bidders at the pre-qualification stage and the appointment of a preferred bidder.

Code of Practice: pre-qualification of bidders

13.9 Each potential bidder which responds to the OJEC advertisement must be requested in the Prequalification Questionnaire to supply information to enable the NHS Trust to assess whether the bidder meets the NHS Trust's minimum standards of economic and financial standing and ability and technical capacity. A model questionnaire is at Appendix 4 of *The PFI Procurement Process*. In relation to employment matters, information sought from bidders should include details of any industrial tribunal hearings outstanding against them or in which they have been involved over the last three years. Bidders should be advised that, subject to any requirements of commercial confidentiality that they may wish to impose, their response relating to employment matters will be made available to appropriate TUs at this stage. Before decisions are taken by the NHS Trust, the TUs should be asked if they wish to make representations to the NHS Trust regarding the information submitted by the bidders.

13.10 The TUs should also be asked to provide the NHS Trust with their views on the bidders in the context of the NHS Trust ensuring that it only accepts relevant and verifiable information on the fitness of potential bidders to be in the field for selection for the competition. All representations must be formally communicated (in writing or at a minuted meeting). Where the EU procurement regulations apply, such fitness must be determined by the NHS Trust in accordance with the criteria for rejection and selection of potential bidders specified in Regulations 14, 15 and 16 of

~~the Public Services Contracts Regulations 1993 SI 93/3228 (the Services Regulations). Relevant information under Regulation 14 will include information on criminal convictions or acts of grave misconduct in the course of the potential bidder's business or profession. The NHS Trust will need to take legal advice on the provisions of Regulations 14 – 16 of the Services Regulations and on the TUs' submissions. It should advise the TU if any information supplied is not relevant to the process of rejection and selection or not capable of being substantiated. Following such consultation with the TUs, submissions must be copied to the appropriate bidders so they are aware of any concerns the TUs may have. Comments on individual bidders must only be copied to them and not to others.~~

~~Code of Practice: evaluating shortlisted bidders~~

~~13.11 In choosing between bidders who respond to the Final Invitation to Negotiate, NHS Trusts must, in accordance with Department of Health policy, evaluate, as part of the qualitative evaluation of bidders' proposals, those bidders' proposals for the scheme in question in respect of:~~

- ~~● TUPE;~~
- ~~● staff management;~~
- ~~● pay, terms and conditions;~~
- ~~● training and labour relations;~~

~~to the extent that these are relevant to delivery of the particular service required and the provisions of the proposed contract. NHS Trusts must remember that at this stage of the procurement process, only factors relating to the award of the contract itself may be taken into account in appointing a preferred bidder.~~

~~13.12 This information should be supplied by bidders as part of their proposals in response to the Final Invitation To Negotiate (ITN) (see chapter 5 of *The PFI Procurement Process*). These factors should be evaluated by the NHS Trust with the intention of establishing the quality of service delivery implicit in bidders' proposals.~~

~~13.13 The NHS Trust should make available to the relevant TUs the relevant information it has received from those bidders in response to the Final ITN. Any release of information is subject to any requirements of commercial confidentiality the NHS Trust has agreed with bidders. Information should only be released to trade union representatives of staff currently employed by the NHS Trust who, at the time the shortlisting decision is made, are anticipated to transfer to the private sector partner as a result of the PFI project (with the agreement of the TUs affected, the information may also be released to the Chairman and Secretary of the Staff Side).~~

~~13.14 The TU representatives should be invited to hold discussions, through interviews for example, with all the shortlisted bidders. The NHS Trust should facilitate the discussion with the bidders and agree with the TUs who should attend from the NHS Trust. Minutes of any meetings/discussions should be formally agreed; in addition TUs should be invited to provide a report to the NHS Trust of the outcome of the discussion. It would be reasonable for the TU representatives to discuss with bidders the NHS Trust's output specifications, the bidders' responses to~~

~~the Final Invitation to Negotiate (which will contain the bidders' proposals for the scheme in respect of TUPE, staff management, pay, terms and conditions, and training and labour relations) and their design proposals. Bidders cannot be expected to discuss pricing information and it should be made clear to staff representatives that they should respect bidders' requests that, other than the reports to NHS Trust management, their discussions remain confidential. Bidders are not expected to have discussions with TUs representing staff who are not expected to transfer to the private sector as a result of the PFI contract.~~

~~13.15 As part of the framework referred to in Paragraph 13.5 above the NHS Trust, in conjunction with its legal advisers, needs to have formulated a strategy for dealing with a refusal by a bidder to participate in the process of discussions with the TUs or to provide particular information (other than on bona fide grounds of commercial confidentiality). It would be reasonable to request the bidder to give reasons for its refusal. The NHS Trust will then need to take legal advice on whether those reasons are legitimate in the context of the EU procurement regulations and the need for the NHS Trust to verify the information already provided or claims made by the bidder in support of its bid.~~

~~13.16 The TUs should be encouraged to discuss their views with the NHS Trust and its legal advisers first before any report by the TUs on the outcome of their discussions with the bidders is submitted. Once the report has been received by the NHS Trust, the relevant sections referring to a particular bidder should be passed back to that bidder for comment. The NHS Trust must, having first obtained legal advice, inform both bidders and TUs what, if any, elements of the report will be disregarded for the purposes of the evaluation exercise. Bidders must be allowed time to respond to any specific concerns raised by the TUs. It is not the intention that this process should have the effect of allowing bidders to revise their bids, which would be unacceptable. Its purpose is to ensure transparency and equal treatment of bidders and to enable the NHS Trust to verify the information that it has been given before appointing the preferred bidder.~~

~~13.17 The NHS Trust should take all the factors set out above – the information received in response to the Final ITN, the minutes of the discussions held with bidders, the possible report and the response from bidders – into consideration in the evaluation exercise for quality and the assessment of best value for money. In so doing, the NHS Trust must observe the criteria which it has adopted for making an award in accordance with Regulation 21 of the Services Regulations. The NHS Trust retains the full and final responsibility for final selection of the preferred bidder which will also need to take into account all the other evaluation criteria for assessing best overall value for money.~~

~~13.18 In order to demonstrate that the process is meaningful, the NHS Trust must respond to the points raised in the TUs discussions with bidders and any subsequent report, and must explain the reasons for any of its decisions which run counter to any valid concerns raised.~~

~~Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE)~~

~~13.19 The statutory consultations in relation to redundancies and TUPE must be observed and conducted alongside the Code of Practice outlined above. Procedural guidance for NHS bodies on managing TUPE is set out in HSC(96)58.~~

~~13.20 TUPE ensures that employment contracts are protected at the point of transfer to a new employer. Thereafter, pay and conditions of service may only be changed as a result of the normal joint process between employer, staff and their TUs, and with the agreement of all sides. Under common law any significant variance from the terms of an existing contract of employment could constitute a breach of contract.~~

~~13.21 Details on how TUPE issues should be managed in PFI contracts is contained in Appendix 1 of *Commercial Issues*.~~

~~Pensions~~

~~13.22 At present, TUPE does not give the right of continued access to the previous employer's pension scheme, but accrued pension rights in that scheme are protected at the time of transfer. However, specific powers have now been secured under EU law to allow the member states to include pension terms in the TUPE provisions. The necessary consultation needed to agree the precise nature of this protection is currently being undertaken by the Department of Trade and Industry.~~

~~13.23 HM Treasury has published guidance to Departments and Agencies on the treatment of Staff Pensions upon transfer from Central Government ("A Fair Deal for Staff Pensions"). So far as PFI is concerned, this requires that:~~

- ~~● transferring staff should be offered a broadly comparable pension by the new employer, both on initial transfer and at second and subsequent contracting rounds;~~
- ~~● the new employer's pension scheme should allow transferring staff the option of moving their accrued credits into that scheme on a fully protected basis;~~
- ~~● new instructions for the involvement of the Government Actuary's Department in assessing broad comparability and bulk transfer agreements should be followed.~~

~~13.24 The Treasury Statement of Practice applies to all NHS bodies, and NHS business cases will only be approved if the new measures have been observed in full. These measures apply without prejudice to the current review of TUPE regulations mentioned in paragraph 13.22; further guidance will be issued on how any new provisions will be implemented and incorporated into PFI contracts.~~

~~13.25 Under TUPE an NHS Trust's current trade union recognition agreements transfer to the new employer automatically. NHS Trusts must ensure that their private sector partners acknowledge in the contract that the NHS Trust's existing trade union recognition agreements must transfer under TUPE.~~

~~13.26 Commentary on how these issues have been discussed and managed must be provided in the FBC (see Appendix 6 of *The Procurement Process*).~~

~~Further information~~

~~The full text of "A Fair Deal for Staff pensions", and the associated Statement of Practice by the Government Actuary, is available from Treasury's Public Enquiry Unit (0171 270 4558) or at www.hm-treasury.gov.uk~~

14. Milestones

14.1 All NHS Trusts undertaking major PFI procurements which are prioritised by Ministers are required to agree with the NHS Executive a series of milestones to be met, both during preparation for procurement (from SOC to OJEC), and then for the duration of the procurement up to financial close. These milestones may be published or used by Ministers in response to queries about the progress of high profile schemes. If an NHS Trust consistently fails to meet milestones and appears to be unable to deliver a prioritised scheme, Ministers will be consulted regarding the appropriate corrective action required.

14.2 There is no prescribed timescale set by the NHS Executive for schemes to progress through the stages up to advertising a project in OJEC. The length of time taken to produce the OBC, undertake necessary consultations and obtain outline planning permission will depend upon circumstances specific to each scheme.

14.3 Milestones from SOC to OJEC could include:

- all output specifications well developed;
- draft Invitation To Negotiate completed;
- draft contract (including payment mechanism and performance regime) largely complete;
- granting of outline planning permission for main site;
- completion of statutory consultation;
- approval of the OBC.

~~Appendix 1: Delegated limits for PFI schemes~~

~~Delegated limits for construction schemes under PFI~~

~~At the time of writing these delegated limits were under review. The NHS Executive will issue an amended list when the review is complete.~~

Total capital cost of scheme	Approving authority
Greater than £0.25m for NHS Trusts with turnover less than £30m	Outline and Full Business Cases to Regional Office of the NHS Executive for approval
Greater than £0.6m for NHS Trusts with turnover between £30m and £80m	
Greater than £1m for NHS Trusts with turnover greater than £80m	
Greater than £1m	Outline and Full Business Cases to Regional Office for approval. Full Business Case to NHS Executive headquarters for sampling; if drawn needs prior NHS Executive headquarters approval to proceed
Greater than £4m	If drawn for NHS Executive headquarters sampling then Full Business Case also goes to HM Treasury for approval
Greater than £10m	NHS Executive headquarters and HM Treasury approval of Full Business Case required
Greater than £50m	Following NHS Executive headquarters' approval, Full Business Case to Ministers for approval

~~Delegated limits for IM&T schemes under the PFI~~

~~New delegated limits for IM&T schemes were introduced in February 1999. These are set out below.~~

~~NHS Executive Regional Offices are being asked to submit plans to the NHS Executive headquarters for managing the rollout of the increased delegation to NHS Trusts; this affects those NHS Trusts with a turnover of less than £80 million. Once the plans have been approved, the Regions then have responsibility for implementing the new delegated limit.~~

Whole life cost of scheme	Approving authority
Less than £1m for NHS Trusts, irrespective of turnover	NHS Trust Board
More than £1m, but less than £20m	NHS Executive Regional Office and Headquarters together, for Outline and Full Business Cases
More than £20m	NHS Executive Regional Office and Headquarters together, for Outline and Full Business case, Treasury approval of Full Business case also required

Note: HM Treasury will not normally see Outline Business Cases under the new limits, but will expect to be consulted on any novel or contentious cases, and on any cases which could set a potentially expensive precedent, or could cause repercussions, whether they are above or below the new delegated limit. NHS Trusts should consult their Regional Offices as needed.

Note: Whole Life Cost = all undiscounted costs over the full investment list (eg 7 years) including related costs such as training, and excluding VAT.

1. Executive summary

A brief self-standing statement of:

- the service objectives of the scheme;
- a summary of the shortlisted options;
- the results of the economic and financial appraisals;
- a statement of the preferred option (including reasons for its superiority);
- a statement of commissioner involvement and unequivocal support for the scheme.

2. Strategic context

2.1 *Overview* of the health strategy for the local healthcare system, drawing on commissioning HAs or PCGs' service strategies, Health Action Zones, Planning and Priorities Guidance and White Paper (the New NHS) requirements (eg Health Improvement Programmes). Also, any relevant local and national reviews (eg National Service frameworks) which have a bearing on where and how different types of services should be provided.

2.2 Assessment of the case for change in the pattern of services needed to meet, for example, commissioning HAs' or PCGs' requirements and future demand (including the rationale for any changes to the current configuration of services or estate); and current/new models of care.

2.3 Description of the NHS Trust's strategy for meeting commissioning HAs or PCGs' service requirements, including how the proposed development will meet those requirements and its impact on other commissioning HAs or PCGs/NHS Trusts/services in the area.

2.4 Justification of the assessment of future services and functions required by reference to commissioning HAs or PCGs' requirements, projected catchment population, changes in medical technology, and other factors influencing the demand for services or the NHS Trust's ability to meet demand.

2.5 Description of the NHS Trust and the catchment area and catchment population for its services, including reference to the NHS Trust's service agreements with the commissioning HAs or PCGs.

2.6 Description of the NHS Trust's business objectives.

2.7 The current activities of the NHS Trust and the range, broad case-mix and quantity of health care services it provides.

2.8 Assessment of the NHS Trust's current financial position and cost structure.

2.9 Assessment of the NHS Trust's resources (assets and manpower) and their current utilisation in service provision (including their functional suitability).

2.10 Assessment of current service performance relative to both commissioning HAs' or PCGs' requirements (patient activity for each of the main specialties and services, proportion of treatments conducted as day cases by speciality, average length of stay for in-patients, turnover interval by specialty, and other relevant performance indicators) and wherever possible some benchmarking against peer group Trusts.

2.11 Explanation of the key assumptions which underlie the assessment of future services and functions.

3. Project objectives and scope

3.1 Description of project objectives and their link to the NHS Trust's strategy and overall business objectives (also link to overall commissioning strategy).

3.2 Description of the desired benefits and why these cannot be delivered under the current configuration of the estate.

3.3 Identification of any constraints on the means of achieving the objectives of the project.

3.4 Description of the clinical services covered in the proposed scheme.

3.5 A brief summary of the output specification for the project (including desired outputs and outcomes, quantity and quality of services, facilities and desired performance standards for facilities and services).

4. Formulation and shortlisting of options

4.1 Description of the longlist of options (both capital and non-capital, including do-nothing or do-minimum) for meeting the project objectives.

4.2 Criteria by which options assessed.

4.3 Reasons for early rejection of options.

4.4 Description of the shortlisted options.

4.5 Identification, timing and assessment of quantifiable benefits associated with shortlisted options.

4.6 Identification and assessment of non-quantifiable benefits associated with shortlisted options (using weighting and scoring techniques).

4.7 Identification and assessment of capital and revenue costs associated with shortlisted options over the life span of the scheme.

4.8 Identification and high-level assessment of risks and uncertainties associated with shortlisted options (a formal risk quantification is only required for the preferred option or shortlisted options with materially different risk profiles).

4.9 Details of key assumptions underlying the assessment of costs, benefits and risks, and the results of sensitivity analysis on these.

4.10 Results of the economic appraisal of the shortlisted options (NPV and/or EAC comparisons).

5. The preferred option

5.1 Detailed description of the preferred option.

5.2 Key factors responsible for its superiority (and why other options are inferior).

5.3 Precise nature of any benefits obtained at higher costs than other options.

5.4 Sensitivity of costs to variations in assumptions.

5.5 Details of the statutory consultation undertaken by the HA, and the NHS Trust's own dialogue with external and internal parties (summary of major issues and how they were addressed).

6. Risk analysis

6.1 A full description of the risks associated with the preferred option, indicating their nature, timing and potential impact.

6.2 A risk allocation matrix indicating the likely risk allocation and contractual arrangements between the NHS Trust and private sector. (It is recognised that this may be subject to change during the course of negotiations and bidding. However, this issue should be considered before finalising tender documents and entering negotiations.)

6.3 Estimate of the cost of the risks associated with the preferred option (both risks likely to be retained by the public sector and those likely to be transferred).

6.4 Description of the methodology used to quantify and value risks.

6.5 Results of sensitivity analysis on the key assumptions underlying the risk evaluation.

6.6 Description of risks which are likely to be retained by the public sector and how they will be managed.

Affordability

7.1 Results of the financial appraisal showing the revenue implications of the preferred option (including capital charges and net effect on prices). This estimate should make allowance for the cost of risk and the full whole life costs of the scheme over a minimum of 30 years. It should also take account of the IM&T and equipment requirements.

7.2 Analysis of the impact on the NHS Trust's balance sheet, cash flow position and income and expenditure account.

7.3 Descriptions of key assumptions made for the financial appraisal and explanation of the methodology used to project income and expenditure.

7.4 Details of key assumptions underlying the financial appraisal, and the results and sensitivity analysis on these.

7.5 Explanation of how the cost of risk has been factored into the financial appraisal.

7.6 Assessment of whether there is flexibility to fund any additional revenue requirements and likely source of funding (for example, the disposal of surplus land).

7.7 Evidence of commissioning HAs or PCGs involvement in the development of the project and support for the scheme (including confirmation that the scheme is affordable, fits their commissioning strategy, and will be properly managed). This should include a statement of what the commissioning HAs or PCGs are prepared to spend on the services to be covered by the proposed scheme.

Project timetable and management arrangements

8.1 Summary of the project plan from development of the OBC to completion of the new facility, including key milestones.

8.2 Description of how the NHS Trust intends to manage the various phases of the project. This should cover the composition and responsibilities of the project team and evidence of their capacity to achieve the various project milestones, evidence of purchaser and other local stakeholder involvement, specific role of external advisers, and estimate of costs which will be incurred during the procurement process).

Appendix 3: Commentary on drawing up “do minimum” option

This appendix sets out an example of the issues to be addressed in compiling a “do minimum” option, based on the experience of a major scheme at an acute NHS Trust.

Do minimum – will be required to satisfy a number of requirements

1. Clinically safe:

- how is this defined?
- whose standards does it need to meet (local clinicians, Royal Colleges, current practice, HA specifications)?

2. Operationally viable:

- can it work in practical terms?
- need not include cost at this stage; need to know when it cannot work whatever extra cost is needed;
- will it be useable by: patients (together with any impact); Ambulance Services/GPs; staff (impact on recruitment and retention)?

3. Acceptability:

- would stakeholders support?

4. Macro-economic implications:

- economic/financial issues (which should not be limited to those of Trust) total NHS resource and cost needs to be considered;
- enhanced/inflated operational costs elsewhere as result at same marginal cost – can include capital (eg re-open closed wards elsewhere, repair inoperative lift to access, extended portering service to staff, etc).

5. Sustainability:

- full FBC option requires flexibility, sustainability options for growth – this is inverse – the option needs to fit in anticipated workload – somewhere in NHS provision locally – can exclude flexibility completely but needs to be sustainable for a while (?5years).

Do minimum – to calculate meaningful figures it must have:

1. A clear description of the solution which satisfies 1-5 above.
2. Same:
 - income – base as preferred option unless solution can be shown to reduce income;
 - price eg different location, less attractive for referrals, etc.

- activity assumption – activity must be found a home somewhere.
- bed/theatre productivity – unless solution can be shown to be less productive, eg split site theatres.
- revenue costs – except where clearly different, eg enhanced cost of less efficiency, different capital charges, non-PFI funded equipment, etc.

Do minimum – information

1. If the ideas above are followed the minimal data and its theoretical support should largely be existing. Presentation of solutions as deviations from the preferred option can keep the required work to a minimum.
2. The service solution needs to have enough drawings/detail to:
 - support the numbers (eg ward size, staffing numbers);
 - show it fits operational (eg number of beds per ward, theatre capacity).
3. No detailed drawings beyond floor sketch plans should be produced. Pre-existing information should reduce the work needed.
4. This option may, however, require the greatest thought and ingenuity as it will require NHS managers to produce a safe service, probably in an environment and set up which is borderline achievable. The thinking should take the time therefore.
5. It can be helpful to the business case team in pre-empting reconsideration of the preferred option to ensure real priorities have been teased out.