

seminar briefing no4



MAKING THE BEST OF THE PRIVATE FINANCE INITIATIVE IN THE NHS

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This briefing is based on the results of a seminar held in London on 30 May 2002. The seminar, entitled *Building long term partnerships*, was organised jointly by the Office of Health Economics and ACCA with the Future Healthcare Network of the NHS Confederation.

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Key Points

- Privately financed procurement is being streamlined but it could be made still quicker and less costly.
- Emphasis should change from how to procure large scale projects to what to build.
- Innovation is already constrained. Opportunities for innovation must be protected as PFI procurement is streamlined.
- The small number of consortia capable of taking on major PFI schemes is a concern but batching projects may reduce competition further.
- Public sector procurement expertise is limited and needs to be well managed nationally.
- Use of public finance, including from the NHS Bank, or quasi-public finance from the European Investment Bank could further reduce costs.
- The Future Healthcare Network, hosted by the NHS Confederation, is working to provide an information exchange for its members.

1 Introduction

The Private Finance Initiative (PFI) has been the dominant source of funding for major new National Health Service (NHS) capital investment projects since 1998. Several PFI hospitals are fully operational, and many more are promised to follow. Despite the maturity of the policy, which has its origins a decade ago, the PFI continues to be controversial. A recent Association of Chartered Certified Accountants (ACCA) survey of its members (ACCA, 2002) working across the public sector found that as many as 39% of those who had direct working experience of a PFI project would not again opt for private sector involvement were they able to decide freely between that and direct public procurement and management. A further 24% were as yet undecided. Sussex (2001) found that the economics of the PFI

specifically in the NHS are finely balanced: PFI leads to higher costs of capital than public funding, but combining design, build and operation in a single long-term contract may yield benefits such as better maintained hospitals in future.

Nevertheless, all the signs from the Government are that the PFI is here to stay for the foreseeable future. In that light, on 30th May 2002, ACCA and the Office of Health Economics held a joint one-day seminar with the NHS Confederation's Future Healthcare Network entitled 'Building long term partnerships'. The purpose was to discuss and identify ways for the NHS to gain greater benefits from the PFI. Discussion was not about whether to replace the PFI but rather how the NHS can make the most of it. Participants included senior NHS and private sector managers and consultants, civil servants and academics. This Briefing summarises the main points from the material presented and the discussions that took place during the seminar.

2 The Current Status of PFI

2.1 Across the public sector

An overview of the current status of the PFI and wider public private partnerships (PPPs) across the whole of the public sector was provided by a speaker from Partnerships UK (see Box 1). PFI is a mature form of PPP, currently providing around £2.5 billion worth of public infrastructure investment every year. Cumulatively to 2000, about one PFI/PPP pound in seven had been spent on health care, but this share has increased over time to the current level of around one PFI/PPP pound in four.

Four major topics dominate the development of PPPs in all parts of the public sector:

- the scope of the services to be covered by a partnership deal – e.g. exactly where to locate the boundary between non-clinical and clinical services in a hospital. This issue remains in PFI/PPP schemes despite the increased use of private sector hospitals by the NHS;
- speeding up, and lowering the costs of, the procurement and implementation process, while ensuring that the process is effective;
- getting more flexibility into contracts; and
- the cost and structure of the finance provided. The rate of return on capital required by private investors has been coming down over time, but it still retains a premium that could be squeezed further.

Because of its relative maturity as a procurement method, current efforts to develop the PFI focus on making incremental improvements to existing processes. More radical innovations concern new models of PPP and using PPPs in new sectors. New models include the approach being adopted by NHS

Lift in primary health care, i.e. joint ventures between public and private partners and covering programmes of investment rather than one-off projects. The extension of PPPs to the activities of government research agencies exemplifies the widening sectoral spread.

The option of using public finance combined with long-term contracts with private consortia to design, build and operate facilities (including maintenance of the fabric) would be worthwhile considering. That is, the financing of the project could be separated from the general procurement. The separation of financing from the rest of the contract was effectively done for the project to refurbish the HM Treasury building in London, for which financing was obtained (albeit from the private sector) in a separate tender from the contract to refurbish and operate the building. The state of the public finances now means that the government could borrow significantly more without breaching its own or the Maastricht criteria (Sussex, 2001, provides more detail on this option).

Box 1 Partnerships UK (www.partnershipsuk.org.uk)

Origin

Partnerships UK was set up by the Government to help public sector bodies in all sectors procure better using private finance. It took over this role from the now defunct HM Treasury Task Force on private finance.

Ownership

Shares in Partnerships UK are held:

- 51% by the private sector – 11 investors, none holding more than 7% of the total shares;
- 49% by the Government, via HM Treasury and the Scottish Executive.

Functions

- Co-sponsor PPPs with public sector procuring authorities.
- Support Government's PPP policy work.
- Assist with development of best practice.
- Assist development and enforcement of standardised PPP contracts.
- Provide help-line and up to two free 'surgeries' per organisation to aid public sector bodies with privately financed procurements.
- Deploy capital to accelerate the flow of good value for money PPPs.

2.2 In the NHS

New developments to PFI/PPP as seen by the Department of Health's Private Finance and Investment Branch were described in five areas:

- staffing issues and the retention of employment model;
- primary care – increasing the role of PFI/PPPs there;
- the NHS Bank;
- streamlining the PFI process;
- batching procurements.

Among these, most discussion in the seminar related to streamlining and truncating the procurement process. But there were also important discussions about creating more room for innovation in the development and design process and in the type and design of facilities built.

The main points from the discussions of all these issues are set out below.

3 Non-clinical Staffing of PFI Hospitals – the Retention of Employment Model

Staffing issues have become more prominent and as yet the practicality of the retention of employment model is unproven. The Government accepts the view that competitive tendering based on price alone unfairly reduces the terms and conditions of employment of certain support staff who are key members of the teams that deliver health care. The staff in question are those who are most vulnerable to market pressures, specifically cleaning, catering, domestic, security and laundry staff. These staff will have their pay and terms protected in future PFI contracts by linking their pay to Whitley or local NHS rates.

The retention of employment model proposed by the Government involves managers being employed by the private sector but operational level staff remaining as NHS employees. The Government wants the managers of these services to be in the private sector so that they can manage the risk in the contracts. Although the staff they manage will remain in the NHS and receive NHS pay and pension entitlements, those staff will be subject to revised disciplinary/appeals procedures. The day to day practicalities of making the retention of employment model work are now being tested.

4 Primary Care and Local Improvement Finance Trusts (LIFT)

The Department of Health has invested 50% of the equity in a holding company – Partnerships for Health – and the rest comes from the private sector.

The holding company will part-own operating companies responsible for upgrading, building and maintaining primary care facilities in each local health economy. The remainder of each local operating company will be owned partly by the local NHS (Primary Care Trusts or GPs) and partly by the private sector, working together in a joint venture Local Improvement Finance Trust (LIFT). LIFTs are intended to provide health care services, such as minor surgery, as well as buildings. The Department's intention is to withdraw from this market once it has been firmly established.

5 The NHS Bank

The Department of Health's April 2002 White Paper *Delivering the NHS Plan* announced the creation of an 'NHS Bank' to oversee lending for NHS capital investment. This requires primary legislation and so will take time to implement. It is also clear that much of the detail of the Bank's powers and responsibilities remains to be worked out. Nevertheless, the Department's view is that the NHS Bank has the potential not only to manage investments and brokerage between NHS bodies, but also to hold equity investments, advise on and manage PFI negotiations (similarly to Partnerships UK) and act as a collection point for expertise. Consideration could be given to the NHS bank providing finance for at least some PPP projects in the NHS. These schemes would then become 'design, build and operate' (DBO) rather than the 'design, build, finance and operate' (DBFO) of PFI schemes to date.

6 Improving the PFI Process and its Outcomes

There was consensus among many at the seminar that the PFI approach to procurement is perpetuating the dominance of the district general hospital (DGH) model in acute secondary care provision. The PFI process does not encourage major innovations such as considering replacing the 1962 DGH model with a radically different concept built around care pathways. An acute policy framework is being developed¹ – too late for the first four waves of PFI projects, but in time for the next ones.

There is a growing body of evidence² that good design reduces length of stay, staff turnover and medical errors – i.e. reduces costs in the system. The business case for good design needs to be acknowledged and included in the business case evaluation.

1 www.doh.gov.uk/configuringhospitals

2 www.healthdesign.org.uk; www.cabe.org.uk; www.architectsforhealth.com; www.sbu.ac.uk/maru; www.kingsfund.architecture; www.princes-foundation.org.uk; www.architecture.com

6.1 Streamlining and truncating the procurement process

Much of the government's effort to increase the speed and reduce the cost of procurement under the PFI has been devoted to standardisation of that process, especially of contracts. Recent measures to increase the efficiency of the PFI procurement process include:

- truncation of the selection process from 6-3-2-1 to 4-2-1 or even, for small schemes, 3-1. This may limit slightly the degree of competition for each contract put out to tender but it should permit a shorter timetable and reduce costs both to the NHS and the private sector;
- creation of standardised pre-qualification questionnaire (PQQ) and preliminary invitation to negotiate (PITN) documentation;
- a shorter PITN stage;
- final invitation to negotiate (FITN) stage becomes the best and final offer (BAFO) stage. This means that any further clarification that takes place after this stage has to be paid for by the Trust.

The Department of Health expects that these changes will simplify the PFI procurement process in the NHS and shorten it by between three and six months, as well as reducing both sides' costs. However, getting sooner to the point where a Trust is left dealing with just two bidders or a single bidder puts a greater onus on getting the specification right early and on avoiding the position where one of two remaining bidders withdraws.

Attempts to shorten the PFI process were applauded by participants at the seminar, as long as the result did not squeeze out the scope for innovation. It was also suggested that delays were more common in the process of gaining Department of Health approval for a project and a proposed deal, than in the technical process of procurement itself. Attention should therefore be devoted to shortening the time taken for approval.

6.2 Room to innovate in the type and design of facilities built

One of the hoped-for benefits of PFI in the NHS is innovation in the type and design of facilities built. A greater focus on outputs to be contracted for, rather than inputs to be specified, was supposed to lead to more creativity in design. However, the general perception expressed was of remarkable similarity between different projects' design outcomes in practice, rather than of notable innovation.

A view commonly expressed was that it is unrealistic to expect significant differences between procurement routes in the amount of innovation possible at the micro level – e.g. 'building a better operating theatre'. But recognition of the 'healing environment' as a key

concept in health care design has grown in the UK and the Patient Environment Action Team has been established. Recent PFI builds have shown that standardisation of good micro level design (e.g. the layouts of nurses' stations, single rooms with en suite bathrooms) has led to helpful time and cost reductions. More work is needed urgently in these areas since most of the Health Building Notes and Health Technical Memoranda are out of date and are largely ignored by the consortia. However the sheer scale of the current building programme and the urgent need to re-think the design of these schemes around care processes and clinical adjacencies makes central guidance highly important.

Another option worthy of consideration would be to create a design bank. In other words, further thought could be given to pooling design expertise rather than arranging design competitions.

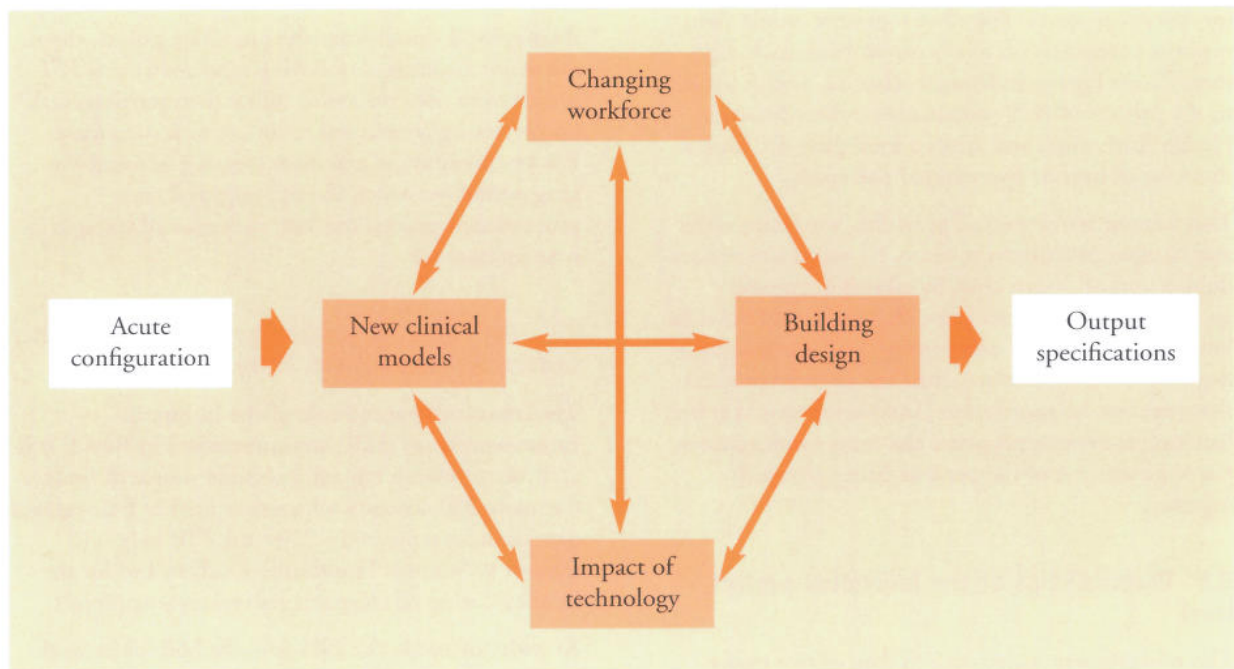
Some seminar participants thought that there was greater scope for creative thinking and novel solutions at a more macro level of design: e.g. how local authority planning constraints might be challenged and loosened; how sites might be more efficiently used; how the physical relationships between specific facilities and departments within hospitals might be improved.

Thus what is needed in the procurement process is time, early on, for such innovation to happen. Standardisation of content across different schemes at a micro level (e.g. the layouts of an individual hospital ward or operating theatre) might lead to helpful time and cost reductions. But standardisation of content too early in the process, at too high a level may squeeze out potential innovation where it could be of most value.

However, not everyone was convinced of the scope for significant innovation even at a macro level. Bidders have to develop and offer individually developed designs, resulting in significant duplication of effort or the development of abortive schemes that never get built. The costs of this duplication and waste eventually get passed on the NHS.

A possible alternative model for strengthening the design element of PFI procurement is to establish the design team early in the project. In this scenario the baseline design solution would be identified before going out to PFI tender, rather than as an outcome of that tendering process. The Trust would select a design team (via competitive tender) of architects and engineers with whom it would develop the best design solution. This design team and its solution would then work with all bidders through the PFI tender and negotiation process and with the eventual successful bidder to completion of the project. For this basic idea to be feasible – one design team rather than several, competition to build and operate rather than design, build and operate – there would need to be:

Figure 1 Integrated planning for PFI



- partnership agreements between each bidder and the pre-selected design team;
- confidentiality clauses to protect any further design developments once the tendering process is under way;
- and the Trust would need to appoint independent design team advisers to sit on their side of the table through to financial close of the contract.

Such an approach, where there is competition *for* a design rather than *between* designs, may appeal where high quality architects and engineers are in short supply or the range of feasible design options is limited to one.

Whichever approach is taken, what is certain is that getting the right outcomes from the pre-procurement planning process is potentially the most difficult and crucial aspect of any scheme. The process is often rushed to fit in with the procurement timetable or its importance is realised only at a late stage leading to delays in the scheme.

6.3 Integrated approach to design

If better clinical planning prior to the procurement process is what is required, it is essential that this is done on an integrated basis including: service requirements (new models of care); ICT; workforce and better environmental design. This needs to be undertaken on a whole system basis, as illustrated in Figure 1.

Starting the process of clinical planning early, before the outline business case (OBC) stage, is very

important for the ultimate success of the procurement. Basing clinical output specifications on models of care, rather than specialties and sub-specialties, permits a less cumbersome specification process (13 models of care in the example presented at the seminar, rather than 70 or so specialties and sub-specialties) and leaves more room for more design innovation by bidders.

Integration with workforce redesign and ICT opportunities for the future are areas which have been largely neglected. It is vital now to develop an integrated approach, particularly as there is a parallel £5 billion ICT procurement getting started.

6.4 Overcoming supply side capacity constraints

A recurring theme in the seminar was the thinness of the supply side of the NHS PFI market. There appear to be just a handful of suppliers with the potential capacity to make credible bids for major PFI projects. If there are too many projects under way at the same time, the result can be that only two serious players might bid, as others may, in the short term at least, lack the capacity to respond to further opportunities. The result may be reduced competition and a greater tendency for major players to 'take turns'.

Batching of projects is one answer being proposed by the Department of Health. But having fewer, bigger bids brings problems as well as benefits. The Department is considering an approach whereby it would invite bids for partner consortia to undertake three or so major PFI projects. Selection of the partner by the Department of Health and the Trusts

involved would be on the basis of overall performance and financial indicators rather than detailed proposals for specific projects. The chosen partner would then negotiate contracts on a concurrent basis with the three Trusts for the individual schemes. This is similar to the process of ICT procurement where Strategic Health Authorities will select a local provider from a short list of four or five selected nationally.

This has the attractions of providing a quicker, easier and cheaper procurement route. It should also reduce duplication of design costs by allowing repeated application of some elements. But against that it risks limiting the extent of competition and introducing a degree of standardisation across the batched projects that may not be appropriate. Innovation would suffer: batching is more appropriate the more homogeneous the requirements of the projects being grouped together.

6.5 Practical tips at the individual project level

The procurement experience to date of two major acute hospital PFI schemes was presented to, and discussed by, the seminar as a source of potentially generalisable practical lessons. Inevitably the experience of any one scheme is strongly coloured by its particular circumstances and by the individual people involved. With that caveat in mind, a number of points of practical interest to those undertaking a major PFI procurement were brought out.

At the OBC stage, it helps to keep and then update a *log of the assumptions made*. This enables the large number of people across the wide range of activities/functions that are involved in bringing together the OBC and subsequently acting on it, to establish and work from a common understanding. This in turn reduces the risk of mutually inconsistent assumptions being built into the specification.

After approval of the OBC, the scheme's *affordability needs to be continually monitored*. National and local policies and other requirements are always changing. In some cases, such as the introduction in 2002 of the 'consumerism' hospital configuration and space requirements, the impact on affordability is so large as to be unmissable. Other, local and national, policy developments may be more subtle in their individual impacts, but cumulatively substantial. To avoid nasty surprises, the affordability picture needs constant monitoring.

Management of all stakeholders is needed from the start. The number of different groups of stakeholders is large. For example, staff and the general public are often sceptical if not overtly hostile to the PFI. Trusts therefore need, from the beginning, to spend time and resources on explaining why private finance is being used, focusing on the benefits it will bring locally. Professional communication throughout the process

pays dividends. Political skills are required as well as technical.

As may be deduced from the preceding points, there are major advantages in having a *fully-resourced PFI project team from the outset*, rather than starting small and accreting people and resources to it piecemeal. For key members of the team, bearing in mind the long period for which the PFI approval and procurement process can last, *succession planning* is a wise precaution.

7 An Alternative Source of Finance: the European Investment Bank

The status and general role of the European Investment Bank (EIB) are summarised in Box 2. It is a, hitherto seldom tapped, potential source of finance for major PFI schemes where they further EU regional development policies. In 2001 the EIB lent 113 million to Summit Healthcare (Dudley) Ltd for the Dudley Group of Hospitals redevelopment project.

As with any bank, the EIB does the bulk of its work between Best and Final Offer (BAFO) and financial close. Its criteria for evaluating lending to an NHS PFI scheme are essentially the same as for any other commercial bank. The particular advantages of EIB finance are that it is geared to providing very long term debt and at interest rates around 0.5 percentage

Box 2 The European Investment Bank (www.eib.org)

The EIB is an independent body set up by the EU in 1958 under the Treaty of Rome.

Its purpose is to finance capital investment furthering European integration by promoting EU policies.

The shareholders are the 15 EU Member States, who together provide its capital.

EIB makes loans, not grants, but at favourable rates of interest. It does not seek a profit and avoids uncontrollable risk.

Since 1997, the EIB has been involved in financing projects which enhance 'human capital' including education and health. Under this heading, nearly €2.5 billion (£1.6 billion) has been invested in health projects since 1997.

Most of these investments are in assisted areas.

points below other commercial banks. However, there is effectively a minimum size for acute hospital schemes, around £75-100 million capital value, below which the EIB will not offer loans.

8 Capturing and Disseminating the Lessons from PFI Experience

The presentations and discussion during the seminar drew attention to the scope that exists for NHS bodies undertaking or contemplating a PFI project to learn from the experiences and acquired expertise of others who have already followed that path. The final discussion on the day was therefore devoted to finding ways of collecting, organising and disseminating this knowledge. Networks of ad hoc bilateral communication spring up naturally. But the exchange of knowledge might be made easier and more effective if a single co-ordinating body were to take on a brokering role: actively seeking information and being a readily identifiable point of enquiry for the whole NHS. The Future Healthcare Network, hosted by the NHS Confederation, is in discussion with the Department of Health Private Finance Unit and is working to provide such an information exchange for its members. This may go some way towards providing national support or an expertise pool which can be tapped into by local PFI projects.

9 Conclusions

Private sector funding looks set to remain the NHS's principal route to capital for major projects for the foreseeable future, and is being extended into smaller, including primary care, projects. Problems with the long duration and costliness of the PFI procurement process are progressively being tackled, but room for further improvement remains. At the same time, new forms of public-private partnerships are being developed with a greater focus on joint ventures rather than straightforward procurements with the NHS as principal and a private consortium as agent. These may have the greatest impact in primary care.

Changing the emphasis from how to procure large scale projects, to what to build is crucial in developing appropriate physical designs for new health care facilities. More resources are needed to support this process and to develop innovative whole system planning.

The extent of innovation in good design achieved by NHS PFI projects hitherto has been questioned. Innovation becomes less attainable when the emphasis is on speeding up the procurement process unless the development of the physical design is handled in a different way as the space to innovate within the procurement process is very limited already.

The small number of consortia capable of taking on major NHS capital schemes, relative to the numbers

of such schemes, is causing concern. But attempting to get around such capacity constraints by batching projects carries the risk of institutionalising the lack of competition that is the source of concern. Less competition may mean less incentive to be innovative, responsive to the customer's needs and efficient, unless the development of the physical design is handled in a different way.

Public sector procurement expertise is also limited. This heightens the need for the expertise that is available to be efficiently and effectively managed nationally.

Use of public finance, including from the NHS Bank, or quasi-public finance from the European Investment Bank could reduce costs without jeopardising the advantages of long-term DBO contracts.

Learning from the PFI experience of others in the NHS is in one respect easy: there is so much experience already available, and in readily identifiable organisations, that there is no shortage of knowledge to draw on. But as the accumulated volume of knowledge increases, so too does the need for a broker organisation to collect and organise it and provide a first point of enquiry. The Future Healthcare Network, hosted by the NHS Confederation, is working to provide just such an intelligent information exchange service.

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- collect and analyse health and health care data from the UK and other countries;
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