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Northern Ireland Audit Office

The Private Finance Initiative: A Review of the Funding and Management of Three Projects in the Health Sector

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

HC 205, 5 February 2004

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Northern Ireland Audit Office

Report by the Comptroller and Auditor General
for Northern Ireland

Ordered by the House of Commons
to be printed 4 February 2004

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HC 205 BELFAST: The Stationery Office £16.00

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987. The report is to be laid before both Houses of Parliament in accordance with paragraph 12 of the Schedule to the Northern Ireland Act 2000, the report being prescribed in the Northern Ireland Act 2000 (Prescribed Documents) Order 2002.

J M Dowdall CB
Comptroller and Auditor General

Northern Ireland Audit Office
4 February 2004

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For further information about the Northern Ireland Audit Office please contact:

Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU
Tel: 028 9025 1100
email: info@niauditoffice.gov.uk
website: www.niauditoffice.gov.uk

List of Abbreviations

CEM	Contract Energy Management
DFP	Department of Finance and Personnel
DHSSPS (The Department)	Department of Health, Social Services and Public Safety
FBC	Full Business Case
Homefirst	Homefirst Community Trust
HPSS	Health and Personal Social Services
NDPB	Non-Departmental Public Body
NHS	National Health Service
NIAO	Northern Ireland Audit Office
NPV	Net Present Value
OBC	Outline Business Case
OJEC	Official Journal of the European Communities
PFI	Private Finance Initiative
PPP	Public Private Partnership
PSC	Public Sector Comparator
QUB	The Queen's University of Belfast
Royal Hospitals	The Royal Group of Hospitals and Dental Hospital Health and Social Services Trust
SIB	Strategic Investment Board
United Hospitals	United Hospitals Health and Social Services Trust

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The Private Finance Initiative: A Review of the Funding and Management of Three Projects in the Health Sector

Introduction

1. Since its launch in November 1992, the Private Finance Initiative (PFI) has become one of the main methods by which the public sector procures services from the private sector. Its underlying objective is to use the best of both public and private sector skills to improve public services. In particular, this means the use by the public sector of capital assets provided, owned and managed by the private sector.

2. In December 1992, the National Health Service in Great Britain Executive (NHS Executive) announced its intention to explore opportunities for the use of PFI in the provision of assets and operation of non clinical services. It reinforced this policy in June 1994 by stipulating that all Trusts making applications for new capital should consider PFI as part of their business planning process. Similarly, in Northern Ireland, the Health and Personal Social Services (HPSS) bodies were being encouraged to exploit the benefits of collaboration with the private sector in developing capital investment projects. The main source of guidance on such projects in the Health Service in Northern Ireland is the Capital Investment Manual issued by the NHS Executive. A Preface to that manual, issued by the Northern Ireland HPSS Management Executive in June 1995, explained how to manage a PFI project and was the principal source of guidance available in proceeding with the projects we reviewed. These were:

- the provision of a car park for the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust (Royal Hospitals) which commenced in 1994 (a project in which the costs are mostly being recovered by charges to third party users, mainly the general public when visiting the hospital);

- the provision of contract energy services for the Homefirst Community Trust at Holywell Hospital, also commencing in 1994 (a project in which the costs are recovered by charges to the Trust); and

- the provision of renal services for the United Hospitals Health and Social Services Trust at Antrim Area Hospital which commenced in 1997 (again a project in which the costs are recovered through charges to the Trust).

3. These were small projects in PFI terms with capital values of £2m, £0.2m and £2.7m respectively. Although undertaken in line with prevailing policy at that time, which encouraged departments to consider PFI for all services regardless of value, they fall well below the proposed minimum threshold of £20m contained in the recent HM Treasury Paper, "PFI: Meeting the Investment Challenge"[1] which recognises that the transaction costs of pursuing PFI can be disproportionate compared with the value of the project. Had this threshold been in operation earlier it would have ruled out these projects. The Treasury policy does not currently apply in Northern Ireland but the proposed threshold does emphasise how crucial the transaction cost issue can be in securing value for money from small PFI projects.

1. Published by HM Treasury on 15 July 2003. Its policy proposals have direct effect only in England, as policy on PFI is devolved in Scotland, Wales and Northern Ireland.

Scope of the Northern Ireland Audit Office Examination

4. **These were three very early PFI projects in Northern Ireland and as such did not have the benefit of the extensive guidance notes[2] developed since then, which aim, among other things, to ensure early consideration of the suitability of projects for PFI and that those going forward are properly scoped. The lack of experience, precedents and role models prior to the development of this guidance increased the risks for departments, particularly in achieving value for money.** However, our approach has been the same as in any other examination of procurement processes i.e. to assess whether the projects were implemented in a sensible way with the justification for any decision clearly set out; whether the process was managed effectively, making best use of any available guidance; whether the risks involved were properly analysed; the projects were implemented in a way that took proper account of those risks; and that value for money was achieved.

5. Our study was based on discussions and interviews with key personnel at the Department of Health, Social Services and Public Safety (the Department), its Health Estates Agency and each of the three Trusts. These were supplemented by a review of key papers, where these were available. Drafts of our report were made available to the Strategic Investment Board (SIB)[3]. Our examination of the Royal Hospitals and Homefirst projects was restricted to the papers that were currently available.

2. Guidance on PFI was developed by the Office of Government Commerce, an independent office of HM Treasury, and promulgated in Northern Ireland by the Department of Finance and Personnel (DFP); details of Best Practice Guidance are provided at Appendix 1. The National Audit Office report, "Examining the Value for Money of Deals Under the Private Finance Initiative (HC 739, Session 1998-99) provides an analytical framework which seeks to cover comprehensively the key value for money issues to which these projects give rise (see Appendix 2).
3. Established by the Strategic Investment and Regeneration of Sites (NI) Order 2003, SIB's remit is to ensure that the Reinvestment and Reform Initiative is planned and delivered in a way that makes the most of all the means and resources available. SIB will also work in partnership with bodies carrying out major investment projects. It is empowered to advise the Executive and public bodies are required to have regard to its advice.

6. **Document retention is an issue we have highlighted before.[4] However, it assumes greater importance in PFI contracts which are long-term deals, lasting up to 25 years or more. Once deals have been signed, projects must be managed effectively so that required services are delivered to an acceptable standard over the life of the contract. In addition, they may be subject to re-financing, re-negotiation or application of contingency arrangements. Ultimately, assessing value for money in a PFI project will only be feasible many years down the line. It is important that key documents are retained for this purpose. We recommended that the Department of Finance and Personnel, in conjunction with the Public Records Office, consider the relevance of current guidance on document retention for PFI projects.**

7. **Our review has also highlighted a number of best practice points and key lessons. Some relate to an individual project while others are common to all three. All are highlighted in the relevant sections of the report. However, they all have wider applicability and the following provides a summary of the main points and lessons.**

Summary of Best Practice Points

1. Project objectives should be clear, focusing on what procuring bodies want having regard to what the private sector can supply;

2. Project management is a key requirement to delivering a successful project. This includes establishing the right team with the right skills at the right time and proportionate to the size and complexity of the project;

3. The appointment of consultants should be subject to competition which takes full account of quality as well as price and, where applicable, the approval of the Department of Finance and Personnel;

4. Budgets for external advisory and internal costs should be set at the outset and monitored and managed throughout the project;

4. Re-Roofing of the Agricultural and Food Science Centre at Newforge; NIA 24/02, October 2002

5. A Public Sector Comparator (PSC) or "Should Cost" model should be produced, even if conventional finance is not available, in order to reach a properly informed decision on the value for money of PFI deals. However, the results from these should not be regarded as a simple pass/fail; selecting the best deal also requires a multi-dimensional evaluation and application of informed judgement taking into account factors such as certainty of delivery and quality of outputs;

6. Competition is central to getting value for money from PFI deals. Part of this is the creation of a good tender list of firms invited to bid. Accordingly, PFI projects should be widely advertised and, where appropriate, the market stimulated in order to maximise the submission of good quality bids;

7. Procuring organisations should be as open as possible with all interested parties throughout the procurement process. However, care should be taken not to disclose information, such as the PSC, which weakens their negotiating position;

8. Appropriate risk allocation between the public and private sectors is the key to achieving value for money in PFI projects. Public sector organisations should identify the scope for risk transfer in advance. This will facilitate optimum transfer by allocating individual risks to those best placed to manage them;

9. In considering the objectives of a project and the degree of risk transfer which might be possible, bodies should be able to draw on expert advice, either from their financial advisers or from a central Government source, as to the target rate of return which might be sought on the basis of the nature of the project and the risks involved for the private sector;

10. Procuring bodies should attempt to accommodate within the scope of the original deal any changes to their requirements which they can foresee at the time. Contracts should also contain proper procedures for introducing and controlling unforeseen changes to services;

11. Where possible, procuring bodies should always seek to utilise standard PPP contracts from within the public sector, setting out the terms and conditions they expect, and negotiate on those;

12. Robust monitoring arrangements, to ensure contract compliance, should be established and applied;

13. Procuring bodies should have in place effective mechanisms to claw back part of any future windfall gains that a supplier may earn so there is at least a sharing of such benefits; and

14. Projects should be subject to an ongoing programme of evaluation to confirm that expected benefits continue to be delivered and to identify key lessons for wider dissemination.

The Provision of Car Parking at the Royal Hospitals

Part 1

The Provision of Car Parking at the Royal Hospitals

Background

1.1 The Royal Group of Hospitals and Dental Hospital Health and Social Services Trust (Royal Hospitals) comprises four hospitals, the Royal Victoria Hospital, the Royal Hospital for Sick Children, the Royal Maternity Hospital and the Dental Hospital which provide a broad range of acute healthcare services to the population of Northern Ireland. There are currently 965 beds on site. In addition, The Queen's University of Belfast (QUB) has a substantial presence on the Royal Hospitals' site in the Institutes of Microbiology, Pathology and Clinical Science and the Schools of Dentistry and Medicine.

Assessment of Need

1.2 The availability of adequate car parking capacity posed a growing problem for the Royal Hospitals through the 1980s and into the early 1990s. Existing provision was recognised as inadequate and there were also growing problems with theft from the existing car parking facilities and vandalism. In addition, the impact of a major construction programme, involving the building of a new hospital block and other work, and prevailing strategic assumptions on the future provision of health care needed to be considered (see Appendix 3). Accordingly, in 1994, the Royal Hospitals appointed consultants to prepare an infrastructure development plan (car parking, landscaping, services) for the site. The consultants estimated that there were 1,715 formal car parking spaces on site and 2,100 altogether when "informal" spaces were included, compared with their estimated requirement for 2,070 spaces. With regard to the future, they estimated

that the pattern of demand would change (more spaces for day patients, fewer for junior staff) but that, overall, demand would stay roughly the same. Given uncertain factors such as growth in car demand and the need to keep circulation roads free of parked cars, they recommended spaces for 2,100 cars.

1.3 Since the construction work being planned was likely to result in the loss of about 500 spaces, together with the need to reduce informal parking, the consultants recommended a two deck (ground and first floor) multi-storey car park as the best option. This would provide an extra 440 car parking spaces at an estimated cost, including upgrading the two existing car parks, of £3.2m. They also reported on landscaping the whole site and on upgrading accommodation for hospital services and recommended, inter alia, the building of a new walk duct along the front of the new multi-storey car park at an estimated cost of £400,000. They noted that the car park was a suitable project for private finance and that the cost of the new walk duct could be reduced if it was built at the same time as the car park.

Funding

1.4 Funding the Royal Hospitals' redevelopment programme was the subject of prolonged discussions between the Trust, DHSS, DFP and the then Health Minister. Royal Hospitals told NIAO that DFP and DHSS were keen to explore the potential for involving the private sector on a risk sharing basis (PFI) but it was concerned that this could unnecessarily delay this much needed project. Following discussions, the Minister of Health announced, in June 1995, that £65m was being made available from public funds to take forward the redevelopment of the hospital. As part of the overall development it was also announced that the provision of car parking would be funded through private finance.

1.5 The decision to build a multi-storey car park and make changes to other car parking arrangements was clearly set within a strategic context, both as regards

the development of the Hospitals on the site and the need to address car parking across the site. However, further unforeseen reviews of health provision, which arose after the contract was signed (see Appendix 3), dictated an increase in demand beyond the Royal Hospitals' original projections (see Appendix 4). As a result, parking demand outstrips the current provision and the Royal Hospitals is in the process of considering options for additional car parking spaces (see paragraph 4.12).

Part 2

Project Management

Introduction

2.1 In line with best practice, the Royal Hospitals established a Project Board. This was done in recognition of the need to expedite construction of the car park so that the main construction project could proceed. The Board was chaired by the Facilities Director and included representatives from the Department's Health Estates Agency (who acted as advisers to the Royal Hospitals), private sector financial and legal advisers and later, QUB. The Project Board reported on progress to an overall steering group, chaired by the Chief Executive, which was managing the larger development programme.

2.2 The Project Board established a project timetable which incorporated key action points. This helped guide the project. However, no formal minutes recording the decisions of Project Board meetings were kept. The Project Board also drew on the advice contained in the NHS Capital Investment Manual which had been made available to Trusts in Northern Ireland in 1995.

Time Recording System

2.3 The Royal Hospitals' auditors recommended the introduction of a time recording system for PFI Projects in November 1997. In October 1998, they noted that a system had still to be introduced. Best practice,[5] recommends that a time recording system for internal costs of any major project should be introduced.

5. Under Projects Run in a Controlled Environment (PRINCE) guidelines, a widely utilised project management tool launched in 1990, a time recording system which can identify, monitor and control project costs, should be introduced.

Such a system would both assist in the management and control of staff associated with the project and determine full project costs for post project evaluation[6].

Advisers

2.4 The appointment of consultants should be subject to competition which takes full account of quality as well as price. The subsequent contract should include the total consultancy cost which should be closely monitored throughout its life cycle (DPS, DFP 2/95 - Use of Consultants). Where applicable, approval should be sought from the relevant sponsor department and the Department of Finance and Personnel (DFP).[7] We found that the Trust did not seek approval from the Department in this case.

2.5 We also found that financial advisers had been appointed without competition. The Royal Hospitals told us that the firm appointed were viewed as having a particular expertise on PFI projects; they had previously been appointed by government to provide PFI Training on the detailed execution of PFI projects to public sector organisations. This expertise was seen as essential given that there was little previous experience of PFI projects in Northern Ireland and available guidance was at an early stage of development. However, they had negotiated an appointment and fee agreement and the roles and responsibilities of the consultants were set out in the fee proposal. The eventual amount paid was within this limit.

2.6 Following their appointment, the financial consultants advised the Royal Hospitals to engage legal advisers. Since the law in Northern Ireland differed in some key areas from that in England, the Royal Hospitals decided to appoint

6. Post Project Evaluation aims to improve project appraisal, design, management and implementation through obtaining the maximum benefit from accrued experience.
7. In line with general expenditure delegations, Departments are required to obtain DFP approval for all consultancy assignments exceeding £50,000. However, this does not apply to Health Trusts who are only required to seek DHSSPS approval for assignments in excess of £20,000. This is currently being reviewed.

local solicitors. This was done following interview by a panel, which included Directors of the Royal Victoria and City Hospitals, the Chief Solicitor of the Central Services Agency and the Health Estates Agency. As the local solicitors did not have experience of the PFI process and contracts, the Royal Hospitals also engaged, following discussions between the Health Estates Agency and public sector colleagues in the UK, a firm of London-based solicitors. The firm was recognised as having leading expertise in PFI, and had agreed to work in partnership with the Northern Ireland practice. The Royal Hospitals has assured us that the process was properly documented at the time. With the passage of time however it acknowledges that not all of the source documents can now be made available.

2.7 The Royal Hospital told us that, due to the lack of public sector experience in managing such projects, (this was one of the first PFI projects in Northern Ireland) it did not have the information to produce an accurate estimate of the legal costs. It added that, as it was not possible to engage legal advisers with a cap on total fees, it appointed both sets of advisers on an hourly or daily rate.

2.8 Total fees payable for financial and legal advice were £220,904 (£69,301 and £151,603 respectively) which represents just over seven per cent of the contract price.

Public Sector Comparator

2.9 The Royal Hospitals had accurate information on car park usage and reasonable estimates of capital expenditure. These could have been used as the basis for a Public Sector Comparator (PSC) or a "Should Cost" Model either of which would have provided the Royal Hospitals with a financial model to establish a benchmark for car park charges and calculate what rate of return a private developer might expect from such a project (Appointment and Evaluation in Central Government - The Green Book, April 1991).

2.10 The Royal Hospitals told us that these were unnecessary; its aim had been simply to find the best bid. In their view and that of their advisers, competition from a wide range of private sector organisations (23 expressions of interest were received) should establish an appropriately competitive proposal, and that this proposal would also have to pass the test of being socially acceptable. We also noted that the Department agreed that a PSC was not needed as the project would be funded entirely by income from the car parks, with no public sector funding being involved (but see paragraph 4.5) and there was to be total risk transfer to the private sector. The Royal Hospitals later interpreted this as meaning that there would be no need to present a "Full Business Case" to the Department for approval before signing final contracts.

2.11 To establish that a deal is good value necessarily requires the procuring body to satisfy itself that the bid selected is superior to its realistic options. To do that should involve a systematic comprehensive and thorough comparison of the PFI option against the PSC or "Should Cost" Model. This should be produced, even if conventional finance is not available in order to reach a properly informed decision on the value for money of PFI deals. In such circumstances, the PSC may be used to benchmark the tender submissions, as a guide to sustainability of the deal, as a means of investigating efficiencies which might be achievable by improvements in public sector management and as a useful tool in negotiating with the preferred bidder.

2.12 Best practice also recommends the production of a full business case (FBC) prior to contract completion, whether it is to be funded conventionally or by PFI.[8] It should incorporate economic analysis, financing implications, arrangements for project management and plans for subsequent monitoring and evaluation. As such, it formally pulls together the case for proceeding with the project and forms the bases for obtaining Departmental and DFP if required.

8. A Step-by-Step guide to the PFI Procurement Process

Best Practice and Key Lessons

- Project management is a key requirement to delivering a successful project. This includes establishing the right team with the right skills at the right time and proportionate to the size and complexity of the project, i.e. once the decision has been made to procure the project;

- A Project Board should be established at commencement of all PFI projects;

- A project timetable incorporating key action points should also be produced at the outset. This forms the basis for monitoring progress and reporting;

- A time recording system for internal costs should be introduced to assist in the management and control of staff associated with the project and to determine full project costs for post project evaluation;

- The appointment of consultants should be subject to competition which takes full account of quality as well as price and, where applicable, approval by the sponsor department and Department of Finance and Personnel. Contracts should include the total costs and should be closely monitored throughout their life cycle;

- A PSC or "Should Cost" model should be produced, even if conventional finance is not available, in order to reach a properly informed decision on the value for money of PFI deals; to benchmark tender submissions; as a guide to sustainability of the deal; as a means of investigating efficiencies; and as a useful negotiating tool; and

- A full business case should be produced prior to contract completion, whether it is to be funded conventionally or by PFI, in order to formally pull the case together for proceeding with the project and to obtain, if required, the necessary approvals from sponsoring departments and, where appropriate, the Department of Finance and Personnel.

Part 3

Selecting a Partner

Stage One

3.1 An advertisement was placed in the Official Journal of the European Communities (OJEC) in July 1995, seeking applications from contractors willing to be considered for inclusion on a select list for the funding, design, construction and management of car parking services at the Royal Hospitals. A similar advertisement appeared in local papers later in the same month.

3.2 As a result, 23 responses were received. These were short listed by reference to weighted criteria which included management experience, development experience, design experience, company profile/track record and financial status. Of the 23 applicants, 10 either withdrew or could not be contacted or made an inappropriate response, 3 were rejected. The remaining 10 were invited to meet the project team. The Department said that, due to the passage of time, none of the 23 expressions of interest was available for examination by NIAO. Other than some working papers, no formal, signed record of the short listing process was available for audit purposes.

Stage Two

3.3 Of the 10 shortlisted, two quickly withdrew on the grounds that the project did not represent a commercially viable opportunity if the Royal Hospitals continued to insist on full transfer of risk to the private sector and on restrictions on the

charges to staff and the public. A third later dropped out. The remaining seven were asked to submit an indicative bid by December, 1995 and a comprehensive briefing document was provided to each.

3.4 In addition to the information to be provided, the document set out the timetable and the criteria to be used in selecting three final tenderers. These were:

- relationship with the Royal Hospitals (and QUB);
- design;
- tariffs including method of review;
- length and type of contract; and
- security arrangements.

3.5 The document also set out the Royal Hospitals' expectations on maximum risk transfer. It advised that 387 staff had reserved spaces for which they paid £176.25 a year; that no dramatic changes in staff levels were expected; that selection would be on the basis of the most economically advantageous bid and that the Royal Hospitals reserved the right to negotiate following an analysis of the three final tenders.

Stage Three

3.6 Selection criteria should always be established before a project is initiated as part of the process of considering precisely what it is the procurer is looking for from the project. We confirmed that the selection criteria used at each stage of the project could be traced back to the original criteria notified to tenderers at Stage 1.

3.7 On the basis of a matrix prepared by the Royal Hospitals' financial advisers, reflecting the criteria notified to the tenderers and suitably weighted, the project team scored the bids. Following an initial evaluation of the bids and a subsequent review process this exercise produced three clear winners, who were issued with a very detailed "Invitation to Tender" setting out the Trust's requirements and minimum construction specifications for the project and an estimate of need subject to a minimum of 2,100 spaces.

3.8 Tenders were sought on three bases;

- the design, construction, funding and operation of a multi-storey car park, bringing all car parks (including the QUB car parks) up to standard, installing access and security systems, management and maintenance of these car parks, and construction of a service duct;

- the above but excluding a small portion of QUB land (this land was eventually excluded); and

- the above excluding all QUB land.

Bidders were also invited to make bids with and without an allowance for business rates and for alternative periods to the 20 years proposed.

Transfer of Risk

3.9 The Invitation to Tender made it clear that, apart from the Service Duct, the Trust expected the project to be funded entirely from car park revenue. To satisfy PFI principles, it would seek value for money (including an appropriate return on any asset made available by the Trust) and risk transfer so that the Project was "off balance sheet".[9]

9. This refers to the accounting treatment and arises where the reporting entity does not recognise an asset in its balance sheet because it is not exposed to the risks and benefits in ownership of the asset.

3.10 Best practice recommends that the public sector body should seek to achieve not the maximum but rather the optimum transfer of risk, which allocates individual risks to those best placed to manage them.

3.11 In this project, the Royal Hospitals sought extensive risk transfer and believes that the only significant risks not to be transferred were those within its control e.g. change in specifications, and changes in law which would increase the winning bidder's costs. An appendix to the Invitation to Tender listed the principal risks and allocated as many as possible to the bidders, including demand risk. However, as demand would depend as much as anything on policies adopted by the Royal Hospitals, e.g. restrictions on tariffs, it is, in our opinion, questionable whether this was appropriate. The Department told us that, in its view, it was appropriate to transfer demand risk given that a number of factors including tariff levels, security, availability and quality would impact upon the levels of demand; they also considered that the private sector was better placed to manage this risk than the Trust".

The Project Agreement

3.12 Contractual documents were signed with the successful bidder in October, 1996. The Project Agreement is a comprehensive document covering all relevant matters. The principal points of interest are:

- car park charges: for visitors, these were set at 60p for up to 4 hours, with higher charges for longer periods. However, this lower rate was subject to adjustment according to a pre-determined formula for any Rates charge, then not settled (in the event, this increased the lower charge to 95p for up to 4 hours). For staff, an annual charge of £185 was proposed. All charges were index linked to the retail price index;

- payments for land: the services provider agreed to pay £25,000 a year for use of the Royal Hospitals' and QUB's land plus, after 4 years, a further £15,000 in every year in which its revenues exceeded forecast; all payments to be indexed linked;

- parking policy: the Royal Hospitals and QUB were obliged to enforce a firm policy to prevent illegal parking and in the event of failure to do so (defined as more than 10 cars parked illegally at any one time) the service provider had rights leading up to a right to take over enforcement;

- change procedures: these included provisions for post-completion changes, including the Royal Hospitals' right to require additional car parking facilities and to claw back up to 10 percent of the land without penalty for purposes of hospital development; and

- performance monitoring: comprehensive monthly monitoring arrangements were agreed for car park management, maintenance and cleaning and grounds maintenance and landscaping which provided for damages of up to £10,000 per month for failure to achieve minimum standards, a formal warning system should poor performance continue and, as a last resort, termination of the contract. Performance was to be self monitored subject to review by the Royal Hospitals.

3.13 In addition to the main Agreement, the documentation included a co-operation agreement between QUB and the Royal Hospitals and various warranty agreements. The co-operation agreement dealt with events during the construction period, provided for QUB to receive 80 per cent of the basic payment by the service provider to the Royal Hospitals and 25 per cent of any share of surplus profits (see paragraph 3.12) and gave QUB the right to take back some of the land in certain circumstances.

Rate of Return

3.14 When considering the objectives of a project and the degree of risk transfer which might be possible, bodies should be able to draw on expertise to advise on the target rate of return which might be sought on the basis of the nature of the project and the risks involved for the private sector.[10]

3.15 In this case the Royal Hospitals told us that it was seeking a balance between securing value for its assets being used for the project and securing the lowest charges for car park users. The winning bidder, based on the detailed information regarding projected activity levels, was willing to assume demand risk within the project, reflecting the fact that a number of factors such as tariff levels, security, availability, and quality would impact on consumer response. In addition, they were willing to do so in the knowledge that capacity could be reduced through claw back of up to 10 per cent of the land by the Trust. In our view a premium may have been included in their pricing structure for doing so. However, the Royal Hospitals has not established if this was the case or the value of the premium.

3.16 The agreement reached with the service provider showed their forecast profits increasing by 37 per cent a year (an internal rate of return of 8.55 percent, and when tested against the Government's test discount rate of 6 per cent, a net present value of some £0.75m). This was considered by the Royal Hospitals' financial advisers to be ambitious. However, we consider that the risks involved were relatively low, with a captive and predictable market and a straight-forward construction job and, in the event, the profits being achieved significantly exceed those envisaged in the original agreement (see paragraph 4.9, Figure 2). The Department's view is that there is no evidence that the Trust overestimated the risk at the time of the agreement. The reference to the captive and predictable market implies that there was no demand risk although several factors, as previously stated, would have influenced the market. In addition there is no

10. PAC Report: Managing the Relationship to Secure a Successful Partnership in PFI Projects (HC 460, Session 2001-2002).

suggestion that the Trust did not appreciate the nature of the construction work to be carried out.

Best Practice and Key Lessons

- PFI projects should be widely advertised including in the Official Journal of the European Communities and local press;
- If necessary, the market should be stimulated in order to maximise the submission of good quality bids;
- Selection criteria should always be established before a project is initiated as part of the process of considering precisely what it is the procurer is looking for from the project;
- The public sector body should seek to achieve not the maximum, but rather the optimum transfer of risk, which allocates individual risks to those best placed to manage them; and
- When consideration is being given to the objectives of the project and the degree of risk transfer which might be possible, bodies should be able to draw on expert advice, either from their financial advisers or from a central Government source, as to the target rate of return which might be sought on the basis of the nature of the project and the risks involved for the private sector.

Part 4

Customer Reaction and Monitoring Arrangements

Introduction

4.1 Best practice recommends that indications of commitment should be obtained from all stakeholders prior to completion of the outline business case. The Trust said that it was aware that any proposal to charge staff an annual fee for parking was a contentious option. Equally, it was aware that in England, where it was similarly contentious, such a charging regime had been successfully introduced at a number of hospital sites. Following broad consultation, some four years previously, staff had been told that car park charging was an option. However, because, during 1995 and the first part of 1996, staff side were refusing to hold discussions with management, in the absence of a joint recognition agreement, staff had received no structured communication or accurate information on the developments taking place.

4.2 Staff side was therefore first told of the proposal to charge staff for car parking (but not the amount) at the first meeting of the newly formed Trust Joint Negotiating Consultative Committee in April, 1996, 14 months before the planned opening in June 1997. The tariff for staff usage of £185 per annum (pro-rata for part-time staff) was notified to staff representatives in a bulletin headed "Construction News" four days after contract signing.

4.3 The Department told us that detailed discussions could not take place until after the contract was signed, due to the need to respect "commercial in confidence" information such as that pertaining to the tariffs that would apply. They also pointed out that notification to staff was some eight months before the planned opening of the car park in June 1997. We noted however that the Royal Hospitals'

actions resulted in an immediate protest from the staff side of the Joint Negotiating Committee, who claimed that they had not been consulted about this matter and that the imposition of this charge on staff amounted to a pay cut. Staff side further contended that it was being imposed irrespective of an ability to pay and did not have the merit of guaranteeing a parking space.

4.4 To counter this opposition the winning bidder held a number of "information days" in February, 1997. In addition the Chief Executive of the Royal Hospitals addressed six well-attended meetings in November 1996. Nevertheless, protests continued from all levels of staff, especially at the amount of the charge and the lack of consultation.

4.5 As a result, when car park charging commenced in June, 1997, there was a lengthy and intense period of dispute during which the functioning of the site was seriously disrupted. Staff formally refused to pay charges to gain entry to the redeveloped car parks and a tactic of parking cars at strategic points to maximise site disruption was pursued. The action continued until February, 1998 when the following deal was struck:

- staff earning less than £25,000 a year to pay only 0.4 per cent of pay; a sliding scale up to £100 a year requiring a contribution of £85 plus per employee a year by the Royal Hospitals; and

- visitors to pay only 50p for the first hour (requiring a contribution of 45p by the Royal Hospitals).

In addition, the Royal Hospitals had already agreed to provide free parking for visitors spending significant time at the Hospital e.g. the parents of very sick children. Figure 1 details payments made by the Royal Hospitals in the five years to 2002-03.

Figure 1: Contributions to Visitor and Staff Car Parking Charges

	Visitors £	First Hour £	Staff £	Total £
1998-99	36,537	65,325	245,519	347,381
1999-00	83,905	74,563	271,960	430,428
2000-01	96,198	75,377	299,929	471,504
2001-02	107,086	78,139	291,871	477,096
2002-03	113,928	84,726	283,786	482,440
Total	437,654	378,130	1,393,065	2,208,849

Source: Royal Hospitals

Note: The visitor and "first hour" payments are made to the service provider but the staff subsidy is paid directly to the staff.

Review of Royal Hospitals' Contributions

4.6 The Royal Hospitals is currently reviewing its contributions and will be discontinuing the first hour subsidy during 2003. This will reduce the Royal Hospitals' contribution by some £78,000 a year. In addition, the subsidy for those visitors spending significant time at the Royal Hospitals is also expected to reduce by some £35,000. The full effect of these savings will be realised in the 2004-05 financial year.

Monitoring

4.7 The Project Agreement acknowledges that the service provider will self-monitor its performance and sets out detailed arrangements under the headings car park

management, maintenance and cleaning, and grounds maintenance and landscaping which the Royal Hospitals could, by notice to the service provider, apply. These arrangements reflect those proposed in the Invitation to Tender. Within each of these areas, detailed standards were to be given weighted scores and the sum total of those scores measured, each month, against a target. Failure to achieve a minimum was to result in financial penalties leading eventually to termination of the contract (see paragraph 3.12 above).

4.8 We were shown monthly inspection record sheets prepared by the service provider and monthly audit reports prepared by the Royal Hospitals. However, these were prepared on different bases and neither accorded with the model in the Project Agreement. Also, there was no mechanism for applying a weighting or for measuring a total score against the targets. We asked why monitoring had not been based on the way provided for in the Agreement. The Royal Hospitals told us that the monitoring process adopted was broadly in accordance with that set out in the Agreement and was agreed by both parties as more appropriate for the purpose of Agreement, given the good working relationship which existed between the Royal Hospitals and the service provider. This is reflected by the fact that no penalties have had to be imposed and any remedial action deemed necessary by the Royal Hospitals has been undertaken promptly by the service provider.

Service Provider's Financial Performance

4.9 A summary of the service provider's turnover and profits/(losses) to date by comparison with its forecasts is set out in Figure 2.

Figure 2: Comparative Summary of Turnover and Profits

Year ended 7 May	Turnover £		Pretax Profit After Interest £	
	Forecast	Actual	Forecast	Actual
1998	687,309	474,265	73,242	(120,511)
1999	721,674	844,121	115,325	283,212
2000	757,758	1,058,571	158,174	250,250
2001	795,646	1,209,040	204,399	477,656
2002	835,428	1,286,606	253,038	574,210

Source: Service Provider

4.10 Trading results for the first year were severely affected by the staff dispute and the loss would have been worse if the Royal Hospitals had not agreed to waive its £25,000 annual licence payment (see paragraph 3.12 above) and the service provider had not waived payments totalling £47,000 for director's salaries, heat and light and audit. Since the end of the dispute, however, trading results have far exceeded expectations. While turnover was expected to rise at 5 per cent a year, year-on-year increases from 1998 to 2002 have been 23, 46, 59 and 62 per cent respectively. Likewise, while the average year-on-year increase in pre-tax profits (after interest) was forecast in the original agreement as 37 per cent (see paragraph 3.16), it has, in reality, been closer to 200 per cent. Profits in 2002 were £574,210, £321,172, above original forecast. However, the Royal Hospitals and QUB can expect a £15,000 annual share of any surplus profit, i.e. profit over and above forecast, after four years. This represents 4.7 per cent of the surplus in 2002.

4.11 In its management letter of October 2001, the Royal Hospitals' Auditors considered that the private operation was generating an unreasonable return on its investment and reported its view, with hindsight, that it would have been better to use public money for the car park. However, the Royal Hospitals told us that this view was not substantiated with detailed costings which they have since estimated at £0.5 million a year to provide and manage the car park. They added that, when the decision was taken to provide a car park, under a public procurement model charges would not have been introduced.

Renegotiation with the Service Provider

4.12 Increased demand for car park spaces (see paragraph 1.5) has led the Royal Hospitals into discussions with the service provider about the provision of additional places. In this regard we noted recent media coverage of public dissatisfaction with the extent of car parking facilities. There are two possibilities; (i) for the service provider to build another deck on the multi-storey or (ii) for the service provider to lay out another surface car park on land on the site. The Agreement provides for post-completion changes, including the construction of additional parking spaces. It also requires the two parties to negotiate in good faith, firstly to agree the amount of necessary capital expenditure and then to agree any changes needed to car parking charges during the unexpired part of the contract period to compensate for the capital expenditure and ensure that the net present value of the project originally expected by the service provider remains the same. The only other option is for the Royal Hospitals to advertise the new opportunity.

Best Practice and Key Lessons

- Indications of commitment should be obtained from all stakeholders prior to completion of the outline business case;

- Robust monitoring arrangements, to ensure contract compliance, should be established and applied;

- Procuring bodies should have in place effective mechanisms to claw back part of any future windfall gains that a supplier may earn so there is at least a sharing of such benefits; and

- Projects should be subject to an ongoing programme of evaluation to confirm that expected benefits continue to be delivered and to identify key lessons for wider dissemination.

Holywell Hospital, Antrim: Provision of Contract Energy Services

Part 1

Holywell Hospital, Antrim: Provision of Contract Energy Services

Background

1.1 Holywell Hospital is the responsibility of Homefirst Community Trust (Homefirst) which, as the Homefirst Unit of Management, was formed from the merger of Bannside and Loughside Units of Management in April, 1994. Homefirst operates within the Northern Health and Social Services Board area. Prior to the merger, a first meeting of an option appraisal group (made up of Bannside administration, finance and estates services employees) held in August 1993, noted that Holywell Hospital was served by three oil fired boilers which had been installed in 1958 with a working life expectancy of 25 years. The boilers provided domestic hot water and heating for some 90 per cent of the extensive Holywell site (the Hospital itself and some of its residential units) and steam to a laundry, a dry cleaning facility and kitchens.

1.2 When responsibility for the Holywell hospital site transferred to Homefirst in April 1994, its Estates Services Directorate drew up a brief for consulting engineers to advise on the replacement plant needed for the boiler house on an "essentially like for like basis" and also on the condition of the distribution system. The work was undertaken by consultants nominated by the Department's Health Estates Agency. They accepted that the boiler plant and associated services needed replacement but estimated the cost at some £538,000 to £551,000 depending on the option chosen. The consultants also examined the distribution system and estimated the cost of replacing the pipe work and structural refurbishment of the ducts at £1.22m. They recommended that all pipe

work and insulation, other than that recently installed, should be replaced within three years.

1.3 In December, 1994, Homefirst was approached by Company A with a proposal for a Contract Energy Management (CEM) arrangement under which it would install three new boilers, at its own risk, and supply energy to Holywell for a 10 year period in return for a service charge and a variable energy charge. Homefirst, quite appropriately, determined that such an offer could not be considered without wider advertisement and in February, 1995 a notice was placed in the Official Journal of the Euopean Community (OJEC) and in the local press. This sought proposals for the financing and provision of energy services rather than merely the financing and provision of new boilers, thus opening up the possibility of innovative responses.

1.4 Three responses were received. After considering such matters as track record and financial stability, Company C was rejected on the grounds that it had a lack of experience and track record in this field and as such did not meet one of the published short-listing criteria.

Part 2

The Project

The Formal Specification

2.1 In June, 1995, Homefirst issued its formal specification for CEM proposals. This required the successful contractor to finance, supply, install and manage (for at least 10 years) all plant, distribution equipment, fuel and personnel necessary for the supply of energy and maintenance of the specified environmental conditions on the total Holywell site. The contractor would be expected to establish a system of performance monitoring to demonstrate that optimum performance was being achieved. The pricing structure was expected to be in two parts; a charge reflecting capital, labour and ancillary costs indexed to national labour indices and an energy charge per unit supplied indexed to the price of fuel purchased. Assessment criteria included cost, quality, experience of the contractor and reliability.

The Tenders

2.2 The two short-listed contractors responded in different ways. The main difference was that under Company B's proposal all boiler replacement and distribution system refurbishment costs would be the responsibility of the Trust. The two proposals were thus quite different in terms of the service offered and the degree of risk each party was willing to assume and these factors were taken into account by Homefirst in determining the way forward. The main features of each of the proposals are set out in Figure 1.

Figure 1: Main Features of Short-listed Proposals

Company A	Company B
Proposed Solution: Straightforward PFI approach involving the installation of new boilers and their operation for a ten-year period	**Proposed Solution: *** Initial Expenditure of £68,000 by Homefirst to keep the existing boilers in service with the company being responsible for their operation. Replacement of the boilers and refurbishment of the distribution system to be phased over a 5-10 year period as and when required.
Payment Mechanism An annual charge reflecting capital, labour and ancillary costs and an energy charge.	**Payment Mechanism:** An annual charge covering labour, maintenance and repairs (up to £3,000 per item) and an energy charge.
Other Features: At the end of the ten-year period, Company A would retain ownership of the plant but Homefirst could potentially be given "quiet possession" at a sum to be agreed between the parties.	All boiler replacement and distribution system refurbishment costs to be met by Homefirst.

*Note: Based on ultrasonic testing of the boilers which found that they did not need to be replaced at that time.

Evaluation

2.3 Before reaching a decision, the options appraisal group visited sites already operated by Companies A and B. An evaluation of their proposals, and a public sector comparator, based on retention of the existing boilers, was then undertaken. This showed that, over a 10 year period, Company B's proposal had

a net present cost of £1.17m compared with £1.77m for Company A's proposal and £2.0m for the in-house option. The major difference between Company A's proposal and those of Company B and the in-house option lay, in the recovery of the total capital costs of their investment through the annual charge mechanism. These costs were largely avoided under the in-house and Company B proposals, although some one-off capital expenditure was included in both options. Sensitivity tests on Company B's proposal showed it to be robust to higher fuel costs and higher boiler replacement costs. Company B also outscored Company A in a quality assessment of such non-quantitative issues as contingency arrangements and quality of service promised. On the basis of these assessments, it was decided to accept the Company B option. A "Report on Proposals for Contract Energy Services", effectively a Full Business Case, was prepared in January, 1996 by the Department's Health Estates Agency on behalf of Homefirst who subsequently formally recommended Company B's proposal to the Management Executive of the Department.

2.4 We noted that a significant issue in comparing the private sector proposals and public sector option and recommending Company B, centred around Homefirst's interpretation of a Departmental circular promulgating Health and Safety Executive guidance on automatically controlled boilers. In essence they interpreted the guidance to mean that whereas a Trust was not permitted to de-man automated steam boiler plant no matter what type of automation was installed, the private sector was not restricted in the same way. The impact of this was that staffing levels reduced from four (pre award of contract) to 1.5 post award. This interpretation also had implications for the Public Sector Comparator (PSC) in that, had the public sector adopted the same approach as the private sector, the PSC may have been the most cost-effective option (see paragraph 3.2). In recommending Company B, Homefirst took the view that, with the transfer of operational responsibilities for the boilers, the risk attached to the need to comply with Health and Safety Executive requirements and ensure safety on site lay with the contractor and not with Homefirst. The Department told us that the line taken by Homefirst, at that time, was reasonable.

The Contract

2.5 In May, 1996, Company B and Homefirst, after rigorous negotiation on terms, signed a contract based on Company B's Standard Utilities Agreement. This reflected the terms set out at paragraph 2.2 above. It provided for a monthly operations charge of £7,375 of which two thirds was indexed to earnings and one third to the index of engineering output prices. The contract also included a penalty on Company B of £100 per hour (after the first half hour) for any failure to supply. This was subject to a maximum of £20,000 a year, i.e. 200 hours of non-supply. This penalty was payable only if Company B failed to use its reasonable endeavours to provide a supply. In addition, although performance targets were laid out in the contract, there were no penalties for failure to achieve them other than the extreme sanction of terminating the contract. The two parties agreed to review the contract and renegotiate as necessary should either of the parties decide that any of the boilers needed to be replaced. Homefirst also agreed to indemnify Company B for any liabilities, etc arising from the application of TUPE[11] (in the event, only one employee transferred to Company B; the other three were temporary employees). The Department told us that the outcome of the negotiations reflected the degree of risk that the supplier was willing to assume and which Homefirst was willing to pay for.

Performance

2.6 In the six years since the contract was signed, Homefirst believes that it has established an excellent partnership arrangement with Company B and is very content with the service it has received. There have been no failures in supply and as such, no penalty payments have been incurred by Company B. An Internal Audit Report noted that the main contract terms were being met and the production of energy was being carried out economically and efficiently. A summary of payments to Company B is set out in Figure 2 below. Initial

11. The Transfer of Undertakings (Protection of Employment) Regulations 1981, aim to safeguard the rights of employees on their transfer to another employer, for example when their work is contracted out.

establishment costs in the first two years amounted to £67,086 against the estimate of £68,000. The payments of £22,821 in 2000-01 were for repairs to the boiler chimney and the installation of new variable speed controls for heating circulation pumps. These controls were an energy conservation measure with a pay back period of around two years. These works were outside the scope of the contract.

Figure 2: Payments Made to Company B

Year	Annual Charge £	Maintenance Charge £	Energy Charge £	Miscellaneous £	Total £
1995-96				32,754	32,754
1996-97	10,000	80,633	121,078	34,332	246,043
1997-98	10,000	93,406	143,973		247,379
1998-99	10,000	88,948	137,628		236,576
1999-00	10,000	100,744	143,160		253,904
2000-01	10,000	104,582	177,152	22,821	314,555
2001-02	10,000	110,531	152,754		273,285
Total	**60,000**	**578,844**	**875,745**	**89,907**	**1,604,496**

Source: Homefirst Trust

2.7 A complete record of Company B's expenditure on repairs which it did not claim under the £3,000 per item rule (see paragraph 2.2, Figure 1 above) was not available. However, Company B's records showed that in the two and a half years to June 2002, its expenditure was at least £107,819 (see Figure 3 - this does not include some minor expenditure). Company B's charge is based on useful therms and tonnage of steam produced. As per the contract, Company B monitors the consumption and output levels and produces a monthly report for Homefirst. Homefirst staff examine the figures produced both in the reports and on invoices supplied to make sure that they are within the contracted parameters

and charges. Any discrepancies are tabled at the next site meeting or, in some circumstances, with local Company B site engineers.

Figure 3: Repairs Carried Out By Company B

Year	Maintenance	Breakdowns	Spares	Safety	Total
	£	£	£	£	£
2000	21,211	13,397	5,438	5,495	45,541
2001	15,467	16,287	14,831	729	47,314
2002 to (June)	7,764	3,404	3,139	657	14,964
Total	**44,442**	**33,088**	**23,408**	**6,881**	**107,819**

Source: Company B

2.8 The laundry was eventually closed in June 1999, and heating requirements can now be met with one boiler running, one in reserve and one mothballed. However, a report by Company B in January 2002 and Homefirst's Estate Service in May 2002, revealed extensive cracking in all three boilers. The two operational boilers were subsequently repaired at a cost of £19,000 which was met by Homefirst; no repairs will be carried out on the mothballed boiler unless this proves necessary from an operational perspective.

Part 3

Conclusions and Recommendations

Specification of Objectives

3.1 Homefirst correctly decided to advertise for the financing and supply of an energy service rather than merely the financing and provision of new boilers, thus putting the emphasis on outputs rather than inputs and opening the way for innovative responses (paragraph 1.3). Bidders were required to ensure that minimum temperature requirements were met and to demonstrate energy efficiency measures to satisfy Homefirst that optimum contract performance was being maintained. However, we saw no evidence, prior to the invitation of bids, that Homefirst had identified the risks associated with the project and the scope for their transfer to the private sector.

Key Lesson:

Appropriate risk allocation between the public and private sectors is the key to achieving value for money in PFI projects. Accordingly, public sector organisations should identify at the start the risks associated with a project and the scope for their transfer to the private sector. This will facilitate not the maximum but rather the optimum transfer of risk, i.e. allocating individual risks to those best placed to manage them.

3.2 The Public Sector Comparator (PSC) produced by Homefirst provided a benchmark against which to measure the bids. However, the size of the gap between the net present cost of Company B's bid (£1.17m) and the PSC (£2.0m) should have also alerted Homefirst management to the fact that the PSC might

not have been prepared on a rigorous enough basis. In addition, Homefirst's interpretation of Health and Safety Executive guidance (paragraph 2.4) restricted its ability to optimise cost savings.

Key Lesson:

To establish that a deal is good value necessarily requires the procuring organisation to satisfy itself that the deal is superior to its realistic alternative option or options. To do that the organisation will need to carry out a systematic, comprehensive and thorough comparison of the PFI option against the public sector comparator. This means that a PSC should be prepared and critically examined by managers at all levels before inviting bids on a basis which seeks, through the application of best practice, to maximise economies and optimise performance.

The Adoption of Proper Processes

3.3 Homefirst, in line with best practice, established a project team to manage the process, which included DHSS Health Estates Agency, and considered all options including a "do nothing" option. While it prepared a project specification for bidders and drew up a PSC, it did not employ advisers on the PFI process itself and no costs, other than administrative costs, were incurred. As regards stimulating interest, Homefirst, in line with normal procedures, advertised the contract in OJEC and local papers. While this generated three responses, in our opinion Homefirst could have done more to stimulate interest prior to the contract being advertised in OJEC. For example, the publication, Contract Energy Management in the Northern Ireland public sector, lists 11 companies willing to provide such a service.

Key Lesson:

Competition is central to getting good value for money from PFI deals. Part of this is the creation of a good tender list of firms invited to bid. This requires sponsoring bodies to actively stimulate, where appropriate, interest in their proposed PFI projects, to publicise their procurement competitions in accordance with the relevant law and regulations, and to give all necessary guidance to potential tenderers on how to submit good deals.

Contract Negotiations

3.4 The final contract reflected the terms put forward by Company B in its standard contract and these were used as a basis for negotiation. In such a situation it might be expected that the contract would be drafted in favour of the contractor and would, therefore, involve the public sector in having to negotiate away unfavourable terms and introduce better ones. This can be a time consuming and, frequently, unrewarding exercise. Homefirst told us that, in their view, they secured a good outcome.

Key Lesson:

Where possible, public sector bodies should always seek to utilise standard PPP contracts developed within the public sector or draft their own, setting out the terms and conditions they expect, and negotiate on those.

Risk Transfer

3.5 Risk transfer is an important component of PFI contracts. In this case, as indicated in paragraph 2.2, the suppliers' proposals differed significantly regarding the degree of risk each was willing to assume and their costs varied as a result. These factors were taken into account in the evaluation of their proposals and in the event, Homefirst selected the provider which offered a more limited transfer of risk on the grounds of cost, quality and future flexibility. As a result, the service payment does not vary with volume and all operator revenue comes from Homefirst; the service payment is only marginally affected by availability levels and/or performance criteria; the service payment is indexed to, and therefore varies with, the underlying cost base; the underlying asset reverts to Homefirst at the end of the contract; and Company B can pass back to Homefirst any major expenditure on the boilers.

3.6 We also noted that:

- Company B did not acquire ownership of the boilers which remained on Homefirst's balance sheet;
- the initial capital expenditure required to bring the boilers up to operational standard by the installation of modern controlled equipment, included in the proposal, was met by Homefirst, as was the annual remedial expenditure on the distribution system;
- Homefirst was to bear the cost of replacing the boilers should they show renewed signs of failing with the result that Company B bore no residual value risk;
- the only penalty clause in the contract was for failure to use reasonable endeavours to supply; and
- Company B did not bear any risk related to variability in the income stream.

3.7 The supplier would undoubtedly have charged a considerable premium to carry the risks, as is reflected in the costs of the alternative supplier proposals. However, a number of not insignificant risks were transferred by the contract, with Company B:

- bearing the cost of all repairs below £3,000 per item, spending £107,000 in the two and a half years to June 2002;
- bearing the liability risk of boiler failure;
- being responsible for the health and safety aspects of operating a fully automatic boiler system; and
- carrying the responsibility to safeguard Homefirst against Legionella developing within the Boiler House Calorifiers.

In addition, through selecting the PFI option, Homefirst claimed that it has been able to avoid the considerable cost of replacing one of the boilers which would subsequently have become surplus to requirements in June 1999 following closure of the laundry.

Value for Money

3.8 The evaluation of the two proposals and PSC produced the following total costs and benefits for the 10 year period:

Figure 4: Evaluation of Proposals

	Company B £'000	Company A £'000	PSC £'000
(i) Capital costs (plant and buildings)	239	25	215
(ii) Annual standing charge/labour cost	985	1,638	960
(iii) Energy cost	1,235	1,558	1,369
(iv) Homefirst management charge	230	230	230
	2,689	3,451	2,774
(v) Less manpower & maintenance savings	1,044	1,044	
(vi) Residual value of plant	100		100
	1,545	2,407	2,674
Net Present Value	**1,175**	**1,767**	**2,001**

Source: Homefirst Trust

3.9 While the evaluation takes into account relevant risk transfer (reflected in Company A and B costs) and Homefirst's interpretation of Health and Safety guidance (see paragraph 2.4), it could, in our opinion, have been enhanced through the adoption of a level playing field approach and through taking into account the residual value of plant in Company A's proposal.

3.10 Figure 5 sets out the evaluation carried out on an equivalent basis. In essence, the direct comparison between Company B and the PSC should have been between the respective capital costs, annual standing charges and energy costs. Thus, although it was calculated that Company B was cheaper, by £58,000 (NPV), over the life of the contract, this was significantly less than that shown in Figure 4 and might have been eliminated in a more careful evaluation of energy cost assumptions, of sensitivities and of the cost of risks transferred and retained, in particular staffing levels. A more comprehensive evaluation might also have revealed why Company B was able to operate more cheaply, particularly as regards energy costs, than the public sector (if that was the case) and whether it would have been possible for Homefirst to have achieved these savings.

3.11 With regard to the residual value, Company A's proposal offered "quiet possession" at a sum to be agreed between the parties (see paragraph 2.2, Figure 1). Homefirst told us that Company A would not disclose the price that would have quantified quiet possession until the end of the ten-year contract period. Therefore, it would not, in their view, have been appropriate to include this element in the evaluation as it could not be quantified. However, this could well have given Homefirst a significant economic benefit which, in line with Treasury guidance[12], should have been recognised in the evaluation and, as such, informed the decision-making process. The Department agrees that Homefirst could have received a significant economic benefit. However, it told us that, as Company A would not disclose the price that would have quantified quiet possession until the end of the ten-year period, it would not have been appropriate to include this element in the evaluation, as it could not be quantified and could not properly inform the decision-making process.

12. Economic Appraisal in Central Government - A Technical Guide for Government Departments; HM Treasury, April 1991.

Figure 5: Evaluation of Proposals - Level Playing Field

	Company B £'000	Company A £'000	PSC £'000
(i) Capital costs	239	25	215
(ii) Annual standing charge/labour cost	985	1,638	960
(iii) Energy cost	1,235	1,558	1,369
(iv) Homefirst management charge	230	230	230
	2,689	3,451	2,774
(vi) Residual value of plant	100		100
	2,589	3,451	2,674
Net Present Value	**1,943**	**2,536**	**2,001**

Source: NIAO

Monitoring Delivery

3.12 Company B monitors and reports on its consumption and output levels which Homefirst examines and provides to the Department's Health Estates Agency for compilation in a published annual report comparing energy usage in similar facilities. Homefirst also carries out checks on fuel consumed and operational efficiencies to confirm that minimum standards are being achieved. An audit of energy usage was carried out at the end of 1996 but this mostly covered the period before Company B's involvement. An Internal Audit Report in 1999 noted that the main contract terms were being met and the production of energy was being carried out economically and efficiently.

Key Lesson:

These are useful reports which go some way to meeting the requirements of project evaluation. However, project evaluation, as defined by Treasury, goes beyond this, aiming to improve project appraisal, design, management and implementation through obtaining the maximum benefit from accrued experience. This is important in all projects but particularly so in those delivered through PFI. However, achieving this requires effective procedures both for initiating the evaluation and for disseminating lessons which have been learnt, be they technical or procedural - for example on the form of contract, or on approval procedures, or clarity of roles. In this instance we consider that the Department's Health Estates Agency was particularly well placed to initiate a review and disseminate the wider lessons.

Overall Comment

3.13 In this early PFI project, Homefirst sought a contract energy management solution to its energy problems through entering into a contract with a company expert in this field. In a positive vein, by contracting with Company B, Homefirst has secured more life from its boilers than expected and postponed capital expenditure on three boilers to a point when only two are now needed. As a result, Homefirst estimated savings over the ten-year contract period to be £430,000, comprising £196,000 capital and £24,000 a year in revenue. Best practice in PFI arrangements would indicate that an important facet of any such agreement is the relationship that exists between the purchaser and the provider. It is clear that Homefirst has developed and maintained an excellent relationship with its PFI partner. During the six years that the arrangement has been operating, Homefirst has been well served by Company B and has considerable confidence in the ability of the company to provide an energy management system to meet its needs.

3.14 However, there is no way of knowing if the deal signed by Homefirst was the optimum one. Even when assessed against more traditional procurement guidelines, there were weaknesses in the way the process was managed. The small number of bids received did not provide enough competition to stimulate

an optimum outcome and the PSC could have been prepared on a more robust basis. As such, there is no reliable evidence to demonstrate that savings have been made by comparison with public sector ownership or that the contract has provided maximum value for money. A greater degree of risk transference could have been attempted (although Company B might have sought an excessive premium for bearing those risks) and greater benefits might have been possible. It must be acknowledged however, that in implementing this PFI arrangement, Homefirst was operating against a background of limited available advice and precedent for such an approach. It is the Department's view however, that, as recognised in paragraph 6, assessing value for money in a PFI project will only be feasible many years down the line and until this assessment is carried out, after the completion of the contract, it would not be possible to determine if the deal signed by Homefirst was the optimum one. However, while we recognise that the ultimate assessment of value for money will be made at a future date, adherence to the principles of good project appraisal and evaluation requires making well informed judgements on value for money throughout the life cycle of a project.

The Provision of Renal Services at Antrim Area Hospital

Part 1

The Provision of Renal Services at Antrim Area Hospital - The Project

Introduction

1.1 The provision of renal services through the private finance initiative at Antrim Area Hospital was identified by the Department of Health and Social Services and Public Safety as a project which could be used as an exemplar of best practice within the wider public sector. Based on discussions and interviews with key staff and a limited review of files, we found that, in the greater part, best practice was adopted and applied. The following paragraphs, in addition to providing essential background to the project, highlight best practice and, in the small number of occasions where it was not applied, the key lessons to be learned.

Background

1.2 In 1994, a Regional Review Group was established by the Department of Health and Social Services to review the provision of renal dialysis services in Northern Ireland. Its work was informed by advice from the Renal Association which, in 1991, had reported that only three-quarters of people in Northern Ireland developing end stage renal failure each year could enter renal replacement programmes, partly due to inaccessibility of renal services and partly due to inadequate health care resources. The Association's recommendation, in 1995, was that thrice weekly dialysis should be the norm. At the time, only 61 per cent of renal patients received dialysis this frequently. The Review Group endorsed these views and based its forecast of future need on anticipated demand derived

from a detailed analysis of clinical activity in recent years at hospitals offering renal services, the length and frequency of dialysis sessions and the shift working patterns within each dialysis unit. To meet the Group's target of giving 90 per cent of dialysis patients three treatment sessions per week, would mean doubling dialysis capacity in Northern Ireland by 2000, although the programme proposed stopped short of that.

1.3 The Review Group concluded that development of future dialysis provision should be focussed on Belfast City, Tyrone County and Antrim Area Hospitals[13]. Accordingly, in November, 1995 the four Health and Social Services Boards asked United Hospitals Health and Social Services Trust (United Hospitals) to bring forward proposals for the provision of a renal dialysis unit consisting of 14 dialysis stations but with the capacity to accommodate 16. Later, but still during the tendering process, this was extended to include capacity for 20 stations.

The Need for a Unit at Antrim Area Hospital

1.4 Antrim Area Hospital is managed by United Hospitals which is responsible for the provision of healthcare services from five hospitals to a population of 330,000 over a wide geographical area in the Northern Health and Social Services Board area. In July, 1995, United Hospitals opened a six station renal dialysis unit by means of the temporary conversion of a surgical ward but, because of demand, only 50 per cent of patients were being treated three times per week. The capacity of the unit was increased in 1996 by the introduction of a third daily shift but the service was still not considered to be up to then current standards. While the unit was able to provide 108 four hour patient sessions per week, best estimates of an annually increasing demand suggested a need to provide capacity for 288 patient sessions per week.

13. A six station unit was later opened at Daisy Hill Hospital, Newry.

Part 2

The PFI Process

The Pre-Qualification Process

2.1 The need to increase capacity and the options for doing so (including the use of the Private Finance Initiative) were first considered by United Hospitals early in 1997 in an Outline Business Case (OBC) which was subsequently approved by the Northern Health and Social Services Board and by the Health and Social Services Executive. The Business Case, which was drawn up by reference to the requirements of the Department's Capital Investment Manual and included a financial evaluation, was revisited on a number of occasions during the project to take account of issues that emerged from discussions with, and presentations by, short-listed bidders. A revised version, which was prepared and approved in March, 1998, provided the basis for the eventual Full Business Case (see paragraph 3.12).

2.2 United Hospitals identified and examined five options considered capable of meeting its objectives, together with a "do nothing" option. These were evaluated on the basis of estimated cost and a number of other criteria, including quality of patient care, volume of activity, quality of treatment, ease of implementation and compatibility with other hospital services. These options were, however, essentially site options within the hospital complex and, as such, did not show a wide variation in results, either in cost or in non-monetary benefit terms. However, one site did score better than the rest and consequently was chosen as the preferred public sector option.

2.3 United Hospitals' core objective was the provision of a new renal dialysis unit to accommodate 14 dialysis stations initially, with the capacity to expand to 16 stations. It would be available for the treatment, training and education of patients, carers and staff for six days per week and be ready to open on 1 April, 2000. In deciding how to provide the new unit, United Hospitals, having undertaken the PFI test required by the Capital Investment Manual, concluded that the Private Finance Initiative could deliver a value for money project. The private sector supplier would be expected to design, build, finance and operate the new unit and also provide both the dialysis machines and a number of facilities management services including support services, building and grounds maintenance, dialysis consumables provisions and maintenance of the dialysis equipment. The estimated capital value of the project, including the dialysis machines, was £2.2m.

2.4 United Hospitals began the process of seeking a private sector partner in September, 1997 when, in line with Purchasing Service guidelines, it placed an advertisement in the Official Journal of the European Community (OJEC). This sparked a high degree of interest but only three structured responses for this specialised project were received. All three were asked in December, 1997 to submit outline proposals. To help them in this process an initial description of the requirements of United Hospitals was set out in an "Information Document".

2.5 Overall direction and control of the project rested with a Project Board, chaired by the Chief Executive, which included representatives of the Department's Health Estates Agency. In carrying out its work, the Project Board was guided by the Capital Investment Manual, by draft guidance from the Department of Finance and Personnel, "The Private Finance Initiative in Northern Ireland: Guidance on Outline and Full Business Cases," and by HM Treasury's publication "Appraisal and Evaluation in Central Government". United Hospitals also benefited from useful

advice obtained from the Belfast City Hospital Trust which was well advanced with its own PFI Renal Services Unit.

2.6 A timetable for the project was established with target dates for, inter alia, receipt of pre-qualification submissions, short listing, issue of the Invitation to Negotiate, nomination of preferred supplier and submission of Final Business Case, all by December, 1998. It also established selection criteria for the initial submissions and for the expected best and final offers. It did not, however, form a view on what rates of return investors might expect from a project such as this. United Hospitals told us that, whilst it did not define a pre-determined rate of return, it did take guidance from its corporate finance advisers that the rates of return put forward in the best and final offers were reasonable.

Best Practice Points and Key Lessons:

- The project objectives were clear, focusing on what United Hospitals wanted having regard to what the private sector could supply;
- An outline business case was prepared including an option appraisal which showed that a PFI approach could deliver value for money; and
- A suitably qualified and experienced Project Board was assembled who took into account best practice guidance, including proper advertising of the project and establishment of a clear timetable for its delivery.

Appointment of Advisers

2.7 The Project Board was supported by legal and financial advisers. Legal advice was provided by a London firm who put forward a proposal based on shared working with its Northern Ireland associate firm, which was able to provide advice on planning matters, employment law, land and other issues specific to Northern Ireland. Appointment was made after a tendering process which, in line with Departmental procedures at that time, was based on a select list of five

approved lawyers issued for use within the HPSS by the Department. This too had been drawn up following previous advertisement and selection by the Department. Although the firm appointed was the only one on the approved list which had responded to United Hospitals' invitation to tender, it was nevertheless required to submit a costed proposal and attend a formal presentation and interview.

2.8 Given the requirement to adhere to the select list previously established by the Department, United Hospitals could not take additional steps to attract interest from other firms of lawyers as a means of stimulating competition for the appointment. Departmental procedures have however, been updated following consideration of the findings of a 1998-99 monitoring report by the Department and the independent review of the use of the legal services select list carried out in 1999 by DFP's Purchasing Service. Due to the developments in PFI and the increase in activity in this area since the select list was introduced, it was considered appropriate to remove PFI from the list from 1999-00 and allow HPSS bodies to secure legal services through open competition.

2.9 Financial advisers were appointed following completion of a competitive selection process initiated through advertisements in local and national newspapers.

2.10 Contrary to best practice, a budget was not prepared for the cost of advisers and management time. United Hospitals told us that it did not receive any additional funding to meet the costs of the PFI process and, as such, could not establish a separate dedicated budget. However, all expenditure relating to the use of the external professional advisers was charged to a separate budgetary line and monitored regularly against the fees agreed at the time of appointment. For both the financial advisers and the lawyers, agreed costs were later increased to cover additional work. The eventual cost of professional advice was £109,775, just over four per cent of the capital value.

2.11 In line with DHSSPS and Department of Finance and Personnel guidance, approval was sought and obtained as the value of the consultancy assignments exceeded the United Hospitals' and Department's respective delegated expenditure limits[14].

2.12 Following the merger of United Hospitals' auditors and corporate finance advisers in July 1998, guidance was sought from Health Service Audit as to how to deal with the potential conflict of interest arising from the same firm providing consultancy advice to a project and acting as auditors who would be required to form an independent view of its treatment as on or off the balance sheet. Due to the stage the procurement process had reached, it was agreed that it would be prejudicial to United Hospitals for the merged company not to act as PFI advisers, including the giving of an opinion as to whether the project could be treated as off balance sheet. It was also agreed that the auditor's ability to be and be seen as independent of the PFI advisers would need to be addressed in respect of the following financial year, 1999-2000, the year in which the accounting treatment would impact on the financial statements. In the event, another firm was appointed as auditors for that year.

Best Practice Points and Key Lessons:

- Financial and legal advisers should be appointed after competition;
- The procuring organisation should set budgets for external advisory costs at the outset; initial budgets can be revised later when more is known about the work that needs to be done;
- Costs should be monitored and managed, which includes ensuring that fees are capped and, where appropriate, subject to Department of Finance and Personnel approval; and
- As in this case, conflicts of interest should be identified at an early juncture and properly resolved.

14. In line with general expenditure delegations, Departments are required to obtain DFP approval for all consultancy assignments exceeding £50,000. However, this does not apply to Health Trusts who are only required to seek DHSSPS approval for assignments in excess of £20,000. This is currently being reviewed.

Part 3

The Deal

Invitation to Negotiate

3.1 Following presentations by the three short listed bidders an Invitation to Negotiate was issued in May, 1998. It required the submission of a bid to design, build, finance and maintain a 14 station dialysis unit with the capacity to accommodate 16 stations. The anticipated contract period was 15 years from a target operational date of March, 2000. However, United Hospitals proposed to offer a 30 year licence for the use of the site on which the new unit was to be built. Accordingly, the prospective providers were asked to include a guaranteed residual value for the building at the end of the contract period in their submissions. These provisions were included as a means of persuading bidders not to seek full recovery of their capital investment costs in the 15 year period of the contract but to take a longer view. To facilitate bidders, United Hospitals provided a copy of the Outline Business Case (which included comparative public sector costs) and also opened a Project Data Room and offered bidders question and answer sessions. NIAO was told that bidders were shown the Outline Business Case to encourage them to tender below the public sector cost. United Hospitals believes that the competitive bidding process between the firms ensured keenly priced tender submissions.

3.2 Best practice guidance at that time encouraged procurers to be as open as possible with all interested parties throughout the procurement process. This included disclosing information regarding the conceptual basis of the relevant comparator and the technical details of the methodology used in its construction.

Where competition was strong, the guidance suggested that it may also be appropriate to share the full outcome of the Public Sector Comparator exercise with bidders. However, where competition is restricted, the guidance recommends that the final outcome of the PSC calculations should not be revealed. It recognised that each case should be judged on its merits but, to ensure proper stewardship of public assets, it was clear that the public sector should never disclose information that weakens its negotiating position. The guidance has now been changed and discourages the disclosure of the PSC.

3.3 Indicative bids were received from two of the bidders in July, 1998; the third withdrew. Following a presentation by the remaining two bidders, the indicative bids were subjected to a detailed evaluation by a Bid Evaluation Team using criteria based on those set out in the Invitation to Negotiate. Only one bidder submitted its own variant proposal and after due consideration, United Hospitals decided not to pursue this option. During discussions with the bidders, the option of building a unit capable of accommodating 20 stations emerged and United Hospitals asked both bidders to consider this. In response, both bidders offered to build a 20 station unit for the same price as a 14 station unit and were asked to submit best and final offers by September, 1998. In the event United Hospitals agreed to the Unit being constructed to allow 20 stations, albeit in the first instance the contract was solely for 14. By 2003-04 the full 20 stations were in use, demonstrating the value and flexibility of the approach taken by United Hospitals.

Evaluation of Best and Final Offers

3.4 Evaluation of best and final offers was carried out by the Bid Evaluation Team who scored each bid against a predetermined weighted criteria. While NIAO did not subject the bids or their evaluation to detailed scrutiny, it noted that Bidder 1 scored higher on both a weighted and an unweighted basis and scored particularly well in relation to financial viability and contractual arrangements.

This was because the bidder proposed to finance the transaction entirely through equity and to base payments due solely on the number of dialysis treatments provided. NIAO was told that, in contrast, the other bidder proposed to establish a separate, debt financed company, without guarantees from its parent company, and was less willing to accept demand risk. On the other hand, Bidder 2 showed a more co-ordinated approach to design and deliverability of the unit and made more satisfactory proposals for quality of equipment. These differences are reflected in each Bidder's respective rates of return which United Hospitals' corporate financial advisers considered to be both reasonable and acceptable.

3.5 The evaluation also included a calculation of the net present values (NPV) of the two bids using the approved H M Treasury discount rate of 6 per cent and after adjusting for the different assumptions used by the bidders. It also tested the sensitivity of the NPV's to an increase in the number of dialysis stations from 14 to 16 or 20 (both bidders had indicated that they would build a 20 station unit for the same price as a 14 station unit). Bidder 1 scored better in all three tests.

Risk Transfer

3.6 Appropriate risk allocation between the public and private sectors is a key requirement to the achievement of value for money on PFI projects. In this instance United Hospitals sought optimum transfer of risk rather than transfer for its own sake. As a first step, it identified the key risks inherent in the project under the six broad headings set out in Figure 1, the potential impact of each in terms of probability and value and, therefore, estimated financial impact. The risks were provisionally allocated to the body best able to carry them, public or private sector or shared. This preliminary allocation was included in the Invitation to Negotiate. Bidders were required to complete a risk allocation matrix indicating for each risk their view of its potential monetary impact in net present value terms. The allocation was subject to negotiation with the bidders and during this period United Hospitals further developed its risk quantification.

Figure 1: Initial Risk Allocation

	Proposed Risk Allocation		
	Trust	Shared	Bidder
Planning Risk			X
Design and Construction Risk		X	
Operating Risk			X
Technological Risk			X
Demand Risk			X
Financial and Legislative Risk			X

Source: United Hospitals

3.7 In calculating the probable financial impact of risks to be transferred, United Hospitals took account of past experience in the Health Service. For example, it assumed a 100 per cent probability of a 12 per cent construction cost overrun if the Unit was built for public sector ownership, i.e. an allowance equivalent to 12 per cent of construction costs. Likewise for maintenance, it assumed a 25 per cent probability of a 10 per cent cost overrun, an allowance of 2.5 per cent for maintenance provision. The value of the risks (which United Hospitals would have been managing under a public sector build) was added to the cost of the PSC. Thus the full cost of the PSC, including risks, was clearly and completely recognised therefore ensuring a fair comparison with the private sector bids

3.8 The preferred supplier accepted both demand risk (perhaps better described as volume risk) and residual value risk both of which were considered to be low/minimal given the high demand for renal services. The proposed payment mechanism was based solely on the actual number of treatments undertaken. However, as the successful bidder would not be able to influence demand it is possible that the bidders included a premium to cover this risk. In NIAO's opinion United Hospitals should have sought bids with and without the private sector bearing this risk, which United Hospitals valued at a net present cost of £133,000 in its public sector comparator. The offer proposed a residual value of

£1.742m for the building thereby reducing the cost of depreciation and, therefore, the annual charge for treatments, during the contract period. As neither United Hospitals nor a successor operator is obliged to buy the unit, this introduced significant financial risk into the proposal. The Design and Construction risk is shown as shared but the detailed assessment shows the bidder taking the greater part.

Public Sector Comparator

3.9 United Hospitals prepared, in accordance with detailed technical guidance set out in the Department's Capital Investment Manual and Treasury publication on economic appraisal in central government, a fully costed and risk adjusted calculation of the likely cost to the public sector of providing a 14, 16 or 20 station unit. The unit was assumed to be open for 6 days per week throughout the year with an average utilisation rate of 90 per cent. Figure 2 provides details.

Figure 2: Summary of Public Sector Comparator

Cost Component	14 Stations NPC £000s	16 Stations NPC £000s	20 Stations NPC £000s
Capital Cost	1,952	1,969	2,069
Revenue Costs	3,556	3,857	4,252
Risk Quantification	516	544	587
Post Risk Total	**6,024**	**6,370**	**6,908**

Source: United Hospitals

3.10 The risk adjusted PSC formed the basis for the value for money assessment against the two private sector proposals. The detail of these options were available to NIAO but were considered by United Hospitals to be "commercial in

confidence". However, our review confirmed that the PSC was more expensive, even before adjustment for risk, than either of the two private sector proposals, with Bidder 1 offering the best value for money.

Full Business Case

3.11 On the basis of all these tests, Bidder 1 was chosen as the preferred supplier. Negotiations continued until December, 1998 when United Hospitals and its advisers produced a comprehensive Full Business Case (FBC) for approval by United Hospitals' Trust Board, the Northern Health and Social Services Board and the Departments of Health and Social Services and Finance and Personnel. The purpose of the FBC was to establish the case for the provision of the new renal dialysis unit at Antrim through PFI. The document reviewed the original case for a new unit set out in the OBC, gave a comprehensive report on the tendering and evaluation process, compared the best offer with the Public Sector Comparator, established the expected through life cost of the project and set out the arrangements for post project evaluation. The FBC also included a considered view of the accounting implications of the project in the light of Statement of Standard Accounting Practice 21, Financial Reporting Standard 5 (then current)[15] and Treasury Technical Note[16]. It concluded that the transaction should be accounted for as a revenue cost of purchasing a comprehensive renal service; a key test of whether the project matched up to PFI guidelines. The value of the land remains on United Hospitals' balance sheet as ownership is not transferred, the service provider being given a 30 year licence for its use.

15. Statements of Standard Account Practice and Financial Reporting Standards are authoritative statements of how particular types of transactions and other events should be reflected in financial statements. Compliance with these will normally be necessary for financial statements to give a true and fair view.
16. Treasury Technical Note 1 was issued by HM Treasury and provided guidance on FRS 5 and its applicability to the public sector.

The Agreement

3.12 The invitation to negotiate included a draft Project Agreement which formed the basis of the Agreement eventually signed in April, 1999. The Agreement was drafted with the help of contractual guidance issued by both the National Health Service Executive and the Treasury Task Force. It provided for the preferred supplier to be responsible for the design and construction of the new renal dialysis unit, the provision of dialysis machines and consumables and the maintenance of both the machines and the building and grounds.

3.13 The construction period was expected to be one year and the operational period 15 years from April, 2000. Payment for the services provided by the supplier is on a price per dialysis session basis, the price being set by reference to a tariff schedule based on bandings defined by the total number of treatments provided during the year. Tariffs are updated annually using "RPI minus x" formula as set out in the agreed contract. United Hospitals offered no guarantee of a minimum number of annual treatments.

3.14 Detailed performance indicators, relating primarily to the availability of a renal dialysis service, allowed for up to 20 per cent of the monthly payment to be at risk for repeated poor performance. The FBC claimed that repeated poor performance could lead to a reduction of 50 per cent. However United Hospitals said that this had been capped at 20 per cent in the final contract negotiations, with a requirement for the service provider to submit a "cure plan" in such circumstances. In the event, no penalties have had to be applied. The Agreement also allocated change of law responsibility between the two parties and provided for future changes in the delivery of the services covered by the agreement. It dealt with default termination and stated that any compensation to the service provider would be based on forecast, not actual, equity returns. There were no provisions which would enable United Hospitals to share in any excess or windfall profit made by the service provider from the project.

3.15 The Agreement provided for United Hospitals to provide funds for any capital expenditure resulting from a Trust request for change, which the service provider was unable or unwilling to finance itself; it provided for United Hospitals to be able to provide insurance for risks that the service provider could not insure at reasonable rates. Where the supplier is unable to obtain insurance for its assigned risks at reasonable rates, it must notify United Hospitals and commence a process of negotiation. This ultimately allows United Hospitals the option of increasing its monthly payment to the supplier to cover the increased risk premium or transferring the specific insurance risk back to itself, if this represents the preferred option. In the latter case, this would also lead to a reduction in the monthly payment to the supplier. This ensures that the supplier is not charging United Hospitals for the risk of unreasonable insurance premiums within its ongoing contract payments. United Hospitals considers that these provisions give it the option to ensure the continued availability of the renal service within its control and are in keeping with its responsibility to patients. In its opinion, it would be under no obligation to provide funding simply because the service provider decided that it did not want to pay. The Agreement also provided for force majeur events and lesser events, outside the control of the parties, which might prevent contractual obligations being discharged. Finally, the Agreement provides for the establishment of a liaison committee jointly chaired by United Hospitals and the service provider and a dispute resolution procedure which starts with a reference to that committee.

Best Practice Points and Key Lessons:

- Procuring organisations should be as open as possible with all interested parties throughout the procurement process. However, care should be taken not to disclose information, such as the PSC, which could weaken their negotiating position;

- Procuring bodies should identify the scope for risk transfer in advance. This is important if individual risks are to be allocated to those best placed to manage them;

- Procuring bodies, as in this case, should attempt to accommodate within the scope of the original deal any changes to their requirements which they can foresee at the time. Contracts should also contain proper procedures for introducing and controlling unforeseen changes to services;

- As in this case, selecting the best deal requires a multi-dimensional evaluation and application of informed judgement;

- The procuring organisation should seek to utilise standard PPP contracts or where these are not suitable, develop a draft agreement and negotiate on this; and

- Contracts should include provisions which allow procuring organisations to share in excess or windfall profits.

Part 4

Performance and Project Evaluation

Performance

4.1 The new Renal Unit opened in April, 2000 and its capacity increased from 14 stations to 16 stations one year later. Payments to the service provider were £680,000 in the year to 31 March, 2001, £822,000 in the year to 31 March, 2002 and £900,000 in the year to 31 March, 2003. United Hospitals told NIAO that it had established a good working relationship with the service provider and is very satisfied with their performance.

4.2 Procedures for project monitoring have, in line with the Full Business Case, been drawn up. These comprise:

- Monthly reviews of activity by the Renal Unit Manager and the service provider's Facility Manager - this is essentially to confirm invoicing details but, if needed, would also highlight any unsatisfactory performance as this would invoke the imposition of penalties, as defined in the agreed contract; and

- Quarterly management reviews of all service issues, including finance, quality, services etc, involving United Hospitals' Chief Executive, Director of Finance and Consultant Nephrologist and the service provider's General Manager, Director and Facilities Manager.

In addition there is regular informal contact between United Hospitals and the service provider's management.

4.3 The Full Business Case envisaged the completion of an evaluation after the implementation phase (no earlier than 12 months after opening). The purpose of this was to ascertain whether or not the expected benefits promised by the project have been realised and whether or not there have been any problems or issues with the standard of service delivery achieved by the contractor. United Hospitals also planned annual reviews of the success of the project thereafter.[17] However, to date no evaluation has been carried out.

Best Practice Point and Key Lesson:

Such reviews are important, both to the organisation and to the wider public sector as they aim to improve project appraisal, design, management and implementation through obtaining the maximum benefit from accrued experience. In this instance, the results from a post project evaluation could usefully have been disseminated within the Health Service to inform the decision making process regarding the provision of further units arising from the most recent Renal Services Review[18].

17. The Office of Government Commerce's Gateway process advises that, for long-term contracts such as PFI/strategic partnering, there should be a formal review of the operational contract every three years.
18. The Department of Health and Social Services and Public Safety completed a Renal Services Review in 2002. This is currently out to public consultation.

APPENDICES & GLOSSARY OF TERMS

Appendix 1

(Paragraph 4)

PFI Guidance and Best Practice

Generic Guidance	Date of Issue	Report Ref
Partnerships for Prosperity	November 1997	Page 25 Para 3.10 Page 45, Para 3.1
A Step-by-Step Guide to the PFI Procurement Process -	Revised April 1998 Revised November 1999	Page 17, Para 2.3 Page 20, Para 2.12

Policy Statements	Date of Issue	Report Ref
PFI and Public Expenditure Allocations	September 1997	
Public Sector Comparators and Value for Money	February 1998	
PFI and Public Expenditure Allocations for NDPBS	August 1998	
PFI Projects: Disclosure of Information and Consultation with Staff and Other Interested Parties	October 1998	Page 29, Para 4.1 Page 62, Para 3.2
Provision of Information to Parliament	September 1999	

Technical Notes	Date of Issue	Report Ref
How to Account for PFI Transactions	Revised June 1999	
How to follow EC Procurement Procedure and Advertise in the OJEC	June 1998	
How to Appoint and Manage Advisers to PFI Projects	August 1998	Page 60, Para 2.10
How to Appoint and Work with a Preferred Bidder	July 1999	
How to Construct a Public Sector Comparator	August 1999	Page 20, Para 2.11 Page 45, Para 3.2
How to Manage the Delivery of Long Term PFI Contracts	September 1999	
How to Achieve Design Quality in PFI Projects		
A Competence Framework for Creating Effective PFI Teams (Draft)		

Appendix 1 (continued)

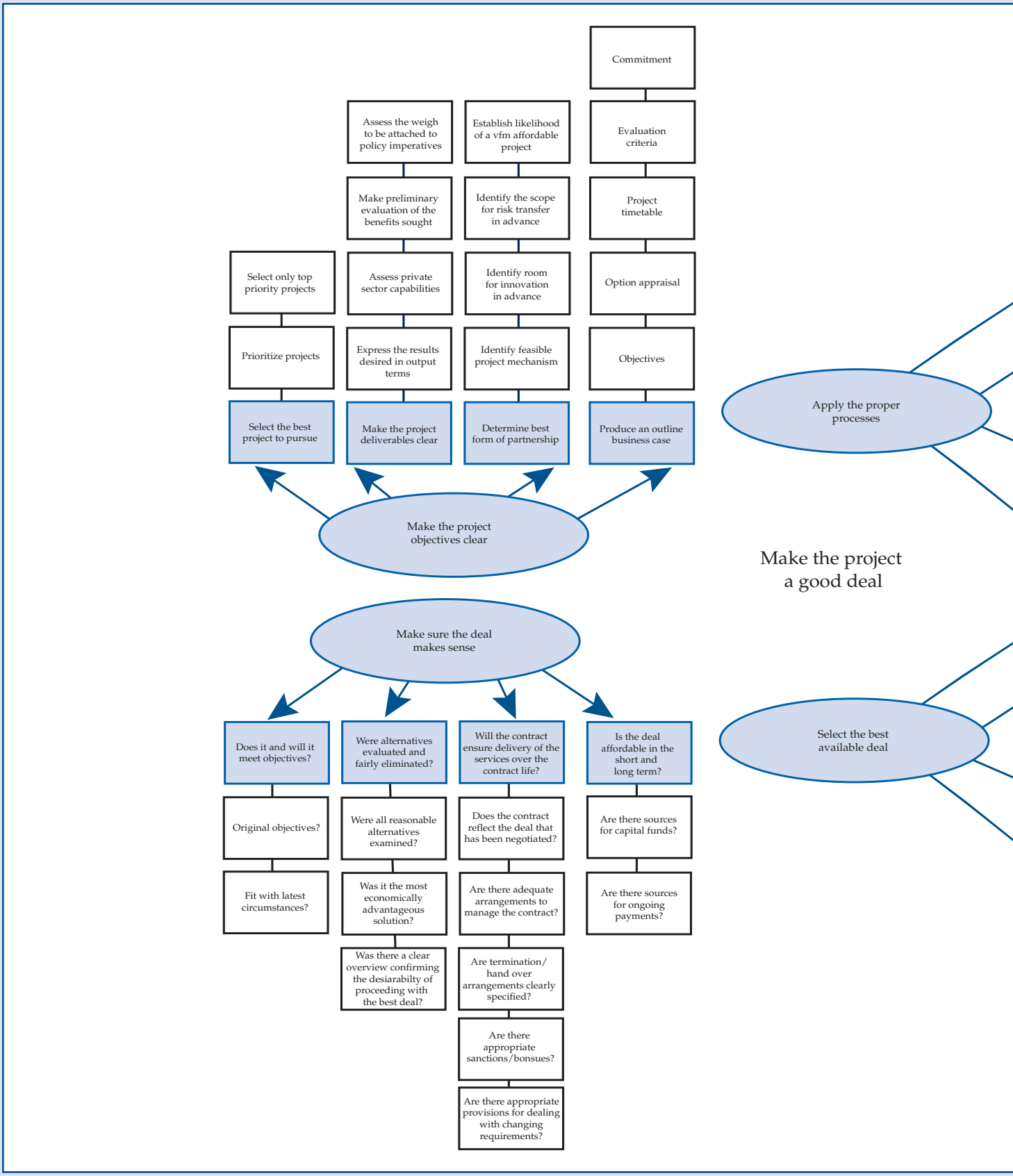
(Paragraph 4)

Draft Technical Note	Date of Issue	Report Ref
A Competence Framework for Creating Effective PFI Project Teams		
Case Studies		
Medium Support Helicopter Aircrew Training Facility PFI Case Study	August 1999	
Employment Service IT Partnership	September 1999	
Private Finance and IS/IT: Case Study TAFMIS	March 1998	
Colfox School, Dorset A Case Study on the First DBFO School Project	March 1998	
OSIRIS Private Finance and IS/IT Case Study for the Welsh Office		
Report on the Procurement of Custodial Services in DCMF Prisons		
DBFO - Value in Roads A Case Study on the first Eight DBFO Roads		
The IND Caseworking Program		
Scottish Health Service Management Executive, Ferryfield House, Edinburgh		
Lewisham Extension to Docklands Light Railway		
Lowdham Grange Prison Services		
Value for Money Report		
Value for Money Drivers in the Private Finance Initiative	17 January 2000	
A Report by Arthur Andersen and Enterprise LSE		
PFI Publications Produced by OGC		
PFI: Meeting The Investment		
Challenge	July 2003	
Amendments to Standardisation of PFI Contracts	April 2003	

Appendix 1 (continued)

(Paragraph 4)

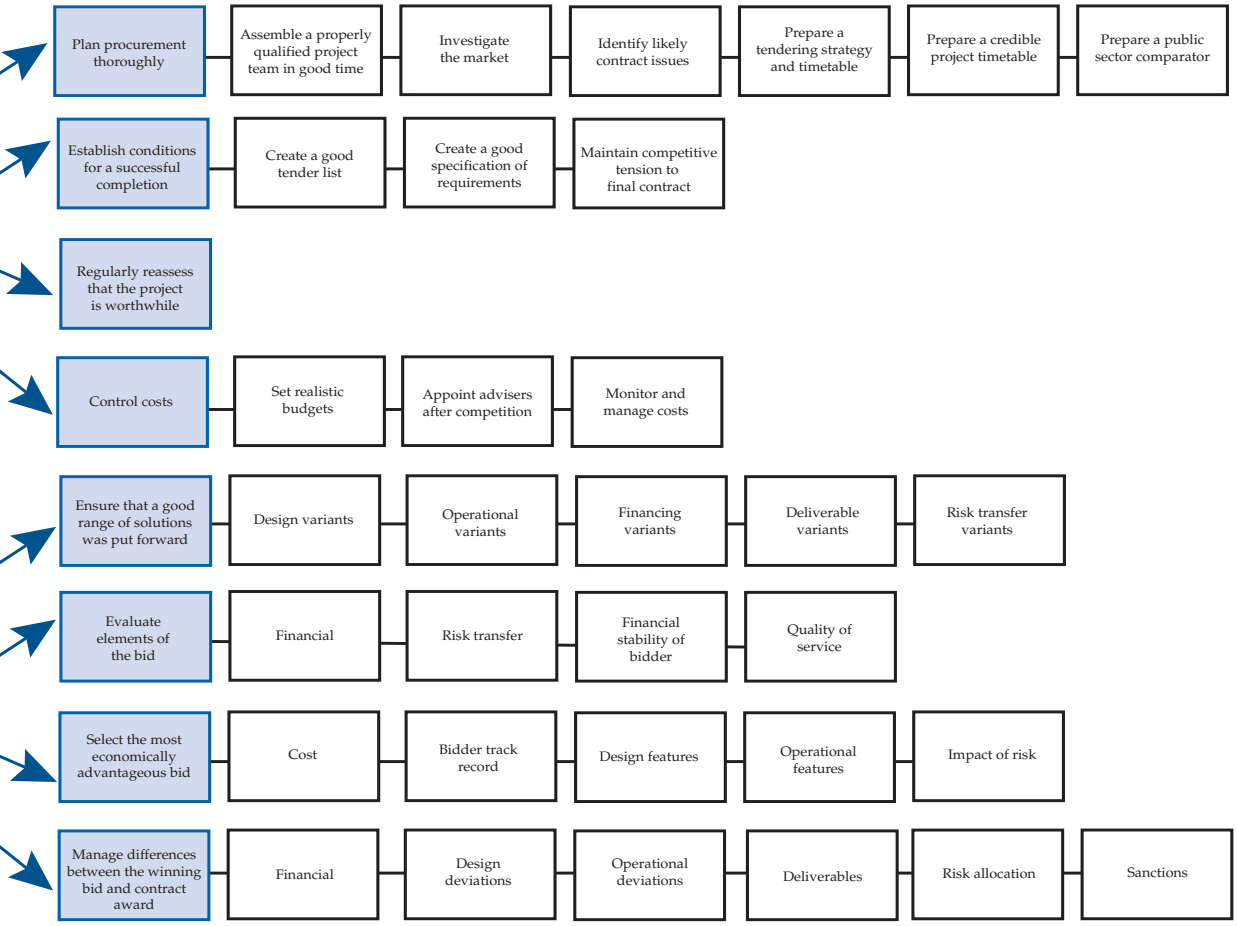
PFI Publications Produced by OGC	Date of Issue	Report Ref
Standardisation of PFI Contracts - Outstanding Issues	March 2003	
Opinion Letters	September 2002	
Project Review Group (PRG) Process and Code of Practice	Working document	
Project Review Group (PRG) Evaluation Framework Guidance to Reviewers		
Delivering Successful PPPs Video	October 2002	
Refinancing of Early PFI Transactions - Code of Conduct		
CABE - Improving the Standards of Design in the Procurement of Public Buildings	October 2002	
OGC Guidance on Insurance Issues	September 2002	
Green Public Private Partnerships	July 2002	
Guidance Note on Refinancing	July 2002	
Guidance on Certain Financing Issues	July 2002	


Make the project a good deal
Make the project objectives clear
Select only top priority projects
Prioritize projects
Select the best project to pursue
Assess the weigh to be attached to policy imperatives
Make preliminary evaluation of the benefits sought
Assess private sector capabilities
Express the results desired in output terms
Make the project deliverables clear
Establish likelihood of a vfm affordable project
Identify the scope for risk transfer in advance
Identify room for innovation in advance
Identify feasible project mechanism
Determine best form of partnership
Commitment
Evaluation criteria
Project timetable
Option appraisal
Objectives
Produce an outline business case
Apply the proper processes
Make sure the deal makes sense
Does it and will it meet objectives?
Original objectives?
Fit with latest circumstances?
Were alternatives evaluated and fairly eliminated?
Were all reasonable alternatives examined?
Was it the most economically advantageous solution?
Was there a clear overview confirming the desiarabilty of proceeding with the best deal?
Will the contract ensure delivery of the services over the contract life?
Does the contract reflect the deal that has been negotiated?
Are there adequate arrangements to manage the contract?
Are termination/ hand over arrangements clearly specified?
Are there appropriate sanctions/bonsues?
Are there appropriate provisions for dealing with changing requirements?
Is the deal affordable in the short and long term?
Are there sources for capital funds?
Are there sources for ongoing payments?
Select the best available deal

Appendix 2

(Paragraph 4)

The National Audit Office's Analytical Framework



Appendix 3

(Royal Hospitals, Paragraphs 1.2 and 1.5)

Strategic Assumptions on the Provision of Healthcare

1. In 1994, in light of the commencement of a new Children's Hospital and a proposed start in 1996 of a major construction programme, involving the building of a new hospital block and other work, the Royal Hospitals Trust appointed consultants to prepare an infrastructure development plan (car parking, landscaping, services) for the site. The plan was to be phased over seven years so that by 2002 the new vision of a modern efficient hospital complex would be complete. In preparing the plan, the consultants were asked to take account of expected significant changes in the way in which the Royal Hospitals delivered their services. These included a reduction in the number of beds from 1,100 to between 500 to 600; an increase in the number of day patients; and a new emphasis on professional teams in the Hospital going out into the community to deliver their services.

2. This reflected the prevailing strategic planning assumptions as set out in the Eastern Health and Social Services Board Strategic Statements of Purchasing Intent. These statements painted a clear picture of service reduction in the central Belfast Hospitals, with services transferring to the Lagan Valley, Mater and Ulster Hospitals. The preparation of the report was overseen by a Group chaired by the Hospital's Facilities Director and included representatives from the Department's Health Estates Agency.

3. The assumptions on which the plans were based were then overtaken by the DHSS sponsored Acute Hospital Review, the McKenna Report, which also concluded that Maternity Services should be provided on the Belfast City Hospital site. Following Ministerial review of that decision in 1997, after the car

parking contract had been signed, Maternity and related services (circa 150 beds, with very substantial outpatient and visitor activity) were to be provided on the Royal site pending further Ministerial review, rather than transfer to the Belfast City Hospital. This was confirmed in June 2003. Fracture services from Belfast City Hospital were also relocated to the Royal Hospitals in 1999 (circa 50 beds, with very significant increase in outpatient activity).

4. The cumulative effect of these events, alongside a review of the business case by DHSS, which concluded that a planned reduction of 100 beds in the original business case was not feasible, given changing clinical trends, was to see the site expand rather than contract over the period since the opening of the car park. In 1996 there was pressure nationally to move to more day patient care and to reduce the number of beds in acute hospitals. In the event, this proved to be unworkable.

Source: Royal Hospitals

Appendix 4

(Royal Hospitals, Paragraph 1.5)

Royal Hospitals: Patient Numbers

Year	Day case	Inpatient	Outpatient	Total Patients	Staff
1994-95	20,266	47,415	314,000	381,681	5,500
1995-96	20,380	48,094	318,000	386,475	5,400
1996-97	20,493	48,772	310,529	379,796	5,400
1997-98	21,583	48,158	304,936	374,681	5,400
1998-99	23,338	50,437	312,858	386,646	6,100
1998-99	23,505	49,865	317,746	391,116	6,100
2000-01	23,406	55,354	335,591	414,632	6,300
2001-02	23,992	53,526	333,827	411,344	6,400
Average Annual Increase	2.41%	1.74%	0.9%	1.08%	2.24%

Source: Royal Hospitals

Glossary

Benchmarking

The process of comparing the time or cost of an operation, service or product against those of other organisations, preferably thought to be the best in the field.

Conventional Finance

A construction contract in which the customer pays the contractor as the works are progressed. Such projects are fully paid for on completion. Maintenance is dealt with in separate contracts.

Discount rate

The percentage rate applied to cash flows to enable comparisons to be made between payments made at different times. The rate quantifies the extent to which a sum of money is worth more to the Government today than the same amount in a year's time.

Dispute resolution

A formal mechanism that can be invoked by either parties when an issue cannot be resolved through normal informal discussion.

Financial models

Spreadsheets designed to show the financial outcome of a particular set of estimated costs, revenues and fixed and capital charges for delivering a service over time.

Full business case

A working document that is used throughout the lifetime of the project which provides the final output specification and project requirements.

Force majeure

Events over which the parties to the contract have little control, but which could have serious impacts on performance of the contract. These may include war, terrorist attack and nuclear, chemical or biological contamination.

ITN - Invitation to negotiate
ITT - Invitation to tender

A formal communication to select suppliers.

Indicative bids

Prices which are set higher than perceived actual costs which are used as a basis for negotiation.

Objective

General statement of service required. Comprises deliverables, cost limits, risk transfer and benefits.

Output specification

Specified aspect of the customer's service requirements or performance specification, for which the customer sets minimum quality standards to be met by bids.

Outline business case

A document providing the initial output specification and service requirements as at the inception of the project.

Prequalification

The process by which organisations demonstrate their capability to tender for, and to carry out if selected, a project or class of projects.

Private Finance Initiative

A policy introduced by the Government in 1992, to harness private sector management and expertise in the delivery of public services.

Private Finance Initiative Principles

The allocation of risk and reward should be clearly defined and private sector returns should be genuinely subject to risk; and the contracts should represent value for money, taking into account the benefits of transferring risk to the private sector and the cost of that transfer.

Public sector comparator / Comparative public sector costs

An estimate of what the project would cost if traditional procurement methods were used. This is used to determine whether private finance offers better value for money than traditional procurement.

Risk

Hazard, danger, chance of loss or injury; the degree of probability of loss; a person, thing or factor likely to cause loss or danger.

Risk transfer

The passing of risk normally borne by the customer to the service provider.

Sensitivity test

Test of the impact on the value for money of bids of changes in the key assumptions underlying the customer's main value for money assessment.

Shortlisting

The first stage in selecting the successful bidder.

Traditional procurement

See conventional finance.

List of NIAO Reports

Title	NIA/HC No.	Date Published
2002		
Northern Ireland tourist Board Accounts 2000/01 Travelling People: Monagh Wood Scheme	NIA45/01	26 February 2002
Indicators of Educational Performance and Provision	NIA48/01	21 February 2002
NIHE Housing the Homeless	NIA55/01	21 March 2002
Repayment of Community Regeneration Loans	NIA59/01	28 March 2002
Investing in Partnership - Government Grants to Voluntary Bodies	NIA78/01	16 May 2002
Northern Ireland Tourist Board: Grant to the Malone Lodge Hotel	NIA83/01	20 May 2002
LEDU: The Export Start Scheme	NIA105/01	2 July 2002
Compensation Payments for Clinical Negligence	NIA112/01	5 July 2002
Re-Roofing of the Agriculture and Food Science Centre at Newforge	NIA24/02	17 October 2002
The Management of Substitution Cover for Teachers	NIA53/02	12 December 2002
2003		
The Sheep Annual Premium Scheme	NIA 75/02	6 February 2003
The PFI Contract for the Education and Library Board's New Computerised Accounting System	NIA99/02	20 March 2003
Areas of Special Scientific Interest	NIA103/02	27 March 2003
Financial Audtiing and Reporting: 2001/02	NIA 107/02	2 April 2003
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Investigaton of Suspected Fraud in the Water Service	HC735	26 June 2003
Management of Industrial Sickness Absence	HC736	1 July2003
Encouraging Take-up of Benefits by Pensioners	HC737	3 July 2003
2004		
Navan Centre	HC204	29 January 2004

Printed in the UK by The Stationery Office Limited on behalf of the controller of
Her Majestys Stationery Office
Dd 1085 C6 02/04

Published by TSO (The Stationery Office) and available from:

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www.tso.co.uk/bookshop

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ISBN 0-10-292523-2

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