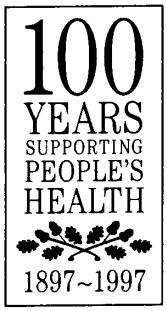
King's Fund

A Capital Conundrum:

The effect of the Private Finance Initiative on strategic change in London's health care

Richard Meara



A Capital Conundrum:

The effect of the Private Finance Initiative on strategic change in London's health care

Richard Meara
Meara Management Consultancy

For further information on Meara Management Consultancy please ring (01932) 863 924.

This report forms part of *The London Health Care System* study carried out for the King's Fund London Commission.

Published by
King's Fund
11–13 Cavendish Square
London W1M 0AN

ISBN 1 85717 164 0

A CIP catalogue record for this book is available from the British Library.

Further copies of this report can be obtained from the King's Fund bookshop.
Telephone 0171 307 2591

This report has been produced to promote dissemination of good practice and quality improvement in health and social care.
It has not been professionally copy-edited or proof-read.

Table of Contents

Acknowledgements

A large number of individuals in NHS purchasers and trusts in London were consulted during the course of preparing this report. The author would like to thank them for their invaluable help without which the document could not have been written.

Section 1

Introduction

1.1 London Commission

This piece of work has been commissioned by the King's Fund London Commission as part of a range of work being undertaken to revisit the needs of London's population for health care and progress in changing the pattern of health services in the capital.

1.2 Aims

The aims of the study have been:

- to define capital schemes (over £10 million) in London that support major service rationalisation;
- to identify the financing approach being adopted and the structure of the consortia established to handle schemes;
- to gather together, as far as possible, information about scheme content and timescale;
- to explore the management experience of some of the schemes in more depth;
- to link information about process and timescale to plans for service and revenue resource change;
- to consider the implications of the PFI (Private Finance Initiative) approach, as identified in the above, for the overall management of service in London in particular to identify where it may create incentives or opportunities for new forms of physical provision;
- to draw conclusions about the overall impact of the PFI and make appropriate recommendations.

1.3 Method

The study has been implemented through:

- a review of the limited literature available, mostly in the form of journal articles. A summary list of the most useful documents consulted is given in Appendix C;
- meetings with staff in the trust units of the NHSE North and South Thames, and with purchasers and providers in London. These usually involved site visits.

In all cases managers have been helpful and have provided useful information about the process being adopted and the problems being encountered. This is a potentially sensitive and controversial area and the author is grateful to all the participants for their time and their candour.

It should be clear that any interpretation and conclusion on the basis of the facts given is entirely that of the author of this report.

Section 2

Making London Better

2.1 A Strategy for London

The report Making London Better was produced in February 1993 as the government's response to Professor Bernard Tomlinson's report which had drawn on the wide ranging work done by the King's Fund London Commission and by numerous earlier reports.

The four main elements to the strategy outlined in Making London Better were:

- developing higher quality, more accessible primary and community health services;
- providing a better balanced hospital service on fewer sites;
- rationalising and developing specialist services;
- merging London's medical schools with multi-faculty colleges of the University of London.

The second and third elements were crucial to the aim of releasing fixed costs.

2.2 Implementation

There has been significant activity over the subsequent 3-4 years to take this agenda forward, in terms of investment, management action and service rationalisation. 'Politics' has ensured that the precise proposals have in some cases been altered but there has been some consistency of direction secured in part by the London Implementation Group and now by North and South Thames Regional Offices, and in part by the recognition even from the most sceptical players that the status quo was simply not an option. Experience to date has however highlighted the intense political difficulties associated with closing whole sites or A&E departments - witness the experience at Guy's, Edgware and Dulwich. There are, therefore, a number of broad areas of concern which this report aims to highlight.

2.3 Key Issues

1	After all the analysis, public consultation, brave ministerial decision taking and organisational mergers, the majority of actual change (i.e.. service rationalisation and site closure) remains dependent on PFI schemes.
2	In anticipation of the above change, the majority of London acute trusts are supported by transitional funding of one sort or another. This money is short term and insecure.
3	Investment in improving primary care via LIZ funding is also time-limited. London health authorities are just beginning to face the financial pressure of picking up ongoing costs from this initial investment.
4	It is likely that there will not be enough major whole site closures to bring about the urgently needed reduction in fixed costs. Whole site closures have been agreed for St Bartholomew's and Middlesex hospitals, but Charing Cross was reprieved early on and part of the Guy's site will continue to provide a range of lower-tech services. A considerable number of smaller site closures hang upon the completion of major PFI schemes. Site closures are taking too long to occur, partly because of the consultation process involved and partly because they are predicated on investment in new assets. London purchasers advised the author that they are wasting money because too much of each purchasing pound is being spent on the fixed costs of a multitude of scattered ageing buildings. London hospitals are failing to cover these costs from the income they generate and are having to be supported by transitional funds.
5	It could be suggested that there has been too much emphasis on financing improvements to GP practice premises and too little on a new range of intermediate care centres which would be London's community hospitals of the future. These centres would focus on rehabilitation services, primarily for older people and for those with chronic long-term conditions; and could also act as resource centres, therapy bases, and as sites for developing extended primary care teams. Such centres, working under both GP and consultant protocols, would have a major role in enabling the acute general hospitals to function effectively with fewer beds.
6	Specialty rationalisation has been slow, and in some instances has stopped. The only conclusion to be drawn is that powerful vested interests have been able to frustrate some of the objectives of the specialty reviews. In many cases early or partial rationalisation was possible without major capital investment, but there have been failures of clinical teams to merge effectively and to agree common operational policies. Many of the PFI schemes do not address specialty rationalisation at all.

2.4 Clearing the Way Forward

This report focuses on the Private Finance Initiative as a vehicle for achieving agreed change in acute hospital services in London.

The PFI is also being used to help achieve the primary care agenda, through smaller scale projects funded by London Implementation Zone money; and to achieve the rationalisation of medical education through schemes developed by the colleges with the Department of Education and Higher Education Funding Council of England. Health authorities have struggled to make the PFI work for primary care schemes, but there are more opportunities in the

education sector for income streams to be generated for private sector partners. For some of the London schemes the inter-relationship between health care and education is crucial. However, the legal status and funding arrangements of universities are different and are not further explored in this report. Some reference is made to these schemes later but acute hospitals are the main focus.

Section 3

The Context for PFI

3.1 Press Coverage

Newspaper headlines in the business and professional press during 1996 have been peppered with bad news headlines about the Private Finance Initiative:

- *"Governments PFI message falls flat"*
- *"Bid to save Private Finance disaster"*
- *"Laing pulls out of race for NHS hospital"*
- *"Builders deal a further blow to PFI"*

It has been hard to find a positive note in any of the comment or articles written, save in the press releases issued by the Department of Health when major PFI schemes were *'given the go-ahead'* by Ministers.

For an initiative that has as yet delivered so little in terms of tangible change and that has had a relatively short life, it is remarkable how much importance is placed on its success and how central it has become to the plans of health service providers and to the working lives of managers and clinicians.

3.2 PFI Launch

It was in his 1992 autumn statement that the Chancellor announced new provisions which allowed that 'where the private sector assumes substantial risk privately financed spending will not count against the PSBR.' This reversed the Ryrie rules of 1981 which set the policy that such privately funded schemes should not be additions to public funding but that public expenditure should be reduced by the level of private finance obtained for a planned public sector project.

The PFI was thus launched in 1992 with the objectives of:

- enabling the public and private sector to work more closely together;
- providing the means by which the private sector can genuinely assume risk;
- ensure projects deliver value for money.

Within the changes joint ventures were encouraged, leasing of assets (under operating leases where the majority of risk lay with the private sector) would not count against NHS trust's

external financing limits, and private provision of services was encouraged in order to help finance capital intensive projects and take them off balance sheets.

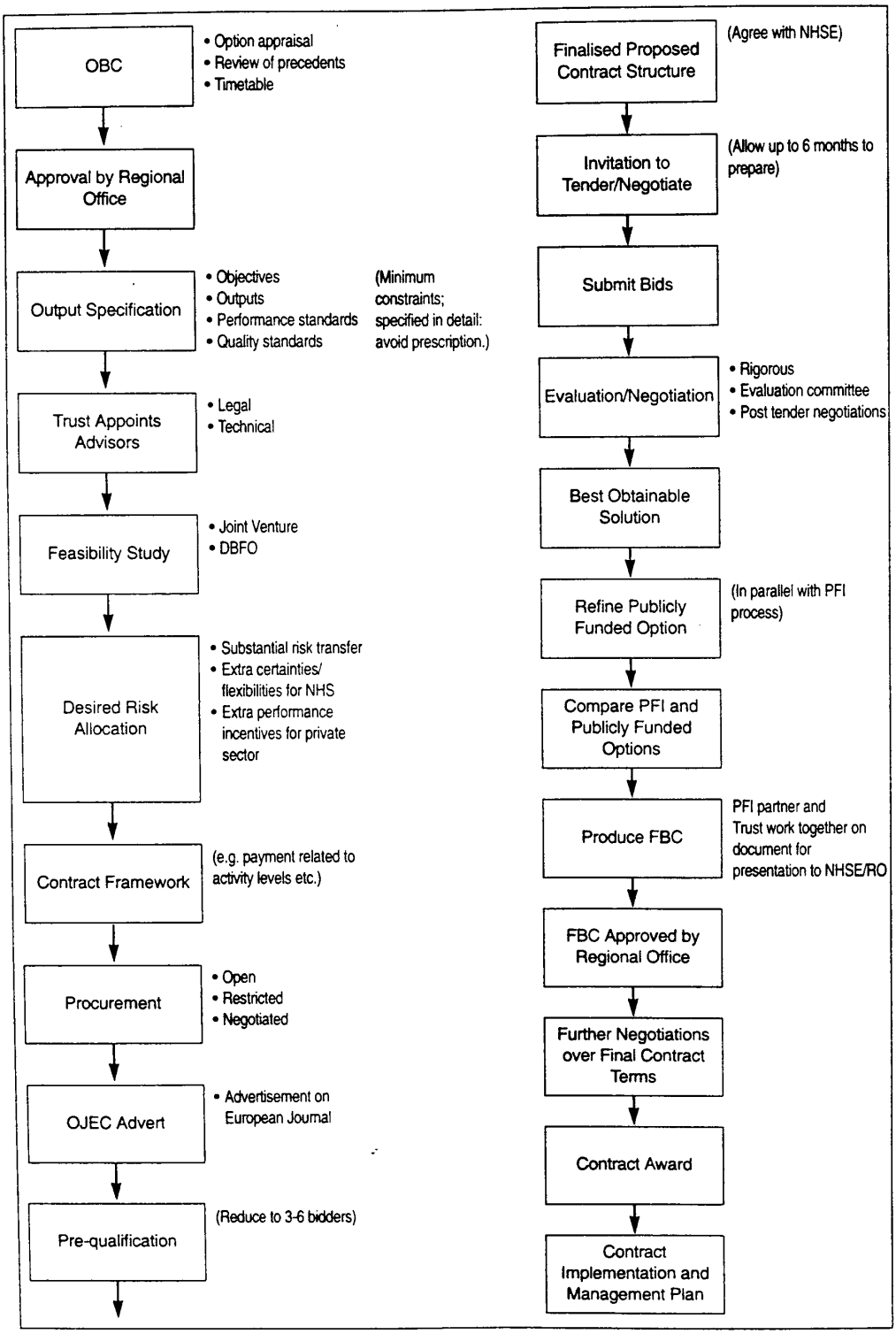
The importance of the PFI in the NHS only became clear gradually. By 1994/95 managers realised that conventional sources of funding, at least for major schemes, were becoming virtually extinct. Many capital schemes were already some way advanced down the planning process under the existing Capital Investment Manual framework. Managers became aware in 1994 and 1995 that the status of any 'approvals' already obtained had changed with the requirement to test all capital schemes for PFI suitability. Thus what were thought to be full business cases reverted overnight to outline business cases and trusts were required not only to explore the private sector funding option but often to restate what the scheme was planned to achieve in less prescriptive and more 'output based' ways.

One of the familiar experiences, in NHS terms at least, has been the way the policy skeleton has been fleshed out over two or more years as managers have tried to implement it. There has been some further policy guidance from the centre, particularly in HSG(94)31, HSG(95)15 and HSG(95)38. These circulars began to define the PFI process, and its difference from the conventional Capital Investment Manual route; and set out European Union directives on public sector purchasing. The NHS private finance unit has also been set up to disseminate experience and good practice. By late 1996 it had yet to produce updated guidance on best practice and the head of the unit admitted there was disagreement over whether to publish anything at this stage. Model documentation was promised and a database of good and bad scheme precedents. In the main both NHS managers and private sector companies have learnt the details by doing, and most of the rules and understanding about the process has been made up as implementation unfolded.

HSG(95)15 set out the stages involved which can be converted into the diagram on page 8. In practice most of the work on risk allocation is now undertaken at the time of the 'invitation to negotiate', and the contract framework has followed the ITN. That period has been divided into a preliminary 'invitation to negotiate' stage and a 'full invitation to negotiate' stage at which only those companies on the final shortlist of 1-3 firms are involved. Finalising the contract has only been carried out at 'full business case' stage.

At the time of writing this report many London trusts were in the final run up to production of the full business case. They faced considerable uncertainty over what would happen next and how long it would take. Most of the advanced major PFI schemes were facing months of unanticipated delay between approval of the FBC and final contract sign off. Again, lessons were being learnt from practical experience, and it is likely that in future the FBC will be approved in stages (e.g. overall strategy, contract framework, payment mechanisms, risk transfer

PFI Process (from HSG(95)15)



etc.) so that final contract signing follows on soon after the final bits of the FBC are approved (the 'series of green lights' from the Treasury approach).

3.3 The Treasury Committee's Verdict

The House of Commons Treasury Committee on PFI produced their most recent report in April 1996. Their chief concerns were:-

- whether the PFI was in practice providing additional or substitutional investment for the public sector;
- how the Treasury proposed to monitor overall PFI commitments and the cumulative effect of their long term revenue streams;
- whether the private sector faced unacceptably high bidding costs and unreasonable risk transfer under the PFI;
- the lack of clarity or changing nature of objectives in some NHS projects, which made the goal posts move as project planning proceeded;
- the need to introduce substantial facilities management deals as an integral part of viable PFI bids with the risk that this could lead to the 'tail wagging the dog' with schemes being structured around an adequate facilities management component rather than service need.

The committee's implied conclusion was that PFI investment was proving to be substitutional rather than additional; this has been confirmed in the report on 'Capital Allocation' in September 1996 by the Capital Review Group which was set up by the NHS Executive to review the system (see Appendix C).

3.4 Adam Smith Institute Report

The issues of excluding smaller inappropriate schemes, of bidding costs and of the lack of clarity in NHS specifications were taken up in a publication in mid 1996 by the Adam Smith Institute titled 'Seize the Initiative'. This examined implementation of the PFI across all government departments but was particularly critical of the track record of the NHS. In particular the authors criticised:-

- the tendency of NHS trusts to constantly reinvent the wheel;
- complexity and confusion of decision making between trusts, health authorities and regional offices;
- poor project management skills;
- production of over prescriptive specifications;

- vested interests hostile to the concept of PFI.

The report made much of the higher cost burden on contractors of tendering for PFI projects over and above conventional methods. PFI tendering costs also tended to increase as a percentage of the total project cost rather than to decrease as under other procurement methods. This led to the authors' recommendation that bidding costs should be reimbursed in full if a project was pulled by the client. Such an unrealistic proposal reflected the partisan stance of the report which was relatively uncritical of the private sector's performance in the PFI process to date.

The report, however, was right to identify the problem of too many schemes having to be considered for PFI funding. The issue was in part one of capacity - "Companies are simply running out of people who can put together these sorts of projects, which are all different and need different risk evaluations." In part it was also one of a failure to discriminate so that effort could be concentrated where there was realistic chance of success. It may be that NHSE regional offices will have to take a more interventionist route in conjunction with their purchasers.

It was becoming clear during 1996 that there were some service specifications where it was extremely difficult for the private sector to assume appropriate risk and find ways of making the required return. These tended to be smaller size projects which required a mix of dispersed small scale buildings and refurbishment. The Adam Smith report recommended abolition of the blanket rule that all projects should be tested against PFI options and that a database of projects deemed unsuitable for PFI should be created so that lessons could be learnt across and between sectors.

Andrew Neil, head of the NHS PFI unit, recognised the frustrations felt by both clients and contractors at the length of time it was taking to sign contracts for the larger deals. At a conference in September 1996 he stated that 50 deals of between £1M and £10M had been signed, featuring MRI scanners, primary care centres, car parks, waste management etc..

At that point there were 27 large schemes at preferred bidder stage. Andrew Neil echoed a theme of the Adam Smith Institute publication when he indicated that a database of precedents was being created to help identify potentially successful and unsuccessful schemes. He was, however, unable to advise when updated guidance on the PFI process and on best practice would be published by the NHS Executive.

With hindsight there is no doubt that both the private sector and the NHS underestimated the complexity of the PFI process and the length of the preparatory planning stage. The development of output based specifications and the handling of risk analysis and transfer have been new experiences for NHS trust managers; strategic service planning remains poorly developed, particularly by purchasers, and capital led planning is still all too common. The private sector,

on the other hand, is in many cases woefully ignorant of the way the NHS works and of the operational issues relating to the management of NHS facilities and services. Several of the NHS clients in NHS trusts in London who were interviewed in the course of this study expressed concern at the failure of the consortia to 'get their act together' because of poor project co-ordination on the private sector's part. Much has been learnt during these first years but so far has been poorly disseminated. Much remains to be learnt.

3.5 Key Issues

1	The PFI has begun to substitute private sector capital for conventional Treasury funds. Exchequer funds will have diminished by 22% between 1994 and 1999; if the PFI works and if property sales contribute the forecast sums, overall growth in capital expenditure over the same period will be a mere 3%. If the PFI fails to deliver its full promise and if capital receipts are more sluggish than expected then the picture for investment in health service assets over the next few years is grim.
2	There is widespread, if tacit, agreement that there is little prospect of growth in Treasury capital for the NHS whichever political party is in power to the millennium. The conventional capital that will be available to trusts through their block allocations and for conventionally funded larger schemes will be needed to deal with backlog maintenance of existing assets and for smaller scale equipment replacement. In other words, there is no alternative to the PFI in some form and thus it must be made to work.
3	The objective of the PFI should be made clearer, both to NHS trusts and to the private sector. The Minister of Health, John Horam, said at a national conference in September 1996:- *"If the PFI just replicates what the public sector option would have done then we will have missed a large part of the objective of the policy."* The Adam Smith Institute paper called for a policy restatement, 'that the PFI is not just about financing, but is about new and better public service provision. This report goes even further and proposes that the problem with the initiative so far is that it has mainly been seen as a way of building buildings. What it should be is a means of radically re-engineering the delivery of health care, in which building design is only one element. This theme will be explored later in the report.
4	The NHS lacks project management skills for major investment and change management tasks. NHS managers have traditionally approached the handling of such projects by adding them on to the duties of existing members of staff. This guarantees sub-optimal delivery, slipped deadlines and frustration for private sector partners.
5	The PFI does not seem to be best suited to investment and change programmes which involve refurbishment and upgrading of existing assets rather than new build. Some way should be found to make such schemes attractive to private sector investors. There is real danger that the PFI will drive the NHS into larger scale and more rapid investment in fixed assets than ever before where the increased revenue costs of servicing those assets will not be covered by either disposal of worn out stock or by greater efficiencies in maintenance and facilities management.

6	There needs to be more discussion about, and wider understanding of, risk handling in PFI schemes. In the early days of the initiative this was viewed by the NHS as 'risk transfer', which implied that commercial risk could simply be moved en masse from the public to the private sector. In some of the schemes examined in this report it is surprising how late in the day there has been detailed analysis of risk and of which party will bear how much of what. There may also be a central problem regarding the reluctance of Treasury officials to make the VFM rules flexible enough to recognise that the private sector needs to charge a premium for accepting some risks.

Section 4

The Key London Schemes

4.1 Critical Schemes

The following rationalisation schemes which require investment through the PFI are examined in this report:

1	Greenwich Healthcare	Development of Queen Elizabeth Hospital site
2	Guy's and St.Thomas'	Create acute and tertiary care centre at St Thomas' and planned care centre at Guy's
3	King's Healthcare	Reinvestment in King's site
4	Royal Hospitals	CO-locate four hospitals plus elements of a fifth on the Royal London site
5	University College London Hospital	CO-locate four hospitals on one site
6	Wellhouse	Redevelopment of Barnet General Hospital

The chart on page 14 shows these schemes in more detail. They have been chosen as examples of critical schemes for facilitating major change in London in line with Making London Better.

There are also other PFI schemes in progress across greater London which involve some site rationalisation. At autumn 1996 these included:

1	St George's Healthcare	Provision of neurosciences and cardiac surgery facilities in place of existing outdated provision and on transfer from Atkinson Morley's Hospital. Also implies changes in service in Sussex.
2	Hammersmith and Queen Charlotte's	Reprovision of services in purpose built unit on Hammersmith site and closure of Queen Charlotte's
3	West Middlesex	Redevelopment of the overall site with closure of small peripheral unit.
4	Newham Healthcare	Absorption of services from St Andrew's Hospital onto the Newham DGH site and closure of St Andrew's
5	Dartford and Gravesend	Reprovision of Joyce Green and West Hill hospital services in new hospital on Darenth Park site.
6	Bromley Hospital	Reprovision of Bromley and Orpington hospital services onto the Farnborough Hospital site
7	St Mary's Hospital	Internal service upgrading with ultimate closure of Samaritan Hospital.

Thirdly, there are other PFI projects being pursued which involve the development or upgrading of specialist services and facilities within the existing site envelope, such as the cardiac catheterisation scheme at Hammersmith, the haemato-oncology and diagnostic imaging centre

Major London PFI Schemes

NHS Trust	Greenwich Healthcare	Guy's and St.Thomas'	King's Healthcare	Royal Hospitals	University College London Hospitals	Wellhouse
Host Purchaser	Bexley and Greenwich HA	Lambeth Southwark and Lewisham HA	Lambeth Southwark and Lewisham HA	East London and the City HA	Camden and Islington HA	Barnet HA
Scheme	Development of Queen Elizabeth Hospital site as acute general hospital for Greenwich	Create acute and tertiary care centre at St.Thomas' and planned care centre at Guy's so that sites are complementary	Reinvestment in King's site to improve quality and operational efficiency	Co-locate four hospitals on the Royal London site	Co-locate four hospitals on one site	Redevelopment of Barnet General Hospital and dispersal of caseload from Edgware General Hospital
Cost	£35m	£92m	£79m	£240m	£115m	£50m
Hospital Sites to Close	The Brook (closed) and Greenwich DGH	No total closure but a large part of the Guy's site will be vacated	Dulwich Hospital (part)	St Bartholomew's London Chest Queen Elizabeth, Hackney	Middlesex Hospital Elizabeth Garrett Anderson/Soho Hospital Hospital for Tropical Diseases	Part of Edgware General site
Saving	Cost of LIG support and Greenwich HA loss of income	Cope with reduction of 7% in elective and 5% in non elective work	c. £8m of value benefit	c. £30m	c. £20m	c. £12m
Objectives	• Develop QEMH site • Close/dispose of Brook site • Close/dispose of Greenwich DGH • Provide residential accommodation • Overall reduction in beds	• Creation of women and children's centre, cancer centre and renal centre at St. Thomas' • Refurbishment and adaptation at St.Thomas' • Creation of planned care centre at Guy's • Outpatient and patient hotel at St.Thomas' • Disposal of part of Guy's site to King's UMDS • Dispose of Lambeth Hosp. site • Reduction in FM service costs • Development of private patient services • Overall reduction in beds	• Centralise services on one site • Create internally configured site based on patient focused and 'transformation' principles • Close Dulwich site • Overall reduction in beds	• Develop Royal London site at Whitechapel • Close St.Bartholomew's, Q.E.Hospital for Children and London Chest hospitals • Redesign patient flows within the new hospital • Create more flexible in-patient accommodation • Overall reduction in beds • Relocate some services from Mile End Hospital to Royal London site • Integrate clinical/teaching/ research campus	• Develop single site • Close Middlesex, EGA/Soho and Hospital for Tropical Diseases sites • Provide flexible facilities that are accessible to patients and in one place • Enable Co-location of women's services • Overall reduction in beds	• Complete redevelopment of Barnet General • Transfer of services from Edgware General • Possible closure of part of Edgware site • Overall reduction in beds

scheme at the Royal Marsden Hospital and the cluster of site rationalisation schemes at the Whittington Hospital.

The fourth group of schemes being pursued via the PFI route are the primary care and community services schemes. Among these are a number of LIZ underwritten projects, and they cover a wide range of provision including GP premises, community clinics, mental health units and intermediate care centres.

4.2 Defining the Objectives

A summary of the objectives of the core PFI schemes is included in the table on page 14.

Most Full Invitation to Negotiate (FITN) documents contained considerable detail of the objectives of the scheme. Those contained in the King's Healthcare document are set out below as an example.

Investment Objectives		
Strategic	**Operational**	**Design**
• To be a major provider of acute healthcare and specialist services.	• To satisfy in all years volume and quality demands across acute and specialist services.	• To offer convenience, patient recognition, privacy and ease of access.
• To provide services based mainly in one hospital with some outreach.	• To improve accessibility and patient focus.	• To enhance staff well being, security, communications and facilities.
• To centralise services on the Denmark Hill site.	• To satisfy purchaser requirements for quality.	• To minimise the life cycle cost of facilities.
• As a university teaching hospital to push back the boundaries of clinical and management expertise.	• To enable the trust to price competitively.	• To enable healthcare to be delivered in an efficient and effective manner.
• To focus on the patient using an integrated care team.	• To provide teaching capacity for 110 medical, 60 dental and 125 postgraduate students.	• To improve the estate to achieve flexibility and scope for increased use of technology.
• To make patient convenience primary.	• To meet the educational and training needs of doctors and dentists.	• To provide an environment to enhance the trust's image.
• To create a unified organisation and corporate culture.	• To provide research facilities in proximity to clinical services.	

Several of the FITN documents provided diagrams which described the functional relationships the trust was looking for in design solutions. Appendix A contains examples of these diagrams. They illustrate the information that was being provided to the consortia and the considerable thought that had gone into defining outputs in design terms without over-specifying.

In all cases the trusts had gone to considerable lengths to involve their professional staff in the specification process. At the Royal London Trust, for example, 15 working groups had defined the requirements, under the following headings:

Front end	Therapy services
Research	Organisational structure
Teaching/training	Building environment
Ward accommodation	Staffing
Clinical futures	Community communications
Balancing emergency and elective admissions	Patient services
Private beds	IM &T
	Finance.

The private sector consortia had access to the work of all these groups in order to help them prepare their proposals. As a result of similar openness in many cases consortia members have been able to get close to staff in the trusts, particularly clinicians, and to work up proposals that met their visions of the future.

Some trusts commented that they had made great efforts to provide information and access to consortium members, but that bidders seemed at times to struggle to get to grips with the volume of information available because of an apparent lack of experience in projects of this type and complexity.

It is difficult to see how any such major initiative could be undertaken without involvement of the professional users but some trusts seem to have tried harder than others. As an aside, there appears to have been much less effort made by trusts to try to establish what patients or the local community want from a 're-engineered' hospital, although the Royal Hospitals Trust has a structured plan to do so in early 1997.

There is, however a downside to such a participative approach which may yet become obvious when health authorities finally consider the affordability of the schemes. Most consortia members do not know enough about the technicalities of healthcare to argue the toss with clinicians and most are eager to show their ability to respond to requirements with innovative solutions. The result may be:-

- over-specified and over engineered provision;
- sub-optimal space utilisation;

- a radical move away from the lower cost standard solutions of the 1970s and 1980s which were represented by the Nucleus approach to building design and construction.

4.3 Bed Reductions and Revenue Savings

Two key objectives of major capital investment in London post-Tomlinson are to enable money to be taken out of the system to reflect the loss of workload coming into the city; and linked to that to reduce the overall bed complement. The table on page 18 shows the extent to which this is planned in a number of key schemes.

4.4 Scheme Inflation

The evidence from the schemes on the drawing board is that there is a trend towards building much larger schemes that would have been the case under conventional exchequer funding. This is not explained purely in terms of providing all the required functionality in one phase rather than two or three. The following are examples of 'scheme inflation':

Scheme	PFI Solution	Previous Exchequer Solution
Wellhouse Phase Ib	£50m	£40m
West Middlesex Rebuild	£50m	£12m
South Bucks DGH	£40m	£30m
Greenwich Queen Elizabeth Hospital	£86	£35

In mitigation it has to be said that one is often not comparing like with like, in that PFI has been used as an opportunity to extend the scope of the scheme. Nevertheless there are other factors at work such as:-

- the preference of banks to fund new stand-alone buildings rather than refurbishment;
- the willingness of consortia to build higher quality buildings and then (in theory) to save on whole life cycle costs;
- the pressure from clinical staff to 'go for broke' in content terms on the basis that they will not get another chance like this for a generation or more;
- the competitive factor in the bidding process which encourages 'innovation' that will help trusts compete in the health marketplace, but which may actually result in increased cost.

Bed Reductions and Revenue Savings

No	Trust	Scheme	Bed Reductions planned		Revenue Saving/Cost Reduction
			Original Complement	Planned Complement	
a)	Greenwich Healthcare	Merger of Greenwich DGH and the Brook services onto QE Hospital site	779	621 (FBC figure)	Saves large amount of LIG funding and compensates purchaser for reduced income. Overall reduction in cost of 12%
b)	Guy's and St Thomas'	Concentration of emergency/specialist work onto St Thomas' site, and reduction in size of Guy's site	Reduction of c. 250 beds		£28m annual revenue savings and a price reduction of 8-10%
c)	King's Healthcare		-	-	c. £8m of value benefit (i.e. extra work without price increases)
d)	Royal Hospitals		Reduction of 200-300 beds from current 5 sites but this cannot all be attributed to the PFI scheme.		£30m annual revenue savings
e)	UCLH		702	597 (revised OBC figure)	c. £20m annual revenue savings
f)	Wellhouse	N/A	-	-	N/A

Note: **Reference to actual revenue savings is open to considerable interpretation. Most savings targets include at least abolition of the current level of transitional support. They may also include savings which purchasers require to meet capitation reductions, as well as cash releasing savings to meet service developments. Given the timescales involved the difficulty is disaggregating savings which are dependent on the PFI scheme from those which can and will occur without it.**

Trust managers interviewed during the course of this study indicated concerns over scheme inflation and a recognition that it would mean costs would have to be cut back once they got together with their purchaser to look at the overall affordability of the scheme. There were some signs in late 1996 that this was indeed happening and that PFI schemes were being scaled down simply to make them affordable.

4.5 The Purchaser's Role

London purchasers expressed open concern at the scope of some of the schemes which were emerging. In most cases they were not directly involved in negotiations with the consortia and were therefore only indirectly able to influence detailed scheme content. A number of purchasers thought their role was solely to define overall strategy, agree caseloads and sign off the business case, but pointed out that their 'back seat' position was a major weakness as schemes changed markedly between outline and full business case stages. Others felt uncomfortable at the gap in between these events, stated that in some cases consortia seemed reluctant to come to see the purchaser, found themselves having to sign up to a fait accompli where they did not fully understand the rationale behind some of the FBC conclusions, and lacked a precise understanding of the likely revenue availability to support them.

4.6 Strategic Plans

A key concern highlighted by this study is the question of how far major investment decisions in London are based on sound purchaser strategic plans. Several London purchasers expressed concern that their acute service strategies, which were produced about 1993 or 1994, badly needed revisiting. Some strategies were actively being rethought in late 1996 in parallel with the approval processes for PFI schemes. The reasons for doing this included:-

- continued loss of their purchasing income base;
- sharp rises in some acute service costs such as ITU and drug therapies;
- huge increases in costs of providing services for mentally disordered offenders;
- increased emergency caseloads and tertiary/specialist referrals.

None of these factors challenges the need for service and site rationalisation: indeed, they suggest that it is not going to go far enough, and that too much compromise and political concession was made in the decisions that have already been taken.

In south London, for example, the acute services strategy of Lambeth, Southwark and Lewisham in 1993 concluded that only two acute general hospital sites were needed for the local

population, but conceded that a third might be justified because of the inflow of commuters. Following extensive consultation, even though the Guy's site will in future provide a more limited range of services, the health authority are still having to plan to purchase services from four major sites.

East London and the City Health Authority remains committed to the rationalisation of four sites into one. Their acute services review is currently examining the size of the development that can be afforded at the Royal London site at Whitechapel. This might lead to a larger or smaller facility at Whitechapel. What is surprising is that it is being carried out at such a late stage in the PFI process.

4.7 What are Purchasers Committed to?

The second area of concern is whether there is clarity over exactly what purchasers are signing up to when they commit to the full business case. Although the purchasers are not signing the contract with the consortium, they are endorsing the trust's decision to do so (given Treasury approval). Does this prevent purchasers from changing referral patterns in the future? How will they cope with fluctuating allocations in future years? What will the effect be of a large proportion of a trust's costs being tied up in regular cash flows to their consortium? How will this affect the ability of trusts to deliver cash releasing cost improvement programmes over future years? The answer to some of these questions is not clear. It remains the case at present that the majority of purchasers sign one year contracts with their acute providers, and they can change the content of these contracts every year.

4.8 Consortia Role in Shaping the Plan

One of the opportunities missed by the private sector consortia has been their failure to become involved in challenging and shaping the service planning that underpins the statements of need for the major schemes in London and elsewhere.

Host purchasers have been involved in defining the caseloads which they forecast they will want to purchase at the millennium from the acute providers. These are variously defined in the OBC, FITN and FBC documents as strategic demand forecasts, activity modelling etc., and appear to be presented more as the work of the provider than the purchaser. This is partly because providers, have done their strategic market analysis, have added to that core requirement the work that they believe they can continue to provide to minority and more distant

purchasers, as well as the requirement for tertiary care. The table below gives some examples of the figures presented:

Strategic Demand Forecasts			
Trust	Total FCEs		Comment
	1995/96	2001+	
UCLH	49,191	48,801	2001 figure increased at purchasers' request.
Guy's/Thomas'	91,967	91,632	Figure hides loss of secondary and gains in tertiary work.
King's	61,500	63,700 78,200	Pessimistic forecast Optimistic forecast
FCE figures include non-elective, secondary and tertiary elective work			

Providers have then agreed strategic performance targets with their purchasers relating to throughput per bed, work to be done on a day case basis, and possibly the split between longer stay and 5 day stay wards. From this work the size of the facility is determined and set out in the outline business case.

Benchmarks have been set differently from one scheme to another, and it is in this area that the enterprising consortium could commission its own work, with the aim of setting more ambitious targets, re-engineering service delivery processes and offering the smallest size of scheme consistent with the project objectives.

Such an approach supplementing the public sector comparator would also enable the purchaser to be drawn back into the sizing and design process at an earlier stage through a dialogue between purchaser, provider and consortium representative.

4.9 Key Issues

1	Achievement of the goals of the Tomlinson report and of 'Making London Better' is wholly dependent on a handful of major PFI schemes which have yet to be approved. Even if approved by spring 1997 none of the schemes will be completed and delivering the service benefits and cost savings until at least 2000. Can transitional funding or its successor be maintained until then?
2	The primary care plank of the 'Making London Better' strategy is also dependent on PFI for its success. Many of the schemes fall into the £0.25m to £2m range and purchasers manage the PFI process. Some have found it difficult to interest the private sector in such schemes; often those that are being developed are based on rental agreements where the requirement of risk transfer will be difficult to demonstrate. Sites are difficult and expensive to acquire; and it remains unclear what source of funding will sustain premises development in the longer term after LIZ funding dries up.

3	There is a need to reappraise the acute strategies produced by London purchasers which are in many cases over 3 years old, to allow for the significant cost pressures that have not been fully addressed, and the revenue implications of PFI schemes.
4	Development of the role of the Regional Office in overall management terms, and in particular in relation to the major investment decisions for the region. The publication 'Capital Allocation' from the NHS Executive in autumn 1996 recommended a mixed regional and national role for prioritising the allocation of discretionary capital to NHS trusts. This approach would exclude consideration of PFI fundable schemes, but it is hard to see how some consideration of their importance in the strategic service framework for the region could be excluded.
5	Purchasers continue to require cash releasing cost improvements from providers. Will trusts be able to find enough sources of savings that are outside the facilities contracts agreed with the consortia? If providers can continue to find both efficiency gains and cash savings from their current un-rationalised operations, does that weaken the case for the number and scope of schemes currently on the drawing board?
6	Does 'scheme inflation' matter? Will the increased size of schemes under PFI be discounted by lower operating costs over their life cycle? Or is the PFI creating an over large and costly fixed asset base for the NHS which will not be matched by the disposal of outdated and redundant assets? The ratio of assets to turnover may be moving in the wrong direction.
7	Consortia may be missing opportunities to offer innovative service planning input and help downsize schemes by failing to examine and challenge the size of facilities that they are asked to construct. The NHS is still strongly influenced by capital-led planning, and the PFI may encourage grandiose schemes.
8	There should be clearer signing off points for purchasers during the PFI process, and between OBC and FBC approvals. Purchasers should be expected to keep in touch with the scheme progress and revisit/challenge the detail in relation to the strategic purchasing context.

Section 5

The PFI Process in London

5.1 Timescales

Trusts have been working on the projects examined in this report for considerable lengths of time, as is shown in the table on page 24. In most cases work has been carried out prior to the production of the outline business case, when trusts believed that they were pursuing a conventional funding route. It may seem unrealistic now, but Greenwich Healthcare in early 1995 confidently believed that Phase I of their scheme (A&E department) would be completed by December 1996 and Phase II (the extended QEMH to allow Greenwich DGH to close) would be open by autumn 1997. None of the projects now expects to be in operation until at least the turn of the century.

In the early stages of the process, some trusts had to whittle down the private sector bidders to a manageable shortlist from large numbers of hopelessly inadequate expressions of interest. The Royal London, for example, reduced an initial 40 bids to 8 and then to three serious contenders. In many cases even shortlisted bidders have withdrawn, often late in the day. This has meant that trusts have ended up in serious negotiations with at most two and sometimes only one bidder. At Wellhouse, Guy's and St.Thomas' and UCLH only one consortium has been left to pursue its PFI bid - this does not mean that they automatically become the preferred partner, and in at least one case there is a serious failure to agree which is hindering the single consortium being formally selected.

It is clear that private sector bidders have become increasingly more selective about the bids they pursue over the past 18 months. Many bidders have withdrawn because of the cost of bidding, and in order to concentrate on those schemes where they have at worst a 1 in 2 chance of being chosen. Several trusts mentioned the poor quality of some consortium submissions, indicating a lack of interest in pursuing bids. The length of time and uncertainty of the process must also be a deterrent. All the trusts indicated that the PFI process had added up to 2 years to the procurement process, which could not be recovered. However, some trusts pointed out that successful PFI schemes are unlikely to suffer from the delays and cancellations of later phases which have bedevilled publicly funded schemes.

5.2 The Special Purpose Vehicle

The PFI has introduced a new concept - that of the special purpose vehicle, which is a legal entity which combines the range of different private sector organisations needed into one consortium. This has been a new concept not only to the NHS but also to private sector companies such as building constructors who have not had to operate in such a way before.

In these first PFI schemes the consortia have in the main been led by construction companies. This is not surprising since the schemes have tended to be seen as construction projects first and foremost, and construction companies possess the project management expertise needed for schemes of this size. Such companies, however, tend to be risk averse and prefer to

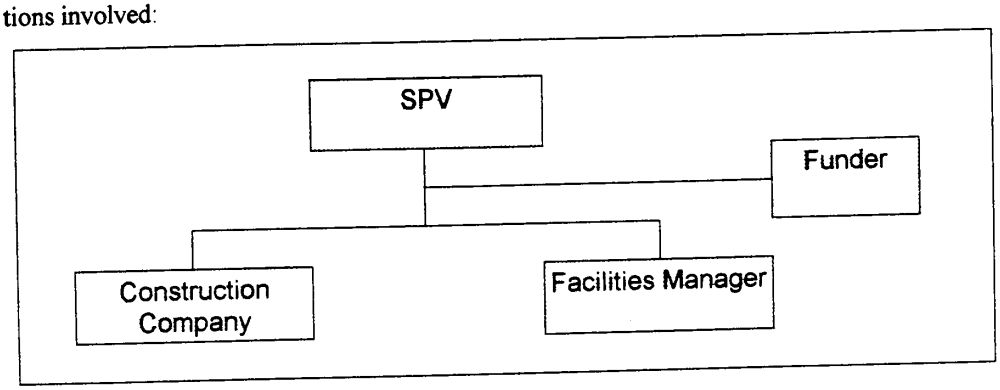
PFI Process Timescale in London

Scheme	OBC produced	Regional Office approval	OJEC advert placed	Consortia shortlisted	Full ITN	Preferred partner selected	FBC produced	FBC approved	Contract signed	Start on site	Completion
Greenwich Healthcare	Mar 1995	April 1995	April 1995	July 1995	Aug. 1995	Feb. 1996	?Nov. 1996	?Jan 1997	?Mar. 1997	?May 1997	2000
Guy's and St.Thomas'	Sept. 1995 (supplement)	Nov. 1995	Nov. 1995	Mar 1996	Apr. 1996	?Nov. 1996	? Dec. 1996	?Mar 1997	?June 1997	?Autumn 1997	2,002
King's Healthcare	Feb. 1995	Aug. 1995	Sept. 1995	Nov. 1995	Apr. 1996	Sept. 1996	?June 1997	?Autumn 1997	?Autumn 1997	? Spring 1998	2,002
Royal Hospitals	Feb. 1995	April 1995	Dec. 1995	Feb. 1996	Apr. 1996	Oct. 1996	Jan. 1997	?Jan 1997	?Spring or Summer 1997	Jan./Feb. 1998	2,001
UCLH	Mar 1994		Jan 1995	Mar 1995	May 1996	Sept. 1996	Dec. 1996	?Spring 1997	?Summer 1997	1,998	2003
Wellhouse	June 1994		Feb. 1995	Nov. 1996	June 1995	Oct. 1995	?Nov. 1996	?Jan 1997	?Spring 1997		

build and walk away. Two distinct types of consortia seem to have emerged:

- the construction led consortia;
- consortia led by entrepreneurs who have come in specifically to exploit this opportunity in the marketplace.

The composition of consortia varies with the project but there is a common core of organisations involved:



The overall contract structure is set out in the diagram on page 26.

In a minority of instances the funding organisation has led the consortium, but this has proved less than satisfactory because of their lack of project management skills and narrow financial interests.

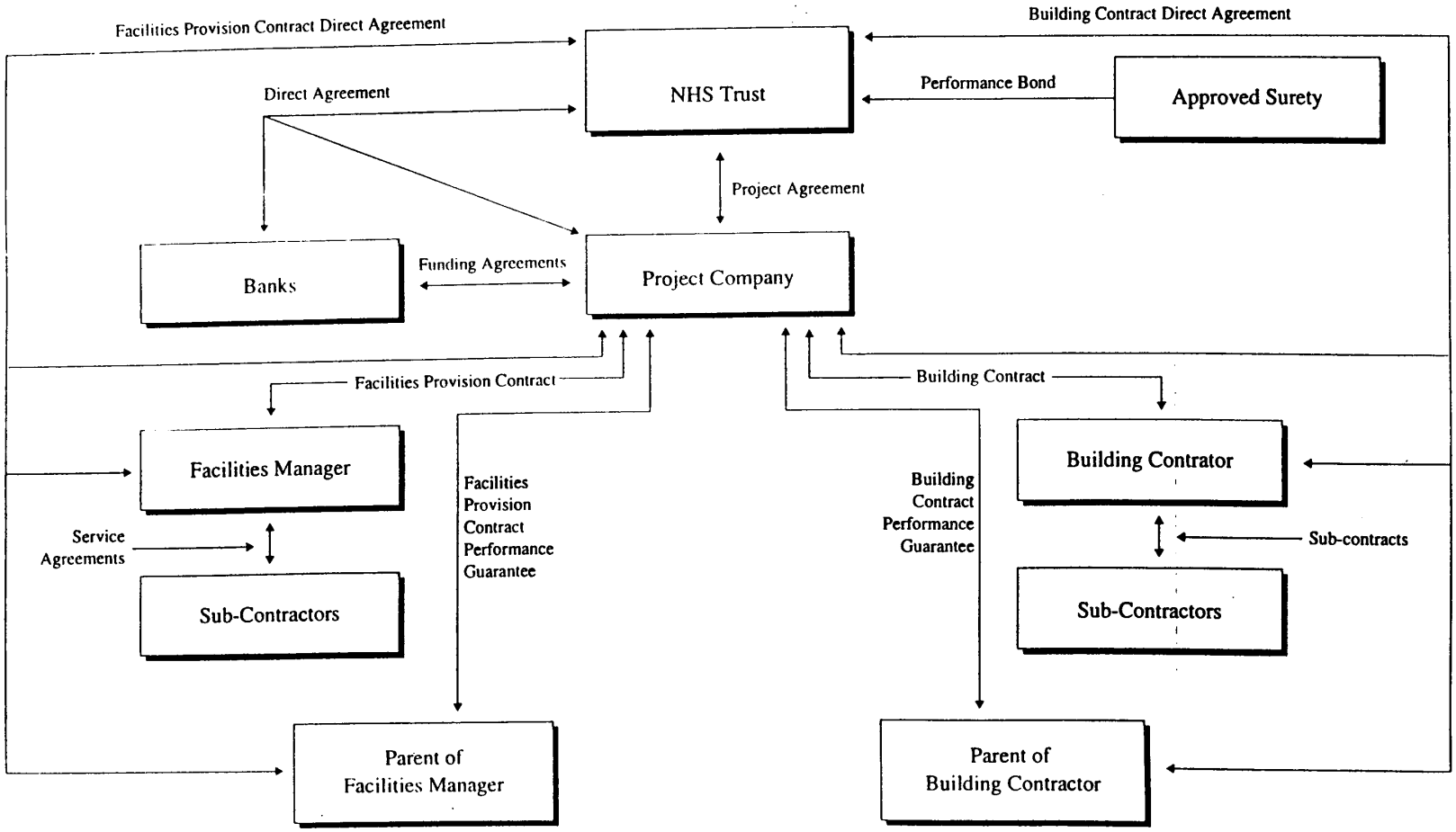
Below this core group are a diverse range of companies which in the projects examined in London , include:

- additional FM organisations (e.g. car parking contractor);
- private patient unit operators;
- residential accommodation developers;
- private laboratories;
- renal suppliers;
- manufacturers of radiotherapy equipment;
- IT supplies and IT FM companies;
- property developers.

NHS trusts in London reported as many as 40 organisations who were involved in the SPV, in some cases with a shadowy presence. In some cases their role was unclear and trusts queried what added value they brought to the project.

Managing the large numbers of people and organisations involved was often a problem, and several of the consortia were criticised for failing to organise themselves and their internal communications properly. It appeared to be a regular occurrence for different members of a

Contract Structure
Including Guarantee and Step-In Arrangements



consortium to disagree amongst themselves in formal meetings and to find it necessary to adjourn in order to agree a common approach. This was further complicated by the fact that each of the main consortium members had their own professional advisers, whose advice was at times in conflict. While one view of the SPV was that it existed in order to transfer risk down the line to the organisation most capable of handling it, the major weakness was that there was little 'tying together' of issues, views and ideas into corporate decision making at the top. If there is too little concern for the totality of what the consortium is trying to do, and too much looking after self interests, at best the process of the PFI scheme will be made more difficult and at worst the scheme will fail. NHS trusts may need to ensure that they are absolutely clear how the consortium is structured, where the leadership/co-ordinating role lies, and how internal communications will be managed.

The financing partners have taken a back seat until relatively late in the PFI process, when a deal is on the table, the consortium has been chosen as preferred partner, and detailed allocation of risk is being finalised. This has had the effect of prolonging negotiations, as the bankers have sought to re-open the issues.

At present the assumption is that the same constituent members of the consortium that makes up the special purpose vehicle will continue for the duration of the contract, which may be for as long as 40 years. However, it would not be impossible for each of the partners to sell on their interest in a future income stream to another party, thus changing over time the complexion of the consortium. This possibility has yet to be tested, but it reinforces the importance for NHS trusts of a clear understanding of and agreement to the modus operandi of the consortium at the beginning.

5.3 Facilities Outsourcing

A key element in the PFI approach is the outsourcing of facilities operations and management. This enables the contractors to obtain part of the return on their investment, and is part of the process of transferring risk. In this way it has been viewed by NHS trusts as the price they must pay for gaining access to new assets.

In reality the change is much more fundamental. At the core of the successful PFI projects will be an approach which is about 'service' and about 'business transformation' rather than just about buildings. It is something that the construction company led consortia have been slowest to realise - that they are now in the service business, and that the NHS is no longer interested in one or two years defects liability periods under the old JCT 80 contracts, but in a 30 year service relationship.

The range of services which consortia have been invited to bid to operate is wide, and covers most of the non-clinical support services. These include:

- Car parking
- Catering
- Domestic services
- Laundry
- Portering
- Security
- Estate management
- Transport
- Clinical waste
- Retail outlets

In addition some trusts have invited outsourcing bids for:

Creditor payments	Pharmacy
Payroll	Pathology
Information technology	Private patients unit
Sterile services	

Information technology is in some schemes becoming a particularly interesting component of major acute hospital PFI projects. it is being used as the vehicle to introduce the electronic patient record into the working of the hospital. This not only leads to a requirement to rethink the operational process and the way in which many clinical staff work, but also to the delivery of significant cost savings from medical records and secretarial departments.

Almost all trusts have specifically excluded clinical services from being outsourced. The only possible exceptions have been exploring private provision of renal dialysis services and of radiology equipment and its maintenance. This was in part because of a belief that the trust needed to retain direct responsibility for such core services; but also because trust management did not consider they would gain support of key staff groups if clinical services were included. In addition there was concern at the capability of external contractors to take on such services. This may well be the case with large complex acute and specialist services. However, in order to create a large enough project and generate sufficiently large revenue streams, outsourcing of clinical services may increasingly have to be seen as part of the package for PFI schemes in the mental health, community and primary care fields.

Information technology was regarded as a core component in only two of the PFI schemes studied. In most cases it had been considered by the trust but left out of the scheme because the trust management were themselves unsure of their requirements.

In the Wellhouse PFI scheme the IT component is seen as critical to the 're-engineering' of the new hospital. This will involve the development and introduction of an electronic patient record and digitised imaging. It has turned the scheme from the provision of a building into a fundamental re-examination of the way the hospital will work, and has galvanised interest in the project amongst clinical staff. It is the most difficult part of the deal in terms of risk transfer and puts pressure on its affordability. The trust is facing a significant reduction in its contract income, and this has driven a radical reappraisal of how it will deliver services when the scheme is completed. The trust envisages a re-engineering agenda that will take the next four years to implement.

The Royal Hospitals Trust also sees IM&T as fundamental to the whole design concept for both the new hospital itself and for the working practices within it.

5.4 Risk Allocation

This is one of the most complex areas in PFI and one that is the principal cause of delays to projects. The Adam Smith Institute in its publication 'Seize the Initiative' criticised the public sector's view that the issue was one of risk transfer:

"So anxious have officials been to pass risk over to the private sector when private finance is involved that many PFI projects ask the contractor to take on levels of risk so high that they either cannot be accepted, or can be accepted only at a charge so high that the potential

gains from the project being better managed become it is in the private sector are entirely negated."

In most cases the overall risk allocation plan was outlined at an early stage, and certainly in the full invitation to negotiate document, in the following format:

Risk Sharing Matrix				
	Type	**Trust Risk**	**Consortium Risk**	**Notes**
1	Construction costs	Some (e.g. own design changes)	Most	*The first five are the traditional risks assumed by construction companies*
2	Timing of construction (i.e. delays)	Some (ditto)	Most	
3	Design/maintenance of facilities	Some (e.g. on retained premises/sites	Most	
4	Availability	None	All	
5	Planning	None	All	
6	Income generation schemes	None	All	
7	Performance (inc. technology/obsolescence risk)	Some	Most	
8	Service volume risk	Shared	Shared	*Complex formulae needed*
9	Changes in funding costs	None	All	
10	Repayment of financing	None	All	*But note bankers step-in rights*
11	Force majeure	Some	Nearly All	*Covered by insurance?*
12	Residual value	None	All	*Do NHS buildings have any?*
13	Legislative changes			
	- General	None	All	
	- Trust specific	All	None	
	- Tax	None	All	
14	Failure to meet non-clinical support service cost targets	None	All	

Perhaps the most important point to note is that income to the contractors will flow over the life of the project, not just on its completion; and will be dependent on availability, quality and performance targets being continually met throughout the project's lifetime. These will relate to continuing availability of the assets, the delivery of contracted service volumes through the buildings and maintenance of statutory standards. Whether it is feasible to set such long term contracts in these terms is untested in the NHS, and may create rigid constraints to service change in the future.

This will mean radically new roles for the remaining directly employed managers and for some clinical staff in the trusts, as they become 'performance approvers' rather than service

deliverers. Some will be familiar with this in small ways through competitive tendering arrangements, but none on the scale that will be ushered in by PFI.

There remains a further concern for private sector funders, which the NHS (Residual Liabilities) Act 1996 has attempted to resolve. It is designed to allow the Secretary of State to deal with an insolvent NHS trust. However the act does not impose a duty on the Secretary of State to dissolve an NHS trust. Because the powers are permissive rather than mandatory there is in theory a possibility that an insolvent trust would not be wound up and finance providers would be left without recourse. Two solicitors in a recent PFI Journal article (vol. I issue 5) considered that *'this worry is likely to continue to prevent the completion of any NHS trust PFI scheme of any significant size...*

5.5 Role of Health Authority and NHSE Regional Office

Purchasers saw their role as confirming the strategic context in which the proposed developments were to take place, and specifically signing off the outline and the full business cases. A number of purchasers expressed relief at the delays that the PFI process was creating because they allowed them time to revisit their acute strategies in light of intervening cost and workload pressures.

Most purchasers were involved in some way in the PFI project management arrangements. Some trusts had monthly meetings with their main purchasers and regional office. The regional offices saw their role as both monitor and support. They identified their role as:

- ensuring the proper procurement process had been followed;
- confirming the affordability of the scheme;
- making sure the VFM comparison was legitimate;
- providing support and advice.

In formal terms this meant approving the OBC and FBC prior to submission to the Treasury: but the regional offices also stressed the importance of the informal role they could play in educating NHS players about the PFI process. This was particularly important with the more open approach of PFI where issues such as how soon to involve the private sector were not laid down.

5.6 Key Issues

1	The early experience of the PFI process is that it can add up to two years to the procurement process. While at the end of the day it may deliver whole schemes more quickly than the conventional route, some steps could be taken to cut down the front-end planning period. These include some way of selecting key strategic schemes for fast-track; improving project management disciplines; sorting out risk allocation issues at an earlier stage; and running in parallel the FBC and contract signing phases.

2	Private sector consortia should re-focus on the 'service' and 're-engineering' business rather than the building business. They should operate in more corporate fashion; and NHS clients should be clear what function each member performs and how they will ensure effective internal communications.
3	Opportunities for outsourcing some clinical services should be considered, particularly for smaller priority care schemes. NHS managers will need to establish new approaches to their informed client role and to performance monitoring PFI contracts.
4	The role of IT could be significant in providing both cost savings and in re-engineering the business and clinical processes of trusts. PFI schemes that include a significant IT element may be able to demonstrate greatest service benefit.
5	Risk allocation needs to be more widely understood by NHS managers. In addition NHS managers need to develop negotiation skills to enable them to negotiate the allocation of risk using the input of their professional advisors.
6	Project management skills need to be better developed by NHS trusts in advance of setting out on the PFI road.

Section 6

Through a Glass Darkly

6.1 Will it Work?

At the time of writing this report (autumn 1996) the conundrum or puzzling question for London remains whether the PFI will work for major hospital projects. London remains over-provided with worn-out assets, faces a huge backlog maintenance bill and duplicated overhead costs which all purchasers recognise cannot be afforded. They accept that things cannot stand still, and that the number of sites from which acute care is delivered must reduce. They have developed plans upon which site rationalisation and bed reductions are based which date back to the early 1990s. Purchasers are trying hard to re-visit their acute strategies in parallel with the developing capital schemes; and the breathing space caused by the lengthy PFI process has only served to heighten their uncertainty about the affordability of some of these capital investment plans.

Purchasers need these schemes to deliver cost reductions in order to:

- fund cost inflation;
- recycle cash savings to other priority developments;
- fund the growth in capital charges;
- repay transitional funding.

Whether the PFI schemes as they currently stand will produce savings of this magnitude is an unanswered question.

Almost the entire Tomlinson and 'Making London Better' acute services rationalisation agenda now hangs on the success of about half a dozen capital schemes that are being pursued through the PFI process. The exception is the investment needed to rationalise specialist and tertiary services which is less dependent on large schemes. However, some purchasers have experienced slow and difficult progress in managing change in these services (which means closing and merging units, beds and supporting facilities, and transferring or making redundant specialist staff).

6.2 Making it Work

It is inconceivable that the PFI in some form will not work. Private sector investment to support public sector services is accepted by both majority political parties as the only realistic way to achieve the scale of investment in its asset base that the NHS needs over the next decade. Some questions need to be tackled if PFI is to work to best advantage:

- Can the planning at the front end of major schemes be speeded up?
- Can the potentially inappropriate schemes in PFI terms be 'sieved out' at an early stage to help concentrate resources?

- Should regional offices adopt a more strategic and directional role, on the basis of strategic service needs, to the prioritisation of capital investment projects, whether PFI or conventionally funded?
- Can London afford the ultimate revenue costs of the currently proposed major PFI schemes or is more radical rationalisation necessary?
- How can the learning in a few sites from the first two years of PFI be shared and communicated more rapidly around the NHS?
- Will PFI constrain the ability of purchasers to require cash releasing efficiency savings or to move service provision in the short term?

6.3 Summing Up

The sites studied in this report considered the overall effect of the PFI on their plans, as follows:

Timescale:	Most considered that PFI had delayed implementation at the front end by up to 2 years; some pointed out that it was unreasonable to look at the front end only and that if successful they would have a complete new hospital in 6 years. Most believed that procurement costs were higher for both sides.
Scheme Content:	Most trusts thought that PFI had made no difference to the required outputs, but had changed the functional content; there was more new-build, better functional relationships and space use. One commented that they would never go back to the original plans; and another welcomed the innovative thinking the PFI approach had brought to the creation of third party revenue streams from research, shops, patient hotels etc..
Design Issues:	Most trusts mentioned the PFI allowed higher quality of build, with contractors focusing on whole life cycle costs. Some mentioned added value from better functional relationships, and better ward design. A number, however, expressed the view that there was not as much innovation as expected.
Strategic Change:	Most trusts confirmed that they were sticking to the strategic changes approved in Making London Better; many also said that PFI enabled greater change because none of the large schemes would ever have been funded by the Treasury in one go. One or two considered that the PFI schemes were more about site rationalisation than service change. There remains a question, however, over their affordability.

Many trusts spoke about management disciplines which PFI had exposed or helped improve, such as:

- the importance of joint working with the purchaser;
- the need for good project management, separately resourced;
- the requirement to think rigorously about outputs;
- the need to create accurate records and information;

- the need to improve negotiating skills;
- the importance of public relations in helping sell the concept of PFI as well as schemes content to local stakeholders;
- the testing and outsourcing of services and facilities management.

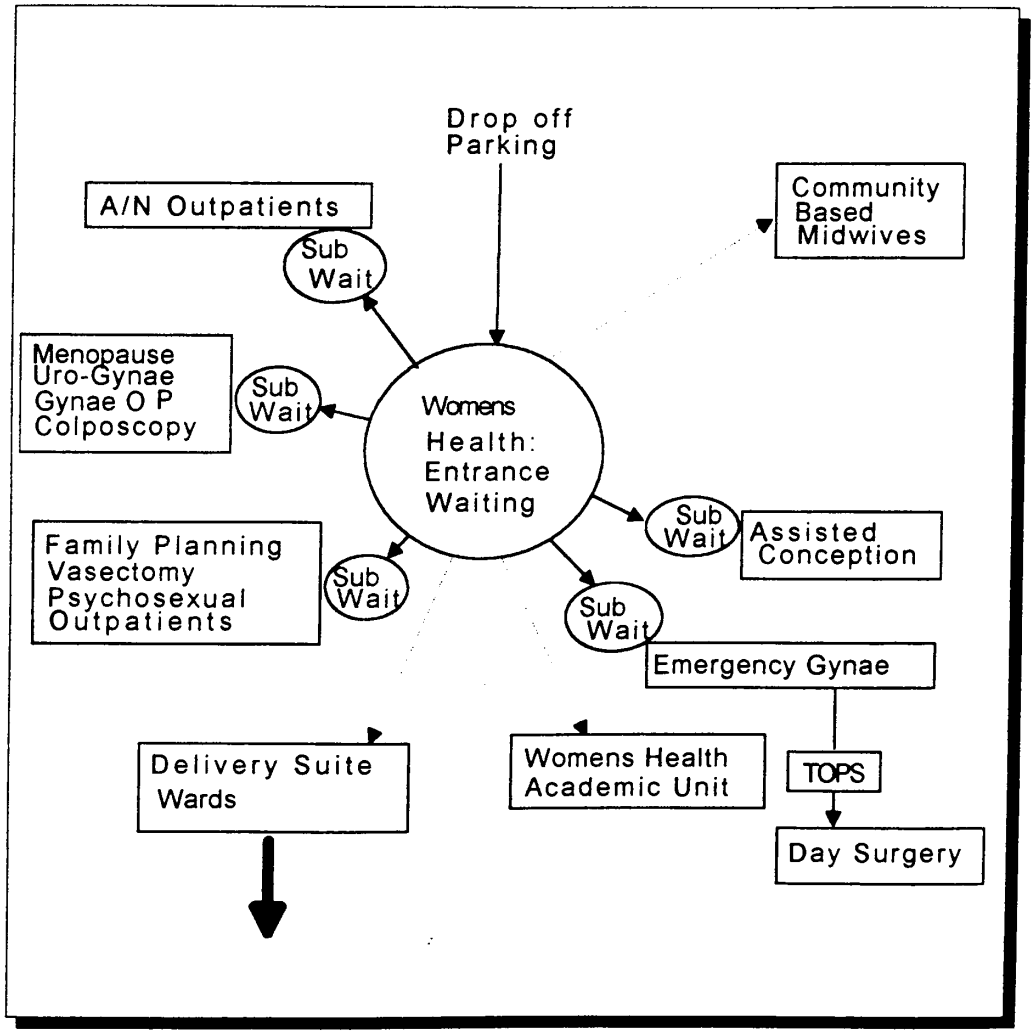
Most trusts emphasised the new focus on the longer term in relation to asset costs and service delivery; but fewer had used the opportunity to radically re-engineer the provision and organisation of clinical as well as support services. There was a general recognition that the expectations of staff in particular had been raised - that it was felt that PFI offered at last a chance of a wholesale improvement in the environment within a reasonable timescale. In many cases these were staff who had lived on promises of better working conditions for many years.

6.4 The Answer?

London purchasers and providers remain committed to implementing the agenda of Making London Better, and the acute sector site rationalisations are essential to unlock change and release resources. The private finance initiative is seen as the key to that lock, but will it work? The conundrum remains.

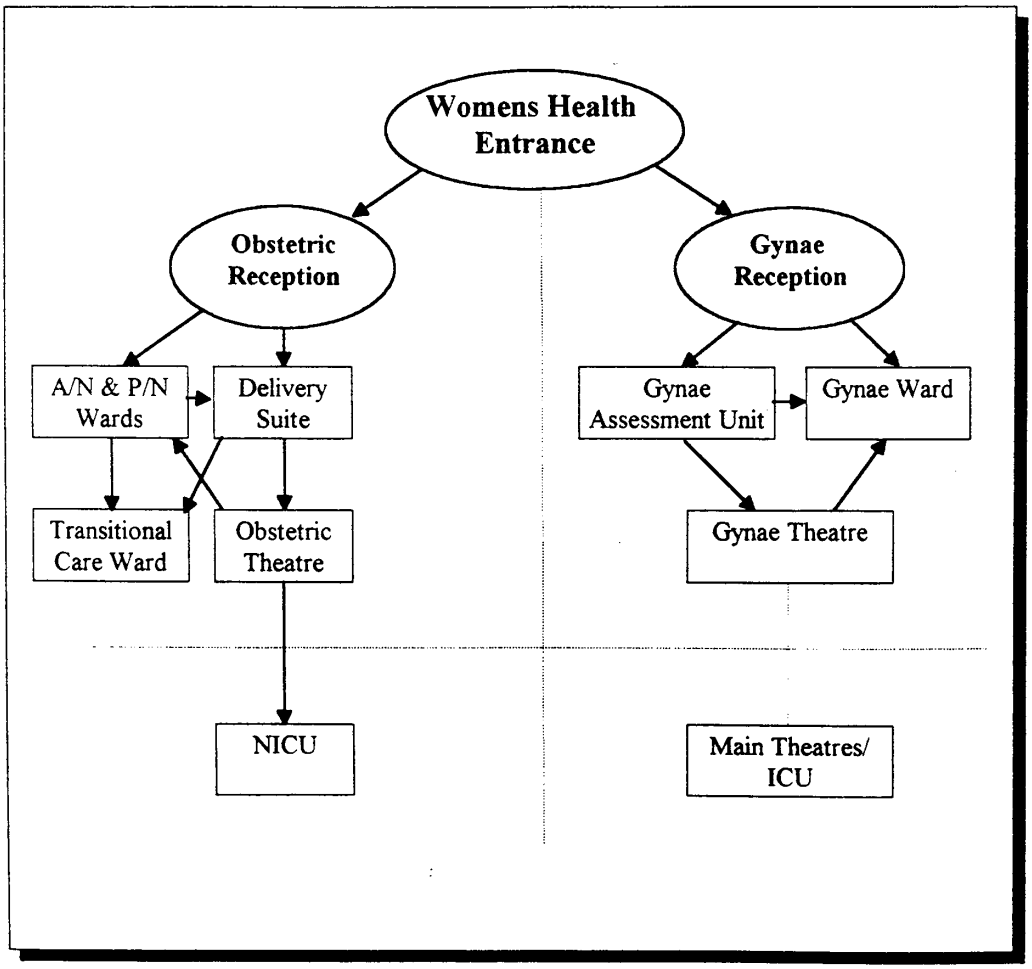
Appendix A

Figure 1: Example of Model Showing Functional Relationships: Women's Health



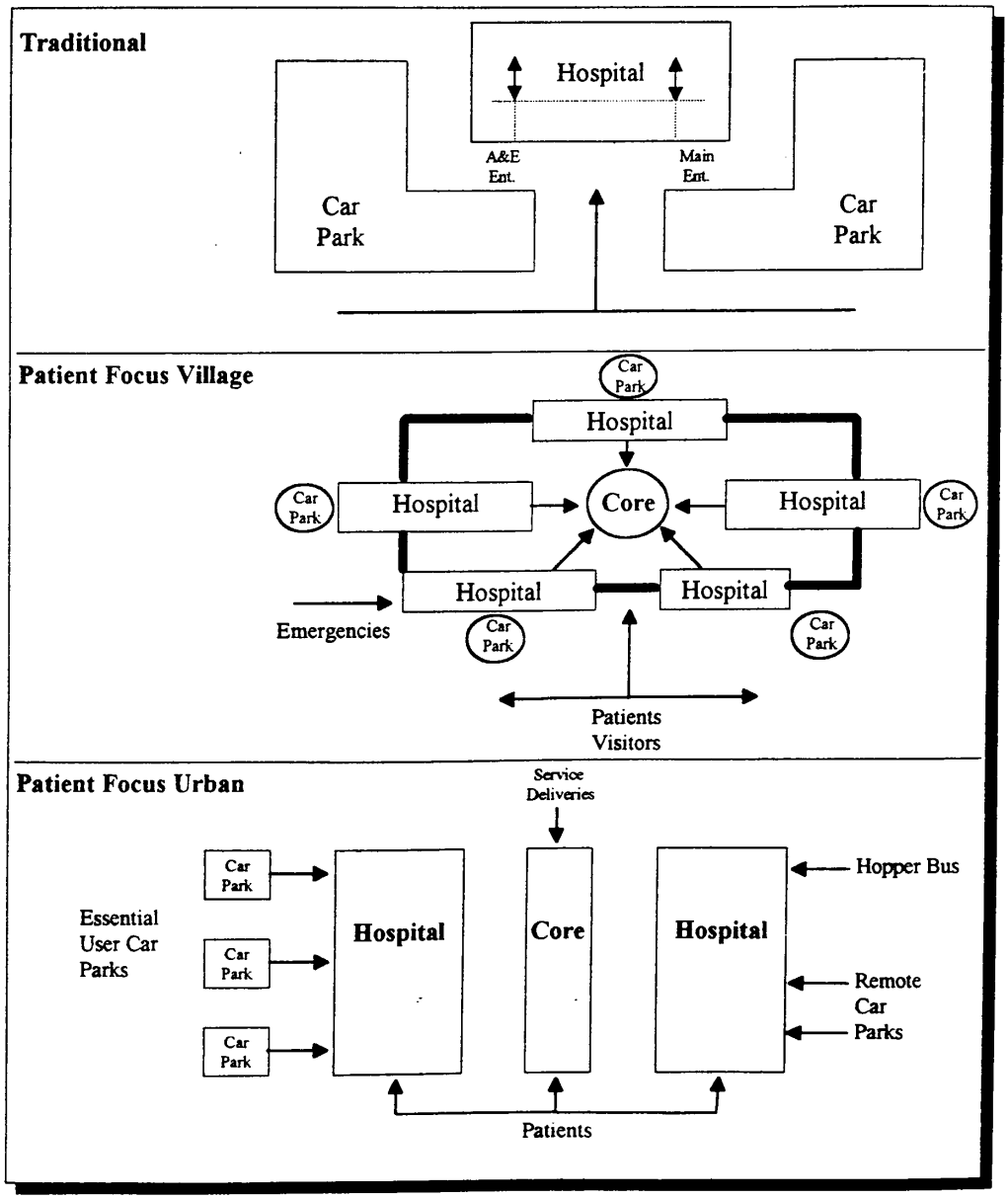
Appendix A

Figure 2: Example of Model Showing Functional Relationships: Women's Health



Appendix A

Figure 3: Overall Hospital Design Models



Appendix B

Useful References (as at October 1996)

1. Sixth report of the House of Commons Treasury Committee on the PFI - April 1996
2. Lease in Our Time - Public Finance - 12th April 1996
3. Can Private Finance Save the NHS - Public Finance - 15th March 1996
4. Laying the Foundations - Public Finance - 8th December 1995
5. In Search of the Holy Grail - Health Service Journal - 15th February 1996
6. Capital Games - Health Service Journal - 15th February 1996
7. Private Finance: Square Pegs and Round Holes - British Journal of Health Care Management - 3rd November 1995
8. Testing Private Finance in the NHS - British Journal of Health Care Management - 21st July 1995
9. Initiative Test - Hospital Development - September 1995
10. Private Finance and Capital Investment Projects - HSG(95)15 NHSE - 20th March 1995
11. Private Finance and the NHS - NAHAT Update - October 1994
12. Public Service Private Finance - EL993)101 - NHSE 1993
13. Newchurch Guide to Private Finance - 1994
14. Site Unseen - Health Service Journal - 22nd August 1996
15. Making PFI A Capital Idea - Health Service Journal - 19th September 1996
16. Is the Spring of PFI here? - The Health Business Summary - April 1996
17. One Law For the Rich - Health Service Journal - 25th July 1996
18. A Leap in the Dark - Nursing Management - May 1996
19. Seize the Initiative - Adam Smith Institute 1996
20. Capital Allocation - NHS E 1996
21. PFI Journal - vol.I.no.5 - 1996
22. NHS (Residential Liabilities) Act 1996 - HMSO

ISBN 1-85717-164-0