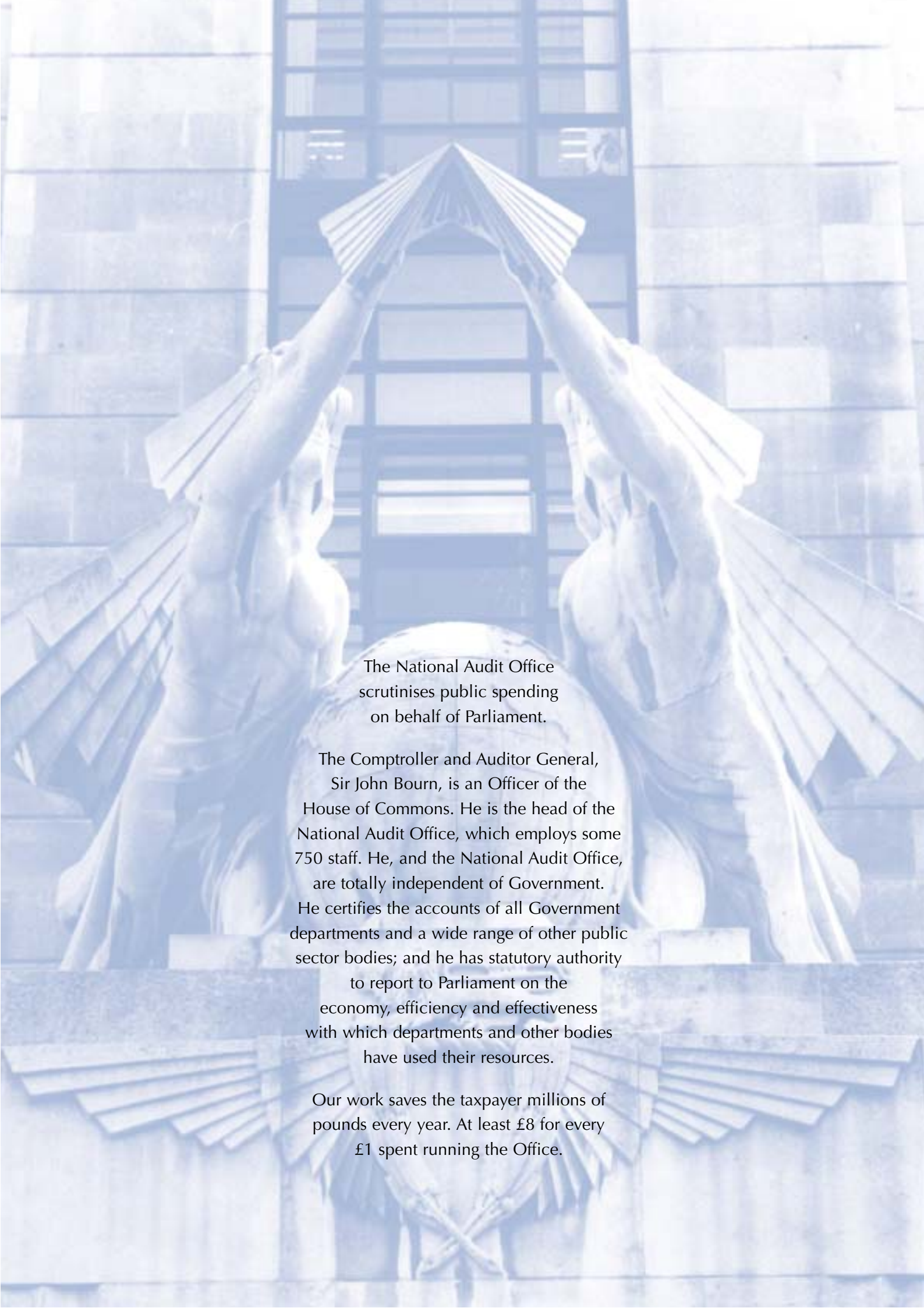


The PFI Contract for the redevelopment of West Middlesex University Hospital

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 49 Session 2002-2003: 21 November 2002





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The PFI Contract for the redevelopment of West Middlesex University Hospital



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HC 49 Session 2002-2003: 21 November 2002

This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn National Audit Office
Comptroller and Auditor General 4 November 2002

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Key Facts of the West Middlesex PFI Deal

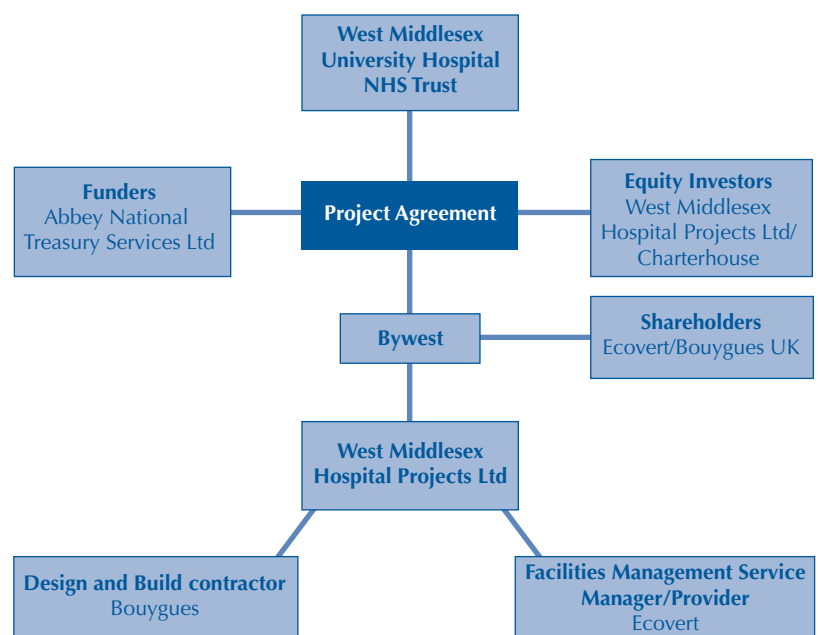
	PFI deal as contracted	Conventional procurement alternative	
Final deal cost at 2001 prices (discounted over 35 years to April 2001 and excluding clinical costs)	<p>£125 million 35 years</p> <p>£130 million 60 years</p> <p>(Based on annual unitary payment of some £10 million)</p>	<p>£130 million 35 years</p> <p>£140 million 60 years</p> <p>(Risk adjusted)</p>	
Cost profiles	Annual unitary charge of some £10 million plus refurbishment costs of £12 million under separate arrangements.	Full capital construction and refurbishment costs of some £62 million (cash estimate) over first four years, followed by ongoing maintenance and ancillary services.	
Risk allocation	<ul style="list-style-type: none"> ■ Remaining with public sector ■ Passed on to private sector 	<ul style="list-style-type: none"> ■ Clinical service provision; ■ Change in Trust requirements; ■ NHS specific regulatory/legislative changes. ■ Construction Design (except changes due to external NHS requirements); ■ Meeting specified performance standards and operating cost risk; ■ Non-NHS specific regulatory/legislative changes. 	Most risks retained by the public sector.
Cost of advisers used in procurement (actual prices)	£2.3 million	The Department has suggested a range of between 2 to 4% of capital value for schemes over £20 million. This would give between £1.2 million and 2.4 million in this case.	
Original estimate of deal cost (based on 30 year contract):			
<ul style="list-style-type: none"> ■ Invitation to negotiate (1998/99 prices) ■ Selection of preferred bidder (February 2000 prices) 	<p>£91 million</p> <p>£95 million</p>	<p>£93 million</p> <p>£98 million</p>	
Trust's assessment of additional benefits of its chosen procurement over conventional procurement	<p>Greater price certainty.</p> <p>Incentivises contractor to complete development on time as full payment only starts once the building is ready for use and occupied.</p> <p>Payment linked to delivery of service which incentivises the PFI contractor to deliver the quality of service which is specified over the contract period.</p> <p>Same contractor designs, maintains and operates building under one contract and is therefore incentivised to adopt whole-life costing.</p>	<p>Cost overruns passed to public body.</p> <p>Only recourse for poor performance is to terminate the contract which can also lead to payments from the Trust.</p> <p>Design, maintenance and operation of building is dealt with under separate contracts.</p>	

executive summary

" PFI has a central role to play in modernising the infrastructure of the NHS - but as an addition, not an alternative to, the public sector capital programme." - The Prime Minister, September 2002.

- 1 It is government policy that some hospitals are going to be built and managed as PFI contracts, as additions to the conventionally procured hospital programme. This report examines one such PFI project to see the extent to which it has absorbed the lessons of previous reports by the Committee of Public Accounts which have been accepted by the government, and how value for money was established in this case.
- 2 In January 2001, the West Middlesex University Hospital NHS Trust (the Trust) let a PFI contract to a private sector consortium called Bywest (Figure 1). The contract is for 35 years and has an estimated net present value (NPV) of unitary payments of some £125 million. There is also the possibility of extending the contract term to 60 years. The contract requires Bywest to redevelop the Trust's site at Isleworth, West London and then to provide ongoing maintenance and facilities services.

1 The Trust and members of the Bywest consortium and its main contractors



3 We examined the extent to which this PFI contract is likely to deliver value for money and whether lessons had been absorbed from the earlier reports by the NAO and the Committee of Public Accounts on the contract for the Dartford and Gravesham PFI hospital¹. The methodology we adopted for this study is set out in Appendix 1. In summary we found that:

- This 35-year deal meets expected local needs, with some flexibility to address inherent uncertainties in wider long-term NHS plans;
- In getting the best available PFI deal the Trust applied common sense and learnt from experience;
- The Trust considered that the unquantifiable benefits of doing this as a PFI deal outweighed the disbenefits.

This 35-year deal meets expected local needs with some flexibility to address inherent uncertainties in wider long-term NHS plans

- 4 As many of the buildings were over 100 years old and dilapidated, the Trust, the local Health Authorities and the NHS London Regional Office (LRO) all considered that a redevelopment of the West Middlesex hospital site was essential to meet local needs for modern, high quality healthcare². In accordance with procedures introduced since the planning of the earlier Dartford and Gravesham PFI project they agreed a strategic outline case for this redevelopment.
- 5 Long-term planning is difficult in the health service because healthcare is changing over time and the local demography may also change. This may affect the optimum type and location of facilities that are required. This exposes the Trust to the risk that it may become locked into a long-term contract for buildings and services that are no longer needed. This issue is not limited to PFI hospitals, but the long-term service contract of a PFI deal makes termination likely to be more expensive. In the West Middlesex deal there is some flexibility to accommodate these uncertainties. Up to six additional wards can be provided or alternatively bed numbers could be decreased. The Trust believes the contract provides sufficient flexibility to address future uncertainties in long-term healthcare.

In getting the best available PFI deal the Trust applied common sense and learnt from experience

- 6 In developing this PFI deal the Trust learnt lessons from the early hospital PFI procurements which included its own experience in developing, but not completing, an earlier version of this project. It ran an effective procurement placing particular emphasis on strong senior management involvement, input from clinicians and other stakeholders, and experienced advisers. It was also able to make use of new guidance including a new standard NHS PFI contract.
- 7 The Trust ran an effective bidding competition. This included a faster bidding process which eliminated an extra round of bidding, reducing the time and costs of both the Trust and the bidders. It selected Bywest as preferred bidder. Bywest's bid offered a slightly lower price than the other bidders, and the Trust judged that the bid offered the best value for money with particular strengths in design, proposed timetable and personnel issues.

1 *The PFI Contract for the new Dartford and Gravesham Hospital: NAO Report HC 423 1998/99; The PFI Contract for the New Dartford and Gravesham Hospital: PAC Report HC 131 1999/00.*

2 *The local health authorities were Ealing, Hammersmith and Hounslow (EHH) Health Authority and Kingston and Richmond (K&R) Health Authority.*





- 8** It took the Trust a year to close the deal (against its expectation of eight months) due to contractual and design issues, including a late proposal for the use of one of the site buildings. The Trust controlled deal drift up to financial close. Bywest's annual price increased by just under 10 per cent, mainly due to inflation and the decision to use land sale proceeds to fund other work. The Trust asked Bywest to confirm in writing at selection of preferred bidder that, assuming the specification remained unchanged, it would hold its proposed price. The Department believes that this innovation had some impact on limiting price increases during the closing stages³.

The Trust saw benefits from this PFI deal that outweighed the disbenefits

9 There are generic benefits from PFI deals such as incentivising the contractor to introduce the required service quickly and to maintain the service delivery to a satisfactory standard. These benefits have to be weighed against possible disbenefits, which include being tied into a long-term contract during which the public sector's requirements may change. There may also be further specific benefits and disbenefits from a PFI approach to a particular project.

- 10** In this project the Trust considered the benefits of the PFI approach outweighed the disbenefits. The Trust placed particular emphasis on the fact that the contract would incentivise Bywest to complete the redevelopment quickly and with price certainty, to maintain the buildings well and to deliver the required standard of service during the 35-year contract period. The Trust has sought to manage the risks of a PFI contract by building into the contract some flexibility and arrangements to test that any contract variations are value for money.

- 11** The Department told us that it would not necessarily withhold approval for a PFI project that appeared slightly more expensive than conventional procurement if there were convincing value for money reasons for proceeding with the deal. In this case the Trust's initial financial comparison did show the PFI price slightly higher than the cost of conventional procurement. Both the Trust and its advisers KPMG considered the PFI option would deliver value for money taking all benefits and disbenefits into account. But they had concerns about the accuracy of the initial financial comparison and whether its results might prevent the project being approved by the Department.



- 12** As part of the iterative process of developing the risk analysis which forms part of the financial comparison, the Trust and KPMG re-appraised the figures to ensure the risks inherent in traditional procurement were properly reflected in the public sector comparator (PSC). The final calculations showed a risk-adjusted saving from using the PFI of £5.5 million compared with a PSC, including project risks and clinical costs, of £989 million over 35 years (net present values)⁴. As with all long-term cost estimates there are inherent uncertainties in this comparison, and particularly regarding the size of the adjustment for risk. The total value for risk was, however, consistent with previous experience with conventional hospital projects and was in the middle of the range indicated by a recent wider study. The re-assessed cost comparison therefore reinforced the value for money case for the PFI deal.

- 13** In this project the financial comparison was not clear-cut. The attention given by the Trust to the figures shown by the financial comparison may have masked evidence of important wider benefits that the PFI approach was expected to secure.

³ The Department of Health and the National Health Service Executive merged in spring 2001. Both are therefore referred throughout the report as 'the Department'.

⁴ £129.3 million net present value excluding clinical costs.

Recommendations

- 14 Those engaged in taking forward PFI projects, both within the Department and in other departments, should continue to have regard to the recommendations set out in our earlier report on the Dartford and Gravesham PFI hospital. As a result of this current further examination of PFI in the NHS we make the following additional recommendations:
- A The strategic outline case for a PFI project should include a clear analysis of the risks of being locked into a long-term contract. It should also explain how these risks would be addressed if the PFI procurement goes ahead and whether, on balance, the benefits of a PFI procurement are likely to outweigh any disbenefits. In making this assessment a department, and all other key stakeholders in the project, should consider the extent to which there are long-term plans and the uncertainties attached to these plans. The outline case should indicate how the proposed project contributes to a department's strategy both in the short-term and into the proposed contract period.
 - B As the Trust demonstrated in this procurement, PFI procurements will benefit greatly from the involvement of senior management, input from key stakeholders and the use of experienced advisers. Trusts may benefit from key stakeholders sharing their experience, particularly how clinical considerations should affect the design of the project.
 - C The Trust moved directly from three bidders to a preferred bidder without an intermediary stage. This may reduce the time and costs of both departments and bidders, and is now part of the Department of Health's guidance. Other departments should consider whether this approach is appropriate. Certain safeguards are needed with this approach (see paragraph 2.21). These include making sure the three final bidders know that there will not be another opportunity to improve their bids and resolving outstanding contractual issues before the selection of the preferred bidder to keep the final negotiations to a minimum.
 - D Other departments should consider whether it will be helpful to PFI procurements if greater use is made of the type of preferred bidder letter obtained by the Department in this project. This sought confirmation from the preferred bidder that, assuming the specification remained unchanged, it would commit itself, for a defined period, to the price it bid prior to its selection as preferred bidder. This confirmation, now reflected in Office of Government Commerce guidance⁵, may help departments to close deals effectively knowing that the contractor has agreed that price changes will only be allowed in exceptional circumstances.
 - E The departmental approval processes for PFI projects should not, explicitly or implicitly, place undue emphasis on the need for projects to demonstrate savings, however small, against a PSC in order to gain approval. The emphasis should be on demonstrating value for money taking all benefits and disbenefits of the PFI approach into account. There is a risk that project teams may devote too much time refining their financial comparison calculations, at the expense of a more rounded and valuable assessment. Financial and wider non-financial should be considered in deciding whether to go ahead with a PFI procurement.

⁵ Standardisation of PFI contract terms, OGC July 2002

Part 1

This 35-year deal meets expected local needs with some flexibility to address inherent uncertainties in wider long-term NHS plans

1.1 The 35-year PFI deal for the redevelopment of the West Middlesex Hospital is for new buildings and facilities management and maintenance services for all of the buildings on the site (which includes some being refurbished under separate arrangements). Difficulties in long-term planning for healthcare arise at all levels in the NHS but the local Health Authorities and the London Regional Office (LRO) are content that this deal, which includes some flexibility, will meet current and anticipated local needs.

The project addresses the current situation at West Middlesex which is unsatisfactory

1.2 The current redevelopment project is the culmination of a series of plans to improve the site that have been circulating since the 1970s and will alleviate the problems created by the sprawling layout of services and the poor, unsafe, condition of some of the buildings.

The West Middlesex hospital site is unsuitable for the provision of modern, high quality healthcare

1.3 The West Middlesex site is large and unwieldy. The layout of interdependent services such as Accident and Emergency (A&E), operating theatres, and rehabilitation units is inefficient and in some instances compromises patients' recovery, as they can spend up to 15 minutes in an electric ambulance being moved around the site. Some essential services, such as X-ray, are provided several times at different locations, leading to inefficient staffing and additional costs.

1.4 Much of the dilapidated building stock on the site is over 100 years old and in recent inspections the site as a whole has failed to meet its statutory fire and health and safety obligations. The layout and conditions therefore make the site unsuitable for modern, high quality healthcare.

1.5 Plans to improve the site have been circulated since the 1970s and the project was originally intended to be part of the proposed first wave of PFI deals in the mid-1990s. The PFI procurement, which was well advanced, was stopped in 1997 when the Department decided to prioritise the schemes that would be completed. West Middlesex Hospital was 14th on a list of urgent projects, the first 13 of which went ahead. The project was included in the next wave of PFI hospital projects taken forward in 1998. London Regional Office (LRO) indicated that the project remained a priority and would have been taken forward through conventional procurement if a PFI solution was not deemed appropriate.

The PFI project is expected to deliver the required improvements

1.6 The PFI project involves demolition and new build for the most dilapidated Victorian buildings. Bywest will also carry out extensive refurbishment of newer, existing buildings, with a capital cost of some £12.2 million. This work will be funded from land sales, rather than by unitary payments under the PFI deal. In addition, the Trust awarded Ecovert, part of the Bywest consortium, a contract for facilities management, worth some £800,000 a year for two years before the unitary payments begin.

April 2001



June 2001



September 2001



December 2001



January 2002



June 2002



September 2002



The project involves creating a new central access point with diagnostic services and theatres located close by

1.7 When the construction is complete there will be no need for electric ambulances to ferry patients around, for duplicate diagnostic suites (X-ray, and ultrasound) or pharmacies. A new central access point will be created with improved facilities for the disabled and, by focusing on the logical relationships between services, the flow of care will be enhanced. There is also considerable refurbishment of other buildings on the site.

1.8 There will be some disruption caused by the building and refurbishment programme but the hospital will remain open throughout, offering its normal range of services. When the project is complete, all health and safety requirements will be met and all buildings will have been brought up to a standard suitable for normal use. There is also a requirement for imaginative use of colour and the incorporation of art to enhance the environment. **Figure 2** shows plans of the old and new hospitals.

The Trust has good contract management arrangements and progress to date is good

1.9 Although there has been a change in the Chief Executive and the Finance Director since the contract was let, contract management has not been compromised. There has been a comparatively seamless transition to the new Chief Executive and the project manager has been retained to see the construction through to completion. There have also been changes in staff of the contractor. This did cause some initial communications problems although these have since been resolved. The contract contains provisions for regular monitoring to ensure the contractor is delivering the required level of service. The Trust is emphasising a partnership approach to making this deal work over the next 35 years⁶. Progress on construction so far has been good and it is expected to be completed ahead of schedule.

⁶ The Trust and Bywest will establish a PFI Monitoring Group, including user representatives that will meet regularly to assess performance. The key objectives of the Group will be to ensure delivery of agreed quality standards and to resolve issues that may prevent this. An existing Liaison Group, including the Trust's Chief Executive and Finance Director and Bywest executives, will continue to meet regularly to evaluate the effectiveness of the Monitoring Group and discuss any strategic issues.

The local Health Authorities approved the business case for the project although there are inherent uncertainties in their long-term plans

1.10 The Trust prepared a strategic outline case (SOC) for the redevelopment of the West Middlesex site in line with current guidance. The local Health Authorities at the time and LRO approved the outline case although the changing nature of healthcare and the introduction of new priorities both locally and nationally created uncertainties.

The local Health Authorities approved the strategic outline case in line with current Departmental guidance

1.11 The Trust prepared a SOC for the proposed redevelopment in 1998. It was in line with the Department's increased emphasis on evidence for strategic planning in PFI projects, which was formalised in guidance issued in 1999.

1.12 Ealing, Hammersmith and Hounslow (EHH) and Kingston and Richmond (K&R) Health Authorities, the relevant local health authorities at the time, were consulted and gave their approval to the scheme⁷. The approval was conditional on the Trust achieving some £1.6 million annual efficiency savings. The Trust developed a plan to achieve these savings. Some savings have already been realised through changes in staffing but some aspects of the plan may need to be revisited: for example, savings on nursing costs as new recommendations on nursing levels are increasing the necessary level of provision and associated costs.

But local long-term health strategies, like those for London as a whole, are not fully developed

There are local-level plans but they reflect uncertainties

1.13 The uncertainties in local long-term strategy mirror those in London and the NHS as a whole. EHH Health Authority issued five-year plans that describe high-level intentions for responding to local healthcare needs. They refer to the redevelopment of West Middlesex and the rationalisation of services, but there is little detail to show how this fits in with an optimum local plan for health services. Primary care groups and community health councils have been sceptical about the existence of a coherent and integrated local healthcare strategy covering all existing and anticipated future needs and provision.

There is an ongoing expectation of services at West Middlesex

1.14 Despite local health plans being not fully developed there is a clear expectation of continued hospital service provision at the West Middlesex site. The current site is the major provider of general and acute hospital services to a population of 310,000. It also provides undergraduate and postgraduate medical education and training. There will, however, always be uncertainty about future local demography. Also, there is ongoing discussion about the precise nature of the services to be provided at West Middlesex. EHH advocates one 'hot site' for emergency work and one 'cold site' dedicated to elective work. This might reduce waiting times and prevent cancellation of elective treatments but there is no clear proposal yet of how this might be taken forward.

EHH and LRO maintain that there are no suitable alternatives to the redevelopment of West Middlesex

1.15 West Middlesex is being redeveloped in preference to either building a new hospital on a green-field site or expanding the provision at other hospitals to take over the services currently provided at West Middlesex. The Health Authority and LRO maintain that neither of these options is realistic. There is no suitable green-field site in the area and there is insufficient capacity at most of the possible alternative sites to accommodate the necessary expansion or create an optimal layout of services. Additionally there would be resistance to the transfer of services from both patients and staff. Any type of alternative provision would require local residents to travel further, thereby reducing access to services.

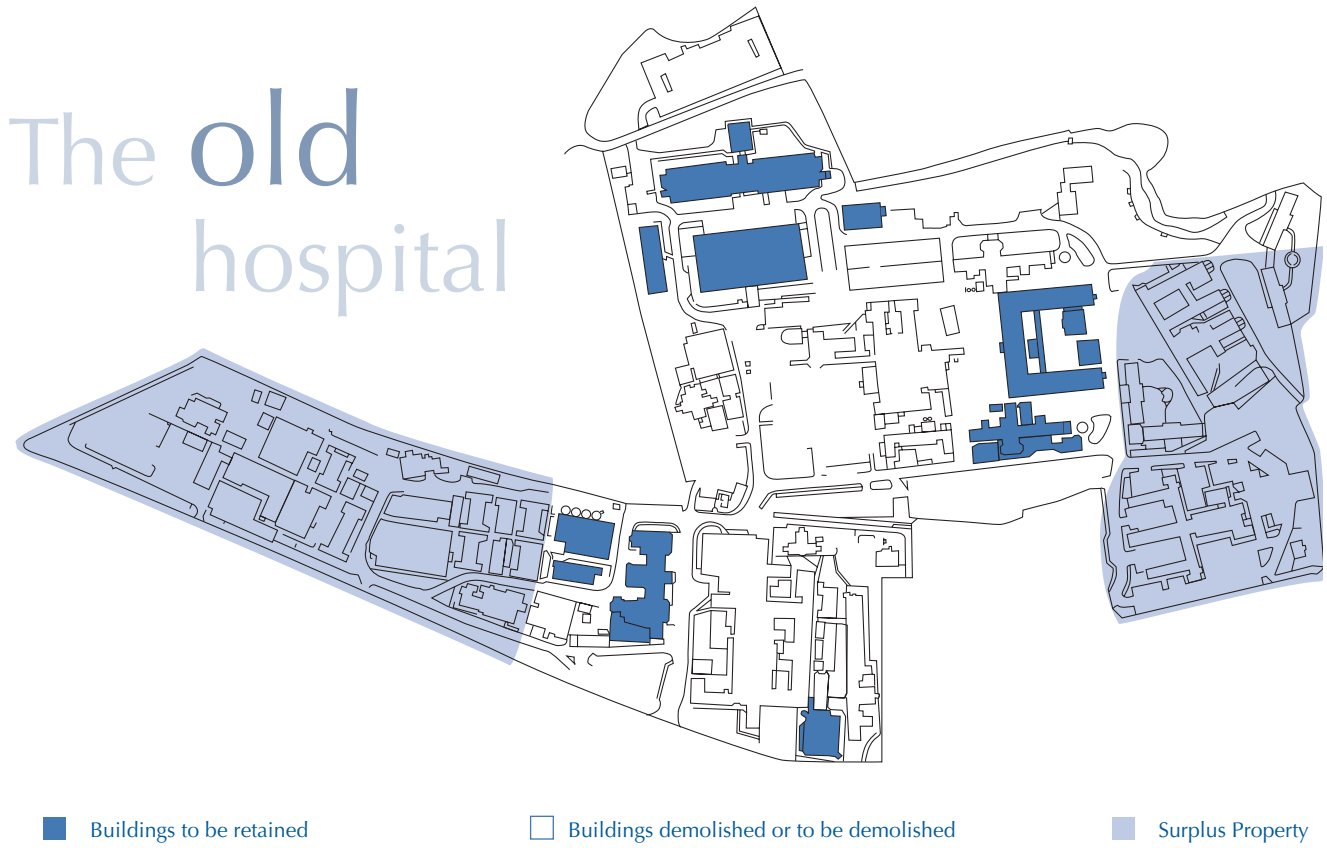
1.16 Even if space and the constraints of creating an optimal co-location of services were not major difficulties, LRO estimates the cost of providing services at existing alternative sites would not be substantially lower than redeveloping the West Middlesex site. However this assessment of similar costs does not take into account the receipts from land sales if the West Middlesex site were to be sold.

⁷ There have been changes to local health authorities recently. See Appendix 3 - changes in responsibility over the last 15 years.

West Middlesex Before & After the Redevelopment

(Source: Department statistics 2000/1)

- | | |
|---|--|
| <ul style="list-style-type: none"> ■ Serves population of 310,000 ■ 1200 staff ■ 424 beds ■ 6 operating theatres ■ 2 day case theatres ■ 155,000 outpatient attendances | <ul style="list-style-type: none"> ■ 58,000 A& E attendances ■ 103,000 x-rays and other diagnostic images ■ 28,000 finished episodes of care ■ 3500 ward attendances ■ Awarded 2 stars in NHS performance rating (2000/1) |
|---|--|



The old site is large and unwieldy. The lay-out of interdependent services such as Accident and Emergency (A&E), theatres, and rehabilitation units. Patients can spend up to 15 minutes in an electric ambulance being moved around the site. Some essential services, such as X-Ray, are provided several times at different locations, leading to inefficient staffing and additional costs. Much of the dilapidated building stock on the site is over 100 years old and in recent inspections the site as a whole has failed to meet its statutory fire and health and safety obligations.



In the new, 434 bed redevelopment there will be no need for electric ambulances to ferry patients around, for duplicate diagnostic suites (X-ray, and Ultrasound) or pharmacies. A new central access point will be created with improved facilities for the disabled and, by focusing on the logical relationships between services, the flow of care will be enhanced. The buildings that are retained from the old site will be refurbished.



The new hospital

■ Buildings to be retained ■ Community & Mental Health Trust ■ New Development



Scale model

Despite the lack of a cohesive long-term plan for West London the NHS considered this project appropriate and sufficiently flexible to meet local needs

1.17 Despite reviews commissioned by the NHS into the provision of healthcare in London, cohesive long-term plans for the whole of West London are not available. However, the NHS expects the West Middlesex project will meet local needs. Uncertainties in demand and the nature of services provided are to some extent allowed for in the flexibility of the building design.

There has never been a clear long-term plan for the whole of West London

1.18 Reviews of London's health services in the 1990s focused on strategies for inner London, leaving strategies for outer London more fragmented and subject to short-term local planning rather than cohesive longer-term planning.

Pan-London health strategy reports focus on Inner London

1.19 In 1992 the Tomlinson report recommended closures, mergers and rationalisations across London but West Middlesex was not mentioned at all as the main focus was on inner London⁸. Six years later the Turnberg report examined the progress on recommendations of the Tomlinson report⁹. The focus remained on the requirements of inner London a fact noted by Turnberg who commented, *'Hospitals in the outer ring, away from the centre of London, should be supported and planned in relation to the local needs of the communities they serve'*.

1.20 There was therefore no considered examination of the way in which West Middlesex might fit into an overall strategic health plan for either West London or for London as a whole. LRO considers that the strategic case for the redevelopment of West Middlesex should be understood in the context of Turnberg's comments that provision for outer London should be based on local needs.

Strategy drivers in the NHS have changed over time

1.21 The NHS has experienced numerous changes in strategic thinking and direction over the past 10 to 15 years with the National Beds Inquiry and the NHS Plan being the latest drivers in health strategy. The Department currently advises that bed occupancy should not exceed 85 per cent. Prior to the redevelopment West Middlesex had a rate of some 89.5 per cent or higher, following the redevelopment West Middlesex is expected to be up to 85 per cent.

1.22 The difficulty in establishing consistent strategic direction in the NHS over time is a factor that affects all hospitals whether procured conventionally or through PFI. Given the long duration of a PFI deal, there is more need for flexibility to be incorporated in the design and contractual arrangements.

There have been some rationalisations of hospitals located around West Middlesex

1.23 **Figure 3** shows the hospitals surrounding West Middlesex as well as those barriers to travel between them such as the river Thames and the M4 motorway.

1.24 Ashford and St Peter's have both been recently downsized. There have also been changes of provision at Hammersmith and Queen Charlotte's hospitals. West Middlesex has seen an increase in the number of outpatient visits and diagnostic procedures while pressure on A&E services in London continues to climb.

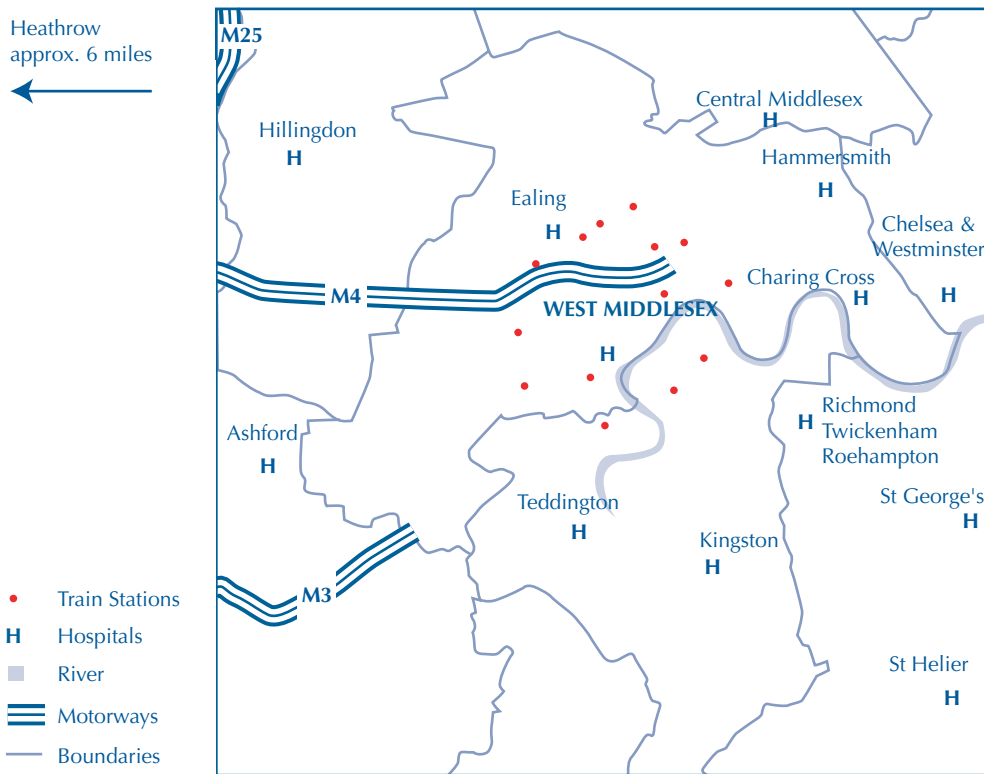
Wider strategic issues resulted in the transfer of mental health services from Ashford Hospital to the West Middlesex site at a late stage in the procurement process

1.25 LRO made a case for the transfer of mental health services from Ashford to West Middlesex in 2000. This was primarily because the existing facilities at Ashford were housed in dilapidated huts which were considered by the Mental Health Commission's inspectors to be unsuitable for use as a mental health inpatient facility. At the same time funds were available from the sale of surplus land at West Middlesex to fund a redevelopment to enable these services to be provided there.

8 Report of the Inquiry into London's health service, medical education and research, Tomlinson 1992

9 Health Services in London - A strategic review, Department of Health 1998

3 Map showing hospitals around the West Middlesex area



Source: The Trust

1.26 Proposals to use T Block, one of the existing buildings at West Middlesex, for the provision of mental health services by the Hounslow and Spelthorne Community and Mental Health Trust were raised before selection of the preferred bidder although this was not finalised until August 2000. At this late stage the Trust decided to handle this as an addition to the PFI contract. Although the business case states that redeveloping T Block was the best option for providing mental health services, local stakeholders had reservations as to whether this was in fact the best option. The Trust has told us that these reservations were considered at the time but that they were outweighed by the advantages of the proposal. The estimated cost of T Block refurbishments is £5.3 million, and this is to be funded from land sales.

The London Regional Office considered this project was consistent with local needs and anticipated future demand

1.27 LRO examined its anticipated demography and demand for health services in West London. They considered the current provision and trends in service delivery as well as changes in national priorities and concluded that the redevelopment of West Middlesex was consistent with local needs and with forecast demand.

There is some flexibility in the 35-year contract which the Trust believes is sufficient to address future healthcare uncertainties

1.28 Before signing up to a long-term contract the inherent uncertainties in planning for future healthcare requirements need to be considered, whatever the form of procurement. The Trust considers that by incorporating flexibility into the design of the building and the contractual arrangements which permit either expansion of buildings or closure of parts of the site and selling of land, these uncertainties are allowed for.

This contract is for buildings and services over a prolonged period

1.29 The contract runs to 35 years with a possibility of extension to 60 years. Healthcare is changing and this exposes the NHS to the risk that they will be locked into a contract for buildings and services that are no longer needed. For example, newer models of care focus on community-based services which might reduce the need for beds or buildings in use at West Middlesex.

The plans for the redevelopment, however, allow for some flexibility

- 1.30 The Trust says that proposed bed numbers will initially be 434 compared to 424 on the old site. In addition, the design allows flexibility to vary bed numbers to meet changes in demand. By refurbishing existing ward accommodation as non-clinical accommodation, the Trust has retained the flexibility to re-provide ward space. The Trust considers that the design allows up to six additional wards (170 beds) to be provided. Some of this flexibility, probably two wards, may be used almost immediately if the current temporary beds used on the site become permanent. Delayed discharge of elderly patients is a key factor in driving the need for additional beds. Local social services have provided some intermediate care facilities that are expected to alleviate this problem.
- 1.31 The deal also allows some flexibility on reducing bed numbers. Where wards are taken out of clinical use, there will be some reduction in the annual unitary payment payable to Bywest. Where closures and reorganisations are great enough, additional land sales could then be made.

Part 2

In getting the best available PFI deal the Trust applied common sense and learnt from experience

2.1 The Trust learnt from both its own and the NHS's experience of the first wave of PFI hospital projects. The Trust used this experience to run an effective procurement and obtained the best available PFI deal at the time based on a new NHS standard contract. The Trust took a year to reach financial close due to contractual and design issues, including a late proposal for the change of use of one of the site buildings. Deal drift was controlled, Bywest's annual price increasing by just under 10 per cent, mainly due to inflation and the decision to use land sale proceeds to fund other work.

The Trust learnt lessons from the early hospital PFI deals

2.2 This procurement was the first of the second wave of PFI hospital contracts to be signed. The Trust learnt lessons, which the Department had disseminated, arising from the experiences of the first wave of PFI hospitals. The Trust also learnt from its own experience from an earlier attempt at a PFI procurement.

The Trust learnt from its previous experience and approached the procurement effectively

- 2.3 The experience the Trust gained during its first, abortive, procurement was very helpful when it embarked on its second attempt at PFI procurement in 1998.
- 2.4 The Trust's prior experience had suggested that there was a need to develop a strong project team with key decision-makers involved. There was also the need to involve key stakeholders in order to ensure buy-in to the project. The role of advisers also needed to be made clearer and their costs monitored regularly.

There was a good project team

2.5 There was strong senior management involvement. The then Trust Chief Executive was the Project Director and the then Trust Chair took a proactive interest in the development. This meant the relevant decision-making members of staff were around the negotiation table

when it mattered most. Bidders and advisers have commented positively on the senior management commitment and consider that it helped ensure that negotiations were effective. The Project Manager was appointed to oversee the whole of the PFI procurement and this was made a full time role. His previous experience in managing health service projects was particularly helpful.

The Trust achieved greater input from all stakeholders

- 2.6 There was greater involvement from EHH than in the previous procurement. The Authority's Finance Director sat on the Trust's Redevelopment Board and was involved in the assessment of bids.
- 2.7 Clinicians were involved in both of the procurement processes and the additional time between the first and the second procurement processes allowed them to refine their ideas on clinical pathways and the optimal layout of services. They were closely involved in drawing-up internally-generated Schedules of Accommodation and then assessing the resultant design proposals generated by bidders. Both bidders and advisers told us they were able to work well with the clinicians and that their input had been essential. Senior clinicians commented that their greater involvement in the design and quality assurance process generated greater ownership by them of the outcome. In their opinion the clinical output that will be achieved is probably better than in other PFI hospital projects. They are keen to share their knowledge and experience with other Trusts undertaking PFI procurement.
- 2.8 The Patients' Partnership Panel and the Trust's Corporate Forum provided an opportunity for patient representatives and staff to keep abreast of developments in the procurement process. The Trust Chief Executive gave presentations to local Community Health Councils and to local Primary Care Groups.
- 2.9 The Trust and London Regional Office (LRO) felt that stakeholder consultation had been effective. There have, however, been some reservations. The local Community Health Councils and Primary Care Groups mentioned a

lack of consultation with them over some aspects of service provision at the new hospital and the Trade Union representatives felt that not enough information had filtered down to grassroots staff. The Trust is holding workshops and briefings with staff to inform them of progress and changes that will affect them.

The Trust monitored and used their external advisers well

- 2.10 The second procurement resulted in a much clearer definition of responsibilities between the legal and financial advisers. The Financial Advisers (KPMG) had extensive experience of hospital PFI deals. The legal firm (MacFarlanes) had extensive knowledge of the Trust from previous work. Both these advisers commented that the chartered surveyors (James Nisbet and Partners) provided excellent analysis of the bidders' proposals.
- 2.11 Advisers were appointed after competitive tendering processes. Following a review, the Trust's external auditors (HLB Kidsons) raised no concerns about the manner of these appointments. The Trust monitored the level of fees (see **Figure 4**), reconciling the fees charged for a programme of work against previously estimated costs for that work provided by the relevant advisers. Reasons given for the overspend include the delay over the agreement of the Standard Contract and the proposed change of use for T Block.

4 Adviser costs

This Figure shows that the cost of advisers was some £2.3 million

Type of adviser	Total cost (£000s)
Financial	967
Legal	803
Project management	204
Quantity surveyor	128
Other	237
Total	2,339

Source: The Trust

The Trust also learnt from wider NHS experience of early PFI schemes

- 2.12 The Department reviewed the experience of the first wave of PFI hospital projects and issued new guidance¹⁰. This guidance addressed many of the issues raised by the NAO and the Committee of Public Accounts (PAC) in their respective reports on Dartford & Gravesham, the first PFI hospital¹¹ (see Appendix 2).

The Trust made use of a standard contract developed by the Department to speed up the second wave of PFI procurements

- 2.13 In 1999 the Treasury published a set of standard contract terms which had been developed in consultation with departments and contractors. The aim was to make the procurement process faster and cheaper as departments would not have to develop each PFI contract from scratch and there would be relatively few parts of the contract that would need to be negotiated on each deal. The Department agreed with the need for standardising PFI contracts but, recognising that it was managing a large number of PFI projects and that various contractual issues were unique to health projects, it decided to develop a standard NHS PFI contract. This new contract (the standard contract) was being finalised during 2000 in discussions with contractors on the West Middlesex and other second wave PFI Hospital deals. It incorporates standardised guidance and wording on key legal issues such as compensation on termination, change of law, and uninsurable risk.
- 2.14 When the West Middlesex contract was being finalised in late 2000 and early 2001 the OGC had started the process of updating its guidance on how refinancing should be treated in new contracts following our report on the Fazakerley PFI prison refinancing¹². The Department's policy at this time was to seek a 30 per cent share of refinancing gains in the absence of explicit revised guidance from the OGC. The Trust succeeded in agreeing a 30 per cent share of refinancing gains with Bywest, which was accepted by the Treasury.
- 2.15 Around this time the OGC, pending the development of revised guidance for new contracts, was informally encouraging departments to negotiate an equitable share of any refinancing gain for new contracts and, where possible, to seek a 50/50 share¹³. However, the OGC recognised that deals at an advanced stage of negotiation, such as West Middlesex, would risk delay and that there would be increased likelihood of an increase in price if departments sought a higher share than was being achieved in the market at the time of the

¹⁰ *Public Private Partnerships in the National Health Service: The Private Finance Initiative.*

¹¹ *The PFI Contract for the new Dartford and Gravesham Hospital: NAO Report HC 423 1998/99; The PFI Contract for the New Dartford and Gravesham Hospital: PAC Report HC 131 1999/00.*

¹² *The refinancing of the Fazakerley PFI prison contract: NAO Report HC 584 1999-2000.*

¹³ *In respect of existing signed contracts, the OGC issued guidance to departments in November 2000 stating that they should seek a 50/50 share of refinancing gains where the contractor was obliged to seek authority approval to refinance a project.*

preferred bidder appointment. The Department considers that the terms on refinancing which were negotiated in the West Middlesex deal helped to establish the NHS's rights to obtain significant shares of refinancing gains. This enabled the Department in autumn 2001 to change its policy to expect a 50 per cent share of refinancing gains in all new PFI contracts, which was consistent with draft guidance on new contracts which the OGC issued at this time¹⁴.

The Trust obtained the best available PFI deal

2.16 The Trust held an effective competition and obtained the best PFI deal available at the time.

The Trust ran an effective competition to preferred bidder stage

2.17 Market interest was stimulated, there was strong competition and the Trust was able to reduce procurement time and costs by going straight from three bidders to the selection of preferred bidder without an intermediary step.

The Trust gauged market interest well and obtained competitive bids

2.18 The Trust held informal meetings with key PFI bidders prior to the strategic outline case (SOC) to sound out interest from the market. After a bidding process (Figure 5), three bidders were given a final invitation to negotiate (FITN). Taylor Woodrow who had been selected as preferred bidder on the previous attempt at procurement had been shortlisted but were not selected as one of the final bidders. Interim submissions were required from the three final bidders and KPMG consider that these were competitive.

The Trust went from three bidders straight to one preferred bidder which seems to have worked well in this procurement

2.19 To save time and costs the Trust elected to go from three bidders straight to a single preferred bidder without an intermediary step involving two final bidders. There was, however, some risk in applying this strategy while a new standardised contract was being negotiated and implemented for the first time. Any negotiations at preferred bidder stage would be carried out in an absence of competitive tension.

2.20 The Trust's approach can provide advantages for both bidders and procurers in the right circumstances. Bidders on this project all felt it was helpful since it led to lower bid costs. Although bidders had to provide more information at an earlier stage than they would have with another round of bidding, avoiding the additional round reduced their overall costs. A faster selection of preferred bidder also allowed the Trust to get a better and clearer picture of the implications of the preferred bidder's design.

5 Bidding process

The figure shows that there were initially 39 expressions of interest, from which Bywest was eventually selected as preferred bidder

Expressions of interest after OJEC	39
Longlist	9
Shortlist (Preliminary invitation to negotiate)	6
Final bidders (Final invitation to negotiate)	3
Preferred bidder	1

Source: The Trust

2.21 Safeguards need to be put in place to maintain competitive tension when using this approach. As the Trust did in this procurement, departments need to:

- Obtain greater bid detail at an early stage;
- Keep the main aspects of the deal constant in the closing stages. This may require discipline in deciding whether policy changes are sufficiently material to warrant a late change to the deal;
- Be prepared to walk away from the preferred bidder and start again if required;
- Make clear to bidders that this process is to be applied so that they know to put in their best bid;
- Seek assurance to price and terms by the preferred bidder when selected, for example, by obtaining a preferred bidder letter (see paragraph 2.27);
- Ensure there are no major open issues for negotiation at selection of preferred bidder stage, in particular, the payment mechanism should be agreed.

14 Revised general guidance on Standardisation of PFI Contracts, including new provisions on refinancing, was published by the OGC in July 2002.

2.22 Where there are outstanding issues to be resolved this method is less appropriate, and moving from three to two final bidders is preferable. The Department has recently introduced new guidance aimed at speeding up the PFI procurement process. This means that schemes with a capital value of £60 million or less (which would have included West Middlesex) have the option of avoiding a preliminary invitation to negotiate (PITN) and can go directly from three bidders at final invitation to negotiate (FITN) to one preferred bidder. However, schemes valued at over £60 million go from four bidders at PITN, and two bidders at FITN prior to selection of a preferred bidder¹⁵.

Bywest was evaluated as the best bidder

2.23 The contractors to the Bywest consortium consisted of Bouygues for construction and Ecovert for facilities management, part of the same group, which provided a unified approach to bidding. During the evaluation Bywest scored highest overall on quality (Figure 6). They were judged to have the strongest design in the key clinical areas and they were also deemed to have the best phasing and timetable for the scheme, ie. one which would cause the least disruption to the continued running of the hospital. Their apparent commitment to health and safety, training and quality assurance impressed the Trust and their human resources policy was considered better than that of their competitors¹⁶.

6 Non-financial assessment scores of the three bidders

The Figure shows the Trust's scores for each of the bids in each category other than bid price

Assessment category	Bywest	NewHealth	SUMMIT
Design and healthcare	252	241	225
Construction	57	49	49
Services approach	167	147	153
Human resources	66	50	50
Equipment	25	25	25
Overall impression	34	20	24
Grand total	601	532	526

Source: The Trust

2.24 The financial evaluation carried out by the Trust's financial advisers judged that the Bywest bid offered the best value for money (see Figure 7).

7 The comparison of bid prices at preferred bidder selection

The Figure shows that Bywest had the lowest estimated present value of unitary payments

	Bywest £000	NewHealth £000	Summit £000
Net present value of the unitary payment discounted to 1/4/99	95,200	95,486	96,631

Source: The Trust, KPMG

The NPV of the final contract with Bywest is £123.8 million. (See Figure 8 for movements after Bywest became preferred bidder.)

Deal drift was controlled despite it taking a year to close the deal due to contractual and design issues

2.25 It took a year to close this deal, partly as a result of queries about the design and the finalisation of the standard contract, including a late proposal for the use of one of the site buildings. The annual price increased by less than 10 per cent during this period, mainly due to inflation and the decision to use land sale proceeds to fund other work.

Although the Trust took steps to encourage an early deal close, it took a year to finalise the negotiations

2.26 The Trust chose Bywest as the preferred bidder in February 2000 and reached financial close nearly a year later on 30 January 2001.

2.27 In order to guard against the possibility of deal drift, the Trust obtained a preferred bidder letter from Bywest in February 2000. This confirmed that, subject to certain conditions, Bywest would stay committed to the price for seven months¹⁷. It would also commit to the timetable for doing the deal (then expected to be October 2000) and all the contract terms, with the exception of uninsurable risk where contract negotiations were ongoing. The Trust considers that Bywest honoured the commitments it gave in that letter. Deal closure was delayed until February 2001 and this delay contributed

15 Improving PFI Procurement: Department of Health, March 2002.
 16 The Trust addressed employment issues before completing the PFI deal and had included the HR policy of the bidders as one of the non-financial assessment criteria. Many non-clinical services had already been contracted out and the staff had already been transferred to the private sector. Only 22 NHS staff were transferred to Bywest's service provider, Ecovert, as a result of the PFI.
 17 After the seven-month fixed period, the price was to be increased according to an agreed index.

towards the price increase. The Trust informed us that some remaining standard contractual uncertainties and design issues were the major factors contributing to the delay. NHS Trusts now ask all preferred bidders to confirm the price and deal closure timetable at the time of initial appointment. These commitment letters are also now part of OGC guidance¹⁸.

8 Changes in annual unitary payment and net present value (NPV) between preferred bidder and contract award

This Figure shows that deal drift was controlled with the annual unitary charge increasing by 8.4 per cent between preferred bidder selection and financial close, mainly due to inflation and an increase in costs as the Trust decided to use land sale proceeds to fund other work. The extension of the contract and other timing factors affected the net present value of the contract.

	Annual unitary charge £000	% change	NPV £m
Bywest's bid - Feb 2000 (in April 1999 prices)	8,595		95.2
Increase in funds as land sales proceeds were replaced by other funding ¹	517		
Inflation uplift ²	446		
Interest rate movements	(361)		
Other negotiations	224		
	826	9.6%	9.2
	9,421		104.4
Timing factors ^{3, 4} :			
Annual unitary payment reduction by extending contract 30 to 35 years	(100)		(1.1)
Increase in NPV due to extension of contract	-		8.4
Change in discount base date	-		7.0
	(100)	(1.2%)	
Final contract price before energy costs	9,321	8.4%	118.7
Energy costs ⁵	453		5.1
	9,774		123.8

NOTES

1. After Bywest became preferred bidder the Trust decided to use proceeds from the land sales associated with the redevelopment to fund other work on the site. Bywest therefore had to seek additional external funding to replace the land sale proceeds which, when bidding, it had assumed would be £7.5 million.
2. The inflation uplift arises through restating Bywest's bid at 1999 prices to March 2001 prices applicable at financial close.
3. After Bywest became preferred bidder the Trust decided to extend the contract period from 30 to 35 years, partly because this would reduce the amount of the annual unitary charge.
4. The NPV at preferred bidder stage was undertaken about a year before financial close and used a different discount base date. The adjustment of £7 million is the result of altering the date so the calculations are on a consistent basis with the final NPV of £123.8 million.
5. Throughout the procurement it had always been agreed that the selected contractor would pass on energy costs based on actual usage. These costs were not included in the February 2000 bids.

Source: The Trust

Negotiations with the preferred bidder were needed on contractual and design issues

- 2.28 The Department was introducing its new standard contract during the time this deal was being negotiated. Bidders had signed up in principle to the terms and conditions of the standard form contract at FITN stage. Most of the terms had been agreed by the time that Bywest was selected as preferred bidder. Some outstanding matters such as uninsurable risk, compensation on termination and the new major issue of refinancing had to be dealt with and this caused delay.
- 2.29 LRO proposed an alternative use for one of the buildings (T Block) on the West Middlesex site late in the procurement process; this complicated the negotiations and resulted in a late alteration to the PFI contract, in the form of an additional schedule to the contract dealing specifically with T Block (see paragraph 1.26).
- 2.30 NHS Estates also needed to discuss detailed design issues with Bywest. This is a normal feature of hospital procurements once a preferred bidder has been selected but still adds to the time taken to reach deal closure.

The delay increased the price but with the increase in annual charge being less than 10 per cent

- 2.31 During the preferred bidder negotiations deal drift was controlled. Bywest's annual price increased from £8.6 million to £9.3 million, an increase of 8.4 per cent (see Figure 8). The Trust's financial advisers, KPMG, together with James Nisbet and Partners, the quantity surveyors, monitored the increases and were satisfied that the final unitary payment still represented value for money and confirmed this in writing.

Bywest obtained competitive financing arrangements

- 2.32 Both bank and bond financing were considered for this deal but bank financing was selected at rates the Trust's advisers consider competitive. A funding competition immediately prior to contract letting was not considered appropriate but Bywest approached different funders and the Trust had the right to compel the consortium to seek alternative finance if its selected financial partner was felt to be uncompetitive.

Bywest selected bank finance as being preferable to bond finance

- 2.33 Bywest researched funders in both the bank and bond finance markets and chose bank finance. Bywest opted for bank finance as the bank offered the same repayment period as bond finance and better margins. In addition, the Trust and KPMG felt that arrangers of bond finance would have difficulty with the uncertainties surrounding the new contract terms being developed by the NHS for this deal. Subsequently the NHS has used bond financing with the new contract terms with deals at Dudley and West Berkshire. Bank finance may also give the Trust an opportunity to benefit from refinancings, which are less likely with bond financing.

The Trust's advisers were satisfied that Bywest had obtained very competitive terms for the bank finance for this deal

- 2.34 The Trust's advisers, KPMG, benchmarked the terms of the bank finance obtained by Bywest. They found the terms on which Abbey National was providing finance were very competitive. They attribute this to Abbey National being keen to finance PFI hospital deals.
- 2.35 Based on the Treasury Building experience, where a funding competition was used after new contract terms had been developed, it can sometimes be helpful to have the financing competed for once the contract has been totally agreed. In this case, KPMG did not think that this would be appropriate as it wanted the selected funder involved in the final negotiations on the new standard contract. KPMG was satisfied that competitive financing would be obtained without a funding competition. In addition, the Trust had the right to compel the consortium to seek alternative financing arrangements if it could show that the original finance terms were not competitive.

Part 3

The Trust considered that the unquantifiable benefits of doing this as a PFI deal outweighed the disbenefits

3.1 There are potential benefits and disbenefits of entering any long-term PFI contract which must be managed effectively to ensure the deal offers value for money. The Trust believes it has managed the potential disbenefits and risks effectively in this contract. The financial comparison between the deal and the public sector comparator was not clear cut, but this comparison did not take account of many of the benefits, which justify doing this as a PFI deal, taking all benefits and disbenefits into account. The Trust's initial financial comparison showed the PFI price slightly higher than conventional procurement. As part of the iterative process of developing the risk analysis the risks were reappraised. The final calculations showed a saving of £5.5 million from the PFI deal based on risk assumptions consistent with previous experience. The deal will be affordable to the Trust provided it achieves estimated operational savings when the new hospital opens.

The Trust expects net benefits from this PFI deal

There are generic benefits and disbenefits arising out of a PFI deal

3.2 As with many PFI deals, there are potential generic benefits and disbenefits from committing to such a long-term relationship with a contractor. Good control and management of these benefits and disbenefits is crucial to achieving long-term value for money under the contract. **Figure 9 overleaf** outlines some of the main generic potential benefits and disbenefits to this long-term type of deal.

The Trust believes it has managed the benefits and risks of disbenefits effectively

3.3 Under this contract, Bywest will not receive any payment until April 2003 when the Trust is scheduled to begin to operate from the new hospital. Bywest is incentivised to ensure that construction and refurbishment are completed on time to provide the Trust's service requirements. No payment will be

made until the assets are completed to the satisfaction of, and signed off by, an Independent Tester appointed by the Trust.

3.4 The payment mechanism is geared towards ensuring that the Trust receives the services agreed in the contract to meet its business needs. Bywest is incentivised to provide services as agreed in the contract. If the level of service falls below that required by the Trust, the Trust will make deductions from the unitary payment (**Figure 10 overleaf**). In early July 2002, the Department introduced a standard payment mechanism that has drawn upon innovative features of the mechanism used in the West Middlesex deal.

3.5 Maintenance at the West Middlesex Hospital site has been neglected in the past and the Trust estimates that this has led to a backlog of maintenance investment of some £28 million. Previously maintenance has been deferred as a result of funding constraints. One of the benefits of the PFI deal is that the contract ensures that the contractor is obliged to maintain the building to ensure there is no deterioration in building stock, which could impact upon service delivery.

The Trust has implemented controls to manage the potential disbenefits and risks of the contract

3.6 The contract ties the Trust to a 35-year relationship with Bywest, with a possible extension to 60 years. Over this long period it is likely that the healthcare needs of the local population and therefore the Trust's needs will change. The lack of a cohesive strategy for the West Middlesex area and other parts of London, together with changes in the structure of healthcare provision add further uncertainty to the longer-term requirements of the Trust. These uncertainties pose potential risks for the long-term PFI contract. These types of longer-term planning uncertainties are not limited to PFI hospitals, and would also affect a conventionally-procured hospital. However, the long-term nature of a PFI contract would be likely to make it more expensive to terminate the ongoing arrangements than a traditionally-procured hospital. The Department considers there is a low risk of terminating this PFI contract.

9 Potential generic benefits and disbenefits of PFI deals

The Figure shows some potential generic benefits and disbenefits of PFI contracts

Benefits	Disbenefits
There can be greater price certainty. The department and contractor agree the annual unitary payment for the services to be provided. This should usually only change as a result of agreed circumstances.	The department is tied into a long-term contract (often around 30 years). Business needs change over time so there is the risk that the contract may become unsuitable for these changing needs during the contract life.
Responsibility for assets is transferred to the contractor. The department is not involved in providing services which may not be part of its core business.	Variations may be needed as the department's business needs change. Management of these may require re-negotiation of contract terms and prices.
PFI brings the scope for innovation in service delivery. The contractor has incentives to introduce innovative ways to meet the department's needs. In the case of hospitals, however, this is limited since currently clinical services are excluded and remain with the NHS Trust.	There could be disbenefits, for example, if innovative methods of service delivery lead to a decrease in the level or quality of service.
Often, the unitary payment will not start until the building is operational, so the contractor has incentives to encourage timely delivery of quality service.	The unitary payment will include charges for the contractor's acceptance of risks, such as construction and service delivery risks, which may not materialise.
The contract provides greater incentives to manage risks over the life of the contract than under traditional procurement. A reduced level or quality of service would lead to compensation paid to the department.	There is the possibility that the contractor may not manage transferred risks well. Or departments may believe they have transferred core business risks, which ultimately remain with them.
A long-term PFI contract encourages the contractor and the department to consider costs over the whole life of the contract, rather than considering the construction and operational periods separately. This can lead to efficiencies through synergies between design and construction and its later operation and maintenance. The contractor takes the risk of getting the design and construction wrong.	The whole life costs will be paid through the unitary payment, which will be based on the contractor arranging financing at commercial rates which tend to be higher than government borrowing rates.

Source: National Audit Office

10 An example of deductions from the unitary payment

The Figure shows the impact on unitary payments of the closure of an operating theatre.

Impact on Bywest of causing an operating theatre to be unavailable for 24 hours (one weekday)

Financial impact on Bywest	Impact on the Trust and patients
The payment deduction on the contractor is approximately £1,400.	More difficult to determine because of the variation in possible types of operation or theatre. A worst case scenario might result in as many as eight cancelled operations

Source: The Trust

3.7 One of the generic risks of PFI contracts mentioned in Figure 9 is the potential difficulty of dealing with contract variations. Changes in healthcare requirements may lead to variations. The contract therefore contains safeguards to control the rate of return Bywest can make in the event of future works variations to the contract. This protects against the risks of the Trust paying excessive prices for any variations.

The financial comparison between the costs of this PFI deal and conventional procurement is not clear cut, but this took no account of other benefits

In estimated cost terms, this PFI deal is similar to conventional procurement

3.8 In line with current PFI guidance, the Trust undertook a financial comparison to compare the costs of the PFI bid with the estimated costs of providing the same level of service using conventional procurement. It compared the net present value (NPV) of the unitary payments under the PFI deal to a public sector comparator (PSC), adjusted for risks transferred under the contract. The final comparison showed that the estimated cost of the PFI deal is slightly lower than the PSC. This is, however heavily dependent on the estimated value of risk transfer (Figure 11).

11 The Trust's financial comparison of the PFI deal as approved by the Department in January 2001¹

The figure shows that the estimated cost of the PFI deal is £5.5 million less than the PSC

	PFI Deal (£ million NPV)	Public sector comparator (£ million NPV)
35 years pre-risk adjusted	984.1	976.5
Risks transferred	-0.6	12.5
Total risk adjusted	983.5	989.0
Total difference		5.5

NOTE

1. Clinical services are outside the scope of the deal, but the Trust included identical clinical costs on each side of the calculation in line with the Department's guidance. The pre-risk adjusted NPV of the unitary payments for the project over 35 years is £123.8 million. The public sector comparator was £129.3 million.

Source: The Trust

There are inherent uncertainties in the comparison

3.9 The comparison covers a 35-year period so there are inevitable uncertainties in forecasting the future, for example, costs of construction and service provision and changes in design or service requirements. These uncertainties are common to all such financial comparisons involving forecasting future costs. The estimates of the value of risks transferred under the deal are also subject to uncertainties and involve elements of judgement. Such judgement is necessary to estimate the likelihood of an uncertain risk event occurring over the life of the deal in order to estimate a money value for the risk transferred.

3.10 The Trust carried out sensitivity analysis to compare the effects on both PFI and PSC calculations of changing a number of the key financial variables, such as capital expenditure and operating costs (Appendix 2).

The Trust's initial comparison showed the PFI price slightly higher than the cost of conventional procurement; the Trust and KPMG considered it important to re-assess details of the risk analysis to ensure they were properly reflected in the PSC and consistent with previous experience

3.11 Before submitting the Full Business Case to the London Regional Office (LRO) and to the Department for approval, the Trust checked the PSC. In doing so the Trust was addressing a recommendation in our report on the Dartford and Gravesham PFI hospital that these calculations should be subject to rigorous review in order to eliminate material errors. The checking work included a review by the Trust and KPMG of the risk analysis which was part of the PSC.

3.12 The Department told us that it would not necessarily withhold approval for a PFI project that appeared slightly more expensive than conventional procurement if there were convincing value for money reasons for proceeding with the deal. In this case the initial estimated costs of the PSC were lower than those of the PFI deal. Both the Trust and KPMG were satisfied with the overall value for money of the deal, taking all benefits and disbenefits into account. But they had concerns about the accuracy of this initial financial comparison and whether an estimate showing the PSC cheaper than the PFI deal would prevent them obtaining Departmental approval.

3.13 Developing the risk assumptions in the risk analysis is an iterative process. As part of this iterative process the Trust and KPMG re-appraised the figures to ensure the risks inherent in traditional procurement were properly reflected in the PSC. The Trust and KPMG believed there were underestimates in the risk figures, some of which related to factors arising from the NHS Plan. KPMG encouraged the Trust to revisit these figures as it

believed the risk analysis was incomplete. Risk workshops were held and adjustments to cost and risk estimates were completed before seeking Departmental approval, which resulted in the PSC becoming slightly higher than the PFI price. The final calculations showed a risk-adjusted saving from using the PFI of £5.5 million compared with a PSC, including project costs and clinical costs, of £989 million over 35 years (net present values). As with all long-term cost estimates there are inherent uncertainties in this comparison, and particularly regarding the size of the adjustment for risk. The Department was satisfied with the resulting risk assumptions. The total value for risk included in the comparator, including about 15 per cent of capital costs for construction and design risks, was reasonable. It fell within the Department's range for expected risk transfer based on historical evidence from PFI projects, and was in the middle of the range indicated by a recent wider study.¹⁹ The re-assessed cost comparison therefore reinforced the value for money case for the PFI deal. There are unquantified benefits which supported the view of the Trust and KPMG that the PFI option would deliver value for money taking all benefits and disbenefits into account.

The emphasis on the detail of the cost comparisons took no account, and indeed masked, the broader benefits of the PFI deal

- 3.14 The financial comparison of the PFI deal and the PSC focused on the estimated costs of the two options, which showed that the estimated costs were similar between the options. Uncertainties inherent in such cost estimation, particularly in respect of the PSC, mean that there was little to choose between the PFI and the traditionally procured options in terms of the financial comparison alone.
- 3.15 Such financial comparisons, however, take no account of the benefits of this type of contract. Indeed they can mask these important benefits, as the focus of the assessment of value for money is on the comparison of two cost figures. It does not explicitly include wider benefits, such as price certainty, incentives for service delivery and transfer of responsibility for assets, which were important considerations for the Trust. Although some benefits of risk transfer were recognised in the calculations, these omit other non-quantifiable benefits and cannot fully reflect the importance which the Trust attached to all the benefits of the PFI approach. Although the financial comparison can be a useful management tool to inform judgement, it is important that the wider benefits and disbenefits of alternative approaches are also taken into account in decision making.

The deal will be affordable to the Trust, provided running cost savings are achieved

The unitary payment is within agreed funding limits

- 3.16 The Health Authorities required net savings of £1.6 million a year from the running costs of the Trust at the time the strategic outline case (SOC) was approved. For example, savings were expected to occur from the increased efficiency of the new building design. This would remove the need for patients to be transported between departments in electric vehicles. It would also reduce the amount of duplication of services and administration caused by the existing fragmented layout of the site. The SOC stated that the Health Authorities would review their commitment to the project if the estimated savings were to fall below £1.6 million.
- 3.17 Towards the end of the negotiation period, Bywest's annual price was some £230,000 greater than the Trust could afford. However, the final unitary payment figure was brought back down within the affordability cap in final negotiations. The Trust agreed to share the inflation risk on some of the unitary payment over the first eight years of the contract. After the first eight years, the whole unitary payment will be indexed to the retail prices index (RPI).

The deal must deliver running cost savings to remain affordable

- 3.18 Over the first four years of the contract, the Trust expects a deficit totalling £2.1 million, until the new hospital buildings and refurbishment are complete and the estimated savings begin to be realised. The LRO will receive revenues from the sales of surplus land, and will use these receipts to provide transitional funding to cover the temporary deficit up to an amount of £2.8 million.
- 3.19 The Trust's budgets have been calculated on the basis of achieving the £1.6 million annual savings, following the period of transitional funding to 2004/05, needed for the deal to remain affordable. Annual savings of £600,000 were achieved and incorporated in the Trust's budgets from 2000/01 onwards. As noted in paragraph 1.12, the Trust has plans for how the further required increase in annual savings will be achieved, but may need to reconsider these in the light of current changes in clinical practice.

¹⁹ A recent study commissioned by the Treasury estimated a range for construction cost overruns in standard building projects of between 2 and 24 per cent: *Review of Large Public Procurement in the UK*, Mott MacDonald July 2002.

Appendix 1

National Audit Office Methodology

- 1 The National Audit Office examined the extent to which the PFI contract for the West Middlesex University Hospital NHS Trust redevelopment is likely to deliver value for money and the Trust's management of this project.
- 2 We used an issue analysis approach to design the scope and nature of the evidence required to complete this examination. That is, we set a series of high-level audit questions that we considered it would be necessary to answer to assess the success or otherwise of the procurement, and collected evidence accordingly. For each of the top-level questions, we identified a subsidiary group of questions, linked logically to the main questions, to direct our detailed work and analysis. Our general report *Examining the value for money of deals under the Private Finance Initiative* (HC 739, 1998-99) provides an outline of this general methodology which acts as a starting point for all of our PFI examinations. We also drew on relevant issues covered in our other PFI reports, particularly our report on the *PFI contract for the New Dartford and Gravesham Hospital* (HC423, 1998-99) and those dealing with accommodation projects or the financing of large PFI deals.
- 3 The top-level questions we set were:
 - Did the Trust learn lessons from the early hospital PFI deals in planning the procurement?
 - Did the Trust undertake an effective procurement?
 - Did the Trust obtain the best deal available?
- 4 Our main evidence has been derived from examining documents provided for us by the Trust and the Department, interviews with relevant staff within the Trust, the appropriate Health Authorities, the Regional Office and the Department. We also spoke to local stakeholders, such as Community Health Councils and Primary Care Groups, as well as the Trust's advisers and the bidders for the deal.

Appendix 2

Action by the NHS in this project in respect of previous NAO and PAC recommendations

NAO Recommendation ¹	PAC Recommendation ¹	Has the West Middlesex deal met the Recommendation? ²
<p>Healthcare strategy</p> <p>The local Health Authority and Regional Office should confirm that the project will contribute to the best use of the Department's funds within the plans for health services in their respective localities. (Rec. 1)</p>	<p>The Department should think carefully about the flexibility required to meet developments in service delivery and changes in demand. Before committing to any long-term PFI contract, it should consider how these requirements for flexibility can be addressed. (Rec. 1)</p> <p>The need for any long-term project should be assessed against the local healthcare strategy and the costs and benefits involved should be compared with those of alternative options for improving services. (Rec. 2)</p>	<p><i>The Trust produced a strategic outline case (SOC) (in line with Departmental Guidance). This was agreed by the local health authorities and the Regional Office who consider it would meet local needs. To address possible long-term changes in demand, the hospital design incorporates both upward and downward flexibility in bed numbers. However, given uncertainties in healthcare planning, it is not clear how West Middlesex would be used in the long term.</i></p>
<p>Affordability</p> <p>Trusts and Health Authorities should agree likely funding limits at the outset and should evaluate these proposals against future spending plans at key stages of the procurement. (Rec. 1)</p> <p>Trusts should provide bidders with clear guidelines on their funding limits to help secure bids which the Trust and the Health Authority can afford. (Rec. 1)</p>	<p>Before approving any long-term project, the Department should identify in full the funding implications and then keep track of these as the project develops. (Rec. 3)</p>	<p><i>The SOC (1998) stated that the local health authorities required that £1.6m of savings should be achieved for their approval to the project.</i></p> <p><i>An affordability ceiling was stated in the final invitation to negotiate (FITN) tender documentation provided to bidders and the Trust monitored the bids against this ceiling during contract negotiations.</i></p>
<p>Analysis of value for money</p> <p>Trusts should carry out a rigorous review of the calculations which compare the expected costs and benefits of the proposed PFI project with the conventionally financed alternative. These comparisons should also be updated to take account of all significant changes to contract terms prior to letting the contract. (Rec. 2)</p>	<p>NHS trusts should formally update their value for money comparisons to take account of changes to contract terms as they arise. (Rec. 6)</p> <p>NHS trusts should seek to evaluate all reasons for any movements in the prices proposed by bidders. (Rec. 16)</p>	<p><i>The Trust compared the costs of the PFI deal with the estimated costs of a public sector comparator (PSC). This was reviewed by the Department who were satisfied with the calculations.</i></p> <p><i>The Trust and its financial advisers updated the risk analysis for incorporation into the PSC in the light of changes in contract terms and the results of negotiations. A record of contract changes was maintained and the resultant effect of these changes on the financial comparison. The Trust's financial adviser was satisfied with the reasons for changes and that the resulting increases in costs to the Trust represented value for money.</i></p>

¹ The recommendations are summaries of those set out in the NAO and PAC reports on the Dartford and Gravesham PFI Hospital Contract.

² The action taken by West Middlesex and the Department should be seen in the light of an evolving approach by the NHS to PFI procurement. Many of these actions were in progress at the publication date of the NAO and PAC reports on the Dartford and Gravesham contract and were addressed in the Treasury Minute in response to the PAC report.

NAO Recommendation ¹	PAC Recommendation ¹	Has the West Middlesex deal met the Recommendation? ²
<p>Calculation of the public sector comparator</p> <p>The costs of the PSC will include provision for possible cost overruns in building the hospital. The accuracy of these calculations might be improved by refining the data available on cost overruns on past traditional hospital procurements to be consistent with the status of the cost estimates used in the public sector comparison under review. The calculations of the various provisions for cost overruns should be reviewed carefully to avoid any possible double counting. (Rec. 3)</p>	<p>NHS trusts and other public sector bodies should prepare PSCs carefully and should subject them to independent checking to minimise the risk of undetected errors. (Rec. 4)</p> <p>Trusts should make reasonable assumptions about their ability to improve their future procurement performance when preparing their PSC. (Rec. 10)</p> <p>The Department should periodically recheck the assumptions for capital and operating costs made in previous value for money assessments against actual experience to inform assessments for future projects. (Rec. 8)</p> <p>NHS trusts should take full account of the financial consequences of risks retained resulting from differing usage levels when comparing the possible use of the PFI against the option of a conventionally-funded hospital. (Rec. 7)</p>	<p><i>The Trust and its financial advisers reviewed the initial financial comparison and certain amendments were made. The Department then reviewed the final PSC.</i></p> <p><i>The cost overrun risk was quantified on the basis of the latest rolling average of actual cost overruns on public schemes collected by NHS Estates. The possibility of future improvements in public procurement is one of the elements covered by the sensitivity analysis.</i></p> <p><i>The Department's review made use of past data on costs, overruns and risk allocations to inform this review. The Department was satisfied that these were reasonable in the West Middlesex deal.</i></p> <p><i>Sensitivity analysis was carried out on the effect of operating cost changes on the valuation of both the PFI and PSC options³. This analysis concluded that the PFI option was cheaper where there was an increase of either 10% or 20% in operating costs but more expensive where operating costs decreased by 10%.</i></p>
<p>Use of public financing</p>	<p>The Department should continue to give proper consideration to the option of using public finance in all hospital projects. (Rec. 11)</p>	<p><i>The importance of this project was such that London Regional Office (LRO) would have used conventional financing if PFI was considered to be inappropriate.</i></p>
<p>Advisers</p> <p>Trusts should normally go out to formal competition to commission advice on a PFI project. (Rec. 5)</p>	<p>NHS trusts should ask their advisers for carefully prepared cost estimates, to update these if there are changes to the work required, and to closely monitor actual costs against the estimates. (Rec. 17)</p>	<p><i>The legal and financial advisers and the Project and Estates Manager posts were all subject to competitive tendering.</i></p> <p><i>The Trust monitored the level of fees, reconciling the fees charged for a programme of work against previously estimated costs for the work as provided by the relevant advisers.</i></p>

3 The sensitivity analysis was conducted on the base NPV costs, i.e. the risk valuation attached to the PSC option was excluded from the calculation.

NAO Recommendation ¹	PAC Recommendation ¹	Has the West Middlesex deal met the Recommendation? ²
<p>Central advice/procurement costs</p> <p>The Department may wish to consider the scope and benefits of commissioning certain advice centrally on common issues, and benchmarking advisers' costs with those incurred on other PFI projects, to help reduce the overall costs to the Department of individual trusts commissioning advice separately. (Rec. 6)</p>	<p>The Department has assured us that lessons have been learnt from this project and the other early PFI hospital projects, and that measures introduced, such as contract templates and new procedures for the reporting and monitoring of project costs, will lead to significant improvements. We expect to see major reductions in the costs of letting PFI hospital contracts particularly as the need for new legislation, which gave rise to delays in this project, should not arise in later projects. (Rec.18)</p>	<p><i>The Department has introduced a standard contract and other new guidance for PFI hospital deals. The West Middlesex deal was the first one on which the new contract template was used.</i></p> <p><i>Adviser costs on the first 18 major hospital PFI schemes (greater than £25m) averaged 3.9% of their total capital value. Some reductions have been observed in later schemes (eg. Dudley's adviser costs were 1.4%) and the Department of Health expects the downward trend will be confirmed by the 29 schemes which were given the go ahead in February 2001.</i></p>
<p>Competitive process</p> <p>Trusts should seek to maximise the extent of competitive tension in the bidding process for PFI projects. They should ensure that bidders feel able to comply with their bidding requirements and the timetable for submission of bids remaining sensitive to the effect of bidding costs on the willingness of bidders to participate in a competition. When selecting final bidders trusts should assess the comparative merit of bids on the basis of overall value for money, not just price. (Rec. 4)</p>	<p>NHS trusts should assess carefully the risks to achieving an effective competition and manage these accordingly. (Rec. 15)</p>	<p><i>The Trust held informal discussions with key PFI bidders to stimulate interest in the project. It was able to ensure that six bids were submitted at the preliminary invitation to negotiate (PITN) stage. This was reduced to three bidders at the final invitation to negotiate (FITN) stage. To save time and costs the Trust elected to go straight to a single preferred bidder without an intermediary stage involving two final bidders. This step was taken with the agreement of all three final bidders and the Department. The Department is now recommending this approach on other PFI projects.</i></p> <p><i>Evaluation of the bids was based on both financial and non-financial criteria.</i></p>
<p>Returns to the contractor</p>	<p>NHS trusts should relate the returns sought by members of private sector consortia to the risks which they will bear. (Rec. 12 and 13)</p> <p>NHS trusts should reach a clearly agreed position on refinancing with their private sector partners when closing a deal. (Rec. 14)</p>	<p><i>The Trust's financial advisers considered that the financing for the Bywest bid offered competitive rates which were reasonable for the risks being undertaken.</i></p> <p><i>Bywest and the Trust agreed a 70:30 split on any re-financing gains that might subsequently occur on the deal.</i></p>

Appendix 3

Changes in local NHS responsibilities over the last 15 years

Date	Provider Organisation	Commissioner Organisation	Intermediate Management Tier
1985 (1)	Acute Unit, Hounslow & Spelthorne Health Authority	Hounslow & Spelthorne Health Authority	North West Thames Regional Health Authority
1992	Acute Unit, Ealing, Hammersmith & Hounslow District Health Authority	Ealing, Hammersmith & Hounslow District Health Authority (2)	North West Thames Regional Health Authority
1993	West Middlesex University Hospital NHS Trust (3)	Ealing, Hammersmith & Hounslow District Health Authority	North West Thames Regional Health Authority
1994	West Middlesex University Hospital NHS Trust	Ealing, Hammersmith & Hounslow Health Agency (4)	North Thames Regional Health Authority (5)
1996	West Middlesex University Hospital NHS Trust	Ealing, Hammersmith & Hounslow Health Authority (6)	North Thames Regional Office of the NHS Management Executive (7)
1999	West Middlesex University Hospital NHS Trust	Ealing, Hammersmith & Hounslow Health Authority	London Regional Office of the NHS Executive (8)
2002	West Middlesex University Hospital NHS Trust	Hounslow PCT (9)	North West London Health Authority (9)

NOTES

- Up to 1990/91, health services were delivered (provided) and funding allocated through a single Health Authority structure - hospitals were managed by Health Authorities. The 1990 legislation created NHS Trusts and separated the provider function from the commissioning function. Commissioning Authorities were set up to purchase healthcare from providers. Also in 1990, the functions of the Regional Health Authority were slimmed down and some functions transferred to Health Authorities. Family Health Services Authorities (FHSA) were also in place to manage the provision of GP services;
- Several health authorities merged to form a new District Health Authority. West Middlesex Hospital was a Directly Managed Unit of the DHA;
- West Middlesex Hospital was a third-Wave NHS Trust and was established in April 1993;
- Several District Health Authorities operated with the FHSAs as a single commissioning organisation;
- North West Thames and North East Thames Regional Health Authorities merged in April 1994 to form North Thames Regional Health Authority;
- The Family Health Services Authorities (FHSA) which dealt with primary care and GP funding were merged with the other local commissioning District Health Authorities to create single healthcare commissioning authorities. This superseded the Health Agency arrangements which had been in place in several areas;
- Regional Health Authorities were abolished. The intermediate management tier function was then undertaken by Regional Offices of the NHS Management Executive, which was part of the Department of Health;
- North Thames and South Thames Regional Offices were merged into a single London Regional Office following the publication of the Turnberg Report in 1998. The LRO operates on a sectoral basis across London (North Central, North West, North East, South East and South West);
- Under 'Shifting the Balance of Power', responsibility for commissioning health services is transferred to Primary Care Trusts (PCTs). Many of the roles of the London Regional Office are transferred to merged Health Authorities which match the former LRO sectors. In October 2002 (subject to legislation) North West London Health Authority will become North West London Strategic Health Authority.