



National Audit Office

**REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL**

**HC 68
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The performance and management of hospital PFI contracts

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National Audit Office

The performance and management of hospital PFI contracts

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Amyas Morse
Comptroller and
Auditor General

National Audit Office

10 June 2010

Private Finance Initiative (PFI) hospital contracts are awarded and managed by local Trusts. The contracts use private funding to build and maintain hospital buildings. The contractor often provides support services, typically including cleaning, catering and portering, often referred to as hotel services.

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Contents

Summary **4**

Part One

Introduction **12**

Part Two

The performance and cost of
PFI hospital contracts **16**

Part Three

PFI contract management **26**

Part Four

The role of the Department **38**

Appendix One

Methodology **42**

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This report can be found on the
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Summary

The Private Finance Initiative in the NHS

- 1 Private Finance Initiative (PFI) hospital contracts are awarded and managed by local Trusts. The contracts use private funding to build and maintain hospital buildings. The contractor often provides support services, typically including cleaning, catering and portering, often referred to as hotel services.
- 2 The Department of Health (the Department) is responsible for approving new contracts with a capital value of over £35 million or those that are high risk. The Department also supports Trusts in negotiating and managing the contracts. The Department currently supports 76 such operational PFI contracts in England, costing £890 million a year.
- 3 The Department's accountability for the contracts depends on the type of Trust managing the contract:
 - a **Thirty-nine per cent of the contracts are managed by Foundation Trusts (Foundations).** Foundations provide NHS services but are independent of the Department. The Department cannot require Foundations to provide information or direct Foundations to take specific action. Each Foundation chief executive is directly accountable to Parliament as an Accounting Officer.
 - b **Forty-nine per cent of the contracts are managed by NHS Trusts.** These Trusts have not yet achieved Foundation status and remain directly accountable to the Department. The Department aims that all NHS Trusts obtain Foundation status by the end of 2013-14.
 - c **Twelve per cent of the contracts are managed by Primary Care Trusts (PCTs).** Some PCTs operate hospitals as part of their provider function. PCTs are formally accountable to the Department via Strategic Health Authorities.

We use the word Trust to include all three types of Trust.

Scope of this report

4 This report is about the performance of the maintenance and support services under the PFI contracts, and how they are managed by the Trusts. It focuses on the stage of the contract once the buildings are open for use, by which time the choice of using PFI has already been made. The report does not examine the decision to use PFI as a procurement route, the financing or design and construction issues. The report highlights the challenge for Trusts with operational contracts of making the most of the contract and their relationship with the contractors, and ensuring they get the services expected.

5 The report also focuses on how the Department supports Trusts in their management of the contracts. The Department devolves delivery of health services to Trusts, as part of a framework of devolved delivery, decision-making, financial incentives and accountability. It is attempting to intervene as little as possible in local delivery and to not direct Trusts nor require information from them superfluously. The report highlights the challenge to the Department of how to balance supporting local delivery with allowing Trusts to manage their affairs.

6 In scoping this report we used three value for money criteria:

a Performance (Part 2).

Are performance and costs as specified in the contract and meeting the needs and expectations of Trusts?

b Management (Part 3).

Are Trusts managing their contracts in line with best practice?

c Role of the centre (Part 4).

Is the Department providing Trusts with effective support in managing their contracts?

Key findings

Performance and cost of services

7 Information collected by the NAO indicates that most contracts are performing satisfactorily or better and meeting the expectations of Trusts. We base this on each Trust's reported satisfaction, and information from their Performance Management Systems. Sixty-seven per cent of Trusts report satisfaction with their contracts, and the majority of Trusts report consistent or improved performance over time. The level of penalties applied for poor performance is low. Fifty three per cent of Trusts charged no deductions in 2008-09, with the remainder charging deductions which represented a low percentage of their annual payments. Although we have some reservations about data quality, we believe that there is strong enough evidence to say that most contracts are delivering the value for money expected of them.

8 However, there is scope for improvements. Thirty-three per cent of Trusts are dissatisfied with at least one of the services they receive under their PFI contracts. None rated all services as excellent. Problems with performance have varied and do not suggest a single set of systematic issues.

9 Available information shows the cost and performance of PFI hotel services are similar to those services in non-PFI hospitals. The cost of each service varies significantly in both PFI and non-PFI hospitals, and there is a large amount of overlap in these price ranges between the PFI and non-PFI groups. Most of the variation in costs cannot be explained using the Department's current information. There is also no difference between Trust assessments of performance against objective measures for cleaning and catering services in PFI and non-PFI hospitals. There are no comparisons of the performance of other services. Our analysis shows:

- cleaning, laundry and portering costs are about the same whether delivered through PFI or not;
- catering is on average slightly cheaper in PFI hospitals; and
- hospitals with PFI buildings spend more on maintenance annually, because the contracts require them to be maintained to a specified high standard.

It was not possible to do this analysis for 2008-09 or 2009-10 because the NHS stopped collecting the data.

10 It is thus not clear whether it is better or worse value for money to include the hotel services within the PFI contract, rather than managing them separately. The value for money of the whole PFI contract, however, depends upon wider factors outside the scope of this report, such as potential benefits from the construction and design of the buildings, risk transfer during the construction phase or having fixed whole life costs, all set against the higher costs of private finance.

Managing contracts

11 Managing PFI contracts is a challenging task. We found four main areas where Trusts are trying to defend value for money in their interactions with contractors:

- a** Interpreting the scope of the contract to defend the Trust's position in any contractual disputes.
- b** Managing the change process to ensure changes to the building and services are value for money and timely.
- c** Fulfilling their obligations to ensure intended risk transfer.
- d** Ensuring that the expected level of performance is delivered.

12 Most Trusts are managing their contracts well day-to-day but need support with certain complex issues. We assessed the way Trusts manage their contracts against best practice. We found, with a few exceptions, that Trusts are currently well equipped to manage their contracts day-to-day and understand the risks to value for money. However, the risks outlined in paragraph 11 remain. We also found that Trusts rely on their support networks and the Department to keep them up-to-date on what is good practice and how to manage more complex issues and risks.

13 Some Trusts are not, however, devoting sufficient resources to contract management. Many Trusts have recently increased the resources they devote to the management of their PFI contracts. These Trusts realised that managing the contracts was a greater challenge than they had at first thought. However, nine of the 76 PFI contracts (12 per cent) have no one assigned to contract management.

14 Trusts are likely to be expected to make efficiency savings over the next few years, but their ability to make savings from their PFI contracts is limited. PFI commitments represent between 0.4 and 18.3 per cent of each Trusts' operating costs. This commitment is relatively fixed in real terms. The contracts allow the price to be increased annually for certain aspects of price inflation in contractors' costs, but Trusts can benefit from certain specific cost reductions:

- through sharing refinancing gains if they occur; and
- if the market price for hotel services is below the price in the PFI contract at value testing reviews which are normally every five years. The experience to date, however, is that these value testing reviews, which can result in price increases or decreases, have rarely led to price reductions for Trusts.

15 There are several reasons why it is difficult for Trusts to further reduce their PFI spend or get service improvements through sharing in efficiency savings:

- a** Unlike refinancing gains, the contracts do not require investors or contractors to share gains they can generate through more efficient management or service delivery in individual contracts, or groups of contracts, where these gains are not reflected in prices offered in the value testing reviews.
- b** We saw little evidence of partnering work between contractors and Trusts aimed at driving down costs and producing mutual benefits.
- c** Although maintenance services are subject to competitive tension in the tendering process, Trusts have not been able to benefit from any efficiencies in building maintenance which contractors achieve over the contract's life. This is because these services are not value tested and contractors do not share with Trusts information on their maintenance spend.

Whilst some Trusts have sought to make savings by reducing the scope or performance requirements of their PFI services, there is little experience of these negotiations or their outcomes. Trusts need to ensure that any decision to reduce services is informed of the long-term consequences to costs and the impact on patients.

The Department's Role

16 The Department has developed significant expertise in how to support Trusts' management of their contracts within its Private Finance Unit. The Unit was set up to manage the programme of new PFI contracts. It provides valuable support through:

- a quarterly forum for contract managers;
- guidance on good practice; and
- providing advice to Trusts with issues.

17 The Private Finance Unit's ability to further support Trusts to manage their contracts is, however, limited by a lack of performance and cost data.

The Department cannot require Foundations to provide them with data on the performance of PFI projects, or to direct them to engage with the support it offers. Whilst it retains more control over other Trusts, it does not require them to provide any data on their PFI schemes. This means that:

- there is a lack of central data on the performance of the PFI portfolio. This restricts the Department's ability to assess value for money and to target its resources towards assisting Trusts most in need of help;
- although the Department spreads good practice amongst Trusts that engage with it, it does not systematically set out to assess, collate and define good practice; and
- the Department does not use its leverage over the market from having 76 contracts in force. With more information on Trusts' projects the Department could use this leverage to update contracts on common issues, or facilitate performance and efficiency improvements.

Conclusion on value for money

18 This report looks at the value for money achieved by hospital PFI contracts once they are operational. We found that most PFI hospital contracts are well managed. And the low level of deductions and high levels of satisfaction indicate they are currently achieving the value for money expected at the point the contracts were signed. However, as the cost and performance of hotel services are similar to those in non-PFI hospitals there is no evidence that including these services in a PFI contract is better or worse value for money than managing them separately.

19 There continues to be risks to the long-term value for money from these contracts. Managing the contracts is complex. The long-term service commitments of PFI contracts and the Trusts' approach to managing the contracts has limited Trusts' ability to make efficiency savings from certain areas of the contract, and to drive continuous service improvement. Investors and contractors will naturally seek to maximise their profit margins, and we have seen examples where this is at the expense of the Trust. Limitations in performance and cost data restrict the Department's support to Trusts and increase the risk of value for money being eroded over time.

Recommendations

20 The management of PFI contracts is challenging and Trusts need to take advantage of available support and help. Trusts are well placed to manage the contracts day-to-day, but require support when issues arise, and need to work together to maximise their chances of retaining the intended value for money. Trusts should:

- a Provide sufficient resources to manage their contracts.** We suggest at least one person works most of their time managing a contract, even on the smallest contracts, and larger teams on larger contracts. Without this investment, Trusts are likely to incur far greater costs and eroded value for money.
- b Engage with available support from the Department.** We do not believe that any Trust can fulfil its obligation to achieve value for money from its contract if it is not accessing good practice from the Department or taking advantage of information collated by the Department and shared from other Trusts managing PFI contracts.

21 The Department's delivery model creates challenges in providing appropriate support to Trusts whilst not interfering with local delivery and accountability.

The Department needs to balance its cost of providing central support with the effective management of risk to the value for money achieved by Trusts. Trusts are capable of managing the contracts day-to-day but the Department's Private Finance Unit is best placed to provide them with support on complex issues and coordinate activities between Trusts. The Department should:

- a Market the services available to Trusts as a formal PFI support club.** The Department needs to ensure that it retains its expertise and makes that expertise available to all Trusts. It will need to make the support attractive to Trusts that have not traditionally engaged with its support. It should, however, make membership dependent on following the club rules, including the provision of benchmarking data.

- b Develop better benchmarking information on the PFI portfolio.** All Trusts are required to provide data on the costs and performance of their estates, using a system known as Eric. However, this information does not currently serve the needs of the Unit and Trusts with PFI projects. The Department should require contract and site specific data, and improve its quality of data collection, to ensure it caters to the needs of the PFI portfolio. This would allow the Department to provide more assurance on the current value for money of the portfolio; provide valuable benchmarking data to Trusts; and challenge and explain the variations in costs identified in this report.
- c Target its support at Trusts with poorly performing contracts or poor contract management.** Better performance data would allow the Department to be proactive in offering tailored support to Trusts most in need of it, including supporting Trusts in updating contracts to reflect changing needs.
- d Share information between Trusts on contractor performance and performance issues.** This would build on the current community of interest groups to share information. It would help Trusts use contractors' reputation risk as a lever to improve performance, and to identify common ways of addressing performance issues. The use of this information is to address contract management issues. It should not impede open and fair competition during procurement.

We believe that these recommendations will have a small cost to the centre and prevent far greater costs to Trusts. The initial investment in the information systems should then produce a better use of the Department's existing resources.

22 Trusts need to make efficiency savings from their PFI contracts without harming services to patients or reducing the upkeep of buildings in a way that ultimately increases whole life costs. Driving efficiency savings from PFI contracts would help to contribute to the current reductions in government spending. In order to introduce more effective ways of working that can drive efficiencies:

- a Trusts need transparency and clarity over contractors' costs and activities.** They should seek to obtain and use open book accounting arrangements. And Trusts should use better benchmarking information to understand cost drivers.
- b Trusts and contractors need to work together to seek more efficient ways of working.** Currently there is little incentive for Trusts to help contractors reduce their costs, because such savings are not shared. Trusts should seek gain share mechanisms and adopt partnering behaviours to help contractors deliver more efficient services.

c The Department should monitor whether Trusts are getting the best possible terms from value testing exercises and support Trusts to use value testing to drive efficiencies. Trusts should seek competitive pricing through value testing. Market testing introduces a competitive process to value testing. It also allows discussion with alternative providers about ways of making service delivery more efficient. If, however, benchmarking information is used then it should be used to guide discussions on what a competitive current price might be. The Department should monitor the steps taken by Trusts to get the best possible outcomes from value testing.

d Future maintenance expenditure should be subject to review at intervals to allow Trusts and contractors to identify opportunities for gain sharing. At present, there is no formal mechanism for assessing whether the initial prices which Trusts agreed to pay for maintenance remain value for money during contract periods which may be over 30 years. Contractors should receive a reasonable return for carrying out maintenance work. However, if contractors' maintenance plans and spend were open for review at least once every five years there may be opportunities for gain sharing if:

- it is now clear that initially prudent provisions for maintenance expenditure can be reduced for future years; or
- new techniques in maintenance provide an opportunity for reducing costs.

However, in making any changes in maintenance expenditure Trusts should ensure that the asset is maintained appropriately and that services are delivered at the contracted level. Short-term reductions in maintenance and refurbishment are unlikely to prove to be value for money over the life of the asset.

e The Department should work with Treasury, who are responsible for PFI policy, to explore ways in which standard PFI contractual terms can be adapted to best encourage partnering and efficiency savings. They should consider how to fit such changes into existing contracts as well as new contracts.

Part One

Introduction

The role of PFI in the NHS

1.1 The Private Finance Initiative (PFI) is a procurement method which uses private capital for major government projects such as hospitals and roads. Private consortia design, build and manage facilities for the lifetime of the contract, typically 30 years, when management of the building and services transfers to the public sector. The Treasury states that the intended benefits of using PFI include:¹

- transferring the risk of failing to deliver services to time and budget to the private sector;
- the maintenance of assets over the life of the contract;
- transparency of service provision cost; and
- innovative approaches to building design and service provision.

1.2 Our report focuses on the 76 schemes which were approved by the Department and were operational by April 2009. It excludes smaller projects without inpatient facilities. Annual spend on these contracts (unitary charge) is £890 million, and their capital value is £6 billion (**Figure 1**). The size of the contracts varies significantly. A complete list of projects with their unitary charge and capital value can be found in the detailed methodology available on our website www.nao.org.uk/pfi-hospitals-2010.

¹ HM Treasury PFI: meeting the investment challenge.

Figure 1
Characteristics of the PFI population

	Minimum	Maximum	Average (mean)	Average (median)	Total
Capital Value (£m) ¹	3.7	512	82	46	6,000
Current Unitary Charge (£m) ²	0.6	63.1	11.8	6.5	890
Contract Length (years) ³	24	60 ⁴	32	30	

NOTES

- 1 Data supplied by the Department and updated with the figure for Dawlish hospital from Partnerships UK database. Three Projects (Hull Phase 5, one of Birmingham and Solihull Mental Health NHS Trust and one of Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust are not included).
- 2 HM Treasury (Hull Phase 5, Sherwood Forest's 'Kings Mill', one of Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust, one of Devon PCT and one of Birmingham and Solihull Mental Health NHS Trust were not included in HM Treasury dataset and are therefore taken from the NAO survey).
- 3 Based on the 67 Trusts who provided data on this in our survey.
- 4 Contracts of 60 years have break clauses which can be exercised at an earlier point.

Source: National Audit Office Survey or HM Treasury Data

Features of PFI Contracts

1.3 The contracts covered in this report:

- are for the design, construction and management of all or part of a hospital;
- require the building to be maintained in a specified condition (maintenance services);
- include two thirds where the contractors provide ancillary services such as cleaning, catering, and portering (hotel services); and
- require contractors to report on their performance through a formal Performance Management System. Trusts use this to charge deductions for failures to meet specified standards.

1.4 Contracts are between a Trust and a ProjectCo which builds and manages the asset. ProjectCos are companies specifically established for the PFI contract, to hold the debt funding and coordinate the subcontractors. They typically consist of a consortium between a construction company and other investors. The ProjectCo subcontracts services to specialist providers; it is common for these subcontractors to be investors in the ProjectCo.

Methods used

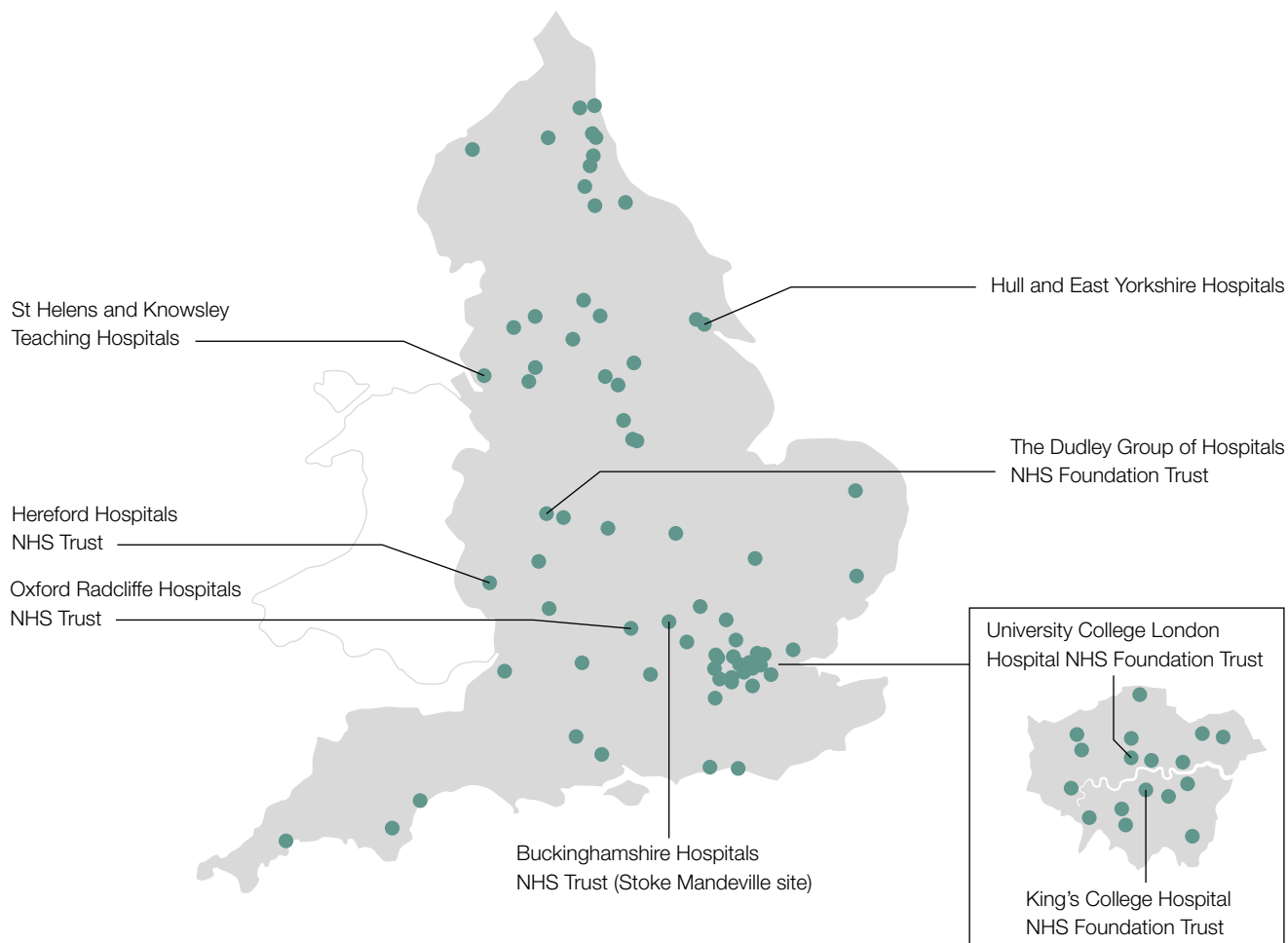
1.5 The key methods used to generate our evidence base were:

- a survey of all Trusts with an operational PFI project;
- a survey of all ProjectCos;
- in-depth case study visits to eight Trusts (**Figure 2**); and
- analysis of centrally collected data.

1.6 For more information on the methods used see Appendix One. The majority of the figures presented in this report come from our survey of Trusts. The survey of Trusts had an overall response rate of 99 per cent.

Figure 2

Operational PFI Schemes in England showing the location of our case studies



Source: Department of Health

Part Two

The performance and cost of PFI hospital contracts

Overall performance of PFI contracts

Most PFI projects are performing satisfactorily or better

2.1 The Department's devolved delivery model means it does not systematically monitor the performance of its PFI projects. Furthermore, the systems used by Trusts do not allow for easy comparison either between contracts or with non-PFI services. We have drawn on a range of evidence to conclude that most PFI contracts are meeting the expectations of Trusts and the Department, and appear to be performing to the standards set in the contracts:

- a** **The Performance Management Systems report that performance typically meets the contractual specification.** These are used by Trusts to monitor performance and charge payment deductions for failure to meet contractual standards (**Figure 3**). Fifty-three per cent of Trusts did not charge any deductions in 2008-09. Of those that charged deductions, the amount ranged from £200 to £651,000 a year, but always represented a reasonably small percentage (0.01-5.18 per cent) of the unitary charge (**Figure 4** on page 18).
- b** **Most PFI providers are meeting Trusts' expectations.** We asked Trusts to rate the performance of their ProjectCo in managing the contract, and their subcontractors in delivering the contractual services. Sixty-seven per cent of Trusts rated all services as at least satisfactory. Of the 72 Trusts that provided data, 11 (15 per cent) rated *all* their services as *better* than satisfactory (**Figure 5** on page 18). These are self-assessments, normally provided by the contract managers on behalf of the Trust. Contract managers may have an incentive to claim that they are achieving value for money, but are normally the best-informed observers.

- c** There is no difference between PFI hospitals and the rest of the NHS in assessments of environment and catering. Patient Environment Action Team scores show that PFI hospitals are not performing significantly better or worse than other hospitals (**Figures 6** and **7** on page 19).
- d** The majority of Trusts report consistent or improved performance over the course of the contract. The majority of Trusts said service delivery had either stayed the same or improved. For cleaning and catering services the majority of Trusts have seen an improvement (**Figure 8** on page 20).

Figure 3

Performance Management Systems and financial deductions

PFI contracts require contractors to report their activity against a set of performance indicators which together form a Performance Management System. This would, for example, record a report of a blocked toilet, when it was mended, and if it was mended within the time specified by the contract. Performance indicators are negotiated during the bidding process and indicators thus vary significantly between contracts.

Trusts can charge financial deductions to the unitary payment for failure to meet performance indicators. Trusts can also charge deductions if parts of the building are not available for use, e.g. a leak preventing the use of patient rooms. Trusts' use of the Performance Management System is covered in more detail in Part Three.

Trusts charging sustained high deductions are unlikely to be achieving value for money

Trusts should use deductions to penalise poor performance and encourage improvement. A sustained high level of deductions, however, is an indication that there are more systemic issues with the Trust, contract, relationship or service provider. The deductions are not intended to be sufficient compensation for persistent poor performance.

For instance, one of our case studies, King's College, has made substantial deductions over a number of years. It is not happy with the level of service and has attempted to improve performance through enforcement of its contractual entitlements. In the Trust's view these deductions have forced the ProjectCo to address the poor performance of their subcontractor, and to include the subcontractor at quarterly performance meetings. We informed the Trust that, in our opinion, it would not achieve value for money until performance improves, but its poor relationship with its contractors inhibited their ability to work together to achieve this. The subcontractor was replaced via market testing in late 2009 and the Trust reports that performance has subsequently improved.

Source: National Audit Office

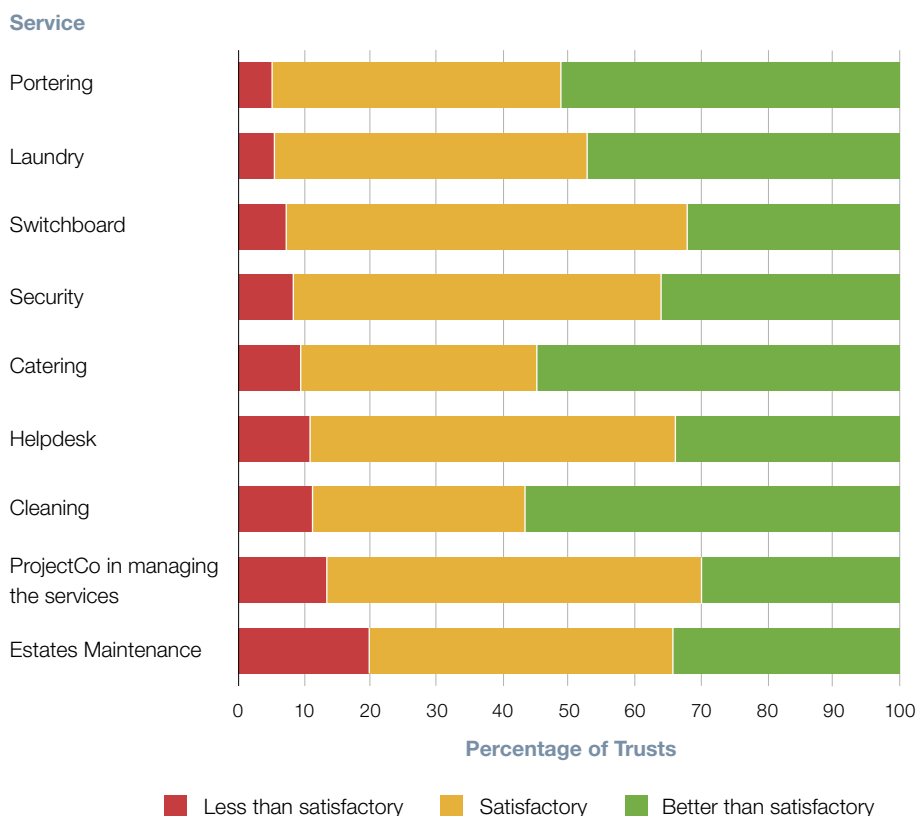
Figure 4
Summary of Deductions 2008-09

	Number who charged deductions (proportion of the population)	Lowest annual deduction by a Trust (£)	Highest annual deduction by a Trust (£)	Mean (£)
Maintenance services	27 (36%)	17	651,000	46,000
Hotel services	21 (28%)	4	436,000	31,000
All services	35 (47%)	200	651,000	54,000

Source: National Audit Office Survey

Figure 5
Trusts' assessment of ProjectCo's and contractors' performance by service

Most Trusts assess performance as satisfactory or better



Source: National Audit Office Survey

Figure 6

Patient Environment Action Team Assessments

Patient Environment Action Teams:

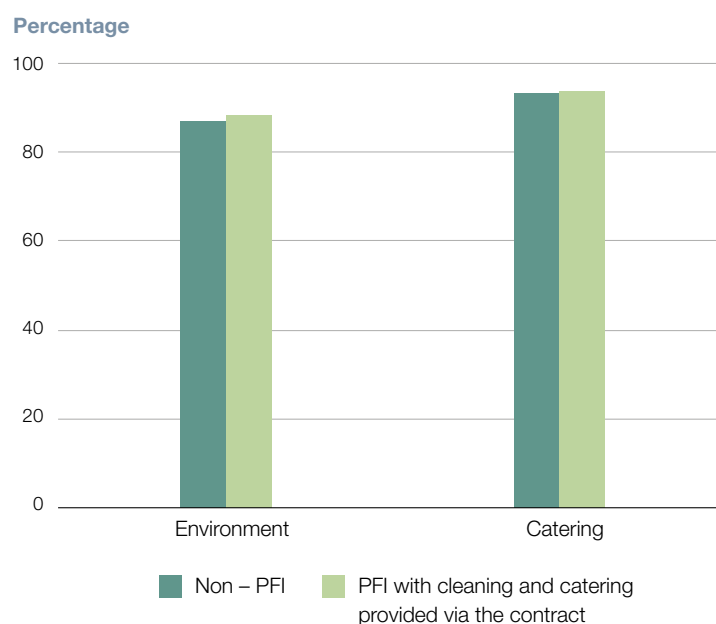
- Are annual assessments of healthcare sites in England. They are carried out by NHS staff and patient representatives chosen by the Trust, with an element of peer review.
- Use objective criteria to assess the quality of environment, catering and patient dignity. The proportion of available points achieved by a hospital in each area translates into a score between 1 (unacceptable) and 5 (excellent) for each category.
- Are conducted at a hospital, rather than Trust level.
- Can be used to see if there is a systematic difference in the standard of the environment (a proxy for the standard of cleaning) and catering in PFI hospitals.

Source: National Patient Safety Agency

Figure 7

Patient Environment Action Team scores as a percentage of the total available points (2009)

There is no significant difference in scores



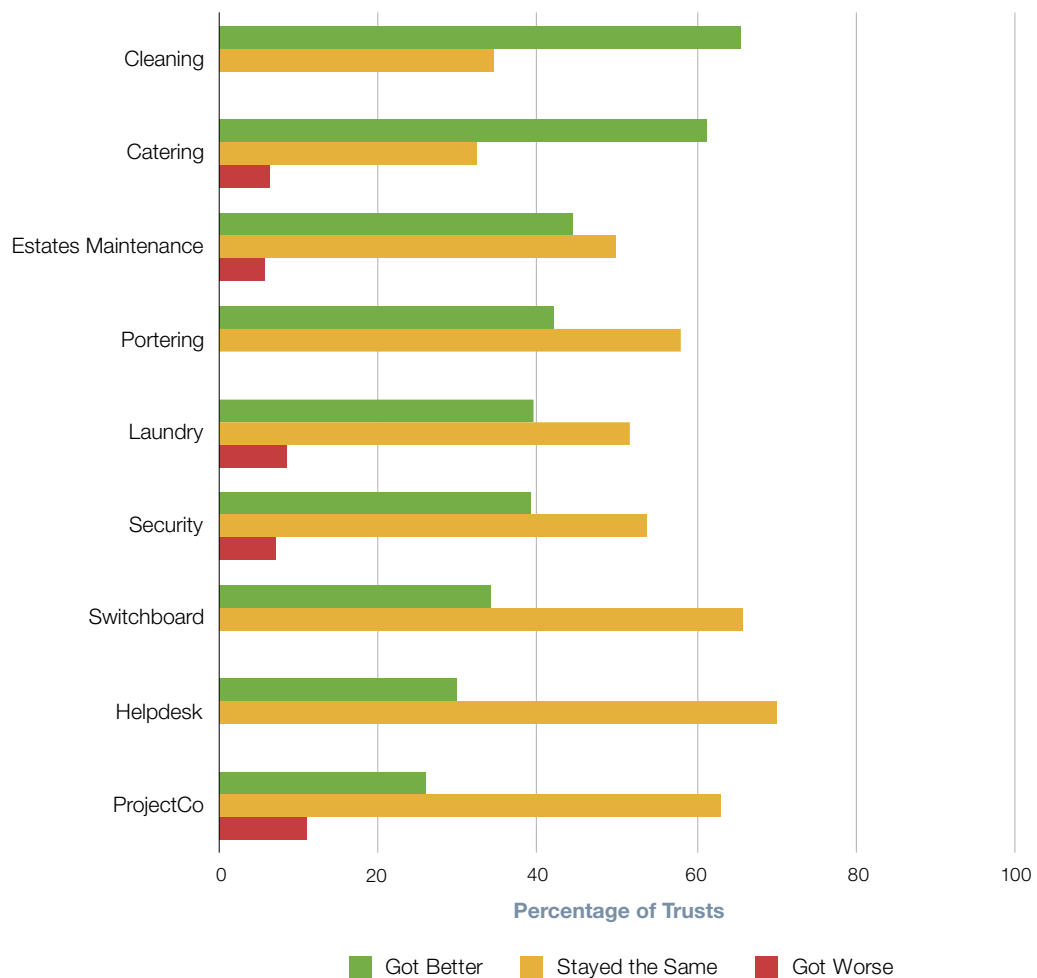
Source: Patient Environment Action Team Database

Figure 8

Trusts' views on service improvement since the contract became operational

Performance is generally improving or staying the same

Service



Source: National Audit Office Survey

2.2 Ostensibly, low deductions should provide assurance that the contractual specifications have been met. In part three we set out our findings on how Trusts are monitoring and driving performance using their Performance Management Systems. Not all Trusts are monitoring these systems sufficiently, and many could be strengthened as a tool for improving performance. On the other hand, 77 per cent of Trusts say their systems are effective in reporting performance and our review of systems at our case studies found that Trusts are generally able to audit and monitor performance. In our judgement, the main reason there are very few deductions and reported problems is that performance is normally meeting the contractual specification. But poor monitoring of performance may explain the low level of deductions at a minority of Trusts.

However, a significant minority of Trusts report problems with the performance of their contractors

2.3 Twenty-four Trusts (33 per cent) rated at least one service as below satisfactory (**Figure 9** on page 22) and no Trust rated all services as excellent. Maintenance services and the ProjectCo's performance in managing the contract were the areas most frequently cited as underperforming. But the issues that Trusts raised varied (**Figure 10** overleaf) and our analysis did not identify a clear set of causes for dissatisfaction. The age of the contract, the subcontractors providing services, or the level of resource invested in contract management are not correlated with the level of satisfaction.

2.4 No Trust reported problems with performance as a result of the current economic downturn.

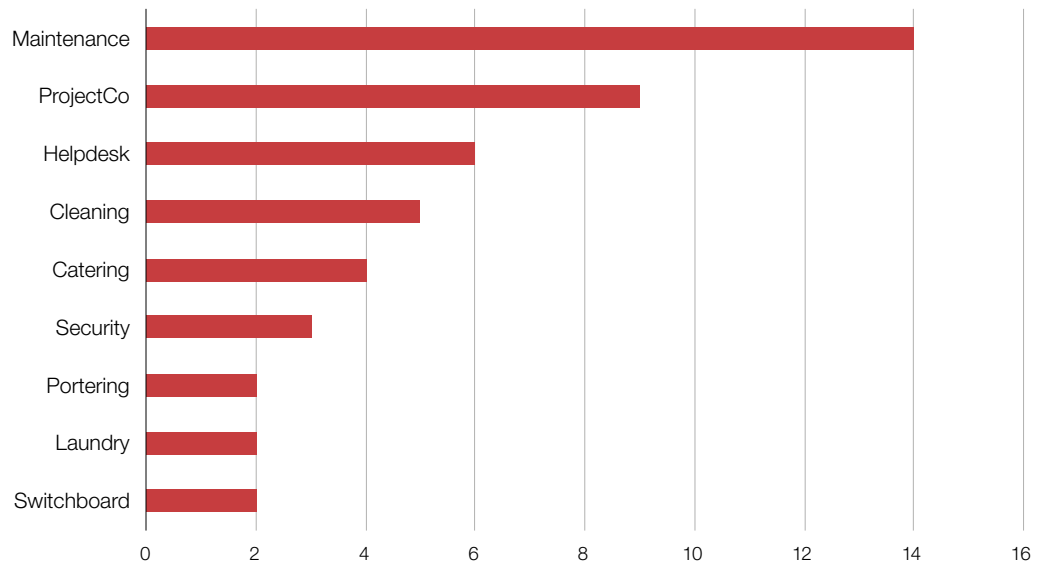
PFI services are generally well integrated with clinical activity

2.5 Our case studies reported that PFI services had not had an adverse impact on clinical activity. They felt the staff delivering the contractual services were well integrated into the hospital and were prepared to work flexibly in order to ensure patient services are not disrupted.

2.6 Only 9 per cent of Trusts agreed that outsourcing staff to the PFI contractor had a negative impact on relationships, and 20 per cent that it inhibited operational flexibility. Of our case studies, Oxford Radcliffe, King's College and University College London Hospitals told us that reliance on temporary domestic staff impedes team integration. Such high turnover is common for inner city hospitals, including clinical staff as well.

Figure 9

Number of Trusts who stated that performance is less than satisfactory

**NOTE**

1 Because some Trusts said more than one service was unsatisfactory, these numbers are not cumulative.

Source: National Audit Office Survey

Figure 10

Examples of problems identified by Trusts

- King's College Hospital was dissatisfied with lift maintenance. Broken lifts meant patients often share lifts with visitors to get to operating theatre. This is an ongoing issue yet to be resolved.
- Oxford Radcliffe Hospitals was dissatisfied with cleaning standards and developed a collaborative working agreement with its contractor to improve performance for the benefit of the Trust and its patients.
- Dudley Group of Hospitals believes the portering function is understaffed and patients are not always moved within the required time, delaying treatment. The Trust worked in partnership with the contractor to improve efficiency by introducing Lean principles.
- Hull and East Yorkshire experienced poor performance on some maintenance work. A high level of involvement from matrons has since ensured that clinical and maintenance services run smoothly together.
- St Helens and Knowsley Hospitals' contractors initially provided inappropriate patient menus and communicated poorly with those on elderly wards. The Trust worked with contractors to resolve issues quickly and now rates its catering highly.
- Buckinghamshire Hospitals NHS Trust believes that change requests often take too long to process and lead to an increase in payments. This can inhibit change, so reducing operational flexibility. It performed a lessons learnt exercise to improve the efficiency of future changes.
- University College London Hospitals stated that the contractor's inconsistent helpdesk service made Trust staff reluctant to use it, which meant problems were unreported. Both parties worked together to develop a plan to feedback regularly on the progress of jobs to build confidence in the contractor's helpdesk processes.

Source: National Audit Office case studies

Cost of PFI services

There is variation in the cost of services but this also exists in non-PFI hospitals

2.7 There is considerable variation of reported costs for services between PFI hospitals. For example, the range of costs reported in 2007-08 for feeding a patient per day was £3.16 - £12 and the cost per item laundered was £0.20 - £0.96 (these figures and our concerns with the quality of the data are covered in **Figure 11** overleaf).

2.8 Typically, the individual costs of PFI services are paid in a single unitary charge to the Trust. High prices on one service may theoretically be compensated by low prices on another. Another major cause of variation in costs is location. However, our analysis shows that there is considerable variation between PFI contracts even after taking account of these factors. A fuller explanation and results of this cost analysis can be found on our website.²

2.9 We could not verify if the difference in costs was due to a difference in the quality of performance or contract specification. There was no correlation between cost and Trust satisfaction or Patient Environment Action Team scores. Given that the causes of the price differences are not known, there may be a risk that some are paying more than they need to.

2.10 There is also considerable variation in the costs of all services in non-PFI hospitals. The range of costs for PFI services overlaps considerably with that of the same services provided outside of PFI contracts. The extent of the overlap is such that the costs are broadly the same between PFI and non-PFI hospitals for all services.

2.11 The average cost of portering, cleaning and laundry services delivered under PFI contracts differ from the average costs of the same services at other hospitals. But the differences are small relative to the range of costs and are not statistically significant. That is, they appear to be due to the general variation between hospitals rather than a systematic difference between PFI and non-PFI hospitals.³

2.12 The average annual spend on estates maintenance is higher in PFI hospitals, although this difference was only statistically different in two of the three years we measured. PFI contracts require the building to be maintained to a high standard and commits the Trust to pay for maintenance over the life of the contract. In conventionally procured hospitals, Trusts have the ability to determine expenditure on maintenance, providing greater flexibility, but potentially leading to higher refurbishment costs later or a degraded physical environment.

2.13 The average cost of patient catering services is cheaper in PFI hospitals, although this was only statistically different in 2007-08. Performance scores (Figure 7 on page 19) do not suggest a significant difference in the quality of catering.

² www.nao.org.uk www.nao.org.uk/pfi-hospitals-2010.

³ There was no difference at the 95 per cent confidence level when a 2-sided T test was applied comparing the PFI population to the rest of the hospital population. This tests whether the variance between sub-sets is greater than could be explained by the variation in the whole population.

Figure 11

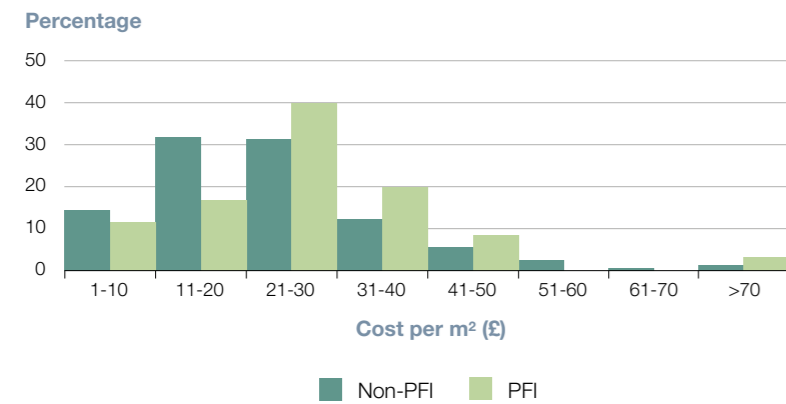
Most PFI services cost the same as services outside PFI

Maintenance

PFI maintenance service costs are consistently on average higher than non-PFI maintenance, although the ranges overlap significantly. This difference was statistically significant in two of the three years for which we have data.

	2005-06		2006-07		2007-08	
	Non-PFI	PFI	Non-PFI	PFI	Non-PFI	PFI
Cost of maintenance per m ² of gross internal site floor area (£)	20.53 ¹	24.32 ¹	21.74	22.82	23.53 ¹	27.53 ¹

Cost of Estates Maintenance 2007-08

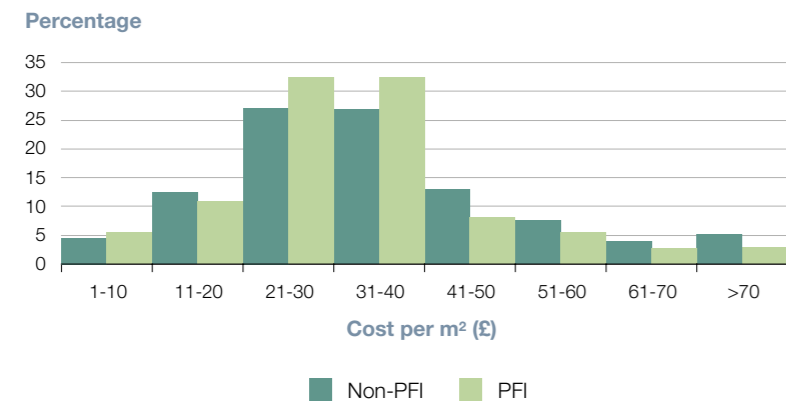


Cleaning

There is no consistent pattern in the difference between PFI and non-PFI cleaning costs, and the differences are not statistically different.

	2005-06		2006-07		2007-08	
	Non-PFI	PFI	Non-PFI	PFI	Non-PFI	PFI
Cleaning cost per m ² of occupied floor area (£)	31.24	28.55	28.76	32.98	35.86	33.05

Cost of cleaning a square metre of hospital 2007-08

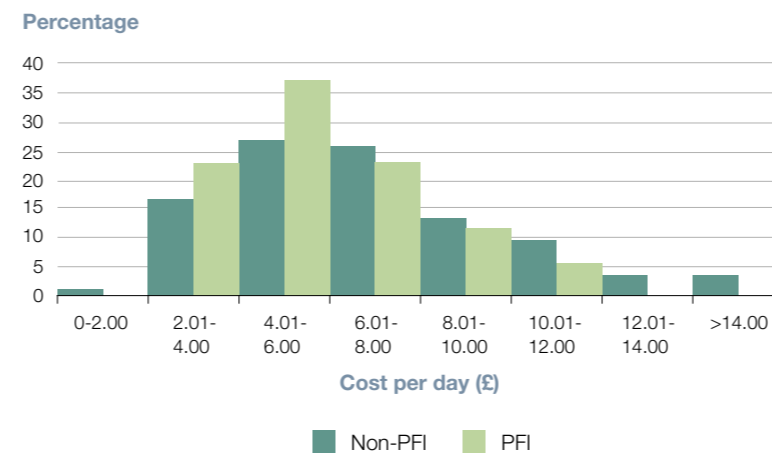


Catering

PFI catering has consistently cost less on average than non-PFI catering. However, the difference only grew wide enough to be statistically significant in 2007-08.

	2005-06		2006-07		2007-08	
	Non-PFI	PFI	Non-PFI	PFI	Non-PFI	PFI
Cost of feeding a patient per day (£)	6.71	6.44	7.39	6.49	7.39 ¹	6.27 ¹

Cost of feeding one patient per day 2007-08

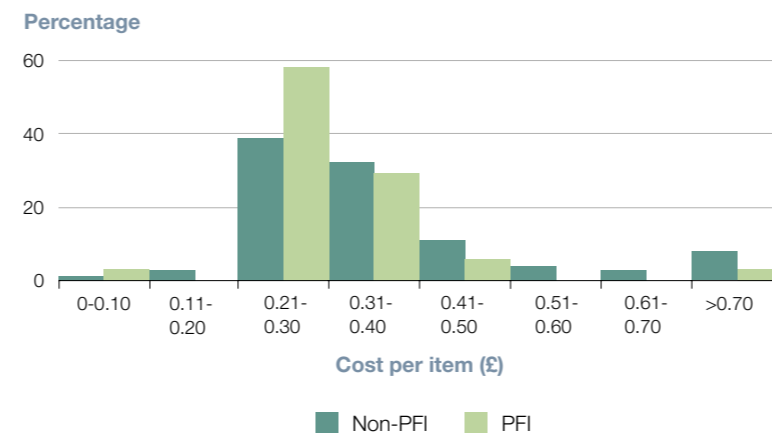


Laundry

There is no consistent pattern in the difference between PFI and non-PFI laundry costs, and the differences are not statistically different.

	2005-06		2006-07		2007-08	
	Non-PFI	PFI	Non-PFI	PFI	Non-PFI	PFI
Cost per item laundered (£)	0.45	0.41	0.41	0.43	0.45	0.44

Cost per item laundered 2007-08

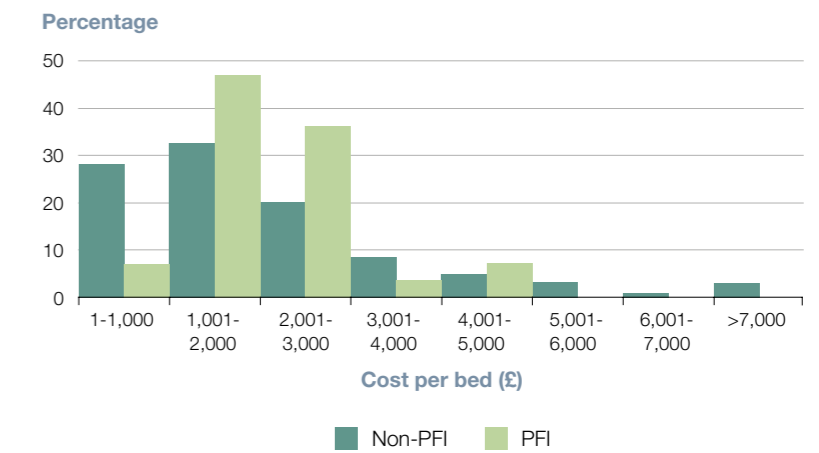


Portering

Portering cost data is very variable, there is no consistent pattern in the difference between PFI and non-PFI, and the differences are not statistically different.

	2005-06		2006-07		2007-08	
	Non-PFI	PFI	Non-PFI	PFI	Non-PFI	PFI
Cost per portering per occupied bed (£)	1,735	1,678	1,973	2,196	2,168	2,037

Cost of Portering per Occupied Bed 2007-08



NOTES

1 Highlighted differences are statistically significant.

Data source: Estates Return Information Collection (Eric) database is a compulsory return for all hospital sites covering the cost, quality and volume of estates services. The extent of the variation in costs in the database raises questions about the integrity of some of the data. Whilst the NHS Information Centre, which compiles the database, has systems in place for challenging Trusts who enter data which vary significantly from the norm, or appear erroneous, it does not change data if the Trust chooses not to update their response.

We have cleaned the data to remove all the erroneous figures outside the bounds of plausibility, but would caution that some of the remaining data, particularly the outliers, may be inaccurate. Nonetheless, the distribution of the data follows a pattern consistent with a low overall error rate and there is no reason to believe there is a systematic bias in the error rate in favour or against PFI. Given the verification systems in place at the NHS Information Centre, it is reasonable to draw the conclusions we have on the similarity of average costs between PFI and non-PFI hospitals. This data was only collected at a Trust level, rather than a site level, in 2008-09. That year is not presented here.

Part Three

PFI contract management

Contract management

Managing PFI contracts is inherently challenging

3.1 Effective contract management by Trusts is essential to ensuring that services are delivered to specified standards, at the price expected. Strong contract management is also necessary to negotiate amendments to the contract and specification in line with Trusts' needs, and to seek continuous improvement in performance and cost efficiency. The Trust's contract managers need to provide assurance to the Trust on the value for money and performance of the contract; manage the risks to value for money; and use the levers at their disposal to drive performance.

3.2 Whilst many Trusts manage large outsourcing contracts, managing PFI contracts can be more challenging and complex because they:

- are long-term and have limited opportunity to renegotiate commercial terms over their life;
- have more complex Performance Management Systems than general outsourcing contracts;
- often account for a significant proportion of each Trusts' annual operating costs (see paragraph 4.4); and
- transfer certain risks, such as building maintenance, to contractors.

3.3 This complexity provides incentives for both Trusts and contractors to attempt to enhance their commercial position. Trusts recognise that contractors have a duty to maximise their returns to their shareholders, and contractors recognise that the Trusts have a duty to protect taxpayers' interests. This creates a dynamic tension and shapes their day-to-day interaction, although most work well together anyway.

Capacity, skills and resources

Most Trusts are well placed to manage contracts day-to-day, but some don't devote sufficient resources towards it

3.4 The size of team a Trust needs to manage its contract depends on the contract's size. The largest contracts have Trust teams of up to 13 people and the smallest require only a small team to manage them.

3.5 Trusts and the Department have tended to focus their resources and attention on the tendering, rather than the management, of PFI contracts. Several of our case studies told us that they initially underestimated the level of resources which would be required to run the contract when it became operational.

3.6 But some Trust teams are too small to cover the basic list of tasks necessary to protect value for money. We consider that the minimum requirement to run even a small PFI contract effectively is one contract manager spending the majority of his or her time managing the contract. Twenty-seven Trusts (36 per cent) have less than one full time person managing their contract. A further nine (12 per cent) do not have anyone spending a day a week managing their PFI contract (**Figure 12** overleaf).

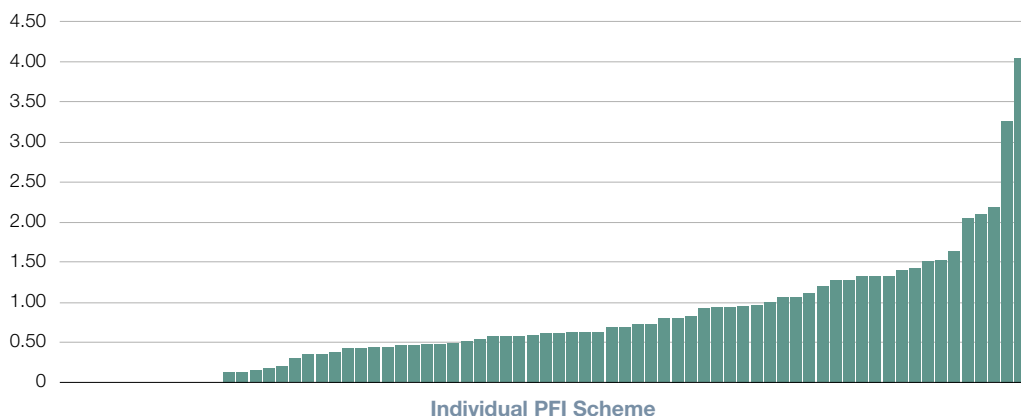
3.7 Our 2007 report on central government service contracts found most Departments believe they could improve value for money through better contract management. The Departments had not allocated appropriate skills and resources to the management of service contracts.⁴ Comparing the 2007 data with the evidence collected for this report, we found Trusts' management of their PFI contracts is comparable with central government departments' management of their major service contracts. The PFI contracts, however, provide more structured management mechanisms and there is better networking between Trust contract managers.

⁴ *Central government's management of service contracts* HC 65 2008-2009.

Figure 12 Contract Management Resources

The amount Trusts spend on managing their contracts varies greatly and some are spending nothing

Contract management spend as a proportion of unitary charge (%)



	Min	Max	Mean
Full Time Equivalent ¹	0.2	12.8	2.3
Annual Spend (£000) ¹	5	672	106
Annual Spend as a Proportion of Unitary Charge (%)	0.1	4.5	0.9

NOTE

¹ Twelve schemes reported no expenditure on contract management.

Source: National Audit Office Survey

Managing risks to expected value for money

Trusts need to manage contracts well to ensure they protect value for money over the life of the contract. Below we identify the four main risks to value for money that Trusts need to manage

Interpretation of the contract

3.8 We found that disputes over contractual terms and specifications are prevalent and part of daily life for contract managers. Examples include:

- disputes over what is damage (which the Trust often pays for) and wear-and-tear (which the ProjectCo pays for);
- disagreements about the meaning of 'clean' in the contract; and
- additional payments because of an increase in patient volume, when the contract made no such provision.

3.9 We found most contract managers understand their contracts well and are able to protect the taxpayer's interests in disputes over interpretation. However, most Trusts rely on a few key people to hold this knowledge, and often their documentation of management processes, contract guides and issues raised are too poor to ensure another could take over their role easily.

Maintaining risk transfer

3.10 Contracts aim to allocate risks to the party best able to manage them. Contractors will, however, seek to pass risk back to the taxpayer if Trusts do not meet their obligations or enforce the contract.

3.11 We found a few Trusts having difficulty meeting their obligations to allow contractors to manage maintenance risk. Clinical activity can often affect the ability of contractors to undertake some preventative maintenance. PFI hospitals have a similar occupancy level to non-PFI hospitals,⁵ and are subject to the same national targets and incentives to keep levels of clinical activity high. However, failure by PFI hospitals to allow scheduled preventative maintenance means they are accepting a risk which they have paid to transfer, until such time that they can allow maintenance to be completed. Twenty-one per cent of survey respondents said occupancy levels were affecting planned preventative maintenance, such as lift maintenance. Twenty-three per cent said it was affecting lifecycle maintenance such as redecorating wards. One case study Trust told us that they had surrendered the right to charge deductions for theatre unavailability because planned preventative maintenance was not completed.

3.12 These issues may become more prevalent as more contracts near their scheduled first major refurbishments, normally between 5 and 10 years after becoming operational.

3.13 In March 2010 the estates maintenance firm Jarvis, which provided services at three operational PFI hospitals, went into administration. At the time of writing, the Trusts were still receiving services and the Department was clear that the risk of ensuring continuity of service sat with the ProjectCo.

Managing changes

3.14 Inevitably, changes will be needed to the building and services of a PFI contract over its lifetime, including changes to the building to accommodate changes in healthcare delivery; or updates to service specifications to reflect changing NHS guidance.

3.15 Changes to PFI buildings and services have to be made through contract variations, agreed by the Trust and the contractors. So far, this has proved flexible enough to meet the changing needs of Trusts. Major changes have included new wings, service reconfiguration within buildings, a major geo-thermal heat source pump, and revised staff terms and conditions.

⁵ Eric data shows that in 2008, the average occupancy of PFI hospitals was 85.1 per cent, compared to 86.9 per cent in non-PFI hospitals.

3.16 Trust staff often view the change process as difficult, but recognise it brings discipline. Thirty-four per cent of Trusts said making major changes was bureaucratic and time consuming, whilst the corresponding figure for minor changes was 39 per cent. Nurses at our case studies were concerned about the cost and time that small changes such as redecorating patient rooms can take. However, 43 per cent of Trusts stated the process ensured robust decision-making for major changes, with 54 per cent saying the same for minor changes.

3.17 Our previous work on making changes to PFI projects across government highlighted a lack of competitive tendering of major changes, and inconsistent methods for validating the wide range of contractors' prices for minor changes.⁶ These remain risks to value for money, but Trusts are taking action to address them:

- a** Competitive tendering is now used in most cases for major changes in the NHS. Thirty-one Trusts reported that they have made a change in excess of £100,000, of which 23 (74 per cent) were competitively tendered. We previously found that only 29 per cent of changes over £100,000 to government PFI projects were competitively tendered, although 41 per cent had been judged to be unsuitable for competitive tendering.⁷
- b** Sixty-nine per cent of Trusts stated that they had a small change threshold, under which changes are not competitively tendered. This allows small changes to be processed more quickly using an agreed schedule of rates. Our testing of Trusts' systems found good controls for tracking changes and challenging costs.

Achieving the expected level of performance

3.18 Although the contractors report on their performance, it is the Trusts' responsibility to ensure that the contracts deliver the required level of performance. Our case studies saw performance improve when Trusts increased their contract monitoring. Without effective contract management there is a risk that the hospital will be unaware if it does not get the performance specified. We discuss driving performance further below.

⁶ *Making Changes in Operational PFI Projects* HC 205 Session 2007-2008.

⁷ *ibid.*

Driving performance

Driving performance can be challenging. Below we outline the four levers Trusts can use to drive performance

Communication and relationships

3.19 Good relationships between Trusts and contractors are crucial to successful performance. Conversely, poor relationships and poor performance drive each other in a vicious circle.⁸ Trusts we visited which had concerns about performance did not have positive and open working relationships and tended not to see the contract as an opportunity for partnership working. Seventy-nine per cent of Trusts, however, said changes in the strength of their relationship with contractors had improved performance.

3.20 In general, Trusts and contractors have positive relationships (**Figure 13** overleaf). But 32 per cent of Trusts rated their relationship with their hotel services provider and 52 per cent rated their relationship with their maintenance provider as deficient in at least one key aspect.⁹

3.21 Although most working relationships are strong, we did not find any that had developed beyond a traditional client-contractor relationship. We saw little partnership working, which we would define as working together to find performance and efficiency improvements that are mutually beneficial.

The Performance Management System

3.22 The Performance Management System is the main lever for monitoring performance (Figure 3 on page 17). These systems are a vital and helpful tool for contract managers that provide incentives for contractors to perform to the specification required and acts as a lever to drive performance. We found:

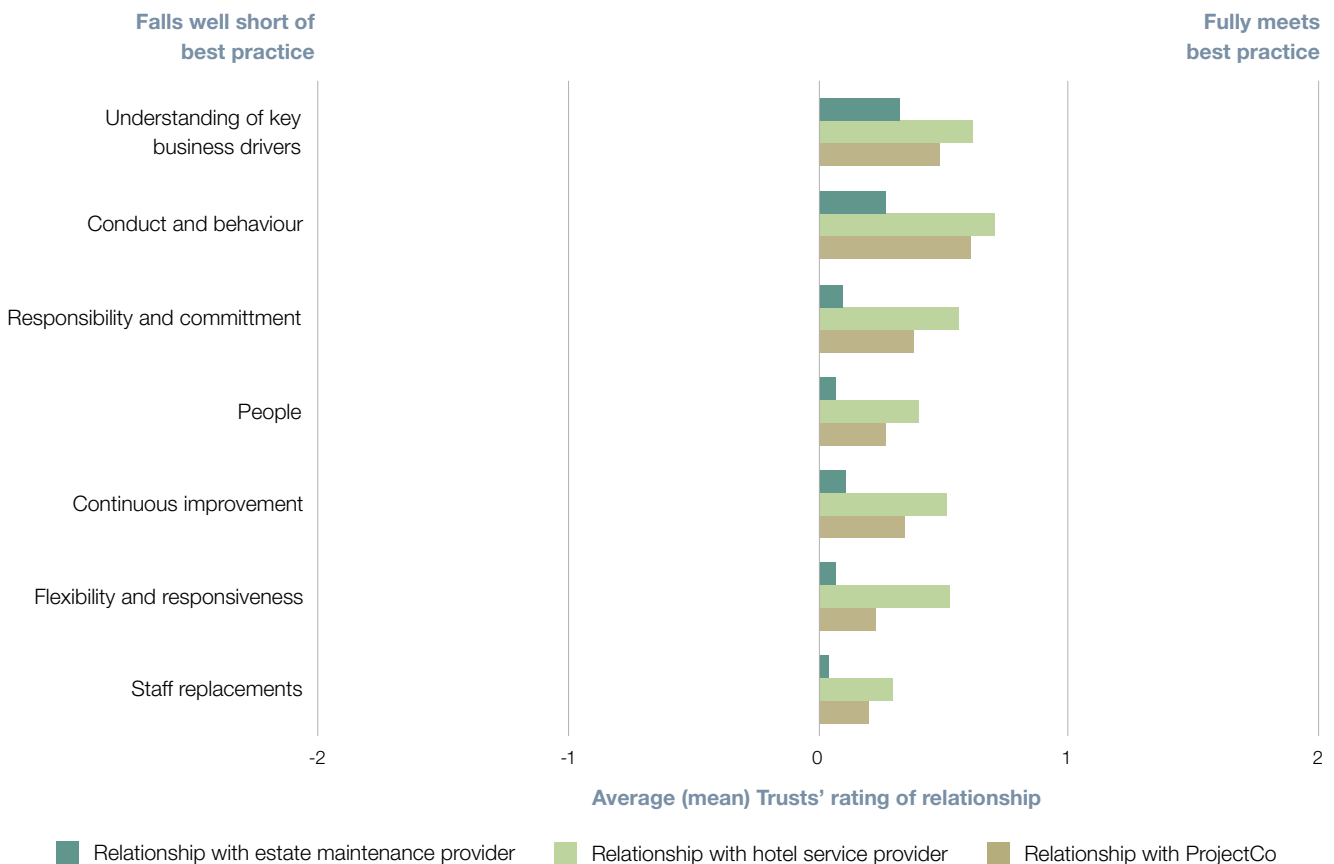
- a** **Trusts are moderately enthusiastic about the effectiveness of the systems.** Forty-seven per cent agreed the systems complied with five of the six key aspects we identified as objectives of a good Performance Management System, although only 28 per cent thought their systems complied with all six (**Figure 14** on Page 33).

⁸ Survey respondents assessed their relationship with their ProjectCo and sub contractors across seven key indicators of relationship strength (Figure 13 on page 32). When these results are aggregated they show a moderate positive correlation between Trusts' assessment of relationship and the performance of their maintenance, and core hotel services (cleaning, catering, laundry and portering). For maintenance $R^2=0.31$ and for hotel services $R^2=0.31$. The effect was clearer at our case studies with very poor performance and very poor relationships and very good performance and very good relationships.

⁹ Fifteen of 47 Trusts whose contract includes hotel services rated at least 1 statement as below 0 for their provider (where -2 is 'falls well short' and +2 'fully meets' the best practice statement). Thirty eight of 73 Trusts in our survey rated at least 1 statement as below 0 for their maintenance provider.

Figure 13
Trusts' Mean Rating of Relationship Strength

In general Trusts and Contractors have positive relationships



We asked Trusts to rate their relationships against seven key aspects of a good relationship. These were:

Understanding of key business drivers: We have a mutual understanding of all relevant issues about the contract and services being delivered and each other's business needs and goals.

Conduct and behaviour: We talk to each other openly and honestly, at all times, on all issues; we have implicit faith in each other's professionalism and integrity.

Responsibilities and commitments: We trust each other to meet our respective responsibilities and deliver what has been agreed.

People: There is mutual trust, confidence and respect at all levels; we are confident in the people we work with; and we are consulted about staff performance.

Continuous improvement: All parties view the relationship as one team, although we recognise our different responsibilities within the team. We continuously seek to improve our team performance and relationship.

Flexibility and responsiveness: All parties always respond quickly and supportively.

Staff replacements: We are consulted about staff replacements, and staff turnover has little impact on our relationship.

NOTE

1 -2 equals the relationship falls well short of the best practice statement and 2 equals relationship fully matches up to the best practice statement.

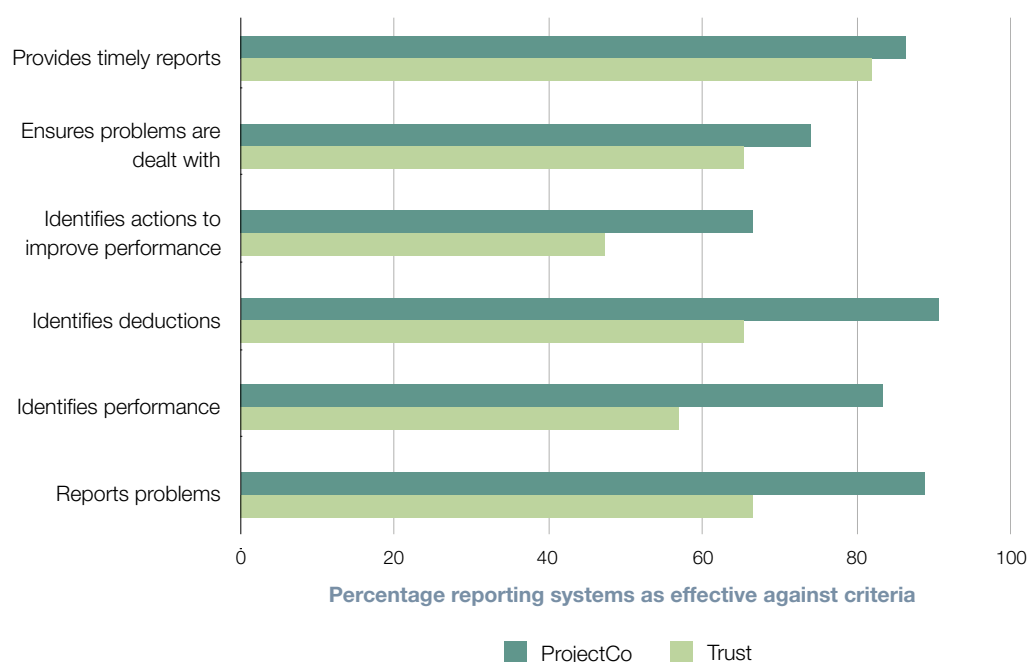
Source: National Audit Office Survey of Trusts

Figure 14

Trusts' and ProjectCos' rating of the various aspects of their Performance Management System

Trusts are moderately enthusiastic about the effectiveness of their Performance Management Systems

Criteria



Source: National Audit Office Survey

- b Individual performance indicators could be improved, but together provide each Trust with an overview of performance.** Most Trusts are positive about most targets, although 45 per cent stated that their systems contained performance indicators that did not meet all of our good practice criteria (Figure 15 overleaf). Seventy-seven per cent of Trusts say their Performance Management System is effective at reporting performance (Figure 14).
- c Most Trusts verify the accuracy of performance reports.** Contracts are designed to be 'self-reporting': the contractors provide the performance information in the Performance Management Systems. But Trusts have a responsibility to verify the information, by sample checking the data, to ensure they are getting the level of service required. Two of our eight case studies, however, carry out no auditing of the data. We also believe some Trusts do not have enough contract management staff to monitor performance (paragraph 3.6).

d The Performance Management Systems do not always provide sufficient incentives to improve performance. Deductions are not intended to reimburse Trusts for the full effects of poor performance. But deductions are sometimes too small to drive performance. For example:

- East Lancashire Hospitals levied a deduction of 47 pence for a failure to fix a tap within the set timeframe.
- At Hereford County Hospital, the contractors told us they decided it was cheaper to receive a deduction than provide an alternative cooling system to keep an operating theatre open whilst they repaired the main system.
- Some systems only penalise initial failures. Oxford Radcliffe's contract allows only one deduction for specific portering failures in an eight-hour period. Thus there is no incentive to meet targets following an initial failure.

Many Trusts and ProjectCos are sceptical that their systems and deductions provide sufficient incentives to contractors (**Figure 16**).

Figure 15
Trust review of performance indicators against good practice criteria

Most Trusts are positive about most targets



We asked Trusts to assess their contractual targets for maintenance, cleaning, catering, portering and laundry against the following criteria:

Objective and measured – i.e. based on a quantifiable standard of performance that does not require judgement;

Focused – i.e. a set of only a few indicators which set clear incentives and priorities and not a long list of unconnected indicators;

Detailed – i.e. set out in sufficient detail to capture the required service level;

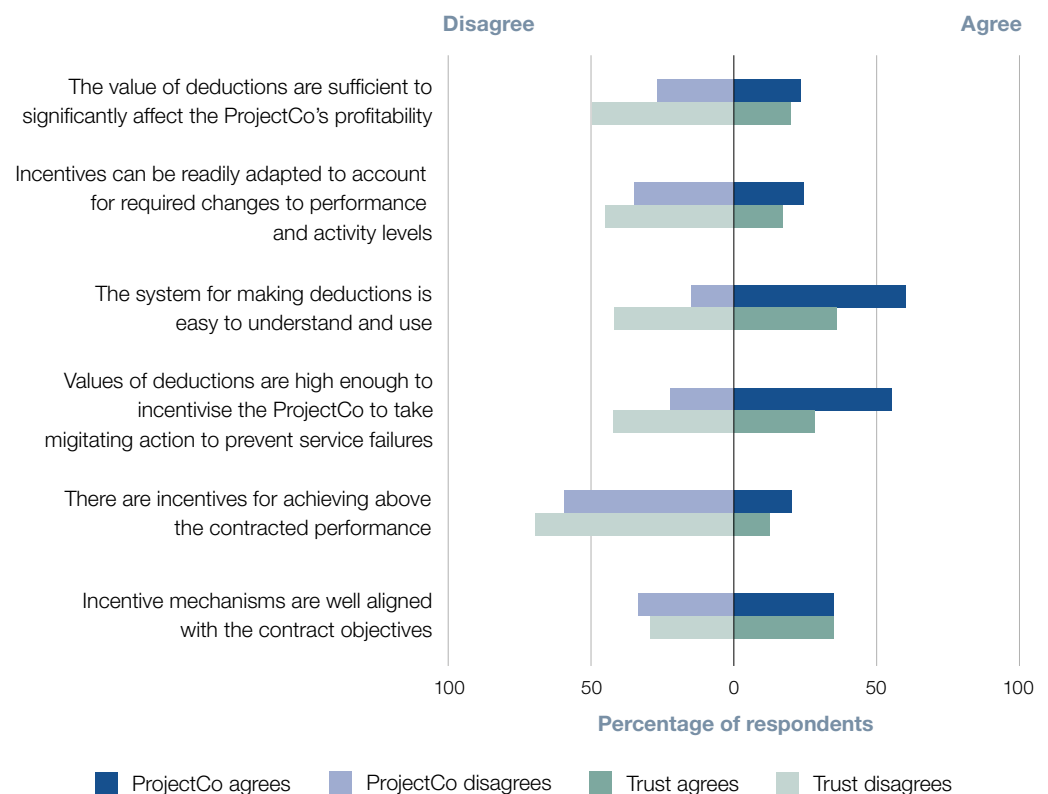
Auditable – i.e. you have a way of checking that the data provided by the contractors against the indicator is accurate; and

Provide the right incentives – i.e. incentives capture all the required tasks and subcontractors cannot meet targets by doing things you do not want.

Source: National Audit Office survey

e A few Trusts do not charge the deductions they should. Our survey identified six Trusts (8 per cent of those who responded) who stated that they had not charged deductions to which they were entitled, because they thought it would affect their relationship with their contractor or not improve performance. Two of our case study Trusts had suspended the use of their Performance Management System to give their contractors a chance to concentrate on specific aspects of performance. For example, we estimate Oxford Radcliffe Trust did not charge around £7,000 of deductions over the six weeks that their Performance Management System was suspended. The Committee of Public Accounts has said that public bodies should always apply financial penalties when contracts entitle them to do so, unless there are very exceptional circumstances why they should not.¹⁰ In the Trust's opinion, the benefit of improved performance delivered through the contractor focusing on overall performance rather than specific targets would be greater than the cost in terms of deductions not levied.

Figure 16
Trusts' and ProjectCos' views about incentive structures



Source: National Audit Office Survey

¹⁰ Public Accounts Committee 2008–09 *Central government's management of service contracts*.

Value testing

3.23 PFI contracts normally allow value testing of hotel services every five years, to ensure that prices remain competitive. Maintenance services are not value tested. Value testing takes two forms:

- a** Benchmarking – the ProjectCo compares subcontractors' prices to the market price for equivalent services and adjusts them accordingly.
- b** Market testing – the ProjectCo re-tenders the hotel services to allow the Trust to test the cost of the contract in the market.

3.24 Although specifications can be updated via the variation process (paragraph 3.16), value testing is also an opportunity to update the service specification. Trusts may also seek to use market testing as an opportunity to change unsatisfactory providers. And Trusts and contractors told us that this was a major incentive for contractors to perform well.

3.25 In 2007, we highlighted lessons from early value testing exercises.¹¹ These lessons were later incorporated into Treasury and Departmental guidance. We found our case study Trusts were aware of these lessons and were starting to put them into practice.

3.26 Value testing has rarely led to price decreases. Of the 18 PFI hospital projects that have undertaken value testing, 11 benchmarked services, five market tested and one carried out both.¹² One decreased their unitary charge; ten increased it, whilst four unitary charges stayed the same.¹³ Six of the ten with an increased price also increased their service specification.

Reputation

3.27 Many contractors told us that their reputation within the NHS is a major driver of their performance. Our analysis of Trusts' ratings of performance did not however, reveal any companies with consistently better or worse performance than their competitors.

3.28 A poor reputation should limit companies' ability to bid successfully for new contracts or those being market tested. But the NHS must have an accurate picture of how suppliers are performing for reputation to work as a driver of performance.

3.29 The Department has set up networks of hospitals with the same supplier to informally spread reputations and share solutions to common issues. Some Trusts, however, have little knowledge of how their contractors perform elsewhere.

¹¹ *Benchmarking and market testing the ongoing services component of PFI projects* HC: 453 2006-2007.

¹² One did not provide the data.

¹³ Three did not provide the data.

Continuous improvement

Trusts cannot easily benefit from process improvements

3.30 Contractors are likely to reduce their costs over the course of the contract, as they learn how best to implement the contract specifications and deploy new technologies. Contractors engaged in multiple PFI hospital contracts have further leverage to secure economies of scale.

3.31 But the contracts do not provide mechanisms for the Trust to:

- identify the changing cost base through open book accounting;
- share in efficiency gains; or
- encourage performance beyond the specification set out in the contract.

Furthermore, we saw little evidence of partnering working aimed at driving efficiencies (paragraph 3.23). Consequently, prices paid by Trusts may become increasingly higher than the cost to the contractors of delivering the services.

3.32 Value testing of hotel services (paragraph 3.24) ensures prices reflect market rates. Given sufficient competition, value testing ensures that prices reflect general improvements in practice and technology. However, even when managed well, value testing is unlikely to achieve sufficient competitive pressure to cause incumbent contractors to share all the efficiencies they should theoretically achieve from a long-term contract. Nor are savings achieved by the contractor between value testing exercises shared. This does not incentivise the Trust to work in partnership with the contractors to help them operate more efficiently.

3.33 Maintenance is not value tested. PFI transfers all maintenance risks to the contractors in order to allow them to manage the whole life costs of constructing and maintaining the building in an efficient manner. The total cost of maintenance is agreed at contract signature. Consequently, the price of maintenance paid by the Trust is likely to become unrelated to the actual cost of delivering the maintenance services. During the contract period the contractor may find ways of delivering maintenance more efficiently. In some cases, initial maintenance provision may prove to be too large, in which case the provider will make substantial profits.

Part Four

The role of the Department

The role of the Department

The Department has a wide role of oversight over its PFI portfolio

4.1 Although PFI contracts are between a Trust and a ProjectCo, the Department has a role in:

- establishing PFI policy and guidance;
- establishing the funding and organisational landscape in which PFI is used;
- scrutinising and approving all new projects in excess of £35 million; and
- providing support to Trusts for their management of contracts.

The funding of PFI

PFI is funded locally and can put pressure on Trusts' financial position

4.2 Unlike the Local Government sector and other parts of Central Government, NHS PFIs are not subsidised centrally by PFI credits or other forms of capital grant. In general, Trusts fund capital investment, including PFIs, from their local income.

4.3 Most Trust income comes from Primary Care Trusts through the Payment by Results scheme. This makes payments for each unit of activity the hospital carries out, rather than block funding hospitals on historical activity. It aims to provide incentives for Trusts to make efficiency savings. The tariff for how much the hospital receives for each unit of activity is set centrally, based on average costs across the NHS. Thus average costs of maintaining the existing estate is factored into the tariff. The annual tariff uplift for inflation and unavoidable costs also includes the average estimated costs of new capital investment. But Trusts wanting to invest in new buildings, through conventional funding or PFI, do not get specific allowances for that investment, and may need to fund some of it from their surpluses.

4.4 PFI annual charge payments represent between 0.4 and 18.3 per cent of a Trust's annual operating costs with a mean of 5.8 per cent. For larger PFI schemes, especially those where the contract covers the whole estate, the PFI represents a large fixed cost. This can make finding efficiencies across the Trusts' cost base more difficult and can exacerbate difficulties for Trusts in financial difficulty. Although the majority of Trusts with a PFI scheme ended 2008-09 in surplus, of the six Trusts with a deficit, five have PFI contracts.¹⁴ These deficits cannot be solely attributed to the use of PFI, but the PFI costs cannot be easily reduced to assist in returning the Trust to financial balance.

4.5 The Department aims for all NHS acute and mental health Trusts to become Foundation Trusts. Foundations are independent of the Department and can retain their surpluses and borrow to invest. Foundations are accountable to their local communities through their members and governors, their commissioners through contracts, to Parliament and to Monitor as their regulator (**Figure 17**).

4.6 Some Trusts have found it difficult to achieve Foundation status with the high fixed costs from their PFI project. For example, St Helens and Knowsley's application was rejected on the grounds that it could not demonstrate that it could fund its PFI from efficiencies. It aims to apply again once the Trust has proved its efficiency programme is working. Other applicant Trusts have reconsidered planned capital investment, or decided to carry it out incrementally, after Monitor has expressed concerns based on PFI affordability.

Figure 17
The role of Monitor in PFI

Monitor is responsible for determining whether a Trust is ready to become an NHS Foundation Trust and ensuring that, once authorised, NHS Foundation Trusts comply with the terms and conditions they signed up to. It makes sure that all Foundations are professionally managed, legally set up and run, and have their finances in good order. This includes assessing Trusts' PFI obligations and how they affect the Trusts' financial stability. It also assesses and comments on new significant capital investments by Foundations, including new PFI projects.

Source: Monitor

¹⁴ Audit Commission, *Evaluation and Use of Resources 2008-09 Summary results for NHS trusts and primary care trusts*, October 2009.

The Private Finance Unit

The Department's Private Finance Unit is highly regarded by Trusts, but has a limited role

4.7 Trusts have the primary responsibility for managing contracts. The Department provides support to Trusts' contract managers through the Private Finance Unit. The Unit consists of 22 people with expertise in corporate finance and contract law. In 2008-09, the Unit spent £3.8 million. Of this, it estimates £111,000 was on activities relating directly to operational PFIs. The Unit also has responsibilities for scrutinising new projects and supporting other corporate finance projects across the NHS.

4.8 The Unit provides high quality and useful support to Trusts that ask for help or who choose to attend its meetings. It:

- a** **Runs a quarterly PFI forum for contract managers.** The forum's agendas focus on topics raised by Trusts or emerging issues identified by the Unit. Two-thirds of Trusts use the forum whilst 98 per cent of users (all except one) describe it as useful.
- b** **Facilitates community-of-interest groups.** These bring Trusts who share a contractor together to discuss common issues.
- c** **Issues good practice guidance.** For example, the Unit has issued guidance on variation protocols and value testing. Seventy-one per cent of Trusts were aware of such guidance, whilst 44 per cent felt that it focused on the right issues.
- d** **Provides a professional mediation service.** This is offered to Trusts who are in dispute with their providers. It has been used four times.
- e** **Offers informal support.** Trusts are encouraged to contact the Unit when they require advice on technical and legal issues, although they will not supplant the Trust's advisers.

4.9 Seventy-two per cent of Trusts believe that the amount of support the Department provides is sufficient. Our case studies generally viewed the Unit, and in particular the PFI forum, as a good source of professional advice. However, some Trust Chief Executives stated that, whilst they could call on the Unit for advice, the Unit is not proactive in engaging Trusts' senior management.

4.10 The Department aims for the NHS to extend its devolved delivery and accountability model in which Trusts have responsibility for managing PFI contracts with appropriate central control. As part of this, it aims for all Trusts to become Foundation Trusts by the end of 2013-14. Whilst the Unit provides support to all Trusts, it does not provide support to those Trusts that do not seek it. This approach has limitations:

- a A lack of oversight. The Department cannot easily require Foundation Trusts to provide performance data, and has not made it mandatory for other Trusts to do so. It also does not use statutory returns to monitor the PFI portfolio.** A lack of central data on the performance of the PFI portfolio restricts the Department's ability to assess its value for money and cannot provide information to Trusts on how their performance compares to others.
- b Restricted lesson learning.** Although the Department spreads good practice amongst Trusts that engage with it, it does not systematically set out to assess, collate and define good practice. Nor does it collate lessons learnt on key areas of risk such as dispute resolution or value testing.
- c A lack of targeting.** The Department cannot know whether Trusts which are not accessing support have unidentified performance issues. It is unable to target its resources to support Trusts most in need of help.
- d Weakened commercial leverage.** The Department has more commercial weight than any single Trust. But with more information on Trusts' projects the Department could use this leverage to update contracts on common issues, or facilitate performance and efficiency improvements.

Appendix One

Methodology

Below is a brief overview of the methods used in this report. A more detailed explanation can be found on our website.

Method	Purpose
Census of 76 Trusts	To gather a range of quantitative and qualitative data including: <ul style="list-style-type: none"> ● Contractor performance ● Deductions charged ● Level of management resources ● Quality of relationship ● Suitability of the Performance Management System ● Management techniques ● Role of the Department
Census of 75 ProjectCos	To assess ProjectCo views on performance, relationship and the Performance Management System, to compare with Trusts' views.
Case studies of eight Trusts	To gain a deeper understanding of the services delivered via PFI and the challenges that Trusts face in managing contracts. Visits included interviews with contracts managers, senior management and clinicians from the Trust and key staff from the ProjectCo and subcontractors. We also carried out a high level review of the systems and controls used to run the contract.
File review of the Department's and Monitor's documentation	To understand the specific role that these organisations play in relation to Trusts with operational schemes.
Comparative analysis of Trusts' cost and performance data	To compare PFI to non-PFI hospitals on high level indicators.
Relative efficiency review	To understand what drives variation in what Trusts are paying for the services received under the contract, the scope to reduce expenditure and to identify Trusts which may benefit most from renegotiating their contracts.



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