Opening the lid on the PFI.

A negotiators guide to PFI procurement documents

April 1998

UNISON
Health Care
LIST OF CONTENTS

1. Introduction
2. The documents
3. The public sector comparator
4. The issues
5. What is the intended case load of the trust under the PFI development?
6. How many beds will there be?
7. What are the performance values?
8. What changes will there be in the workforce, both clinical and non clinical?
9. What changes will there be in the estate?
10. How will the scheme affect other hospitals and healthcare providers in the area?
11. What is the estimated capital cost?
12. What is the unitary payment?

Appendix 1. Structure of PFI Business Cases
Appendix 2. A PFI Glossary
1. Introduction

1.1 This text provides a brief guide to the documents produced during the PFI procurement process for NHS acute hospital developments and their use in identifying and researching key issues about PFI.

1.2 PFI involves building up the detail on an initially sketchy outline plan over the course of procurement. The process is more a matter of negotiation and bargaining between the different private and public sector agents than of rational planning as it has traditionally been understood in the public sector. Whereas in the initial stages of procurement the financial and strategic pressures on health authorities and trusts are paramount, the entry of a ‘private sector partner’ (or partners) introduces a new stakeholder whose interests can fundamentally alter the nature of the development. The process is thus one in which, as more detail is added to the projected scheme, it is also open to transformation.

1.3 This guide is intended to contribute to the greater involvement of UNISON representatives in influencing the procurement process on behalf of members and in defence of public sector values: to enabling representatives to identify campaigning issues arising out of procurement and to take them up with confidence in the wider public arena; to encouraging the early release into the public domain of information which has in the past been jealously confined to the ‘major players’ in the process.

1.4 The latter will become particularly important as the government’s policy of disclosure of information on PFI schemes begins to bite. We have already seen, in the Full Business Case summary produced for public consumption by South Manchester University Hospital NHS Trust, how information from business cases can be presented in a highly misleading manner. It will thus be very important to monitor the quality of information released and, where necessary, demand that it be improved.

"...all too often PFI schemes have been surrounded by secrecy. I can announce today an end to such secrecy. In future NHS trusts will have to publish all the key PFI projects documents. What's more I have ordered that the documents covering existing schemes should be made publicly available."

Alan Milburn MP Health Minister, speaking at UNISON's Health Group Conference in Brighton on 7 April 1998

UNISON: Opening the lid on PFI: A negotiators guide to PFI procurement documents
2. **The documents**

2.1 PFI schemes in the acute sector have to go through a number of stages of approval before NHS trusts can sign contracts with their 'private sector partners'. The documents produced during the PFI process are all tied to particular stages in that process. Thus the **Outline Business Case** (OBC) has to be approved not only by the chief purchasing health authority but also by the regional office of the NHS Executive. The **Full Business Case** (FBC), which is drawn up after the trust has selected a preferred partner from private sector bidders, has to be approved by the Department of Health and, where the scheme is worth over £50m., by the Treasury.

2.2 Although on the whole the system has remained the same under Labour as under the previous government, there have been some changes to the process which involve the introduction of a new document, the **Strategic Outline Case** (SOC), at the earliest stage of the process. It is important therefore to distinguish between those schemes which were prioritised (i.e. given leave to go ahead) by the new government in 1997 and all future schemes.

2.3 The new **Strategic Outline Case** was introduced in order to prevent trusts spending a lot of money on procurement costs for schemes that might never receive final approval from the Department of Health or the Treasury. (On a rough average, procurement costs such as the fees of management consultants were amounting to around £3m. before Full Business Cases were completed.) Labour has introduced a new level of scrutiny into the earliest stages of procurement. SOCs, essentially short sketches for Outline Business Cases, are prepared by trusts in collaboration with NHS regional offices and submitted to a new Department of Health body, the Capital Prioritisation Advisory Group. If an SOC is approved, the trust can then proceed to filling out the sketch into an Outline Business Case.

2.4 With the exception of the filtering mechanism of the SOC there is no indication that the essential stages of PFI procurement will change. Under the Tories, the first stage in the procurement process was the preparation of an Outline Business Case by the NHS trust. In principle, OBCs are not PFI documents: the decision on whether a scheme will progress under public or private funding is, officially, made on the basis of the OBC. Of course in reality, the knowledge that public funding will almost certainly not be made available means that any trust preparing an OBC will be thinking in terms of the private sector.

2.5 In the OBC, various options for investment are costed and compared. Costings are based on historical public sector procurement costs. This costing becomes the basis for the **Public Sector Comparator** (PSC) when the private sector becomes involved. A crucial element in the
Full Business Case is the comparison of costs between the privately financed option and the Public Sector Comparator.

2.6 Outline and Full Business Cases have the same three main elements:

(i) Strategic context

This sets out the current profile of services and makes the case for new investment on the basis of future demand and deficiencies in current services.

(ii) Option appraisal

This looks at different options for providing the solutions demanded by (i). At least three options must be considered, including a ‘do nothing’ and a ‘do minimum’ option.

(iii) Financial appraisal

The different options are costed in two ways: in terms of overall capital cost and in terms of the year on year effect on purchasers.

2.7 Business case documents are designed to be read by a range of participants in the PFI process, including health authorities, the Department of Health and the Treasury. Other documents are produced in order to brief the private sector. When trusts respond to the trusts’ advertisement in the Official Journal of the European Union (OJEC) (the official starting point for PFI procurement) they are provided with a pack of Pre-qualification documents or an Outline Information Memorandum setting out the services to be provided. Consortia which pass this stage are provided with an Invitation to Negotiate containing fuller information.

2.8 These documents are important because of the division of responsibilities between the public and private sectors in PFI procurement. The brief for the private sector is not expressed in terms of bed or staff numbers, areas of floorspace or materials to be used, but in terms of the services to be provided. These are referred to as outputs (as opposed to inputs). The briefs provided to consortia in the Pre-qualification documents and the Invitation to Negotiate are output specifications.

2.9 This output based approach gives the private sector the leading role in the design of facilities and considerable influence over the structure of the hospital service. Moreover, the output specifications which are produced by the trust at this stage are extremely sketchy: as with other
aspects of the business case details are built up over the course of procurement through negotiations between trust and private sector. A revised output specification is produced after a 'preferred partner' has been chosen. Revisions to output specifications are important for a number of reasons, but from a campaigning perspective the most important is that clinical activity (the number of treatments to be provided) is one of the 'outputs'. It is of the greatest importance to find out whether estimates of future activity have been changed in the course of negotiations with the private sector.

3. The public sector comparator

3.1 Getting approval for a PFI scheme turns on presenting convincing proof that it is not more expensive than it would have been under public sector procurement. The full business case thus includes a comparison of costs between the privately financed development and a notional publicly funded scheme, the public sector comparator (PSC).

3.2 The public sector comparator is derived from the preferred option arrived at in the outline business case. As we have seen, the costing of options in the OBC is done on the basis of historical NHS costs. Private sector costs are not used because at the OBC stage there is no private sector involvement. Thus the preferred option in the OBC provides a costed benchmark against which the PFI scheme can be assessed.

3.3 Of course, PFI schemes do cost more than public sector procurement. Proving the opposite in the full business case is however relatively easy for the following reasons:

(i) the PSC can be adjusted to reflect the fact that government funding may not be available for several years. This means that costs incurred while waiting for the new investment have to be added to the cost of the PSC. Department of Health guidance insists this be done.

(ii) the PSC can't adopt the same sort of cost cutting moves as the privately financed option, as it has to be based on guidelines set out by the Department of Health. For example, traditional procurement would not allow the size of wards to be trimmed to save on construction costs.

(iii) the PSC has to be adjusted to take account of 'risk' transferred to the private sector under the concession agreement. Risk is a nebulous concept and putting a price on it is a highly subjective process: there is
ample opportunity for bumping up the price of the publicly funded option.

In all business case documents that we have examined, the comparison of costs is to the advantage of the publicly funded option until risk transfer is introduced.

4. The issues

4.1 Crucial decisions about PFI schemes are made, and sometimes reversed, in the course of the procurement. When dealing with a scheme which has already been in procurement for a long time it is important to see how the scheme has changed over time. The essential questions set out below thus need to be asked with regard to different stages in the process. Strategic Outline Case, output specification, Outline Business Case, negotiations with private sector and Full Business Case.

5. What is the intended caseload of the Trust under the PFI development?

5.1 Caseload is the number of cases to be provided at a hospital in a given year.

Caseload is usually expressed in terms of finished consultant episodes (FCEs) but for planning purposes it is sometimes expressed in terms of admissions, generally referred to as discharges and deaths. In looking at caseload planning, it is always important to establish which currency is being used. A single admission can correspond to several FCEs, and for this reason FCEs and admissions are not directly comparable. Planning documents should consistently use one currency or the other, and if they don't, the trust or commissioner concerned should be asked to reconcile the figures.

5.2 Caseload counts as an output in the PFI process, and therefore enters into the output specifications prepared for private sector bidders.

Factors that can lead to changes in projected caseload during procurement include: decisions by commissioners to reduce the level of expenditure on hospital services; pressure to reduce hospitalisation rates in particular localities; decisions to shift caseload from one provider to another; changes in the methodology used to calculate future caseload.

5.3 Caseload modelling is usually contracted out by trusts and commissioners to private sector consultancy firms. Projections are notoriously inaccurate, and in many cases the original modelling has
had to be revised in the light of unanticipated rises in caseload during procurement. Projections of future caseload thus usually derive from a series of studies, and officers should seek to obtain all studies produced by all the parties involved (trusts, commissioners/health authorities, the private sector, the regional office).

Caseload projections for hospital developments are provided in:

5.4 the Trust’s contribution to the strategic context in the Strategic Outline Case (where a scheme was first proposed after July 1997)

Projected Demand for Hospital Services’ in the ‘Strategic Context’ section of the Outline Business Case

the appendix to the Outline Business Case on future activity projections (if there is one)

draft output specification included in the Pre-qualification documents and in the Invitation to negotiate

the revised output specification produced during negotiations with the PFI consortium

‘Projected demand for hospital services’ in the Full Business Case and any reports on future activity appended to the FBC

6 How many beds will there be?

6.1 Bed planning is a separate exercise to caseload planning. Whereas in the past bed numbers per thousand population were the subject of national norms, they are now calculated separately (using the measure of occupied bed days) for each individual scheme on the basis of performance values (see below) and projected caseload.

6.2 Bed numbers are counted as inputs and therefore are not planned solely by the trust, but are influenced by negotiation between the trust and its private sector partner. The PFI consortium may well therefore carry out bed planning as part of its ‘design brief’, while trusts or health authorities will also commission bed planning studies of their own. As with caseload planning, it is important to obtain all reports on bed planning produced by all parties to the process in order to get a measure of the factors determining the final bed numbers. However, getting access to the PFI consortium’s planning documents may be difficult, as the number of beds may be influenced by the model of hospital care used by the consortium - on which they may claim commercial confidentiality!
6.3 Since the introduction of PFI, trusts have been unwilling to give firm predictions of future bed numbers. Bed numbers have frequently gone down in the course of procurement, although this may have as much to do with pressure to cut beds from the regional offices as with the cost of PFI procurement.

6.4 In looking at projected bed numbers it is important to distinguish between different types of bed. All too often trusts have been found to have exaggerated projected bed numbers by including unstaffed ‘reserve’ beds, daycase beds and ‘bed equivalents’ (trolleys). The distinction should also be made between five-day beds (which are used only on weekdays) and seven-day beds, which are staffed throughout the week.

6.5 It goes without saying that other bed losses in the Health Authority area should be taken account of in assessing the likely impact of schemes.

6.6 Figures on proposed bed numbers are likely to be contained in:

- a ‘Sizing Logic’ commissioned by the trust or commissioner
- the section on ‘Future services’ in the Strategic Context section of the Outline Business Case
- the Option appraisal in the Outline Business Case
- the section on ‘Future services’ in the Strategic Context section of the Full Business Case
- the Option appraisal in the Full Business Case.

7. What are the performance values?

7.1 Performance values are productivity measures, showing the relationship between assets (beds) and numbers of cases treated per year. The essential measures are

- **Bed occupancy**
- **Throughput** (the number of FCEs per bed per year)
- **ALOS** (average length of stay)
7.2 The performance values for individual specialties, together with projected caseload, are the basis for planning future bed numbers.

7.3 Performance values frequently change during the procurement process, in order to reduce bed numbers (due to the cost of private finance) or due to pressure from the regional office. Moreover, private finance consortia sometimes set their own performance targets.

7.4 Apart from the daycase rate, there are no national recommended performance values: rather trusts are encouraged to experiment in matching productivity at other hospitals. Setting performance targets usually takes the form of taking a sample from hospitals in the top 10% - 25% of ‘efficiency’. In some cases targets have been taken not from UK hospitals but from the United States, and in at least one case performance values were pushed up on the basis of a comparison with targets in other PFI business cases, in other words, with targets that had not yet been met.

7.5 Increasing performance values is one of the main ways of controlling the capital cost of PFI schemes: higher productivity projections (whether achievable or not) mean fewer beds. It is therefore particularly important to be alert to changes in performance values over the course of the procurement process, and to ensure that documents from different stages in the process are checked.

7.6 Information on performance values is contained in

- the trust’s contribution to the Strategic context section in the Strategic Outline Case
- future services in the strategic context section in the Outline Business Case
- the pre-qualification documents and invitation to Negotiate report on performance values appended to Full Business Case
8. What changes will there be in the workforce, both clinical and non-clinical?

8.1 Although managers usually try to build public and professional support for PFI schemes by stressing the dilapidated condition of buildings and the need for investment in infrastructure, the driving force behind investment decisions is the need to drive down costs in the long term, and the main component of all NHS hospital costs is labour, which accounts on average for 75% of hospitals’ running costs. The current wave of ‘investment’ has little to do with bricks and mortar and everything to do with restructuring the hospital sector so as to reduce the wages bill in the long term.

8.2 This will partly be achieved by transferring most if not all ‘non-clinical’ staff out of the public sector and by reductions in clinical staff as a result of centralising services on single sites. But an equally important factor is the aim of reducing the proportion of unit costs (i.e., cost per treatment) which is accounted for by labour. This will be done by (1) reducing the labour component in all treatments by reducing length of stay and (2) offloading those types of care where the proportion of labour in unit costs is particularly high, such as long term medical care for the elderly. The new NHS will be one which concentrates on quick, high-tech procedures with a fast turnover.

8.3 Other services, such as rehabilitation and long term care services will, it is argued, be provided in the primary and community care sectors. However, there is no evidence to suggest that shifting services to other sectors will in itself reduce costs: savings will only be made by offloading costs on to patients, their families and their carers.

8.4 The thinking behind this approach comes from the private sector advisors who work for NHS trusts and PFI consortia. The assumption that private sector principles can be applied to public sector institutions (in the name of efficiency) demonstrates a failure to recognise that the public sector’s strengths lie in the fact that it is not subject to commercial constraints.

8.5 Information on projected labour costs and redundancy payments is contained in the financial appraisal in the Full Business Case: look in particular for the breakdown of future costs. Look for the current and projected revenue costs of wards or of beds. These are essentially labour costs. Any ‘savings’ achieved on these costs will indicate the extent to which labour is being shed. These should be compared where
9. What changes will there be to the estate?

9.1 PFI investment usually involves using the existing assets of the NHS, in particular land, in order to fund debt repayments. Most schemes involve the disposal of land identified as 'surplus': obviously there is a strong incentive on trusts to use their most valuable land to fund the PFI. There is thus a tendency for sites with good development potential to be identified as surplus to requirement, and for hospital services to be centralised on less valuable sites. As the value of a site, particularly for retail developers, turns to a large extent on its accessibility, the risk is that hospital services will drift to out of town sites. The Princess Margaret Hospital in Swindon, for example, which was built in the 1970s is to be demolished and replaced by a smaller out of town hospital at a cost of £143m under a PFI development: the value of the original site will be used to fund the PFI. The original bid for public money was for a refurbishment of the existing site at a cost of £45m.

9.2 It is important to distinguish between the 'book value' of a site and its potential market value. The 'book value' is the value of land which appears on the trust's balance sheet. It represents the value of land under its current use. (The trust pays capital charges on this valuation of its assets.) The real market value of the land depends on its potential use rather than its current use, and can be enormously greater than the book value. In order to see what contribution land is making to the costs of a PFI development, it is essential to know what the estimated market value with planning permission for retail or housing development is.

9.3 The value of land disposed of has the effect of reducing the annual PFI repayments. In the earlier days of PFI, trusts tended to treat land as a 'free good' and not count it as a cost of procurement. Land now has to be accounted for in the financial appraisal when PFI costs are being compared with the Public Sector Comparator.

9.4 In looking at the history of individual schemes it is important to find out at what point in the procurement process particular parcels of land were added to the deal and at whose suggestion. This information can be used to identify the influence of private finance on the location and design of future hospital facilities.

The new Strategic Outline Case will identify land which can be used to finance deals.

UNISON: Opening the lid on PFI: A negotiators guide to PFI procurement documents
A report on the current state of the estate is included in the strategic context section of Outline and Full Business Cases.

The value of land used to finance the deal should be derivable from the financial appraisal in the Full Business Case.

10. How will the scheme affect other hospitals and healthcare providers in the area?

10.1 In preparing for PFI procurement trusts are obliged to carry out a market analysis of local healthcare provision. This involves looking at the workload of other NHS trusts and seeing how the proposed scheme will fit in with their provision. Under the previous government this was often quite explicitly an attempt to identify opportunities to increase ‘market share’ at the expense of competitors, with ruthless analysis of the strengths and weaknesses of other providers. With the new government’s stress on ‘partnership’ rather than competition, we can expect future business cases to be somewhat less predatory in conception, although market analysis will still play a central role in establishing the ‘strategic context’. In the case of the schemes which were prioritised in July 1997, the market analysis was done under the old system and can be expected, in many cases, to reflect the raw competition at the heart of the internal market.

10.2 Market analysis is a sensitive area because it is here that the implications of schemes for the local healthcare system become apparent. Health authorities are often unwilling to spell out these implications for the other providers affected, especially if a PFI development at one hospital depends on the closure of another. The market analyses produced at various stages in the procurement process can thus throw light on when crucial decisions were made (in many cases, long before they became public knowledge). Again, it is important to see how this aspect of the business case has changed over time, especially with the introduction of a private sector partner.

The Strategic Outline Case, Outline Business Case and Full Business Case contain market analyses in the strategic context sections.

11. What is the estimated capital cost?

11.1 There are three different ways in which the costs of investment proposals are measured, and they need to be carefully distinguished.

The capital cost is the amount that needs to be raised (by the development. It includes the fees of architects, lawyers etc. as well as construction costs.

UNISON: Opening the lid on PFI: A negotiators guide to PFI procurement documents
The **unitary payment** for a scheme is the annual fee that the NHS trust pays to the private sector for the use of the hospital.

The **Net Present Value (NPV)** is a figure representing the sum total of all annual fees paid in the course of the contract, but with the fees discounted at 6% per annum, supposedly to express the diminishing value of future expenditure the further away in time it is. Although the NPV of the PFI payments is a virtually meaningless figure, it plays a crucial role in the comparison of costs with the Public Sector Comparator. It is also the only measure of the cost of a PFI scheme to the public sector as a whole (rather than to an individual trust or health authority). As NPVs represent payments of millions of pounds annually over periods of 30 to 35 years, expect them to be very high figures (in many schemes more than a billion pounds). For Calderdale Healthcare Trust for example the NPV of the PFI option is £1.209 billion.

11.2 It is important to identify variations in capital costs between the Outline and Full Business Cases. A recently published report ("Can the NHS afford the Private Finance Initiative") BMA Health Policy and Economic Research Unit 1997) has shown that on average capital costs for the first wave of NHS PFI schemes exceed original (Outline Business Case) cost estimates by 73%.

11.3 In order to justify higher capital costs, the Department of Health appeals to the concept of risk transfer. The claim is that the private sector is taking on risk by engaging in PFI procurement and that the cost of transferring this risk out of the public sector accounts for differences in cost.

11.4 The original capital cost estimate is contained in the **financial appraisal** in the **Outline Business Case**. Note that this will be for a **publicly funded** scheme.

11.5 The PFI capital costs are in the **financial appraisal** in the **Full Business Case**. This also includes the comparison of PFI capital costs with the Public Sector Comparator. Union representatives should be aware that in some cases the PSC has been revised in the course of procurement, and should demand a full explanation of any changes that have been made.

A brief statement of costs should be contained in the **Executive Summary** to the **Full Business Case**.

---

UNISON: Opening the lid on PFI: A negotiators guide to PFI procurement documents
12. What is the unitary payment?

12.1 The unitary payment is the trust’s annual contractual payment to its PFI partner for the use of the hospital. The bulk of this fee is ‘debt repayment’: the trust is paying off the consortium’s capital cost with interest (as well as its profits, of course). This is essentially a mortgage arrangement with the sole difference that at the end of the repayment schedule the trust will in most cases not own the hospital.

12.2 The annual cost also includes any fees paid to the consortium for providing Facilities Management Services, e.g. cleaning, catering, portering. The unitary charge is thus comprised of an availability payment, which represents debt repayment, a usage payment covering facilities management services and a relatively minor conditional performance payment. The fact that the payment includes these different elements is often used to disguise the cost of the PFI debt.

12.3 The proportions of the three components will vary from scheme to scheme, although the availability payment will always be by far the most important. In Calderdale the estimated annual cost of £13,723,000 breaks down into £8,736,000 for debt repayment and £4,987,000 for usage.

12.4 The PFI unitary payment has to be paid out of a ‘pot’ (the Trust’s future revenue) which is fixed in advance. This gives the PFI consortium an incentive to maximise the availability component of the payment, as this is where the consortium will make most of its profits.

12.5 The annual charge for PFI contracts is the outcome of an extended period of negotiation and is not finalised until contract signature. Trusts and the Department of Health so far have refused to disclose information on projected annual costs on the grounds that this could affect ongoing negotiations.

12.6 However, in the new Strategic Outline Cases, which will be made public, trusts are required to give details of the estimated annual cost. At the same time they are also required to make a statement of what they currently spend on the services to be provided under the scheme.

12.7 Business cases include financial appraisals which compare the costs of different options for change. The annual costs for the preferred option identified in the OBC should be compared with those in the FBC.
NHS Executive, SOCs are the first stage of approval for PFI developments. They are submitted to the CPAG for prioritisation.

**Unitary payment** The annual payment made by an NHS trust to its PFI partner under the concession agreement. Consists of an availability payment and a usage payment: also a relatively minor performance payment.

**Usage payment** Fee for the facilities management services provided by the PFI consortium under the concession agreement.

**Value for money** The other main criterion (along with affordability) for Treasury approval of PFI schemes. This is tested for in the economic appraisal. PFI schemes which are more expensive than their public sector comparators on a net present value analysis are held not to show value for money.

Acknowledgement: UNISON would like to thank Declan Gaffney for his work in producing this negotiators guide.