
Buying the best for the NHS

Ensuring smarter capital procurement

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Foreword

A properly funded, efficient and effective National Health Service is of vital importance to business.

Business funds the NHS through taxation and relies on it to ensure a healthy workforce. And business increasingly plays a role in providing the high-quality healthcare, support services and infrastructure the modern NHS relies on.

Recent years have seen big increases in both capital investment and current spending in the NHS. In England this has led to big falls in waiting lists and waiting times. Patients are being offered more choice over care and this competition is driving up efficiency and quality.

Reform works and the private sector has been at the heart of it.

Most of our large towns and cities are now equipped with hospitals, built and managed by the private sector, fit for the 21st century. The private sector has added to NHS capacity through new treatment and diagnostic centres and through large-scale provision of elective operations. New models of partnership with private and voluntary sector providers are now being developed to modernise and strengthen GP services.

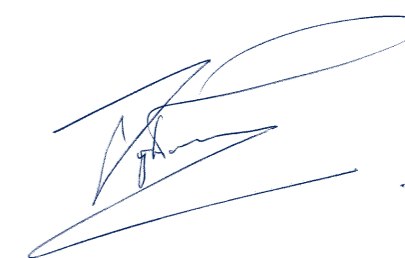
There is plenty of criticism directed towards private sector involvement in healthcare. Little of it is justified. The private sector has delivered more facilities and services on time and to budget than the old system of public design and construction ever did.

Yet problems remain. At the point when the NHS makes purchases—before the private sector takes control of projects—delays are all too common and costly. Sometimes the financial realities of schemes are not considered until contracts are about to be signed, so lengthy reviews need to take place. Or the NHS does not have a clear idea of what it wants, so companies have to submit and revise bids several times.

Now, the programme of investment in the health service is set to continue, but in a new environment. New facilities will be constructed, but will have to be paid for in an era when the large increases in NHS funding in recent years are over. The CBI believes it is all the more important, therefore, that the lessons of previous purchases are learnt.

This report highlights five case studies of good practice in procurement, focusing on large-scale capital and service projects. It draws on the case studies to provide a number of action points for improving the procurement process.

Our recommendations show how costs can be minimised without cutting quality. Our aim is that good practice becomes the norm, and we have every reason to believe this can happen.



Sir Digby Jones, Director-General, CBI

1: Investing in health

Buying the best for the NHS is an expensive business. Since 1997, the government has made a significant investment in new facilities and services for the health service. Major capital programmes worth over £23bn have been launched in England.¹ More routine modernisation of facilities will cost the NHS £5.25bn in financial year 2006-7 alone.²

This investment is essential to the long-term future of the NHS. Modern, technologically advanced facilities and innovative services are crucial to providing the patient-led, high-quality NHS that we all expect in the 21st century.

A great start has been made: since the early 1990s, a large part of the hospital estate has been renewed and new services have helped to bring waiting lists down to historically low levels.

But there is still much to do. Over 50 hospital building projects are underway or in the pipeline, and the fourth wave of the Local Improvement Finance Trust (LIFT) programme for new primary care facilities has started. The government's recent white paper, *Our health, our care, our say: a new direction for community services* points to the need for further investment in primary care to ensure patients have genuine choice and quality of healthcare in the community.

Yet this continuing investment in the future of our health service will have to take place in a new climate of funding for the NHS. After 2008, the recent increases in health service funding are set to slow. More than ever, it will be important that every major purchase for the NHS is closely accounted for and represents good value for money. And crucially, it is important that the manner in which purchases for the health service are made—the procurement—does not add unnecessary costs to the NHS now or in the future.

2: Why procurement matters

The technical processes behind procurement are rarely commented on—no doubt due to their complexity. Yet, if we are to have a world-class, patient-led health service in the future, it is essential to get the procurement of new health facilities right.

The cost of delay

Delays to procurement processes add significant extra costs to the purchases the NHS makes. While the specifications for schemes are being redesigned, or the final arrangements for projects are being reviewed, staff working on the project must be retained, and other fixed costs build up.

The NHS, for example, recommends that the procurement process for a Private Finance Initiative (PFI) hospital scheme should take 18 months.³ But on average it takes 21 months longer than this. Based on a CBI estimate⁴, average delay costs represent 1.05% of the capital value of each PFI scheme. For schemes with a higher capital value, the costs of delay are likely to be even larger than this—as shown by the estimated £600,000 a day lost due to delays to the Bart's and Royal London regeneration scheme.⁵

Based on this estimate, almost £100m has been lost to overruns on 40 major PFI hospital projects alone since the first wave of schemes began in 1994. While this is a considerable figure, it is a conservative estimate.⁶ Delays have also occurred to other programmes, such as LIFT, and have had considerable cost impacts.

The impact of delay

Wherever and whenever they occur, the costs of delay always end up on the NHS' bill. If the bidding process is delayed, it may be the bidders who pick up the cost of the hold-up. However, it is likely that these extra costs will, as the Department of Health stresses, “be ultimately recovered by the private sector in [the price of] subsequent... schemes.”⁷ Other delay costs—some that occur in the bidding process and some after a preferred bidder has been appointed—are added to the fees the NHS must pay to use the new services and facilities.

Extra purchasing costs are an unnecessary burden to local trusts and to the Department of Health. Given that new facilities and services will operate in an era of patient choice and payment by results—when the incomes of hospitals, primary care facilities and treatment centres are no longer certain—it is essential that these costs are avoided. While the costs of delay are small in comparison to the scale of overall investment, they could make the difference between solvency and financial instability for trusts in the years to come.

The fact that the majority of costs are incurred by the private sector upfront presents another problem. Delays cost an average of £2.45m per PFI scheme.⁸ The NHS only begins paying that money back when the facilities have been constructed and services are in operation. On a large-scale project, such as a PFI scheme, the contractor may therefore have to wait 30 years or more before it receives the money it is owed for the delay. Some companies will not be able to absorb these costs upfront, leading to a major barrier to entry in the market. This in turn means that bidding competitions are restricted to companies that have the necessary financial solidity to absorb these extra costs—reducing competition and the potential for the NHS to achieve value for money in the projects it commissions.

The wider significance of delay

Delays to the procurement process are also symptomatic of wider problems with large-scale purchases. The central purpose of the procurement process is to identify which facilities and services are needed to meet the needs of the local health economy, how those facilities should be provided, and what would be the most innovative and cost-effective way of providing them. Without a clear strategy behind each purchase, it is likely not only that reviews of the scheme will be required during the procurement process—thereby causing delay—but also that inappropriate facilities and services could be bought for the NHS. Given the impact that payment by results and patient choice is likely to have, poor purchasing could have serious consequences.

3: Spreading good practice

In some parts of the NHS, good practice in procurement is taking place, helping to ensure delays are avoided and the right facilities are bought. Often, however, projects demonstrate good practice only in certain areas of their work; sometimes, only some of the many stakeholders in a major project may be working effectively.

For the procurement of major health facilities and services to improve, the CBI believes all stakeholders must work together to share and implement good practice across the board. This report includes a number of case studies which demonstrate existing good practice in health procurement and build part of the case for how it could be improved. The lessons in good practice they provide have been combined with CBI member interviews and wider research to create a set of policy recommendations.

Many of the recommendations focus on changes that could be made without legislation. Often, improvements could be made simply through better partnership between those involved in the procurement process, or better planning. Yet where there are structural barriers to efficient purchasing, it is essential that the government takes a clear lead in making reforms to the process that help to avoid delays and make sure that the best is bought for the NHS.

The lessons that the CBI believes should be learnt from the case studies and other examples of good practice in health procurement are set out below.

1 Conduct a health-needs analysis

Before any major purchase, it is essential that the NHS undertakes a clear analysis of existing capacity in each local area. Only then, having decided what gaps in capacity exist and what facilities need to be replaced, should trusts and the Department of Health consider which purchases need to be made.

The analysis of existing capacity should be wide-ranging. It must take account of local funding for the health service, and how new facilities will be paid for. The views of local

patients, and the facilities to be provided for those with chronic conditions, are also important. It should take account of key stakeholders such as local politicians and all relevant health service organisations. The analysis should also assess the impact of national policies such as payment by results and regional and national developments in health technology and specialisation.

Based on the results of the analysis, the local NHS should develop a long-term strategy for the future of the health service in its area. The strategy should identify the capital projects that are required and set a timetable for their conception and completion. It may also market test innovative projects in order to explore their scope, deliverability and commercial viability. Projects should be considered initially with outcomes, rather than inputs, in mind, and the local NHS should explore potentially innovative solutions.

The benefits of conducting a health-needs analysis
Schemes are liable to delay if they do not have a clear strategy behind them. If the procuring party does not have a clear idea at the beginning of the process of how the new facility or service will fit into the local NHS, it is likely that specifications will change during the bidding process, causing delay. Similarly, if the analysis that takes place prior to the start of the scheme does not take account of affordability, then reviews will be needed at a later stage to test the financial viability of projects. Good practice in procurement therefore requires the NHS to conduct a comprehensive assessment of the facilities it needs in each local area before such a project is even begun.

The case study of General Healthcare's involvement in the government's scheme to purchase extra operations across the country from the independent sector (known as the G Supp 2 programme) shows that a clear strategic context for a project is central to ensuring that the procurement process goes well. The G Supp 2 programme was part of a clear strategy aimed at eliminating local waiting lists for specific procedures—the need for additional capacity in each Strategic Health Authority was therefore closely analysed. This meant that the eventual service filled a clear gap in local health capacity, did not duplicate existing facilities and was affordable, since it provided almost exactly the number of procedures that were required for each area.

RECOMMENDATION 1:

Before any major purchase begins, a health needs analysis should be conducted in the area in which the new facility is to be situated. This analysis should cover existing health facilities, gaps in provision, financial factors, the views of key stakeholders and all relevant health service organisations. It should also take account of regional and national developments in technology and specialisation, and national policies such as payment by results.

2 Set clear timeframes with sanctions for failure to respect them

The cost of delays to the procurement process can be significant. It is important, therefore, that delays are avoided as much as possible in order to lessen their impact on project costs and to allow more money to be allocated to the design and construction of facilities providing first-class patient care. There are two main ways to avoid delays: setting clear timeframes for each project and imposing penalties for failure to respect them.

In the procurement phase of complex projects, the incentives for each side to complete the process are not always well defined. There are many stakeholders who influence the process, making it more difficult to manage. Of these, the private sector bidders and contractors are required to pay the majority of the costs of delay upfront.

It is right that there should be proper consultation and agreement for each scheme. Yet, while each project should be scrutinised for the quality of the services it will provide and the value for money it represents, it is important to balance this with a clear end-point for the procurement process. The case study provided by Carillion Healthcare shows that where such an end-point exists as a feature of a particular scheme, the speed of the procurement process is significantly improved. The fact that the Oxford Radcliffe Hospitals NHS Trust had a property contract, which contained large financial penalties should it move out of the old Radcliffe Infirmary later than the agreed deadline, gave an end-point for all parties to work towards. Financial close on the project was concluded less than a year after the appointment of the preferred bidder.

If an endpoint does not exist and the incentives against delay are missing, problems occur. With incentives, procuring parties are more likely to conduct a full health needs analysis before they begin the purchasing process. This will help to avoid specification changes and the subsequent need to refine bids. The financial viability of schemes may be more

adequately assessed when designs are drawn up, avoiding last-minute reviews and revisions of the project. Creating incentives that encourage all parties to adhere to agreed timetables would help to avoid delays, and their associated, unnecessary costs.

RECOMMENDATION 2:

A clear procurement timetable should be set for each project. This should include individual commitments for the amount of time it will take to reach preferred bidder status and financial close. The timetable should be set after expressions of interest have been sought. It should be calculated according to the complexity of the scheme and agreed by all key stakeholders, including bidders.

RECOMMENDATION 3:

Should the procurement process extend beyond the agreed timeframes, the lead procuring party should be responsible for paying the costs of delay, upfront, to all qualified bidders and to contractors. This should include costs which bidders incur when delays happen before the preferred bidder stage.

3 Consult patients from an early stage and as the scheme progresses

In a patient-led NHS it is essential for major purchases to include early local consultation with patients and the public. Patients are a great source of insight on how facilities and services could be improved—particularly with regard to primary care, which they use more frequently than acute care services. Research should also be conducted into the number of local people with particular health conditions and their treatment needs. This research should be forward looking and focus particularly on long-term conditions such as diabetes, so that facilities can better prepare for future requirements.

There is currently a statutory requirement on local trusts and health authorities to consult local patients when services change significantly.⁹ But such consultation is often minimal. Given the cost of buying the best for the NHS, patient involvement is essential in order to build facilities that are attractive to the public and therefore financially viable.

But it is also important that this consultation process forms only part of a strategic needs analysis and only part of the procurement process. New facilities and services should be subject to a rigorous cost-benefit analysis and considered within the context of regional specialisation and national developments in health policy and technology.

RECOMMENDATION 4:

Consultation at the beginning of major projects should be as wide-ranging as possible and take account of the views of all sections of the community, so that special interests do not take over schemes. Public meetings and large-scale surveys would be the best format for early-stage involvement.

The government and NHS should also give consideration to the ways in which patients' representatives could be kept involved as the procurement process progresses. For example, a 'consumer advocate', whose role would be to highlight and speak in favour of patients' interests, could attend major meetings of public and private sector project teams. All patient consultation on major schemes should, however, be married to a realistic assessment of the context in which the new facility would operate.

4 Ensure close partnership between public and private sectors

Partnership between all those involved in the procurement process is essential for a project to avoid delays. The General Healthcare case study demonstrates that where a close partnership between the NHS and contractors has developed, and an atmosphere of trust has resulted, the services provided after financial close are flexible and adaptable to new circumstances. After one Strategic Health Authority refused to take part in the G Supp 2 programme, General Healthcare and the Department of Health worked together to ensure the company could provide the operations it was contracted to carry out, but in another location. This made sure that the NHS was not paying for services it did not in the end receive.

Similarly, better partnership can allow the key commercial issues in a procurement to be identified and solved quickly. This in turn helps to avoid changes of specifications, reviews and subsequent delays. In its case study, Barclays Bank commented that the experience and commitment of the Northern General Hospital's project director allowed the key commercial issues in that procurement—such as the trust's foundation status—to be identified and resolved quickly. Indeed, it has been the experience of CBI members that foundation trusts, with their wider powers and freedoms, are particularly interested in developing new ways of working in partnership to deliver innovative solutions.

To ensure a level playing field, any partnership before the preferred bidder stage should be strictly limited and controlled. Partnership at this stage between the public and private sectors is acceptable where the procuring parties are not directly involved. As the collaboration between BUPA and the Surrey and Sussex Healthcare Trust on the Redwood centre project shows, such partnership can be valuable to pathfinder projects that implement new policies, use new procurement models, or involve the procurement of new types of facilities and services. BUPA was able to work with the trust without compromising the neutrality of the procuring authority, the Department of Health.

Where there is no other non-procuring, public sector organisation for a consortium to work with prior to the preferred bidder stage, partnership is still possible. As the KPMG case study shows, advisers can be used as an intermediary between a procuring party and bidders, holding workshops to help bidders produce submissions that conform closely to specifications, while also maintaining a level playing field. The competitive dialogue procedure, introduced in January under EU Procurement Rules for complex projects,¹⁰ also offers the opportunity for the procuring party to explore potential solutions with bidders and come up with innovative ways to achieve results.

Once the preferred bidder has been announced, partnership becomes essential for the parties to work together to achieve financial close. There are few statutory or regulatory instruments that can be used to ensure a partnership develops, as this is up to the parties themselves. But there are some procurement models which encourage collaboration: every company formed to carry out a LIFT scheme, for example, is made up of both public and private sector stakeholders, and Partnerships UK is jointly owned by the public and private sectors. By locking the private sector into partnership with public bodies only once the preferred bidder has been chosen, the LIFT model accrues the benefits of collaboration without compromising competitive neutrality.

Yet sometimes there are organisational barriers to partners coming together on a scheme. On the Independent Sector Treatment Centre (ISTC) programme, for example, bidders are not allowed to come together in partnership with local trusts, despite the fact that the programme is centrally procured through the Department of Health and despite BUPA's success in working with the trust on the pathfinder project. It is important that all such barriers are eliminated whilst maintaining a level playing field between bidders.

Sometimes, partnership breaks down between different stakeholders on a project and delays result. When this happens an independent mediation process can help to resolve the dispute and bring the consortium and the public sector back into co-operation.

RECOMMENDATION 5:

The government, NHS and independent sector should collectively examine new ways of ensuring effective partnership develops in the procurement stage of every major capital project, while ensuring a level playing field between bidders. Models that tie the NHS, contractors and other stakeholders together with equal incentives for success, should be encouraged.

RECOMMENDATION 6:

The government and NHS should investigate creating a mediation process, designed to informally investigate procurement delays, help resolve disputes between parties and ensure a level playing field between bidders. While the parties would still have recourse to the legal avenues available under competition and procurement law, such a process would help to bring both consortia and the public sector back into partnership where it has broken down.

The process could be managed within existing procurement oversight bodies, such as the Department of Health's Commercial Directorate and Private Finance Unit and Partnerships for Health.

5 Secure good value for money

Given the new climate of funding that the NHS faces, particularly after 2008, it is essential that every new purchase of services and facilities represents value for money (VfM). Government accounting regulations stipulate that procuring parties are responsible for achieving VfM.¹¹ However, adherence to this is patchy and procuring parties can list price as the most important factor in all bids. It should take account of many other factors, such as:

- The reliability of the organisations involved
- The innovations that the scheme will provide in terms of more efficient layouts and treatment techniques
- Use of technology, in particular IT
- Supply chain management
- Employment practices
- Long-term costs (eg expected lifetime maintenance)
- Environmental factors
- Wider impact on the area's overall health strategy.

Value for money on schemes that include clinical services, such as on the ISTC programme, should also take account of:

- Clinical governance arrangements
- Application of clinical workforce issues and Agenda for Change

- Patient experience and quality of care
- Quality of customer service.

Sometimes a consortium will submit a bid which is higher in price than other bidders but which offers better value for money. In this case, the procuring authorities should not be afraid to choose this option. In the past, trusts have argued that some major capital projects are lacking in innovation and new solutions for health services¹². Innovation, of course, costs money in the short run, but if it is to become a feature of major schemes, it will have to be given a higher priority.

RECOMMENDATION 7:

Bids for major capital projects should be assessed not just on price, but on value for money. This should include a wide variety of components that contribute to quality and efficiency. Procuring authorities should not be afraid to award contracts to bids that are higher in price than others but which provide better value for money. They should also place an emphasis on innovation by ensuring it is weighted strongly in bid evaluation criteria, and by making project specifications outcome rather than input-led.

6 Build in flexibility for the future

Flexibility in provision can be important to allow services and facilities to adapt to new circumstances and healthcare technologies. It is essential for flexibility to be built-in at the procurement stage, as this is the point at which the contracts defining how services will be provided—often for a considerable time—are signed. The LIFT programme, which specifically builds in flexibility in the use of facilities over the period of the contract, has shown that it is possible to incorporate this into a procurement model.

RECOMMENDATION 8:

Given technology's likely impact on healthcare provision in the future and the impact of national policy changes such as payment by results, the government and NHS should encourage procurement models that promote flexibility of service provision and critical care.

7 Ensure better procurement skills

Large-scale projects are complex and multi-faceted, with those who are managing them from both the private and public sector sides requiring many specialist skills.¹³ Where these skills are developed, it is important that they are retained.

CBI members have often commented on the lack of training provided to public sector project teams. While all NHS project directors of major capital schemes were required to go through a training course in project management and procurement from 2001, only 60 candidates have completed the official course at one of the three main providers.¹⁴ A lack of procurement skills can often cause delays to schemes, especially when specifications are not fully formed and the financial viability of schemes is not properly tested. Where procurement skills do exist and a strategy is established upfront, reviews are avoided and the process moves quickly to financial close—as the involvement of the NHS project director in the Barclays case study shows.

But those involved in the procurement process who are successful and have acquired the necessary skills, may leave the health service within a short time due to low rewards. In the private sector, where skills are retained and augmented, procurement experts have often worked on a variety of different projects¹⁵ and had the benefit of formal training. This mismatch may have dangerous consequences for the procurement process and the procurement party's capability to act as an 'intelligent customer'.

Sharing good practice

Both CBI members and NHS representatives have commented that good practice in procurement is rarely spread. Why does the NHS often fail to repeat the success of individual projects? A 2005 survey of trusts by the NHS Confederation found that as trusts can only commission one large capital scheme every thirty years, members of project teams usually move on to other jobs in the NHS when that project is finished. Knowledge of what makes a successful PFI project is therefore being lost.¹⁶

This is not the case in commodity purchasing. In March 2004 the Department of Health's Commercial Directorate launched the Supply Chain Excellence Programme (SCEP). SCEP is designed to establish collaborative procurement hubs for NHS bodies across the whole of a Strategic Health Authority's area and to grow an NHS consumables supply chain and procurement service. On its website, the NHS Procurement and Supply Agency (PASA) has set up a database of good practice

in commodity purchasing.¹⁷ A similar programme encouraging the dissemination of good practice needs to be developed for more complex projects.

RECOMMENDATION 9:

The government and NHS should ensure that procurement professionals are properly trained and retained and that key decision makers are experienced. To this end, the government should consider establishing a national procurement academy to formalise training for procurement professionals. All key members of public sector project teams should undergo similar training. Those trained by the academy could form a cadre of health procurement specialists who work on successive procurements, gathering experience as they go.

RECOMMENDATION 10:

Case studies of good practice in public sector procurement should be compiled and made available to those undertaking major capital schemes. The case studies should include lessons learnt from international procurement methods. The information should be made easily available to project teams via a website.

8 Cut out unnecessary bureaucracy

It is important that every stage of the procurement process is relevant to ensuring the quality and viability of the final project. At the moment, in some areas of health procurement, there are stages of the process that could be rationalised.

One part that has been consistently highlighted is the Pre-Qualification Questionnaire (PQQ). The questionnaire is lengthy, contains basic details and adds a significant amount of time and cost to each scheme. Often, companies who have provided services to the NHS previously and demonstrated that they have the necessary expertise to do so are required to fill out the PQQ for every scheme.

A potential way ahead has been shown in NHS commodity purchasing, where the PQQ stage has been streamlined significantly. PASA currently operates the NHS Supplier Information Database (NHS SID), which seeks to minimise replication of effort at the pre-qualification stage for the benefit of suppliers and the public sector. Details about suppliers are held centrally and can only be accessed by authorised personnel engaged in NHS purchasing activity. Bidders update the information annually.

Creating a similar scheme for complex procurements could radically streamline the pre-qualification process and ensure much of the information in the PQQ has to be submitted only once. Information about financial standing, currently a key part of the PQQ, could also be held centrally on the database. It is inevitable that issues of technical capability that are specific to a particular project will exist and that bidders will therefore have to submit additional information to supplement that held on the database. But such a database would be a considerable step forward in cutting down the length of the procurement process and avoiding delays.

RECOMMENDATION 11:

The Department of Health and the NHS should consider creating a centralised database of pre-qualification information for complex projects. This should hold as much information as possible on bidders, including details of financial backing, in order to avoid replication of effort during the PQQ process. Bidders should revise their submissions to the database annually. Only extra information relating to specific technical capability should be requested during the PQQ stage of individual schemes.

CASE STUDY 1

CARILLION HEALTH AND THE OXFORD RADCLIFFE HOSPITALS NHS TRUST ACUTE HEALTH SCHEME

Key factors for success:

- **Conduct a health-needs analysis**
- **Ensure better procurement skills**
- **Set clear timeframes with sanctions for failure to respect them.**

Background

Carillion Health, a subsidiary of Carillion Plc, is a major provider to the public sector health market. The company designs and builds new health facilities, delivers clinical services and provides support functions to the NHS. Carillion Health has worked on a number of major capital procurement projects since 1997 and is involved in the ISTC programme.

In December 2002, a consortium headed by Carillion Health was awarded preferred-bidder status on the John Radcliffe Hospital PFI scheme. The development of the hospital is the major part of a plan by the Oxford Radcliffe Hospitals NHS Trust to relocate services from the ageing Radcliffe Infirmary in the centre of Oxford to the John Radcliffe Hospital site outside the city centre.

The project has a capital value of £134m and involves relocating neuroscience and general surgery from the infirmary to the John Radcliffe site. Under the scheme, a new children's hospital is also to be constructed. The new facilities, along with existing services that are provided on the site, will serve 2.3 million people once they start operations in December 2006.

Conduct a health-needs analysis

The trust conducted a detailed health needs analysis at the beginning of the scheme. This ensured that there were few changes to the specifications and the scope of the project during the procurement phase, which helped the

trust and the consortium avoid delays. The relative certainty surrounding the aims of the scheme allowed the project teams to concentrate on the development of a known solution with clear clinical adjacencies, rather than seek to define the scope of the project during the procurement phase.

This certainty could in part be traced to the planning and level of detail in scheme specifications the trust achieved prior to the commencement of the project. This ensured that there was a robust brief for Carillion to work with.

The development of the John Radcliffe site was part of a wider redevelopment strategy by the trust to develop Oxford's secondary care services. This involved the disposal of the trust's existing estate in central Oxford and the provision and regeneration of services outside the city centre.

Ensure better procurement skills

Both the trust and consortium project teams contained the experience and expertise to ensure the preferred bidder phase was managed effectively. The trust project director had previous experience of closing a PFI deal which, though smaller in scale, involved a similar set of requirements as the John Radcliffe scheme. She was described by those who worked on the project from the contractor side as an extremely capable manager. The rest of the trust's project team were also committed to the project and there was a continuity of staff throughout the procurement phase. This meant that the aims and rationale for the project were consistently displayed in the trust's dealings with the consortium. This contributed to the certainty of strategy behind the project.

Set clear timeframes with sanctions for failure to respect them

The trust had a clear incentive and commitment to achieve financial close by the end of 2003. During the preferred bidder period, the trust sold the infirmary site to the University of Oxford. The deal with the university was based on the trust continuing to occupy the infirmary until mid-2007. If the trust failed to vacate the property by this point, it would be subject to a financial penalty.

Given the need for a period to demobilise and vacate the Infirmary site, the trust decided that the new facilities would have to be available in spring 2007. Construction timings and some financial considerations dictated that the scheme would have to reach financial close by the end of 2003. This timeframe gave all parties an objective to work for in the procurement phase — with real incentives to encourage them to meet the targets.

Financial close was achieved a year after the preferred bidder stage. This was thanks to the work requirements being set within an overall programme to which both parties were committed.

The results

Expressions of interest in the project were sought in August 2001. Preferred bidder status was reached in December 2002. Financial close occurred on 19 December 2003. The relocated services are due to begin operation on the site in January 2007.

CASE STUDY 2

GENERAL HEALTHCARE GROUP AND THE G SUPP 2 PROCUREMENT

Key factors for success:

- **Ensure close partnership between public and private sectors**
- **Build in flexibility for the future**
- **Secure good value for money**
- **Conduct a health-needs analysis.**

Background

General Healthcare Group is the holding company for two major providers of health services: BMI Healthcare, the leading private hospital provider, and Amicus Healthcare, a supplier of clinical services and facilities to the public sector.

In 2005 the Department of Health announced a new programme to purchase several thousand operations from the private sector for NHS patients. The programme, General Supplementary 2 (or G Supp 2), aimed to reduce residual NHS waiting lists on commonly performed elective procedures such as hip and knee operations. A previous programme, G Supp 1, had completed 27,000 operations for patients, making a significant reduction to waiting times.

The overall value of the contracts for G Supp 2 was £54m and work was divided amongst three providers, with General Healthcare winning three-quarters. The procurement was organised centrally by the Department of Health under its new purchasing arm, the Commercial Directorate.

Before the procurement process began, the need for extra elective procedures in each of the 28 Strategic Health Authorities across the country was identified, with a particular emphasis put on areas where people had been waiting the longest for the types of operations the programme would provide. In May 2005 a competitive tendering process was launched, with independent providers bidding for each health authority area and the number of procedures assigned to it.

Under its agreement with the Department of Health, General Healthcare used spare capacity in its private hospital network to carry out the procedures and organise outpatient attendances. Most of the work is now complete.

Ensure close partnership between private and public sectors

From the beginning of the procurement process, a close partnership was developed between General Healthcare and the Department of Health. The company presented a continuity in the relationship, always sending the same people to meetings even while many changes were occurring in the Commercial Directorate. The department helped to co-ordinate the programme by asking SHAs to send details of individuals who had been waiting longest for the procedures to be carried out in their areas onto the company. General Healthcare then contacted these patients, sending them brochures and asking them if they would like to have their treatment carried out more quickly under the programme. An NHS liaison officer was employed by the company in each area to ensure co-ordination between the NHS and the independent sector in transferring patients and their records.

Build in flexibility for the future

The contracts agreed between General Healthcare and the Department of Health stuck to core principles of payment and independent sector performance, but were flexible in practice. The spirit of goodwill that operated between the company and the Department of Health was such that, when one SHA declined to send any patients to the programme, General Healthcare agreed it would carry out the number of procedures it had been awarded for that area somewhere else. This was despite the fact that the company was contracted to be paid for each area whether they carried out the procedures or not.

The Commercial Directorate was able to organise another location where General Healthcare could carry out the procedures for the same price.

Secure good value for money

The fact that the programme was centrally procured allowed bulk buying and economies of scale to come into play. General Healthcare used its existing network of hospitals to provide the procedures. This meant that the fixed overheads associated with the treatment had been paid for already in constructing and running the company's private hospital network — the NHS procedures simply utilised available spare capacity in the network. It is notable that General Healthcare did not bid for contracts in areas in which its own network was already running at capacity — other providers with capacity to spare delivered the work in these authorities.

Conduct a health-needs analysis

The whole programme was underpinned by a clear strategy: to reduce the legacy of long waiting times for patients. A clear assessment of the needs of local health economies was undertaken, and the number of procedures that needed to be carried out in each SHA was identified. This process occurred before the procurement process began. The Department of Health then proceeded to launch the competitive tendering process. It was this clarity of strategy that enabled the procurement process to occur quickly and with little change of specifications.

The results

Expressions of interest in the project were sought in May 2005. By June, a total of £54m in contracts had been awarded. Between July and August, the first procedures were carried out, with most of the work completed by December.

CASE STUDY 3

BUPA HOSPITALS AND THE REDWOOD TREATMENT AND DIAGNOSTIC CENTRE

Key factors for success:

- **Conduct a health-needs analysis**
- **Ensure close partnership between public and private sectors.**

Background

BUPA Hospitals Limited (BHL), part of the BUPA Group, operates 26 independent hospitals in the UK providing healthcare services to privately insured and self-pay patients and to the NHS. In December 2002, with the agreement of the Department of Health, BUPA entered into a five-year contract with Surrey and Sussex Healthcare NHS Trust to provide dedicated in-patient and day-care capacity in orthopaedics, gynaecology, general surgery and diagnostic endoscopy to the NHS at Redwood Hospital in Redhill, Surrey.

This contract was the first example of the NHS using the independent sector to provide elective care to the health service in a treatment centre. It helped the Department of Health develop the subsequent Independent Sector Treatment Centre (ISTC) programme, which the government announced in October 2002. This programme, which aims to shift some elective treatment and diagnostic tests away from NHS hospitals, was centrally purchased by the Department of Health's Commercial Directorate. Under wave one of the programme, contracts were awarded to 34 centres to provide up to 171,000 procedures a year over five years. This represented an investment by the government of approximately £1.6bn. The evaluation of bids for a second wave of centres is under way.

BUPA's Redwood Treatment and Diagnostic Centre was contracted to carry out 60,000 procedures over a five-year period. Since opening in December 2002, the centre has treated over 35,000 patients in the Surrey and

Sussex area. Patient satisfaction is high, with 87% of patients in a recent survey rating their care as either 'excellent' or 'very good'. Innovation has also been a feature of the project, with new clinical pathways helping to reduce the length of time patients need to stay in the centre.

Conduct a health-needs analysis

BUPA and Surrey and Sussex NHS Trust both recognised during 2001/2 that the Redwood Diagnostic and Treatment Centre offered the potential to provide the NHS with additional capacity. At the time, the facility was not meeting its full potential and was under-utilised. The Department of Health encouraged the Strategic Health Authority, the Trust and BUPA to work together to develop a proposal to make Redwood into a Diagnosis and Treatment Centre, a pathfinder for the eventual ISTC programme.

The goals for private and public sectors were clearly defined. By concentrating on elective admissions and operating without the pressures associated with emergency treatment, the centre would be able to provide the local trust with an efficient source of routine procedures that often had long waiting times. Simultaneously both sectors were able to come together and utilise existing facilities and capacity in the local health economy better.

Ensure close partnership between the private and public sectors

The parties developed a strong working relationship quickly. BUPA and the NHS bodies formed a joint team to develop the proposal and the commercial framework to achieve the goals. Key challenges for the scheme were the development of a novel contract and associated commercial arrangements for such a centre, secondment

arrangements for NHS staff and the stewardship of national and local interests in a leading-edge project.

The team was made up of a number of experienced representatives from all relevant stakeholders. From the NHS, meetings were attended by the chief executive and senior managers of the trust, a director of the SHA and the access and choice director from the Department of Health. BUPA's team was made up of the company's deputy managing director, finance director, head of NHS business development and the general manager for the new centre.

The eventual operational solution gave clear accountabilities to each stakeholder and every party was fully committed to make the solution work in practice. The NHS and BUPA organised their resources to focus on the delivery of the project and made the mobilisation of the project a top priority. The centre was fully integrated with services provided in the local NHS acute hospital and it was arranged that local NHS clinical training placements would encompass work not only at publicly provided facilities, but also at Redwood.

The close partnership that developed in the original procurement is likely to be taken further: BUPA and the trust are working together to obtain colorectal cancer screening unit status for the centre in September 2006.

Results

The Department of Health announced the idea of establishing a Diagnostic and Treatment Centre (DTC) in December 2001. Following BUPA's response to this announcement, negotiations during the course of 2002 led to a contract being agreed in September 2002. The centre opened in December 2002.

CASE STUDY 4

KPMG AND THE OXFORD RADCLIFFE HOSPITALS NHS TRUST ACUTE HEALTH SCHEME

Key factors for success:

- **Ensure better procurement skills**
- **Ensure close partnership between public and private sectors.**

Background

KPMG has provided advice to a number of primary care, acute and mental health trusts in recent years. Its work has included guidance on procurement to the private and public sectors and it has built up a considerable amount of experience across multiple procurement projects and models.

Recent advisory contracts have included the development of the LIFT initiative from 2001–3 and the subsequent first three waves of LIFT procurement. The firm has also been involved in several NHS PFI projects and other public-private partnerships in the health sector.

As part of its service to NHS organisations and private providers on procurement projects, KPMG delivers knowledge and understanding of the contractual documentation, financial issues and local strategic planning that underpin every new scheme. The firm has built up its experience across a number of projects, so that it is able to quickly identify the issues that trusts face on procurement schemes, and help deal with them.

The Oxford Radcliffe Hospitals NHS Trust acute health scheme

From 2001, KPMG acted as a financial advisor to the Oxford Radcliffe Hospitals NHS Trust on its acute

health scheme to build new facilities and provide facilities management services on the John Radcliffe site in Headington, just outside Oxford. The scheme was part of the trust's long-term strategy for the relocation of the old Radcliffe Infirmary, which had previously provided many of the main acute healthcare services in Oxford, to new sites.

The scheme involved relocation of the Infirmary's Neuroscience, Head and Neck, and Plastic Surgery services. Part of the John Radcliffe Hospital was refitted and a new children's hospital was also built on the site. A private provider took over service provision for the whole site under a fully integrated payment mechanism.

KPMG assisted the trust in developing its outline business case and provided financial advisory services – on tax, accounting, and VAT through to financial close.

Ensure better procurement skills

The skills and experience in procurement that KPMG provided were important to the success of the scheme. The firm was able to guide the trust through key sections of the process, and acted as a constant sounding board for the project director on all the commercial areas of the scheme.

The advisors appointed to the scheme developed the payment mechanism for the facilities management contract and negotiated and evaluated the commercial and financial elements

of the bids on behalf of the trust. The firm advised on a bank financing competition, which helped to significantly reduce the future charges for the trust for using the facilities.

Ensure close partnership between public and private sectors

The firm acted as an intermediary between the trust and companies bidding for the contract to carry out the project. In order to make sure specifications for the project were communicated effectively to potential providers, KPMG held a series of workshops with bidders. This ensured bids were closely aligned with the trust's wishes for the scheme. KPMG's objective involvement as an intermediary developed a strong partnership between bidders and the trust in the procurement stage.

KPMG subsequently worked with the trust on its Oxford Churchill project, which reached financial close in December 2005. The continuity of advisory services on the two projects helped to lend strategic direction to the overall long-term acute health services relocation strategy in Oxford.

Results

Expressions of interest in the project were sought in August 2001. In December 2002 preferred bidder stage was reached. Financial close occurred on 19 December 2003. The relocated services should be available on-site in January 2007.

CASE STUDY 5

BARCLAYS BANK AND THE SHEFFIELD TEACHING HOSPITALS
NHS FOUNDATION TRUST**Key factors for success:**

- **Ensure better procurement skills**
- **Conducting a health needs analysis**
- **Close partnership between public and private sectors.**

Background

As providers of significant funds to major capital projects managed under PFI and other procurement models, financial services organisations are crucial to the viability of the procurement process. Typically, banks become involved in schemes at the Pre-Qualification Questionnaire stage (PQQ). The consortia that come together on each scheme are required to show that they can provide adequate funding for the project upfront. Funding organisations issue a letter of support to certify that the contractors have the necessary backing.

Later in the process, banks are asked to comment on the payment mechanism and the funding structure of the bid in which they are involved. They also submit further supporting documents and issue lending terms and conditions. At the Preferred Bidder stage, banks work with advisors on the projects to scrutinise the specifics of schemes before they lend.

Barclays Bank is a major provider of funding for the full spectrum of government infrastructure projects. In the health sector, the bank's PFI Unit has closed over 30 transactions with a cumulative funding requirement in excess of £1bn. Along with its work on PFI hospital projects, the bank has also provided funding for LIFT schemes and parts of the ISTC programme.

In 2003, the Sheffield Teaching Hospitals NHS Foundation Trust announced a scheme for the private sector to design, build, finance and operate a new ward at the Northern General Hospital in Sheffield. The new ward,

an addition to the existing hospital site, will have 190 beds when completed in 2007. Kajima Construction and Kajima Project Investments came together with UME Group and Dalkia Plc to win the contract for the scheme. Barclays arranged £32m of debt and hedging facilities for the consortium.

Ensure better procurement skills

In the negotiations towards the end of the procurement process, Barclays was struck by the experience of those working on the project in the public sector, and their willingness to achieve a successful outcome. Members of the bank's PFI Unit who worked on the scheme commented that the trust's project director 'lived and breathed the project' and was motivated by a desire to get the facility up and running for patients as soon as possible. Similarly, the project director for the contractor was able to prioritise the key commercial issues for the scheme at an early stage, which was crucial to avoiding delay.

Conduct a health-needs analysis

There were few specific issues to be dealt with in the later stages of the procurement. This was due to the work done by the trust at an early stage of the scheme to identify specifications for the project and resolve potential issues such as property ownership. The result was that the standard form contract for PFI procurements could be used with little customisation. This in turn prevented extra negotiations and delays.

Partnership between public and private sectors

The commercial issues identified at an early stage by the trust were prioritised over more minor issues and solved through partnership with everyone involved in the process. The issues centred around:

- The site's former status as part of the hospital's car park and the associated need for new parking facilities elsewhere on the site
- Access to the new facility
- The trust's legal status as a foundation trust. This issue focused on the financial backing such a trust would have from the government if it fell into deficit.

The issues identified were solved through commercial meetings involving all stakeholders. The trust agreed to take responsibility for the access and car parking issues, removing that aspect from the deal and thereby a potential source of complication.

The trust's foundation status was more difficult to resolve. Whereas non-foundation trusts are covered by the Residual Liabilities Act, which guarantees government funding in the face of major financial deficits, foundation trusts are not covered by the act. This could have significantly increased the risk of the project for both Barclays and the consortium and ultimately had an impact on the price. However, the Sheffield Teaching Hospitals Foundation Trust came together with the Private Finance Unit of the Department of Health to produce a deed of safeguard that gave some guarantees to the private sector of the continued operation of the contract in the event of a major deficit.

Results

Expressions of interest in the project were sought in early 2003. The preferred bidder stage was reached in June 2004. The project reached financial close on 20 December 2004. To date, the project is still the PFI health scheme which has progressed fastest from preferred bidder stage to financial close.

Annex 1: Methodology

The case studies

The five case studies in this report demonstrate good practice in NHS procurement. The examples are taken from the work of CBI members involved in a wide variety of purchasing in the health sector; from large-scale PFI hospital projects to the ISTC programme and spot purchasing. The case studies chosen reflect the wide range of interaction that the public sector makes with the private sector in purchasing new facilities—with professional advisory services, finance organisations, construction companies and companies involved in direct clinical provision.

While the case studies build up a picture of good practice, they are indicative only of some parts of the procurement process and a few major projects. In addition to the case studies, the evidence used to form the analysis and policy recommendations in the report is based on CBI member interviews, conversations with those involved in procurement in the public sector and other desk research.

Calculating the costs of delay

Estimates of the costs of delay to PFI health schemes are quoted early in the report. These include:

- On average the costs of delay as a percentage of the capital value of each scheme: 1.05%
- An estimate of the total amount lost to procurement overruns under PFI health schemes: £98m
- The average cost of delay to each PFI health scheme—£2.45m.

The methodology used for reaching these figures is explained below.

The cost for each month a PFI health scheme is delayed

The CBI estimates that the average monthly cost of delay on a mid-sized PFI health scheme¹⁸ is £115,000. A CBI member compiled a list of costs which, in the event of an over-run on a procurement project, could not be redeployed elsewhere.

These costs included:

Employees of the contractor's project team, including:

- The bid director
- The bid manager
- The commercial manager
- The design and construction lead
- The design manager
- The facilities management lead
- The finance manager.

External employees:

- Architects
- Engineers
- Advisers (including legal advisers).

Site costs:

- Equipment
- Site accommodation
- Consumables
- Document control.

Estimate of the total amount lost to procurement overruns

Based on the monthly cost of delay identified above, the CBI compiled an estimate of the cost of all the overruns on 40 major PFI health schemes.

We selected all the schemes that have taken place since 1994 and have a capital value of over £60m. For each scheme, the Official Journal of the European Union (OJEU)¹⁹ date and the final close date were acquired. Using the NHS' guideline timetable of 18 months²⁰ for a PFI procurement, each scheme's overrun was calculated in months, by subtracting the guideline timetable from the actual time it took schemes to progress from OJEU to financial close.

Where schemes did not overrun, or closed before the timetable, the period of overrun was marked as zero. Where schemes had not yet closed, the day on which the report was dispatched to the printers was taken as an indicative date for financial close.

Based on this information, an estimate of the total lost to procurement overruns across the 40 projects could be calculated. The CBI estimated the cost of delay to each scheme by multiplying the number of months it overran by the £115,000 monthly delay cost. The totals for each scheme were then added together to give a final total of £98m; this represents on average 1.05% of the capital value of each PFI health scheme.

This is a conservative figure and does not include:

- The greater monthly costs of delays for larger schemes
- The costs of delay on projects with a capital value of under £60m
- The costs of delays on the same projects to public sector teams—including project teams and advisory services
- The costs to other bidders of delays that take place before the preferred bidder is announced
- Any estimate of the impact of delays to the commencement of procurement—also considerable due to the need for the private sector to maintain bidding capability in anticipation of the work to come.

The average cost of delay to each PFI health scheme

Using the total overrun figure of £98m, the average cost of delay in the procurement phase for each scheme was calculated. The total was divided by the number of schemes—40—to produce the figure.

Annex 2: Glossary

Competitive neutrality—the concept that competition should be fair between different classes of market participants so that there is a level playing field between public, private and voluntary providers of goods and services. See the CBI's recent publication *A fair field and no favours: competitive neutrality in UK public service markets* for more details.

Financial close—the end of the procurement process, when the project is approved by government and contracts are signed.

Independent Sector Treatment Centre (ISTC)

programme—a programme set up by the government in 2002 to move certain operations to community treatment centres. The programme was piloted at BUPA's Redwood treatment and diagnosis centre (see case study 3). The treatment centres established by the programme are provided solely by the private sector.

Local health economy—a term used to describe the interaction between all the health services in a defined area of the country. In this report, we use the term to describe the surrounding context in which any new facility or service will operate.

Local Improvement Finance Trust (LIFT)—The LIFT programme develops and invests in primary care facilities. It is a form of public-private partnership (PPP), although the partnership between the two sectors in LIFT is closer than in PFI. Once a preferred bidder has been selected, several Primary Care Trusts (covering the scale of the scheme) and the contractors come together to form a LIFT company (known as a LIFTCo). Mental Health Trusts and local authorities may also be involved. LIFT has some important differences from PFI. Partnerships for Health (a national body which comprises public and private sector partners) and local NHS bodies both hold shares in each LIFTCo, whereas the Special Purpose Vehicle under PFI is solely owned by the private sector. So far, three waves of the LIFT programme have been completed and a fourth is underway.

Official Journal of the European Union (OJEU)—the journal in which major public procurement projects must be advertised to bidders.

Preferred bidder stage—reached when the winning bidder for the scheme is announced following the bidding competition.

Pre-Qualification Questionnaire (PQQ)—one of the earliest stages of the procurement process. After each project is advertised, bidders are advised to submit a PQQ to show their organisational capability for delivering the outcomes the procuring party requires. The PQQ includes the need for contractors to demonstrate financial backing. Based on the PQQ, a shortlist of bidders is compiled by the procuring party. The shortlisted companies are then asked to submit a tender for the project.

Private Finance Initiative (PFI)—a model of procurement for large-scale capital projects that was launched by HM Treasury in the early 1990s. The model is used not only in the health sector but across a wide range of government purchasing. Under each PFI scheme, the private sector has the responsibility of designing, constructing and maintaining the new facility. The private consortium (which usually includes a bank, a construction company and a facilities management provider) takes control of the asset and leases it to the public sector, which pays a yearly fee for using the facility. Through this fee, the public sector pays back the money required to finance the construction of the facility and to operate it and maintain it during its lifecycle. Typically the fee, known as the concession, will be levied for a period of 30 or 40 years. PFI has been used for the vast majority of hospital renewal and construction projects over the last ten years.

Private Finance Unit—the team in the Department of Health dedicated to assisting trusts with PFI schemes and overseeing and approving PFI hospital projects.

Procurement skills—a number of skills that private and public sector project teams must acquire if procurement is to be successful. They include:

- Project management
- Financial accounting
- Negotiation skills
- Investment appraisal
- Design
- Public relations
- Preparing output specifications
- Estates management
- Corporate finance
- Legal skills
- Risk assessment
- Planning
- Communications
- Management of advisers

Procuring party—the part of the NHS or the government in charge of purchasing a new facility or service. Legally, the procuring party is the organisation within the NHS/Department of Health that signs the eventual contracts at the end of the procurement process.

NHS Purchasing and Supply Agency (PASA)—a government agency that acts as a centre of expertise, knowledge and excellence in purchasing and supply matters for the health service. PASA also advises government on the strategic direction of procurement. The agency contracts on a national basis for products and services which are strategically critical to the NHS. It also acts in cases where aggregated purchasing power will yield greater economic savings than those achieved by contracting on a local or regional basis. It mostly deals with commodities rather than complex capital and service provision projects.

Footnotes

- 1 This includes projects which have reached financial close, are underway, or are planned for the future. The figure includes:
 - 39 PFI hospital projects that have reached financial close since May 1997, with a capital value of £5.275bn
 - 18 PFI hospital schemes where the procurement process is underway, with a capital value of £6.035bn
 - 23 PFI hospital schemes for which the procurement has not yet started, with a capital value of £5.896bn
 - Six traditionally procured hospital/mental health schemes, with a capital value of £500m
 - The first wave of the Independent Sector Treatment Centre Programme, valued at £1.6bn
 - The second wave of the same programme, valued at £3bn
 - The LIFT programme for primary care renewal, valued at £1.195bn. This comprises the £1bn of private investment the government aims to attract to the programme before 2010, and £195m in start-up costs provided by the Department of Health.
- 2 See <http://www.dh.gov.uk/assetRoot/04/10/81/43/04108143.pdf>.
- 3 See Department of Health, 'Section 2: The PFI Procurement Process', *Public Private Partnerships in the National Health Service: The Private Finance Initiative*, p. 51.
- 4 See Methodology.
- 5 Sandra Laville and Terry Laville, 'Plan to rebuild London teaching Hospitals finally gets go-ahead', *The Guardian*, 9th March 2006. See http://www.guardian.co.uk/uk_news/story/0,,1726629,00.html.
- 6 See Methodology.
- 7 Department of Health, *Improving PFI Procurement* (December 2002), p. 1.
- 8 See Methodology.
- 9 Under Section 11 of the Health and Social Care Act 2001.
- 10 Consolidated Public Procurement Directive (Directive 2004/18/EC). The directive came into force on 31 January 2006.
- 11 See *Government Accounting 2000*, section 22.2 and annex 22.1. See <http://www.government-accounting.gov.uk>.
- 12 NHS Confederation, *The Future of PFI* (2005), p. 1. 13 NHS Trusts were surveyed.
- 13 See the glossary for a full explanation of the different types of skills that project teams require.
- 14 The NHS Project Director Accreditation Scheme was set up in 2001 and provided principally at Lancaster University. The scheme has now been replaced by a new programme which deals more generically with project management. Information provided by Paul Ferguson, Lancaster University.
- 15 NHS Confederation, p. 2.
- 16 NHS Confederation, p. 1.
- 17 <http://www.pasa.doh.gov.uk/bestpractice>.
- 18 The figures refer to schemes with a capital value of between £100m and £250m. The average capital value of a major PFI health scheme is £233m.
- 19 See Glossary.
- 20 Department of Health, 'Section 2, The PFI Procurement Process', p. 51.