
Obstacles to Best Value in NHS PFI Projects: Evidence from Two Hospitals

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Abstract

The Private Finance Initiative (PFI) and Best Value policies were introduced by the UK government as part of a drive to improve public service provision. Both Best Value and PFI focus on harmonising the interaction between the public and private sectors in the context of public private partnerships. In recent years, PFI procurement in the NHS has been subjected to severe criticism which suggests that NHS Trusts often encounter problems in achieving value for money. This paper investigates these issues on the basis of interviews conducted with project participants in two PFI hospitals. Focusing on obstacles to Best Value encountered in these two PFI hospitals, the paper argues that many problems arising in the context of PFI-based procurement are attributable to a lack of risk management expertise within the public sector, rather than market conditions which reduce competitive pressures on bidders.

Public Service Provision and the Best Value Paradigm

The Best Value regime was introduced in 1997 by the Labour Government. At its core, this policy focused on ensuring that modern public services are procured and provided at 'optimum' cost. The duty to ensure Best Value was formalised in the Local Government Act 1999, which requires councils in England and Wales to "secure continuous improvement in the way their functions are exercised, having regard to a combination of economy, efficiency and effectiveness" (HM Stationary Office, 1999). In Scotland, similarly, the achievement of Best Value is monitored by the Best Value Task Force, earlier versions of which focused primarily on the introduction of market principles into the public sector. The contemporary Best Value regime emphasises the participation of user groups, as well as consultation with respect to future policy initiatives. In addition, the Best Value regime is expected to set in motion long-term processes in which public sector bodies gradually acquire enhanced commercial skills as well as an enhanced ability to achieve cost-effective solutions.

Perhaps because of these broad and shifting expectations, Best Value, as a guiding principle for political decision making, has remained difficult to tackle. The Society of Local Authority Chief Executives has described Best Value as "the continuous search by a council to improve quality, efficiency and effectiveness of all its activities for the public" (Filkin, 1997). Boyne (1999), meanwhile, has suggested that Best Value rests on three concepts which relate to organisational performance, organisational process and the relationship between performance and process. The first concept emphasises the level of service provided by the council to the public and concentrates on five criteria namely cost, efficiency, effectiveness, quality and fair access (Department of the Environment, Transport and the Regions, 1998). The second concept relates to the organisational process and the extent to which this process complies with approved standard procedures. The third concept combines the previous two approaches by emphasising the need to meet standards, both in terms of organisational performance and organisational process. A 1999 consultation paper by the Department of the Environment, Transport and the Regions, similarly, identified four foundation principles for achieving Best Value, namely accountability, transparency, continuous improvement, and ownership, all of which are to guide the implementation of the Best Value initiatives (DETR, 1999). This approach denoted a shift in emphasis to processes rather than outputs, and can therefore be interpreted as a recognition of the fact that specific output targets in connection with the provision of public services are often difficult to define and implement (Asenova, Beck, Akintoye, Hardcastle and Chinyio, 2002). The specific research framework adopted in this paper focuses on Best Value as a relationship between performance and process. In order to investigate obstacles to the achievement of Best Value, the paper investigates the handling of risk management issues arising in two NHS PFI projects. The paper is structured as follows: after a brief introduction, section one investigates the concepts of Value for Money, Best Value and PFI, section two outlines the development of the PFI in the NHS. Section three presents the methodology, sections four and five present two case studies while the final section draws conclusions.

Value for Money, Best Value and PFI

The passage of the Local Government Act 1999, which introduced the Best Value concept, coincided with the publication of the new Treasury guidance on procurement, which ascribed a central role to PFI (HM Treasury, 1999). While the two concepts were connected in terms of their focus on harmonising public and private sector practices, they nonetheless encompass different goals. Thus, Best Value, which is often understood as a part of the obligation of public bodies to ensure Value for Money (VFM), is primarily intended to guide the activities of public sector procurers, while PFI has been seen as the government's preferred procurement strategy, which, in practice, may or may not be compatible with VFM or Best Value requirements (Arthur, 1999).

The overlap between the two policy initiatives can be further elaborated on by examining some of the past and current guidance on PFIs. When, in 1997, the new Labour government abandoned the requirement for universal testing, it reversed the rule that all public sector projects were to be considered for PFI (HM Stationary Office, 2000). According to the new requirement the PFI option had to be applied only if "a robust assessment of the options in each set of circumstances confirms that the private sector proposal demonstrates considerable advantages over the public estimates" (HM Stationary Office, 1998). Similarly, the Treasury Taskforce's paper, *Partnership for Prosperity* (1997) specified that "PFI solutions should be pursued where they are likely to deliver better VFM". VFM in this context was assumed to involve a combination of competitive tendering processes and optimum risk transfer. In parallel with the relaxation of the universal testing rule, New Labour's guidance documents have sought to emphasise the public-private partnership aspect of PFI over purely economic considerations (Treasury Taskforce, 1997; HM Treasury, 1999).

In line with this emphasis on 'voluntary partnering', current government guidelines give the public sector client a high degree of flexibility (HM Stationary Office, 2000). Before financial close, the client can, on the basis of the information collected during the PFI procurement process, reverse the decision to implement a project via the PFI option. Moreover, any project modifications during the construction and operational phases which affect the risk allocation, can also repeal the off-balance sheet treatment of the project. In its PFI procurement guidelines, the government further recommends that two Value for Money (VFM) exercises be undertaken in order to evidence compliance with Best Value criteria. Accordingly, an initial VFM assessment is to be conducted once the business need has been identified. This assessment serves two purposes. Firstly, it provides an estimate for potential savings arising from the PFI procurement option, and secondly, it gives an assessment of the likelihood that these savings will materialise (Treasury Taskforce, 1997). In addition to this, the public sector client is expected to demonstrate that the project lends itself to the PFI option on the basis of pre-set conditions. These conditions include a clear operational need, scope for sufficient risk transfer, and the availability of adequate market interest from potential private sector bidders to ensure genuine competition. A complete estimate of whether a particular project fulfils this requirement has to be made later, on the basis of the full business case, the bids received and the outcome of final negotiations (National Audit Office, 1999; Akintoye, Beck, Hardcastle, Chinyio and Asenova, 2001).

In order to establish a benchmark for assessing the private sector bids, the public sector client develops a financial model known as a public sector comparator, which reflects all revenues and costs associated with particular project (Treasury Task Force, 1998). While the public sector comparator is now a key measure for ensuring VFM, it is not the only criterion. In addition, government guidance recommends that other project aspects, such as service quality, risk transfer, and wider policy objectives be investigated. This had been made explicit in a 1998 document published by the Treasury Taskforce, which stated that "whilst a comparator can be a very important aid to forming a judgement regarding VFM it should be never the only factor considered and lowest cost should not automatically be equated with best VFM" (Treasury Taskforce, 1998).

In recent years, the National Audit Office (1999) has identified a number of preconditions for successful PFI procurement, which can be seen as underpinning earlier guidance. Accordingly, success in PFI is preconditioned on the setting of clear objectives from the procuring department's top management, compliance with relevant laws and regulations during the procurement process, the selection of the best available deal in the market and the ability of the client to ensure that the private sector partner delivers on terms that were set at the onset of the project.

Both earlier guidance by the Treasury Taskforce, as well as more recent reports by the National Audit Office (Treasury Taskforce, 1997; Treasury Taskforce, 1999; National Audit Office 1999; HM Stationary Office, 2000; National Audit Office, 2000) indicate that much of the success of PFI projects hinges on the client's ability to manage a project effectively through its implementation and operational phase, together with its aptitude in assessing and managing risks proactively. Problems, meanwhile, appear to arise particularly in those projects where public sector clients lack necessary project management experience or fail to acquire this experience from external sources. Since 1997, a series of three government reports - the *First Bates Report* (1997), the *Gershon Report* (1999), and the *Second Bates Report* (1999) - have highlighted the need for better staff training and an improvement in the deal-making expertise of departmental PFI units. Notably, these reports and the Second Bates Report in particular, emphasised that the lack of essential skills in managing PFIs had not yet been overcome and continued to present a barrier to creating effective partnerships.

The NHS and PFI Procurement

The provision of healthcare is one of the core services to the public traditionally provided by the government in the UK. Over recent years the government has recognised that the quality of the health services provided throughout the country often does not meet the expectations of the public. In parallel with this recognition, there has been a realisation that the NHS will require substantial capital investments over the next decades. These future investments, needless to say, are to be guided by Best Value requirements which call for an assessment of a diversity of available procurement options including partnerships with private sector companies in public sector projects.

While PFI projects are said to have provided a successful answer to the challenges of Best Value in sectors such as prisons and roads (OGC, 2000; Robinson, 2000; IPFA, 2002), the record of PFI procurement in the NHS appears to be more ambiguous. Accordingly, PFIs in the hospital sector have been criticised for their complex and opaque decision making during the planning phase, the low standard of physical facilities provided once the project was completed, the lack of cost effectiveness and other aspects (Pollock, 1995; Gaffey *et al.*, 1999; Pollock, Shaoul and Vickers, 2002).

The first 'flagship' PFI hospital built from scratch under PFI procurement, the Cumberland Infirmary, has been the subject of bad publicity from the commencement of its operational phase (UNISON, 1999; BBC News, 2001). The £87 million contract for building the Cumberland Infirmary in Carlisle was signed in 1997. The hospital was designed as an impressive modern construction and, being completed ahead of the schedule, was opened by the Prime Minister in 2000. However, subsequently, the project came under criticism on account of a number of flaws. The new hospital accommodates 90 beds less than the old one (Anon, 2001), which has meant that, at times, accommodation capacity has been insufficient. Further to this, the small size of the wards has required the trust to buy new smaller resuscitation trolleys at the cost of £180,000. Due to the shortage of storage space, patients' records and X-ray images have to be gathered in the old premises which, in effect, has increased the waiting time for radiologists. There have been other instances of poor design and execution. For example, in the absence of air-conditioning or ventilation, the glass roof construction has led to very high temperatures during

the hot season, and noise during rainfalls. Further to this, there have been broken pipes and floods in the operating theatre, falling ceilings, sewage system problems, and damage to some expensive equipment. In 1999 UNISON sponsored a report on the Cumberland Infirmary Carlisle (UNISON, 1999) which questioned the level of financial diligence and accountability of the respective NHS trust. Specifically this report stated:

Secondly we conclude that the deal does not give the taxpayer value for money. We have shown that the interest rate assumption at the heart of the economic appraisal has been deliberately set to favour the private sector, and that after only a minor adjustment the alleged advantages of the PFI option disappear. However, in Carlisle's case, political manipulation alone was insufficient to make the economic case. Only major errors in the Trust's economic calculations could do that. If these were rectified, the PFI option would be seen to be a bad economic option, more costly than the public alternative by £11 million. On a proper economic appraisal, Carlisle's PFI should never left the drawing board. (UNISON, 1999)

The Cumberland Infirmary is not an isolated case. In Guy's hospital in London, PFI was used to finance the refurbishment of the existing facilities. Guy's hospital gained bad publicity due to disputes between the consortia members, which delayed the completion period by three years. In addition, the review conducted by the National Audit Office found that the actual costs exceeded the initial budget by £68.7 million (Anon, 2002).

Criticisms of PFI hospitals also often focus on a reduction in the number of beds in the new built facilities. Thus, a survey conducted by The Times, for instance, claims that more than 2,000 beds have already been cut, while research conducted by University College London estimates that the first wave of PFI hospitals will cut existing capacity by nearly 30% (Wright, 2000). While there is little doubt that a decrease in hospital bed capacity has accompanied the building of new hospitals, it is doubtful that these cutbacks genuinely arise from the choice of PFI as procurement method. The competitive involvement of the private sector in hospital procurement may lead to somewhat less generous specifications, in terms of storage space and similar issues. However, explicit capacity specifications in terms of numbers are rarely left to the private sector partner to decide.

As a response to widespread concerns, the government commissioned a report on the operation of the PFI procurement in the health sector, which was published in May 2002. Authorised by the House of Commons Health Committee, this report is entitled the *'First Report on the Role of the Private Sector in NHS'* and provides a comprehensive review of the performance of PFI procurement in the NHS. The report focuses on the long term implications of PFI procurement, while recognising the polarised nature of the PFI debate. It points out three key benefits from the utilisation of PFI procurement, including the transfer of construction risks (time and cost overruns), fixed payments over the life of the project, as well as the link between the quality of service provided and the actual amount of payment to the private sector (House of Commons 2002). While recognising the lack of sufficient evidence for innovation, the report argues that criticisms relating to the viability and performance of the PFI procurement are largely unsubstantiated. In relation to the claim that PFI procurement leads to a reduction in beds, the report explicitly states that bed numbers have to be specified by NHS Trusts. As concerns the performance of the NHS as a purchaser, the report acknowledges that "trusts are often negotiating contracts for the first time with companies who bring far greater experience to bear." This led the report to argue in favour of improving expertise on the public sector side. Similarly, as concerns criticisms about the lack of flexibility in PFI contracts, the report emphasises that care should be taken to incorporate greater flexibility. Overall, the report re-iterates that need for greater transparency, accountability and openness in the context of the PFI process.

In July 2002 the Department of Health published a response to the Health Committee report, which provided specific suggestions for addressing the criticism made in the report. In relation to the performance of the NHS as a purchaser and partner in PFI procurement, this document details four specific measures, which include (Department of Health, 2002):

- A further development of staff competencies via different methods including guidance and mentoring from the project initiation by NHS units dealing with PFI projects.
- The utilisation of the existing expertise of other bodies such as OGC by the DoH in order to ensure that best practice is applied. In this context, the DoH is to provide “independent peer review of NHS schemes at stages in the procurement.”
- The establishment of project directors’ courses at universities which will equip team leaders with necessary expertise (some NHS estates have already established such courses).
- The creation of systems for maintaining and developing PFI related knowledge and expertise via a transfer of some managers and directors from one project to another.

PFI procurement was introduced in 1992, and the first PFI projects in the NHS became operational only in 2000. In this sense, PFI for the NHS is a relatively novel form of procurement. In addition to this novelty, PFI projects pose unique challenges to the NHS on account of the complexity of matching NHS standards with private sector practices. Private sector participants too, have often found their involvement in PFI hospital schemes to be more challenging than what they experienced in non-NHS projects. The following two case studies of relatively recent hospital projects highlight some of the obstacles which NHS Trusts have experienced in achieving Best Value. In this context it is noted that the need to assess and manage risks in the planning and implementation phase poses major problems to project partners. These problems are, in part, attributable to the lack of risk management expertise of the public sector client. By contrast to previous analyses, this paper suggests that overcoming difficulties in the public sector’s approach to risk management may be more important than changes to market conditions which allow for competitive pressures to be maintained. In comparing the two hospitals it is noted that the first hospital suffered from a lack of foresight and flexibility during the planning stage. These problems were less pronounced in the second project, which appears to have come closer to the ideals of Best Value, even though the procurement itself was not fully competitive.

Methodology

Whilst there is ample documentary evidence on the failures of NHS trusts in managing PFI procurement, little attention has been paid to the practical processes that impinge on the public sector ability to achieve best value. The following analysis centres on two hospital projects developed under the PFI. These two projects were selected on account of two rationales. Firstly, one of the private sector partners to the research project was representing a company involved in case study B and therefore was able to facilitate the access of the researchers to senior representatives of the project management team. Secondly, it was felt that having projects with different capital requirements, one based in England and one in Scotland would provide better insights of the range of problems faced by NHS trusts.

Both projects were initially investigated in conjunction with a UK government grant entitled ‘A Standardized Framework for Risk Analysis and Management of PFI Projects’. Interviews for the two case studies were conducted during the second half of 2001 over a time frame of six months, with follow up research being conducted in the summer and fall of 2002. In the case of the first project, the interviewees included the previous public sector project manager who had negotiated and signed the PFI contract on behalf of the NHS trust, as well as the current project manager who was responsible for the ongoing project operation. Both individuals participated in separate in-depth interviews that lasted slightly more than one hour. Although the focus of the investigation was on

the public sector's approach, the project team also engaged in discussions with the leading construction company in order to gain a better understanding of the project features and risk. In the second case study, the main interview was conducted with the project manager. Similarly to case study A, the research team conducted supplementary interviews with representatives of the main construction and operational companies. In order to facilitate responses, all interviewees had been briefed about the purpose of the interview, and the nature of the questions, by telephone some days before the interviews took place. The interviews themselves were semi-structured and relied on a question bank which had been developed in conjunction with an extensive literature review. All interviews were taped with the consent of the interviewees and professionally transcribed for ease of analysis. On average, each of the three main interviews with the public sector representatives last 50 to 70 minutes, yielding a total of over 3 hours of tapes. Information gathered in these interviews was supplemented by documentary material such as the project memorandum and the business case for project A as well as some general project information which was available in the public domain. While some of these information sources remain under restrictions of commercial confidentiality, the respective project managers consented to a limited use of project documentation for academic purposes.

Hospital Project A

In the eighties, this Hospital Trust intended to close an old hospital, which was distant from the city centre and could not be upgraded to meet the needs of the local population. The Hospital Trust had planned to build a new facility consisting of a geriatric unit and a day care centre adjacent to the existing hospital. A couple of business cases were produced but, due to lack of funds, they did not progress to the development stage. The PFI route was investigated in 1995 primarily because it offered prospects for a greater risk transfer to the private sector and the possibility of long term cost efficiencies. The decision to take the PFI route was made in 1996, at which time the Trust commenced creating the procurement specifications.

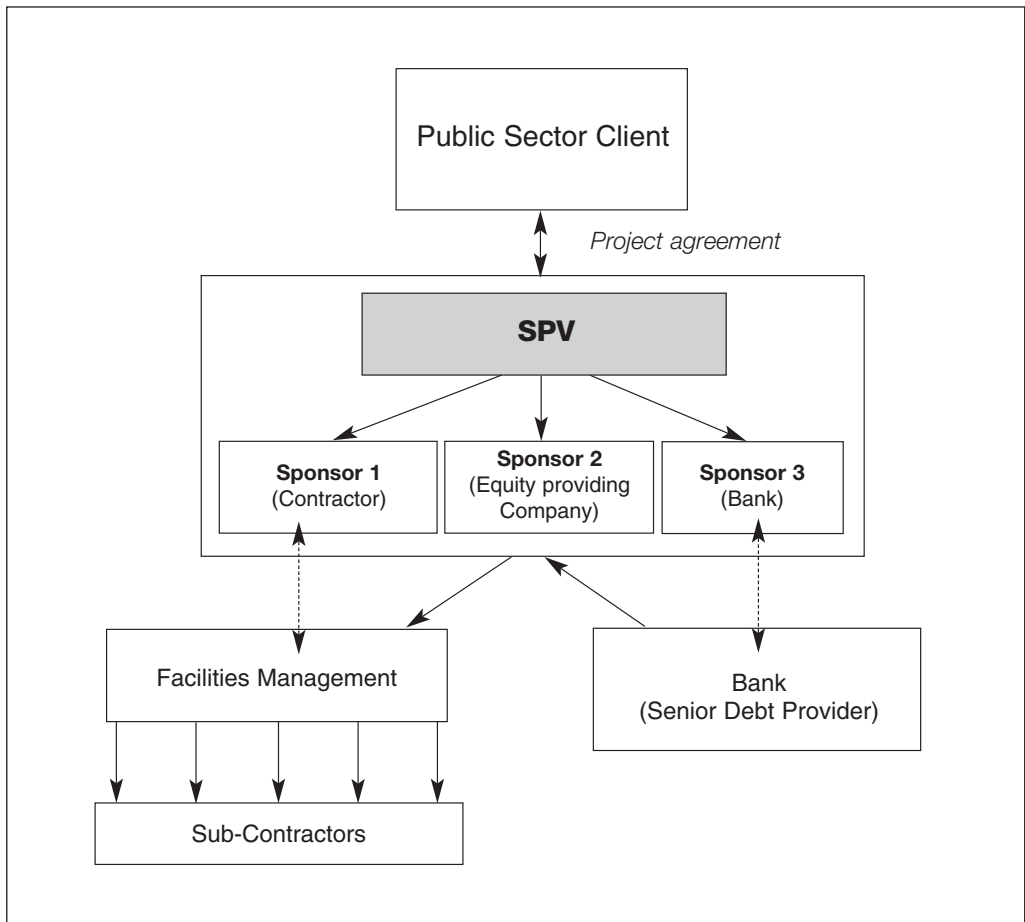
When the authors conducted interviews with the project participants, the hospital had been in its operational phase for more than one year.

Technical Details: Project A

This PFI hospital provides a relatively small residential facility in the south of Scotland, where complex activities like operations do not take place. The unit holds 118 beds and is partitioned into three sections: a geriatric assessment unit (86 beds), a psycho-geriatric unit (24 beds), and a rehabilitation unit for physically disabled patients (8 beds). The plans initially envisaged the construction of a unit for the elderly only, but were consecutively expanded to include a unit for young physically disabled patients as well as elderly patients with mental illnesses.

The client of this project is a Hospital Trust. The major participants who formed the project company also known as special purpose vehicle (SPV) in this PFI scheme were a construction and civil engineering company, a firm of equity providers and a bank. The organisational structure of the key participants is shown in Figure 1. In relation to the soft facilities management services (catering, cleaning, portering, etc.) no independent facilities management company was involved in this project as these services remained a part of the main hospital provisions. The previous project managers noted that even after extensive negotiations with the private sector service provider the proposed operational costs of the private company were approximately £100,000 per annum higher for the first operational year when compared with the costs associated with in-house service provisions. Over the life of the contract, this difference was increasing which was making this option even less desirable. Meanwhile the building maintenance services were undertaken by the facilities management division of the construction company, as their bid appeared to provide better value for money.

Figure 1
Organisational structure of key participants in the hospital project A



The capital price (capex) of the scheme was approximately £10 million, which included some types of non-medical equipment such as cabinets, wardrobes, refrigerators, etc. The funding structure was £100,000 equity, £800,000 subordinated debt and £8.95 million senior debt. The operational value of the project is about £90,000 per annum. The net present value of the project is now £12.23 million.

The project advertisement was published in the Official Journal of the European Community in February 1996. The pre-qualification process comprised of two stages, which included an investigation of the financial and operational credentials of the bidding consortia, as well as submission of non-binding project estimates. The review of the financial and operational credentials included issues such as previous experience in relevant projects, financial standing of the parent companies and an assessment of their ability participate in long-term partnership. The specific criteria for ranking the submissions included project aspects such as: availability of financial provision, quality of the clinical solution, technical characteristics, overall project cost and risk distribution proposed. As Table 1 demonstrates these criteria were given different weighting with the highest weighting associated with the clinical and the technical solution offered by the private bids.

Table 1
Criteria used for assessing the private sector bids and weighting attached.

Criteria	Weight
Provision of finance	10%
Quality of clinical solution	30%
Technical characteristics	25%
Project cost	20%
Risk transfer	15%

The public sector team focused on five specific areas of risk transfer, including design and construction risk, demand or volume risk, commissioning and operations risk, residual value risk and regulatory risk. All risks included in these risk categories were assessed in terms of probability and impact, and the final value of the risks was derived through simple multiplication. This formed the notional estimate for the value of the risk transferred to the private sector consortia.

According to the project manager the costs associated with all private sector proposals exceeded the public sector estimates, which resulted in an affordability gap. From the seven bids that were initially submitted, three were short-listed, however one of the bidders subsequently withdrew, which reduced the level of competition to two consortia.

Table 2 depicts the cost discrepancies between the public sector estimates and the estimates in the short-listed bids. *The public sector manager noted that in the view of the unavailability of public funds for the PSC should be considered as purely notional estimate as it was not practically deliverable.* Thus for example the estimates for the cost inputs were based on existing budgets which were adjusted to take into account the scale of new built facility and the savings anticipated from improved design and management.

Table 2
Comparison between the cost estimates in the PSC and the short-listed bids.

	PSC (£'000)	Risk Adjusted PSC (£'000)	Bid I (£'000)	Bid II (£'000)
Total clinical costs	3,500	3,713	3,713	3,713
Total relevant costs	1,655	1,716	2,334	2,513
Total service costs	5,155	5,469	6,047	6,226
Affordability gap Year 1			578	757

On the basis of this financial appraisal, it was accepted that Bid I offered better value for money. In the course of the negotiations the public sector client made a number of upward corrections to the initial estimates. This included an increase in the capital costs due to delayed construction, increased building maintenance charges, and correspondingly increased capital charges. The public sector manager noted that despite these increased costs the affordability gap was reduced to 2.8% of the overall project costs. Subsequently, this affordability gap was built into the financial appraisal which necessitated the allocation of additional funding. Following the economic and financial appraisal, the preferred bidder was selected in July 1997 and the contract was signed in May 1999.

The period between the publication of the project advertisement and financial close lasted 30 months. According to the project manager, this extended negotiation period was largely due to a number of factors, one of which relates to the restructuring of the NHS trusts during the first half of 1999. As a result of this restructuring the NHS trust that initiated the project ceased to exist and was replaced by another trust that had to assemble a new team and a new project manager in order to complete the negotiations. The construction company representative noted that at times this slow pace of development caused frustration and possibly was a factor that contributed to the decision of one bidding consortia to withdraw. Further delays resulted from the fact that the project was one of the first PFI hospital schemes undertaken in the UK and the solicitors were not very familiar with the PFI arrangements. Thus they had to draft most documents 'from scratch'. On the public sector side, even specifying the precise contractual conditions with private sector companies was a novel activity for the client which caused hesitation and added to the delays. The main project features were specified by the client with the help of their technical and medical advisers. According to the project manager, the client tried to ensure the accuracy of the medical specifications by organising liaison meetings with medical staff. The construction company representative noted that the design team had extensive experience with hospital projects, which helped in "designing out" some risks. However, according to the same respondent problems arose during the design and specification process due to the indecision of the client as well as the introduction of repeated changes in the specification of the uses of the facility. In hindsight, most of the delays were primarily attributable to the lack of experience of the client and their advisors, while the construction of the project itself, which was entirely in the hands of the private sector contractor, proceeded ahead of schedule.

The construction period, commenced in July 1999 and lasted for 65 weeks. The physical construction was finished in September 2000 and the project is now fully operational. Construction was three months ahead of schedule and the Unit was completed and handed over to the Trust in November 2000 instead of February 2001. According to the project manager the early project completion was not foreseen in the contract provisions and presented the client with unexpected problems as the NHS trust encountered additional expenses in maintaining the facilities.

According to the construction company representative, the top risks, which were considered in the planning and execution of the project were mainly related to their desire to provide an accurate interpretation of the requirements as well as the need to warrant the building for 25 years. Thus some key risks were associated with the following:

- Heavy wear of doors and accompanying ironmongery.
- The need to incorporate financial provisions for replacing the floor-finish several times during the 25-year concession period.
- Decanting difficulties that would attend major replacements or repairs.

Risk Assessment: Project A

According to the NHS manager the PFI option was selected on the assumption that conventional public sector investment was unavailable at that particular time. Notably, due to the backlog of

investment, the facilities were deteriorating rapidly and any delays in the capital investment process were increasing the future costs. During the negotiations, the public sector focused on transferring as many risks as possible to the project company. In doing so, the client overlooked the fact that some risks could only be transferred at substantial additional cost. Paradoxically, this failure to recognise the cost of some risk transfers paralleled a period during which the client was concerned that the project would not receive long term finance. Due to the client's lack of experience, the discussions on risk transfer eventually lasted for over 30 months, during which time a risk allocation was achieved which must, by today's standards, be considered sub-optimal.

The main risks concerning the client, meanwhile, were related to design and construction risks including the possibility of time and cost overruns, the transfer of some facilities management services, and making sure that the scheme was put together as an off-balance sheet transaction. These risks were listed and evaluated when the public sector comparator was constructed. This was later used for analysing the offers from the private sector.

The process of risk identification and evaluation was supported by a number of consultants including financial advisors, lawyers, technical advisers, architects, and quantity surveyors. According to the interviewee, the client did not rely on published guidance in conducting its risk assessments. However, some advisers apparently relied on documents designed for an earlier project. The main risk assessment techniques used by the public sector client included:

- Inference from past experience,
- Probability analysis,
- Risks weighted in accordance with opinion of advisers,
- Expected Net Present Value,
- Expected Monetary Value,
- Sensitivity analysis,
- Brainstorming, and
- Intuition.

The public sector organised a project team to procure the project that included clinicians, estate specialists, a finance specialist and a facilities management specialist. This team was closely involved in clarifying the client's requirements during the negotiation process. However, due to changes to the composition of the project team, the client revised the specifications several times during the planning and negotiation stages.

Following the publication of the project advertisement in the Official Journal of the European Community, there were about 20 expressions of interest in the project. The Trust conducted a briefing day, where the project details were clarified to the private sector companies. Thereafter the client received seven outline bids, following which three consortia were short-listed to proceed to the bidding stage, although as one of them withdrew the client was left with two bidders. As the negotiations progressed, one of the two competing consortia pulled out, leaving only one private sector bidder which was headed by a construction outfit. The client was happy with this situation since the construction company had an established track record, and appeared to offer a cost effective solution which was close to clinical requirements. However, in terms of Best Value, this situation was unsatisfactory, in that it removed competitive pressure from the bidding process at relatively early stage.

Problems: Project A

During the planning phase, the Director of Estates of the old hospital was appointed to act as project manager and was given responsibility for the overall risk monitoring and management. One major issue that concerned the project manager was the extent of the private sector's involvement

in the provision of facilities management services. The client team decided that, since the new unit was going to be attached to an existing hospital, it was more cost effective for them to provide the soft facilities management services and to transfer to the consortia only the building maintenance. This decision reduced the degree to which potential future costs and risks were professionally assessed at the planning stage. In general the client team had great difficulty in putting a monetary value on various risks. This led to prolonged discussions that focused on ensuring that the transaction would go off balance sheet.

One unexpected risk, which materialised during the planning stage arose from the fact that NHS Trusts were restructured in 1999 before the project had reached financial close. The Trust that was handling the project before the restructuring was disbanded and many staff involved in it were transferred to different locations. As a result, the project was transferred to a newly created NHS Trust with a different project team and project manager. Six weeks after this drastic change, the project reached financial close. At that time, the Scottish Executive were keen for the project to go ahead, and, as a consequence, the Chairman of the Trust was given permission to sign the project agreement.

The project manager noted that the series of delays and organisational problems which characterised much of the planning and construction phase were followed by a series of operational problems. On the first day the hospital unit was opened in February 2001, a problem with the hot water supply was discovered, which was reported to the client by the operators. This problem was traced to a fault within the interface of the domestic cold and hot water systems that allowed a contamination of the hot water system. An emergency plan was introduced by the operators which enabled the project company to supply the hospital with hot water. Also within the first week of operation, two visitors got stuck in a lift and the alarm bell was not properly designated to allow elderly patients to recognise it. The client promptly investigated the penalty clauses of the contract with respect to these incidents.

The earlier completion of this project and the lack of adequate contractual provisions meant that the client had to commit extra resources to manage the unit for three more months. This had not been anticipated. As the contract did not cover for this, the client had to bear this risk at all costs (security and fencing, equipping and furnishing the facility over Christmas), for six weeks while the unit was not being used. Following complaints by the client, the project company agreed to a 10% reduction in the unitary fee for the first three months.

In conclusion, the current project manager noted that the interaction with the private sector companies had presented the public sector officers with a range of unexpected difficulties, for which the project team was often unprepared. Personnel changes in the client's team also created obstacles to the required learning process. The present project manager further noted that her nursing background did not prepare her adequately for the operational issues which arose in connection with the project.

Summary: Project A

Overall the main obstacles to achieving Best Value in this project arose from five sources:

- The inexperience and indecision of the client in developing project specifications.
- Delays in creating a contractual framework for the project due to personnel changes.
- An excessive transfer of risks to the private sector.

- Changes in final project specifications which obscured financial models such as the public sector comparator.
- The exceptional focus on minor risks that did not materialise, while other risks, such as early completion, were ignored.

Arguably, many of these problems could have been prevented had the client adopted a more systematic and proactive approach to risk management. Equally, the involvement of an experienced public sector manager who had been involved in public-private partnerships before could have reduced some of the delays which characterised the early phase of the project.

Hospital Project B

This hospital was built in 2000 to replace three out-dated hospitals in a location near London. The hospital serves three major towns and is one of the first privately financed acute hospitals. Apart from hospital wards, the facilities of this scheme included six modern operating theatres, three day-care theatres, an accident and emergency unit, an elderly care unit, a day surgery, ante-natal care buildings, out-patient clinics and a day hospital.

The entire project has been developed for a NHS Trust by a consortium which was led by a major UK construction company which has 'Services' and 'Building' divisions within its fold. The other members of the consortium included a medical company, a major UK-based bank and a financial institution specialising in private finance (See Figure 2).

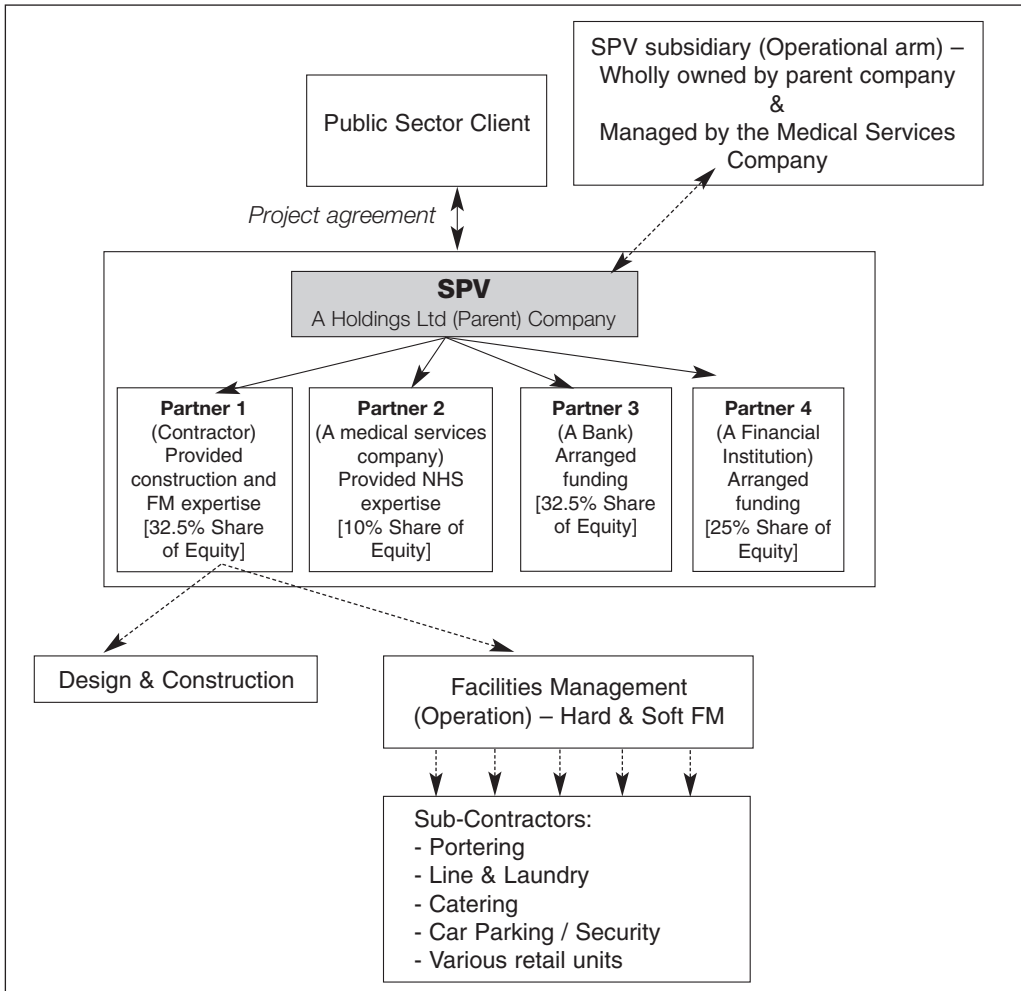
Technical Details: Project B

According to the contract signed for the project, the consortium is responsible for the non-clinical running of the hospital for the next 25 years, including catering, laundry, portering, domestics, estates and building maintenance, plus transport, energy supply and telecommunications. The client, meanwhile, retains direct control of all clinical healthcare services. By the time the authors conducted the interviews this hospital had been accepting and treating patients for two years. The following analysis again draws on interviews with the chief public sector project manager as well as material supplied by the Trust.

The construction subcontractor and other subcontractors in the project were given a substantial portfolio of risks by the project company. These risks were accepted in exchange for its involvement in a community development scheme and for obtaining planning permission for the PFI scheme.

By the late 1990s, the client, a NHS Trust, was keenly aware that it needed new buildings and that funding for a new hospital was not available other than through PFI. Once the decision was made to pursue the PFI route, a larger team appointed by the client identified a list of risks, while a smaller team quantified these risks. The wider team included the Chief Executive, Finance Director, Head of Personnel, Project Director, Head of Nursing, Head of IT, and, Head of Operations. A consultancy firm of advisers supported the activities of the client's core team and led the risk assessment process on behalf of the client.

By contrast to the much smaller project discussed earlier, this project team relied on a host of detailed risk identification and assessment techniques. Some of the techniques used by the team included risks weighted in accordance with the opinion of advisers, assessment of 'NPV', sensitivity analysis, simple scaling (low, medium, high), brainstorming and intuition. A team of solicitors also played a part in the risk management process, by investigating, inter alia, the technical capabilities and financial standing of the bidding consortia.

Figure 2**Organisational structure depicting the main project participants of project B**

In this project, all facilities management services (laundry, catering, portering) were outsourced. The design and construction risks were also transferred by the project company to other providers. However, the client retained semi-core health services like out-patients services, radiology, pathology, and the risks associated with them. This represented a generally acceptable distribution of risks which largely followed the presumption that, in order to achieve Best Value, risks ought to be allocated to those parties which are best able to manage them. In addition to maintaining full responsibility for semi-core services, the management of hospital staff was also retained by the Trust. This set-up gave the Trust sufficient flexibility to respond to unexpected events. At the same time, the level of outsourcing ensured that the public sector did not retain risks which it was ill equipped to manage. Overall, the project achieved a risk allocation between public and private sector partners which is similar to that of contemporary projects.

Problems Encountered: Project B

In terms of the client's risk management process, problems arose primarily from the need to quantify certain risks in monetary terms. The client initially involved a large team in identifying risks. Later,

specialised consultants became involved in the process who provided a detailed costing of project and life-cycle risks. Evidently, the team which had initially been involved in the risk identification process had difficulty in following some of the analyses conducted by consultants. This led to discussions about the significance of different risks which could have been avoided had these teams cooperated more closely.

Although the operational phase of the project brought no major unexpected problems, it was soon discovered that the aggregate cost of running the hospital exceeded initial estimates. Currently, the hospital is receiving £4 million per year as an additional subsidy. This need for a subsidy is indicative of the limited skills of trusts in estimating the total costs of running a large-scale project. In the future it is unlikely that trusts will be able to draw on additional external funding if major cost overruns of this type occur, which would suggest that greater emphasis will have to be placed on assessing the risk of cost overruns.

As concerns the competitive nature, or otherwise, of the bidding process, the project also encountered some obstacles to achieving Best Value. Following a lengthy bidding process, this Trust, like that of the first hospital, received only one final bid. Another bidder did not submit a final bid on account of the Trust's demanding timetable. In order to compensate for the lack of competitive pressure, the Trust benchmarked the proposed package of the final bidder on the basis of historic costs. As a consequence of this approach, most of the contract terms agreed on over a period of twelve months emerged from negotiation rather than competitive bidding.

Although the absence of a competitive bidding process and the requirement for an additional subsidiary would appear to suggest that financial risks were poorly managed, an analysis by the National Audit Office indicates that this PFI project has, by and large, been successful. According to the National Audit Office, the Trust had estimated that the PFI deal would deliver savings of £17 million or 9 per cent compared with traditional procurement. In recalculating these estimates, the National Audit Office concluded that the public sector comparator had been overstated by £12 million, reducing estimated savings to £5 million or 3 per cent. In other words, although the project did not deliver the expected performance, there is still an expectation that it is good value for money.

Conclusion

In each of the two hospitals studied, the clients project teams relied heavily on external consultants who had been engaged to lead the risk assessment. The project company of hospital project A, de-emphasised quantitative risk assessment. As the scope of works was small, this approach did not impact adversely on the project. However, in this project significant problems and delays arose from the indecision of the client and its repeated change of specifications. In addition, project A was characterised by relatively poor communications between the project company members and the client, which led to a situation where the project was completed before the client was able to make use of the facility.

In project B, by contrast, the client undertook a very detailed risk analysis, which included a host of quantitative measures, and involved a wide range of external expert consultants. Despite these analyses, project costs were poorly estimated, leading to a situation where the Trust required a subsidy to meet expenses. Meanwhile, project B, appears to have encountered fewer operational problems than the much smaller project A. In addition, the more appropriate allocation of risks among the various participants in project B is likely to financially benefit the project over time, especially if opportunities for re-financing arise.

Interestingly, both the small project A and the much larger project B, were characterised by a situation where the client was unable to ensure that competitive pressure on bidders was maintained. Thus, in both cases, the client was eventually forced to negotiate with a single bidder

before financial close. While conventional wisdom would suggest that the absence of competitive pressure adversely affects Value for Money, these case studies appear to indicate that Value for Money in PFI projects crucially depends on the proper assessment and allocation of project risks rather than market conditions. Accordingly, it could be argued that improving the risk management expertise of senior public sector managers is more likely to improve the performance of hospital PFI projects than are changes in the bidding process.

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