

Research Full Report

The Private Finance Initiative in the National Health Service

Nature, Emergence and the Role of Management Accounting in Decision Making and Post-Decision Project Evaluation

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The Private Finance Initiative in the National Health Service: Nature, Emergence and the Role of Management Accounting in Decision Making and Post-Decision Project Evaluation

Abstract and Executive Summary

The Private Finance Initiative (PFI), whereby private finance is sought to supply public sector services over a period of up to 60 years, has been in existence from 1992. This monograph provides an introduction to PFI with the specific purpose of tracing its nature and the way it has developed and should develop within the National Health Service (NHS). This analysis is undertaken with a particular concern to trace the implications of this development for management accounting. Three key research questions structure the contents of the monograph from which the implications for management accounting are drawn.

First, we have attempted to clarify what is the underlying nature of PFI. Here we conclude that there has been genuine confusion as to whether PFI is a macro fiscal device to reduce Government borrowing or a micro procurement process that provides value for money. In accounting terms the former gives greater emphasis to financial accounting and the balance sheet treatment and the latter to a more management accounting concern related to investment strategy. The history of the development of PFI shows some oscillation between these two purposes, although it is now generally accepted that PFI is a micro procurement process for the provision of services from the private sector to the public sector that is intended to generate value for money for the latter in the context of risk transfer to the former. However, the macro fiscal emphasis is still present and active, albeit more in the background, with its composite links to the financial accounting question concerning balance sheet treatment.

Second, we have analysed why and how PFI decisions are, and should be, made with specific reference to the NHS and, in the process, clarified the management accounting information/systems needed for these decisions. We conclude that of central importance in the decision process is an assessment of value for money by the use of a net discounted cost comparison of the PFI option relative to procuring the same (output defined) service through a traditional public sector funded route. The latter involves the formation of what is referred to as a Public Sector Comparator (PSC) in which risk assessment and allocation (between public and private sectors) is a central component. Risk assessment and allocation is not only key in the decision process but also in the financial accounting decision concerning asset status and ownership. Increasingly, however, this quantitative analysis is seen to be needing to be complemented with a more qualitative set of concerns surrounding particular forms of shared risks and benefit analysis. Primarily the Government and the National Audit Office have led this development. At the moment these qualitative concerns are used as more marginal to the financial quantitative analysis but our conclusion is that this is, and should, change to become a key part of the decision criteria. The accurate calculation and allocation of cost and quantitative transferred risks, qualitative shared risks and benefits and their combination to guide PFI decision-making are important challenges for management accounting.

Third, we have explored the nature of management accounting/control systems that both are, as well as should be, in place to assess the effects of PFI decisions in the NHS. A number of conclusions are derived:

- First, given that only a few PFI projects are in operation, an initial evaluation will only be possible in several years time and these will need to be repeated at intervals before any final judgement will be possible. What is important, at this juncture, however, is to design a system to allow this evaluation to occur. Management accounting is central to the design of this system.
- Second, despite the view that an evaluation is only possible in several years time, this has not prevented a number of attempts at arriving at a judgement on the merit and worth of PFI. The monograph critically analyses a number of these attempts finding considerable problems in those that concentrate on single characteristics (such as finances or bed numbers) and that lead to, in our view, premature value for money judgements. We are more sympathetic, however, to the more long term, multiple characteristic, systems-based approaches of bodies such as the National Audit Office and the Institute of Public Policy Research.

- Third, we also looked at the intentions for the design of PPE systems in the Full Business Cases of 17 of the first 25 completed PFI projects. What we found was that the vast majority of these intentions emphasised the need to concentrate on the unique PFI elements in any PPE system (notably the achievement of anticipated risk transfer and risk sharing and, in this context, the design of adequate Facilities Management (FM) systems, along with a concern with the cultural non-financial positive and negative benefits of the PFI partnership). What was also apparent was the need to be proactive rather than reactive in the PPE system with an emphasis that risks were indeed shared as anticipated and transferred risks were transferred.
- Fourth, we also analysed not just the intentions but also the actual PPE systems of 8 (of the 17) PFI projects and found that they were all exclusively FM systems. Based on our analysis of the quantified transferred risks this accounts for only 43% of all these transferred risks. Such systems therefore are not addressing the remaining 57% of transferred risks or shared risks or non-financial benefits.
- Fifth, our conclusion, based on this analysis, is that the design of a PPE system, which, in due course, can be used to judge value for money and the merit and worth of PFI, should be proactive in nature, addressed to the attainment of all quantified costs and transferred risks, be clear about the way shared risks will be managed and should be both attentive to, as well as proactively engaged with, the qualitative views of all stakeholders concerning the PFI partnership as it develops. Our view is that management accounting should provide the base for such a design.

The monograph ends with eight key recommendations and challenges for management accounting. The first three of these relate to management accounting systems for pre-decision processes, the next three for post-decision processes and the last two to wider issues concerning evaluation and leadership in PFI policy. We recommend the need to develop management accounting systems that:

- First, improves general cost estimation processes over the period of the 30 to 35 (and up to 60) years of the contract, and so develop better quantitative estimates for construction, operation and other transferred risks.
- Second, rigorously defines the nature and allocation of the shared risks and stakeholder benefits for the pre-decision stage in the PFI process.
- Third, allows a meaningful and balanced combination of the above quantitative and qualitative analysis (1 and 2) to lead and develop the PFI decision-making process.
- Fourth, ensures cost attainment and the realisation of expectations concerning transferred risks.
- Fifth, ensures that the allocation of expected shared risks are as intended at the pre-decision stage.
- Sixth, systematically gathers stakeholder views leading to active consideration and appropriate action by management.
- Seventh, provides a summative 5 to 7 year analysis (based on recommendations 3, 4 and 5 above) of the handling of transferred risks, shared risks and stakeholder views that can be audited and can be used to lead to a subsequent discursive process that will arrive at periodic judgements on the value for money and merit and worth of the PFI option.
- Eighth, provide input for both the value for money audit methodologies of these systems by the National Audit Office and, where appropriate, the Audit Commission as well as HM Treasury and NHS Guidance in respect of pre-decision processes and PPEs for PFI.

1 Introduction

1.0 The Private Finance Initiative (PFI):

Background and Origins

In the Autumn Statement of 1992 the then Chancellor of the Exchequer, Norman Lamont, announced that the Private Finance Initiative (PFI) would be launched. Against a background of recession the Chancellor set out to re-organise the framework of monetary policy (on the exit of the pound from the European Exchange Rate Mechanism), to control fiscal policy and limit public sector spending and to increase the growth rate of the economy. The latter was seen to be best achieved by

'... pressing ahead with our policies on privatisation, deregulation, cutting out waste and keeping the tax burden of companies and individuals as low as we can', (Norman Lamont, House of Commons Hansard (HCH), 12/11/92, column C 994). In this context there was recognition of the on-going need for capital expenditure in the public sector. Whilst the Chancellor sought to give some protection to the provision of capital from public resources a major theme was the development of the 'private financing of capital projects' (Norman Lamont, HCH, 12/11/92, C 998).

Three developments were announced: any privately financed project in the public sector which could be profitable should be allowed to proceed; joint ventures that allowed a sensible transfer of risk to the private sector should be encouraged; and leasing that permitted good value for money and for risk to remain with the private sector should also be allowed. These changes were to be the start of a developing policy which, in 1997, was adopted and taken forward by the new Labour Government following their General Election success. This monograph provides an introduction to this policy development with a specific aim of providing an overview of its nature and its outworking in the National Health Service (NHS) from which a number of management accounting implications and unanswered research questions are drawn.

Arguably, until the introduction of PFI, little effort had been given by the previous Conservative Government towards either infrastructure developments in the public sector or to a consideration of different approaches to funding these developments. Throughout the 18 years, from 1979, of the Conservative Government, capital expenditure had been somewhat neglected even though the needs for infrastructure developments were considerable. Terry (1996 p.9) makes a general, rather less party focused, point about this neglect when he indicated that capital expenditure tends to have a lower political priority and does not have the immediate impact that follow from not fulfilling revenue commitments (e.g. the immediate political backlash and social ramification that comes from, say, reductions in social security benefits). However, the cumulative effect of under-investment in capital stock inevitably increases through time. Perhaps it was the reality of this pressing infrastructure need, alongside the equally pressing requirement to keep public expenditure under control, which, when coupled with an ideological commitment to involve the private sector in the

public sector, led the Conservative Government to launch PFI in 1992. The ideal solution to the infrastructure problem, to the Conservatives, was seemingly, wherever possible, privatisation of the public sector. However, by 1992, the majority of the state enterprises that could be privatised had been, leaving the Government with a need for new ideas to involve the private sector in the public sector. PFI supplied this new idea.

The Labour government, when it took office, despite some commentators wondering if this would be the case, also adopted the Initiative. The thrust of their approach was one that emphasised the notion of partnership and was dressed in their adoption of a 'third way' but nevertheless the PFI was given an impetus by this new administration, albeit within a wider framework that the new Administration referred to a Public Private Partnerships¹.

PFI, therefore, is an Initiative that crosses over two seemingly disparate political persuasions. It is an Initiative of great complexity raising many implications and questions. It is an Initiative that has generated considerable financial investment of private sector money in the public sector. Approximately £7 billion had been raised from the private sector from the outset of PFI in 1992 to the General Election on 1 May 1997 – £5 billion of this had been in transport schemes (not least the channel tunnel link costing over £3 billion). To date, with the impetus coming from the Labour Government, following their May 1997 election success, the total, up to April 2003², now stands at approximately £35.5 billion covering over 563 individual projects. Four hundred and fifty one PFI projects are now operational delivering over 600 new public facilities. There has also been a change in volume of activity – so, for instance in 1995 there was only 9 signed projects worth approximately £667 million whereas in 2002 there were 65 signed projects worth £7.6 billion. The figures alone indicate how enthusiastically and successfully the Labour Government has taken forward PFI, which is now pursued in all departments of central and local Government. Yet, it is not the only source of money available for infrastructure-based developments. Thanks to the Comprehensive Spending Reviews, PFI, in 2003/04, for instance constitutes only 11% of total capital investment. Yet this aggregated figure disguises variability across Government Departments. In the Department of Health, for instance, until recently, any infrastructure-based investment of over £25 million³ had to be met by PFI or not undertaken at all.

¹ Interesting Public Private Partnerships is the label that is used internationally to describe the working together of the two sectors on infrastructure-based projects (cf. Broadbent and Laughlin, forthcoming).

² All figures in the remainder of this paragraph are taken from HM Treasury (2003).

³ This has recently been increased to £40 million in the most recent call for bids for capital developments which closed in April 2004.

1.1. Research Questions

Many unanswered questions surround PFI. We have looked at this in the past by tracing a broad research agenda that PFI generates (cf. Broadbent and Laughlin, 1999; Broadbent, Haslam and Laughlin, 2000; Broadbent and Laughlin, 2004; Broadbent and Laughlin, forthcoming). This highlights a number of crucial issues. One important area relates to the financial accounting for PFI, particularly in relation to decisions as to whether PFI transactions are 'on' or 'off' public sector balance sheets (Broadbent and Laughlin, 2002, 2004). Another are the contracting issues that come with PFI with particular reference to the health projects (Broadbent, Gill and Laughlin, 2003). Accountability has also been addressed in the way that pressure for greater accountability for how the Government is pursuing PFI has provided increased clarity into its inherent nature (Broadbent and Laughlin, 2003). Issues surrounding the vexed question about how to judge the 'value for money' (VFM) of PFI (Broadbent and Laughlin, 2004 (A)) is another important area. This monograph draws from and extends the work in all these areas and makes a number of key recommendations coming from this analysis.

The research from which the contents of this monograph draw includes data gathered from a number of sources, including the documentation from seventeen NHS Trusts who are involved in PFI projects. It also draws from interviews from members of eight of these Trusts. The eight NHS Trusts, all of which are now fully operational, are in the order of opening: with the earliest first: Dartford and Gravesham, North Cumbria Acute Hospitals (Carlisle), South Buckinghamshire, Queen Elizabeth Hospital (Greenwich), Calderdale and Huddersfield, Norfolk and Norwich, Worcestershire Acute Hospitals, South Durham Healthcare. Much of the material that was collected from these NHS Trusts is commercially confidential, thus, where any of this data is used in this monograph that is not available in the public sphere, the source is disguised. We have also relied heavily on a range of public documents from a number of Government sources and national bodies.

This extensive and wide-ranging material is brought together to address three specific research questions. First, over time, how is PFI defined? Second, with specific reference to the NHS, why and how are PFI decisions made and what management accounting information/systems are key in this process? Third, what management accounting/control systems are in place to assess the effects of PFI decisions in the NHS? The monograph provides insights into answers to these research questions, leading to some key recommendations, as well as clarifying what still needs to be discovered and how this might occur.

1.2 Outline of the Monograph

In order to explore these issues the monograph is divided into four further substantive chapters followed by a reflective conclusion. Chapter 2 explores the first research question asking what is the nature of PFI. It traces how this has changed over the period of its existence. This has involved a shift from its promotion as a procurement device for the public sector that was initially dominated by macro economic considerations to an initiative which now has a key micro economic agenda intended for the provision of services that can bring about risk transfer and yield value for money. Chapters 3 and 4 concentrate on the development of PFI in the NHS and hence address the second question of why and how PFI decisions are taken and what management accounting is involved. Chapter 3 is devoted to an historical account of the developments of PFI in the NHS located within a time span, which stretches before 1992. Chapter 4 clarifies how PFI decisions are made in the NHS with particular attention being given to the NHS PFI Guidance published in 1999 (NHS, 1999) and the subsequent changes that have been made to this Guidance⁴. Chapter 5 looks at how we might analyse the effects of PFI, again with a particular emphasis on the NHS. It thus addresses the third research question. The concluding Chapter 6 draws from the previous Chapters and clarifies how far we have progressed in answering the original questions of the monograph. It also provides the recommendations, which emerge from this research.

4 There have been numerous minor changes to this Guidance since it was originally issued in 1999 but not to such an extent that the original Guidance is unrecognisable. The new draft HM Treasury Guidance (2003, 2004) discussed in Section 4.3, however, is likely to change this situation. When this is clearer it will have far-reaching effects on the 1999 NHS Guidance. Until this occurs the 1999 document is still operational. We will therefore refer extensively to the 1999 Guidance but weave the changes to this into the discussion whilst still citing the key and original reference as NHS (1999).

2 The Emerging and Changing Nature of the Private Finance Initiative

2.0 Introduction

The justification of private finance to fund public sector infrastructure and service developments in the UK has been through at least three phases (cf. Broadbent and Laughlin, 1999, Broadbent, Haslam and Laughlin, 2000). We will, in the following, briefly explore these stages since, together, they provide an important contextual appreciation of what is now a significant, but nevertheless controversial, commitment by the previous Conservative Government and current Labour Government.

These three historic phases emphasise fundamental differences of view as to the nature and public purpose of PFI in which management accounting is heavily implicated. Put simply, the key question is whether PFI is either 'a means by which to avoid public expenditure controls and thereby achieve investment that could not be afforded otherwise' or 'a public procurement approach that can yield value for money and risk transfer to the benefit of the public' (Broadbent, Haslam and Laughlin (2000) p.23). Even though there is clearly some overlap between these two purposes they lead to different emphases when it comes to the fundamental nature of PFI. The first purpose gives greater emphasis to the macro fiscal aspects of PFI whereas the latter concentrates on micro value for money concerns. It is probably fair to say that for the period prior to the launch of PFI (pre 1992) the macro fiscal argument dominated. From 1992 to 1997 the justification was a mixture of macro fiscal elements with a growing emphasis on micro financial considerations. From 1997 to date, however, the micro VFM arguments have become more and more dominant even though the criteria used to judge this has been changing over time. In simple terms the macro/micro dilemma gives different emphases as to whether PFI is a concern for financial or management accounting. A macro emphasis tends to give particular emphasis to the financial accounting⁵ process, particularly in relation to whether PFI transactions are 'on' or 'off' public sector balance sheets, and the ramifications this has for national accounts and the macro fiscal situation. A micro emphasis, on the other hand, relies heavily on management accounting to judge value for money and risk transfer. In this context the history of the PFI, therefore, provides a story of a shift from something which originally was a financial to now a management accounting problem.

⁵ As we will argue this macro fiscal argument does not necessarily dominate. This does not, however, belittle the importance of the decision concerning balance sheet treatment and the financial accounting information that provides this judgement. However, as will be made clear, this financial accounting decision is largely reliant on a management accounting analysis of risk assessment and transfer.

The following is divided into four further subsections. The first three sub-sections explore these three stages in the development of PFI and the fourth, drawing from this detail, clarifies what can be concluded about the nature of PFI.

2.1 Views on Private Finance Pre-1992

Before 1992 the UK Government was wary about seeking private sector money to fund public sector developments. But this needs to be set within the Government's, seemingly inconsistent, enthusiasm for wide-scale privatisation of major parts of the public sector. Technically private sector money could be sought as long as it satisfied certain 'hurdles' set down in what came to be known as the Ryrie Rules (after Sir William Ryrie, a Second Permanent Secretary to the Treasury). These Rules were the predecessors of PFI. They were set up, originally, to control the relationship of the public and private sector in terms of investment capital in the nationalised industries where, it was argued, lack of public sector finance meant that profitable opportunities were being lost. Some means of allowing private financing was, therefore, developed to create the possibility that government funding restrictions would not stop possible private sector schemes in the public sector. Despite their formal intent, Heald (1997 p.579) notes the comments of David Willetts (a Conservative Member of Parliament) writing in 1993, that the Ryrie rules were really there to stop the development of public-private schemes. The documentation provided by the Private Finance Panel, which had been formed to promote PFI, provided a rather more diplomatic summary, indicating that the Ryrie Rules: '... were regularly criticised for being too restrictive and giving public bodies no incentive to seek privately funded solutions' (Private Finance Panel (1995), paragraph 2.2, p.6). One interpretation of this is that the Treasury was afraid that without very tight criteria, schemes might be undertaken which would be too costly in terms of their macro fiscal effect given tight public sector expenditure controls.

It is generally recognised that the Ryrie Rules were partially retired in 1989 and finally abandoned in 1992 with the launch of the PFI. In 1989 the Chief Secretary to the Treasury (John Major) announced that in future '... the Treasury would not require reductions in public expenditure programmes fully to offset privately funded projects' (Private Finance Panel (1995) paragraph 2.3, p. 6). This announcement was a major relaxation of the requirements that private sector finance would be a substitute for and hence a reduction in public expenditure. However, the important comparator with alternative public sector financing, which still gave an inevitable preference to the use of public finance, remained. Invariably the Government could obtain finance for capital projects at a cheaper rate than the private sector which made the 'hurdle rate' that much harder to achieve for private finance projects.

Despite the ambivalence to private sector money demonstrated through the Ryrie Rules, no such hesitations were apparent in terms of a commitment to privatise large sections of the public sector. The 1980s and early 1990s saw an unprecedented period of privatization of numerous institutions and utilities owned by the public sector. This was a central policy of the then Conservative Government led by Margaret Thatcher. The view was that the private sector was more efficient and could manage things better if they had complete control. It was also assumed they could solve the chronic infrastructure problems in these industries. So everything that could be sold, without too much of a public outcry, was sold, generating considerable injections of money into Government finances. The ideological commitment to the view that the private sector is more efficient than the public sector is reflected in the development of the PFI.

In all these strategies nevertheless a common concern for the macro fiscal considerations of controlling public sector levels of investment and borrowing predominated.

2.2 PFI from 1992 to 1997

The Autumn Statements of 1992, 1993 and 1994 gave birth to PFI and shaped and reshaped its design and nature. PFI was launched in the Autumn Statement of 1992 by the then Chancellor of the Exchequer (Norman Lamont) who made plain that:

'... self-financing projects undertaken by the private sector would no longer need to be compared with the theoretical public sector alternatives; the Government would actively encourage the private sector to take the lead in joint ventures with the public sector; the public sector would have greater opportunity to use leasing where it involved significant transfer of risk to the private sector and offered good value for money' (Private Finance Panel (1995) paragraph 2.4, p.7).

This reflected again the Conservative Government's underlying commitment to the private sector's involvement in the provision of public services.

Despite this important launch, interest in PFI by the private sector was somewhat muted. As a result the new Chancellor (Kenneth Clarke) gave the PFI greater impetus by announcing, in the Autumn Statement of 1993, that a new Private Finance Panel should be created. Its role would be:

'... to encourage greater participation in the initiative by both private and public sectors, to stimulate new ideas, to identify new areas of public sector activity where the private sector could get involved, and to seek solutions to problems which might impede progress' (Private Finance Panel (1995) paragraph 2.5, p.7).

In the Autumn Statement of 1994 the Chancellor (still Kenneth Clarke) ensured engagement with the private sector by making plain that the Treasury would not approve any capital project unless options to secure private finance had been explored. This 'universal testing for private finance' was the final culmination of a very determined policy by the previous Conservative Government to ensure not only the survival but also the centrality of the PFI in securing service/building developments in the public sector. Like so many developments in the public sector at this time, this 'universal testing' policy was implemented without consideration of the costs involved (which were considerable not least in terms of legal and financial advisory costs) or an exploration as to the real value of this change. It was an ideological driven change based on a belief in the private sector to solve the problems in the public sector.

Meanwhile, in April 1996, the Local Authority Associations established the Public Private Partnerships Programme (4Ps) in England and Wales. Local Authorities have greater autonomy than any other area within the public sector and thus were only partly directed by the Private Finance Panel. The 4Ps was set up: '...with the express aim of bringing about increased investment in local services through PFI and other public/private partnerships' (Private Finance Treasury Taskforce (PFTT) (1997) paragraph 2.7, p.6). With the formation of this new body both central and local government was covered institutionally to encourage the growth of PFI yet, as the new Labour Private Finance Treasury Taskforce later made plain, for '... five years the PFI fell well short of the targets set for it' (PFTT (1997) paragraph 2, p.4).

The macro/micro nature of PFI was in some flux during the period up to the General Election in 1997. The macro fiscal arguments for PFI and its value to the Public Sector Borrowing Requirement continued to dominate; some more micro, value for money, issues were raised but were left at some level of vagueness. So, for instance, in the 1995 Private Finance Panel paper it was stated that:

'There are two fundamental requirements for a PFI project: i. value for money must be demonstrated for any expenditure by the public sector; ii. the private sector must genuinely assume risk. The significance of these two criteria differs depending on the type of privately financed project.' (Private Finance Panel (1995) Paragraph 3.1 p.12)

In this context the simple principle in relation to risk was that '...risk should be allocated to whoever is best able to manage it' (Private Finance Panel (1995) Paragraph 3.6 p.13). On the issue of value for money the view was, in the main, that competition would be the key determinant although sometimes the use of a public sector comparator could be useful:

'A critical question in deciding whether to go ahead with a PFI option is identifying best value for money. Competition is the best guarantor of value for money. As a result of the competitive process, the best PFI options should emerge. These may involve comparison with a conventionally procured alternative – the public sector comparator. Certain kinds of PFI projects do not need a public sector comparator ... This is an important innovation since the old Ryrie Rules, although it needs to be interpreted sensibly. Public sector comparators are not necessary for projects which involve no public sector money or which would not have gone ahead other than as PFI projects.' (Private Finance Panel (1995) Paragraph 3.35/6 p.19).

2.3 PFI from 1997 to Date

There were some political worries about whether PFI was actually privatisation of the public sector by a different route in the run-up to the General Election in 1997. Thus, there was uncertainty about whether PFI would survive if the Labour Government were elected. In the end the incoming Labour Government gave its unequivocal support to the idea. Within a week of taking office the new Paymaster General (Geoffrey Robinson) announced that he had appointed Malcolm Bates (Chairman of the Pearl Group and of Premier Farnell) to conduct a wide-ranging review of the PFI. He was required to produce – by 23 June 1997 – a report to Treasury Ministers with clear recommendations on how PFI should be developed and organised. In addition, and on the same day, Geoffrey Robinson also announced that the required

'... universal testing of private sector financing' for all public sector capital projects, which had been introduced in the 1994 Autumn Statement, would be abandoned immediately. The view was that this universal testing had been: '... a recipe for frustration and delay and works against the concept of prioritisation which we want to build. Departments should not spend time and money trying to develop models for private finance where these will not work.' (HM Treasury Press Notice No. 41/97, 8 May 1997).

However, he then immediately made plain that:

'...this does not mean departments can expect any increase in their capital budgets and we will expect a high level of suitable projects to be brought forward to achieve the aims of PFI' (HM Treasury Press Notice No. 41/97, 8 May 1997).

The Bates Review made 29 key recommendations many of which were to do with structural arrangements for PFI. The key recommendation was to disband the Private Finance Panel and to control PFI directly from HM Treasury by the formation of a new Private Finance Treasury Taskforce (PFTT) to co-ordinate and steer the development of PFI. Organisationally the Taskforce was to have separate 'projects' and 'policy' wings to it, the former having a limited life (up to 1999 – see below for more details on this following the Second Bates Review of 1999). The 'projects' wing was intended to provide technical advice to Government Departments concerning the design and approval of specific projects and the 'policy' wing to help clarify overall policy on PFI. The intention was that different Government Departments would develop their own unique project emphasis and expertise that, over time, would not need the central support of the PFTT. Central to the Bates Review, therefore, was a mixture (and tension) of centralisation (through the formation of the PFTT) and decentralisation (through encouraging Government Departments to build up their own expertise on PFI). A typical example of this emphasis (and tension) is the PFTT's support for the 4Ps which they saw as continuing to:

'... play a critical role on behalf of Local Government. They will champion the interests of local authorities generally, and work closely with individual authorities in advocating and working up proposals so as to enhance the viability of projects, thus increasing the chances of securing endorsement' (PFTT (1997) paragraph 2.18, p. 7).

They also pointed out that the:

'... 4Ps will be developing close links with the Treasury Taskforce projects team in particular' (PFTT (1997) paragraph 2.17 p.7).

Since 1997 there has been an ever-expanding level of centralisation and standardisation in the development of thinking about PFI. First, in relation to a final resolution of how to account for PFI. Second, through the development by the PFTT and now the Office for Government Commerce (OGC), of standard procurement and contracting arrangements and education packages. Third, through formalising and standardising the 'signing off' arrangements for all PFI contracts e.g. the emergence of the Project Review Group to 'sign off' all local authority PFI projects. Fourth, through the introduction of 'Partnerships UK' coming from (now Sir) Malcolm Bates second review of PFI. Fifth, through resolving the long-standing and complex issue concerning the employment issues and rights of staff originally employed by the public sector but part of PFI project plans. We will briefly look at each of these in turn.

First, the long running debate about how to account for PFI which had grown out of a disagreement between the ASB and the Treasury as to whether it should be seen as 'on' or 'off' balance sheet was finally resolved. It was one of the key recommendations of the original Bates Review that the accounting for PFI needed to be resolved. The issues and complexity surrounding this have been considerable. In the following we can only touch on some aspects of this (see Broadbent and Laughlin (2002, 2004); Hodges and Mellett (1999, 2002) and Rutherford (2003) for more details). The issue, in simple terms, is whether the property element involved in the PFI deal should appear on the balance sheet for the public sector procurer or whether it should appear on the balance sheet for the private sector supplier. How this judgement is made is based on accounting rules and it is here where there has been considerable disagreement. The key accounting requirements for this important decision are contained in SSAP 21 ('Accounting for Leases and Hire Purchase Agreements') issued in August 1984 (ASB, 1984), FRS5 ('Reporting the Substance of Transactions') issued in April 1994 (ASB, 1994), Private Finance Treasury Taskforce's Technical Note No. 1 ('How to Account for PFI Transactions') issued in September 1997 (PFTT, 1997a), Amendment to FRS5 ('Reporting the Substance of Transactions: The Private Finance Initiative') the Exposure Draft of which was issued in December 1997 and the standard in September 1998 (ASB, 1998) and finally the Private Finance Treasury Taskforce's Technical Note No. 1 (Revised) ('How to Account for PFI Transactions') issued in June 1999 (PFTT, 1999a). Put simply the original Treasury Guidelines led to most PFI transactions being 'off' public sector balance sheets whilst the Accounting Standards Board's (ASB) September 1998 Standard leads to greater likelihood that PFI transactions will be 'on' public sector balance sheets. The somewhat reluctant issuing of the Treasury's 'Revised Guidelines' was an attempt to provide an 'interpretation' of the ASB's Standard but in such a way that, wherever possible, PFI transactions remain 'off' public sector balance sheets⁶. A more recent view, however, is that:

'The accounting treatment of a PFI project on a Departmental balance sheet, and its reflection as an asset in the national accounts, is not material to the Government's decisions about when to use PFI. These are based on value for money alone. In fact, the majority – 57 per cent – of projects by capital value are reported on Departmental balance sheets ... Accounting and reporting treatment follows rules set by a series of independent national and international organisations, and is decided by independent auditors (HM Treasury (2003) paragraph 2.26).'

⁶ The reasons why this seeming housekeeping matter has been so difficult to resolve as well why the Government is so keen – and they are unquestionably keen – that PFI transactions be 'off' balance sheet for the public sector, are complex. We will not explore these here but for more details see Broadbent and Laughlin (2002) and some pointers to these issues will be raised below.

This recent view is built on changing fiscal rules and shifting attitudes but in the late 1990s the evidence suggests that views were rather different.

The second area, where centralisation and standardisation has been apparent, is in the work of the Public Finance Treasury Taskforce (PFTT) which, from 1999, was subsumed under a new Office for Government Commerce (OGC)⁷ in issuing all manner of standard guidance and education packages on PFI. Four of particular note should be highlighted. First, is the publication in July 1997 (with several minor subsequent revisions by both the PFTT and OGC) of a Step by Step Guide to the PFI Procurement Process, which explores, in some depth, the stages that need to be undertaken in any PFI deal (PFTT, 1998). Second, is the Standardisation of PFI Contracts issued originally in July 1999 and recently (in July 2002) revised by the OGC. This guidance determines what should be in all and every PFI contracts. As the news release (Treasury New Release No. 118/99) made plain these guidelines

'... will act as a blueprint for the future development of PFI and ensure that future PFI contracts across different public services will be able to follow a consistent approach by incorporating standard conditions into the contracts'.

Third, was the issue of Technical Note No. 5 on How to Construct a Public Sector Comparator issued in October 1999 (PFTT, 1999) and remaining unrevised at the time of writing but no doubt will change given the recent thinking of HM Treasury (2003, 2004). This Guidance defined, in detail, how to judge value for money for all PFI transactions. With the publication of this document the shift to value for money considerations for PFI was completed. However, whilst this remains the major basis for judging VFM it is not necessarily the only criteria to judge this. Increasingly HM Treasury is using other more qualitative concerns about, for instance, the ability of PFI to offer 'deliverables' by way of providing new schools, hospitals etc. built and opened on time and to contract price, as a complement to and part of judging whether VFM has been achieved – see Section 4.3 for more details. Finally, in relation to standard guidance, the PFTT have, with PricewaterhouseCoopers, designed 'A Comprehensive Approach to PFI Training' at three different levels (introductory, intermediary and specialist) to provide practitioners a standard learning package to assist those undertaking PFI projects. This programme launched its first teaching modules in October 1999.

⁷ Although as the April 2003 issue of the PFI Report (p.2) indicated these 'PFI policy functions' have now reverted back to the Treasury. OGC will concentrate more on 'ensuring effective procurement and contract management'.

Thirdly, there has been an increasing formalisation in the provision of advice and in the 'singing off' of all PFI deals and contracts, bringing again greater standardisation into decision-making. No large PFI contract can be entered into unless it has been at some level, and at some time, approved by the PFTT. Some Departments, such as Health, has delegated powers to approve PFI projects – up to £100 million for the Department of Health – but all projects over this amount still need PFTT approval. In other areas delegated powers are more restricted. So, for instance, in November 1997, the Department of the Environment, Transport and the Regions announced the setting up of a Project Review Group in the PFTT through whom all potential PFI projects have had to pass and be approved.

The fourth development, ensuring greater centralisation and standardisation of PFI processes, has come through the proposals from the second Bates Review of PFI. In the light of the first Bates review proposals that the projects wing of the PFTT would cease to be needed from 1999, it was announced on 12 November 1998 (Treasury News Release 187/98) that a second review of PFI would be undertaken by Sir Malcolm Bates to directly address this question as well as other matters concerning PFI. This second review was published on 22 July 1999. There are many recommendations that are made but perhaps three could be highlighted which get to the heart of the Review as well as demonstrate the strong moves to centralisation and standardisation that has occurred since he originally looked at PFI.

- First, was for the creation of a new organisation called Partnerships UK (PUK) to replace the 'projects' wing of the PFTT. This was intended to provide a new influential body made up of private sector experts, within HM Treasury, with advice to give, and some money to invest in, PFI projects. The services it offers is to come alongside any public sector body and work with them from initial beginnings to final contract exchange. Unlike advisors, who deal with specific once-off areas of concern, PUK has become a full member of the project team, where they have been invited to be involved, bringing past experience to aid the successful completion of the negotiations. PUK has been operational for a few years now but its full ramifications are yet to be seen. However, PUK, it was anticipated, would become significant in determining PFI deals, even though it was made plain that there '...should be no obligation on any procuring authority to use UKPPP's (as PUK is referred to in the Bates Review) services; on the contrary, it should win business by the strength of its offer' (Recommendation 32, Bates 2).

- Second, in Recommendation 2 and 3, it was made clear that departments '... should only issue their own standard documents if they have been agreed by the Taskforce to be consistent with the general standards laid down by the Treasury's own generic guidance'. The OGC have, to date, taken on this role to co-ordinate this generic advice but they have simply taken over most of the PFTT instructions under their logo. OGC's recently (July 2002) published 'Standardisation of Contracts' (OGC, 2002) is the start to what is anticipated a wide ranging revision of all PFTT advice. However, given the recent change of a reversion of PFI responsibilities to the Treasury (see footnote 2) under whose logo any revisions will appear remains uncertain⁸. If it is for this reason that in the following we will continue to use the PFTT as the source of these publications, except for the more recent HM Treasury reports, even though in some cases they have been 'rebadged' OGC.

- Third, in Recommendation 9, the view was that the introduction of the Project Review Group (PRG) should not only continue but '...should extend to other parts of the public sector'. Clearly the original plans for departments to be allowed and encouraged to develop their own way of proceeding on PFI has been reversed with a highly centralised system being introduced⁹.

Fifth, and finally, there has been a concern to standardise the employment contracts and relations of public sector staff who are part of any PFI service provision. This has been a particularly acute problem in the NHS where the disagreements surrounding PFI, particularly by the health sector union, UNISON, became focussed on this issue. Previously all staff were transferred from the public sector to being employed by the private sector with suitable safeguards as specified through what are known as Transfer of Undertakings and Protection of Employment (TUPE) arrangements. Yet such was the concern about this that the Government realised that a new arrangement was required. This they found through experimenting in three sites (Queen Mary's in Roehampton, Havering in East London and Stoke Mandeville in Buckinghamshire) of a new Retention of Employment (RoE) Model. RoE involves, as its name suggests, that original employment arrangements continue with staff seconded to the private sector. It was seen as an acceptable way forward by UNISON and, before a full evaluation was undertaken, this was 'rolled out' as the way to proceed for all NHS projects. The experimentation caused considerable uncertainties on the part of the private sector supplier to such a degree that few PFI deals were signed during 2001. The universal acceptance of RoE, despite the continuing dislike that the private sector partner has with it, has, at least, led to some further movement in the NHS PFI market.

⁸ Judging by recent reports, however, the logo seems not to be returning to PFTT but to HM Treasury judging by recent Guidance suggestions (HM Treasury, 2003, 2004).

⁹ Interestingly this Recommendation has not been implemented if the Department of Health with its delegated powers for projects up to £100 million is typical.

2.4. Clarifying the Nature of PFI

The view of PFI as a macro fiscal instrument has been increasingly under pressure ever since the Labour Government was elected. This was exacerbated by the change in the macro fiscal management arrangements. Debates on the Public Sector Borrowing Requirements (PSBR) were replaced by the introduction of the 'golden rule' and the 'sustainable investment rule' as measures of prudence for public finances. The result of this change has made the macro fiscal argument for PFI, dubious in the extreme. However, it took until 2000 to finally show analytically the questionable logic of this assumption (cf. Robinson, 2000; Hawksworth, 2000) even though it had been under sustained pressure since 1997. Thus it was demonstrated that borrowing requirements for funding PFI projects by conventional means would not have threatened macro-fiscal targets (Hawksworth, 2000). It would be wrong, however, to say that the macro fiscal argument plays no part in defining the nature of PFI. The very fact that the financial accounting question remains a significant issue suggests that the macro considerations (in which the financial accounting treatment is intimately entwined) has not been totally removed by these recent persuasive arguments.

Not only has the macro fiscal argument for PFI been under question but this has been intensified by challenges to the Initiative more generally. This has resulted in a growing need to justify PFI with the electorate. With an undermining of the ability to use macro fiscal arguments, focus has now shifted to micro value for money (VFM) arguments with an increasing concentration on the need to use public sector comparators in this context. This has come through two interconnected routes – through Government policy statements and through the work of the National Audit Office (NAO). Our argument is that it is possible to see an increasing level of interdependence between Government and the NAO where the leader and the led is difficult to clearly discern (cf. Broadbent and Laughlin, 2003). What is clear is that certainly Government policy, contained in PFTT's Technical Note No 5, is something that the NAO either played a large part in forming and/or was happy to offer its support as an appropriate strategy to judge the worth of PFI¹⁰.

Whilst the NAO have been active in looking at PFI since 1995, they have made plain that '... it is not the role of the NAO to express an opinion on the merits of the PFI, that is a matter for Government policy' (NAO Press Release No 68/95, 14 December 1995). However, in August 1999 NAO published, what was in effect, a policy document (NAO, 1999) which focused on '... four pillars which contribute to the overarching aim of getting a good deal in a PFI project' (NAO Press Notice, 13 August 1999). As this Press Notice makes plain:

¹⁰ More recent changes in the views of both HM Treasury and the NAO suggest that this reinforcing relationship is not as tight or as clear cut as it appeared previously – see Section 4.3 for more details.

'It sets out how to assess the value for money of PFI deals on a systematic basis using an analytical framework which covers comprehensively the key value for money issues which arise in these projects. The National Audit Office have consistently stated that they will not stand in the way of well thought through innovation and risk taking. Those involved in PFI deals will find that the National Audit Office's analytical framework will assist them in thinking through the key issues and should help them to make a success of the PFI. The framework and the National Audit Office's accompanying commentary, represents a comprehensive good practice guide' (NAO Press Notice, 13 August 1999)

The importance of competition in judging VFM was still retained but in a very conditional sense:

'Crucial to getting good value for money will be a procurement process which is as fully competitive as possible throughout the whole period of the procurement. It is not good enough for the procedures to be competitive in form; they must be competitive in substance ... However the private sector are unlikely to be willing to compete strongly if departments are asking an excessive number of firms to submit bids and commit the substantial resources that the preparation of a full bid involves ... It will therefore make sense for departments to limit the number of bidders expected to commit substantial resources to submitting full bids.' (NAO (1999) Paragraphs 1.18 and 1.23, p.8 and 10)

However, no such hesitations appear necessary for the use of the PSC¹¹:

'Finally as part of the planning of the procurement, departments should establish a public sector comparator against which they will be judging the bills ... They should aim to complete as much of the comparator as possible before receipt of best and final offers if it is to help in their assessment of bids ... To establish that a deal is good value necessarily requires the procuring department to satisfy themselves that it is superior to their realistic alternative option or options. To do that they will need to carry out a systematic comprehensive, and thorough comparison of the PFI option against the public sector comparator.' (NAO (1999) Paragraphs 1.25 and 1.41, p.11 and 18)

¹¹ As we see below this was not exactly the NAO's intention. In fact it has been rumoured that the NAO, in hindsight, regretted the inclusion of this sentence. Their view certainly now and they argue then was a rather more cautious view about the role of PSCs.

It is not normal practice for the NAO to issue a report of this nature. How they conduct value for money audits can normally only be discovered through an ex post analysis of the published reports. Rather the 1999 Guidance provides ex ante direction on how the NAO 'examine the value for money of deals reached under the Private Finance Initiative' providing 'a hierarchy of statements expressed in terms of advice to the procurer' to 'make this project a good deal' (NAO (1999) Paragraphs 1.1 and 1.4, p.1).

In terms of the Labour Government there has been a slow movement away from macro fiscal arguments to micro ones and, with regard to the latter, to a move from the use of competition to a commitment to the use of PSCs, to judge VFM. In this regard the PFTT (formed, as pointed out above, from one of the main recommendations of the Review of May 1997) issued an overview of the Initiative in July 1997 (PFTT, 1997). Competition was still an important consideration but PSCs were becoming much more central to judge VFM in this Report:

'Healthy competition is often the best guarantor of value for money. In most cases, value for money will need to be demonstrated by comparison of private sector PFI bids with a detailed public sector comparator (PSC). The PSC describes the option of what it would cost the public sector to provide the outputs it is requesting from the private sector by a non-PFI route ... The key is that decision makers should have available a reference point against which to compare PFI bids.' (PFTT (1997) Paragraphs 3.10 and 3.12, p. 9 and 10)

In February 1998 the PFTT issued Policy Statement No 2 (PFTT, 1998). In this Statement the transition to the use of PSCs rather than competition in judging VFM was almost complete even though concerns about what was possible to include in PSCs was clearly apparent:

'The principal evidence that value for money has been achieved is normally provided through the use of a comparator. However sophisticated the comparator it is important to remember that this process inevitably focuses on the factors that can be easily quantified and expressed in monetary terms. Other factors, notably risk transfer, service quality and wider policy objectives are less easy to quantify and may not be fully¹² reflected in the comparator ... With the Government now keen to use PFI in circumstances where it is the best value for money option, it will be sensible, in almost all strategic procurement

projects, to produce a comparator to provide a benchmark to help make that judgement ... Whilst competitive tension can provide compelling evidence that the procurer has obtained the best available method of procuring the chosen service under PFI, competition is no longer seen as an alternative to compiling and evaluating evidence regarding the cost of other forms of procurement. Therefore the presumption should now be that some form of comparator is necessary for PFI projects.' (PFTT (1998) Paragraphs 2.2.1, 2.3.1 and 2.3.2)

The next move from macro to micro justifications for PFI, and the concentration on the use of PSCs rather than competition to make this judgement, came in October 1999 with the issuing of Technical Note No 5 (on 'How to Construct a Public Sector Comparator') (PFTT, 1999). The Treasury Press Release made plain that the NAO had been actively consulted about the contents:

'The new guidance reflects the intensive consultation with departments, PFI contractors and the National Audit Office, whose reports on early PFI transactions helped clarify the issues on which such guidance was needed' (Treasury Press Release No 177/99, 29 October 1999)

'The NAO have been consulted during the preparation of this guidance and it has been prepared with the benefit of their experience of conducting value for money studies of PFI procurement.' (PFTT (1999) Paragraph 1.1.6)

The Press Release goes on with a quote from Jeremy Coleman, the NAO's Assistant Auditor General in charge of PFI value for money audits:

'The public sector comparator is a key part of the financial evaluation of proposed PFI projects. The public sector comparator is an important guide to judgement on the overall value for money of a PFI project. In one case we have found basic arithmetical errors, but more generally experience shows these calculations can be difficult. The NAO therefore welcomes this new guidance from the Treasury on how to get them right. The public sector comparator should not be a pass or fail test, but needs to be seen in the context of a systematic evaluation of all the costs and benefits of the project.' (Treasury Press Release No 177/99, 29 October 1999)

¹² Paragraph 2.2.4 goes further than this to say that the transfer of risks is '... not quantifiable and hence not reflected in the PSC'. The Technical Note in 1999, as we will see, distances itself from this limited understanding of a PSC.

As the Technical Note made absolutely clear the

'...key objective of public sector procurement is to ensure that taxpayers get value for money' (PFTT (1999) Paragraph 2.1.1).

Any wavering views about the macro fiscal arguments in support of PFI had long disappeared. Competition too was also rapidly diminishing in emphasis:

'While competition ensures that the private sector will provide its most efficient bids, there is still a need to compare the best PFI option with a publicly financed benchmark. This allows the Accounting Officer to make a judgement on whether the client is likely to achieve value for money from a PFI project.' (PFTT (1999) Paragraph 2.2.1)

However, the emphasis on PSCs

'... should never be regarded as a pass/fail test, but instead as a quantitative way of informing judgement' (PFTT (1999) Paragraph 2.2.3).

Nevertheless, unlike previous attempts at defining the PSC, which had tended to say that items such as the transfer of risk cannot be measured and thus are excluded from the PSC, the Technical Note is more inclusive of the possibilities to take account of these items. This is nicely captured in the definition of the PSC:

'... as a hypothetical risk adjusted costing, by the public sector as a supplier, to an output specification produced as part of a PFI procurement exercise. It:

- is expressed in net present value terms;
- is based on the recent actual public sector method of providing that defined output (including any reasonably foreseeable efficiencies the public sector could make) and

takes full account of the risks which would be encountered by that style of procurement.' (PFTT (1999) Paragraph 2.3.1)

More recently the language has changed again or, as the NAO have argued, their original views have been clarified. It has been reported that Jeremy Colman, who has, as indicated above, overall responsibility for PFI VFM studies in the NAO, has now

'...described the comparators as prone to error, irrelevant, unrealistic and based on "psuedo-scientific mumbo jumbo"' (The PFI Report, July 2002. Issue 65 p.36).

This growing distance from the PSC as the panacea for the VFM judgement and an increasing emphasis on more qualitative measures to clarify this decision coupled with the new language of 'deliverables' (HM Treasury, 2003, 2004) suggest a new era of VFM criteria is emerging. But this does not detract from what seems to be a lasting change, that the justification for its use rests on the characterization of the nature of PFI as a means to solve a micro rather than macro concern.

In summary, it is now clear that the nature of PFI is

'... for the provision of services that can bring about risk transfer and yield value for money' (Broadbent, Haslam and Laughlin (2000) p. 23).

It has taken a long time to get to this clarity as hopefully the above makes plain. Management accounting information is key in this micro-based decision. If the nature of PFI had proved to be closer to the macro fiscal agenda, financial accounting information would have predominated¹³. It is interesting to remember, however, that the financial accounting debate has been far from uncomplicated (cf. Broadbent and Laughlin, 2002, 2004). It was finally (seemingly) resolved in July 1999 after two years disagreement during which time the shift from macro to micro was in full flow. It is not too fanciful to assume that this painful process, which finally involved the Government, through HM Treasury, in effect, changing its views and agreeing with the Accounting Standards Board, might have had more than a passing effect on the very clear shift to a micro emphasis. However maybe this is giving too much power to accounting-led change. That notwithstanding, there is now clarity that PFI has a clear micro emphasis, in which management accounting information is of central importance. However, this still should not belittle the importance of the financial accounting decision, even if led by management accounting information. Despite the now predominant micro emphasis it is still preferable, for reasons that link into departmental capital spending limits, that, if possible, PFI transactions remain off the balance sheets of the public sector.

With this generic understanding of PFI we now analyse the second research question about how this Initiative has been developed in the National Health Service (NHS). We will explore this in the next Chapter and then turn to the more technical aspects of how PFI decisions are made in the NHS in Chapter 4.

¹³ However, as indicated in Footnote 5, and as will become clear, management accounting information on risk assessment and allocation is central to resolving this financial accounting problem as well.

3 PFI in the NHS: An Historical Overview

3.0 Introduction

The specific background to PFI in the National Health Service (NHS) is traceable to the introduction of the internal market and capital charging following the National Health Service and Community Act of 1990. What this created was, in effect, separate quasi-independent hospital trusts with responsibility for not only recurrent revenue and expenditure but also whatever was their capital stock (for which they were required to pay a 'capital charge') that constituted their hospital buildings and contents. However, what these trusts were inheriting was not pristine plant but rather buildings which were old and in poor repair due to ongoing capital and maintenance starvation over decades of neglect. The Audit Commission's report (NHS Estate Management and Property Maintenance) of 1991 estimated that £2 billion¹⁴ worth of backlog repairs were being taken over by the newly created quasi-independent hospital trusts. It was facts such as this, and an unwillingness of the Government to make suitable investment available to solve this problem, which gave considerable impetus to the development of PFI both generally and certainly in the context of the NHS.

This chapter explores this development into PFI set within the context of capital investment in the NHS pre the 1990 Act (Section 3.1), post the Act (Section 3.2) which leads to the 'PFI era' (Section 3.3).

3.1. Capital Investment Pre the 1990 National Health Service and Community Care Act

Before 1990 the limited capital finance that was available was allocated to the NHS Regions¹⁵. It was then the responsibility of Regions to allocate to District Health Authorities this capital fund. This was done, as Appleby (1999 p.79) points out: '... through a system of bidding together with option appraisal of their schemes'. Capital amounts were, therefore, allocated rather like revenue amounts – to be consumed within the year of allocation with no thought to future cost or benefit apart from the time when money was allocated. There was no sense of any ongoing contractual relationships. The allocation from any Region to any District Health Authority was the completion of the contract (not that this descriptive language was used). Once hospitals were built and operational there was no further direct tie between the two bodies in relation to this transaction. Accountability related to the expenditure in the year in question not to amounts allocated in previous years whether of a capital or revenue nature.

¹⁴ This estimate for backlog repairs has increased rather than decreased during the 1990s and to date.

¹⁵ Prior to 1991 three different levels were involved in the management of the secondary (hospital) sector of the NHS. The NHS Executive was, in effect, the head office and then the country was divided into a number of major geographic Regions. Nested within Regions were District Health Authorities who handled healthcare in a smaller geographical area. Each District Health Authority had, within it, a number of hospitals for whom it had responsibility.

All this changed with the introduction of the National Health Service and Community Care Act of 1990. The changes that come from this Act were considerable. In terms of capital the Act introduced 'capital charging' and 'external financing limits'. But to understand these we need to first look at the fundamental intention of the Act – namely the introduction of what has come to be known as the 'purchaser/provider' split in healthcare provision. District Health Authorities (renamed simply Health Authorities) and some GP practices (called 'fundholders') were the new 'purchasers' of secondary care from hospitals which were now seen as 'providers'. These hospitals initially were seen as either 'directly managed units' (still under the control of health authorities) or new NHS Trusts (who were independent from health authorities). Whilst many hospitals for a while remained as directly managed units, over time all have become NHS Trusts.

NHS Trusts have a unique legal status since they are quasi-independent public corporations who, on establishment, took ownership of their land, buildings, plant and equipment whilst, at the same time, incurred

'... an interest bearing debt equal to the value of the initial assets' (Working for Patients, White Paper, Working Paper No 1, paragraph 4.4).

So emerged the 'capital charging' system whereby NHS Trusts would incur an agreed 6% charge on the net asset base (or more accurately the equivalent debt) to be paid to the NHS Executive. As many authors have indicated in their analysis of the capital charging system (cf. Mayston, 1989, 1990; Perrin, 1989; Mellett, 1990; Heald and Scott, 1995, 1996; Shaoul, 1998; Pollock and Gaffney, 1998) the total cost to the NHS as a whole was and is nil but to the individual NHS Trusts they have created an additional cost item of some substance. Receipts for NHS Trusts came from services purchased by Health Authorities and GP Fundholding practices¹⁶. These amounts are based on contracted costs for particular services for the patients within the jurisdiction of the purchasing authorities. The money available to meet these contracts is implicitly inflated by the amount of capital charges that circulate around from the NHS Trusts to the NHS Executive and then back again. In terms of expenditure the NHS Trusts, to breakeven, have to cover their day to day costs, required depreciation on their assets (following defined NHS rules) and the capital charges.

¹⁶ These have now ceased to exist and, once fully operational, the new purchasing authority will be Primary Care Trusts (PCTs). PCTs have a complex history of their own as Broadbent, Jacobs and Laughlin (2001) indicate. Unfortunately space restrictions prevents being in a position to clarify this development in any great depth.

3.2. Capital Investment Post the 1990 National Health Service and Community Care Act

Apart from the initial capital distribution to NHS Trusts further capital allocations were, from 1991, allocated only by the NHS Executive and it is here where the introduction of 'external financing limits' (EFLs) came into existence. As from April 1991, instead of capital allocations being made through Regions all capital allocations were determined by a top-sliced budget held by the NHS Executive. NHS Trusts could put a case to the NHS Executive to borrow from this fund to pay for any capital developments. Decisions taken were dependent on a number of factors not least the approval of the purchasers to the capital development and whether the NHS Trust could repay the capital charges. This required the NHS Trust to have a positive EFL, demonstrating an ability to carry the extra capital charges, if they stood any chance of securing central funding for any planned new development.

Positive EFLs were few and far between for much of the 1990s but more importantly the top sliced budget was increasingly used to cover current deficits which the NHS had been facing for most of this period. Such virement was, in the 1990s, both possible as well as widely practiced. Quite simply up to the time of the first Comprehensive Spending Review (CSR) in 1998 (see below) capital projects, in the main, could either be funded through NHS Trust surpluses (which have not been in abundance) or more likely through PFI.

17 The 1994 Capital Investment Manual of the NHS Executive (NHS, 1994) was interpreted into a specific Circular in 1995 on how to make investments with a private sector partners (entitled 'Private Finance and Capital Investment Projects' (HSG(95)15)). This has since been superseded by the new NHS Guidance entitled Public Private Partnerships in the National Health Service: The Private Finance Initiative which was made available in 1999 (NHS, 1999). This still forms the key Guidance although there has been some modification in the contents over the last few years. The nature of this Guidance will be looked at in some depth in the next Chapter.

3.3. The Development of PFI in the NHS

EFLs continue to be a central feature for obtaining public finance for capital projects even though two changes have occurred in recent years. The first has been the introduction of PFI in the NHS. This was accompanied by a Government public sector requirement in 1994 that all capital projects should seek possible private finance. Clear directions followed this requirement on procedures to be followed in seeking to secure these private sector resources¹⁷. The second is the fixed capital budget that has been allocated through the Government's Comprehensive Spending Reviews starting in 1998¹⁸. Capital allocations of public finance must now be invested in capital projects – no longer are they allowed to be siphoned off to cover deficits on the recurrent budget as has been the case in previous years¹⁹.

18 Prior to 1998 the Government worked on annual budgets. Gordon Brown, Chancellor of the Exchequer in the new Labour Government, has now moved to a three year planning cycle. Capital Budgets for the NHS for the tax years from 1998/99 to 2001/02 were approved at levels of £228m, £280m, £352m and £411m respectively. However, PFI investment during the same period was targeted to generate £310m, £610m, £740m and £690m. Further Comprehensive Spending Reviews were issued in 2000 (for the tax years 2001/02 to 2003/04) and 2002 (for the tax years 2003/04 to 2005/06) which have delivered substantial capital and revenue increases for the NHS. Current projection for capital expenditure and PFI investment are as follows: 2001/02 (£2,236m with an additional £723m from PFI); 2002/03 (£2,756m with an additional £783m from PFI) 2003/04 (£3,168m with an additional £934m from PFI) (taken from the Annual Departmental Reports of the NHS). Similar projections for 2004/05 and 2005/06 are apparent from the Comprehensive Reviews. These capital projections suggest a greater role for public funded capital projects although in all cases PFI investment remains a major ingredient, particularly for major developments to hospital complexes. Such a huge injection of money for capital and current expenditure has required some careful investment strategies which are contained in a 10 year plan for the NHS (The NHS Plan (Department of Health, 2000a)).

19 This has been accompanied by changes in Government accounting to reflect a clear distinction between capital and revenue. Resource Accounting and Budgeting as it is called (cf. Likierman, 1995) has made virement – usually the use of capital budgets for revenue needs – which was previously a widespread practice, to be a thing of the past.

The result of these PFI requirements, particularly during the period prior to the Comprehensive Spending Reviews, led to considerable activity on behalf of hospital trusts to seek private sector partnership deals but with little tangible result. In terms of activity Baroness Cumberlege, speaking on 3 June 1997 in the House of Lords, summarised the situation as follows:

'... 71 NHS PFI schemes have been approved since the launch of the scheme, bringing in private sector capital amounting to £626 million. Of these, 43, with a capital value of £317 million, have reached contract signature state – 32 have been completed and 11 are under way.

Larger Schemes are now starting to reach contract signature: the Norfolk and Norwich project, with a capital value of £194 million, was signed in November 1996, although it has yet to reach financial closure.

A further 150 schemes with a total capital value of about £2.1 billion are testing private finance options. They include 22 schemes worth over £10 million each that have got as far as appointing a preferred bidder. Their combined capital value has been some £1.7 billion.' (Lords Hansard, 3 June 1997, Column 579)

During the same debate Baroness Jay of Paddington pointed out that this frenetic activity had cost £30 million on 'legal and financial advice and other consultancy fees' but then added '... without a single major contract being secured' (Lords Hansard, 3 June 1997, Column 576).

We will look at the factors leading to this delay below but before exploring this it is important to set the debate in the context of the change of Government. The new Labour Administration, apart from instituting a general review of PFI, took three further actions in relation to PFI projects in the NHS. The first, which applied not just to the health area, involved the announcement that the universal requirement to seek private finance for all capital projects would be abandoned (HM Treasury News Release 41/97). The second was a commitment, made in the Queen's Speech, to introduce legislation to

'... free the logjam of privately financed hospital projects' (Independent 9/5/97).

The third was to make a commitment that 'clinical services' would be exempt from any private finance arrangements. Despite considerable uncertainty as to what constitute 'clinical' services the view was and is that it would only be 'non-clinical' services, which would feature in any PFI scheme.

The lack of progress on signing contracts on NHS projects prior to the General Election was because of a serious worry about the viability and legality of hospital trusts to enter into long-term PFI contracts as well as an underlying political uncertainty as to what the Labour Party, if elected, was going to do with PFI. The key overt issue was related to clarifying who would be liable if a Trust entering into a PFI contract becomes bankrupt. The essential question was could the banks – who provide finance to fund the private sector's investment – call on the Government to cover long term leasing costs, if Trusts should become bankrupt. The Conservative Government passed the NHS (Residual Liabilities) Act in 1996 to supposedly cover this concern. What this Act did was commit the Government to pay the debts of a bankrupt Trust. However, lawyers found a 'loophole' in the Act that did not provide the watertight commitment the banks were wanting. Despite a further 'comfort letter' (Accountancy Age 9/1/97) from the then Secretary for State for Health (Stephen Dorrell) the banks were still not prepared to release the money and hence agree to the signing of the contracts. Part of this was a genuine doubt, but it could be seen that this was exaggerated by the political uncertainties at that time. Whatever the reason, led by one bank which was followed by all other bankers, demanded assurances leading to a further Bill and Act to cover this loophole. The new Act which was to

'... remove any element of doubt' (Baroness Cumberlege, Lords Hansard, 3 June 1997, column 578)

was available before the General Election but was passed by the new Labour Administration even though the bill was

'... word for word [that] drafted by the previous government' (Baroness Cumberlege, Lords Hansard, 3 June 1997, column 578).

The Act (National Health Service (Private Finance) Act 1997) became law on 14 July 1997 virtually unchanged from its original design by the Conservative Government.

There was much debate and considerable confusion in both the Lords and Commons as to why two Acts within a year of each other, which seemed to address similar concerns, was necessary. The reason, however, was reasonably straightforward: the banks, who are so vital for allowing PFI to progress, were unwilling to put forward money without this watertight legal protection. As Alan Milburn (the Minister for State for Health responsible for steering the Bill through Parliament) made clear, this Bill

'... is about removing doubt, providing certainty and, above all, getting new hospitals built' (Commons Hansard, 14 July 1997, column 155).

More directly, as Baroness Jay of Paddington made plain,

'the banks concerned have seen and agreed the wording of the Bill and have made clear that it satisfies all their concerns' (Lords Hansard, 3 June 1997, column 577).

Interestingly Mr John MacGregor (MP for South Norfolk) suggested that maybe it was not initially all the banks who were demanding this additional Act but they became a united force once one had expressed doubts:

'The 1996 legislation gave the banking consortiums that intended to help finance the PFI the assurances they sought. I am informed that the Norfolk and Norwich project would have gone ahead, and the Octagon partnership was quite content with assurances of that legislation, until one of the banks involved in the Dartford hospital project raised certain doubts. The Minister of State's legal advice was probably perfectly correct, but in order to provide the belt and braces that one of the banks involved in the Dartford hospital project appears to want, the bill has had to be introduced.

When it was seen that one of the banks involved in the hospital project had raised doubts, those involved in other projects also wanted the safety of belt and braces'. (Commons Hansard, 14 July 1997, Column 105)

This theme about the acceptability of the Bill to the banks was an ongoing concern throughout the debates in both Lords and Commons. It was an overriding factor in the rejection of virtually all the amendments that were put forward. Apart from one amendment, which provided a clause to be expressed in clearer English, all amendments were defeated, using the banks initial approval as an often overt but always covert reason for rejecting any proposed changes. What the debates on the Bill did provide was an important airing of some of the key concerns and issues about PFI in the health area. Whilst interesting, what is more important for this study is to explore the other actions and activities which have come from the passing of this Act.

In anticipation of the Act being passed 14 PFI hospital projects, worth an estimated £1.3 billion, were given the 'green light' (Department of Health Press Notice, 3 July 1997, 97/155) to proceed. Hospitals in North Durham (£96m), South Buckinghamshire (£38m), Calderdale (£77m), Carlisle (£63m), Hereford (£63m), Wellhouse (£40m), Worcester (£93m), Bishop Auckland (£52m), South Manchester (£89m), South Tees (£106m), Swindon (£148m), Bromley (£120m) as well as the two 'flag ship' projects of Norfolk and Norwich (£194m) and Dartford and Gravesham (£115m) were allowed to proceed. A further (15th) hospital (Greenwich) was allowed to proceed on 30 September 1997. Despite these developments, as the article in the Financial Times by Nicholas Timmins on 17 July 1997 made plain:

'Last month's decision to cut the projects to 14 has its down side. It might, at £1.3 bn, be the biggest hospital building programme ever in cash terms, but it was also the biggest hospital cancellation programme ever. Twenty-three projects worth another £1 bn have been told to stop work, while another six in and around London worth more than £500m are on hold pending the autumn outcome of the government's NHS review in London.

The result has been a bitter disappointment in Leeds, Sheffield, Hull and elsewhere where projects were thrown back to competing for a share of ever shrinking conventional NHS capital, or taking their chances in the next wave of PFI projects'

It was seen that even with the extra £1.2 billion public funds that the Chancellor of the Exchequer allowed for the NHS the chances of this swelling the money available for the capital programme financed by internal funds remained slim. Those who failed to make the first round were encouraged to secure funding through internal NHS sources or see whether they could be approved in the second round which, in fact, was announced in the Spring of 1998. On the internal funding possibilities Health Minister Alan Milburn was quite clear that the

'... overwhelming majority of new hospitals for the foreseeable future will be built on a private-public partnership ... When there is a limited amount of public sector capital available, as there is, it's PFI or bust' (The Health Services Journal, 10 July 1997, p.7).

Three decision criteria were used to evaluate the 43 schemes to arrive at the 14 (and the 15th added soon after) schemes chosen to proceed. These were described in The Health Services Journal (10 July 1997 p.7) as follows:

'... service need – how far the scheme meets strategic healthcare objectives; PFIability – whether a deal could be signed in the next 18 months; and PFI status – the stage reached in the procurement process.'

A scoring system (of 1 to 5) was used to assess each project on these three criteria but the concern was that it was those who scored highest marks on 'PFIability' and 'PFI status' which really were the ones which were given the go ahead. As Lyn Whitfield made plain (in The Health Services Journal, 24 July 1997, p.8)

'Two of the 14 selected projects failed to get top-mark five for 'service priority', while three of the projects 'not selected to proceed' were given a five'.

The implication was that it was the short-term operationality of securing a contractual agreement that became the overwhelming criteria.

The misgivings about the way these criteria were defined and used in making the decisions led to a number of appeals from the 23 rejected projects (the six London-based projects were on hold anyway awaiting the London Review). All these planned projects were at an advanced stage of completion, many had spent years building up their cases and invested considerable amounts of money in getting to this stage. With the instruction from the Department of Health to 'cease any further work on their contracts' (The Health Service Journal, 24 July 1997, p.8). These appeals were all rejected. Those who appealed received a 'standard letter' (The Health Services Journal, 28 August 1997, p.4) rejecting their concerns, making plain that they would still be 'eligible for consideration' by the (to be formed at that time) NHS Capital Prioritisation Advisory Group or reapply for part of the 1998 second wave of PFI projects. As Lyn Whitfield (in The Health Services Journal, 28 August 1997, p.4) suggested this 'advisory group' was still at an 'embryonic stage' of development with either 'its terms of reference or membership agreed by ministers'. What concerned the rejected projects was how to apply for the second round. This dilemma was articulated by Malcolm Lowe-Lauri, Chief Executive of Peterborough Hospitals Trust, a rejected original bidder and receiver of the 'standard letter' following his appeal:

'There are some really good PFI schemes around' he said. 'We need new guidance on PFI and how to get those good schemes included in the next round' (The Health Services Journal, 28 August 1997, p.4).

Partly in response to this pressure the NHS Executive formed (in December 1997) a Capital Prioritisation Advisory Group (CPAG). This Group signs off all capital projects for the NHS. In relation to PFI, CPAG has added to the original 15 first wave hospital schemes, with a further 10 projects (the second wave) in April 1998 and an additional 10 third wave schemes in July 1999. CPAG has also approved a further 29 major PFI schemes in the fourth, fifth and sixth waves. The latter were announced in The NHS Plan (Department of Health, 2000a). Together there are now 64 major PFI schemes in the NHS underway, given approval through the six waves worth approximately £11.1 billion in new investment as Table 1 indicates.

Table 1 shows that at May 2004, 21 of the 64 schemes were operational. Of the remainder 6 further schemes have reached financial close and building is underway. Six further schemes are near financial close whereas 18 have placed their intentions to proceed (which they have to do) in the Official Journal of the European Communities (OJEC) whilst the remaining 12 have not as yet to this stage. This time profile suggests how long it takes to move from initial conception to operation. It is probably for this reason that it is only in 2004 there has been a further round of bids for planned developments. This bid process closed in April 2004 with decisions planned to be made during summer 2004.

With this background we can now turn to how PFI decisions are made in the NHS.

Table 1 Private Finance and Investment

Major Capital Schemes approved to go ahead since May 1997 (England)

PFI Schemes reached Financial Close which are completed and operational		
Strategic Health Authority		Capital Value £m
Kent & Medway	Dartford & Gravesham NHS Trust	94
Cumbria & Lancashire	Buckinghamshire Hospitals NHS Trust	67
Thames Valley	Queen Elizabeth Hospital NHS Trust	45
South East London	Calderdale & Huddersfield NHS Trust	96
West Yorkshire	Calderdale & Huddersfield NHS Trust	65
County Durham & Tees Valley	County Durham & Darlington Acute Hospitals NHS Trust – North	61
Greater Manchester	South Manchester University Hospitals NHS Trust	67
Norfolk, Suffolk, Cambridgeshire	Norfolk & Norwich NHS Trust	158
Coventry, Warwickshire, Herefordshire & Worcestershire	Hereford Hospitals NHS Trust	64
Coventry, Warwickshire, Herefordshire & Worcestershire	Worcestershire Acute Hospitals NHS Trust	87
North Central London	Barnet & Chase Farm Hospitals NHS Trust	54
County Durham & Tees Valley	County Durham & Darlington Acute Hospitals NHS Trust – South	48
Avon, Gloucestershire & Wiltshire	Swindon & Marlborough NHS Trust	100
West Yorkshire	Leeds Community & Mental Health Services Teaching Trust	47
South East London	King's Healthcare NHS Trust	76
North West London	Bromley Healthcare NHS Trust	118
North & East Yorkshire & Northern Lincolnshire	Hull & East Yorkshire Hospitals NHS Trust	22
Thames Valley	Berkshire Healthcare NHS Trust	30
North West London	West Middlesex University Hospitals NHS Trust	60
County Durham & Tees Valley	South Tees Acute Hospitals NHS Trust	122
South West London	St George's Hospital NHS Trust	46
21	Total PFI Schemes at Financial Close which are completed and open	1,527
PFI Schemes reached Financial Close with work started on site		
Strategic Health Authority		Capital Value £m
North Central London	University College London Hospitals NHS Trust	422
Birmingham & the Black Country	Dudley Group of Hospitals NHS Trust	137
Coventry & Warwickshire, Herefordshire & Worcestershire	University Hospitals Coventry and Warwickshire NHS Trust	379
Avon, Gloucestershire & Wiltshire	Gloucestershire Royal NHS Trust	32
Trent	Southern Derbyshire Acute Hospitals NHS Trust	312
Cumbria & Lancashire	East Lancashire Hospitals NHS Trust – Blackburn	110
6	Total PFI Schemes reached Financial Close with work started on site	1,392
27	Total PFI Schemes with work started on site or open	2,919
PFI Schemes in negotiation but not yet reached financial close		
2nd Wave Schemes Prioritised		
Strategic Health Authority		Capital Value £m
North East London	Barts & The London NHS Trust (remaining Wave 1A)	1,052
Greater Manchester	Central Manchester Healthcare/Manchester Children's Hospitals NHS Trusts	420
Northumberland, Tyne & Wear	Newcastle Upon Tyne Hospitals NHS Trust	220
3	Total 2nd Wave Schemes Prioritised	1,692

PFI Schemes in negotiation but not yet reached financial close		
3rd Wave Schemes Prioritised		
Strategic Health Authority		Capital Value £m
West Yorkshire	Leeds Teaching Hospitals NHS Trust	174
Thames Valley	Oxford Radcliffe Hospitals NHS Trust	134
North East London	Barking, Havering & Redbridge Hospitals NHS Trust	238
Hampshire & Isle of Wight	Portsmouth Hospitals NHS Trust	192
4	Total 3rd Wave Schemes Prioritised	738
PFI Schemes in negotiation but not yet reached financial close		
4th, 5th and 6th wave schemes which have placed OJEC adverts		
Strategic Health Authority		Capital Value £m
Birmingham & the Black Country	University Hospital Birmingham/South Birmingham MH NHS Trust	379
Avon, Gloucestershire & Wiltshire	Avon & Western Wiltshire Mental Health NHS Trust	83
Shropshire & Staffordshire	North Staffordshire Hospital NHS Trusts	269
Leicestershire, Northamptonshire & Rutland	University Hospitals of Leicester NHS Trust	403
South East London	Lewisham Hospital NHS Trust	47
North & East Yorkshire & Northern Lincolnshire	Hull & East Yorkshire Hospitals NHS Trust	56
West Yorkshire	Mid Yorkshire Hospitals – Wakefield	211
Cheshire & Merseyside	St Helens & Knowsley Hospitals NHS Trust	229
North West London	North West London Hospitals NHS Trust	69
North West London	North Middlesex Hospitals NHS Trust	74
Surrey & Sussex	Brighton Health Care NHS Trust	44
Essex	Mid Essex Hospitals NHS Trust	110
Thames Valley	Oxford Radcliffe Hospitals NHS Trust	94
Greater Manchester	Salford Royal Hospitals NHS Trusts	196
West Yorkshire	Bradford Hospitals NHS Trust	191
Greater Manchester	Tameside & Glossop Acute Services NHS Trust	84
Trent	Sherwood Forest Hospitals NHS Trust	125
Norfolk, Suffolk, Cambridgeshire	Peterborough Hospitals NHS Trust	293
18	Total 4th, 5th and 6th wave schemes which have placed OJECs	2,957

PFI Schemes in negotiation but not yet reached financial close		
4th, 5th and 6th wave schemes which have not yet placed OJEC adverts		
Strategic Health Authority		Capital Value £m
North West London	St Mary's NHS Trust – Paddington Basin	800
Birmingham & the Black Country	Walsall Hospitals NHS Trust	117
North East London	Whipps Cross Hospitals NHS Trust	328
Avon, Gloucestershire & Wiltshire	United Bristol Healthcare NHS Trust	104
North Central London	Barnet & Chase Farm Hospitals NHS Trust	76
Essex	Essec Rivers Healthcare NHS Trust	127
Surrey & Sussex	Maidstone & Tunbridge Wells/Invicta Community Care NHS Trusts	290
South West Peninsula	Plymouth Hospitals NHS Trust	274
Birmingham & the Black Country	Royal Wolverhampton Hospitals NHS Trust	312
Hampshire & Isle of Wight	Southampton University Hospitals NHS Trust	60
South Wst Peninsula	South Devon Healthcare NHS Trust	120
Kent & Medway	East Kent Hospitals NHS Trust	200
12	Total 4th, 5th and 6th wave schemes which have not yet placed OJECs	2,808
64	Total PFI	11,114
Publicly Funded Schemes		
Publicly Funded Schemes which are completed		
Strategic Health Authority		Capital Value £m
Greater Manchester	Rochdale Healthcare NHS Trustg	24
South Yorkshire	Central Sheffield University Hospitals NHS Trust	24
Thames Valley	Royal Berkshire & Battle Hospital NHS Trust	84
3	Total Publicly Funded schemes with work started on site	132
Publicly Funded Schemes with work started on site		
Strategic Health Authority		Capital Value £m
South East London	Guys & St Thomas NHS Trust	50
1	Publicly Funded schemes with work started on site	50
4	Total Publicly Funded schemes with work started on site or completed	182
68	Total Major Capital Investment given go ahead	11,296

Footnotes:

(1) Schemes still in early stages of development: capital values may change.

Note: As PFI procures a service rather than the underlying asset, capital values shown are necessarily estimates. The capital value of PFI schemes are approximate and defined as: Total Capital Cost to the Private Sector includes the costs of land, construction, equipment and professional fees but excludes VAT, rolled up interest and financing costs such as bank arrangement fees, bank due diligence fees, banks' lawyers fees and third party equity costs.

Key facts:**All Schemes**

Since May 97, 68 major hospital building projects worth over £8.5 billion have been approved to proceed. 16 are completed and operational; a further 12 schemes have reached financial close or Public sector equivalent and are under construction.

PFI Schemes

64 major hospital developments worth over £8.3 billion have been given approval to proceed under the Private Finance initiative since 1st May 1997. The PFI Hospitals at Carlisle, Dartford & Gravesham, South Bucks, Greenwich, Calderdale, North Durham, South Manchester, Norfolk and Norwich, Hereford, Worcester, Barnet and Chase Farm, South Durham and King's have completed construction and become operational.

Publicly Funded Schemes

The go ahead has been given to 4 major publicly funded schemes worth £172m, the schemes at Rochdale, Central Sheffield (Stonegrove) and Royal Berks & Battle have completed construction and become operational; work has started on site for the remaining one.

4 PFI Decision Making in the NHS: Pointers to New Challenges for Management Accounting

4.0 Introduction and Overview

In June 1999 the NHS Executive issued its 'good practice' Guidance on PFI decision making (NHS, 1999). Despite its delayed appearance much of what was made clear in this Guidance had been in operation for a number of years either through practice or through previous publications. It remains the main source of Guidance for PFI decision making in the NHS to this day. The changes that have been made to the contents over the last few years are more marginal rather than fundamental²⁰. The Guidance is built on the NHS Capital Investment Manual issued in 1994 (NHS, 1994) and the interpretation of this in the Health Service Guidance (HSG) in 1995 (NHS, 1995) specifically related to PFI. The 1999 Guidance supercedes HSG (95) 15 (NHS, 1995) but not the Capital Investment Manual which continues to be extensively referenced. The Capital Investment Manual, in turn, has been subject to minor changes over the years although recently (July 2002) has been extended to include a revised section on PPEs (for all capital projects including PFIs). It also builds upon and links clearly to the Private Finance Treasury Taskforce's (PFTT) 'Step-by-Step Guide to the PFI Procurement Process' issued originally in July 1997 but marginally updated in 1998 and 1999 (PFTT, 1998a²¹). It also relies on the Treasury's Guidance on 'Appraisal and Evaluation in Central Government' better known as 'The Green Book' (HM Treasury, 1997) the latter which has recently been updated to provide a new edition (HM Treasury, 2002)²². Despite its clear linkage to these previous publications the Guidance not only brings these together but also extends and develops the detail in the light of the considerable experience gained since the first NHS PFI projects were signed in 1997.

In this Chapter we will provide a brief overview of this Guidance concentrating particularly on the unique aspects of PFI decisions in which new challenges for management accounting are apparent. These, as we will see, relate to risk assessment and allocation in the context of first, value for money analyses and second, to allow decisions on balance sheet treatment. Risk²³ assessment and allocation is the key to PFI decision making and to PFI more generally. It is one in which management accounting has a unique role but the assessment process is complicated when involved with PFI.

20 Although, as indicated in Chapter 1, more fundamental changes are likely to be needed when the new HM Treasury Guidelines, discussed in Section 4.3, are finalised and become new requirements for Departments to follow.

21 Again this Guidance, like all similar PFTT publications, is now published under the OGC logo. As indicated above we will continue to cite the original rather than current publisher for this and other work where the OGC has not, to date, extensively changed the contents.

22 The changes in the new 'Green Book' are significant, particularly in relation to the discount rate and risk factors. These have quite major implications for the 1999 NHS Guidance which will be picked up in the discussion that follows.

(i) Risk and the PSC

To decide whether procurement should be through PFI requires a comparison of the Net Present cost of the PFI with the net present cost providing the same outputs, through a normal public procurement. If the PFI offers the lower net present cost then it should proceed since this demonstrates value for money. Key to this decision, is the estimation of the costs of the conventional procurement – a Public Sector Comparator (PSC) – which will be used as a benchmark to compare with the costs involved in a PFI deal. Central to this is the estimation of the value of risks attached to particular cost profiles. In the case of a full public sector procurement with the public sector taking full responsibility for the service provision, all the costs involved in these risks must be borne by the public sector. They must therefore appear in the PSC alongside the estimated cash flows for providing the service if the NPC of each scheme is to be comparable. The point of the PFI is that some of these risks, if they materialise, will be borne directly by the private sector. The cost of accepting these risks will appear in a different guise through a risk premium that is impacted in the charges they make to the public sector. It is argued that if an adjustment for the cost of risk is not made in the calculations for the PSC then the PFI, which will automatically carry a risk premium in its pricing structure, will always be at a disadvantage. It is for this reason that risk identification, assessment/valuation and allocation between private and public partners is of such central importance in PFI. Without accurate risk assessment the PSC is argued to become a poor basis for judging the worth of the PFI alternative. This has been reinforced even more forcefully in the most recent version of 'The Green Book' (HM Treasury, 2002) which calls for an avoidance in 'optimism bias' in the estimating of costs including those for risks.

23 Risk is usefully and pragmatically defined in the NHS Guidance as a something which '... represents the possibility that things will not go as expected' (NHS (1999) Part 3 p. 4). Whilst risks can bring positive benefits more concern is given to what can be called 'downside' risks. The NHS Guidance is no exception to this. Their concern is that risks lead to increased estimated costs and these are what need to be recognised. As such the Guidance is only concerned with risks that can be estimated and costed. This position implicitly recognises the distinction that is often made in the academic literature between the definitions aligned to risk and uncertainty where the latter deals with events that are deemed to be beyond estimation. Although as we will see this distinction and what is included and excluded is not quite as straightforward in relation to PFI – see also Broadbent, Gill and Laughlin (2004) for more details.

(ii) Risk and Balance Sheet Status of PFI

Risk assessment and allocation is also of central importance because of its impact in respect of the financial accounting question as to whether PFI transactions are 'on' or 'off' public sector balance sheets. Whilst this is a financial accounting question an answer to it is provided by management accounting information to judge

'..the extent to which each party bears the potential variations in property profits (costs and revenues that flow from features of the property)' (PFTT (1999a) Paragraph 4.4, p.12).

Variations are, of course, another name for risks and are assessed and valued in the same way. Who carries the variations (risks) that align to 'features of the property' is an indication of ownership and hence asset status. Management accounting information is required to answer this question. But it is important to stress that the risk factors to decide balance sheet treatment and VFM overlap but are not the same – for an insightful analysis of this see Heald (2003).

(iii) Risk and Net Present Cost

In the context of the calculation of the NPC of the PSC another important management accounting concern has been the figure used as the actual discount rate in the net present value calculations. As every management accountant knows discount rates are meant to reflect the cost of capital and the time preference of money. The cost of capital itself may well also reflect the risk of the project to be evaluated. It is also well recognised that hurdle rate choice is crucial yet is also highly problematic because it impacts directly on the outcome of the calculation of the final NPC. A standard hurdle rate is used to calculate the NPC of the PSC and PFI which links to the discount rate used in all Government capital investment strategies. HM Treasury had this to say on this decision in 1997:

'The practical choice of 6 per cent, from the top of the range, for the cost of capital and the time preference rate, is an operational judgement, reflecting, for example, concern to ensure that there is no inefficient bias against private sector supply, and for most practical decisions this choice, rather than say 4 or 5 per cent has little if any impact. It is usually far more important to choose options well, to assess risks soundly and to estimate costs and benefits reliably (and then to manage the expenditure well thereafter). However occasionally the precise value of the discount rate can have a substantial impact and these special cases should be considered on their merits.' (HM Treasury (1997) 'The Green Book' Appendix to Annex G, Paragraph 15, p.84)

HM Treasury's view is now somewhat different maintaining that a 3.5% discount rate should be used:

'For individuals, time preference can be measured by the real rate on money lent or borrowed. Amongst other investments, people invest at fixed, low risk rates, hoping to receive more in the future (net of tax) to compensate for the deferral of consumption now. The real rates of return give some indication of their individual pure time preference rate. Society as a whole, also prefers to receive goods and services sooner rather than later, and to defer costs to future generations. This is known as 'social time preference'; the 'social time preference rate' (STPR) is the rate at which society values the present compared to the future.

The discount rate is used to convert all costs and benefits to 'present values', so that they can be compared. The recommended discount rate is 3.5%. Calculating the present value of the difference between the streams of costs and benefits provides the net present value (NPV) of an option. The NPV is the primary criterion for deciding whether action can be justified.' (HM Treasury (2002) 'The Green Book' Paragraph 5.49, p.26)

The difficulty is that the margins on the comparative analysis are small making the size of the discount rate a sensitive issue as Gaffney, Pollock, Price and Shaoul (1999b), Broadbent, Haslam and Laughlin (2000) and Arthur Andersen (2000) have argued. We will return to this below but the possibly more important point at this stage is to highlight again the stress that HM Treasury have laid, in the relevant versions of 'The Green Book', on the accurate estimation of risk and costs and benefits. The evaluation of these elements, as we will argue, is substantially the responsibility of management accounting information.

With this background and overview the remainder of this Chapter comprises three further sections. Section 4.1 provides a more detailed exposition of the procurement process and the various stages involved in this process whilst Section 4.2 analyses in greater depth the important question concerning risk assessment and allocation. Section 4.3, on the other hand, looks at the recent Guidance being put forward by HM Treasury, which is likely to have far reaching effects on how to judge VFM.

4.1 The PFI Procurement Process

An overview of the PFI procurement process in the NHS is portrayed in the 1999 Guidance (NHS, 1999). This is presented in diagrammatic form in Figures 1 and 2. Figure 1 compares the three stage process in the NHS with the 14 stage process suggested by the Private Finance Treasury Taskforce's 'step by step guide' (PFTT, 1998a). This linkage is very important since, as we have seen, one of the recommendations of the second Bates review of PFI was that no Guidance should be issued which doesn't link directly with the Guidance from PFTT. Figure 2 provides more detail on the processes from OJEC notice to PPE. There are five key documentary elements that need to be produced in this process. These are the formation and agreement of the Strategic Outline Case (SOC) and the Outline Business Case (OBC) in the 'Selection and Preparation of Schemes' stage; the Invitation to Negotiate (ITN) and the Full Business Case (FBC) in 'The PFI Procurement Process' stage; and the Post-Decision Project Evaluation (PPE) in the 'Post-Contract Award' stage. We will look at each of these documents in turn below.

4.1.1 Strategic Outline Cases (SOCs)

SOCs were introduced in December 1997 for all capital projects that are likely to cost over £25 million (£40 million from 2004). They came into being at the same time as the Capital Prioritisation Advisory Group (CPAG) was launched following the considerable disquiet surrounding the first 'wave' of PFI schemes to be agreed (see previous Chapter for more details). The £25 (£40) million cut-off point provides the benchmark as to when CPAG needs to be actively involved in decision-making – below £25 (£40) million (or Strategic Health Authorities (SHA) can take primary responsibility for progressing the proposal. SOC's have to be produced in consultation with the Trust, the Health Authority (or now Primary Care Group/Trust (PCG/T)) and the SHA. The SHA has the final say over content of the SOC's. It puts these forward to CPAG for approval – in 1997/98 (2nd Wave) and 1998/99 (3rd Wave) these were no more than 2 schemes per year per region. It is only after approval has been given by CPAG that an OBC can be produced. The SOC has five key elements in its design: clarification of the 'strategic context', the 'health service need', the 'formulation of options' and 'affordability' in terms of an upper ceiling on costs. No one option need necessarily be preferred but if it is it should be stated. If the Trust is committed to pursuing a PFI as the chosen procurement route this needs to be made clear at this point. Whilst £25 (£40) million is not the de jure cut-off between going down a PFI route and a public sector funded project, de facto, to date, this often seems to be the situation. The implicit expectation, made rather more explicit in the 2004 bid invitation, is that PFI will be the procurement route. In this sense the specification of the funding route is likely to be clear in the SOC and this will invariably have been supported by and worked through with the SHA.

4.1.2 Outline Business Cases (OBCs)

Once CPAG has approved the scheme the next stage is to produce an OBC. The design of this is specified in the Capital Investment Manual (NHS, 1994). It should be clear about the preferred option and the reasons for it relative to other alternatives. Risk factors need to be costed into an analysis of the preferred option. A number of key elements should be present in the OBC: an analysis of the 'strategic context' (as with the SOC's), 'project objectives and scope', 'formulation and shortlisting of options' (including identification and assessment of non-quantifiable benefits for short listed options), 'the preferred option', 'risk analysis', 'affordability' and 'project timetable and management arrangements'. Whilst the Trust develops the OBC in consultation with PCG/Ts it has to be submitted to the SHA for approval. Without securing this approval the move to advertising through the Official Journal of the European Communities (OJEC) is not possible.

4.1.3 Invitation to Negotiate (ITN)

The pathway from OBC to OJEC advertisement to FBC is complex involving a number of key steps as Figure 2 indicates. One, but far from being the only, key document involved in this process is what is referred to as an Invitation to Negotiate (ITN). With larger schemes a preliminary ITN should be used as Figure 2 indicates – however, this, in effect, is nothing more profound than a draft (final) ITN. The ITN is intended to leave the bidders in no doubt whatsoever as to what is expected from them by way of provision of services. It needs to include details of 'background information' into the Trust, 'output specifications' (this is key in PFI projects since this specifies what the NHS Trust wants in the way of services expressed through forms of outputs), the 'affordability ceiling', 'risk allocation and value for money' indicating clearly which risks are to be allocated and which retained and the value for money assumptions that align to this and the contract more generally, a draft of the 'NHS standard form contract', 'the contract terms', 'payment mechanism' and the 'timetable'. The ITN clearly is trying to be as specific as possible so that negotiations with the private sector bidders are restricted to who can provide the best deal in relation to a highly specified set of requirements.

Figure 1 The PFI Procurement Process:

A Comparison of NHS and HM Treasury Guidances

HMT 'Step-by-Step' Guide Stages

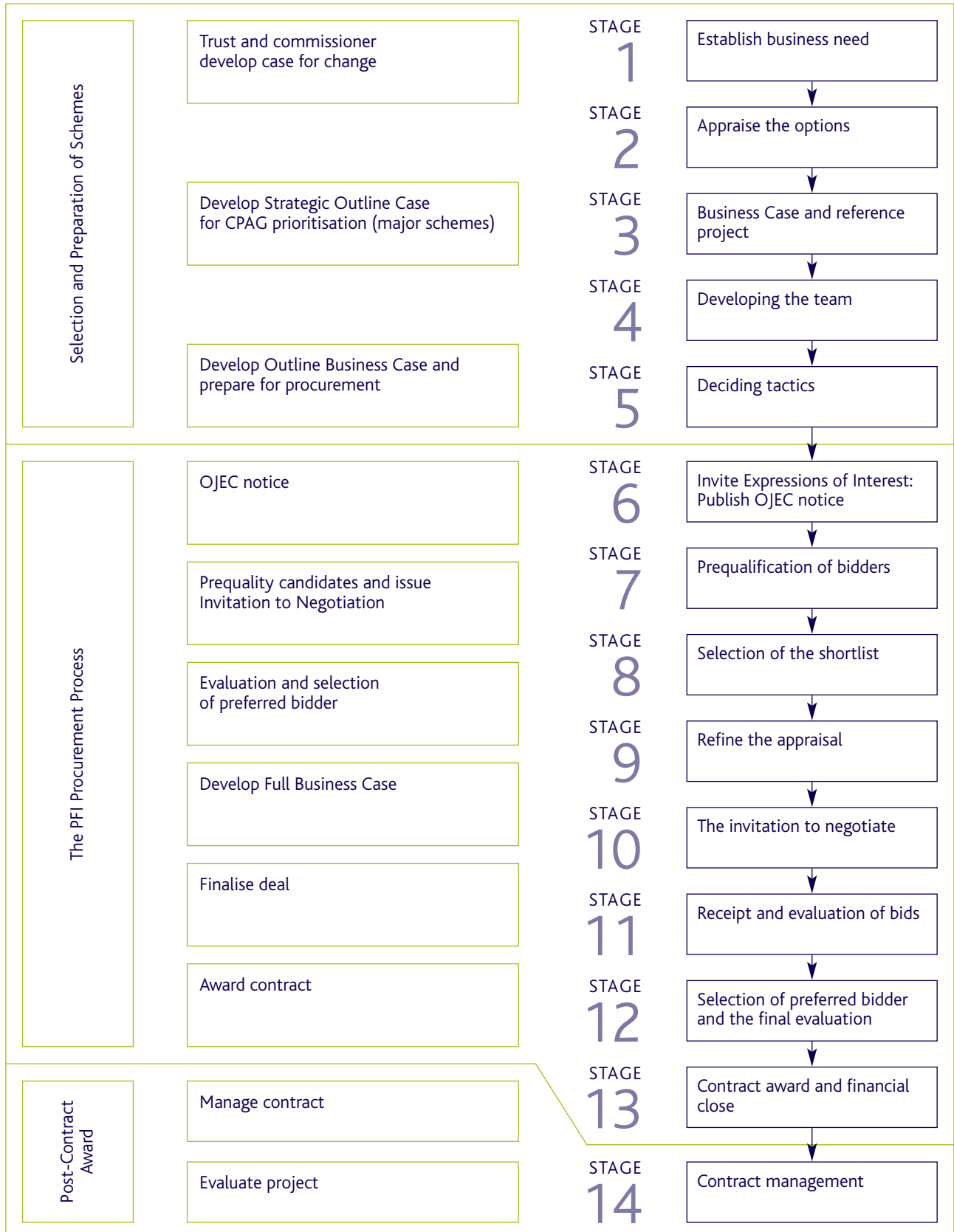
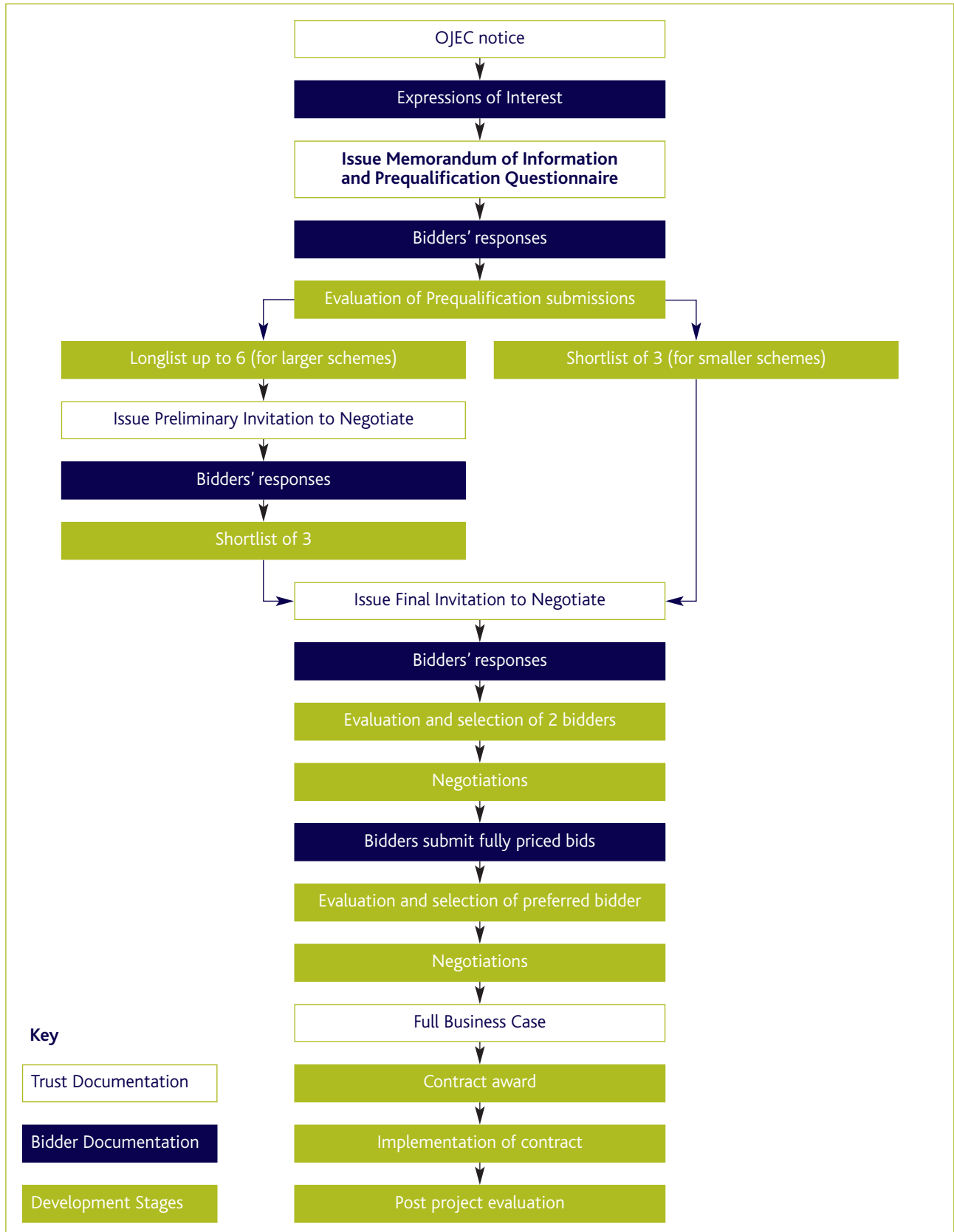


Figure 2 Formal Procurement Process from OJEC to Financial Close

(from NHS (1999) Overview p.8)



4.1.4 Full Business Cases (FBCs)

The ITN, and a clarification of who best delivers the specified requirements, however, is not the final hurdle before the contract is awarded. As Figure 2 indicates, once the preferred bidder is selected, a Full Business Case (FBC) needs to be developed and only when approved (by the Department of Health, HM Treasury Health Expenditure Team and Ministers of State (for schemes over £100 million in value) can the project move to contract award and 'financial close'.

Appendix 6 of Part 2 of the Guidance (NHS, 1999) lists 20 key sets of elements that form a 'checklist' of items that would be expected to be seen in an FBC:

- 1 Executive Summary
- 2 Strategic Context
- 3 The Outline Business Case
- 4 The Public Sector Comparator
- 5 The PFI Procurement Process
- 6 The Preferred PFI Solution
- 7 Economic Appraisal (Value for Money Analysis)
- 8 Risk Analysis
9. Financial Appraisal (Affordability Analysis)
- 10 Summary of the Contract Structure
- 11 Financing of the Scheme
- 12 Accounting Treatment of the PFI Scheme
13. Project Management Arrangements
- 14 Benefits Assessment and Benefits Realisation Plan
- 15 Human Resources
16. Information Technology
- 17 Equipment
- 18 Risk Management Strategy
- 19 Post Project Evaluation Plan
- 20 Conclusion

It is expected once the FBC has been approved – this could take a minimum of 2 months, after agreement by the SHA, but could take much longer particularly when approval from Ministers of State are required – contracts can be exchanged and financial close can occur. Only after this can building commence.

4.1.5 Post-Decision Project Evaluation

The final document is a Post-Decision Project Evaluation (PPEs) but there is no mention of the design of this in the Guidance. Rather we have to look to the 1994 Capital Investment Manual, which has a chapter on PPEs, and this has now been extensively updated in a new version of this part of the Manual in 2002 (NHS, 2002). This, however, applies to PPEs in all capital investment strategies in the NHS – it does not distinguish between those that are publicly and privately funded. The suggested PPEs in the adapted version of the Capital Investment Manual involves a four stage process. The first is the specification of how the PPE will be undertaken at the project appraisal stage to be summarised in an 'Evaluation Plan'. This, as we have seen, involves specifying in the FBC this planned process and how it will be managed and costed. Second, it involves what is, in effect, a technical monitoring of progress and evaluation of the project once completed as to whether it was completed on time, within cost parameters etc. Third, is the requirement to undertake an initial PPE within a year of completion to assess the 'service outcomes'. Fourthly, a 'follow-up' PPE must be undertaken two years after the opening of the facility and then subsequently every 5 to 7 years after any 'market testing or benchmarking exercise' to 'assess longer-term service outcomes'.

Procurement through PFI, however, generates not just the concerns of any new building development but also provides new structures of provision. As will become apparent in Chapter 5 our view is that the reliance, for the design of PPEs systems, on only the contents of the Capital Investment Manual, even with the substantive modifications that have been introduced, is not sufficient when looking at PFI 'investments'. But this is moving the argument on too quickly and the matter will be returned to in Chapter 5.

4.1.6 A Concluding Comment

Whilst some points of detail have been omitted from the above summary, hopefully there is enough detail to indicate the main aspects of the process and the many parties that have to be involved. Clearly the above is written from the perspective of the public sector. It has nothing to say about how the private sector might see, or would prefer, an alternative process. It is clear, however, that they have very little choice in design of the different stages although they do have the choice to exit and disengage. Presumably the very fact that certain private sector contractors enter into this extensive and expensive partnership suggests that it has clear benefits to them. However, for the purposes of this monograph, we can only touch on an analysis of these perceptions. Our focus remains from the public sector viewpoint and, more especially, with issues about risk allocation and valuation, value for money and the public sector comparators. It is to these we now turn.

4.2 Risk Assessment and Allocation

As we have already indicated risk assessment and allocation is key in two major areas. First, it is key in determining value for money of the PFI option relative to traditional procurement. Second, it is central to the financial accounting question as to whether a PFI transaction, once entered into, results in the property element appearing on the public sector's balance sheet. These two issues are constant concerns throughout the entire process of decision-making yet it is the value for money criteria that predominates.

4.2.1 Nature and Importance of Risk Assessment: An Overview

The key importance of value for money aspects of risk analysis is well captured in diagrammatic form in the PFTT's Technical Note 5 (PFTT, 1999). This is reproduced as Figure 3. As has already been made clear a judgement on value for money is through comparison with a public sector comparator (PSC).²⁴ Figure 3 not only demonstrates the importance of the PSC it also indicates the centrality of risk assessment and allocation. As Figure 3 makes clear the PSC has three elements of cost – a base net present value cost and an estimate of risks subdivided between those that are retained by the public sector and those that are assumed to be transferred. The costs of the PFI deal contain just two elements: the cost of the service provision and the valuation of risks that are retained by the public sector (which, of course, will be the same figure as used in the PSC calculation). It is probably only the 'cost of service payments', which is reasonably easy to calculate from the public sector viewpoint on the grounds that it will be supplied by the private sector.²⁵ The real challenge of estimation is with regard to the 'base costs' and, more especially, with the valuation of risks both retained and transferred. The PFTT's Technical Note 5 indicate that these base costs are divided into capital and operating costs. Both are real costs rather than non-quantifiable or non-financial costs/benefits, despite these being introduced at the OBC stage as part of the basis to evaluate the value of the preferred option. It was probably the realisation that there are complications enough with estimating real capital and operating costs of a comparable alternative (i.e. one which looks ahead for, in the first instance, 25 years) without venturing into the more subjective world of non-quantifiable benefits/costs. Yet this attitude is now changing as there is some realisation, as indicated in Chapter 2 and Section 4.3, of problems involved in cost estimation and the increasing importance of more subjective qualitative information. Nevertheless, even with this shift in emphasis, it is still the valuation of risks both retained and transferred, which takes the issues into new levels of complexity.

²⁴ This remains the situation despite, as we will see in Section 4.3, the wider VFM criteria that have been put forward recently by HM Treasury (2003, 2004).

The complexities of valuing risks are, of course, not novel, yet their crucial importance in PFI decisions cannot be underestimated. It is not just the problems involved in the calculation of a total risk element that is important in PFI but also the allocation of this total between two competing alternatives, which produces a considerable challenge. The interplay of total estimation of the risks, their allocation and the ramifications for going down a public or private route take this measurement problem into new realms of importance and complexity. Errors in totals and/or allocation could swing the decisions away from one to another. This is accentuated even further now that the risk element has been removed from the discount rate – the 3.5% rate that has been proposed in the new 'Green Book' is the risk free rate. But this, in turn, shifts even more onus on the risk estimation and the need to avoid 'optimism bias' as the new Green Book refers to over optimistic (as judged from the public sector view) cost and risk assessment.

Taken together cost and risk assessment creates many measurement problems as well as considerable challenges for management accounting.

It is for this reason that so much attention is devoted both by HM Treasury and the Department of Health into risk assessment and allocation. Both are of one mind²⁶ that the risks involved can be clustered into ten different categories:

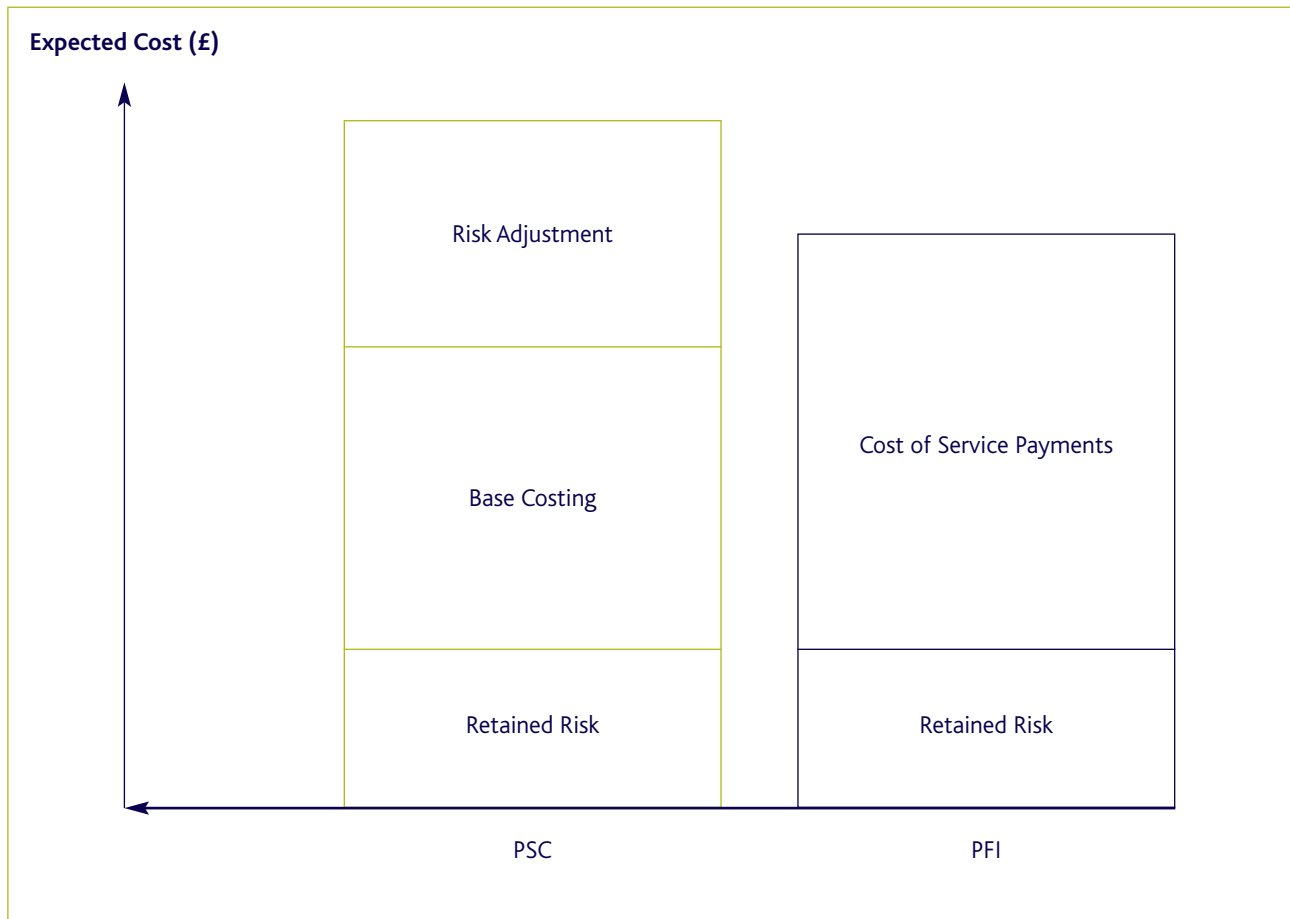
- 1 Design Risks
- 2 Construction and Development Risks
- 3 Performance Risks
- 4 Operating Cost Risks
- 5 Variability of Revenue Risks
- 6 Termination Risks
- 7 Technology and Obsolescence Risks
- 8 Control Risks
- 9 Residual Value Risks
- 10 Other Project Risks

²⁵ This is not saying it is easy for the private sector contractor to estimate this figure – in fact it must be an extremely difficult undertaking. However, as we indicated above, for the purposes of this monograph, our primary perspective is the public sector.

²⁶ For instance Appendix 1 of Part 3 from the NHS Guidance (NHS 1999) is identical in content with Appendix F of Technical Note 5 from the PFTT (PFTT 1999).

Figure 3 Cost Elements in Public Sector Comparators and PFI Transactions

(from PFTT (1999) p.2)



What specific risks are involved under each of these headings and the suggested allocation of these between the public and private sectors is well illustrated in Appendix F of PFTT's Technical Note No 5. This Appendix is reproduced in full in Appendix 1.

This 'Risk Matrix' provides a very important check-list for all those entering into PFI contracts. It has been complemented with a helpful list of 'ways to transfer risks' in the context of deriving a set of answers from a list of questions. These are contained in Annex B of HSG(95)15 (NHS, 1985) and are reproduced in full in Appendix 2. A recognition that the 'theory' of risk assessment and allocation is intended to provide a helpful guide to practice suggests the need to see what indeed is happening in practice. It is to this we now turn.

4.2.2 Risk Assessment and Allocations: Experiences from Practice

This sub-section draws from the data we have gathered from some of the PFI projects that have reached financial close. In the following we concentrate on the pre-decision risk assessment process in 8 cases that we have explored in detail. There are differences of emphasis between the 8 cases we have examined but there are also remarkable similarities. We will first concentrate upon these commonalities in the following and will, in particular, use the detail of the pre-decision processes drawn from Dartford and Gravesham NHS Trust, which was subject to a National Audit Office (NAO) value for money study (NAO, 1999a). The emphasis, in the following, will be on the publicly available information contained in the NAO's final report.

Broadbent, Gill and Laughlin (2003) and Froud (2003) make plain it is in the design and nature of the initial contract where risk definition and allocation is decided and specified. It is in these initial contractual negotiations (between the potential partners to the contract) that clarification of their respective expectations and concerns for the (up to) 60-year relationship will become apparent. In all the cases we examined this whole process was fraught, with extensive involvement by financial and legal advisers for both parties to the contract. In these negotiations the risks and uncertainties discussed in the earlier part of this Chapter are aired and hammered out.

In all the eight PFI cases we studied risks were divided into three broad categories. The first category includes those risks transferred to the private sector. The second contains those risks shared between the private and public sector and the third are all those risks retained by the public sector.

(i) Risks Transferred to the Private Sector

In all eight cases, as would be expected given the processes defined by Treasury and the NHS Executive, the risks transferred to the private sector were costed and formed part of the value for money calculations in the Final Business Cases (FBC). In each case the ex risk net present cost of the PSC was smaller than the PFI alternative. However, when the transferred net present cost of the risk was added to the net present costs of the PSC, the PFI alternative was cheaper than the PSC. The differences varied in magnitude. In the case of Dartford and Gravesham, the original excess was estimated to be £17.2m. However, after the NAO's investigation this was reduced by £12.1m to produce a net saving of the PFI alternative over the PSC of £5.1m (or 3% of total costs). This disagreement is a powerful demonstration of the tenuous nature of this technical calculation²⁷.

In the 8 cases there is remarkable similarity in the nature and relative magnitude of the risks that are transferred to the private sector. Whilst there might be minor differences of emphasis, four sets of risks are transferred. Three of these are in relation to what the NAO, in the case of Dartford and Gravesham, refer to as 'construction cost overruns ... service cost increases ... and risks associated with maintaining the hospital' (NAO (1999a) Appendix 7 p.71). The fourth category is a collection of what can be referred to as 'other' risks, often related to financial or legal matters. The percentage of these four items relative to total risks do differ slightly between the eight Trusts but the Dartford and Gravesham is, within a few percentage points, typical of all the PFI projects we analysed, and is as follows:

Design and Construction	50%
Services	27%
Maintenance	16%
Other	7%

²⁷ It should also be noted that as the original calculation was prepared by one of the 'Big 4' accounting firms there is no evidence of consensus of methods of calculation even at the technical level.

The detailed nature of these different risks is specified in Appendix 4 (on pages 59 to 64) of NAO (1999a). All quotes in the following are taken from this Appendix.

Design and Construction (50% of the total risks; Total: £22m)

- Construction lasts longer than expected
'Pentland²⁸ are not paid until the hospital is finished. They are required to pay the Trust damages for any delay in the hospital completion. Instead the period over which they will earn revenue is reduced to take account of any delay, except in certain circumstances where the delay is not their fault, is due to the Trust or is the result of changes in the design.'
- Failure to provide the hospital to specification
'Pentland have to complete the hospital, and rectify any defects, to the approved specification and design. However it is they who decide when construction has been completed satisfactorily, although the Trust can refer the decision for disputes resolution if they disagree. The Trust will also be able to reduce their payments to Pentland if areas of the hospital are not available for clinical use on its opening.'
- Construction costs more than expected
'Pentland will meet cost overruns unless they were due to Trust changes or certain changes in legal requirements.'
- Adherence to the terms of the planning permission
'Pentland are to build the hospital in accordance with the consents obtained. However, if there are substantial changes to these, the contract can be terminated with no default and the Trust will have to pay Pentland compensation. By February 1999 there had been no such changes nor did the Trust expect any prior to the hospital's opening.'

²⁸ The Special Purpose Vehicle (The Project Company) created to contract with Dartford and Gravesham NHS Trust is called Pentland.

Services (27% of the total risks; Total: £12m)

- Pentland fails to meet performance standards
'Payments to Pentland are reduced except in certain circumstances. Persistent failure may result in the contract's termination, although the Trust may have to pay compensation in this case.'
- Number of hospital areas available is lower than contractually required
'Except in certain circumstances payments to Pentland are reduced if areas of the hospital are not used because Pentland have failed to make them available. Persistent failure may result in the contract's termination, although the Trust may have to pay compensation in this case.'

NB: The NAO note that 'The Treasury PFI Taskforce 1999 Guidance recommends that there should also be partial deductions to payments if areas which are substandard are nevertheless used by the Trust. This is important in the context of a hospital where the operational pressures mean that there is no real alternative for a Trust but to use facilities even when their condition is not up to standard. On this project the Trust can make partial deductions, although they are only very small. The NHS Executive consider that larger deductions could not have been secured at the time this deal was signed.'

- Staff surplus to requirements after their transfer to Pentland are made redundant
'The Trust are responsible for ensuring that the agreed number of staff transfer to Pentland and will meet the costs of any redundancies necessary to ensure this. As at October 1998 the Trust still expect to be able to reduce staff numbers to the agreed levels without the need for such redundancies.'

Maintenance (16% of total risks; Total: £7m)

- The hospital's condition is not properly maintained
'Pentland are responsible for maintaining the hospital and the Trust can reduce their payments if they fail to do this.'
- Maintenance costs increase by more than the rate of inflation
'Pentland's charges for maintenance are indexed each year in line with the Retail Price Index. If their costs increase more than this, they will meet the excess.'

Other: Financial/Commercial/Legal (7% of the total risks; Total: £3m)

- Revenue from alternative sources is less than planned
'Pentland's fee will not be increased if such income is less than expected.'

- Sale of surplus land raises less than expected
'Pentland's fee will not be increased if the sale of these sites raises less than expected. However, the Trust will have to repay Pentland £7.4 million if, for certain reasons, the Joyce Green site is unable to be redeveloped. In certain circumstances the Trust will share in the extra income received if the sale of these sites raises more than expected.'

Cost containment is a key characteristic of these risks. In effect they are indicating that potential cost increases in the various areas listed and under the terms specified are no longer the responsibility of the public sector partner. The assumption is that without the PFI contract the cost of these downside risks would have to be borne by the purchaser (the NHS Trust) if the same level of service was to be provided via a public sector procurement route.

(ii) Risks Shared with the Private Sector

Whilst the nature of the risks that are transferred are reasonably clear, if difficult to cost, those that are shared are not. Invariably these issues are buried deep in the contracts and often part of the 'commercially confidential' information and thus not accessible to public scrutiny. However, sometimes they can be picked up from reports from consultants who were used by Trusts in their risk assessment. The reports that we have seen often link back directly to the list of 20 risks from Annex B in the Health Service Guidance (HSG(95)15 (NHS, 1995))²⁹ clarifying the answers to each of the listed risks as to which are to be transferred, which shared and which retained for the particular Trust in question.

What is clear in that these shared risks reflect the 'best guess' set of problems that might arise along with the agreed levels of responsibility if the 'what ifs' should occur. However, these are not given either any attached costs or any probabilities of occurrence. These are not risks as such but are closer to the uncertainties to which Froud (2003) refers and which, by definition, cannot be given a quantitative probability on which to base a valuation. Interestingly even the proportions of the responsibilities are not specified. All that is stated is if something should happen that falls within the specified terms then any resulting costs involved will be 'shared'. But this does not necessarily imply a 50/50 split. The actual division of responsibility, when something within the terms occurs, will be dependent upon the event in question, how much is involved and negotiations/legal arbitration at the time. These are not specified and, in this sense, they are dealing more with uncertainties than risks.

²⁹ As already indicated in the previous section this Guidance was issued after the last, 1994, 'Green Book' (HM Treasury, 1994). HSG(95)15 was an interpretation of the Green Book for public private partnerships in the National Health Service. These questions are reproduced in Appendix 2 of this monograph.

The 'shared risks' in the Dartford and Gravesham PFI project are drawn together in Appendix 4 of the NAO Report (NAO, 1999a). Again all quotes that follow are taken directly from this Report.

The risks, divided again into the four categories (with 'service and maintenance' combined due to the close linkage between the concerns) that are to be shared in the Dartford and Gravesham PFI project, are as follows:

Design and Construction:

- The hospital's design causes operational problems
'Pentland will be paid less if an unsatisfactory design results in the unavailability of areas of the hospital or the poor performance of the facilities management services, except where an area is unavailable due to the design's non-compliance with legal requirements. The Trust will have to manage any effect on the clinical services, although the reductions in the payments to Pentland will contribute to the extra cost of this'

Services and Maintenance:

- Pentland's costs are no longer in line with market rates
'Pentland's initial charges to the Trust were determined competitively. Once the hospital opens, the charges for all facilities management services except estates and maintenance are re-set every five years at higher or lower levels, if necessary after benchmarking against market rates or market-testing.'
- Impact of Pentland's failure to perform adequately on the Trust's provision of clinical services
'The Trust are responsible for clinical services, although the reductions in the payments to Pentland for their poor performance will contribute to any extra costs the Trust incur providing these services.'
- Maintenance of insurance cover during hospital's operation
'The Trust will meet the costs of insurance cover, apart from employer liability cover for Pentland, since they identified that this would be cheaper than transferring responsibility to Pentland.'

NB: The NAO note that the Treasury Taskforce comment that '... it is normally not now appropriate for Trusts to bear such a large share of the insurance risk on the project during the hospital's operation. Insurance risk – both price and availability – is routinely taken by the private sector because the price of insurance is directly linked to the contractor's performance.'

- Changes in other legislation increase Pentland's costs
'Pentland will meet the costs of changes in corporate tax legislation and legislative changes which were reasonably foreseeable in February 1997 and when Pentland's facilities management changes are re-set every five years. They will also meet the costs of any changes in the first five years in environmental and health and safety legislation, although their liabilities for any extra capital costs will be capped to a maximum of £2 million. The Trust will meet the costs of other changes in legislation.'

NB: The NAO make clear that 'The Treasury PFI Taskforce comment that Pentland's exposure to legislative change is severely limited both in time and amount. They would recommend a more sophisticated mechanism of sharing the risk between private and public sector – perhaps on a sliding scale – in a way which does not impose excessive burdens on the private sector but which nevertheless incentivises both parties to keep cost consequences to a minimum.'

- Improvements in technology make the hospital's design or operation obsolescent
'After 25 years and in every fifth year thereafter, the Trust can terminate the contract if they have decided to close the hospital. Pentland will receive no compensation and will remain responsible for the building for the remainder of the lease of the site.'
- Inflation increases Pentland's costs
'Pentland's fee is indexed each year in line with the Retail Price Index. If their costs increase more than this, they will meet the excess until, for all services except estates and maintenance, the next point at which they can reset their fee levels.'
- Changes in the tax regime increase Pentland's costs
'Pentland will bear these costs except in so far as these changes affect the cost of all services (excluding estates and maintenance) where Pentland can reset their fee levels for these every five years.'
- Changes in Trust staff terms and conditions prior to their transfer increase costs
'Pentland will meet the costs of changes in the terms and conditions of NHS staff generally. The Trust will meet the cost of other changes including the introduction of a national minimum wage and the provisions of the Social Chapter.'
- Demand falls to such an extent that the hospital closes
'The Trust bears this risk for the first 25 years of the hospital's operation. After 25 years, and in every fifth year thereafter, the Trust can terminate the contract if they have decided to close the hospital. Pentland will receive no compensation and will remain responsible for the building for the remainder of the lease of the site.'

Other:

- Corruption on the part of Pentland
 'Although the contract forbids such corruption, the Trust have no right to terminate the contract should it occur. The absence of this right is contrary to Treasury guidance, which recommends that the public sector should retain the right to terminate the contract but only after giving the private sector an opportunity to deal with the corruption. The Trust, however, will be able to sue Pentland for any losses they might have suffered as a result of this corruption.'
- Interest rate movements are different than assumed in Pentland's financing
 'The whole of Pentland's fee is indexed each year in line with the Retail Price Index. Pentland therefore bear the risk that, if their costs increase more than this, they will meet the excess. For the first four years and seven months Pentland have fixed their financing costs by entering into an interest swap arrangement. As the fixed interest arrangement reflects the financial market's views on future interest rate movements, the Trust are effectively bearing the risk that future movements in the RPI exceed the market's assumptions about interest rate movements and Pentland the risk that RPI movements are less.'

Apart from the above general observations about these risks (or uncertainties) there are a further three specific points to emphasise. First, a number of the risks are set within a time context. From the Trust's viewpoint this has positive as well as negative aspects. So, for instance, if costs increase at a greater rate than inflation then there is nothing the Project Company can do until the 5-year point when a renegotiation of fee levels can occur. This highlights the short-term cost containment advantages to the Trust – but this is limited until the point of renegotiation of the contract. However, more negatively, if the facilities prove obsolete or demand falls, there is nothing this Trust can do for 25 years³⁰. Second, and related to the first point, in the longer term the Trust is restricted should there be a marked change in the nature of what constitutes medical care³¹. It is also potentially restricted in its remedies if there is corruption on the part of the Project Company, which might well be more serious relative to the other restrictions. Third, and by way of an extension to the first two points, there is some recognition that entering into this contract brings with it sets of problems and uncertainties, which come from the PFI contractual relationship itself. Thus PFI brings with it what have been called 'system risks' (Beck, 1992). Whilst these 'system risks' are often recognised, despite this recognition, it has still be deemed worthwhile to proceed judging by the number of PFI contracts that are underway.

In this respect, the management at Dartford and Gravesham, as in the other Trusts, chose the PFI option since it offered 'delivery' now even though they had to buy into a defined future pattern of care in an uncertain future. The key point to emphasise is that for longer than the Dartford and Gravesham Trust like to remember there had been attempts to find the resources to build a new hospital without success. The PFI option, when it came, had to be undertaken; the PSC was not a real alternative – the public sector procurement route was actually not available. This somewhat extends Froud's (2003) rightful concern about how undertaking a PFI contract undermines the power of Government to deal with uncertainties such as changing medical care. We would argue it is because the Government will not accept responsibility for this uncertainty that the need for PFI arose in the first instance. If, as in Dartford and Gravesham, there were a genuine public sector alternative they, like the other Trusts, would no doubt have pursued this. Hence, the lack of potential future flexibility in the delivery of healthcare that comes with PFI is the result of the Government's intention to accept such restrictions on the grounds that the perceived benefits outweigh these costs. Whether this will change with the considerable injection of public sector money for capital projects, coming from the Comprehensive Spending Reviews will become clear but only in the future. At the time Dartford and Gravesham entered into the PFI contract it was either PFI or nothing. Put simply and bluntly they chose something, even with the risks associated with this choice, rather than have nothing.

However, taking these policy points aside, the recognition of shared risks is acknowledgement of some important uncertainties in the contract formation process. It remains unclear as to how these risks and uncertainties will be dealt with when, or if, they occur, even though certain directions are provided. The listing of shared risks is simply highlighting the areas where resolution will be required in the future should the foreseen set of difficulties happen.

30 But it is important to note that much the same restrictions applies with a service development supplied and financed through exchequer funding. Admittedly there may be a chance that further funding will be supplied if a clear disaster has occurred and, of course, HM Treasury does have the potential to do this. Yet whether it would have the will to do so, given the demands from other possibly more needy causes, is less clear.

31 Again this could also apply to the public procurement option as well with all the same problems discussed in Footnote 30. The key factor that is now being talked about in all PFI options is 'flexibility in design' to aid the necessity to cover as many eventualities as possible should care patterns change.

(iii) Risks Retained by the Public Sector

Finally, there are a number of risks (or uncertainties), which are retained completely by the public sector partner. Given that these risks are considered in the context of the PFI contract, they are likely to only list those that are in some way related to this contract. They do not, therefore, provide a full listing of all those risks retained by the public sector purchaser.

As with the shared risks/uncertainties those that are retained are buried in the contract detail for all the eight cases but the NAO's depiction of Dartford and Gravesham provides a reasonable portrayal of the typical set of risks considered. As before we have divided these into the same overall categories, except they cover a rather more restricted set.

Services

- The cost of utilities is more than expected.
'The Trust meet all utilities costs since they identified that this would be cheaper than transferring responsibility to Pentland. Pentland are only required to use the energy and other utilities they need to provide the facilities management services as economically and efficiently as possible.'
- There is less need for, or use of, the hospital than planned.
'Pentland are paid for the hospital's availability, not for the use the Trust make of this. However, there may be reductions to the service charge if there are reductions in Pentland's costs in providing these services because of the Trust's decreased usage.'
- Trust staff surplus to requirements at the building's completion are made redundant.
'The Trust are responsible for ensuring that the agreed number of staff transfer to Pentland and will meet the costs of any redundancies necessary to ensure this. As at October 1998 the Trust still expect to be able to reduce staff numbers to the agreed levels with the need for such redundancies.'

Other:

- Changes in legislation specific to the NHS or the PFI increase the Pentland's costs.
'The Trust will meet the costs of such changes.'

These risks/uncertainties are of two different kinds. First, there is a set that reminds the Trust of their obligations in relation to specific details of the contract. Second, they provide a further reminder of the wider uncertainties that fall upon the hospital management in relation to clinical and cost-related NHS organisational changes. These are highlighted in the PFI contract to make absolutely clear that it is the Trust, not the private sector partner, who bears the full responsibilities for these potential uncertainties.

(iv) A Concluding Comment

What this description of practice indicates is a number of important points concerning risk assessment and allocation. First, it shows that the 'Risk Matrix' from the PFI Guidance (NHS (1999) reproduced as Appendix 1 in this monograph) is only a partial picture and aid to practice. A key underlying assumption is that all risks in this Matrix are equal and can, in the final analysis, be costed and hence will feature in the pre-decision value for money comparative model. This links to the second observation: not all risks are quantified many remaining in qualitative form. This ties into the increasing emphasis of both the Government and the NAO that the qualitative aspects of PFI projects need both understanding as well as forming an important element in decision-making – see Section 4.3 for more details. Third, that for those risks that are quantified the single most important risk element is in relation to Design and Construction (50% of the total value for all risks transferred). This is based on the assumption that all construction projects undertaken under the direction and responsibility of the public sector have always been late. The NAO have recently confirmed this point by showing that their investigations indicated that 73% of all public sector constructions were indeed late and over budget whilst only 22% of PFI projects suffered similar slippage (NAO, 2003).

4.2.3 Risk Assessment and the Balance Sheet Question

Risk assessment also plays a major part in the financial accounting decision as to whether the resulting PFI decision (assuming it reaches contract exchange and financial close) leads to some part of it being classified as an asset and, therefore, giving rise to the question on whose (public or private sector) balance sheet it should appear. Whilst this is a separate exercise the overlap with the value for money risk assessment is considerable – see Heald (2003) for more details on this.

Although, at one level, this accounting treatment could be seen as a 'housekeeping' matter – and officials from HM Treasury are increasingly dismissing it in this way – it has caused some considerable consternation in Government circles. These debates and disagreements have been analysed in depth elsewhere (cf. Broadbent and Laughlin, 2002, 2004; Hodges and Mellett, 1999, 2002; Rutherford, 2003). We do not intend to recount these dynamics here but it is worth noting some of the views expressed in the 1999 NHS Guidance, which starts to touch on some of these sensitivities:

'One of the governing principles for PFI is that a successful PFI project must be for the provision of a service over a number of years rather than the purchase of an asset. A PFI contract which is simply the purchase of an asset by the public sector under a financing agreement is likely to offer poor value for money. Whether a PFI contract is the provision of a service or the purchase of an asset by the public sector will also be reflected in the accounting treatment of the transaction ... Where the assessment of the accounting treatment of a transaction is that it should be accounted for as the purchase of an asset on the NHS Trust's balance sheet, then this expenditure is treated in substance as borrowing and will score against the Public Sector Net Borrowing (PSNB). This means that the cost of the asset will be capitalised and charged in the first year of operation against the NHS Trust's External Financing Limits ... The assessment of the accounting treatment of a scheme is a helpful guide to assessing the level of risk transfer and hence value for money of a PFI scheme. Schemes will normally be expected to be able to demonstrate that they will not be on an NHS's Trust's balance sheet. It is critical that the accounting implications of any changes to the basic contract structure are understood before they are agreed. Securing an off balance sheet opinion for an NHS PFI contract is not a simple process.' (NHS (1999) Section 3 Paragraphs 4.1 – 4.3, p.22)

There are some questionable elements in this argument in relation to the macro fiscal implications if asset recognition is the outcome (cf. Robinson, 2000; Hawksworth, 2000; Broadbent, Haslam and Laughlin, 2000). Despite this caveat a number of important points are clear from this quote. First, that wherever possible PFI transactions should be accounted for as purchasing services. Second, that if they register as assets this would have tangible effects on External Financing Limits – this is probably the only unequivocal macro fiscal implication. Third, that risk assessment and allocation is key in determining the accounting treatment which kicks in, as we have seen, to demonstrating value for money. Finally, that being able to secure an '... off balance sheet opinion ... is not a simple process'.

The initial Treasury Guidelines (PFTT, 1997a) developed rules that, in effect, left only a minority of transactions to be considered under SSAP21 and FRS5. Key in considering whether these standards apply related to the potential to separate the PFI contract into property and service elements. The judgement on separability was to find out what should be included for consideration under SSAP21 and FRS5. Even if contracts could be separated the rules as to whether the property element of any transaction could be deemed to be either an actual finance lease (under SSAP21) or in substance a finance lease (under FRS5) were such that few would be either.

The ASB guidelines (issued as an Exposure Draft in December 1997 and then as an Amendment to FRS5 in September 1998) (ASB, 1998), however, involve all PFI transactions falling within the accounting considerations of either SSAP21 or FRS5. This is partly because of a more stringent understanding of what is a separable contract, even though the rather harsher criteria in the Exposure Draft was modified in the Standard (following the extensive discussion that surrounded separability in responses to the Exposure Draft). The judgement on separability is only to find out what should be excluded from consideration under SSAP21 and FRS5 since, even if a contract is not separable, FRS5 immediately is brought into play. It is only the 'pure' service element that is allowed to be excluded. The ASB also have rather more exacting rules as to whether either the separable or non-separable contracts are actual financing leases (under SSAP21) or, in substance, financing leases (under FRS5). The majority of PFI transactions come under consideration of FRS5 and the rules related to:

'Whether a party has an asset of the property will depend on whether it has access to the benefits of the property and exposure to the associated risks. This will be reflected in the extent to which each party bears the variations in profits (or losses) relating to the property. The principle here is to distinguish potential variations in costs and revenues that flow from features of the property – which are relevant to determining who has an asset of the property – and those that do not – and which are therefore not relevant to determining who has an asset of the property.' (paragraph F19 p.12 (ASB, 1998))

The ASB issued its Standard without resolving what arguably are continuing fundamental differences of view with the Treasury. The press release for the issue of the Standard made plain that it was '... for the Government to decide how the Application Note should be implemented by the public sector' (ASB Press Notice 122 p.3). Nevertheless, Geoffrey Robinson '.. accepted the principles published by the ASB' (HM Treasury News Release 146/98, (9 September 1998) (all quotes in the remainder of this paragraph are from the same News Release)) and announced that he was '... putting in hand preparation of new guidance that will apply these principles in a way that will ensure consistency and cost effective compliance throughout the public sector'. This guidance was intended to be available towards the end of 1998 but actually only appeared in June 1999. Some indication of what this guidance should relate to was more than hinted at in this News Release. It was anticipated that there would be '... no retrospective changes to signed deals and those out to Best and Final Offers will not be affected. For newer projects, even with good procurement and delivery times, any changes following the new principles would not have a significant impact until after 2001-02 at the earliest'. Above all it was the view of the Treasury that they do '...not expect capitalisation judgements to change greatly and that the private sector contractor's ownership of the assets will in most instances continue to be recognised'.

The actual Guidance that appeared in June 1999 (PFTT, 1999a) did indeed accept the ASB's Standard but gave it a particular interpretation that, it is suspected, was intended to lead to PFI transactions remaining 'off' balance sheet. However, the original claim that there would be no retrospective analysis of the 250 or so PFI deals was not upheld. Any attempt to avoid this was quashed by the Financial Reporting Advisory Board, which has been formed to monitor and regulate Government accounting practices. The 'revised' Guidance bears little to no resemblance to the original 1997 version. Instead it involves an interpretation of the Standard by concentrating on the key discriminator of 'the extent to which each party bears the potential variations in property profits (costs and revenues that flow from features of the property)' (PFTT (1999a) paragraph 4.4, p.12). In the final analysis, as the Guidance makes plain: 'Determining the substance of transactions is a matter of professional judgement, which involves weighing up all the relevant indicators (both qualitative and quantitative) of which party has an asset to the property' (PFTT (1999a) paragraph 4.4, p.12). The ASB's Standard implies a certain procedural precision in arriving at how the asset ownership can be decided. It is this which the Treasury Guidance makes problematic. These interpretations follow the 'letter of the law' of the ASB but provide an understanding, which will, it was anticipated at their development, lead to PFI transactions remaining 'off' balance sheet. It was also hoped that most of the transactions already entered into would also be in the same position. Certainly for all future PFI transactions the Guidance will constantly be in mind as they progress through to contract agreement to ensure 'off' balance sheet

treatment. Thus the claim that it is '... value for money, and not the accounting treatment, which is the key determinant of whether a project should go ahead or not' (PFTT (1999a) paragraph 1.8, p.3 (emphasis in the original)) is correct yet the accounting treatment is inextricably mixed up in arriving at this judgement. This is because, as the NHS Guidance makes plain, the '... assessment of the accounting treatment of a scheme is a helpful guide to assessing the level of risk transfer and hence value for money of a PFI scheme'. They then go further to argue that: 'Schemes will normally be expected to be able to demonstrate that they will not be on an NHS's Trust's balance sheet' (NHS (1999) Section 3 Paragraphs 4.1 to 4.3, p.22).

The PFTT Technical Note 1 (Revised) (PFTT, 1999a) is a careful interpretation of the ASB's guidance to try to ensure that this is the case. It involves a careful working through of the risks which are highlighted by the ASB and makes clear that the assessment and allocation of these need to involve a mixture of quantitative and qualitative analysis upon which professional judgement must be exercised. The risks, involved in this balance sheet judgement, and hence associated with the 'features of the property' are who bears the variabilities with regard to:

- Demand Risk
- The presence, if any of third party revenues
- Penalties for underperformance or non-availability
- How changes in operating costs are dealt with
- Who determines the nature of the property
- Obsolescence, including the effects of changes in technology
- The arrangements at the end of the contract and residual value risk

(ASB (1998) Paragraphs F21 and F22, p.13)

Whoever bears the majority of these risks is deemed to have asset ownership and, therefore, an obligation to record the amount involved on their balance sheet.

4.2.4. A Concluding Comment

In summary, it is risk assessment and risk allocation which is at the heart of the PFI decision-making process and the balance sheet treatment. It is an area where management accounting is of central importance. With PFI the problems in getting the calculations wrong have far-reaching implications. This brings considerable challenges for management accountants. These challenges become even greater when the demands of PPE systems are added to this agenda – something to which we will turn to in the next Chapter. However, these challenges for management accounting, even at the pre-decision stage are likely to increase even more if and when recent proposals by HM Treasury are operationalised. It is to these changes we turn in Section 4.3 below.

4.3 New Thinking on VFM from HM Treasury

Even as it became clear that the PSC/PFI comparison was to be key in judging VFM doubts were surrounding it. Thus, despite the NAO's seeming support for the Treasury Taskforce's 1999 pronouncement on the PSC (PFTT, 1999) they were actually setting out a rather more qualitative understanding of how VFM should be judged (NAO, 1999). Yet it was not until 2002, when Jeremy Coleman from the NAO, made his rather dramatic comment that some of the comparators are 'pseudo scientific mumbo jumbo' (The PFI Report, July 2002, Issue 65, p.36) that the real differences between HM Treasury and NAO, on the role of PSC, became clear allowing the real messages from the NAO's 1999 Report to be heard. Up to this time there were conflicting messages coming from the NAO on their support for the PSC, making it difficult to see who was the leader and led in support for this criteria (Broadbent and Laughlin, 2003). Jeremy Colman's statement changed all that.

Whether because of this comment or not, what is clear is that now attitudes in HM Treasury are changing and whilst the PSC/PFI comparison remains important, other changes are needed not least complementing the PSC comparison with other criteria, if VFM is to be accurately assessed (HM Treasury, 2003, 2004). HM Treasury puts the case as follows:

'Recent NAO reports have highlighted a number of issues relating to the use of the PSC as an effective appraisal tool, specifically noting that in some instances procuring authorities had treated the PSC as a single pass/fail test to justify the choice of a PFI procurement route, and potentially striven for spurious accuracy. The NAO has put considerable emphasis on the fact that financial appraisal is just one part of an overall assessment of a project's value for money, suggesting that public sector managers should in future ensure that value for money decisions are not based on one-dimensional comparisons of single figures.

The Government believes that a rigorous economic assessment is important to ensure that the right procurement option is chosen on the basis of value for money. The Government agrees with the NAO, however, about the dangers of putting disproportionate emphasis on a single figure comparison. It therefore believes that the PSC continues to have an important role but as the second stage in a three stage process, and needs some reform in itself.' (HM Treasury (2003) paragraphs 7.9 and 7.10, page 80)

Whilst the exact design of this new model is, at the time of writing (May 2004) still evolving a number of dimensions are becoming clearer. HM Treasury are suggesting that there should be a new three-stage procedure for judging VFM. This they describe as the investment, project and procurement stages. How they interconnect and link to previous elements in the procurement process (see Section 4.1 and Figures 1 and 2) is encapsulated in diagrammatic form. This is reproduced as Figure 4 in this monograph. HM Treasury describe the three stages as follows:

– instituting a new assessment of the potential value for money of procurement options when overall investment decisions are being made in the context of the Spending Review, to ensure PFI is only used when it is the best option and has a good prospect of offering value for money;

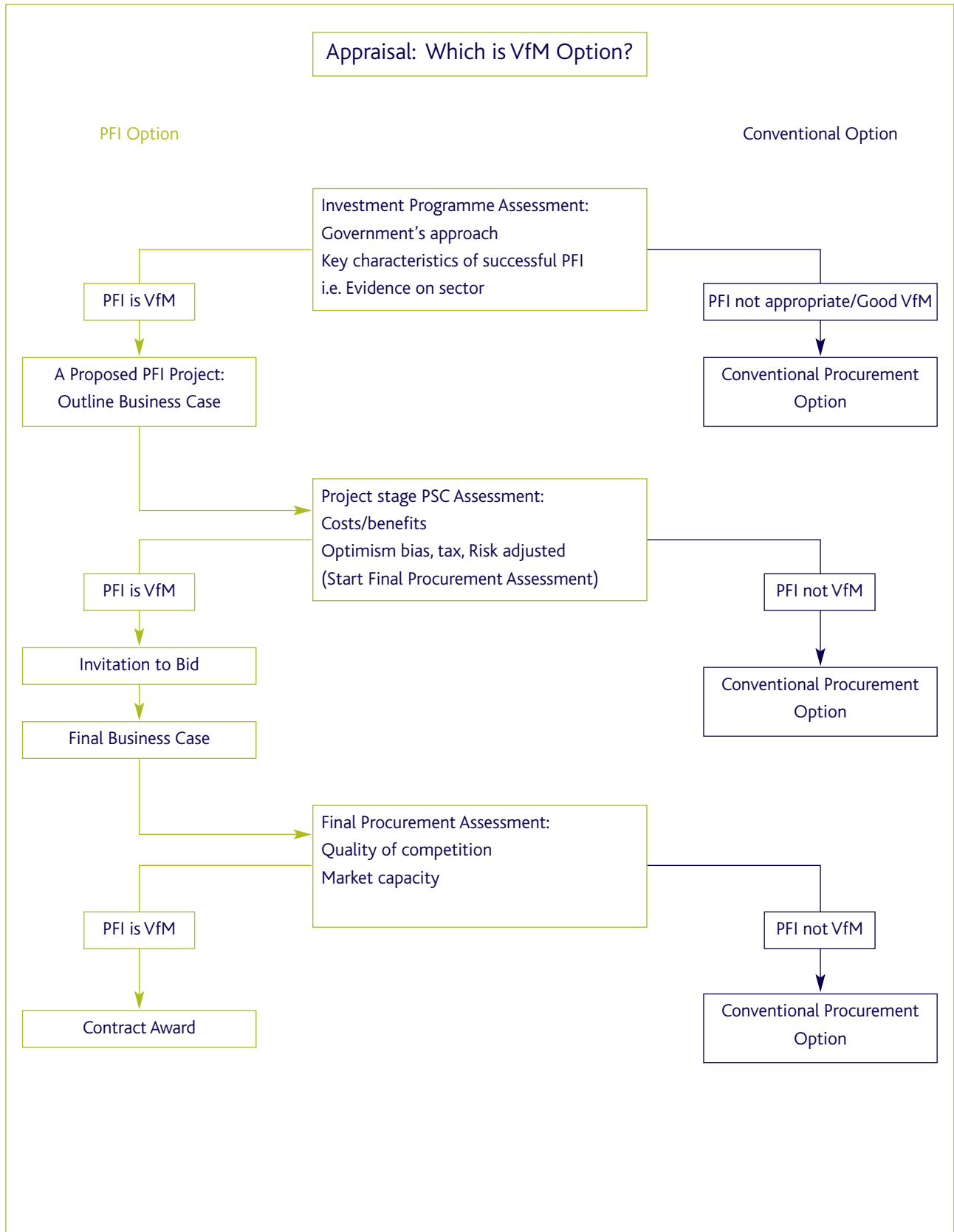
– reforming the Public Sector Comparator (PSC) into an early, rigorous economic appraisal of an individual project at the outline business case stage prior to involving the private sector, to allow projects to proceed down alternative procurement routes where they offer value for money; and

– setting up a final assessment of competitive interest in a project, and the market's capacity to deliver at the procurement stage.' (HM Treasury (2003) paragraph 7.4, page 79)

There are four key changes in these proposals. First, the introduction of a new 'investment stage' set at Department level where decisions as to the level of PFI in an overall investment strategy needs to be agreed and justified. For the 2004 Spending Review, Department's will need to make clear how much of any planned investment programme will be met through PFI and justify this on qualitatively-based VFM grounds. Second, the use of a revised PSC is now shifted from the FBC to the OBC stages and accompanied by more qualitative criteria to judge VFM. Third, a final stage, just before the contract award stage, is now heightened which allows a further reflection on whether the proposed contractor will deliver 'on time and on budget' (HM Treasury (2003) paragraph 1.12, page 3). Fourth, at each stage a qualitative analysis is argued to be as important as a quantitative analysis.

Figure 4: Three Stages in VfM Appraisal

(from HM Treasury (2003) Box 7.2 p.82)



In relation to this final point, even with the further report (HM Treasury, 2004), where the need for qualitative analysis is argued more forcefully, the exact nature of this and how it will be combined with the quantitative analysis remains to be fully developed. So, for instance, at new Stages 1 and 2 the detailed methodology for the qualitative assessment clusters the qualitative concerns around three terms – viability, desirability and overall achievability. The end state after facing a number of detailed questions under each of these headings is to lead to the following judgements:

'Overall, in deciding to proceed with PFI, is the accounting officer satisfied that an operable contract with built-in flexibility can be constructed, and that strategic and regulatory issues can be overcome?

Overall, is the accounting officer satisfied that PFI would bring sufficient benefits that would outweigh the expected higher cost of capital?

Overall, is the accounting officer, satisfied that a PFI procurement programme is achievable, given client side capability, and the attractiveness of the proposals to the market?' (HM Treasury (2004) paragraph 5.2, pages 18 and 19)

With regard to Stage 3 there are two sub-stages – first pre OJEC advertisement and second at the post- OJEC stage. At the pre-OJEC sub-stage 'likely quality of the competition will be key to these decisions' (HM Treasury (2004) paragraph 7.1, page 27). It is also deemed important to return to check again on the visibility, desirability and achievability conclusions from Stage 2. At the post-OJEC sub-stage a qualitative assessment should involve:

'... a series of ongoing 'checks' on value for money. There are three main value for money drivers:

- the quality of the competition;
- the success achieved in transferring to the private sector an appropriate level of risk; and
- the reasonableness and stability of the costs emerging from the competition following an efficient procurement process.

Procuring authorities should also keep in mind the affordability envelope.' (HM Treasury (2004) paragraph 7.7, page 28)

These requirements and how they are going to be combined with the clearer quantitative analysis to direct decision-making is not very clear very largely, so HM Treasury argue, because of the lack of 'evidenced-based' studies of past experiences. HM Treasury are of the view that:

'Collecting information on actual outcomes is key to investment appraisal. This information should be used in appraising all future programmes and projects and should be shared across the public sector. Departments are required to put mechanisms for collating, retaining and sharing information in place from the start of the spending round. Evidence collected and properly interpreted from past experience is fundamental to the development of a rigorous quantitative and qualitative assessment, it is vital that information from all stages of the procurement process, and information from post-implementation evaluation exercises, be collected and shared.' (HM Treasury (2004) paragraph 2.3, p.5)

The difficulty is that this information is not yet available. It is probably for this reason that one of the key recommendations of the 2004 Report is that:

'Departments will be required to hold a series of project and management information, including post evaluation date. This is discussed in more detail in Section 8 (to be added shortly).' (HM Treasury (2004) paragraph 2.4, page 5)

It is interesting to note that neither this evidence nor Section 8's requirements are available which probably is the real reason why the detailed criteria is rather lacking.

The plan is that Stage 1 will be operational during the formation of the Fourth Comprehensive Spending Review due to agreed by Summer 2004, whereas Stages 2 and 3 will be operational from the 2005/06 Spending Round. The suggestions for Stages 2 and 3 are 'open to consultation' which is likely to continue for sometime to come until the practical direction is rather clearer. Whether this tight timetable for Stages 2 and 3 can be achieved depends on how quickly the many detailed issues can be resolved and possibly more importantly the 'evidence-based' learning gathered.

As and when this Guidance is finally agreed the proposals are going to lead to far reaching changes in assessing VFM for PFI. They will, of necessity, lead to major changes in the 1999 NHS Guidance. Until this time comes the NHS Guidance, with its minor changes over the last few years, remains in force.

5 Post-decision Project Evaluation Systems of PFI in the NHS

5.0 Introduction

Post-decision project evaluation (PPE) of PFI decisions in the NHS has at least two dimensions to it – the first is in terms of anticipation and the second the actuality. Much of the material discussed in the previous Chapter is nested within the first dimension. The use of the PSC and risk valuation and allocation has an anticipatory emphasis. In this sense everything we have discussed is leading to or looking forward to the PPE of the PFI development.

Yet the very title of PPE gives an indication of a judgement on worth once the hospital complex is finished and operational. It is here where we have problems since the first schemes are only now coming into service. The gestation period from SOC formation to being in operation is considerable. Table 1 provides a profile of where the 64 PFI projects that are underway in the NHS are in the process leading to completion. What Table 1 makes plain is that, in April 2003, only 21 of the 64 schemes are fully operational, 6 are currently in the build stage, with the remaining 37 at various stages in the process but none having, as yet, reached financial close (after which building can commence). If we see PPE as involving some judgement on operational worth then we are going to have to wait some time to arrive at a judgement as to the effects of PFI in the NHS. Anticipation of effects are likely to be the norm for some time to come.

However, even though it will take some time to undertake a full evaluation, it is necessary to put in place now the systems to allow this judgement to be made. On this the NHS Guidance is remarkably silent even though the recently revised Capital Investment Manual does provide an attempt at a PPE system. The problem is that this applies to all capital projects, independent of the procurement route. Yet it is unsurprising, in some ways, that there is so little in the way of suggestions of how to evaluate PFI, as distinct from publicly funded, schemes. This lacunae is probably not because the Department of Health is unaware of the differences between the alternative procurement routes – having laboured long and hard to produce some specific PFI Guidance, the distinctiveness is recognised. This gap in the Guidance is more likely to be caused by an understandable tendency to be overly preoccupied in making sure the pre-decision making processes are in an appropriate form³². Yet, despite this legitimate and wholly understandable concern, a PPE system for PFI, as distinct from publicly procured, projects is required. PFI projects are different from normal public sector procurement and it is wrong to subsume these in a general framework as is the case with the revision to the Capital Investment Manual. This Chapter develops this argument tracing the management accounting implications coming from such a position.

We use two 'building blocks' to arrive at a possible alternative design of a PPE system. Our first 'building block' is the attempts that have already been made to build a system for a post-decision project evaluation of PFI. This is explored in Section 5.1. The second 'building block' is the PPE intentions of 17 of the 27 PFI projects that have reached financial close and of the actual PPE practices of 8 of the first 21 PFI that are operational. These are explored in Section 5.2. Finally, in Section 5.3 we draw from the contents of these two previous Sections to develop a possible a PPE system suitably developed through some recent thinking from evaluation theory. Whilst the first three sections provide the base for developing a system for PPE they do not indicate how the suggested system might be put into practice. Whilst Section 5.2 depicts current practice, this is not, as will become apparent, the same as the suggestions in Section 5.3. Thus there is a need to think through both the practicalities and, more especially, who would have the authority to adopt and use this PPE in actual PFI schemes. This set of complex concerns is the focus for Section 5.4, which also concludes the chapter.

5.1 Current Attempts at PPE of PFI

There have been a number of attempts to arrive at a PPE of PFI. As we have already made plain the pre-decision processes discussed in the previous Chapter have clear post-decision intentions, due to their emphasis on future quantitative cash flows and qualitative benefits. However, there have been a number of other very deliberate attempts, which are explicitly geared towards a PPE. Yet even though the intentions of these attempts are clear the very fact that few PFI projects are as yet operational makes the claim to be truly 'post-decision' inevitably limited. This is, of course, an inevitable restriction. It is for this reason that the concentration in this Chapter is with the design and focus of a system for a PPE.

This Section is divided into three parts. In Section 5.1.1, what we refer to as the 'single characteristic' systems for making a PPE of PFI, are explored. Section 5.1.2 looks at the work of particularly the National Audit Office (NAO) in their attempt to offer their views on VFM of PFI, with particular emphasis on the health PFI Projects. Whilst the Audit Commission is also active in VFM studies of PFI, their focus, not surprisingly given their primary concern is local government, has concentrated on that level. Their work on PFI in schools is particularly important but, given our concern is with the NHS, our overview of VFM studies in national audit bodies will, therefore, be restricted to the NAO. Finally, in Section 5.1.3, we turn to some of the suggestions that have been put forward for a more 'multiple characteristic' design for a PPE system.

³² It should also be recognised that PPE has generally not been given as much attention as has prior appraisal.

5.1.1 Single Characteristic Approaches to PPE

For convenience we can look at these critiques in two major clusters. First are those that relate to the financial aspects, referred to as the financial evaluation (FE) in this Chapter. Second are the non-financial aspects, which we will refer to as the non-financial evaluation (NFE)³³. Each has a number of sub-themes. In each case cited it is generally assumed that a concentration on the single characteristic alone allows a judgement to be drawn on the merit and worth of PFI.

(i) Financial Evaluation (FE) of PFI in Health

An important criteria for deciding whether to pursue PFI in the NHS rests on the financial case used to justify this procurement alternative. This single characteristic, some have argued, is the real criteria to judge the merit and worth of this procurement method. It should be the total base for a PPE system. Yet, so the logic goes, there are multiple problems involved in the way this financial evaluation is undertaken. Particularly, but not exclusively, these relate to the issues of risk assessment and allocation that raise serious doubts about the value of continuing with PFI.

A key concern of this single characteristic FE is in relation to the robustness and accuracy of the figures in both the public sector comparator (PSC) and the PFI alternative. When the process is over a longer period of time and passes through a number of different stages – as is the case with PFI and the PSC – the estimates and assumptions are likely to be refined and revisited a number of times. This may mean that the argument that was embarked upon at the beginning of the process is not reflected in the final figures. Froud and Shaoul (2001) highlight these issues in some depth and convincingly demonstrate how, even accepting this is the sole and only way to judge VFM, the difficulties are immense. We have already shown this in relation to the case of Dartford and Gravesham where the NAO report (NAO, 1999a) demonstrated that there was a £12 million error in a claimed £17 million surplus in the costs. However, the Trust's financial advisors, a reputable firm of accountants, provided the original calculations. They based their figures on other assumptions. The conclusion is that the process itself is not precise, but is arbitrary at best and, if so arbitrary, gives little credence to the value of the PFI alternative. This is an issue that is now well recognised by the NAO and HM Treasury. In this regard the NAO note in relation to the redevelopment of the West Middlesex University Hospital that 'As with all long-term cost estimates there are inherent uncertainties...' (NAO, 2002a, p. 3). It is, for this reason, that NAO, like others, are moving away from any sole, particularly quantitative basis to judge VFM and, therefore, the design of a PPE system. But this is moving the argument along too quickly.

33 It should be noted that the pre-decision processes for PFI also assume there is a possibility of achieving non-financial as well as financial benefits. In fact, as Section 4.3 indicates, the importance of non-financial, qualitative concerns in pre-decision processes are likely to increase when the new Guidance by HM Treasury (2003, 2004) becomes clearer and operationalised. See also Chapter 6 in relation to our recommendations for an extension of this concern.

This overall concern is complemented with similar doubts related to two other particular areas: risk and the discount rate. Critiques, concentrating on this sub-part of the financial case, come to the same conclusion: the calculations are so questionable that, given the reliance on this single financial characteristic, the VFM argument and hence the value of PFI flounders. We will look at these two major aspects separately below but in many ways these two issues are inextricably intertwined, as one way of dealing with risk is to account for it in the discount rate applied.

The question of risk raises two concerns. First, is the nature of the measurement that is used to quantify risk. This is important not least since the quantification of risk is important for the calculation of the PSC – see above³⁴. Second, is the decision as to who should bear the risk element once it can be appropriately measured.

The problems involved in the valuation and transfer of risk were clearly recognised by an investigation of the VFM of PFI carried out on behalf of the PFTT (cf. Arthur Andersen, 2000). Whilst noting that PFI schemes did provide VFM the report added that risk transfer savings amounted to 60% of the forecast cost savings (Paragraph 2.1 p.3). And, further, that over half of this was aligned to cost over-runs in construction projects in the NHS³⁵. The recent NAO Report (NAO, 2003) provides an argument in support of this claim by showing how over 70% of all projects that were not procured through PFI were late and more expensive. Transferring the downside risks to the private sector through PFI arguably leads to substantial savings. Whether it is the equivalent of 50% of all transferred risks is a little more debatable.

34 It is also required, as we have seen, for accounting purposes to calculate whether PFI schemes should be 'on' or 'off' the public sector balance sheet.

35 This is also borne out by our own study which indicates that in the Dartford and Gravesham PFI project, 50% of its transferred risk was in relation to construction risk and this was within a percentage point or two replicated in the other 7 PFI projects we investigated.

The discount rate used to calculate the net present costs of the schemes is also a focus for critical analysis. This is important in that the cash flows for a conventional procurement are front-loaded and those for a PFI are spread more evenly over the life of the project. Thus differences become amplified in the net discounted costs with changes in the discount rate when cash flows are spread over a long period of time. As Gaffney et al (1999b) demonstrate, small changes in the discount rate applied will vary the outcome as to which scheme is the best VFM. This actually is not allowed to happen as all schemes have, to date, had to use the same discount rate of 6%. There has been considerable debate as to whether this is a sensible rate to apply or not. Gaffney et al (1999b) argue that, as the 6% is above the risk free rate for government borrowing, then some element of risk is already impacted into the discount rate. Thus, they argue, as the PSC already is risk-adjusted, there is some double counting of the cost of risk, to the disadvantage of the public sector. Grout (1997) argues, instead, that the disadvantage of the VFM test is that it is biased against the private sector. This argument is based on the view that for the public sector the risk is based on cost and for the private sector it is based on revenues; the former are lower risk than the latter and hence the discount factors should reflect this. In essence his view is that there should be diversity in discount rates rather than a blanket hurdle rate. However, it is claimed (Arthur Andersen, 2000, Paragraph 2.1, p.3) that the gap between public and private sector costs of borrowing is narrowing as the PFI is understood better and more experience of how it works is obtained.

This ties in with the views that changes in the 6% norm were needed. Both Grout (1997) and Smith (1999) discuss whether the use of more sophisticated models such as the Capital Asset Pricing Model or the Arbitrage Pricing Model could provide a better basis for deciding appropriate discount rates. Sussex (2001) argues that a rate of 4% is a better reflection of the time preference rate. The IPPR report from their Commission on Public Private Partnerships (IPPR 2001) suggests a rate of 5%.

The new 'Green Book' (HM Treasury, 2002) – the Government's Guidance on procurement criteria – has finally recommended that the discount rate should be 3.5%. However, as made clear in Chapter 4, it has also registered that the cost- overrun element, as a risk adjustment, should increase, to avoid any 'optimism bias' in cost estimation. Most commentators suggest these changes will still make the net discounted cost of the PFI more expensive than the net discounted cost of the PSC, despite the greater 'realism' in the discount rate and the risk transfer.

In summary there has been considerable development in the design of the PSC and the PSC/PFI comparison. These developments are likely to continue. The point remains that using the PSC/PFI comparison as the sole pre- and post-decision focus is limited, something with which HM Treasury is clearly in sympathy.

(ii) Non- Financial Evaluation (NFE) of PFI in Health

In the NFE there has been a concentration of three separate areas – any one of which, when used to judge VFM, raises serious doubts about the value of PFI. First, is the extent to which PFI negatively affects bed numbers and clinical care. Second, is in relation to issues of design and how PFI can lead to unsuitable buildings that cannot be adapted due to the long-term nature of the contractual agreement. Third, is the potential problematic nature of the contract itself which links disparate bodies pursuing different goals over a 60-year timeframe. We will look at each of these in turn below.

On bed reductions it has been argued that in order to be affordable, it has been necessary to reduce the bed numbers in PFI Schemes. Therefore, the assumption is that, because of this, PFI cannot be VFM. The reductions started from a peak of 250,000 beds in 1960 – well before the start of PFI – were a deliberate national policy but have recently been reversed (Department of Health, 2000). However, Pollock et al (2001) show that average bed-reductions in the first 14 schemes were of the order of 33%. The work of Alyson Pollock and various associates (see for example Gaffney, Pollock, Price and Shaoul, 1999a, 1999b, 1999c; Pollock, Dunnigan, Gaffney, Price and Shaoul, 1999) majors on this concern.

Clearly there has been a considerable reduction in bed numbers in recent years but arguably this is not the result of adopting PFI, or any alternative form of procurement, but is due to changing medical and policy initiatives (cf. Coates, 2000). In the recent past, shortages of NHS funding had led to hospital management using the closure of wards as a means of reducing expenditure and, as a result, not all the capacity available has always been used. This has been accompanied by changes in medical technology and attitudes to what is appropriate care. The use of day care surgery has grown over the last 30 years. There has also been a move to seek to develop a more community-based focus and to differentiate intermediate and acute care. This has all been accompanied by the desire to use 'managed care pathways' (ACCA, 1999) as a means of developing protocols to ensure integration in the delivery of care for patients being dealt with in multi-agencies. Thus it is policy and technology changes that have driven an overall policy desire to reduce the provision of beds and not PFI. This is borne out to some extent by looking at the very few publicly funded hospitals (see Table 1 for details) built during recent years all of which have reduced bed numbers. This policy, however, has now been reversed and it is interesting to note that beds in one of the flagship PFI hospitals (Norfolk and Norwich) has actually increased its bed numbers by 144. Clearly the design of the original hospital had scope to undertake this expansion.

Mayston (1999) alerts us to the way in which questions of affordability impinge upon this issue. The long-term affordability of a PFI scheme is supposedly tested, in theory and practice, in the context of the option appraisal of the PFI procurement route against a Public Sector Comparator (PSC). Over the entire life cycle of the scheme, provided that the figures are robust – which, given our discussion above, is a brave assumption – PFI should be cheaper, in the long term, than the public sector alternative or it will not be the chosen route of procurement. Adherents of the PFI approach would therefore dismiss the charge that the PFI option is more expensive over the longer term and because of this fewer beds can be afforded. The argument is that the PSC, with a similar output specification in terms of beds and other medical requirements, is actually more expensive over the longer term. There may or may not be short-term affordability problems but even here it is claimed that money will be found to cover any additional costs (see General PFI Question and Answer Briefing – <http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnerships/>)

Whilst it is, therefore, problematic to see PFI as causal in the reduction in bed numbers, it is in relation to this area that the controversies about PFI have had most impact. What is clear is that the issue of bed reductions has a great impact on the perceived legitimacy of PFI. This was clearly recognised by the House of Commons Health Committee in their Report on the 'Role of the Private Sector in the NHS' (House of Commons (2002)) who maintained that '... there was no connection between PFI and bed numbers' but then went on to make clear that 'What is not in doubt is the fact that the lack of transparency in the PFI process has been partly responsible for the impression that PFI can be equated with a reduction in the number of beds' (Recommendation (r)). This has not been helped by the views of the research team from University College London's Health Policy and Health Services Research Unit (HPHSRU) headed by Professor Alyson Pollock who have consistently made these connections and are still doing so. This is despite the rather damning comment by the House of Commons Select Committee that they '... were unimpressed with much of HPHSRU's research and its arguments against the Private Finance Initiative' (House of Commons (2002) paragraph 65).

Turning to design issues, in the Outline Business Case (OBC) and Full Business Case (FBC) the analysis conducted specifically considers this important issue. At the OBC stage this is used in the comparisons of the different design options to resolve the service problems. At the FBC stage it is used as part of the comparison of the procurement of the preferred option (i.e. a comparison between the PSC and the PFI alternatives). Along with bed numbers this is the other area of NFE that has raised explicit critical discussion in the academic and popular literature as well as being used to judge VFM. This is considered in two ways. First, that the claimed justification for PFI is that VFM will be achieved by efficient working practices as the private sector will introduce

innovations in service delivery. Second, that because of the fact that the private sector will own³⁶ the hospital buildings, as well as running and maintaining them, they will, therefore, be more careful about design and build quality.

Both these elements are difficult to substantiate certainly before the hospitals are commissioned and operating but there has been some comment on the existing projects. Sir Stuart Lipton, the Government-appointed 'architecture tsar', was reported in the Observer (20th August 2000) as being critical of the design of the first 15 hospitals. He noted that the designs were 'not uplifting and won't do anything for society'³⁷. More concretely it was noted that in the Swindon project, the theatre and post-operative recovery rooms were 80 metres apart and this was seen as dangerous to patients³⁸. The Observer also reported in the same piece that the need for speed in the design process and the emphasis on cost had been criticised as disadvantageous to good design by architects at a King's Fund think-tank symposium. The benefit of introducing shorter time scales in bringing the design to completion is interesting and the evidence is contradictory. Cost over-runs are often associated with longer cycles of planning to completion, but this can lead to difficulties in consulting stakeholders and thereby optimising design.

Building design (apart from clinical adjacencies – see footnote 38) is primarily a private sector responsibility but is given direction by output requirements. The public sector is required to provide the private sector contractor with an output specification of what services are required. The private sector supplier then is intended to be free to design the services, which invariably includes a building, which meets these output requirements. It is the same output specification that is used for the somewhat surreal design of the Public Sector Comparator, which is used in comparison with the PFI alternative. This is invariably not the same building, procured differently, but a completely different building, which is an imagined alternative to satisfy the output requirements and used only for comparative purposes. Therefore, a vital element that impacts on the value of the ultimate PFI design, is the accuracy and workability of this original output specification.

36 Subject to the financial accounting treatment giving asset ownership to the private sector (cf. Broadbent and Laughlin, 2002, 2004)

37 As a reviewer to a previous draft of this monograph pointed out this criticism needs to be treated with some caution. Apparently in 2003 Norfolk and Norwich PFI hospital was nominated for a design award by a Committee chaired by Sir Stuart Lipton, suggesting he might have had a change of view or at least, if he had not changed, a view that was not shared by all.

38 As this same reviewer indicated this too should be treated with some caution. As he makes plain in his review '...clinical layout is a risk for the trust to sign up to. Thus, in terms of risk allocation, clinical adjacencies is a trust risk, not a private sector risk. The distance between the operating theatres and recovery rooms at Swindon must have been one that the trust themselves were content with.'

One final issue concerning the NFE of PFI relates to the issues related to the contracting and partnership relationships. The process of negotiation that is undertaken in agreeing the contract is based on an adversarial relationship whereby each party must look to securing its position in the case of the contract failing. Contracts for PFI are for periods of between 30 and 35 years, which can be extended to 60 years, and although there is an assumption that the contract will attempt to reflect all the aspects of the future relationship this is clearly impossible. The issue of social relations is important and it should be recognised that the motives of the NHS are not assumed to be built on profit, but those of the private sector are. The assumptions each party makes about each other are built upon the resulting prior typifications.

Given this understanding of the contracting parties two polarised views have arisen. The first maintains that the values between the two parties are unbridgeable and, if this is the case, PFI is fundamentally flawed. An alternative more positive view is that, despite these fundamental differences, both parties will have to find ways to make the relationship 'work'. The NAO are of this view: building effective partnerships and relationships is one of the key proposals of a recent report by the NAO (NAO, 2001) on the successful operational of PFI projects. We have also made the argument (Broadbent Gill and Laughlin, 2003) that the contracting process will inevitably move to being a relational one (Campbell, 1997) in which there is an approach to contracting based on social relationships and elements of goodwill trust (Sako, 1992) to avoid potentially constant recourse to contractual obligations and possible legal arbitration.

(iii) A Concluding Thought

Our view is that no one of these single characteristics alone can be used to provide an all-encompassing framework for a PPE. Many are necessary but none are sufficient on their own to constitute this framework. This is partly because they deal with different aspects of the issues. But also because many are trying to draw conclusions on the VFM judgement when the information to make this decision is incomplete.

In addition, as we have already suggested, some of the VFM critiques are not the result of PFI alone. The bed reduction issue and the discount rate arguments are of this type. The bed reduction issue is a national policy issue, driven by some factors that are unrelated to the procurement method for services (the national trend to reduce bed numbers). The discount issue is clearly controlled by HM Treasury, therefore, is something that is outside the power of any individual NHS Trust. Trusts must use the accepted rate.

There are, however, within these critiques, three pointers as to what is important for a PPE. First, that there is a need to concentrate on only those elements that are unique to the particular procurement route of PFI. The peculiar comparison with the PSC, the risk valuation and transfer, the design and contracting issues are all elements unique to PFI. Second, it is not just financial aspects that need to be taken into account but also non-financial elements as well. The two need to be taken together to arrive at judgements concerning VFM both at the pre- and post- decision stages – a view which is increasingly being accepted. Third, that single point-estimates of VFM, certainly prior to proceeding with the PFI option, are always going to be incomplete. With contracts lasting up to 60 years a long-term evaluation is required. Clearly at the point when the PFI option is compared with the PSC the former can be shown not to be VFM and will not proceed. Similar points apply even when this is developed to include qualitative criteria. But there is considerable leeway in the quantitative and qualitative estimation process to avoid this happening. Therefore, any definitive conclusion derived from the accounting figures that accords a claimed accuracy to the accounting numbers is something which the critical, interdisciplinary accounting community have long been demonstrating is highly suspect.

5.1.2 Institutional VFM Studies by the National Audit Office

As indicated in Chapter 2, the National Audit Office (NAO) has been involved in VFM studies of PFI since 1995. To date they have published 30 different studies with a further 5 that are underway (at the time of writing in May 2004) under the generic title of 'public/private partnerships' (PPP). As PFI is by far the most dominant of all PPPs the overall emphasis in all these studies are PFI projects. Of these 35 studies, 31 are specific VFM studies of PFI projects, whilst the remaining 4 have a more generic policy-related emphasis.

Although the NAO by law has no right to challenge Government policy this does not mean that it cannot offer policy-related advice. Of the four studies that we would see as broadly policy-related, we have already looked at (in Chapter 2) the NAO's important Report on how they judge VFM (NAO, 1999). Our argument in Broadbent and Laughlin (2003) is that this has had more than a passing effect on Government policy with regard to giving PFI a micro VFM emphasis in its nature. Our view goes further and suggests this NAO Report might well have provided a 'legitimacy' to this Government policy even though now the distance between HM Treasury and the NAO is rather more distant – see Section 4.3 for more details.

The remaining 3, of this set of 4 Reports, are concerned with 'managing the relationship to secure a successful partnership in PFI' (NAO, 2001), 'refinancing' of PFI deals (NAO, 2002), 'construction performance' (NAO, 2003) all have a similar policy-related emphasis. We have already looked at the 'construction performance' NAO report, which provides evidence to support the surmise that public sector procurement invariably takes longer and costs more than anticipated. This has had more than a passing effect on the changes in discount rate and higher levels of risk assessment to avoid 'optimism bias' contained in the new Green Book (HM Treasury, 2002). In the same way the 'managing relationships' report provides details of a survey of PFI projects, which emphasises the importance of qualitatively-defined and genuine 'partnerships', and all that means, if PFI contracts are to be successful. This Report has extensive advice on how this might occur which it wants the Government and Departments to hear and hopefully act upon. Similarly the 'refinancing' Report, which explores the ramification of the fact that once the building work for any PFI project is complete, and risks are reduced, it is possible for the private sector partner to renegotiate a rather less expensive financing deal from banks, and other financing sources, leading to potential substantial savings. In July 2002 the OGC advised that these savings should be split 50-50 between the private and public partners. The NAO Report aimed to see how many formal contracts of PFI projects allowed for this possibility. They found that 61% had no provision. This, in turn, has led to advice to the OGC that the PFI standard contract needs to be changed. Rather than being critical of Government policy – which it is not allowed to do – it can lend support but also in the process, legitimise Government policy.

Of the remaining 31 studies these are all related to specific PFI projects in a range of Government Departments only 3 of which relate to projects in the NHS. These are Dartford and Gravesham NHS Trust (NAO, 1999, forthcoming) and West Middlesex University Hospital Trust (NAO, 2002a)³⁹. As Table 1 indicates Dartford and Gravesham's PFI and West Middlesex are both fully operational. What is interesting about these two NAO Reports is the different emphasis that comes across in how the NAO conducted their VFM evaluation. We will turn to this below but, put simply and directly, in the earlier, Dartford and Gravesham, study the concentration on the quantitative accuracy of the PSC comparison and risk assessment played a much more major role than any emphasis on qualitative benefits. In the West Middlesex Report the total opposite is apparent.

³⁹ There is also an intention to undertake a more general analysis of the PFI projects in the NHS similar to the study that the NAO undertook with regard to PFI projects in prisons (NAO, 2003a). Whilst this has not been announced on the NAO website it is known that the NAO are widely consulting with many people (including ourselves) about how best to undertake this wide-ranging study.

This emphasis on the more quantitative financial benefits was apparent in the Dartford and Gravesham PFI Press Release for the NAO's Project Report when it was indicated that:

'The National Audit Office found that:

- The contract is likely to deliver the services the Trust wanted.
- Additional financial support is required to meet the costs of the new hospital ... additional financial support of £4m will be needed. The Health Authority and the NHS Executive were nevertheless satisfied that the new hospital remained good value for money and offered significant health benefits;
- The PFI deal is expected to deliver additional non-financial benefits compared with traditional procurement. This is because the timetable for bringing the new hospital into operation (September 2000) is considerably faster than most publicly financed hospitals. Other benefits include innovative design and the opportunity for the Trust to concentrate on delivering clinical services rather than building maintenance and support services.
- There is uncertainty as to the exact level of savings, if any, that will be achieved. The Trust had estimated that the PFI deal would deliver savings of £17 million or 9 per cent compared with traditional procurement. The costs of the public sector comparator were overstated by £12 million, reducing the estimated savings to £5 million or 3 percent. While this does not affect the reasonableness of the NHS's decision to proceed with the PFI option, there is a greater possibility than the Trust estimated that the PFI solution could prove more expensive than traditional procurement.
- The procurement was not fully competitive but the Trust benchmarked most of the costs. The Trust received only one bid ... The Trust sought to address the absence of competition by benchmarking most of Pentland's costs but the contract terms eventually agreed arose from a period of negotiation over twelve months rather than through competitive bidding.' (NAO Press Notice 39/99, 19/5/99)

What is clear from this is that the comparison with the PSC was crucial – even though the Trust apparently got the calculations wrong. This even offsets the additional year-by-year revenue cost – since the total revised calculation still gives a saving over the PSC. Apart from concentration on the financial analysis, the NAO also made a number of interesting points in relation to non-financial benefits – albeit these appear more in passing. Early completion of the building and the lack of having to worry about providing effective and efficient building maintenance and support services and the consequent greater time to concentrate on clinical services are seen as key non-financial benefits. It should be noted that the NAO, writing in early 1999, before the building was completed and certainly operational, could only surmise that these benefits would arise. It is possibly for this reason that the NAO have now returned to Dartford and Gravesham to see how the contractual relationships are performing and developing.

Interestingly the Public Accounts Committee (PAC) when they considered the NAO Report on the Dartford and Gravesham PFI project concentrated their attention primarily on the need for more rigorous cost estimates. They also raised some questions concerning the costs of the advisers who had supplied the advice on costs in the first place. The headline conclusions of the PAC were that:

- 'The NHS failed to estimate correctly the costs of this long-term contract;
- Value for money comparisons must be rigorously checked;
- Departments must understand the full range of risks and potential rewards available to the private sector when negotiating contracts;
- The NHS must use its experience of the PFI to drive down advisers' costs.' (Select Committee on Public Accounts Twelfth Report, 29 March 2000, Paragraph 7)

Thus, to the NAO and to the PAC, based on the Dartford and Gravesham report, the key basis for a PPE is in relation to seeing whether the cost estimates are accurate and realised. However, the NAO, and to a lesser extent the PAC, were also interested in what they refer to as the non-financial qualitative benefits. Both parties were, however, fully aware of the problems involved in the assessment of these qualitative benefits both generally as well as prior to full operation of the new hospital complex.

In the NAO Report on West Middlesex (2002a) the financial emphasis is a rather less intense focus whilst 'wider benefits' are given more prominence. It is possible to go further and note that there are hardly any actual figures provided either in the body of the text or in appendices – unlike the case with the Dartford and Gravesham case. Perhaps a few quotes from the Executive Summary can provide something of the change of emphasis that has occurred in the VFM studies of NHS PFI projects:

'It is government policy that some hospitals are going to be built and managed as PFI contracts' (Paragraph 1 page 1 from NAO (2002) (NB: all quotes that follow come from this Report))

'The Trust judged that the bid offered the best value for money with particular strengths in design, proposed timetable and personnel issues.' (Paragraph 7 page 2)

'In this project the Trust considered the benefits of the PFI approach outweighed the disbenefits. The Trust placed particular emphasis on the fact that the contract would incentivise Bywest (the Project Company) to complete the redevelopment quickly and with price certainty, to maintain the buildings well and to deliver the required standard of service during the 35-year contract period. The Trust has sought to manage the risks of a PFI contract by building into the contract some flexibility and arrangements to test that any contract variations are value for money.' (Paragraph 10 page 3)

'Both the Trust and its advisers KPMG considered the PFI option would deliver value for money taking all benefits and disbenefits into account. But they had concerns about the accuracy of the initial financial comparisons ... (Paragraph 11, page 3)

'The final calculations showed a risk-adjusted saving from using the PFI of £5.5 million compared with a PSC, including project risks and clinical costs, of £989 million over 35 years (Net present values). As with all long-term cost estimates there are inherent uncertainties in this comparison, and particularly regarding the size and the adjustment for risk.' (Paragraph 12, page 3)

'In this project the financial comparison was not clear-cut. The attention given by the Trust to the figures shown by the financial comparison may have masked evidence of important wider benefits that the PFI approach was expected to secure.' (Paragraph 13, page 3)

What the above quotes hopefully demonstrate is an overall flavour of the nature of this Report and how different it is to the NAO study of Dartford and Gravesham. The task is to acknowledge the financial comparison and the inherent inaccuracies in the construction of these figures but a clear recognition for a more 'all rounded' approach to arrive at a VFM judgement. Gone are the days of trying to correct the figures from the comparison with the PSC, as was the case with the Dartford and Gravesham case – instead a more balanced financial and non-financial view seems to be appearing.

This more balanced view recognises a number of things. First that PFI is a Government policy and priority that needs to be made to 'work'. Second, that taking the financial case as a sole basis for judging VFM is too simplistic. Third, that the financial comparison with the PSC is fraught with difficulties and this needs to be recognised rather than adjusted on the basis of questionable logic. Fourth, that the non-financial benefits need to be more apparent, are of equal importance to the financial analysis and need to be key in judging VFM both in the pre-decision process as well as in PPEs.

As indicated in Section 2.4 this change in emphasis is clear in their 1999 Report (NAO, 1999). Getting a 'good deal' from multiple primarily qualitative but also quantitative perspectives – built on 'four pillars' as they argue – is how they judge VFM. In this sense it could be argued that the original Dartford and Gravesham study is based more on 'old' thinking by the NAO and the West Middlesex study on their 'new' model for judging VFM.

Therefore, unlike the single characteristic approaches to PPE considered in Section 5.1.1, the NAO are now adopting a more multiple characteristic approach. It is quite probable that their 1999 'four pillars' Report is not the final word on the matter and it is known that they are currently undertaking a wide-ranging review of this framework. This development has been possible due to a growing distancing from the use of PSCs as the key or even very significant way to judge VFM. This change has had an effect on the thinking of HM Treasury even though the PSC remains important to them. It remains a very important part, rather than only element, in the criteria to judge VFM. Whilst the NAO cannot directly comment on policy, it has the possibility to affect policy direction through its generic reports, which provide guidance on how they will judge the outcome of policies. But the relationship between HM Treasury and the NAO is complex and there does appear at the moment a genuine distance between the two – each developing a rather different perspective on how to judge VFM which was not apparent previously (cf. Broadbent and Laughlin, 2003). However, as HM Treasury is the legitimate authority for policy development it is to their views that will no doubt predominate.

5.1.3 Other Multiple Characteristic Approaches to PPE

The NAO, are not the only organisation which seems to now be clearly taking a multiple characteristic approach to PPE. There have been at least three further calls for this move from different sources – one of which is more detailed than the other two.

The Arthur Andersen (2000) (AA) Report⁴⁰ builds their own survey of views of public sector project managers with a range of their own ideas to arrive at a quite detailed approach to PPE. Their analysis develops key findings about value for money analysis as well as making a range of recommendations about how value for money should be judged in the future. There are a number of findings from their study but four stand out of central importance – the use of PSCs, discount rates, risk transfer and service performance. In the following we will look briefly at each of these areas apart from their concerns about the discount rate. In the new Green Book (HM Treasury, 2002) the AA's recommendation on discount rates has been, in effect, given unequivocal acceptance.

In terms of PSC's they conclude:

'The average percentage estimated savings against the PSC for our sample of projects was 17%. On the basis of the public sector's own figures, the PFI therefore appears to offer excellent value for money ... It is important also to recognise the limitations of the exercise. A PSC provides a one-off snapshot of the value for money of a PFI project. It gives the answer to the question, given what we know now, is the PFI option likely to deliver best value for money? But in the absence of subsequent monitoring of contractor performance and contract payments against the assumptions made at the time the PSC was compiled, a firm view cannot be taken about whether value for money is being delivered in practice. To assure continuing value for money, public sector project managers will need to make full use of the provisions that now commonly feature in PFI contracts for periodic benchmarking of project costs ... We would also note that the PSC does not normally include an allowance for pre-contract costs such as advisers' fees ... we consider that the costs should be factored into the value for money equation if it is to properly reflect the relative costs of conventional and PFI procurement.'

(Arthur Andersen (2000) paragraphs 2.1, 4.68 and 4.69, pages 3 and 39)

This argument raises questions about the contents of the PSC as well as the need to look at this calculation on an ongoing basis to really be able to judge value for money.

⁴⁰ This was before AA was disbanded following their close association particularly with Enron but also WorldCom.

On risk valuation and allocation the AA Report highlights the sensitivity surrounding this process as well as the need for clear guidance to be derived:

'Of the 17 projects, the projection that the project would deliver value for money is entirely dependent upon the risk transfer valuation in six cases. In three of these six cases ... a 20% reduction in the risk transfer valuation would have led to a different decision about whether the PFI option offered better value for money. Risk Transfer valuations accounted for 60% of the total cost savings forecast for the 17 projects ... We consider it is important that individual departments should issue guidance from time to time on the valuation of risk transfer, particularly with regard to construction cost overruns on traditionally procured projects (including post completion rectification and maintenance costs) within the sector. The figures used in PSCs should relate to the actual experience of projects with similar characteristics. Project managers should be expected to use these valuations within their PSCs unless they can point to substantive justification for employing a different figure.' (Arthur Andersen (2000) paragraphs 5.9 and 2.7, pages 54 and 4)

Clearly the NHS has done more than many Government departments to address this concern but the argument of the AA Report is that there is still much to do. Risk valuation and allocation needs to become more accurate very largely because of its immense importance for the value for money judgement. This also needs to be considered in the light of the need to revise the PSC over time – a similar point applies to risk valuation and allocation.

Finally, the AA Report returns to the importance of monitoring the more non-financial benefits and tracing the linkages of these to the financial costs and benefits over time. Drawing from the comments of Project Managers the AA Report concludes:

'... the jury is still out on the extent to which PFI contracts will deliver the benefits promised. We think there are reasonable grounds for optimism. But a lot more work needs to be done on gathering operational information. This should cover several areas:

- the level of penalties being incurred by contractors in relation to performance that is deemed to be below the required standard. This will help understanding of whether incentives are working in practice;
- logging the performance of individual contractors and making it known to other procuring authorities whom are the best and worst performers. It is in the public sector's interest that success should breed success and that the lessons learned are captured and fed into the procurement of new projects ...

- capturing information on actual costs and benefits compared to the business case assumptions; and
- sharing practical information on best practice in measuring and incentivising performance.

We are not aware of any systems in place on a central basis to capture this information both within and across sectors. We would recommend that the benefits and practicalities of such a benchmarking system be investigated. The ongoing measurement of performance on PFI contracts will be critical in demonstrating value for money to taxpayers over the term of these contracts.' (Arthur Andersen (2000) paragraphs 4.41 and 4.44, pages 29 and 30)

Again the AA Report makes clear that value for money is not a once off judgement but one which needs to be made over time and not just in terms of directly financial benefits and costs. They make clear that one of the key elements in making this value for money judgement has to include the way the PFI contract is operationalised particularly in relation to the effectiveness of the facilities management provision to the NHS Trusts over time.

Whilst the AA have defined in broad terms what might form the basis for the design of a PPE system further developments are provided by the Institute for Public Policy Research (IPPR) in their major Commission on Public Private Partnerships (PPPs) (2001). The overall thrust of their argument is apparent at the start of their report where they maintain that in judging VFM '... prejudice and anecdote have tended to dominate analysis and evidence' (IPPR (2001) p.1). Their approach is to avoid two 'intransigent perspectives on public-private relations' (IPPR (2001) p.1) and hence the 'blind alleys' of the 'privatisers: private good, public bad' and the 'monopolists: public good, private bad' (IPPR (2001) p.20, 21 and 23). Instead the IPPR present a four step 'evidence-based' approach: first, to remake 'the case for public funding of services' which is to prevent the doubters that being open to experiment is intended to deny the fundamental importance of public provision of public services; second, to 'distinguish funding from provision' and so to concentrate on service quality rather than the funding route; third, to be 'open minded about the case for partnership and diversity' to avoid dogged entrenchment and fourth, to be clear to establish the 'criteria for assessing partnerships' so that meaningful judgements can be made (all quotes from Chapter 1 of IPPR (2001)).

On the final point they put forward a wide-ranging approach to this challenge yet sadly, in their interpretation, keep returning to a more narrow financial focus. The IPPR's overarching stance is clearly captured in the following, which gives particular emphasis to the pre-decision processes but also implies a post-decision concern:

'If a project is not expected to deliver value-for-money then it should not proceed. Making a reality of this statement requires two things. Firstly, there needs to be a shared understanding of what the term value-for-money actually means. It does not focus only on cost-effectiveness in the delivery of public services. The concept of value-for-money gives equal weight to quality considerations: it is the optimum combination of cost and quality in meeting the needs of service users (discussed in Chapter 4). Achieving value-for-money should be about identifying the most cost-effective way of securing a high quality service – if the quality of a service deteriorates then a partnership has failed. The second requirement is that there needs to be a credible and transparent procedure for determining whether or not value-for-money is being attained.' (IPPR (2001) p.32)

Unfortunately, whilst this indicates a clear call for an approach which balances all key factors involved, and leans towards more 'analysis and evidence' than 'prejudice and anecdote' there is still an uncertainty as to how exactly to interpret such a high ideal. The interpretation, particularly in Chapter 4 of IPPR (2001) – see reference to this in the above quote – deals with the non-financial elements only briefly, concentrating, almost exclusively, on the financial elements. Yet, at least, the IPPR are advocating a broad-based approach even if they may not, at this stage, have the detailed answers to the questions and concern they pose.

The final call to a multiple perspective approach to PPE is in the House of Commons Health Committee Report (House of Commons, 2002). The Health Committee does not offer specific solutions but, as with the IPPR, their intentions are clear:

Recommendation (q)

'PFI is still being blamed for numerous ills not directly related to it whereas the many benefits ascribed to PFI have yet to be proved. The time has come for a more rational and objective debate, and it is the responsibility of the Government to take the lead in achieving this. In order to achieve this there has to be more transparency, openness and accountability.'

The Government's response to this is also clear:

'The Government welcomes the call for a more rational and objective debate about the Private Finance Initiative (PFI), and accepts the Government's role in this. The Government will continue to provide as much information as possible in response to inquiries and reports, for example to this Committee and the National Audit Office' (Department of Health (2002) p.18)

Little is provided either in the Committee's Report or in the Government's response as to either the detailed nature of this PPE or how they might proceed but their intention is clear. It needs to be broad-based and not narrowly focussed on just the financial concern and that the Government does see it as their responsibility to provide policy advice on this. They have started to do this through the Guidance from HM Treasury (HM Treasury, 2004) and their call for 'evidence-based' criteria to be formed. But as indicated in Section 4.3 there is a long way to go in achieving this.

5.1.4 A Concluding Comment

There are two points that come from the contents of this Section and the studies that we have discussed. First, that a single characteristic approach to PPE is inappropriate. Based on these studies a single characteristic often means the financial element and given all the problems involved in this calculation and comparison with the PSC this concentration is likely to lead to spurious judgements – something which is (now?) clearly recognised by the NAO and HM Treasury. Second, PPE of PFI is such an important activity it needs societally significant institutional bodies to be actively involved in ensuring that it is undertaken. If we follow the Health Committee's recommendations it should be Government – which they have confirmed is the case. Alternatively given that this does come within the societal remit of the NAO it could be that the work they are already doing is already fulfilling, or should fulfil, this requirement. But before exploring this further we need to look at our second building block on intentions and practices of PPE (Section 5.2) before getting to our views on what should be the design of a PPE system (in Section 5.3). We can then turn to a consideration of whose responsibility it should be to operationalise this system (to be explored in Section 5.4).

5.2. PPE Systems in Practice

This second building block relates to the anticipated and actual practices of NHS Trusts for their PPE systems. This is the focus of the current Section. It is divided into two parts. First, it looks at the PPE intentions of NHS Trusts for their PFI projects contained in their Full Business Cases (FBC). This is explored in Section 5.2.1. Section 5.2.2, on the other hand, looks not at intentions but the actual practices of NHS Trusts whose PFI projects are already operational. Section 5.2.3 brings together some of the key themes that comes from this important excursion into practice.

5.2.1 PPE: Evidence from the Plans from Existing NHS PFI Projects

Table 2, summarises the nature of PPE intentions for 17 of the possible 27 projects that have reached FBC⁴¹ stage. Table 2 divides the characteristics of the PPE plans of these 17 cases in terms of what we refer to as a 'primary' and 'secondary' emphasis. The primary emphasis is one which is dominant and distinguishes between what we have referred to as a 'reactive' or 'proactive' stance – the former being trying to adopt a more 'arms length' emphasis to the PPE whereas the latter takes the view that this evaluation should be active in trying to ensure that benefits planned are achieved. The secondary emphasis is more to do with overall function and intention. This is divided into one that relies on the evaluation concerns highlighted in the 1994 NHS Capital Investment Manual⁴² (to which all comply) and 10 who develop a specific PFI emphasis. The former emphasis is unsurprising since the main guide for these PPEs has been the Capital Investment Manual issued in 1994 (NHS 1994) and the interpretation of this in the Heath Service Guidance in 1995 (HSG(95)15) (NHS 1995) (see also footnote 27). It was not until 1999 that specific Guidance (NHS 1999) on major service developments procured through PFI was made available. Whilst the 1999 Guidance superseded HSG(95)15 it did not supersede the 1994 Capital Investment Manual. The 1999 Guidance was, as we have seen, also completely silent on issues related to PPE. Thus even though 10 of the 17 cases take a specific PFI emphasis they are doing this without direction or formal guidance.

41 This material is drawn from documentation from the first 64 PFI schemes. However, only 27 of these have reached FBC stage where the PPE intentions are made plain. Table 1 lists all the schemes but the numbers in Table 2 do not have a one to one relationship with this listing. For confidentiality reasons we have developed our own numbering system of these 27 schemes to one that relates to actual and anticipated completion dates. We were only able to obtain 17 of the FBCs of these 27 PFI projects and therefore the numbering of the Trusts is neither complete nor sequential. The remaining 37 projects are at various stages in the process but none have a completed FBC where the details of the PPEs as made apparent.

42 This is not meant to make the prejudgement that PFI is capital expenditure. This remains disputed. The point is that the Capital Expenditure Manual, as we will argue is the only Guidance available to these trusts in relation to how to design a PPE. As indicated in Chapter 4 the PPE section of this 1994 manual was updated in 2002. This builds on rather than changes fundamentally the contents of the 1994 manual. However, as all of the 17 NHS Trusts considered in this Section produced their Full Business Cases long before 2002 they could not have used this updated section of the Manual.

What the Capital Investment manual prescribes is a three-stage process. The first stage involves specifying the 'objectives' of the project, the 'performance indicators' to be used to measure achievement of these objectives, a specification of the 'method of measurement' to be used to judge the achievement of the performance indicators and the objectives and finally, a clarification of the 'assumptions and risks' 'underlying the project' (Section 1.9.1 NHS (1994) p.6). The latter is in relation to the contents of the previous elements. The Capital Investment Manual encourages the production of a spreadsheet with four columns to record these elements.⁴³ The second stage involves project monitoring primarily related to the construction process and its successful completion. Finally, the third stage, requires a 'review of project objectives' involving:

'... a more wide-ranging evaluation of the costs and benefits of the project ... This may include elements of stage 2. It will involve reviewing the performance of the project in terms of the project objectives. These will have been defined clearly at stage 1 of the evaluation exercise.' (Paragraph 3.1.1 NHS (1994) p.8)

All of the 17 FBCs contain an explicit or an implicit reference to the approach suggested in the Capital Investment Manual. Only 4 of the 17 involve some work on the part of the reader to make the connection but the links are quite clear in the remaining 13. In fact in most of these cases the four column matrix of 'objectives', 'performance measurement', 'methods of measurement' and 'assumptions and risks' is invariably reproduced verbatim with clear links to a monitoring strategy in relation to the contents of this matrix. This connection is not surprising since it is the only official instructions these NHS Trusts could have used for their PPE plans in their FBCs.

43 This presentational point is indeed minor at one level yet, as we will see, it is significant that a large number of the PPE intentions looked at in our sample replicated this spreadsheet even down to some of the illustrative headings specified in the Capital Investment Manual.

Table 2 NHS Trusts' PFI Projects: Post-Project Evaluation Characteristics

NHS Hospital Trust	Primary Distinction	Primary Distinction	Secondary Characteristics	Secondary Characteristics
	Traditional 'Arms Length' Reactive Evaluation	Proactive Achievement Evaluation Strategy	Capital Investment Manual Emphasis	PFI Emphasis
1		✓	✓	✓
2		✓	✓	
3		✓	✓	
4	✓		✓	✓
5		✓	✓	✓
6		✓	✓	✓
7		✓	✓	✓
9		✓	✓	✓
10	✓		✓	
11	✓		✓	
13		✓	✓	✓
14		✓	✓	✓
15	✓		✓	
17	✓		✓	
23		✓	✓	✓
24		✓	✓	✓
25		✓	✓	
Totals	5	12	17	10

Before looking in more depth at the 10 PFI projects that went beyond the emphasis of the Capital Investment Manual it is important to explore in greater detail the distinction between what we have referred to as a 'reactive' and 'proactive' stance towards PPE. As Table 2 indicates, of the 17 cases, 12 have a more 'proactive' stance and only 5 a 'reactive' one. Those who intend to be proactive are making plain that their PPE involves active engagement on the part of different forms of management to ensure that benefits are achieved. Where benefits are not achieved there is an intention that remedial action will be taken. For these NHS Trusts PPE is a feed-forward process – there to provide advance warnings of what might need attention. Those of a 'reactive' nature, on the other hand, see PPE in a feedback mode, which seeks to clarify how things have developed in a seemingly independent review.

An illustration of a 'proactive' NHS Trust is No. 1⁴⁴. This Trust argues that any 'variations/non-conformance issues' will be 'appropriately managed' (No 1 FBC paragraph 812 p.63). Similarly proactive is No 2's desire for a 'promoter/sponsor (a senior manager involved in benefit identification and responsible for its realisation)' (No 2 FBC paragraph 13.3 p. 122). Another example is the descriptor of a 'Benefit Realisation Plan' (No 7 FBC paragraph 18 p.128), which involves a 'plan detailing the benefits to be accrued from the scheme, action required, proposed outcomes and measures' (No 7 FBC paragraph 18.1 p.128). Trust No 9 make plain that 'benefits don't just happen' and then goes to show '... examples of some benefits and how they will be achieved' (No 9 FBC paragraph 28.8).

On the other hand the 'reactive' group of NHS Trusts are more circumspect calling for 'on-going regular monitoring of achievements in attaining financial targets, non-financial benefit targets and risk management' and for 'auditable PPEs at key milestones for the Scheme' (No 4 FBC paragraph 7.4.6 p.129). There is a real concern within this group to assess, in a seemingly 'arms length' fashion, '... the extent to which planned benefits are realised' (No 15 FBC paragraph 15.5) or '... how well the scheme met its objectives and performed in terms of cost control' (No 17 FBC paragraph 14.1 page 124). There is a genuine intention within this group not to interfere in the achievement of the benefits but rather to make an independent, (hoped for) unbiased judgement on whether these benefits have actually been achieved.

44 As indicated previously the numbers on Table 2 refer to some of the first 27 of the 64 major PFI projects listed in Table 1. Numbers rather than names are used for confidentiality reasons.

45 Interestingly this is also the view of the NAO as we have seen. As their recent report on PFI indicates (NAO, 2001) the 'key question' is whether NHS Trusts 'manage their PFI relationships to secure a successful partnership' (Paragraph 4 of the Executive Summary).

Whilst this distance is, at one level, commendable, there is a sense that it is probably unrealistic. Arguably, this is the reason why so many of the NHS Trusts have been overtly proactive in their stance. It is difficult to imagine that the remaining 5 will not be similarly concerned to pursue active strategies when benefits are not being achieved. The natural tendency will be to try to do something about difficulties as they arise whether successful or not. Not to do so runs the risk of living with possible failure for 30 to 35, and even up to, 60 years, which is not likely to be acceptable. Our view is that a proactive stance will inevitably be part of any evaluation⁴⁵.

One of the most interesting points to come from these 17 cases is not just the dominant proactive emphasis but also recognition of the need to concentrate on specific PFI aspects in any evaluation. As already indicated, only 10 of the 17 Trusts make this important linkage. This is perhaps for two reasons. First, the inevitable ignorance that comes with moving into a new set of relationships, which PFI projects bring. Second, because of the lack of outside reference points on how to undertake a PPE. As noted earlier, most PPEs are built on the Capital Investment Manual, which provides an external reference point that is not specifically related to PFI⁴⁶. Thus, there is considerable uncertainty and variability in those NHS Trusts who do give emphasis to PFI aspects.

However, despite this uncertainty and variability three concerns are apparent in the 10 FBCs that give emphasis to PFI aspects in their planned PPEs. First, there is an emphasis on an assessment of whether the cost estimations made at the pre-decision stage are correct and whether risk assessment and allocation is as predicted. Second, and connected with some aspects related to operations risk transfer, there is a focus on facilities management (FM) (i.e. whether the facilities provided through the PFI contract achieve the standards intended for the planned payment). Third, and rather less central, is a concern with a non-financial benefit analysis. Of the 10 projects that provide this PFI emphasis, 2 look to all three of these concerns, 2 concentrate on risks and FM, 4 highlight risks alone and 2 only FM.

Those addressing risk, whether in combination with other cost factors or considered in isolation, typically seek to develop a '... rolling programme of annual reviews of risk management strategy' (No 4 FBC p.132). This includes a derivation of '... costs attributable to any identified and unidentified risks' (No. 4 FBC p.132) which extends into wider cost issues such as an analysis of whether '... financial consequences [have] been as expected' (No. 9 FBC paragraph 28.2) accompanied by an '... exception report on the risk sharing issues' (No. 6 FBC paragraph 19.1 p. 137) with an underlying concern as to whether '... risk transfer [has] been achieved' (No. 9 FBC paragraph 28.2).

46 As noted previously the new version of this in the 2002 addition to the Capital Investment Manual also does not distinguish between PFI and other public procured investments.

The consideration of FM is well captured by NHS Trust No. 1 which notes a concern to capture whether: '... the construction, commissioning and operational preparation of facilities management services are undertaken satisfactorily and any variations/non-conformance issues are appropriately managed' (No. 1 FBC paragraph 812 p.63). More specifically this involves ensuring '... that the ongoing performance of the facilities management services and the hospital infrastructure are reviewed and any variations/non-conformance issues are appropriately managed' (No. 1 FBC paragraph 812 p.63). An insight into some of the dynamics involved in this management system is given in the FBC of No. 23 when it is pointed out that '...performance will be monitored on a monthly basis in terms of service quality, value for money and compliance with agreed service specifications' (No. 23 FBC paragraph 18.3.4 p. 136). This performance management system through to longer term financial control implications is developed by No.14 where it is pointed out that '...market testing of Hotel Services will be undertaken at 7 year intervals and at 14 year intervals for Estate Services' (No. 14 FBC paragraph 16.3.1 (iii) p.139).

Finally, is the overt recognition in two cases that PFI has non-financial effects that need to be part of any PPE. No. 6 talks of producing '... a progress report on how the scheme is progressing' to '... highlight any problems encountered' but realising that the '... content of the report cannot readily be predicted in advance'. However they make plain that it is likely to need to cover not only the '...impact of the private sector managing FM services' and '...an exception report on risk sharing issues' but also about 'cultural change' (all quotes from No. 6 FBC paragraph 19.1 p. 137). There is no explication of what is likely to be involved in this but there is a clear implication that there could be cultural effects that come from service developments procured through PFI. It is reasonable to surmise that this is because new relationships are being developed with the private sector. NHS Trust No. 4 would want to capture allied non-financial matters through 'patient satisfaction surveys' and 'staff satisfaction surveys' (No. 4 FBC p.132). Whether this is the most appropriate vehicle for discovering 'cultural change' is clearly debatable⁴⁷. The more important point is that there are perceived to be non-financial effects that are uniquely related to a PFI, as distinct to a public sector, procured development and these need to be captured in any PPE. However, whilst it is clear that these non-financial aspects are important (albeit only to a limited number of NHS trusts at the moment, based on the sample) there is little clarity on how these issues are to be captured.

⁴⁷ NHS Trust No. 4 is, as Table 2 indicates, content to undertake a 'reactive' approach to the PPE. It is thus not surprising that they would feel comfortable with a survey approach to ascertain views. However, again as Table 2 indicates, No.4 is the only one of the 5 'reactive' Trusts who recognises the unique PFI elements in the development and that this should be a central part of the PPE. Thus the surveys they are referring to apply more to the PFI aspects of the development rather than some general view about 'satisfaction'. It is satisfaction in relation to the PFI elements that is the focus.

Whilst there is little detail on how to judge these non-financial aspects, the intended design of the risk and FM monitoring systems, is clearer and are contained in the concession agreement between the NHS Trusts and their private sector partners. Some of these are apparent in and through the PPE systems in practice which we have analysed. It is to these we now turn.

5.2.2 PPE Systems in Practice

Of the 8 operational PFI projects (coming from the above 17) that we have looked at in depth it is interesting to note that all, without exception, have concentrated their on-going PPE systems almost exclusively on the design and working of Facilities Management (FM) systems.

It is important to explore what FM does and does not cover in terms of the risks highlighted at the pre-decision stage. Three points need to be highlighted in this respect.

First, FM concentrates primarily on transferred risks and the services and maintenance risk elements of these. The primary focus of all FM systems is performance evaluation for all 'soft' facilities (e.g. laundry, cleaning, portering, catering etc) and ensuring the building is available and well maintained. The downside risks of unpredicted costs related to these services are assumed to be borne by the private sector. The FM system ensures not only that standards are maintained but also that these risks related to increased costs are not passed back to the public sector. As such, therefore, using the percentages from Dartford and Gravesham NHS Trust, FM systems focus on the monthly costs for the services as well as the 43% of the transferred quantified and costed risks.

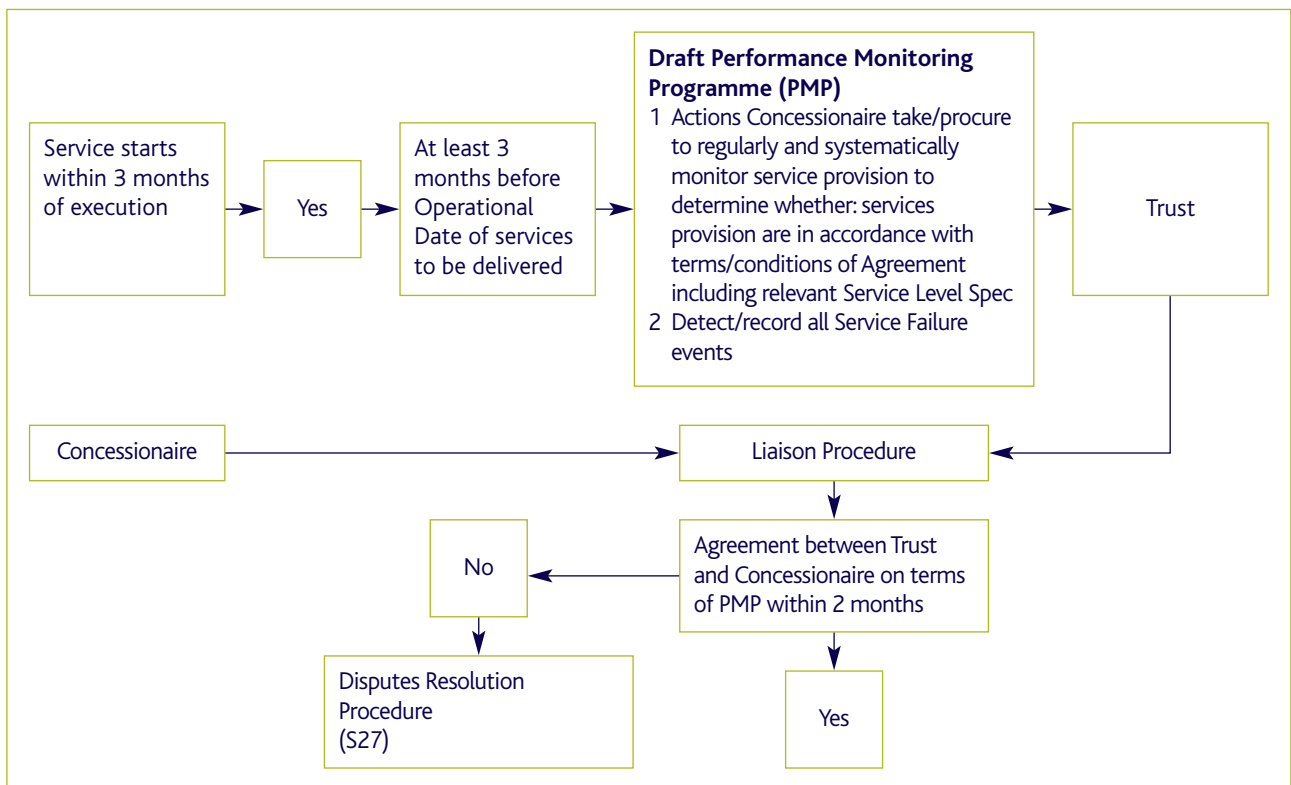
Second, FM systems do not consider 57% of the transferred risks, the vast majority (50%) of which relate to design and construction. A simple way to judge whether this latter risk has been transferred from the Trust is whether the building is handed over on time and to contract price. However, this disguises two concerns. First, whether the risk was correctly estimated in the first place given that the original estimate was based on a statistical and financial assumption that public sector procured buildings are always late and more expensive. Opening on time is hardly an accurate verification of the magnitude of these estimates, but it is all there is. Second, the pressure to complete on time – since it is only when this occurs the Project Company starts to receive its monthly payments – has led to some difficulties in agreeing hand-over arrangements and 'signing off' the building as complete. It is at these points when many difficulties have emerged in the 8 NHS Trusts with which we have been in contact. These negotiations are not part of the FM systems monitoring, which can only start to operate when all 'snagging' has been completed and financial responsibility allocated.

Third, and finally, FM systems have nothing to say about shared, non-quantified risks. These, as will be recalled, relate to significant cost, medical and environmental concerns. They are one-off issues that happen either only infrequently (e.g. every 5 or 7 years when contracts are to be renewed or after 25 years if the hospital closed etc.) or may never happen at all (e.g. the Project Company becomes corrupt or medical practice develops to such an extent that the hospital is obsolete etc.). The FM systems, judging by the 8 cases we have studied in depth, do not address any of these concerns; neither do they consider how they are going to proceed with contract renewal negotiations. The latter will take place, for the 8 cases considered, 5 years from opening. In summary, the FM systems address only part of the pre-decision risks. This does not detract from the extraordinary sophistication that has gone into designing these systems.

A typical example of these systems is BeeTrust⁴⁸. The essence of what is involved is encapsulated in Figures 4, 5 and 6. Figure 4 looks at how the Performance Monitoring Programme (PMP) was agreed which feeds into and provides the Performance Monitoring Reports leading to payment. The latter is contained in Figure 5. Finally, Figure 6 looks at the complexity about how to judge unavailability of the building and how to resolve/compensate unavailability should it occur.

Figure 5: BeeTrust : Performance Monitoring Programme

(Source: Schedule 19, Performance and Provision of Services)



48 Again in the spirit of confidentiality we have disguised the real name of this NHS Trust.

Figure 6: BeeTrust PFI Scheme: Performance Reports

(Source: Schedule 19, Performance and Provision of Services)

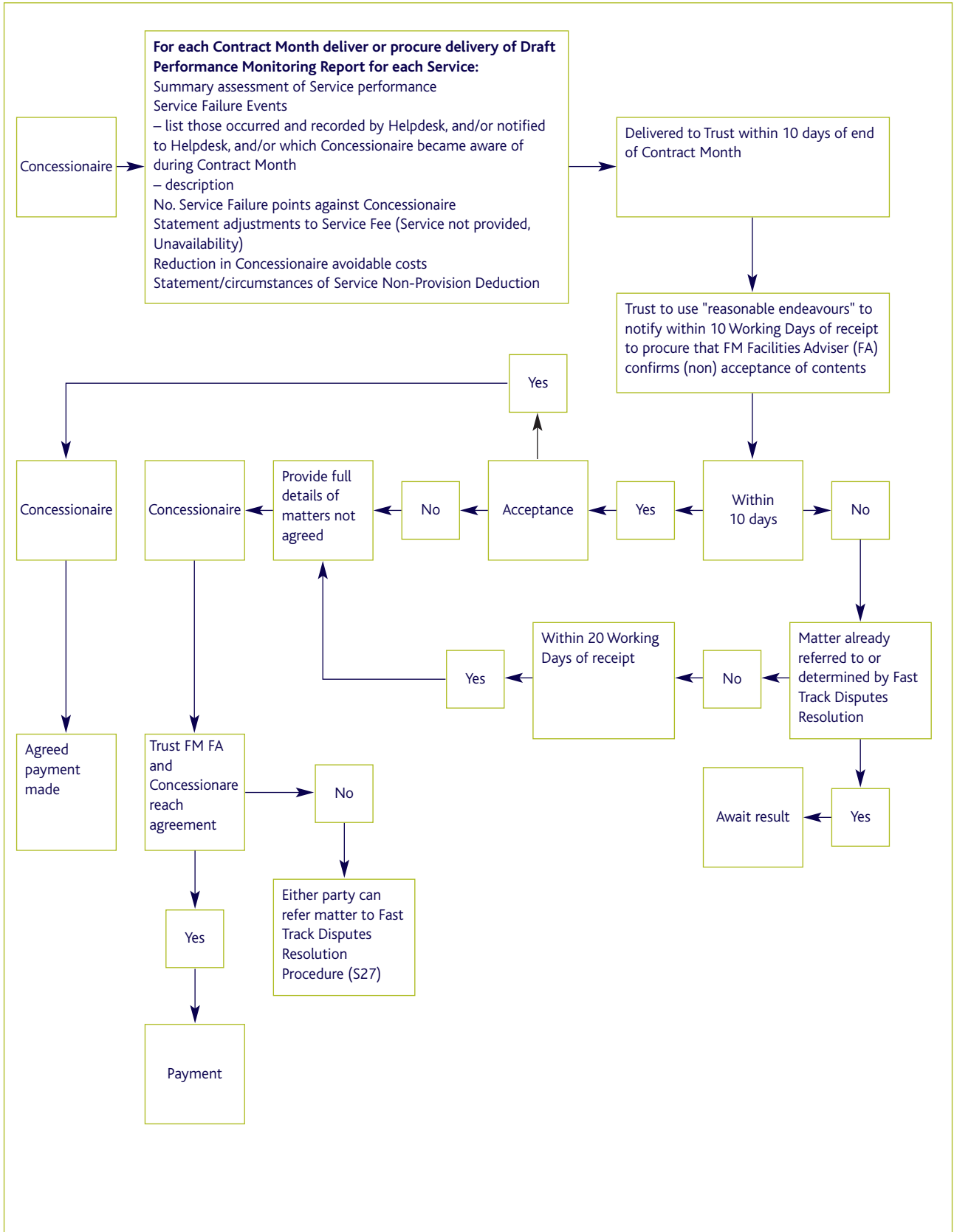
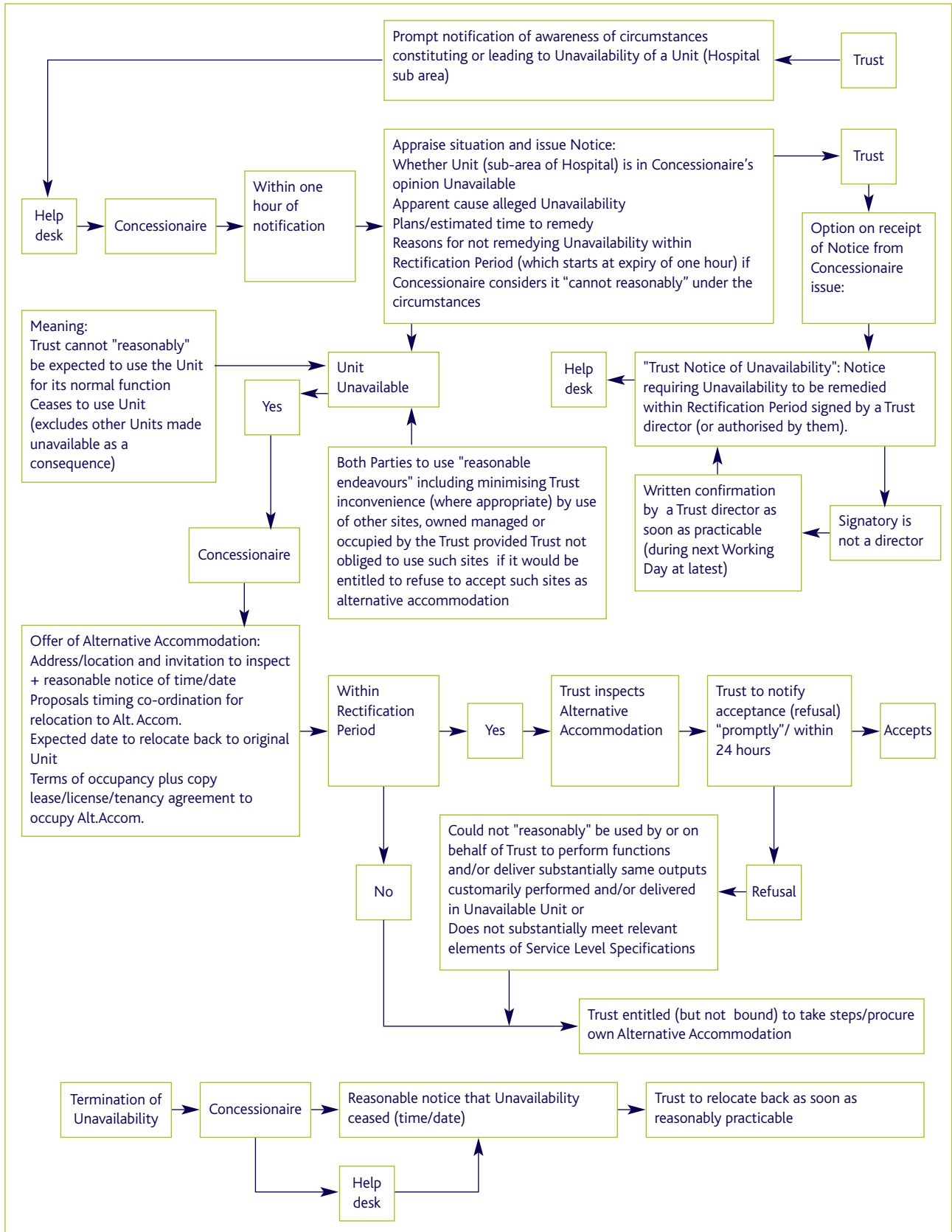


Figure 7: BeeTrust PFI Scheme: Unavailability

Source: Schedule 18 Unavailability



The monthly payment to the private sector supplier was in the past divided into two parts: the first relating to the availability of the hospital and the second to cover service provision. More recently these payments have been combined into a unitary payment. The case of Dartford and Gravesham (NAO (1999) paragraph 1.25, page 22) similarly provides a good indication of the original split in these two monthly payments. Using 1996 prices the NAO make plain that the monthly payment for the Dartford project was to be £1.320m – £879,000 for availability and £441,000 for service performance, or 67% and 33% of the total fee respectively. In financial terms the FM system is primarily trying to judge whether full payment should be made to the Project Company in any month. It does this by developing a monitoring 'regime', the details of which are contained in the 'Concession Agreement' – the interpretation of the contract to manage the ongoing relationships between the NHS Trust and the Project Company – which then becomes the FM system. These contractual interpretive 'schedules' basically spell out how it is possible to judge whether the Project Company has made the hospital available and whether it has provided the services agreed at the appropriate service levels. Where this does not occur the 'schedules' also specify the deductions that can be made. Figures 4 to 6 summarise, in diagrammatic form, the contents of these Schedules for BeeTrust. They do not, however, either fully encapsulate all the details even from these Schedules or necessarily depict the de facto application of these procedures. In the following we comment briefly on the nature of the three Figures supplementing with additional information from the Schedules and interviews with BeeTrust staff.

Before looking at the detailed outworkings of these contractual relationships it is worth reflecting on the complexity of the contract that is being entered into through a PFI arrangement. The NHS Guidance (NHS, 1999) provides a general depiction of the parties involved in a typical PFI contract. This is reproduced as Figure 8 below. Key is the 'project agreement' (or sometimes called 'concession agreement') between the NHS Trust and the Project Company (often called the Hospital Company). This is a contract, which spans 30 to 35 (and up to 60) years and includes both the construction as well as the provision of facilities. The Project Company, in turn, contracts with other companies for the provision of the services to this Company who, through these contracts, satisfy their obligations to the NHS Trust. In effect then the NHS Trust is not directly involved in contracting with the companies that either build the hospital complex or service it over the life of the 60 year relationship. As we point out in Broadbent, Gill and Laughlin (2003) this, coupled with the length of the contract, brings levels of uncertainty into the effectiveness of the provision of services which will only become apparent once the hospital is operational. This is borne out by the following.

Figure 8: Contractual Relationships Under PFI

(from NHS (1999) Overview p.5)

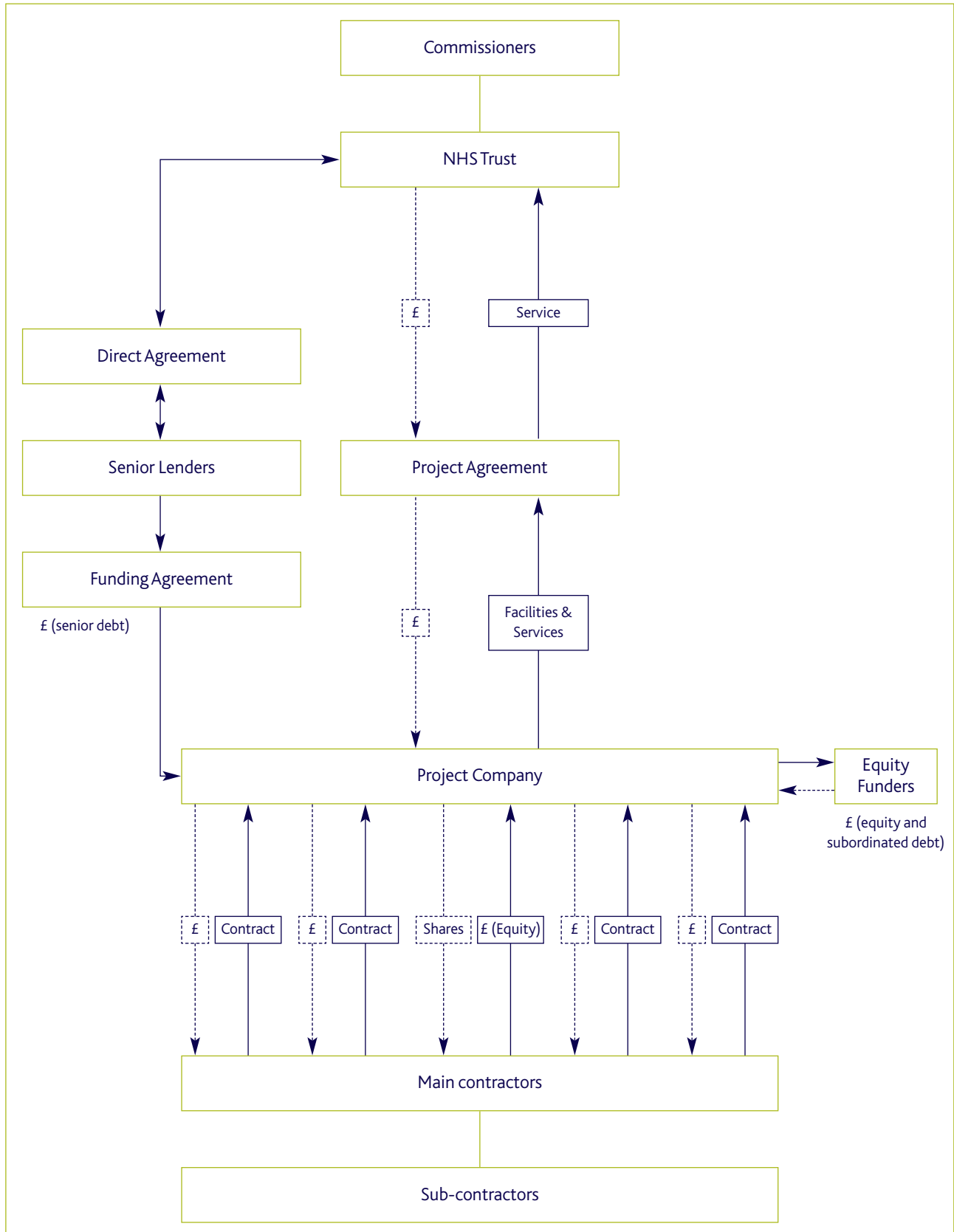


Figure 5 clarifies the one-off process to agree the way monitoring of performance should occur. It is one-off since it is what was agreed by the parties 3 months prior to the operational start of the contract and was intended to apply throughout the contract period. This started with the Project Company (in BeeTrust called the Concessionaire) drawing up some proposals that were then passed on to the Trust. In this case these were to be 'Concessionaire-led' – the private sector partner was going to take the primary lead on monitoring and reporting, leaving the Trust in a more reactive role to the initial reports. This proposal was initially put to the Trust who then met with the Concessionaire to either find an acceptable pattern or alternatively pursue a complex 'Disputes Resolution Procedure' which basically brings an outside arbitrator or panel together to resolve any dispute.

There are three points to bring out with regard to agreeing this PMP. First, all 8 Trusts have followed similar procedures – most but not all of which have resulted in the Project Company being the main monitor of performance. Second, all 8 Trusts have a formal Disputes Resolution Procedure not just to agree the PMP but also for all other areas where disagreements persist. All involve an outside person or more usually panel, often including the Chief Executives of the NHS Trust and Project Company, to resolve differences. Third, in the case of BeeTrust, the Concessionaire-led model was largely followed even though the Trust undertook its own audit of the monitoring. As the Facilities Director pointed out:

'... the monitoring is ... from the Trust point of view not extensive ... But there is a need for some direct Trust monitoring. Otherwise you don't know whether you're getting the service that you're told you're getting ... The ability of the Trust to audit the data that was being provided by [the Project Company] was always available, always an option. And it was the main option that the Trust used. It has not set up, and doesn't see it should set up, a large monitoring team for a PFI scheme. I think it actually goes against the principle of what you're doing. Hopefully this scheme will develop into a true partnership.'

Figure 6 provides details of the monthly performance review leading to the payment in full or with deductions. The process starts with the Project Company sending to the Trust, within ten days of the end of the month, a detailed report of service provision during the previous month with any suggested deductions to be made. The background to this report is that each 'service failure' is logged in a 'Help Desk' and classified as being one of four 'categories' – the 4th being more serious than the 1st. There is then a set rectification period allowed for each of these categories. If the fault is resolved in these periods then the matter is closed. If not then 'service failure points' are given – 1 for Category 1, 5 for Category 2, 15 for Category 3 and 25 for Category 4. The resulting deductions are financially assessed as follows:

- Up to 50 service failure points – no deduction
- Between 50 and 100 service failure points – 5% plus 0.1% for each point above 51
- More than 100 – 10% plus 0.15% for each point above 100

These 'histories' are recounted in the Report that goes to the Trust along with recommendations for either full payment or with deductions following this arrangement. The Trust then has 10 days to decide whether to agree to the contents. If they do accept either they can pay directly on the contents of the Report or have the opportunity to disagree with their initial agreement and reconsider certain items through discussion and even go to dispute resolution processes. If initial agreement cannot be reached within 10 days then the Trust have another 10 days to build a case of their concerns which need to be resolved through either further negotiation or through disputes resolution processes before payment is made.

There are three observations to make about this performance monitoring system. First, the 8 Trusts all have similar systems in place although the deduction regime can vary considerably. Second, even though the system at BeeTrust is quite a tough example it is still somewhat difficult, even following the rules, for deductions to be made. Various stages have to occur before there is a reduction in the fees payable. Third, just as the systems can vary, how they are operationalised can also vary. Some Trusts did the monitoring more as a demonstration that it was occurring using the system to provide warnings for improvement. BeeTrust, on the other hand, was more of an outlier in its contractual emphasis, which had more than a passing effect on the nature of the contractual requirements. As the Finance Director made plain:

'The performance regime is deductive, its not ... if 90 per cent of the jobs are done it's OK. What there is, is a points system and if they acquire a certain number of points then performance deductions are made ... And it doesn't take much to acquire a point. You know, you're 10 minutes late for cleaning up a dirty ward then you've acquired a point. And the fact that a porter isn't here or a domestic isn't there on time, costs you ... focuses their mind very nicely ... It's very unambiguous ... there have been debates about what counts as mitigating ... why this isn't really a performance failure but at the end of the day if someone rings the right number at the right time and asks for something to happen and it doesn't happen on time, then there's not a great deal we can say is there? It's a performance failure'

The Project Company, however, in BeeTrust, not surprisingly, seriously challenged such clarity, and over time a 'softer' interpretation, more in line with the experience of other Trusts, has started to emerge. The more general rule is that the contract and the monitoring process are there as a reminder to keep standards high and if deductions can be avoided it is much to be preferred. The Finance Director more than hinted at this when he said:

'... if a contractual relationship is working well ... if the contractual relationship is working exactly as envisaged, then there's actually very little need to go back to the contract. The contract is there for when things go wrong, and when joint pressures occur where there's a protocol for managing them.'

Figure 7 clarifies BeeTrust's procedures for dealing with unavailability of the hospital building. This is prompted by a concern by the Trust that a part of the building is perceived to be unavailable. The Concessionaire then must agree that the area is actually unavailable. If so, a 'Notice of Unavailability' is issued and signed by the Trust's representative with the area being classified in terms of 'type' – from A to D with 'A' being a more significant loss than 'D'. Once classified and agreed the Project Company has a certain number of hours to resolve the problem – 2 hours for Type A area, 4 hours for Type B, 6 hours for Type C and 7 hours for Type D. At the same time a further procedure is implemented to offer the Trust alternative accommodation, the use of which is difficult to refuse if it is 'reasonable'. If the rectification is not undertaken in time and the unit found as a replacement is deemed not suitable then, and only then, can a procedure be implemented to make a deduction from the availability payment based on the following calculation:

1 x	Weighting x	No of sessions unavailable x Annual Availability Payment
Total No. of Units in Sub Area	100	1095

Two more general observations can be made about this unavailability part of the FM system. First, BeeTrust is typical of the 8 Trusts we have looked at but, if anything, it is rather simpler than some of the others. Deciding unavailability is not something that is either easy or straightforward. Second, BeeTrust is typical in the sense that getting to the point where deductions are possible is extraordinarily difficult. BeeTrust is much tougher contractually on the Project Company than many of the others we have seen yet even in this rather more rigorous routine it is still difficult to see how any deductions could be possible. This seems to be borne out by the lack of reference to availability deductions in the interviews we conducted in BeeTrust apart from some confirmation of these difficulties.

5.2.3 A Concluding Comment

What is clear from the above is that the actual PPEs in practice are limited in their scope of concern. Based on our empirical sample the wide-ranging risk assessment at the pre-decision stage is restricted to ensuring that systems are in place to ensure that agreed payments for availability and performance are not exceeded and that where these are not up to standard then deductions are made. This latter situation is limited even further by the tendency, even in the rigorous BeeTrust, to use these sophisticated systems more as symbolic threats that deductions can be made rather than actually being made. This concentration of effort therefore is addressed to only the equivalent of 43% of the total transferred, quantified, costed risks and has nothing to say about the other transferred risks let alone those that are to be shared. Yet it demonstrates quite clearly the very close relationship between management/regulation and risk. The entire PPEs are devoted to managing relevant risks to ensure that cost charges are contained and are incurred for adequate levels of performance and availability. However, the important point remains that not all relevant risks are considered by these regimes.

With this in mind we turn to the next section, which, in the light of this appreciation of the limited nature of current PPEs either in terms of intentions or in practice, develops an alternative (richer) model.

5.3. A Possible Design of a System for PPE

Consideration of the pre-decision VFM analysis and the PPE intentions and practices of the schemes that are underway provide a base for the design of a PPE system. Our conclusion is that this design needs to have three key characteristics:

- first, that the PPE should concentrate on the unique PFI aspects of the development such as costs, risk allocation, FM systems and non-financial aspects if we are going to arrive at a view about PFI relative to other forms of procurement. This will not ignore wider aspects of the development of the hospital complex but will have a primary focus on this particular form of procurement;
- second, that it should recognise that the PPE should be largely proactive in nature, particularly in relation to the financial and risk aspects; and,
- third, that non-financial, culturally-related, operational aspects of the PFI project needs to be a central part of any PPE design.

Before proceeding to look at these different elements (in Sections 5.3.1 to 5.3.3 below) two preparatory points need to be stressed. First, in relation to the different emphases, at the pre-contract and post-contract stages, that is given to the non-financial aspects. Our view is that at the pre-contract stage the non-financial issues, related to design or cultural factors, etc., are important but are not as dominant as the financial. Changes are underway in terms of the views of the NAO and HM Treasury to give greater emphasis to these non-financial concerns, yet the exact configuration of this change is only partly apparent. It is probably still fair to say that the comparison of the net present cost of PFI and the PSC still dominates. The recent changes to the discount rate, and accompanying increase in the construction risk element in the calculation of the PSC, as highlighted in the recently published 'Green Book' (HM Treasury, 2002), will only reinforce this dominance. As we will argue below, whilst the financial emphasis should be an important part of the PPE, non-financial concerns should be of equal importance. Second, it is important to be reminded that, because of the length and complexity of any PFI contract, any meaningful evaluation will take several years to complete. With contracts running for 30 to 35 and even 60 years, where the costs are shifting over time, any hope of conducting a one-off episodic evaluation is impossible. At best some definitive answers might be possible at the end of the first renewal of the FM contract (often 5 or 7 years into the contract) but even here conclusions would have to be tentative. However, because we anticipate relationships between the two partners will be starting to 'bed down' after a year or two of the project becoming operational some conclusions might well be able to be drawn at that point. Systems need to put into place now to handle these matters and management accounting has a key part to play in their design and operation.

5.3.1 Concentrating on PFI Aspects

With these points in mind we need to turn to look at the first of the three characteristics, starting with the importance of concentrating on only the PFI aspects of the contract in any PPE. The Capital Investment Manual, even with its recent extension – which is, as will be recalled, the only external referent for all PFI projects – concentrates on an evaluation, which is both episodic in nature as well as making no recognition that a PFI project is different from a public sector procurement. This should not detract from the importance of this wider form of evaluation and that by concentrating on PFI aspects will not cover these wider concerns particularly in relation to use/stakeholder views. But PFI projects do bring unique aspects to service improvements. By primarily concentrating on these aspects will allow a judgement to be made on merit and worth of this form of procurement relative to traditional forms. This does not exclude the use of the Guidance for evaluating PFI projects but relying on it exclusively would be inappropriate.

Our argument is that for PFI projects it must be the Guidance plus an analysis of the unique PFI aspects. This can be justified conceptually but is also reinforced empirically – with 10 of the 17 NHS PFI cases investigated realising that any PPE of PFI must move beyond this Guidance. This leads to the conclusion that any PFI PPE should concentrate on those aspects that are linked to and derive from choosing to develop hospital services through this procurement route. In sum it is the set of issues that are unique to PFI that should be the focus of the design of a PPE. This drives the contents of the following, which explicates this overarching assumption.

5.3.2 Proactive and Reactive PPE: A Clarification of the Proactive Agenda

Our view is that the design of a PPE system should recognise a 'proactive' rather than 'reactive' emphasis in the basic design. In this regard the PPE will have a clear intention to not only monitor outcomes but also to do something about what is found. This also links directly to the distinction we have made between a financial evaluation (FE) and non-financial evaluation (NFE). In simple terms, FE is likely to be more naturally 'proactive' and NFE more 'reactive'. FE is assumed to include primarily cost realisation, risk allocation achievement (whether costed and quantified or not⁴⁹). All of these should be monitored by key NHS management staff who will have the sole intention of trying, as far as they are able, to ensure that planned levels of costs are realised, risks are allocated or shared as anticipated and, where not, are managerial justified. This will be conducted by management staff who have the authority to undertake remedial action if needs be. Our view is that this is an entirely sensible way to proceed and should be a central part of any PPE and, whilst somewhat unconventional in evaluation terms, needs to be accepted as such. If legitimacy is required, it is a proactive stance that the NAO supports – see NAO (2001) on '*managing successful partnerships*' (our emphasis). A similar proactive emphasis needs to apply to the NFE parts of the PPE as we will argue below.

49 Whilst risks assessment and allocation are part of any FE it is important to realise that not all risks highlighted are always given a direct cost value at the pre-decision stage. Those risks that are deemed to be 'shared' between private and public sectors are often of this sort. Invariably a cost value will not be placed on these and even the proportion of the 'share' is not clarified. These decisions are left until the event has occurred for resolution.

This links directly to our observations from PPE practices. Two observations can be made. First, the PPEs that are in operation, judging by our investigation of 8 Trusts in some depth and building on the analysis of 17 cases (which includes the 8) are strongly managerial and regulatory. 'Facilities Management' (FM) systems are, in effect, the entirety of what constitutes the PPEs in all Trusts. These 'proactive' FM (PPE) systems are there to ensure that the monthly payments that are made for availability and maintenance of the building and for other 'softer' services (e.g. catering, laundry, portering etc) are at specified standards or, if not, suitable deductions are made. Second, all FM(PPE) systems that are in place deal only with transferred risks but only a limited set of these risks. What is clear is that these FM(PPE) systems are limited only to service and maintenance risks that are costed and transferred to the private sector. Based on our analysis of Dartford and Gravesham this, therefore, accounts for only 43% of the total transferred (costed) risks. The FM system does not deal with construction risks or 'other', often financial and legal, risks. Apart from these risks, none of the other non-quantified and non-costed risks, particularly those that are shared, and considered so carefully at the pre-decision stage, are given any attention.

Our view is that there is a need to expand the proactive elements of any PPE system in two ways. First, to develop systems to manage the remaining 53% of the quantified, costed and transferred risks. Second, to be proactive about not only the uncosted shared risks/uncertainties (cf. Broadbent, Gill and Laughlin, 2004) but also in relation to user/stakeholder views and concerns.

If we turn to the first of these concerns then an important focus is, particularly, but not exclusively, construction risk, which accounts for approximately 50% of the remaining transferred risks. It is tempting to assume that if the building is handed over on time and without extra cost then the transferred construction risk has been achieved. In many ways this is true and this can be used as a key performance criteria – but not, as we will argue, the only criteria⁵⁰. There are, however, other issues that need to be carefully monitored at the point of hand-over. For example, on the hand-over of the building, various 'snags' may not be identified in time for them to be dealt with adequately. There may be a dispute about where liability for snags lies, despite the fact that the service provider and the construction companies are often in

50 Given the enormity of construction risk (approximately 50% of all transferred costed risks) and its centrality for giving the PFI alternative legitimacy to proceed, it is odd to think that there is no other way to judge the accuracy of this costed figure relative to performance. Despite the extensive work that has been undertaken recently to give greater legitimacy to the calculation of this figure at the pre-decision stage, no matter what its total it will still always and only be known to be realised if the building is handed over on time and at the predicted cost. But if this is the only way to make this judgement, it will always be incapable of confirming the magnitude of the amount involved.

a consortium of companies⁵¹. Equally, if there have to be more substantial variations due to failure in the original design after hand-over then correcting these errors will be expensive due to the set up costs of getting contractors back on site. To get the original contractor to incur these costs may well entail expensive legal enforcement. Alternatively the costs fall inevitably on the public sector partner. The point to stress is the fact that the building being handed-over on time and at cost is too simplistic a measure to demonstrate that all elements of design construction risk were avoided. More rigorous measures of performance need to be devised which we would see as something management accounting could help in supplying. This applies not just to design and construction risk but to all other transferred risks so carefully costed at the pre-decision stage but, to date, rather poorly monitored at the PPE stage. Put simply, the rigour by which FM systems are proactively monitored needs replication in relation to the remaining 57% of the transferred risks.

Of possibly even more significance is the omission of any clear systems in place to monitor the handling of the shared risks. This brings us to part of our second area for extension in terms of being proactive. No thought to date has been given to these other risks and how they will actually be handled. Notable amongst these relate to the handling of the periodic (often 5 year) contract re-negotiation. The contract re-negotiation is going to be complex and could well be very difficult and very expensive for the public sector. How this is to be handled needs to be agreed at this juncture and not left until just before contract renewal. More generally, strategies need to be put in place for dealing with each of the shared risks so that a proactive process can be put directly into place for whatever is either certain to or might possibly occur. To date this is not the situation. Again our view is that the design of these systems is something for which management accounting can provide considerable assistance. The other non-financial aspects, under this second area are addressed in the following sub-section.

51 We have seen evidence of this in some schemes where the construction arm of the consortium has sought to pass responsibility for dealing with snags to the operations arm much to the latter's concern due to their independence as a trading organisation and the inevitably impact this could have on their profit margins.

5.3.3 Developing the Reactive Emphasis: Clarifying the Non-Financial Issues in PPEs

Of at least equal significance is the overtly non-financial effect of PFI hospitals on medical provision and the adaptability to changing medical care. Part of the reason for this lack of attention in PPEs is that, to date, it has seemed that the quantitative analysis through comparison with the PSC has been actually more important at the pre-decision stage than any qualitative analysis. The NAO, judging by both their 'four pillars' Report as well as the West Middlesex VFM analysis (NAO, 1999, 2002) are recognising the shortcomings of the PSC/PFI economic appraisal and developing more wide-ranging qualitative criteria to judge VFM. Equally HM Treasury are also actively encouraging qualitative considerations at the pre-decision stage. This renewed emphasis on the qualitative, hopefully, will filter down into PPE design as well.

There is, therefore, an increasing awareness that there is another side to any PFI PPE even though this is likely to remain a somewhat 'reactive' part of any PPE system without active encouragement to be otherwise. At both the OBC and FBC stages there are a number of issues surrounding any new development, not least the workability of the design of the building, that cannot be expressed in and through the financial flows or the quantified or even shared risk matrix. Most of this analysis, at both the OBC and FBC stages, has sought stakeholder⁵² views on the comparative advantage of alternative solution possibilities (for the OBC) and of the PFI over the PSC alternatives (for the FBC). The focus for this NFE has to be different at the PPE stage, yet the importance of seeking views is not dissimilar. It is important to consult with all stakeholders but this time the focus should be on their qualitative judgements as to the success or otherwise of the PFI development.

There are two important points to bear in mind with regard to ascertaining the views of stakeholders. First, there is likely to a relative lack of power, in the main, although not in all cases, of those who will be canvassed in this exercise. Whilst it is important to know what the different stakeholders think about the workings of PFI in any service project development, how much note is taken of their views and what action ensues cannot be guaranteed. This is inevitable if the stakeholder group are not part of NHS management. Therefore, there is a need for a formal mechanism to ensure that management hears and acts upon these views. We would want to go further and argue that these views should both feed into wider national debates about PFI projects as well as provide the base for systematising, as well as making more important, the NFE at the time when the decisions to pursue PFI are being considered. Therefore, secondly, we argue that the person or organisation accessing these views needs to have the authority and influence to do something in relation to these views – a point we develop further in Section 5.4.

⁵² Those affected by the development whether internally part of the Trust or external funding and community institutions and people.

In relation to the canvassing and delivery of stakeholder views there are a number of dimensions to consider which we can only touch on briefly in the following. The key problem is the role of the facilitator/evaluator in gathering these stakeholder views both in terms of his/her approach to discovery and then how these views are communicated to others. On the first point there has been a lively and extensive debate in evaluation theory, which has questioned and challenged the perceived intrusive role and power of the evaluator and evaluations more generally (cf. Guba and Lincoln, 1989; Laughlin and Broadbent, 1996; House and Howe, 1999). Following a growing rejection of the problem solving role of evaluations and the evaluator as expert, current thinking is to concentrate on what Greene (2001 p. 186) refers to as 'dialogic evaluation'. In the view of Abma (2001 p.157) 'dialogue is important for evaluation since it acknowledges that there is no external standard for what is good or bad' but this does not mean, as he continues, that we have to conclude '... that this implies that anything goes'. Karlsson (2001, p.215) develops this further by calling for a 'critical role' for the evaluator to 'question and probe into the heart of the matter, asking for explanations and stimulating reflection on underlying assumptions'. Explaining what he means by this Karlsson (2001, p.215) continues that this:

'... critical examination is to gain practical and theoretical knowledge about how we ought to live and how the world is. Another aim should be to develop a deeper understanding of what the programme means for different stakeholders in terms of limitations and possibilities, and to reach a greater insight and clarity about the foundations of one's own and others' judgements. Ideally, through this process each party in the dialogue is enlightened, thus able to make insightful and informed decisions and more willing to redress injustice. At the same time each becomes fully aware of the limits of their perspective, and the possibilities and limitations of reaching a complete understanding of how things really are.' (Karlsson (2001) p. 215)

This is in marked contrast to the 'traditionally defined' practice of evaluation which is '... about problem solving in which each party plays a particular role and carries out some particular set of responsibilities' (Schwandt (2001) p.271). In contrast the new role of the evaluator is as an '... interpreter rather than an expert' (Abma et al (2001) p.173). It is this listening, probing role of the evaluator to obtain understanding of the views of the stakeholders that is the approach we would recommend for this non-financial part of the PPE.

5.4. Some Concluding Comments and Defining Responsibilities

In conclusion, our view is that a PPE system needs to focus on those aspects that relate to the specific and particular aspects that come with this peculiar form of procurement. Wider forms of PPE, applicable to all forms of procurement, are covered in the NHS's Capital Investment Manual (NHS, 1994) and its recent development in 2002 (NHS, 2002) but these make no distinction between a PPE for a service development procured through PFI or through traditional means. This is in our view necessary but not sufficient for a PPE of PFI. This PFI PPE needs to concentrate equally on financial as well as non-financial aspects and should be 'proactive' leading to remedies and resolutions if problems are discovered in either area.

With regard to the financial aspects there will be an inevitable intention on the part of NHS management to make, as far as possible, the financial aspects of the PFI project 'work', yet current practice at the moment, is restricted in its focus. Current practice is concentrating almost exclusively on the design of Facilities Management (FM) systems. These systems are becoming very sophisticated as is apparent from the examples drawn from BeeTrust. They are likely to continue this trajectory of development and are already involving both management accountants and management accounting in their design and operation. Yet despite this important innovation, which is already underway, it is important to be reminded that this is only dealing with part of the design of PPEs in relation to this financial concern. Given that cost profiles and risk estimates are so intimately bound together in PFI schemes our view, based on the data taken from Dartford and Gravesham, is that this is only dealing with 43% of the variability in the cost profile or put another way 43% of the risks assumed to be transferred to the private sector partner. The remaining 57%, of which the vast majority is related to construction risks, in the form of cost and time overruns, have not to date been actively developed. Current systems, such as the simple acceptance of completion on time and to cost to reflect construction risk, provide an insufficient PPE. More needs to be done and management accountants need to be at the forefront in this development.

These challenges, great as they are, are probably not as challenging as those related to the design of a PPE system to take account of non-financial aspects related to the effect of the PFI project on shared risks and on care processes and care futures. These repercussions, viewed from the perspectives of the multiple stakeholders involved in any PFI project, need equal, rather than subsidiary, as at the pre-decision stage, recognition. The insights forthcoming from this analysis need to influence not just future management action but also give greater importance to the non-financial aspects at the pre-decision stage and future national guidance in this regard – something which, fortunately, judging by recent thinking and pronouncements by both HM Treasury as well as the NAO, is occurring. To develop these non-financial aspects of the PPE system, leading to improving guidance for pre-decision processes is unquestionably a challenge of considerable proportions. It is hoped that management accountants and management accounting will be at the forefront of these developments.

We will make a number of further comments about these management accounting implications in our recommendation section in Chapter 6 but it is important here to make one or two points about the important evaluator role in the PPE. As indicated in Section 5.3, we have argued that the evaluator needs to be a very careful conduit for information but one who can enforce action from Trust management to the reactions of multiple stakeholders. It is also someone who has the authority to steer the design of pre-decision processes to reflect these wider non-financial aspects. The evaluator will also need to be actively guiding the PPE system for the financial aspects as well. But this is likely to be easier and more acceptable to Trust management as distinct from the more unpredictable non-financial views of stakeholders.

Our view is that this evaluator role is best performed by the National Audit Office in the main and the Audit Commission (for local authorities) both of whom are already actively involved in VFM studies of PFI. They alone have the authority to undertake the tasks involved. The developments suggested would expand their current role to new levels, whilst, at the same time, not taking them far away from current trajectories in their work – particularly the NAO who, as we have suggested in Section 5.1.2, as well as elsewhere in this monograph, are already working on new ways to judge VFM in PFI projects. The proposed development, for both national audit bodies, would take their current VFM work into a new longitudinal, qualitative, evaluatory emphasis but one which has 'teeth' to guide management behaviour. This, we would argue, adds, rather than detracts, value to their current endeavours.

6 Some Concluding Thoughts

This monograph has been structured around three policy-related research questions. These are:

- First, what is the nature of PFI?
- Second, why and how are PFI decisions made with specific reference to the NHS and what management/accounting information systems are key in this process?
- Third, what management accounting/control systems are, and should be, in place to assess the effects of PFI decisions in the NHS?

The contents of the monograph have explored how far we have come in answering these questions and what still needs to be done. In this final concluding Chapter we will summarise the insights from this study (in Section 6.1) and then clarify some recommendations and thoughts on the challenges for management accounting and management accountants for the future that comes with the operationalisation of PFI specifically in the context of the NHS.

6.1. Summarising the Arguments

As Chapter 2 indicated the route to defining the currently accepted nature of PFI has been long and somewhat tortuous. However, there is now a reasonable consensus that PFI is a micro procurement process for the provision of services from the private sector to the public sector that is intended to generate value for money for the latter in the context of allocating risk to those best equipped to manage it which inevitably means risk transfer to the former. At one stage a more macro fiscal emphasis was apparent that involved a close alignment between exploring the effects of PFI on public sector borrowing. The latter emphasis made the balance sheet treatment of paramount importance and this still resonates in the current attitudes to PFI. Despite the demise of this macro fiscal emphasis the balance sheet treatment is still important. The outcome of the balance sheet treatment, like the micro value for money emphasis that now predominates, centres on the nature of risk valuation and allocation. Management accounting is of central importance in determining these factors.

In Chapters 3 and 4 we have explored the development of PFI in the NHS and the way PFI decisions are made as well as clarifying the role of management accounting in these decision processes. What is clear from this summary is the complex and rich history that surrounds the development of PFI in the NHS. Despite many attempts to launch PFI in the NHS, from the outset of the Initiative and during the last five years of the Conservative Government no PFI projects were started. It required the introduction of two Acts of Parliament – the last in 1997 being a Conservative Bill enacted unchanged by the new Labour Government when they came to power – to allow this logjam to be released. Now 64 PFI projects with 21 fully operational as at the time of writing (May 2004).

Where there has been more consistent progress is on how PFI decisions should be made. This is moving from a primarily quantitative to a more mixed qualitative and quantitative emphasis. Of central and continuing importance is the quantitative, financial, value for money judgement. This involves a comparison of the discounted cost of the PFI option against a Public Sector Comparator (PSC) where the latter is the cost of the same service provision being provided through a traditional public sector procurement route. Key in this calculation is a quantitative estimate of the downside risks that are transferred to the private sector. These are added to the net discounted cost of the PSC, resulting, in the main, the PFI option becoming cheaper of the two alternatives. However, there is an increasing emphasis that this quantitative analysis should be complemented with more qualitative concerns. Although this movement is not as yet complete there is wide recognition by both HM Treasury and the NAO that is the way decision processes should develop. Based on our analysis this development should concentrate on two areas. First, is in the area of shared risks. Second, is in relation to the benefits assessment in the Outline and Full Business Cases. Much needs to be done both in making this qualitative analysis more rigorous as well as finding ways for the insights forthcoming to be used alongside the quantitative analysis. We will have more to say about this in Section 6.2 when discussing our recommendations, but, for now, it is important to note the changing emphasis. The National Audit Office has been central in this shifting pattern as is apparent from the more quantitative judgements in their report on the Dartford and Gravesham PFI project (NAO, 1999a) and the more qualitative emphasis in their study of the West Middlesex PFI project (NAO, 2002). This changing qualitative emphasis was also made apparent in their unprecedented report into how the NAO are judging value for money (NAO, 1999) based on what they referred to as 'getting a good deal' which involved a number of 'pillars' only one of which was quantitative and financial. HM Treasury (2003, 2004) are also moving in this direction even though their reliance on the PSC/PFI comparison continues.

Whilst the pre-decision processes are developing a reasonably clear trajectory, the PPE systems for judging the merit and worth of PFI both generally and specifically in the NHS are not as well advanced. As Chapter 5 indicated, our conclusion is that it is only possible at this stage in the development of PFI projects, certainly in the context of the NHS, to talk about the design of PPE systems very largely because so few PFI projects have been fully operational for any period of time. Our view is that we will not be in a position to make any meaningful judgement on the merit and worth of PFI until at least a five year period has elapsed from becoming operational. This, however, should not detract from the importance of developing systems for this PPE to occur.

Chapter 5 explored a number of attempts that have been made to design these PPE systems both conceptually as well as in relation to intended and actual practice. Conceptually we looked at a number of 'single characteristic' attempts, including the view that linked reducing bed numbers to PFI, with resulting 'blame' on the PFI option, and found such perspectives limiting at best and highly questionable at worst. It also explored the institutional attempts at a PPE system through the VFM studies of the NAO. As indicated above what is apparent in these studies is the changing emphasis in these studies from one dominated by the quantitative, financial emphasis to one that is more balanced to include qualitative concerns. This more balanced quantitative and qualitative emphasis, coupled with an increasing acceptance of an inevitable longer time frame for being able to judge whether PFI is VFM, was also apparent in some recent calls, most notably by the Institute of Public Policy Research (IPPR, 2001), for a long term, balanced, even handed, quantitative and qualitative PPE system.

In Chapter 5, to develop this more balanced emphasis for the design of PPE system, we also looked at the PPE intentions of 17 NHS PFI projects as contained in the Full Business Cases (FBCs) as well as the actual practices of 8 of these projects, all of which are currently operational. What was apparent in the intentions of the 17 FBCs that we looked at was the heavy reliance on the NHS's Capital Investment Manual (NHS, 1994) for the PPE. This Manual in its original form (and even in the recent 2002 revised form which was not available to any of these 17 cases) does not distinguish between traditional public sector or PFI procurement routes for the new development. Yet these alternative routes generate different concerns and issues related to risk, facilities management and cultural/social issues. Interestingly 10 out of the 17 PFI cases approach their PPE intentions with this specific PFI emphasis in mind. There is also a strong, what we referred to as a proactive, rather than more arms-length reactive, emphasis in these PPE intentions. Put simply there was an intention in most of these cases to use the PPE to isolate problems and deal with them as they occur rather than allow problems to remain unaddressed. The 8 fully operational PFI projects demonstrated that, despite what was intended, the PPE practices concentrated almost exclusively on ensuring that suitable facilities management (FM) systems are in place to provide services to the public sector partner at the appropriate contracted prices. However, based on the NAO's analysis of Dartford and Gravesham's PFI project, FM systems control monthly service costs and, in effect, 43% of the possible downside risks transferred to the private sector. These PPE systems in practice, therefore, do not directly control the remaining 57% of transferred risks or the qualitatively defined shared risks or the other forms of qualitative benefits.

Our proposal for the design of a PPE system builds on this conceptual literature, as well as these intentions and actual practices, and has a number of key characteristics. These are that the PPE system:

- Should be proactive in managing predicted costs by setting up control systems to ensure that transferred risks occur and that costs estimated at the pre-decision stage are achieved.
- Should be managerially proactive with regard to the formation of systems to ensure an equitable management of all qualitatively defined shared risks, particularly, but not exclusively, in relation to the periodic renegotiation of the contract between the public and private partners.
- Should actively seek the qualitative views of all stakeholders concerning the workings and cultural effects of the PFI project with systems in place to ensure that such reactive views are proactively considered by management and suitable actions are undertaken.

Taken together these three elements provide the basis for a PPE system which, depending on the success or otherwise of the way they are operationalised, will allow a judgement to be made as to the merit and worth of the PFI projects once underway. Ideally all intended transferred risks should be transferred, all shared risks could be shared in a way that satisfies both parties and all stakeholders views should be regularly gathered and acted upon. If this ideal should occur it is likely that the PFI option has real merit and worth and is VFM but our view is that this cannot be concluded without a further evaluatory discourse between stakeholders, using this information as evidence and as the base for drawing conclusions.

This leads to the more general question as to the level of external monitoring and management that is required to come to this conclusion. Our view is that with so many other pressures on Trusts some of elements of the suggested PPE would be undertaken without external monitoring and management but many others would not. It is here where we think the NAO have a unique role to play, which would fit well with their current desire to expand the nature of their VFM studies. Our view is that the NAO should undertake a type of effectiveness audit of the PPE systems periodically – maybe every five or seven years – to see how well the Trust is undertaking its proactive quantitative and qualitative activities. The NAO should also call together the stakeholders and organise and manage a wide-ranging discourse, using the material and information from the PPE system and the effectiveness audit, to come to a conclusion at that time as to whether the project has merit and worth and is VFM relative. Such a conclusion would be time-bound and would need to be revisited when the next 5 to 7 year analysis is undertaken.

Before turning to these final recommendations we can make a number of key conclusions. First, there is currently a reasonably clear consensus about the justification for PFI. It seems unlikely that there will, in the short term, be a shift away from the micro value for money emphasis that has now come to dominate thinking on the nature of PFI. It is also clear that the Government, through HM Treasury, have reacted well to the many problems of PFI to try to make it work. This has been achieved by legislation, standardisation and more specific issues such as changing the advice of the 'Green Book', as well as recent calls for the introduction of more qualitative considerations. Second, the real challenges for the future lie in refining the pre and post decision processes for the PFI option. In the pre-decision stage the extension in the criteria used to include a qualitative analysis is a considerable challenge for the future, as is finding ways to use qualitative and quantitative criteria together to decide whether or not to proceed with the PFI option. In terms of PPE the challenge is to find ways to extend the systems to proactively consider and control all transferred and shared risks and to find ways to discover stakeholder views on the operation of the PFI project which will lead to proactive managerial change and finally to a periodic judgement of merit and worth and VFM.

6.2. Recommendations

We would like to end this monograph with eight key recommendations for management accounting and management accountants that will assist with the development and design of pre-decision and PPE systems for PFI projects in the NHS. These recommendations cannot be claimed to solve all the practical problems involved in their operation but, we would argue, they provide important pointers to areas where developments are needed. It should be noted that the recommendations are generic rather than specific as there will be a need, in all cases, to ensure that the pre-decision and PPE systems are designed in the specific context of each scheme.

These recommendations are challenges to develop improved management accounting systems for PFI pre and post decision analysis. The first three of these relate to management accounting systems for pre-decision processes, the next three for post-decision processes and the last two to wider issues concerning evaluation and leadership in PFI policy. We recommend the need to develop management accounting systems that:

Pre-Decision Systems

- First, improves general cost estimation processes over the period of the 30 to 35 (and up to 60) years of the contract, and so develop better quantitative estimates for construction, operation and other transferred risks.
- Second, rigorously defines the nature and allocation of the shared risks and stakeholder benefits for the pre-decision stage in the PFI process.

- Third, allows a meaningful and balanced combination of the above quantitative and qualitative analysis (1 and 2) to lead and develop the PFI decision-making process.

Post-Decision Systems

- Fourth, ensures cost attainment and the realisation of expectations concerning transferred risks.
- Fifth, ensures that the allocation of expected shared risks are as intended at the pre-decision stage.
- Sixth, systematically gathers stakeholder views leading to active consideration and appropriate action by management.

Wider Considerations

- Seventh, provides a summative 5 to 7 year analysis (based on recommendations 4, 5 and 6 above) of the handling of transferred risks, shared risks and stakeholder views that can be audited and can be used to lead to a subsequent discursive process that will arrive at periodic judgements on the value for money and merit and worth of the PFI option.
- Eighth, provide input for both the value for money audit methodologies of these systems by the National Audit Office and, where appropriate, the Audit Commission as well as HM Treasury and NHS Guidance in respect of pre-decision processes and PPEs for PFI.

Where there has been most development is in relation to the design of management accounting systems for the quantitative and qualitative pre-decision systems (Recommendations 1 and 2) and the quantitative post-decision analysis (Recommendation 4). However, whilst Recommendation 1 is the most developed, more can and should be done in terms of cost and risk estimation. With regard to Recommendation 2, whilst all the Full Business Cases we have looked at have developed some form of qualitative pre-decision systems related to shared risks and benefits analysis, there is no systematisation of these designs and no formal guidance drawn from these practices. More can and should be done in this area and hopefully the recent recommendations by HM Treasury (2003, 2004), once fully operational, will give further direction in this area. With regard to the quantitative post-decision analysis (Recommendation 4) considerable work has gone into designing highly complex FM systems but monitoring systems for construction and design risk and other quantified transferred risks remain rather rudimentary and undeveloped.

There is need for some considerable development in the management accounting systems design at the pre-decision stage, particularly in relation to the way the improved quantitative and qualitative concerns (Recommendations 1 and 2) can be combined to develop decision-making (Recommendations 3). At the moment the quantitative analysis is dominant in the pre-decision stage. The qualitative concerns are more background data and are unlikely to sway the final decision. However, the indications are that this will change when HM Treasury's Guidance becomes clearer and is operationalised. The real challenge for management accounting will be to find ways which can give equal weighting to these qualitative concerns in the pre-decision criteria that are used to decide whether to pursue the PFI option.

There has been little to no attention in management accounting system design in the PPE systems for handling both shared risks as well as the stakeholder views on benefits (Recommendations 5 and 6). Whilst these concerns feature at the pre-decision stage – admittedly not as strongly as they should (see Recommendation 2) – they seem to be totally forgotten at the PPE stage. Management accounting systems that can agree the way shared risks are handled, should they occur, and for gathering and designing ways to actively consider and act upon stakeholder views, are urgently required.

There is also a need to develop management accounting systems that can bring together the PPE assessments (Recommendations 4, 5, 6) so that a periodic summary picture can be formulated which can be audited and used as an information base for a further discourse between stakeholders to arrive at periodic judgements relating to VFM and merit and worth (Recommendation 7). It is important that this should be undertaken at appropriate times. The most obvious time is the 5 or so years after opening when, typically, the FM contract is renegotiated. At this anniversary, and at subsequent key points in the 30 to 35 (and up to 60) year contract, it is important to draw the analysis together to arrive at a view as to the current situation leading to judgements on the VFM and the merit and worth of the PFI option. To provide such a summative analysis requires a sophisticated and sensitive management accounting system. The audit of these systems and their subsequent use to arrive at an evaluation judgement, we believe, should be undertaken by the NAO who have the societal authority and resources to undertake such analytical work.

Finally, there is a role for management accounting to provide input to national VFM auditing and for the design of national guidance (Recommendation 8). At the moment, particularly with regard to the design of PPE systems but also for pre-decision processes, the national systems could be greatly aided if there were greater levels of meaningful information coming from practice. This ties in directly with HM Treasury's call for 'evidence-based' policy direction to guide pre-decision and PPE processes. Prescription without this engagement with practice has a tendency to be more wishful thinking rather than something that draws from the experience of practice. This provides, therefore, a unique opportunity, if the above proposals are met, for management accountants to play a major role in providing key direction for these national debates.

This links directly to a final concluding comment. Taken together these provide significant challenges for management accounting. To develop systems like this at the practice level of NHS Trust management, guided by the conceptual thinking which comes from this study, allows a theoretically-informed 'bottom up' development for national guidance. This clearly cannot be undertaken without the 'top down' support and reinforcement from the NAO, the Department of Health and the HM Treasury. However, at present, the national guidance, even with the most recent developments, is not as developed as it should be, very largely because there is not enough research on PFI to inform these processes and engagement with practice is not as extensive as it might be. At the same time current PPE practice is only loosely coupled with both the national guidance as well as the experiences of other NHS PFI projects. This study has tried to bridge this gap between conceptualisation and practice. But the success of the bridge building is dependent on the development of management accounting and control systems along the lines suggested in the above eight recommendations.

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Appendices

Appendix 1 An example of a Risk Matrix

The following is an extract from the NHS Executive's 'The Private Finance Initiative in the National Health Service – Section 3 Technical Issues' (NHS, 1999)

1 Design Risk

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
1.1	Failure to	Failure to translate design to brief requirement of the NHS Trust into the design.		●	
1.2	Continuing development of design	The detail of the design should be development developed within an agreed framework and timetable. A failure to do so may lead to additional design and construction costs.		●	
1.3	Change in requirements of the NHS Trust	The NHS Trust may require changes to the design. Leading to additional design costs.	●		
1.4	Change in design required by Operator	There is a risk that the operator need require changes to design leading to additional design costs.		●	
1.5	Change in design required due to external influences specific to NHS	There is risk that the designs will need to change due to legislative or regulatory change specific to the NHS.	●		
1.6	Failure to build to brief	Misinterpretation of design or failure to build to specification during construction can lead to additional design and construction costs.		●	

2. Construction and Development Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
2.1	Incorrect cost estimates	The estimated cost of construction may be incorrect.		●	
2.2	Incorrect time estimate	The time taken to complete the construction phase may be different from the estimated time.		●	
2.3	Unforeseen ground/site conditions	Unforeseen ground/site conditions may lead to variations in the estimated cost.		●	
2.4	Unforeseen ground/site conditions under the footprint of existing facilities	Additional costs resulting from where the private sector is unable to carry out necessary surveys prior to commencing work because facilities are currently occupied.	●		
2.5	Delay in gaining access to the site	A delay in gaining access to the site may put back the entire project.			●
2.6	Responsibility for maintaining on-site security	Theft and/or damage to equipment and materials may lead to unforeseen cost in terms of replacing damaged items, and delay.		●	
2.7	Responsibility for maintaining site safety	The Construction, Design and Management (CDM) regulations must be complied with.		●	
2.8	Third party claims	This risk refers to the costs associated with third party claims due to loss of amenity and ground subsidence on adjacent properties.		●	
2.9	"Compensation Events"	An event of this kind may delay or impede the performance of the contract and cause additional expense.	●		
2.10	"Delay Event"	An event of this kind may delay or impede the performance of the contract and cause additional expense.			●
2.11	Force Majeure	In the event of Force Majeure additional costs will be incurred. Facilities may also be unavailable.			●
2.12	Termination due to force majeure	There is a risk that an event of force majeure will mean they are no longer able to perform the contract.			●

2. Construction and Development Risks (continued)

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
2.13	Legislative/regulatory change: non-NHS specific	A change in non-specific legislation/regulations taking effect during the construction phase, leading to a change in the requirements and variations in costs.	●		
2.14	Legislative/regulatory change: non-NHS specific	A change on non-specific legislation/regulations taking effect during the construction phase, leading to a change in the requirements and variations in costs.		●	
2.15	Changes in taxation	Changes in taxation may affect the cost of the project.		●	
2.16	Change in the rate of VAT	Changes in the rate of VAT may increase the costs of the project. VAT should generally be refundable to the NHS Trust.	●		
2.17	Other changes in VAT	Changes in VAT legislation other than changes in the rate of VAT payable.	●		
2.18	Contractor default	In the case of contractor default, additional costs may be incurred in appointing a replacement, and may cause a delay.		●	
2.19	Poor project management	There is a risk that poor project management will lead to additional costs. For example, if sub-contractors are not well co-ordinated, one sub-contractor could be delayed because the work of another is incomplete.		●	
2.20	Contractor/sub-contractor industrial action	Industrial action may cause the construction to be delayed, as well as incurring additional management costs.		●	
2.21	Protester action	Protester action against the development may incur additional costs, such as security costs.	●		
2.22	Incorrect time and cost estimates for decanting from existing buildings	The estimated cost of decanting from existing buildings may be incorrect, there may also be delays leading to further costs. Public sector risks unless delays and cost attributable to the private sector operator.	●		
2.23	Incorrect time and cost estimates for commissioning new building	The estimated cost of commissioning new buildings may be incorrect, there may also be delays leading to further costs.		●	

3. Performance Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
3.1	Latent defects in new build	Latent defects to the structure of the building(s), which require repair, may become patent.		●	
3.2	Change in specification initiated by procuring entity	There is a chance that, during the operating phase of the project, the procuring entity of the services will require changes to the specification.	●		
3.3	Performance of sub-contractors	Poor management of sub-contractors can lead to poor co-ordination, and under-performance by the contractors. This may create additional costs in the provision of services.		●	
3.4	Default by contractor or sub-contractor	In the case of default by a contractor or sub-contractor, there may be a need to make emergency provision. There may also be additional costs involved in finding a replacement.		●	
3.5	Industrial action	Industrial action by the staff involved in providing facilities services would lead to higher costs and/or performance failures.		●	
3.6	Failure to meet performance standards	There is a risk that facilities management (FM) will not provide the required quality of services. This may be costly to correct, and operator may incur financial penalties.		●	
3.7	Availability of facilities	There is a risk that some or all of the facility will not be available for the use to which it is intended. There may be costs involved in making the facility available.		●	
3.8	"Relief Events"	An event of this kind may delay or impede the performance of the contract and cause additional expense.			●
3.9	Force Majeure	In the event of Force Majeure additional costs will be incurred. Facilities may also be unavailable.			●
3.10	Termination due to force majeure	There is a risk that an event of force majeure will mean the parties are no longer able to perform the contract.			●

4. Operating Cost Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
4.1	Incorrect estimated cost of providing specific services under the contract: within market testing periods	The cost of providing these services may be different to the expected, because of unexpected changes in the cost of equipment, labour, utilities, and other supplies.		●	
4.2	Incorrect estimated cost of providing specific services under the contract: at point of market testing	The cost of providing these services may be different to the expected, because of unexpected changes in the cost of equipment, labour, utilities, and other supplies. This risk would be shared if the PFI contract envisages that changes in cost at the point of market testing are shared between the NHS Trust and the operator.	●		
4.3	legislative/ regulatory change having capital cost consequences: NHS specific	NHS specific changes to legislation/regulations may lead to additional construction costs, and higher building, maintenance, equipment, or labour costs.	●		
4.4	Legislative/ regulatory change: non-NHS specific	Non-NHS specific changes to legislation/regulations may lead to additional construction costs, and higher maintenance.			●
4.5	Changes in taxation	The scope and level of taxation will affect the cost of providing services.		●	
4.6	Changes in VAT	This may increase the cost of the provision of services to the NHS Trust. However changes in VAT are generally refundable to the NHS Trust.		●	
4.7	Incorrect estimated cost of providing clinical services	The cost of providing clinical services may be different from the expected. These costs include: staff, recruitment, training, equipment and supplies.	●		
4.8	Incorrect estimated cost of maintenance	The cost of building and engineering maintenance may be different from the expected costs.		●	
4.9	Incorrect estimated cost of energy used	Failure to meet energy efficiency targets or to control energy costs.		●	

4. Operating Cost Risks (continued)

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
4.10	Patient infection caused by poor facilities management	There is a risk that a patient infection could be traced directly to the actions of staff employed and managed by the facilities manager. This may include, for example, food poisoning and wound infection from incorrectly sterilised dressings. This risk may lead to increased treatment costs, and possibly legal costs if the patient takes legal action.			●
4.11	Patient infection – other	Patient infection caused by staff employed by and controlled by the procuring body. This risk may lead to increased treatment costs, and possibly legal costs.			●
4.12	Estimated cost of transferring the employment of staff to new employer is incorrect	The estimated cost of the transfer of the employment of staff, under TUPE, may be incorrect. This includes the cost of any legal appeals. The NHS Trust may be asked to warrant information.			●
4.13	Estimated cost of restructuring the workforce providing services under the contract is incorrect	The estimated cost of restructuring the workforce at any time during the operating phase, such as recruitment costs and redundancy payments, may be incorrect.		●	

5.Variability of Revenue Risk

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
5.1	Non-performance of services	The cost of providing these services may be different Payment will only be made by the NHS Trust for services received.		●	
5.2	Poor performance of services	The operator will incur deductions from the performance payment for the poor performance of services.		●	
5.3	Changes in the size of the allocation of resources fro the provision of health care	There is a risk that the resources allocated to the area are reduced or increased. If such changes do occur, there may be a need to rescale the provision of services.	●		
5.4	Changes in the volume of demand for patient services	There is a risk that the volume of demand for health care will change, because of changes in the size of the catchment area. This may occur because there is, for example, an unexpected increase in the size of the population, leading to an increase in demand; or the provision of a new alternative provider of health care, leading to a reduction in demand.	●		
5.5	Unexpected changes in medical technology	Unexpected changes in medical technology may lead to a need to rescale or reconfigure the provision of services. For example, if the increase in day surgery is greater than expected, the total number of required beds may fall.	●		
5.6	Unexpected changes in the epidemiology of the people in the catchment area	Unexpected changes to the epidemiology of the people in the catchment area may lead to a reconfiguration or rescaling of the provision of services.	●		
5.7	Unexpected sudden increases in demand, due to major incident	There is a risk of large unexpected increases in demand (e.g. due to a major incident).			●
5.8	Estimates income from income generating schemes is incorrect	There is a risk that income generating schemes, such as car parking and retail outlets generate less or more income than expected.		●	

6. Termination Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
6.1	Termination due to default by the procuring entity	The risk that the procuring entity defaults leading to contract termination and compensation for the private sector.	●		
6.2	Default by the operator leading to step-in by financiers	The risk that the operator or individual service providers default and financiers step in leading to higher costs than agreed in the contract.		●	
6.3	Termination due to default by the operator	The risk that the operator defaults and step-in rights are exercised by financiers but that they are unsuccessful leading to contract termination.		●	

7. Technology and Obsolescence Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
7.1	Technological change/asset obsolescence	Buildings, plant, and equipment may become obsolete during the contract.		●	
7.2	Technological change	Technical changes may cause the Trust to revise its output specifications.	●		

8. Control Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
8.1	Control of clinical services	The NHS Trust retains control of clinical services which means that it retains significant control of the nature of the services provided by the operator.	●		
8.2	Control of services provided under the PFI contract	The operator should retain control of those subject to 8.1 above.		●	

9. Residual Value Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
9.1	Procuring entity no longer requires assets at the end of contract	The risk that the procuring entity will wish to vacate the assets at the end of the contract period, and that the operator may be faced with decommissioning costs.		●	

10. Other Project Risks

No.	Risk Heading	Definition	Allocation		
			public sector	private sector	shared
10.1	Incorrect cost estimates for planning approval	Estimated cost of receiving detailed permission is incorrect including the cost of satisfying unforeseen planning requirements.		●	
10.2	Delayed planning approval	A delay in receiving planning permission may have broader cost implications for the project, as well as the loss of potential savings.			●
10.3	Land sale receipts	The estimated receipts from the sale of surplus land may be incorrect.		●	

Appendix 2

20 Ways to Transfer Risks

(From HSG (95) 15 Annex B)

Questions to consider include the following:

Could a private partner protect the NHS against risks of:

1. construction costs overrunning?
2. losses through completion delay?
3. costs of latent defects?
4. losses through unavailability of any aspect of facilities?
5. escalating maintenance and repair costs?
6. failure to meet energy efficiency targets?
7. failure to meet facilities management cost targets?
8. income generation schemes failing to meet net income targets?
9. costs of new investment to maintain performance of income generation schemes?
10. quality standards of facilities failing to meet pre-set performance targets?
11. quality standards failing to keep up with new levels being achieved by competitors?
12. losses through shortages of key inputs?
13. problems through facilities failing to keep pace with new technology?
14. problems through design of facilities hindering effectiveness?
15. losses through design of facilities proving inefficient in use?
16. escalation of general operating costs?
17. losses through costs exceeding competitors' prices?
18. losses through facilities proving too big or too small for needs?
19. costs of adaptation for alternative use?
20. lower than expected residual or sale value?

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