



House of Commons
Committee of Public Accounts

The Paddington Health Campus Scheme

Ninth Report of Session 2006–07

*Report, together with formal minutes, oral and
written evidence*

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The Committee of Public Accounts

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Contents

Report	<i>Page</i>
Summary	3
Conclusions and recommendations	5
1 The role of local management in the Paddington Health Campus scheme	8
2 The role of the Department of Health	12
Formal Minutes	15
Witnesses	16
List of written evidence	16
List of Reports from the Committee of Public Accounts Session 2006–07	17

Summary

The Paddington Health Campus Scheme was a complex and ambitious attempt to build a world class healthcare facility which would replace three run-down hospitals (St Mary's, the Royal Brompton and the Harefield) and address problems with the configuration of specialist services in north-west London. However, after five years and £15 million spent trying to develop a robust business case, the Paddington Health Campus scheme collapsed.

In 2000, the approved Outline Business Case estimated that the redevelopment would cost £300 million (£411 million in 2005 prices), with completion by 2006. By May 2005, projected costs had risen to £894 million and the expected completion date had slipped to 2013. Reasons for the delay and cost increases include the fact that Campus partners had failed to secure adequate land for the scheme, and disagreements about the content and affordability. Whilst St Mary's NHS Trust approved the revised business case in May 2005, the Royal Brompton and Harefield NHS Trust declined to recommend it for approval and consequently, in June 2005, the Department cancelled the scheme.

The Department of Health is currently reconsidering the scale of its £13 billion capital investment programme and expects to reduce its level of investment to £7-9 billion, following a review of each scheme's affordability. Whilst the circumstances that led to the collapse of the Paddington Health Campus Scheme were unique, there are lessons for all NHS capital investment schemes. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department and NHS on two main issues: the way in which the local NHS developed the Campus scheme and the role of the Department.¹

We found that the Campus partners were imprudent in submitting an Outline Business Case in 2000 which was manifestly inadequate. At that stage they had not consulted their own doctors and nurses as to the required clinical content of the Campus and were thus unable to determine with any degree of accuracy the land requirements and the likely cost. The eventual collapse of the scheme can be traced directly to the ill-informed decisions taken at the outset by the NHS in north-west London. When the scale of the cost increases became evident in 2002-2003, there was a lost opportunity either to put a stop to the scheme or to require a new outline business case. Overall, the scheme was simply too ambitious for the capacities of those responsible for delivering it.

Many of the failings seen in the Paddington scheme are familiar from past examinations of major capital projects. The Department and the NHS in north-west London repeated many of the mistakes that we identified in our 1999 report on the Guy's Phase III project. The Department failed to provide effective critical challenge when it approved the Paddington scheme in 2000 and thereafter failed to hold the scheme to account against its own guidance in its Capital Investment Manual.

The Department believes there are no more 'Paddingtons' elsewhere in the hospital building programme and that its current review of pre-contract schemes will identify

1 C&AG's Report, *The Paddington Health Campus scheme HC (2005-06)* 1045

affordability problems if they exist elsewhere. There has, however, been too little control of the capital investment programme as a result of the Department's 'hands-off' approach, and forecast costs are some £4 billion above approved outline business case costs. The Department now plans to scale the programme back to £7-9 billion through a one-off review, but it remains to be seen whether this action will be sufficient to get a grip on a programme, which continues to be managed by the NHS locally.

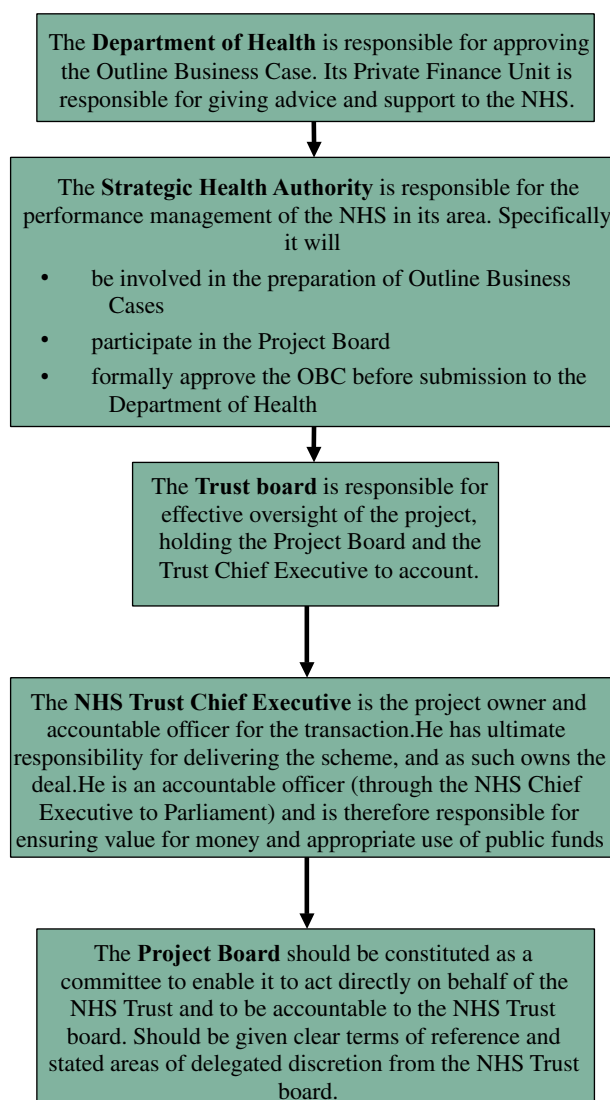
Conclusions and recommendations

- 1. The Paddington Health Campus scheme, as proposed by the Campus partners in 2000, was based on an inadequate Outline Business Case, constructed without the benefit of input from doctors and nurses as to the required clinical content.** Incomplete or inadequate business cases should not be approved until all material issues, including sufficient design work, have been addressed.
- 2. The Royal Brompton and Harefield NHS Trust and St Mary's NHS Trust had unreconciled organisational, clinical and financial interests and in the end the two Trusts took incompatible views of the way ahead.** Capital schemes in the NHS should only proceed with more than one partner when there is a clearly identified single sponsor.
- 3. It took several years after the initial outline business case for the Campus partners to reach a clear position on the clinical content of the Campus, the land required, the planning constraints and the likely cost and affordability of the scheme.** The scheme's development was also handicapped by insufficient manpower and capability. NHS Trusts taking forward building schemes should have early external assessments, for example by the Department's Private Finance Unit, of their capacity to deliver complex schemes and firm timetables against which they can measure progress.
- 4. The North West London Strategic Health Authority failed to manage effectively the development of the scheme by the Campus partners.** The local responsibility for monitoring the scheme fell initially to the Kensington and Chelsea Health Authority and, after March 2002, the North West London Strategic Health Authority. The Strategic Health Authority should have either cancelled or fundamentally reassessed the scheme in early 2003. Instead it strongly encouraged the Campus partners to pursue additional accommodation for the scheme. New Strategic Health Authorities should establish clear criteria for monitoring each scheme's progress and take decisive action when schemes go off-track.
- 5. The bed capacity required by the scheme to meet patients' healthcare needs—and thus its cost and affordability—fluctuated as it was being developed, largely for reasons beyond the control of the Campus partners.** Planned bed numbers ranged from 835 NHS beds to 1,200 across the five-year development of the Campus, and St Mary's NHS Trust was using different planning assumptions to the North West London Strategic Health Authority. Bed numbers, or at least an upper capacity, should be fixed as part of the Outline Business Case approval process.
- 6. The hospital building programme in the NHS was estimated to cost £4 billion more than the approved costs.** The Department's Capital Investment Manual requires a full reappraisal if costs on a scheme are forecast to rise by more than 10%. The average rise above approved costs is 117%, more than doubling the cost. The Department should enforce the requirement for compliance with its guidance and agree with Trusts who breach these guidelines an action plan to bring projects under

closer control, especially where they forecast cost-overruns above approved expenditure levels. It should develop and disseminate to NHS bodies details of the factors that will trigger intervention.

- 7. Forecast cost increases over all current schemes exceed the 40% maximum addition to forecast capital costs which is allowed to correct for optimism bias.** The allowance does not therefore adequately reflect Trusts' over-optimism on the costs of such schemes. To introduce a proper perspective on the likely affordability of schemes, the Department and the Treasury should agree on the appropriate level of optimism bias for NHS capital schemes, based on experience to date.
- 8. The Department was not adequately aware of the state of the Campus scheme because it viewed scheme development as a local issue.** As a result it was slow to respond to the failure of the scheme to make progress. The Department should benchmark the capacity of its Private Finance Unit against similar Units in other Government Departments and against relevant Treasury guidance, to ensure that it has the capacity to provide sufficient support to procurement teams.
- 9. The Campus partners believed that the Department lacked clarity in its role and objectives.** The Department acted as both champion and challenger for the scheme, causing uncertainty and confusion in the Campus partners. The Department, through its Private Finance Unit, should develop flexible and transparent criteria with a greater emphasis on affordability, value for money and viability of projects. It should concentrate on the role of challenger and satisfy itself that hospital building schemes are compatible with these criteria and with other relevant NHS objectives and guidance.
- 10. At one stage the on-balance sheet treatment of the land deal supporting the 2004 Outline Business Case was deemed to render the scheme unaffordable.** The Campus partners were therefore going to leave the scheme. While the Department said it had no requirement that the scheme or supporting land deal be off-balance sheet, the accounting treatment influenced the affordability of the supporting land deal. The Department should confirm to trusts that in evaluating affordability, value for money should drive decisions, and not balance sheet treatment.
- 11. The Department has not been close enough to the development of capital investment projects in the NHS.** While it has a one-off programme to review all pre-contract capital investment schemes valued at over £75 million, there needs to be sustained scrutiny of large projects (over £200 million) by the Department so that NHS Trusts procure these assets within shorter timeframes and with improved value for money.

Figure 1: The principal organisations involved in the Paddington Health Campus



1 The role of local management in the Paddington Health Campus scheme

1. The Paddington Health Campus scheme was an ambitious attempt to replace and renew the estate of two large run-down NHS Trusts. The original vision for the scheme was strong with significant commitment from the trusts involved. The goal was to build state of the art clinical accommodation and research facilities which would address the need for clinical and academic reconfiguration and concentrate specialist services in north-west London at a reduced number of sites. However, the Campus partners were never able to persuade the Department that they had an affordable scheme to match this vision.²

2. The 2000 Outline Business Case had an estimated capital construction cost of £300 million (£411 million at 2005 prices) but the full valuation for the scheme was £894 million in 2005. In 1999, our predecessors said it was a disgrace that the Guy's Hospital Phase III project cost £115 million against an approved original estimate of £35.5 million and looked to the Department to ensure that priorities were based on realistic cost estimates. The Campus partners accept that the 2000 Outline Business Case was inadequate but it was still approved by the Department.³

3. The Campus partners now accept that they submitted what they describe as a 'highly unusual and high-level' business case to the London Regional Office of the Department. It was only after the Regional Office approved the scheme (**Figure 1**) that the Campus partners engaged with their doctors and nurses to determine the clinical content the scheme would require.⁴

4. The original vision was to use the St Mary's site in Paddington for the Campus with clinical content requirements determining the land required. As the details of the clinical content requirements emerged and their impact on the Campus were better understood, the inadequacy of the available land and the impact of planning constraints became evident. The Royal Institute of British Architects told us that early and thorough testing of a design brief could have been used to test the capacity of the land at an earlier stage. St Mary's NHS Trust acknowledged that not understanding the full scale of the task at the approval stage in 2000 had hampered the scheme from the outset.⁵

5. The Campus partners also recognised from the start that they did not have the skills necessary to develop a robust scheme on the scale of the Paddington Health Campus without the support of expert advisers. The 2000 Outline Business Case was developed with the assistance of experienced management consultants. As the scheme progressed it became clear that the first Project Director, appointed in October 2000 lacked the skills to do a job of this magnitude. In October 2002, therefore, after two years of disappointing

2 Qq 2, 9, 13, 21 and 116, C&AG's Report, para 5.1

3 C&AG's Report, para 3 and Appendix 5, Qq 5, 76

4 Qq 133-134

5 Qq 9, 48, 127-135, C&AG's Report, para 1.5

progress in meeting project milestones his contract was terminated by mutual consent. Further experts were engaged to give advice on specific aspects of the scheme at a cost of £7.8 million, with advice on procurement of consultants and property advice from Partnerships UK from November 2002 onwards. Overall the Campus partners spent £14.9 million on developing the scheme (Figure 2).⁶

Figure 2: Expenditure on developing the Paddington Scheme

Spend by Year from 1999		Total cost to 30/06/05
	£'000	£'000
Advisers		
Technical	1,891	
Town Planning	1,721	
Legal	763	
Healthcare planning	758	
Corporate finance	613	
NHS finance	460	
Decant	451	
Property	303	
Communications	221	
IM&T	248	
FM Support	143	
Equipment	94	
Audit	71	
Accommodation	25	
Other	21	
Insurance	8	7,792
Pay		4,762
Accommodation & other		
Project costs		1,272
Direct costs from Partnerships UK		1,071
Total		14,898

Source: Note to Q 92

6. The resources available for development of the Outline Business Case were capped by the capital value of the approved Outline Business Case at approximately £6.3 million. This sum was insufficient to develop a scheme of this scale and inadequate funding handicapped the scheme's management capability throughout the planning phase. Only £4.9 million development funding from the co-sponsor of the scheme, Partnerships UK, allowed the scheme to be developed further. Even then, in 2004 the scheme opted to defer implementing embedded risk management on what was by then a £900 million scheme

because it could not be afforded at the same time as developing a new Outline Business Case.⁷

7. When the original Outline Business Case was submitted in 2000 the Department approved it, with reservations, but now recognises that the scheme should arguably not have gone ahead at that stage. The Campus partners also agree that the scheme should have been either cancelled or resubmitted in early 2003 when costs had doubled and there was no planning permission for the scheme. Following a critical report from the Department, the Treasury and the National Audit Office in October 2004, further consideration was given to stopping the project. But, at all of these points, the Campus partners continued with the scheme believing that the vision was worth the effort, although the Department accepts that, with hindsight, the process went on too long.⁸

8. In October 2003 the Treasury requested a new Outline Business Case to replace that drawn up in 2000. A new Case was submitted by the Campus partners in December 2004, with assumptions on balance sheet treatment and affordability that were not acceptable to the Department. The Campus partners resolved to cancel the scheme but, with the consent of the Department, accepted an offer from Westminster City Council to assemble a package of land for the site. They believed that such an offer could turn the economics of the scheme upside down and therefore felt it ought to be considered.⁹

9. The Campus partners could not agree on the affordability of the final scheme in May 2005. While the scheme was more affordable than the December 2004 Outline Business Case, the constantly changing forecasts of revenue, based on evolving Departmental guidance, and the cost of the land deal undermined the confidence of the North West London Strategic Health Authority and Royal Brompton and Harefield NHS Trust Board in the financial robustness of the scheme. The Department told us it had expressed very significant reservations about the affordability of the scheme in January 2005, after receiving the December 2004 revised Outline Business Case.¹⁰

10. The immediate cause of the collapse of the scheme in May 2005 was the failure of the two NHS Trusts to agree on an Addendum to the December 2004 Outline Business Case. The principal difference between the Trusts was Royal Brompton and Harefield NHS Trust's concern that there was inadequate land available for the scheme, given planning constraints, and that without land the required facilities could not be built. This left the scheme dependent on Westminster City Council and the property developer who owned the land required.¹¹

11. The scheme originally planned for 1,000 beds in 2000, then 1,200 by November 2002, 1,088 in October 2003 and 835 NHS beds in May 2005. The North West London Strategic Health Authority was responsible for bed capacity planning at a strategic level but the Strategic Health Authority and St Mary's NHS Trust were using different planning

7 C&AG's Report, paras 22, 2.14-2.21, Q182

8 C&AG's Report, Appendix 1, Qq 1, 25-26, 93-104, 143-145

9 C&AG's Report, para 3.2, 3.9-10, Q1

10 Qq 141-143, 154, C&AG's Report, para 17

11 C&AG's Report para 3.1 and Q117

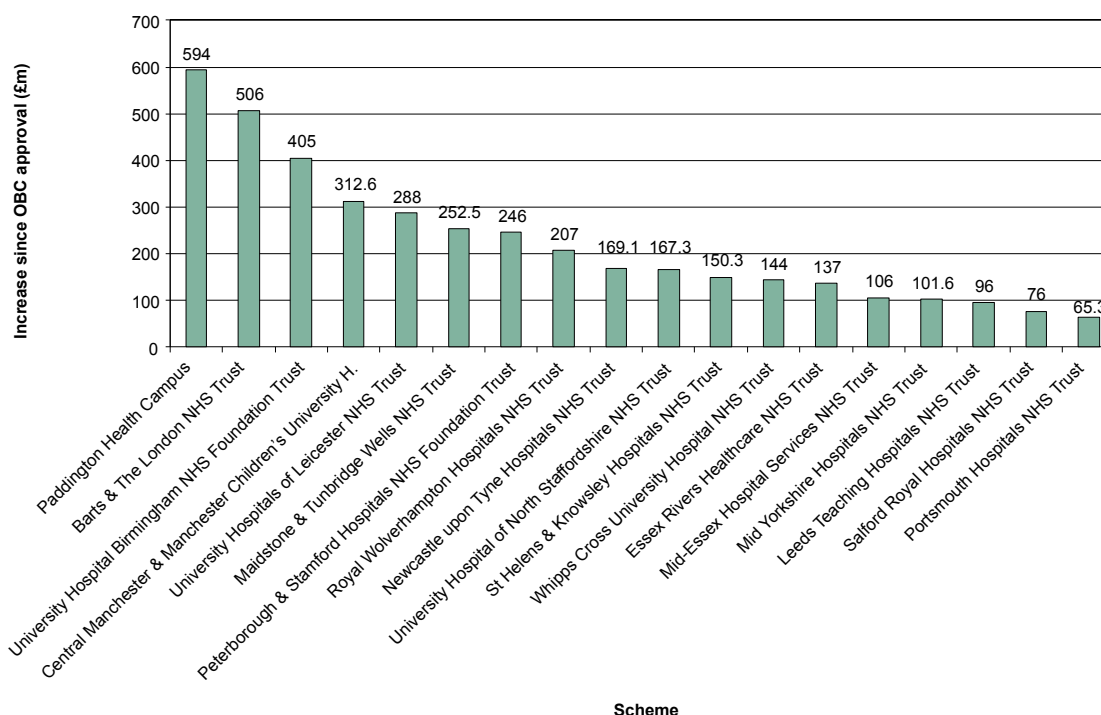
assumptions. The Department took the view that it was up to the local NHS organisations to make their own assumptions in planning capacity, even though they had no track record on which to base their assumptions.¹²

12 Qq 20, 27-34, 56-59, 176-178, C&AG's Report, para 3.27

2 The role of the Department of Health

12. By the end of 2005 the Department had approved in principle the development of capital investment schemes with an estimated capital value of £13 billion. Local NHS Trusts would contract with private sector suppliers, who would build hospitals. The value of the capital programme represented a substantial increase over the original approved schemes. For the 17 schemes over £75 million that the Department reported on in November 2005 and the cancelled Paddington scheme, the estimated valuation in November 2005 was some £4 billion above the approved scheme valuations (**Figure 3**). Overall the schemes increased by an average of 117% over the original approved values.¹³

Figure 3: Increase in estimated capital construction costs since Outline Business Case approval stage



Source: Memorandum received from the Department of Health containing Replies to a Written Questionnaire from the Health Select Committee, HC 736, Session 2005-06, 5 May 2006, and Comptroller and Auditor General's Report

13. The Department is currently reviewing all 38 unsigned PFI schemes over £75 million to determine how the commissioning of major capital schemes through PFI can be reconciled with long-term affordability and policies on choice, Payment by Results and the movement of care away from acute hospitals to the primary care sector. As a result it expects the scale of the PFI programme to fall from £13 billion to £7-9 billion. The review is still to be

completed and the Department believes that costs are not likely to rise in the meantime to an extent that would outweigh the benefits of such a review.¹⁴

14. Over the period in which the Paddington Health Campus scheme was being developed, the Department introduced a number of national policies with local implications. These included new guidance on bed numbers, consumerism standards, new Treatment Centres, Payment by Results and choice at the point of GP referral. Local NHS organisations had to make their own estimates of the impact of such new policies. The Department accepted that local NHS organisations, in making their own assumptions in planning capacity, had no track record on which to base their assumptions.¹⁵

15. The Department played two key roles in the development of the Paddington Health Campus scheme. It supported the vision of the scheme as a means of meeting the clinical and estate needs of the local NHS organisations but it also challenged the affordability and deliverability of the scheme. As both ‘champion’ and ‘challenger’ the Department, and elements within it, gave mixed messages to the Campus partners, so much so that the partners were uncertain whether the Department did in fact want the Campus scheme to succeed.¹⁶

16. When the Department approved the inadequate Outline Business Case for the Paddington Health Campus scheme in 2000 it did so with a number of qualifications. The Campus partners told us this was a high level business case, but the Department agreed it was not close enough to the development of the scheme to perform an effective critical challenge. In October 2003 it was the Treasury, rather than the Department, which requested a review of the scheme and withdrew the approval of the 2000 Outline Business Case.¹⁷

17. The Department approved the Outline Business Case in 2000 despite the existence of a strong condition from the Royal Brompton and Harefield NHS Trust that it would not proceed with the scheme if it was required to merge with St Mary’s NHS Trust. The Department believed that such a merger might make delivery of the campus easier, but did not propose or require one as a condition of the scheme proceeding, as it believed such a requirement would have stopped the scheme.¹⁸

18. The 2000 Outline Business Case was developed under the Department’s Capital Investment Manual. That Manual required a review if the estimated cost rose by more than 10%; that outline planning permission be secured prior to advertising in the Official Journal of the European Union; and that risk management be adequate to ensure that the preferred option in an Outline Business Case was affordable and represented the optimum solution. None of these conditions were met by the Campus partners or the scheme. The

14 Qq 18, 36-37, C&AG’s Report, para 2.30 and Note to Q75

15 Qq 59-62, 132, C&AG’s Report, para 2.32

16 Q 148

17 Qq 3-5, 9

18 Qq 159-161 and C&AG’s Report 2.13

Department accepts that it should implement its own guidance, and told us that schemes coming forward now are subject to central scrutiny which was not the case in 2000.¹⁹

19. In approving capital investment, for which the taxpayer ultimately pays, the Department has stressed the need for affordable schemes. In the case of the Paddington scheme, at the time the December 2004 Outline Business Case was submitted the land deal supporting the scheme was on-balance sheet. The NHS Trusts could not afford the scheme with the land deal on-balance sheet and the Department did not have the resources at that time to fund such a deal, which resulted in the Campus scheme partners resolving to exit the scheme.²⁰

19 C&AG's Report, para 27a, 2.6, 2.14 and Q5

20 Qq 50-54, C&AG's Report, para 16, 3.8-3.9

Formal Minutes

MONDAY 15 JANUARY 2007

Mr Edward Leigh, in the Chair

Annette Brooke

Mr Ian Davidson

Helen Goodman

Mr Sadiq Khan

Mr Austin Mitchell

Dr John Pugh

Mr Don Touhig

Mr Alan Williams

Draft Reports

A draft Report (The Paddington Health Campus scheme), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 19 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Ninth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions.

[Adjourned until Wednesday 17 January at 3.30 pm.]

Witnesses

Monday 5 June 2006

Mr Hugh Taylor CB, Acting Permanent Secretary, Department of Health, **Mr Bob Bell**, Chief Executive, Royal Brompton and Harefield NHS Trust, **Dr Gareth Goodier**, Chief Executive, North West London Strategic Health Authority, **Mr Julian Nettel**, Chief Executive, St Mary's NHS Trust and **Mr Jack Pringle**, President, Royal Institute of British Architects

Ev 1

List of written evidence

- | | | |
|---|---------------------------------------|-------|
| 1 | Royal Institute of British Architects | Ev 19 |
| 2 | Department of Health | Ev 22 |

List of Reports from the Committee of Public Accounts Session 2006–07

First Report	Tsunami: Provision of support for humanitarian assistance	HC 25
Second Report	Improving literacy and numeracy in schools (Northern Ireland)	HC 108
Third Report	Collections management in the National museums and galleries of Northern Ireland	HC 109
Fourth Report	Gas distribution networks: Ofgem's role in their sale, restructuring and future regulation	HC 110
Fifth Report	Postcomm and the quality of mail services	HC 111
Sixth Report	Gaining and retaining a job: the Department for Work and Pensions support for disabled people into work	HC 112
Seventh Report	Department for Work and Pensions: Using leaflets to communicate with the public about services and entitlements	HC 133
Eighth Report	Tackling Child Obesity—First Steps	HC 157
Ninth Report	The Paddington Health Campus scheme	HC 244

Oral evidence

Taken before the Committee of Public Accounts

on Monday 5 June 2006

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Greg Clark
Mr David Curry
Mr Ian Davidson
Helen Goodman

Mr Sadiq Khan
Mr Austin Mitchell
Dr John Pugh
Mr Alan Williams

Sir John Bourn KCB, Comptroller and Auditor General, National Audit Office, was in attendance and gave oral evidence.

Ms Paula Diggle, Treasury Officer of Accounts, HM Treasury, gave evidence.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

DEPARTMENT OF HEALTH

THE PADDINGTON HEALTH CAMPUS SCHEME (HC 1045)

Witnesses: **Mr Hugh Taylor CB**, Acting Permanent Secretary, Department of Health, **Mr Bob Bell**, Chief Executive, Royal Brompton and Harefield NHS Trust, **Dr Gareth Goodier**, Chief Executive, North West London Strategic Health Authority, **Mr Julian Nettel**, Chief Executive, St Mary's NHS Trust and **Mr Jack Pringle**, President, Royal Institute of British Architects, gave evidence.

Q1 Chairman: Good afternoon and welcome to the Committee of Public Accounts where today we are looking at the Comptroller and Auditor General's Report on *The Paddington Health Campus scheme*. I should like to welcome back Mr Hugh Taylor, who is the Acting Permanent Secretary at the Department of Health, also Bob Bell, who is Chief Executive of the Royal Brompton and Harefield NHS Trust, Dr Gareth Goodier, who is the Chief Executive of the North West London Strategy Health Authority, Julian Nettel, who is the Chief Executive of St Mary's NHS Trust and Jack Pringle, who is President of the Royal Institute of British Architects. A very distinguished crowd of witnesses; thank you very much for coming. Mr Taylor, perhaps I could start with you. Five years and £15 million wasted. Why did it take so long to decide that the business case did not stack up and what were you doing about it? By the way, while you are thinking of an answer, may I just say that the Committee had a very interesting visit to the site of the Campus in the shape of Mr Bacon, Greg Clark and myself; we are very grateful to all those who hosted that visit and we learned a lot. Mr Taylor over to you.

Mr Taylor: The first thing to say is that the original vision for the scheme was very strong and there was a lot of commitment to it from the trusts involved. There were issues with the scheme from the outset and with hindsight it is clear that there were flaws in its set-up. Throughout the project developments occurred which in effect kept it live, which people felt ought to be addressed, which, towards the end of the scheme as various options for looking at the land

requirement were considered, could have turned the economics of the scheme upside down. So it is not difficult to see in real time why the delay occurred, but in retrospect, it was clearly regrettable and all of us now recognise that it went on too long.

Q2 Chairman: Do you accept that, in retrospect, you were too hands-off as a Department? Put it another way, are you satisfied that the Campus partners had the resources and the ability to put together such an enormous scheme without greater help from you?

Mr Taylor: The Report which was done in 2004, in which the Department participated with the NAO, indicated our concerns about the level of capability on project management of the scheme. The Department was engaged with the scheme and did seek to support colleagues in the trust and in the SHA on the scheme as it went forward. Of itself just greater departmental involvement in the process would not necessarily have helped. The key question, which the NAO Report has brought out, is whether critical challenge should have been brought to bear on the scheme at an earlier stage than it was. With hindsight the answer to that question is yes, though I understand why colleagues kept looking at options as they went along.

Q3 Chairman: Did you know what was going on? Could you look at paragraph 3.3 please? Are you telling us that you were sufficiently on the ball with this? It was the Treasury not you, was it not, that insisted on a new outline business case and a review of the scheme? Was it the Treasury?

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Mr Taylor: Yes, it was indeed.

Q4 Chairman: Why did you leave it to the Treasury? Why were you not actually in there insisting that their review should take place?

Mr Taylor: That is a legitimate criticism.

Q5 Chairman: It is a fairly fundamental criticism, is it not?

Mr Taylor: The outline business case was originally qualified by the London regional office, then a part of the Department. It is clear from the NAO Report that the evaluation of the cost of the project escalated. It is clear, and we all accept the NAO conclusion, that in 2002–03 an opportunity was lost either frankly to put a stop to the scheme or to seek a further outline business case at that stage. Properly it was the responsibility of the partners and the SHA to take that step at that stage, but now we would as a Department be closer to the scheme than that and probably expect to be involved more directly. In any event, it is also true now that an outline business case coming to the Department would have central scrutiny in a way that was not the case at the time.

Q6 Chairman: Will you look at paragraph 16 and will you explain to us why the Department would not accept any outline business case unless the scheme and any supporting land deal was off balance sheet? Why did it have to be off balance sheet?

Mr Taylor: The Department's concerns at the time were not specifically whether the scheme should be on or off balance sheet. The Department's concerns were about the affordability of the scheme.

Q7 Chairman: Hang on. It says here in paragraph 16 "... the Department would not accept any OBC outline business case if the OBC or supporting land deal was on balance sheet".

Mr Taylor: It says actually "... the Campus partners believed" that was the case. The Department did not, as far as I am aware, say to the partners that it had to be off or on balance sheet. What we should look at is the affordability of either option. If it ended up being on balance sheet, then an affordability question would arise and to my recollection, having looked at the papers, one of the points that was made to the trust partners in January 2005 was that if the balance sheet treatment was not right, the potential costs in terms of capital cost to the Department would be so significant that the scheme would be unaffordable.

Q8 Chairman: Would you look at figure 3 please on page 16? You seem to have a fairly poor grip on your hospital building programme. As far as we can see from this figure, on average schemes are doubling their cost after approval. Why is this?

Mr Taylor: This figure disguises some of the different drivers of additional costs in the way it is presented. For example, from the first quarter of 2000 to the first quarter of 2006, building cost inflation has risen by 48%. So, invariably across these different schemes, building cost inflation

would be one of the factors which are taken into account. Similarly, as the lifetime of a scheme goes on, and sometimes they are quite long, service changes, service additions will be added, will be made to the scheme, quite legitimately to take account of growth sometimes and because the money available to the NHS has been increasing it is quite permissible to have service additions. Similarly, we have, over this period, sent new guidelines out to the NHS on issues to do with quality of patient care, to do with the number of single rooms in hospitals and so on and those will have affected the figures. There are a number of driving factors behind those figures, but that is not to say that they are satisfactory; they are not and we have learned lessons from this and other schemes which mean we are now approaching PFI approvals and monitoring in a very, very different way. For example, we are now looking at all cases above £75 million, at outline business case—

Q9 Chairman: I am going to have to stop you there because we have very little time. We shall just have to try and get down the detail of this particular scheme. Mr Nettel, why did you put forward such an inadequate case in 2000 do you think?

Mr Nettel: The case was put forward by all the partners involved. This was a whole system scheme involving the two trusts, Imperial College, the then health authority, Kensington, Chelsea and Westminster and we all agreed that this was the way in which we wanted to develop hospital services in north-west London. As my colleague Mr Taylor has indicated, there was huge support for this. St Mary's has to be redeveloped; it certainly needed to be redeveloped when the scheme was first considered and that has not changed. There were serious and continued to be serious problems about specialist services in north-west London for children and adults because of the way in which they are currently configured. Paddington was the way in which we could get those issues resolved. It is true to say, as the NAO indicates, that the business case in 2000 was a high-level business case. It was agreed with the regional office at that time that it would be a high-level business case and that there would have to be further work done on that case after its initial approval. That is what happened. In a way, that is what in a sense we have been trying to recover from. That process probably was flawed, looking back, and has led to the difficulties that are now set out in the Report from the NAO.

Q10 Chairman: Mr Bell, may I ask you to look at the chronology, as there is something I do not understand. Is it right that in December 2004 the scheme was going to have an estimated deficit of £10 million and then you were presumably happy with that, but you withdrew support in May 2005 when the estimated deficit had decreased to only £3 million? Is that right? What was going on?

Mr Bell: The scheme that was approved by the Royal Brompton and Harefield Trust in December 2004 was approved subject to a number of

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

conditions. Those conditions were not fulfilled and in May 2005 in fact we found ourselves having to be in a position to resubmit an outline business case addendum without these conditions being—

Q11 Chairman: But I do not understand why you withdrew support. You had this estimated deficit of £10 million when you were prepared to go ahead with it and then when it is decreased to £3 million you pull the plug. Why?

Mr Bell: It is more than just the issue of the deficits. There were other conditions. The key condition that positioned us to withdraw support from the outline business case, not the scheme, was that there was no land available.

Q12 Mr Mitchell: This looks like a mess. It is manual of how not to do it, is it not, of how to have so many fingers in the pie that nobody is actually in control? Surely the main responsibility therefore rests with the Department of Health as the one body in overall control which is pushing trusts into developing PFI hospitals and leaving the responsibility to them. What position did the Department of Health take initially on the desirability of this Campus?

Mr Taylor: The proposal to go ahead with the scheme was approved within the Department of Health as a result of a process of prioritising a number of capital scheme proposals from the NHS; this was in the late 1990s. That was on the basis of the strategic outline case. The process of approving the outline business case was then delegated to the regional office of the Department. What that meant was that the Department supported the strategic vision set out in the original case and at that stage was looking then to the NHS to develop the schemes and bring them forward, first to outline business case and then to procurement phase. At that stage the Department did have a more hands-off approach than it would have now and did not really get involved in details till the final business case. If what lies behind your question is whether the Department should stay closer to big capital schemes of this kind, then the answer is yes and we now do.

Q13 Mr Mitchell: That would be my answer too, but why in that case did the partners believe that they had your strategic support, political support for the scheme? They believed they were God's chosen; you had put it high on the list of priorities presumably and it was their job to get on with it.

Mr Taylor: They put forward the scheme and it was approved. Of course we as a Department were briefed by our colleagues and subsequently by the strategic health authority on the progress of the scheme and ministers were seized of the potential that it had to improve services for these organisations. So it had support in that sense. But support is not absolute; it has to be conditional on there being an affordable case. The original OBC was qualified on the grounds that there were still issues to explore and in the end the Department would have had to have been persuaded that the

revised outline business case was affordable. The Department's support was there for an affordable scheme as the NAO Report reports.

Q14 Mr Mitchell: In 2000 the London regional office said yes, go ahead and they supported it. So that carried implicit support for the scheme as it was then.

Mr Taylor: Yes, it did.

Q15 Mr Mitchell: Why was there no concern at that time, given the fact that you had had experience of other schemes over a substantial period by this stage, at the fact that there was no united control? Surely a big project like this needs one person, one authority, one body in charge of it. You could not even get the two trusts to merge.

Mr Taylor: There are two separate issues there.

Q16 Mr Mitchell: Yes there are, but I should like to muddle them up.

Mr Taylor: Let me deal with the issue of whether the Department should have allowed a partnership scheme to go forward. First of all, I accept the conclusions of the Report that leadership of these schemes is important and governance is important. The proposal here was for a partnership to develop a scheme, a PFI scheme, and we had delivered examples of PFI schemes which were partnerships.

Q17 Mr Mitchell: In those was there somebody clearly in control or were the partners still arguing?

Mr Taylor: The critical thing is to ensure that you have governance which sorts out any issues and since this experience and with more experience we have looked critically at scheme proposals which have involved partnerships and in at least two cases comparatively recently, as a result of some challenge that we put into the process on governance, we have pushed back on schemes which were proposing partnerships and they then reverted and have broken back down into their constituent parts and gone for single schemes. So we do take an active interest in this. In this case, we thought that the partnership arrangements, the arrangements for the trust to work in partnership under a single project management, in principle could have produced the right solution.

Q18 Mr Mitchell: The Royal Institute of British Architects thinks the arrangements were not adequate and needed much tighter centralised control. Indeed did the assessment by independent experts not say exactly that?

Mr Taylor: It is fair to say that we have been putting in stronger central controls and central governance over PFI schemes in more recent years. For example, we now deal with the OBC upstream and we have just at the moment called in all PFI schemes and are reviewing all PFI schemes over £75 million to test them against some of the recent policy developments which may or may not affect them. We would not accept that there should be a complete bar on moving forward with schemes where partnerships

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

are proposed if they can be run forward successfully. There is a separate question which you raise, about whether we should have moved forward in a scheme where effectively there was a pre-condition against merger. That is a separate question and frankly, if you press me on that, I should say now that we should want to be much more questioning of that approach.

Q19 Mr Mitchell: It is true that you should have maintained a much tighter control over those which are partnership schemes just to see that the effective control is being maintained. But the Department itself kept changing its views on affordability and certainly there were changes in the numbers of beds that were deemed necessary, reductions in the numbers of beds that were deemed appropriate to the area. So your control was not consistent.

Mr Taylor: We were looking primarily to the local NHS to take a view on the right levels of capacity for the area. Our view on affordability was not changing in the sense that we were questioning affordability issues from the outset. I am not sure that I can go any further than that. I am not quite sure that I have understood the implication of your question.

Q20 Mr Mitchell: The estimates of the number of beds necessary in the health service have been falling, have they not, and that must affect a grandiose project like this if you start out with 1,000 beds and it gets reduced to 800 and then falls below that? If you do not have a consistent estimate of the number of beds you are going to need it is difficult to know about the finances of the thing.

Mr Taylor: It is true that when the scheme was launched it was at a time following the publication of the national beds inquiry when there was a lot of emphasis nationally on increasing capacity in the NHS and increasing the number of beds. There was no question about that. Since then and since capacity has been increased it is true that there have been revisions of the assessment of capacity in areas. That is primarily, with respect, for my colleagues in the local NHS, the commissioners and the strategic health authority to pursue. We would not necessarily want to second guess the local areas on that, particularly in respect of where they want capacity to be placed, that is whether it should be on this Campus or elsewhere.

Q21 Mr Mitchell: I just wonder what the reaction was in the Department and in the London regional office as the problems seemed to multiply and the costs went up. There must have been several brown-trouser moments in this kind of situation. Was there a situation in which you considered cancelling it before 2005?

Mr Taylor: There were, as the Report indicates, at least two occasions when not the Department specifically but the partners and the SHA considered cancellation and on both occasions something turned up. In other words, new proposals came forward, first from Westminster City Council, which colleagues, including colleagues in the Department

felt genuinely had to be looked at. In other words, they could have turned the economics of the situation, although in retrospect that process looked as though it went on for too long—and it is difficult to feel that it did not go on too long—it probably would have felt as though it was unreasonable not to have those options explored at the time. There was a growing feeling, which is reflected in the correspondence in the Department, that the scheme was looking unaffordable and that is clearly documented in January 2005.

Q22 Mr Mitchell: Until right to the end.

Mr Taylor: Yes.

Q23 Mr Mitchell: One final question. I am a bit puzzled as to Westminster City Council's role in this. What assessment was made of Westminster's own interest? Was it pursuing its own interest in flogging this land to the trust? Was this a self-interested move or a genuinely altruistic concern that the project should go ahead?

Mr Taylor: Its primary interest was that they were genuinely keen to see development of the St Mary's site in particular.

Mr Nettel: Those of you who know Paddington will know that it is an area that it is undergoing significant regeneration and is a priority area, Praed Street in particular, and St Mary's is in the middle of that. The Council have been extremely keen to see St Mary's prosper as we are the only NHS hospital in the City of Westminster and they care about us to that extent. However, they also knew that if they could get the scheme as it was designed at the end of this process off the ground, then this would release most of the St Mary's site as it currently stands next to Paddington station for complete redevelopment, which was one of their key urban development priorities and has been for a very long time.

Q24 Chairman: Dr Goodier may I just ask you about that, because you have not had a chance to say anything yet? We have had this point about Westminster City Council. They advised that the scheme could not fit on the land available, so why did you not cancel it at that stage in 2002–03? Costs had doubled, Westminster Council was obviously dubious about it, why did you not just step in and cancel it then?

Dr Goodier: The SHA was formed in April 2002 and took a few months to settle in.

Q25 Chairman: I am talking about late 2002/early 2003.

Dr Goodier: Yes, an opportunity was missed there and with hindsight we would agree—

Q26 Chairman: You should have cancelled it then.

Dr Goodier:—it should have been withdrawn or there should have been a new outline business case. There is no question about that.

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Q27 Helen Goodman: Mr Goodier, I should also like to ask you about this beds forecast which Mr Mitchell has raised. We are constantly being told that throughput is being increased and people only need to stay in hospital for two or three days and occupy a bed for two or three days. Would that be the average occupancy that you would have expected in this hospital for these beds?

Dr Goodier: The modelling that we have been doing is based upon a specific diagnosis and the length of stay for that and particularly taking some account of peer group hospitals.

Q28 Helen Goodman: What is the average occupancy then that you were projecting in this forecast?

Dr Goodier: The point to establish is that to have a length of stay for a hospital is of not much value to anybody because you need to have a length of stay for a particular medical condition. If you took the whole hospital and they treated very simple district general hospital conditions, the length of stay could be very low, but if it were a complex hospital such as Hammersmith which is dealing with very complex cases, you would expect it to be higher. What we try to do is to compare the length of stay for a condition against another condition. For example, for a fractured neck of femur there is an NHS median length of stay of 25 days and some of the hospitals in north-west London were reporting 38 days. This was not an issue about one or two days.

Q29 Helen Goodman: If it was 20 days, and we can see here that the estimates changed in a five-year period by 1,500 beds, we would be talking about more than 15,000 patients a year. How could you forecast change for the number of patients needed to such a large extent in that time?

Dr Goodier: May I just ask you where the figure for 1,500 beds came from?

Q30 Helen Goodman: You have just told me 20 days, there are 365 days in a year, there are 1,500 bed changes set out in paragraphs 2.18 through to 2.24, just do the arithmetic.

Dr Goodier: What I suggested was for one particular condition.

Q31 Helen Goodman: And I asked you the average and you could not give me that, so I took the number you did give me. Could you tell me what the change in the number of patients was that underlay this change in the number of beds you estimated?

Dr Goodier: The total number of beds for the Paddington Health Campus scheme was over 1,000 beds and it reduced to 800 and something and it varied. It was not simply just plain length of stay by condition that was driving that. It was the anticipation of the recent White Paper, where there was a move to more ambulatory care given into community facilities.

Q32 Helen Goodman: No, it was not a change of 200 beds. If you look at paragraphs 3.27 and 3.29, you can see that at the outset you were forecasting an increase in the number of beds needed to the tune of 1,200 and by the end of the period, you were saying you needed 600 fewer beds in the area. That is a 1,800-bed change in your forecasting.

Dr Goodier: I am sorry, I thought you were talking about Paddington Health Campus, but if you are talking about the whole area, the whole of north-west London, then that would be a different quantum that is for sure. The point being that we focused a great deal on comparing north-west London with the rest of the NHS in similar hospitals and trying to achieve the same level of efficiency and productivity and using that as the benchmark for which we aspire in north-west London. That was partly for planning purposes but also partly because north-west London has historically been an area which had large deficits. It was a review of that efficiency and productivity which was driving some of these assumptions.

Q33 Helen Goodman: So you think this really rather large swing in the number of beds needed in the forecasting within a five-year period is absolutely to be expected. It does not alarm you that your forecasting might not be all it ought to be.

Dr Goodier: It alarms me that there was such a large anticipated increase. I can really only give the detailed understanding of what currently exists and what north-west London bed numbers and capacity look like when compared with the NHS today and going forward.

Q34 Helen Goodman: Mr Taylor what are you doing to ensure that bed forecasting around the country is slightly more accurate now than it was in this period?

Mr Taylor: In relation to the whole process of forward planning in the NHS, we now, through the local delivery planning process, take a more strategic view, area by area, of proposed growth across a strategic health authority area, for example at the time when local delivery plans are put in. So, for example, at the moment, we shall be looking quite critically at the plans for the forthcoming year which will take into account the amount of capacity that is forecast in the system and that is subject to some pretty intensive modelling interrogation within the department. For the future, one of the things that we shall be doing is applying that kind of critical analysis to outline business cases as they come forward and indeed to the review of the over £75 million PFIs that we are looking at at the moment. While it is always a matter for the local health area in the end to decide where it is going to put its capacity, how to balance it out, we shall be challenging assumptions about capacity as we go along.

Q35 Helen Goodman: Another of the risks which the NAO Report identifies is changes in policy over the period and one thing which seems to have been a problem was the reorganisation in the NHS. Are you

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

confident that capital projects that are being undertaken at the moment across the NHS will not be similarly impacted by the current round of reorganisations?

Mr Taylor: Yes, we are reasonably confident about that. The fact is that we were, over the time when this PFI was going forward, able to take a number of schemes forward to take them through to final business case approval, so the policy and other risks, which the NAO quite properly refer to in their Report here, were managed; it was not just this one scheme facing those risks, it was other schemes as well.

Q36 Helen Goodman: If you look at paragraph 2.30, it is not what it says. This Report gives the impression that there was a large number of policy uncertainties. Are you telling me that policies on choice, policies on payment by results and the movement of care away from acute hospitals to primary care sector are now very well modelled and the Department knows exactly what the impact is for future hospital build?

Mr Taylor: No, I did not quite say that. Let me make two separate points. The first is that in the last six months, five of the biggest PFI schemes that we have brought forward, worth a total of £2.5 billion, have had business case approval and they have been managing the risks which are set out in this document. They have had to work through those risks and we have been working with those PFI schemes to ensure that the risks are as well balanced as they can be. Second, we have, since the announcement in particular of the White Paper on a shift of emphasis away from the acute sector to community services as part of that overall development, announced in January this year that we are going to review all the schemes currently operating over £75 million to take a look at how they are faring against what we agree is a challenging set of policy issues. That is not to say that we think that should freeze all PFIs or stop them going forward: quite the reverse. However, we are looking at each of them in turn. We have started with the ones which are closest to closure and we are looking against things like the capacity modelling and what sensitivity factors they have looked at for PFI. Broadly speaking, as a general benchmark, what we are saying is that we are looking at long-term affordability, using a ratio, not as a straitjacket, of 15% unitary charge to trust income as a benchmark. We are looking at how they measure up to that kind of benchmark and then seeing whether there are ways of reducing costs. One of the things we are trying to do is to set a new envelope effectively of £7 to £9 billion for PFI schemes against what was around £13 billion. We are cognizant of the risks which are referred to in the NHS report and are trying to tighten up our arrangements to manage them.

Q37 Helen Goodman: Are you aware that when your predecessor gave evidence to us a few months ago, he told us that, for example, on the introduction of

patient choice the extra capacity needed across the NHS would be something between 10% and 15%? Have you built that into the capital programme?

Mr Taylor: Yes, that is one of the things that we are taking into account as we look at those schemes.

Q38 Chairman: Dr Goodier, you have to try to give Mrs Goodman a better answer and try a bit harder. I shall give you one more go. You knew in 2004 that this scheme had marginal affordability. You knew that there were already too many beds in your strategic health authority area, why did you not cancel it at that stage?

Dr Goodier: It was not simply a question of how many beds for north-west London, it was a balance between the old fabric and old stock in the hospitals around north-west London; in other words we needed to have some new fabric. In fact so much of the hospital stock was old, 48% was pre World War II, that we needed to have a considerable number of new beds. The challenge was really the configuration of where those new beds were and what the clinical services were.

Q39 Mr Bacon: Mr Pringle, as the President of the Royal Institute of British Architects, we can safely assume you study projects and project failure probably more closely than most. This particular project seems to have such a large number of risks which were basically ignored. What do you think could have been done to have minimised the risk?

Mr Pringle: A number of things could have been done and a lot of them are obviously identified in the Report, such as the client structure and the management structure. I should not like to focus on those. I should like to look at some of the areas that we have been looking at more generally to do with PFI. Although it is said in the Report that as this project did not reach PFI bidding stage there are no implications for PFI, that is not actually the case, because the run-up to the project, the building of the brief *et cetera* and the outline business case is predicated on a PFI model. So you have to look at it in the round and one of the things that we are observing generally and which this might be an example of, is one of the failures or the weaknesses of PFI, though there are plenty of strengths of PFI and we are not knocking the system entirely. You have a system in PFI where it is assumed that virtually all of the design is going to be done by the PFI consortia and so design is pretty much abstracted from the client side of the equation. We are seeing that briefs which need to be tested by looking at early designs, whether this will work for us in this way, whether there is not a better way of doing it, briefs which could be tested by affordability if an outline design were done at an earlier stage, briefs which could be tested for their suitability to a site, even getting an outline planning permission, is not being done in PFI projects to their detriment.

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Q40 Mr Bacon: Are you basically saying there is something in the nature of the process itself that actually inhibits the preparation of a robust outline business case?

Mr Pringle: Yes. At the moment the PFI mechanism does inhibit initial design exemplars being done to the site and we believe that these could be done to the benefit of that. Indeed the Treasury now believes that this is the case and the latest advice from the Treasury is that more upfront designs should be done in order to develop the briefs, test the briefs and to minimise the risks; minimise the risk to the whole project, minimise the risk to the bidding consortia.

Q41 Mr Bacon: There is something inherently odd, is there not, in going off to a potential provider and asking them to build a hospital without yourself having a fairly good idea, at least in outline, of what it is that you are wanting back in terms of what it does. Not necessarily what it looks like in terms of the material used to construct the cladding on the outside but what it looks like in terms of roughly the space it occupies, roughly its size and to a fair degree of specificity what it is you want; effectively a design brief.

Mr Pringle: That is absolutely right. The more design that can be done up front, the better prepared the project is to go to the market as well as also dialling out some of those risks that this project seems to have tripped up on.

Q42 Mr Bacon: I should like to ask you about costs, because the putative costs obviously went up significantly on this project and we have seen that on many projects; famously on the Scottish Parliament, on Portcullis House across the road and on a number of other projects, some of which were notorious and dragged on for many years. In the case of the Scottish Parliament, I always wondered, having looked at lots of other projects, how anyone thought that £40 million would be an adequate sum and £400 million sounded roughly more in the ballpark of what it might end up being, which of course it did. Is it the case that we are actually looking at spiralling costs or is it that we are looking at inadequate information about what the real true costs are?

Mr Pringle: It would be wise not to get into the Scottish Parliament.

Q43 Mr Bacon: No; no. Especially with Mr Davidson here. The point is, is it simply that they really spiralled, is it that the costs really shot up through the roof or is it really that a better and fuller understanding of what the costs, and those costs always had been as such, actually were?

Mr Pringle: It is our belief that some of those initial bids were completely unrealistic, as the costs revealed themselves at a later stage when they were properly analysed. That is not to say that some costs do not get out of control as additional requirements are put into projects and there are then the issues of change control. If you stuck to the single point, testing the consequences of the brief, in other words

what any particular client in the public sector wants from the buildings, can be most effectively done when an outline design is done at an early stage. You can actually see the consequences, the physical and the spatial consequences, how it is going to have to fit on a site, whether there are transportation issues *et cetera, et cetera*. Those can then be costed in the most direct way and it is not being done in an abstract way and a cost per bed way. The case, in terms of controlling costs, is well made for an outline design at an early stage.

Q44 Mr Bacon: I visited the Belfast City Cancer Hospital where what they call the exemplar approach was adopted and the early project design phase from the client side was led by an architect working with a range of different professionals who knew before they went out to bid that it would cost £48.2 million and that is more or less exactly what it cost. Is it actually the case that you can take an example like that and read it across to any kind of project or were there things which were special about Belfast that made it possible there, but which would not be possible elsewhere?

Mr Pringle: The Belfast example you give is a good pilot of the proposals that we are putting forward for PFI generally and yes, you can pretty much read it across. It is a good example of the sort of certainty that you can get in almost any type of project if you do that much more work up front.

Q45 Mr Bacon: In your note to the Committee you talk about better resourced clients and one of the points you make, and I quote, is "Too often, at the moment, the public sector gatekeepers are inexperienced and under-supported in terms of professional, expert advice".¹ Would not somebody in response to that say "Well that is the whole point of having a bid process constructed around PFI, because you have professional expert advice available and it is available to the PFI bidders"?

Mr Pringle: No, it does not quite work like that. They are indeed expert; in fact there is an inequality of expertise on the client and the PFI consortia bidders' side. Public sector clients are generally inexperienced and that is not to say they are unintelligent, it is just that there has not been a lot of public sector work going around for the last 30 years and now there is a huge amount of it suddenly on the scene. What we regularly find is that good clients, well-structured, regularly get good projects and public sector clients who are suddenly thrown into building projects which they are not used to, often really struggle to manage the complexities of these huge new capital projects which they are landed with. That is another good reason for getting a really comprehensive professional team on the client side to advise them on their side of the consortium, PFI, contract on how they should be proceeding, how they should be structuring their ideas, how they should be structuring their approach to the whole thing. Their inexperience needs support. One of the

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**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

things we have done at the RIBA is set a complete group of people up to do exactly that, to give help, not to go in and be designers, just to help clients think their way through these sorts of problems.

Q46 Mr Bacon: We have seen in the Ministry of Defence that smart acquisition at least aims to spend more in the assessment phase early on whereby, effectively before they get a long way into the manufacturing or the design phase, they have a better idea of where it is they are going. Is there an analogy that can apply or a comparison that can usefully be applied between smart acquisition for weapon systems in the MoD and smart procurement generally?

Mr Pringle: It is the same thing. It does not matter what sort of project you are doing: the better your preparation before you enter into the real thick of the project, the better your outcome is going to be. Again, that is what we are recommending.

Q47 Mr Bacon: One thing I really do not understand about this is the land issue. Common sense would suggest that something as central as the land issue must be sorted out very early on. How do you think that something so central as land in this could only be identified so late in the day?

Mr Pringle: Two reasons have brought that about from my reading of the papers. One is the change in the brief requirements with the alteration to the brief both from consumerism, which ups the space standards per bed, and other changes to the brief. A bigger hospital was required and then, as I understand it, the understanding of the local authority's height requirements capped the limits of the available site to contain a particular project and so they essentially ran out of road, ran out of land.

Q48 Mr Bacon: Do you think, if an approach such as you are recommending had been adopted, that this land issue could have been either solved or flagged up for the significant issue that it was to a greater extent earlier on?

Mr Pringle: Well I would like to think so, because what we are advocating is better scrutiny of the brief, better development of the brief, better signing off of the brief and of course if you are doing early design work, you can very naturally test the capacity of the land and you can talk with the local authority and you can even obtain your outline planning permission at that stage.

Chairman: Thank you Mr Pringle. It is very helpful to have an independent voice.

Q49 Greg Clark: May I start with a declaration? I was a member of Westminster Council during the period in question, but I do not recall being part of any discussions about this subject. My question is about a different subject. First of all, just starting with Mr Taylor, in answer to one of the Chairman's questions, I think I heard you say that there was no stated requirement from the Department that the finances of this should be off balance sheet. Did I hear that correctly?

Mr Taylor: What I said was that the guidance we were giving to the trusts was about the affordability of the scheme. So it was not a condition *per se* of the scheme going forward that it had to be off balance sheet, as I understand it.

Q50 Greg Clark: Mr Nettel that does not seem to be your recollection. You thought this needed to be off balance sheet. That is correct, is it not?

Mr Nettel: Mr Taylor is right in the strict sense, but in so far as at one stage the discussions did involve on balance sheet discussions, it had a consequence on the overall capital spend within the NHS, because the numbers that we were talking about, due to the treatment of some of the financial issues involving the business case in 2004, were significantly large to affect the overall spending power of the Department of Health in capital terms across the NHS.

Q51 Greg Clark: Mr Goodier, is that your recollection? Do you have any recollection as to whether it was important that it was on balance sheet or off balance sheet?

Dr Goodier: Yes, I would agree would Julian Nettel's view of that. At one stage the bridging funding would have amounted to something like 50% of the NHS's capital for that year. It was that sort of quantum. It was huge.

Q52 Greg Clark: Can we just turn to page 24 of the Report, paragraph 3.8? According to the National Audit Office: "... the Department considered the proposed land deal was unacceptable because it meant the land purchase would appear on its balance sheet". Has the NAO got that wrong?

Mr Taylor: What we were saying was that on balance sheet it would have been unaffordable at that stage. It was clearly signalled in a letter to the trust organisations, that the potential risk associated with the sum of money involved with an on balance sheet transaction would have meant that, had the scheme come to the Department in that way, it would have been unaffordable.

Q53 Greg Clark: Why would it have been better if it were off balance sheet?

Mr Taylor: Because off balance sheet the costs would then not have fallen directly on the Department's capital vote.

Q54 Greg Clark: It seems a rather complex issue. I have to say any layman reading the Report, when it says "... the Department considered the proposed land deal was unacceptable because it... would appear on its balance sheet" would regard the answer to the Chairman's question to be at odds with it.

Mr Taylor: I am perhaps being over-defensive about this because there is a sort of theological point at stake here. It is not that we are opposed to on balance schemes, capital schemes, which is sometimes the accusation. The question here was

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

whether, if it had been on balance sheet, it would it have been affordable. At the scale that we were talking about here it would not have been.

Q55 Greg Clark: So where it appears, whether it is on balance sheet or off balance sheet, renders it affordable or not, and that has nothing to do with the value for money offered by this.

Mr Taylor: No, because in practice, we were also raising questions about the affordability at that stage of an off balance sheet scheme. In the same letter which drew attention to that we were also raising wider questions about the affordability of the scheme. It was not a simple proposition.

Q56 Greg Clark: Clearly it was not simple. May I pick up on some of Helen Goodman's questions about the bed numbers and the changes in capacity which were required and invite you to turn to page 20 of the Report? The latter part of paragraph 2.33 says: "Each trust will need to make their own assumptions as to how patient choice and Payment by Results will impact on their future revenues but they have no track record on which to base those assumptions". How can you expect them to do that?

Mr Taylor: As I have indicated, at the time that this scheme was going forward, PBR (Payment by Results) at that stage was not in operation and there was patient choice. At that stage we were telling trusts to take the scheme as it stands and judge it on affordability as it stands and apply some kind of sensitivity analysis to how PBR and choice might operate.

Q57 Greg Clark: "How they might operate"? These are your policies. They are not the trusts' policies. They are imposed on them and yet they have to guess at what the impact is going to be. How can they do that? On what basis can they make that assessment?

Mr Taylor: They have to make that assessment. If you take foundation trusts, for example, which are now no longer directly the responsibility of—

Q58 Greg Clark: Sure, but if it is your policy, should you not have an expectation yourself as to what its impact should be, that you then communicate to the trusts to be able to make their assessment? Why are they expected to fly blind?

Mr Taylor: First of all, in the case of many trusts that would not now be our responsibility.

Q59 Greg Clark: So you have changed your policy on that; that statement in the Report is no longer true. Each trust no longer needs to make their own assumptions. Bottom of paragraph 2.33, page 20.

Mr Taylor: No, it is precisely right. Every NHS trust or organisation has to make some assumptions about how it is going to fare in a world of payment by results and choice. That is implicit in the policy.

Q60 Greg Clark: How do you guide them?

Mr Taylor: In relation to a PFI scheme or generally?

Q61 Greg Clark: In relation to a PFI scheme. How do they interpret the potential impact of payment by results?

Mr Taylor: What I should expect them to do is, first of all, they have a business to run effectively and they will be making their own assumptions about it because they cannot operate in the current environment without making some estimation.

Q62 Greg Clark: That seems to be it. You are confirming that they basically have to guess themselves what the effect of the new government policy will be.

Mr Taylor: Secondly, they would be talking and being guided by the strategic health authority in their area who will be sharing, with local organisations and commissioners, the assumptions which are going to be made year on year about volumes and about the contracts which are going to be let through the commissioning process. Each of them will have forward business plans.

Q63 Greg Clark: Just on those business plans. Again, in answer to some of the Chairman's questions, you indicated the Department was going to take a closer look at the outline business cases in future, presumably in the light of this, but on page 37, paragraph 5.6, it says that the Department will no longer approve strategic outline cases. Is that correct?

Mr Taylor: That is because we are moving upstream to put more emphasis on approving the outline business case.

Q64 Greg Clark: So does the outline business case come before the strategic outline case?

Mr Taylor: No, it is the other way around.

Q65 Greg Clark: It is the other way around. So the strategic outline case is after the outline business case.

Mr Taylor: No. The strategic outline case comes first.

Q66 Greg Clark: You are not involved in that.

Mr Taylor: No, we are not involved in that.

Q67 Greg Clark: Why not? Surely the lesson from this study is that the Department should have been involved earlier and more deeply.

Mr Taylor: What it should have been involved in more deeply was what is called the outline business case, which is the point at which effectively the strategic decision is taken to move forward in detail with the scheme.

Q68 Greg Clark: I see. You now have this review and you referred to it, that you were expecting to reduce the PFI programme from £12 billion to between £7 and £8 billion. When do you expect to conclude this review?

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Mr Taylor: We are moving on a case by case basis. I am not sure that I know the answer to that.

Q69 Greg Clark: When did you start the review?

Mr Taylor: We effectively started the review in January.

Q70 Greg Clark: January and you do not know when it will be concluded?

Mr Taylor: We have already looked at the first six cases, we have another eight cases that we are about to tackle. I am advised six months is how long we are expecting the review to take.

Q71 Greg Clark: Six months from now or six months from January?

Mr Taylor: Six months from now we shall have completed that.

Q72 Greg Clark: So the end of the year. It has taken a year in other words to conduct these reviews. This is significant Chairman because we have been discussing here the impact of delays to these PFI projects and the NAO Report is very clear as to the cost of this. What is the total value of the projects under review? Just remind us.

Mr Taylor: It is between £7 to £9 billion, from £13 billion.

Q73 Greg Clark: So £13 billion and it will be a year to conduct these reviews. According to the Report, a five-year delay has resulted in these projects costing 37% more because of the high rate of construction inflation, which is about 7% a year above inflation. So we are talking about this costing something like £2 billion more as a result of you deciding to have these reviews. Is that good value for money? What would £2 billion buy in a hospital? Would that be equivalent to a new hospital?

Mr Taylor: I am not quite sure how you have calculated that?

Q74 Greg Clark: Well let me explain. A five-year delay was 37% more in terms of construction inflation, which is about 7% a year. If you have a building programme of £13 billion then about 7% of that, if you assume that the inflation has been 7% a year, is something like £2 billion, is it not; £2 billion has evaporated because you have had this year's review?

Mr Taylor: We are certainly not expecting in effect to lose the sort of money that you are talking about.

Q75 Greg Clark: You are not expecting to, but every month that goes by costs money. Time is money in this, as we know. This is the point of this hearing, the point of this Report and yet in answer to my question as to how long these reviews are going to take, we discover that it is going to be a year from January. A year has gone, £2 billion has evaporated and that seems to be a hospital to me. We have lost a hospital because you have taken a year.

Mr Taylor: May I just illustrate what we have been doing? It is a fair question and I probably ought to offer a proper note to the Committee setting out the process for doing this.² If we just take one example, St Helen's and Knowsley, which we subjected to this review process, as a result of that we have agreed, and these are schemes which are close to financial close so those are the ones we have prioritised, to reduce the unitary charge by £8.5 million as a result of the scrutiny. We made similar sorts of changes in the Birmingham scheme which just went forward where we agreed to put on hold 100 additional beds. Already the process of scrutiny is proving its value and we have done six of the schemes closest to financial closure. We are now moving on to eight other schemes where we have already engaged contractors and then we shall move to the other schemes.

Greg Clark: I am keen that you get on with them, but I should have said perhaps before I touched on these questions that there is a PFI scheme in my constituency that may be one of the eight. Perhaps I should put that on the record as well.

Q76 Mr Khan: Mr Nettel, do you accept that the outline business case in 2000 was inadequate?

Mr Nettel: Yes.

Q77 Mr Khan: What expert advice did you receive when that was prepared?

Mr Nettel: It was prepared by the West London Partnership Forum under the auspices of that group of organisations as set out in the Report.

Q78 Mr Khan: What expert advice did you receive?

Mr Nettel: We used, in large part, a group of consultants who worked out the option appraisal exercise and took advice from the trusts on what was required.

Q79 Mr Khan: How many previous schemes had those consultants worked on?

Mr Nettel: I am afraid I simply do not know that, I shall have to give a note on that.³

Q80 Mr Khan: Have you taken legal advice as to whether you have any redress against them?

Mr Nettel: No, we have not.

Q81 Mr Khan: Would that not be a course of action worthy of exploration?

Mr Nettel: It has not occurred to us.

Q82 Mr Khan: You instruct experts to advise you, they help you prepare a report which is inadequate, £14.9 million are wasted.

Mr Nettel: Well there is room for argument there. Certainly, it is worth taking a legal view on it now you mention it. It is a reasonable idea, but I suspect that our lawyers will tell us that this is possibly a recipe for a significant legal cost without necessarily any redress because the consultants of course will in

² Ev 22-23

³ Ev 24-31

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

the circumstances, I suspect, have a defence which is that they took a brief from the organisations concerned and worked within that brief.

Q83 Mr Khan: Let us just follow that through. The London regional office said they had concerns about this inadequate plan and presumably you would have gone back to the experts and said "Hold on a sec, we paid you some good money for the advice, the NAO are concerned about this, what do you say to this?"

Mr Nettel: It did not quite work like that.

Q84 Mr Khan: How did it work?

Mr Nettel: The business case, as I referred to earlier, was agreed on the basis of a high level document and the regional office signed off that business case at the time, recognising that further work needed to be done, which incidentally did not involve the consultants that we used to draw up the original business case.

Q85 Mr Khan: Right, so you did not use experts to do the follow-up work.

Mr Nettel: We did indeed. For instance, we had some important financial analysis to do.

Q86 Mr Khan: Can we have a note of the experts that were used and how much they cost?⁴

Mr Nettel: Yes, all of that information is available and has been supplied to the NAO.

Q87 Mr Khan: Great. When the NAO made their concerns known to you, did you have those concerns signed off by them after you had dealt with them?

Mr Nettel: The documentation on that does not seem to suggest that is the case. I have looked at this from a St Mary's point of view and it is certainly the case that there was follow-up action on each of the items raised after the original business case.

Q88 Mr Khan: Why did the original project director leave after two years?

Mr Nettel: Mr Sorenson left because it was felt that his particular abilities and experience were not relevant to the project at that particular time.

Q89 Mr Khan: You had a project director without the skills to do the job.

Mr Nettel: We appointed Mr Sorenson anticipating in fact just the sorts of things we needed at the back end of the project when we were negotiating with our Campus partners within Paddington various land deals in order to make this scheme work. We anticipated that.

Q90 Mr Khan: He did not have the skills to do the job?

Mr Nettel: He did not have the skills to do the job at the time that he was appointed.

Q91 Mr Khan: Did you take legal advice when you terminated his employment?

Mr Nettel: Yes, we did.

Q92 Mr Khan: When you do your note for us, could you include the advice at all stages that your experts used when you do your breakdown of costs?⁵ Could we also have a breakdown of the £14.9 million, the wasted costs? That does not seem to be in the Report. I may have missed it.

Mr Nettel: It is available. Yes; absolutely.

Q93 Mr Khan: May I take you to appendix two? Appendix two sets out some of the external reviews of the Campus scheme. Mr Taylor at what stage do you think that this project should have been stopped?

Mr Taylor: There is a case for arguing that it should not have gone ahead at the OBC stage.

Q94 Mr Khan: Good. In May 2000 the OBC raises a number of concerns; one of them is the affordability of the scheme as well as the other concerns. You said that things have now changed and any scheme above £75 million has to be approved centrally. So presumably this scheme would nowadays have been stopped.

Mr Taylor: It would not have been allowed to go forward without the qualifications being satisfactorily resolved.

Q95 Mr Khan: But notwithstanding that, even looking at this, you think there is a case for saying in late 2000 this should have been stopped.

Mr Taylor: There is a case for saying that, yes.

Q96 Mr Khan: How many employees have been disciplined for not taking steps to stop this?

Mr Taylor: None that I am aware of.

Q97 Mr Khan: No employee has been disciplined because of this.

Mr Taylor: Not that I am aware of.

Q98 Mr Khan: You accept that as early as late 2000 there were good grounds for stopping the scheme.

Mr Taylor: What I said was that there was a case to be answered and I also think that if it came forward now, it probably would certainly not go forward in the way that it went forward. It has to be said that at the time the scheme was operating under delegation to the regional office.

Q99 Mr Khan: I am not blaming you; I am not saying that you should have stopped it. You are saying there was a case for it to have been stopped in May 2000. Do you think there was a stronger case for it being stopped in 2003?

⁴ Ev 31–32

⁵ Ev 33–34

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Mr Taylor: I agree with what the NAO Report says which was that in 2003, what should have happened was that either the scheme should have been stopped or at that stage a revised OBC should have been called for.

Q100 Mr Khan: In your current role what steps have you taken to see whether any employees currently in post are to blame for it not being stopped at that stage? In other words, if no disciplinary action was taken for the decision not to stop it in late 2000, there could be an argument for there being stronger calls for disciplinary action in 2003.

Mr Taylor: I doubt whether—

Q101 Mr Khan: The question was: what steps have you taken, if any?

Mr Taylor: I have not personally taken any steps to consider whether disciplinary action ought to be taken against any of the individuals concerned.

Q102 Mr Khan: So far we have almost £15 million of taxpayers' money wasted. Apart from this project director not equipped to do the job, leaving by amicable agreement and I am sure with a hefty settlement, nobody has been disciplined for this waste of taxpayers' money. In 2004, the joint review, alarm bells should have rung even louder than I suppose.

Mr Taylor: Alarm bells were ringing very loud by that stage.

Q103 Mr Khan: Do you accept that there was an even stronger case for the plug to be pulled then?

Mr Taylor: It is right and the Report brings it out that consideration was given to stopping the scheme at that stage.

Q104 Mr Khan: I tell you the problem with the Report bringing this out. A common theme is that two things happen. One is that the Permanent Secretaries say "Lessons have been learned. Had we had this evidence hearing 12 months ago, you would have had a case to argue, but we have learned our lesson and things have improved". That is the first thing we hear. The second thing we hear which is common is that nobody is ever disciplined. Can you see the frustration that some of us have about that?

Mr Taylor: I understand it. It is also important to recognise that these events happen in real time with people under real pressure. In 2004, when the Report was received from the DH and the NAO clearly calling into question the original outline business case, the trusts went to work on a different outline business case, I was not there at the time but my colleagues will recall this, and active consideration was given to stopping the scheme at that stage. At that stage then, proposals came forward which could have turned the scheme around, which could have made it look viable. In retrospect it is easy to say somebody should have pulled the plug then, but frankly people would have felt that they were acting

unreasonably if they had not given proper consideration to the proposals put forward by Westminster City Council at that stage.

Q105 Mr Khan: As a matter of interest, a third thing which is often said is "I was not in the job at the time".

Mr Taylor: I do not want to use that excuse because I am accountable now.

Q106 Mr Khan: Mr Pringle, one for you. Should any of the blame be apportioned to Westminster Council *vis-à-vis* planning issues or withholding consent and/or negotiations for land?

Mr Pringle: I am not aware of any blame that should be held against Westminster Council but I am not that close to the detail of the project.

Q107 Mr Khan: What you may be able to answer is whether you think the plans were too ambitious for the amount of land? Too greedy?

Mr Pringle: The brief inflated over time and that could well have been one of the root problems in not fitting on the land. From my reading of the documentation, a smaller scheme was initiated in 2000 which grew for a number of reasons and then did not fit on the land.

Q108 Mr Curry: Mr Bell, I should like to turn to you. You are an accountant, I think.

Mr Bell: I am an engineer.

Q109 Mr Curry: You are an engineer but you worked for an accountancy company for a long time.

Mr Bell: I did.

Q110 Mr Curry: And you arrived to take up this job from Canada in March of 2005.

Mr Bell: That is correct.

Q111 Mr Curry: And two months later you pulled the plug on this, did you not?

Mr Bell: I certainly would not sign off on the outline business case.

Q112 Mr Curry: In other words you pulled the plug. Using political epigrams, that is right. So you took one look at this and went into meltdown did you not?

Mr Bell: Well it certainly looked like a project in very serious trouble.

Q113 Mr Curry: What was your reaction? You came. We had this slightly surrealistic scheme where we had the regional office of the NHS bothered about it pretty well from the beginning, according to the National Audit Office Report the Government and the Department of Health did not regard it as being any sort of flagship scheme at all, it kept adding new sorts of bits and pieces as it went along, the land was not available and you suddenly came and found everyone was gaily carrying on with this here scheme. What did you say to yourself when you

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

went home? On your first night home, having looked at these accounts, what did you say to your shaving mirror?

Mr Bell: It is not what I said to myself, it is what I shared with my colleagues.

Q114 Mr Curry: Could you share it with us? It would be very helpful.

Mr Bell: I basically wanted to get down to understand all the details that constituted this scheme as envisaged at the time and sort of participated in a process of getting under the skin of understanding all the issues.

Q115 Mr Curry: When you looked at it, what did you think was right about this scheme?

Mr Bell: I thought that the vision was right.

Q116 Mr Curry: Visions usually are, are they not?

Mr Bell: It was a very bold vision, a very appropriate vision. What was right about the scheme was definitely that our hospitals, both the Brompton and Harefield as well as St Mary's, are in dire need of replacement and renewal and this scheme provided an opportunity for the renewal of much needed hospitals.

Q117 Mr Curry: The problem with vision is that it then has to be translated into something people can visit, get bandages put on and elastoplasts and all this, have health duties performed there. What went wrong then in your view? Did it go wrong from the very start or was there some point at which you said to yourself, this was where it went off the rails and nobody picked it up in time?

Mr Bell: From my examination of the record, historically as well as what I was able to come to a conclusion at in the period of April and May 2005, the key fundamental that was missing was that there was no land and without land it is very difficult to translate the vision into something concrete.

Q118 Mr Curry: I do not wish to sound terribly naïve about this, but those of us who are laymen, neither accountants nor engineers, normally think when you plan to build something, you have something to build it on. Is that a sort of curious notion?

Mr Bell: No, it is not curious at all.

Q119 Mr Curry: The fact that you did not have anything to build it on might be regarded from the start as being a weakness, if not more than that.

Mr Bell: Well, as I said to you, it was a vision.

Q120 Mr Curry: Visions usually turn out to be very expensive I find in this Committee I have to say. Let us just look at this. If you look at this map in the middle about the site, it is wonderful. This hospital has migrated the entire way across whatever this bit of Paddington is called, has it not? It all started on the south bank, giving it an air of romance no doubt, then it migrated to the north of Paddington and the

whole lot is pretty well north of the Paddington basin by the time you have finished. It has been a wonderful process.

Mr Bell: That is what planning is about.

Q121 Mr Curry: I know that, but I could put in an outline planning application to redevelop the Houses of Parliament. Westminster would look at it because applying for planning permission is a long way from being in a position to do anything. This is perhaps not a fair question but let me ask you one question first about Canadian practice. Another thing I have discovered is the optimism bias. Is this a way of saying these people cannot add up so we had better add 20% for luck? Did you have optimism biases in Canada?

Mr Bell: Well we certainly would have done sensitivity analyses, which would be the equivalent of an optimism bias, to show worst case and best.

Q122 Mr Curry: Is there some fixed percentage for an optimum bias? Do you add on X%?

Mr Bell: You would apply a percentage to the sensitivity analysis, yes.

Q123 Mr Curry: However polite we are, what you are saying is that this lot are trying to pull the wool over our eyes because it is bound to cost more than they think.

Mr Bell: As the record shows, many of these projects do have a tendency to come in much higher than the original estimate.

Q124 Mr Curry: How big an optimism bias do you think we ought to put on a project for a new nuclear power station?

Mr Bell: I have no idea. I am not an expert on nuclear power.

Q125 Mr Curry: It would have to be quite big though, would you not think? Mr Pringle, what would be the standard optimism bias. How many projects have got optimism biases in them?

Mr Pringle: It is a feature of the public sector now, but all projects have contingency sums because precise estimating does not take into account—

Q126 Mr Curry: Is there any such thing as a pessimism bias?

Mr Pringle: I have not come across a pessimism bias but I have come across targets for bringing things in under budget: bonuses.

Q127 Mr Curry: Yes, those are prevalent in the health service at the moment, are they not? Any of us who have had conversations with our PCTs recently will be very much aware of that. So that is fairly standard practice. Back to the land. Presumably right at the beginning of it, somebody sort of potted along to Westminster Council and said "Can we talk about this chaps?"

Mr Nettel: At the beginning of this, we had a scheme that was very close to outline planning permission.

Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects

Q128 Mr Curry: Right, so you did have land at the beginning did you, or not? If nothing had changed and the money had been okay, would the assumption have been that the scheme you had would have been consistent with the council's planning policies and the land would have been adequate for that?

Mr Nettel: Correct.

Q129 Mr Curry: Okay. Meanwhile what happens is that the scheme changes and that is because it is required to do different things, is that right, or a new criterion for what you have to accommodate?

Mr Nettel: As a result of the work we did after this OBC, and the scheme had been designed on that basis, we realised that we had a bigger project on our hands than we originally thought.

Q130 Mr Curry: It was a bigger project, because the original conception had not been right or because you were required to incorporate in it new functions and new facilities or new criteria?

Mr Nettel: The latter. We went through a very detailed process, from memory with 32 different clinical groups across both hospital trusts, to establish precisely what was required in clinical terms.

Q131 Mr Curry: But this was internal in the sense that these were your stakeholders as it were who were telling you things.

Mr Nettel: Our doctors, nurses and therapists.

Q132 Mr Curry: Doctors and nurses, right. So this was not because the Department of Health had suddenly said "No you have to have that, this and the other".

Mr Nettel: No. There was also the question of consumerism and the guidance that was emerging at that time about how much space there had to be between beds and the number of single rooms and so on.

Q133 Mr Curry: The impression I am getting now is that you talked to your doctors and your nurses and your midwives and whoever after you had put together your original concept.

Mr Nettel: Correct.

Q134 Mr Curry: Again, am I being counter-intuitive in thinking it might have been more sensible the other way round?

Mr Nettel: No, you are absolutely right and this is why the way in which the original OBC was constructed was highly unusual and high level and did not have the benefit of that detailed clinical planning and that was the problem.

Q135 Mr Curry: Right. So in a sense you were putting a hospital, which you had not determined was what was wanted, subject to a criterion which might yet be imposed upon you but that is part of the normal risk of the development of policy, on land

which had ceased to be appropriate or adequate for its purpose at a costing which was subject to accretion?

Mr Nettel: Absolutely. As the amount of space required grew, and once we understood the real requirements of these hospitals, the cost grew accordingly.

Q136 Mr Curry: So we come back to the site and we see this gradual process of migration and in the last image of this what we actually find is that the old NHS trust hospital buildings there are going to disappear entirely, are they not? They are going to fund the scheme, are they not?

Mr Nettel: Indeed so. That site will be the subject of complete redevelopment.

Q137 Mr Curry: Housing, because that is where you get the money, is it not?

Mr Nettel: That I could not say. In the end, it will probably be a mixture of housing and commercial development.

Q138 Mr Curry: Would it have paid for the whole project then?

Mr Nettel: No, it would not have done so. It would have certainly paid for any of the land that we required that we were going to purchase from Westminster City Council and our other commercial partners eventually.

Q139 Mr Curry: But there would have been a time lag obviously, would there not?

Mr Nettel: But there was a time lag; correct.

Q140 Mr Curry: And that time lag would have been expensive because you would have borrowed money to tide you over.

Mr Nettel: That was the subject of a great deal of analysis and discussion but in the end, the cost of that time lag and the bridging finance required to enable the scheme to proceed had reduced significantly between the December 2004 business case and 2005.

Q141 Mr Curry: May I come back to Mr Bell. So you arrive, you get off the plane at Heathrow and you take up this job and you suddenly find that you have a big problem on your hands. What was the one thing which made you say "We simply cannot carry on. We really do have to pull the plug on this before it gets any worse"?

Mr Bell: In May 2005 both Mr Nettel and I, as accountable officers, would have been required to sign off on an addendum to an outline business case to be submitted to the Department and to certify that these plans were ones that we were endorsing. I simply felt, as the accountable officer, that I could not do that.

Q142 Mr Curry: And Mr Nettel, you were in the same position at that stage?

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Mr Nettel: No, I was in a different position.

Q143 Mr Curry: Sorry, how was yours different?

Mr Nettel: My board supported the addendum to the business case. Having looked at it and seen that it was in many respects superior in affordability in overall terms to the business case that we all but approved, with caveats, in December, we felt it would have been inconsistent and illogical not to support the business case in May 2005.

Q144 Mr Curry: So you felt that Mr Bell was lacking in vision and he probably felt you were lacking in financial expertise. Was that it?

Mr Nettel: We understood the specific reasons, which were made very clear by my colleagues at the Royal Brompton and Harefield Trust, why they felt they could not recommend the addendum.

Q145 Mr Curry: Now we are little bit further down the road are you glad you did that or do you still think it was a mistake?

Mr Nettel: I still am filled with dismay and disappointment that the vision that we had and the huge benefits to the local regional and national populations that would have flowed for patients and staff, that those opportunities and benefits will now not happen.

Chairman: We are filled with dismay and disappointment at the loss of £15 million and years of useless work.

Q146 Mr Davidson: I was going to pick up that point that Mr Nettel has just made and clarify it. Are you saying to us that the service which is being provided to people in the affected area is now worse than it would have been had this not gone ahead?

Mr Nettel: We are a successful organisation. We have some of the best survival rates in the country at St Mary's and that is because of the quality of the people that work there, but it is not helped by the facilities which three Members of this Committee took the trouble to look at a couple of weeks ago and they may well agree that we are labouring in very difficult circumstances.

Q147 Mr Davidson: May I turn to the role of the Department of Health in this? The thing that has puzzled me particularly is in paragraph 24 on page 8, where the first sentence says: "... the Department had no strategic position on the desirability to the NHS or 'UK plc' of a successful health campus". Is it the case that the Department of Health really did not care one way or the other whether or not this went ahead? Later on in that paragraph, it suggests that the trusts, Partnership UK and Westminster City Council said that they in fact were "... uncertain whether the Department did in fact want the Campus scheme to succeed". Is that fair?

Mr Taylor: This is very carefully worded. What the Department wanted was a scheme that was affordable.

Q148 Mr Davidson: No, no. May I just clarify this? On the first point of a successful health Campus are you saying that your only reservations were on the question of affordability?

Mr Taylor: Ministers made it clear in the House on a number of occasions that they supported the vision for this Campus and my colleagues in the Department spent quite a lot of time over this period working with the trusts and the strategic health authority to support the scheme. The Report makes that clear.

Q149 Mr Davidson: In that case you did have a view on the desirability of a successful health Campus and therefore you would disagree with what is written here.

Mr Taylor: No, the emphasis here is a "strategic position". I agree this is in danger of causivity, but the point that is being made here is that we did not see this as necessarily a national or flagship scheme which was to be pursued at all cost. This was a scheme which had come forward from the NHS, which had been supported by the Department, which we were willing to help and that is really all that is trying to say. It would be unwise to read more into it than that.

Q150 Mr Davidson: Further on in that paragraph, just coming back, it says that they were all "... uncertain whether the Department did in fact want the Campus scheme to succeed". You have agreed to this wording and therefore if you are unhappy with that, you should have corrected it at that stage. How can we have a situation where a variety of organisations are under the impression that the Department's position is unclear as to whether or not they want to support it? This just seems bizarre in the extreme to me.

Mr Taylor: What this reflects is, to some extent, what is inevitably the Department in two modes. One is the Department working with the NHS on a scheme which it wants to take forward and try to help that. The second is applying, arguably, as some of your colleagues have suggested, belatedly a critical challenge as to whether the scheme was affordable.

Q151 Mr Davidson: Surely these are entirely different to this point. I understand completely your issue about affordability because we would assume that the Department always wants to make sure that something is affordable, but it is entirely possible for you to be enthusiastically supportive of something, provided it is affordable. That is entirely distinct from what is said here which is what you have agreed. May I ask Mr Nettel and Mr Bell whether or not this is their impression? Were you of the view that the Department really did not care one way or the other, or did you think that they were either enthusiastically for or against this in principle?

Mr Nettel: They did not represent a homogeneous view. There were people doing different things and different functions within the Department

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

legitimately that could be interpreted as having quite widely differing levels of enthusiasm about the scheme proceeding.

Q152 Mr Davidson: And that that would therefore be somewhat confusing.

Mr Nettel: It was from time to time difficult for us to interpret precisely what was happening.

Mr Bell: That is a fair answer. Certainly the perspective we had towards the period from March to May 2005 was that the Department was interested in getting an outline business case proposition, but we did not have any confidence that, at the end of the day, whatever outline business case proposition would—

Q153 Mr Davidson: I understand that. Was that your impression of the Department's position?

Dr Goodier: Julian summed it up very well.

Q154 Mr Davidson: Mr Taylor, how can that be? I do not want to accuse the Department of Health of being not fit-for-purpose, but that really is the phrase that comes to mind. If you are partnering people or organisations, how can it be that you are sending out mixed messages?

Mr Taylor: A pretty clear message had gone out from the Department in January 2005 that at that stage we had very, very significant reservations about the likely affordability of the scheme and that is a matter of record.

Q155 Mr Davidson: Sorry, you keep diverting onto that and I understand completely that you will always have this issue about affordability, but the issue that seems to be covered in this paragraph, which you or your predecessors have agreed, is the question of just the general intent, the sharing of the vision and the desirability. Now if you are saying to me that you do not accept what has been written in the Report, I accept that now. There is an issue about whether or not you should have checked it earlier on.

Mr Taylor: What I am saying is that I can understand how this perception, which has just been described by my colleagues, arose. On the one hand we were by this stage asking some very tough questions about the scheme and on the other hand we were still trying to work with the campus partners to make it work. I can see that they come across as mixed messages. In the eyes of the Department it was a balance which we were to-ing and fro-ing between affordability and supporting the scheme and probably, with the benefit of hindsight, we should have come down harder one way or the other. I am being straight with you about that. Probably the Department should have taken its critical approach to this at an earlier stage, but I fully understand why colleagues wanted to work with the partners as apparently new opportunities to keep this scheme open arose and they should not be criticised for that.

Q156 Mr Davidson: That is fine. Saying that you can now is very helpful because it is all about learning lessons. Could I therefore come to the role of the Brompton? I get the impression that the Brompton was really never as keen to be involved as the others were on seeing this going forward and that the fact that you made a pre-condition that you were not going to have a merger then trapped everybody into preserving your position. Can you just clarify for me whether or not there was anything more to that than just simply being precious? I recognise there was a huge amount of vested interest, particularly from clinicians who lead so many of these things and they would wind up patients and so on and so forth. You wanted to keep your autonomy and independence. Was there more to it than that?

Mr Bell: My examination of the record points to more issues and more amplification to your question. You have to remember that the Brompton is a combination of a merger itself of the Brompton and the Harefield hospitals which came into being in 1998 and when we signed up to become members of the scheme in February 2000 we were still in the throes of trying to make a challenging merger of two hospitals located 14 miles apart work. For us to have considered at that time that we could move forward with a scheme in which we would further merge would have been a greater step than we were ready to take.

Q157 Mr Davidson: Okay, I can understand that perhaps at that stage but I just get the impression that that carried on all the way through and that you continued to be precious throughout this whole exercise. Is that fair?

Mr Bell: It is fair and the reason for that is that mergers do come with a fair amount of challenge and cost and really the position that we—

Q158 Mr Davidson: I understand that. Time is limited. Mr Taylor, can I just come back then to this point in paragraph 18 where the Department seemed to have believed that a merger was actually necessary between the two hospitals, but did not actually do anything about it. That sounds a bit unduly hands-off, does it not?

Mr Taylor: There was a recognition at the time that the outline business case went forward and subsequently, that if the issue of the merger had been pressed then Brompton and Harefield would have pulled out of the scheme.

Q159 Mr Davidson: So Brompton and Harefield effectively had a veto on it because they were having difficulty amalgamating themselves.

Mr Taylor: It is not fair to say that they had a veto.

Q160 Mr Davidson: Let me be clear. They did not have a veto, but they were going to pull out if they did not get their own way. That sounds pretty much like a veto to me.

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Mr Taylor: Yes, it is a very strong condition; I agree.

Q161 Mr Davidson: In those circumstances was it sensible to go forward with these organisations as partners? Was the whole thing not basically flawed from the beginning? The Department thought that a merger was necessary, one of the people involved was not going to have a merger under any circumstances for a variety of reasons and there was a flaw at the heart of the whole business.

Mr Taylor: That was a very difficult judgment call for my colleagues. There was a perception in the Department at the time that as the scheme moved forward the potential desirability of a merger would become more apparent to parties and, in the words of the Report, it was inevitable and that could be resolved at a later stage. I am not sure whether that was the right judgment to take: that was the judgment taken at the time. What I have said to you is that when we look at schemes now, partly in the light of this experience and others, we look much harder at proposals which are coming before us which involve partnership. In some cases we press them back to the organisations concerned to say whether this is really going to work and they back off then.

Q162 Mr Davidson: May I ask about bonuses for senior officials in all of this? We heard earlier that nobody was disciplined, nobody was sacked. Do I take it that bonuses for all the senior officials involved went on regardless? Is there any evidence that anybody, as a result of what has not been a shining success, actually lost any bonus they would otherwise have received? Can anybody tell me? Did anybody at Harefield lose any bonus?

Mr Bell: We never received any bonuses.

Q163 Mr Davidson: That is a good position to be in sometimes.

Mr Nettel: Same answer.

Dr Goodier: Most of my staff are not on a bonus. I was on a bonus personally.

Q164 Mr Davidson: Did you lose anything as a result of this success or otherwise?

Dr Goodier: No, not initially.

Q165 Mr Davidson: That is a pretty good position. What does “not initially” mean?

Dr Goodier: In the last review I lost some of my bonus.

Q166 Mr Davidson: How much of your bonus did you lose?

Dr Goodier: About 35%.

Q167 Mr Davidson: How much is that in money?

Dr Goodier: About £3,500.

Mr Davidson: So staff involved have lost £3,500 and nobody else has lost anything as far as we can see and the public sector has lost £15 million and enormous opportunity costs for improving the health of the people involved.

Q168 Mr Bacon: How much was Mr Sorenson paid in severance payment?

Mr Nettel: He was paid a net amount, net of tax: six months' salary, which was his notice period under his contract.

Q169 Mr Bacon: Which was how much?

Mr Nettel: From memory, around £60,000 to £70,000.

Q170 Mr Bacon: If you could confirm that in writing to the Committee that would be great.⁶

Mr Nettel: Certainly.

Q171 Mr Bacon: Mr Taylor, plainly it was not the only factor, because indeed paragraph 3.8 says that the Department's view of the premium over open market value that would be paid to PDCL was excessive. It is also true that the extra cost of keeping it on balance sheet was one of the reasons why it was considered unaffordable. In fact you said as much yourself.

Mr Taylor: Yes.

Q172 Mr Bacon: Could you say, if a scheme like this were to go ahead off balance sheet, who ultimately would be paying the annual unitary charge in a PFI scheme?

Mr Taylor: Ultimately it is the taxpayer.

Q173 Mr Bacon: Right; the taxpayer. That is what I thought. If the scheme is on balance sheet and thus in your terms unaffordable—although there are other reasons why it might be unaffordable—who ultimately pays the cost of an on balance sheet scheme?

Mr Taylor: The taxpayer.

Q174 Mr Bacon: So either way, whether it is on balance sheet or off balance sheet, it is ultimately the taxpayer who picks up the tab.

Mr Taylor: That is correct.

Q175 Mr Bacon: Yet one is affordable and another is unaffordable. This is what I find it difficult to get my head round. At the end of the day, if it is the same person paying, either they can afford it or they cannot. Sir John, in paragraph 16 of the Report there is a reference to an opinion you had expressed. The Report says: “The Comptroller and Auditor General has expressed his concern that the need to have transactions off balance sheets was inappropriately distorting decision making”. It is quite unusual to read an opinion like that from you in a report like this. Could you say what you mean by “inappropriately distorting decision making”?

Sir John Bourn: I mean by it the kind of account we have heard this afternoon, where you have a scheme and whether it is on balance sheet or off

⁶ *Note by witness:* Eric Sorensen was paid £67,353 gross on 22 November 2002, consisting of 24 weeks net pay, under a compromise agreement in lieu of 6 months notice due under his contract of employment.

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

balance sheet the taxpayer pays for it. However, if it is on balance sheet and therefore counts against a capital allocation, in terms of the capital allocation it may be unaffordable, whereas if you pay for it, not by capital up front, but by a series of payments over a period of time, then it is okay. This is an accounting requirement driving management decisions, which is entirely the wrong way round. As you will recall, this is something we have argued against and continue to do so. It is not entirely logical to run together economic concepts with accounting concepts in this way.

Q176 Mr Bacon: Dr Goodier, whose job is it to plan bed capacity? Is it correct that it is the job of the strategic health authorities?

Dr Goodier: It is. The strategic part of that is for the strategic health authority. The local trusts have to work out their own capacity issues and it is usually a dialogue between the two.

Q177 Mr Bacon: And you talk to each other?

Dr Goodier: All the time.

Q178 Mr Bacon: Why was St Mary's using different bed planning assumptions to the strategic health authority when it is your job, as the SHA, to plan capacity?

Dr Goodier: The use of that methodology was fairly new to the planning of the capacity of the NHS. Therefore what we found was that we were using different technical approaches to achieve these numbers. That only came to light in October 2004.

Q179 Greg Clark: Just on the point of being a champion, I have some sympathy with the Department's problem here and I do think that it is unreasonable to expect the Department both to be a champion for a scheme and also the scrutineer of that scheme. What I think is important is that that scrutiny is engaged in quickly, effectively and thoroughly and the concern for me here is some of the delay. It strikes me from this hearing that most PFI schemes, most campaigns for new hospitals, have a huge degree of community support. However, it is clear in this case that not only was a large proportion of the staff opposed to it, but there was a very strong campaign in the heart of Harefield which was especially effective. Is that right?

Mr Bell: Yes.

Q180 Greg Clark: How did they campaign? How did they make their importance felt in this process?

Mr Bell: They are very effective in many ways: they attend board meetings; they certainly present us with detailed briefs; they communicate directly with the media as well as with the community in question; they are very much present and hold us accountable.

Q181 Greg Clark: Would you say that it is reasonable to expect in a scheme like this that for it to go ahead there would be community support rather than community opposition?

Mr Bell: One of the challenges with a scheme like this is that in the case of the Royal Brompton and Harefield we really are hospitals which serve the nation and our community is spread all over the country. We do have a local market which we serve, but the vast majority of our patients really come from outside London. St Mary's can speak for themselves with respect to the definition of their community, but our community, by definition, is people in need of very, very specialised services coming to us largely on a referral basis from all parts of the country.

Q182 Chairman: Mr Nettel, could you look at paragraph 2.17? It says there that you did not embed risk management controls in 2004 because you could not afford to fund such processes. We are talking about a £900 million scheme. How could you afford not to have such processes?

Mr Nettel: The Report sets out quite clearly what we did about risk management. There were three separate stages. When we introduced specific risk registers into the process as part of the OBC work after 2000 we had a very comprehensive risk register, in fact that was then updated for the scheme in 2003 which involved The Point in a very detailed way. The 2004 OBC included an updated risk register and a risk management strategy. The issue which the Committee needs to focus on is not whether we had a risk register and whether we followed the letter of the law in the way in which these things are managed, but whether in fact we assessed the risk which had to be assessed. In the Report there are four specific areas which the NAO point to which required specific attention. One was having two NHS trusts and three responsible officers. That had an issue relating to governance. I can tell you that the joint project board, because we have checked this, we have gone through the notes of every joint project board which took place throughout the period of the project, considered this on 22 separate occasions explicitly. The second issue was commissioners' reluctance to support the scheme's development costs. That was considered by the joint project board 25 times. The absence of strategic support from the Department itself was also considered by the joint project board on 19 occasions. I can supply the dates.

Q183 Chairman: Okay. You have covered your backside. Finally, how many more Paddingtons are there limping along in search of a deal which is beyond them?

Mr Taylor: I hope there are none. Certainly part of the point of the review to which I have referred is to ensure that there are none.

**Department of Health, Royal Brompton and Harefield NHS Trust, North West London Strategic Health Authority,
St Mary's NHS Trust and Royal Institute of British Architects**

Q184 Chairman: There are none.

Mr Taylor: That is the ambition.

Q185 Mr Mitchell: Can you round it off by telling us what happens now? At what stage are the costs of whatever needs to be done, because these are presumably older buildings and St Mary's was going to be sold off for commercial and residential development, which may or may not be over-bedded or under-bedded, I do not know, taken into consideration, when does the cost of any alternatives begin to enter into it and what decisions have been taken on that?

Mr Taylor: I know that proposals are under consideration locally.

Dr Goodier: Each trust is planning its own independent view of the future. The strategic health authority has had an independent external review of tertiary specialist paediatrics in the area. We have formed an opinion about heart and vascular services within the SHA. We have been looking at the issues to do with capacity and efficiency and what is an appropriate capacity for north-west London. We have been modelling role delineation to try to work out how that capacity is spread across the various different hospitals and organisations in north-west London and of course we have taken on board the issues raised in the White Paper to do with the move towards ambulatory care centres and so on. However, as you will understand, we are in the process of being disbanded as an SHA and since February we have started to look on the wider London SHA perspective of trying to look at one-London planning. That is an issue here as well because a lot of London hospitals are very close to one another. St Mary's is really quite close to University College Hospital, only three miles or something away. So those cross-boundary issues of the SHA boundaries which were raised in these reviews and the need to plan across the whole of London are being embraced now. We have had quite a bit of work going on in the background to

compare how each of the different SHAs in London has been looking at its approach to planning, modelling and the capacity issues therein.

Q186 Mr Mitchell: This looks like a postponement to the Ides of Forever, does it not, with new requirements and new plans, new situations coming in? Can you give us any idea when we shall have some costings and plans for the existing hospitals?

Dr Goodier: Each hospital is doing its own plans at the moment.

Mr Bell: We are following a staged process at this stage. Rather than going for a big bang solution as this vision would have, we have now had to retrench to a very methodical staged process, much more modest in terms of the need to address some of the immediate inadequacies which do exist in some of our buildings and to plan on a longer basis for the things which extend beyond the five to ten-year horizon. In our case we have completed to this stage a five-year planning process.

Mr Nettel: More or less the same position as St Mary's. We are looking at a phased development and will hopefully have firmer plans about what that might look like towards the end of this calendar year.

Chairman: Thank you very much gentlemen. The Department has a capital investment programme of nearly £8 billion, reduced from £12 billion. If this sorry saga is anything to go by, that does not fill us with great confidence. This is unfortunate for the taxpayer who has lost £15 million and five years of wasted effort, but it is a tragedy for the people of west and central London. We visited some of these facilities and you would not expect to find them anywhere in the middle of central London, one of the great capitals. This is very unfortunate. Clearly we had a scheme which was too ambitious for the abilities of those involved in the scheme. Thank you very much.

Memorandum submitted by the Royal Institute of British Architects

INTRODUCTION

The Royal Institute of British Architects welcomes this opportunity to provide written evidence to the Committee of Public Accounts on the Paddington Health Campus scheme.

The Royal Institute of British Architects is one of the most influential architectural institutions in the world, and has been promoting architecture and architects since being awarded its Royal Charter in 1837. The 30,000-strong professional institute is committed to serving the public interest through good design. It also represents 85% of registered architects in the UK through its regional structure as well as a significant number of international members. Our mission statement is simple—to advance architecture by demonstrating benefit to society and promoting excellence in the profession.

While we draw attention to some of the lessons learned from the collapse of the Paddington Health Campus scheme in particular, our evidence focuses on our own proposals to improve the operation of the Private Finance Initiative in general and how those proposals could improve the procurement of major public projects in the future.

We look forward to giving oral evidence to the Committee on Monday 5 June.

THE PADDINGTON HEALTH CAMPUS SCHEME

Many of the reasons for Paddington's failure could have been averted if some additional design work had been carried out at the beginning of the process. The Report by the Comptroller and Auditor General¹ identifies the way in which the Campus partners organised and carried through the scheme, including the failure to secure adequate land for the scheme, as a major reason for its failure. Early design work would have enabled better-informed discussions about the project based on a more comprehensive site analysis.

The earlier report by the Paddington Health Campus Independent Review Panel² similarly identified an absence of reliable processes and united leadership throughout the management chain (responsible for sponsoring, managing and delivering the project) that allowed the project to continue as long as it did before the final decision to terminate the scheme was taken, by which time building costs had risen by some 18%. Early design work and a better advised, more client-focused process would have allowed more accurate cost projections to have been made.

The Paddington Health Campus scheme did not reach the procurement stage due to the lack of a robust, approvable business case. Continued uncertainty over land requirements was cited by the Independent Review Panel as a major reason for the worsening affordability of the scheme, as each time there was a change to the land solution being pursued, significant work was involved in developing building designs to the new land configuration. The Panel said that poor decision making, delay and unproductive effort were all consequences of this weakness; and that without mutual consistency between core clinical activity, land, urban planning requirements and income, the scheme could never be viable.

Following sustained lobbying by the Royal Institute of British Architects, HM Treasury has recently announced it intends to introduce significant changes to the way PFI projects are designed and procured. We believe that the proposals would represent a major step towards achieving better schools and hospitals and—hopefully—preventing a repetition of the Paddington saga elsewhere.

SMART PFI—THE RIBA'S PROPOSALS

The RIBA identified the poor quality and timing of design in PFI projects as a major problem that had yet to be tackled, despite nearly fifteen years of PFI experience. Following a series of events including an expert seminar with cross-industry representatives, the institute began to identify the problems affecting PFI—principally high bid costs and low quality of design—and some possible solutions.

The RIBA's "Smart PFI" consultation proposed some alternative models to Government, fellow professionals and the wider construction industry. The first model we proposed provided a mechanism that gives the public sector client responsibility for the establishment of need, strategic planning, quality objectives, concept design and the determination of affordability. This requires public sector clients to be better informed, and to take a higher degree of preparation, including design work, before going to the market. We firmly believe that this model will result in a significantly improved design solution while simultaneously reducing both the cost and time required to complete the PFI bidding process.

MORE DESIGN UPFRONT

There is continuing evidence that procuring authorities are allocating insufficient resources to adequately prepare and develop their projects and test their requirements before formal engagement with the market. This lack of preparation and advice, particularly on design issues, has resulted in sub-standard projects getting the go-ahead with clients clearly unsure of what they can expect to be delivered on their behalf.

The Paddington Health Campus Independent Review Panel report noted the good intentions behind the campus project team's recognition that more detailed design earlier in the project could reduce uncertainty for a PFI partner. The report states that once the design for the campus was dependent on a significantly taller building, detailed design rather than outline design was necessary for planning approval—but given that to have done this would have been counter-PFI practice, a masterplanning approach was instead adopted to show compliance with planning requirements. The Panel recognised that while the intention was to lessen the uncertainty for a PFI partner, this would have needed recognition as a valid risk management surrogate by the PFI industry.

We are pleased that HM Treasury is now working to adapt PFI policy in order to allow better preparation through design to take place earlier in the PFI process. We hope that PFI guidance will be changed accordingly and that clients will be given the early resources needed to enable more up-front design work to take place.

Allowing clients to work with architects to a greater degree before appointing the consortia would:

- Place greater focus on improving the resourcing of the vital early design stages;

¹ The Paddington Health Campus scheme: Report by the Comptroller and Auditor General HC 1045 Session 2005–06, 19 May 2006.

² Final Report to the North West London Strategic Health Authority from the Independent Review Panel: Lessons Learned from the Paddington Health Campus Project, 30 September 2005.

- Enable the user-client, with responsibility for the strategic delivery of core services, to retain control of the strategic planning, concept design and quality issues leading to better design quality solutions;
- Allow the public sector client to have a proper understanding of cost and affordability issues prior to engaging with the private sector;
- Provide the private sector with the confidence to take full responsibility for the funding, detailed design, construction, maintenance and availability of the facility.

The change in the scheduling of the detailed conceptual design work is significant. It will take place at the very earliest stages of the procurement process and require close client involvement, before identifying the construction team—an innovation the RIBA has long proposed. Speaking to *Contract Journal* in early March³, Richard Abadie (Head of PFI, HM Treasury) indicated that he supported the principle that privately financed schemes must go to the market with greater specification in order to drive down costs:

“The message is that authorities should do some degree of design work upfront themselves, rather than leaving it to the private sector. This is what we will be saying in our policy message and in our presentations in future.”

In effect, the changes will allow clients to enter the market with a much clearer, well-tested and accurately costed idea of what they will receive through the construction phase. They will themselves be better briefed on what can be achieved, and the benefits or costs of the decisions they take in conjunction with the conceptual design team. The level of risk for contractors will be reduced, as they will have a clearer idea of what is required, but still have the latitude to apply their own innovations in delivering the client's specifications or bettering them.

BETTER RESOURCED CLIENTS

HM Treasury has recognised that, if this approach is to prove a success, public sector clients must be better skilled and advised at the early stages of procuring a project. The Government has subsequently argued that experienced public sector clients must be retained and provided with the advice and support they require to ensure a high standard of design quality. Too often, at the moment, the public sector gatekeepers are inexperienced and under-supported in terms of professional, expert advice. A good scheme absolutely requires a good client.

The need for good client skills was recognised by the Paddington Health Campus Independent Review Panel which recommended that the programme board of each major health investment programme (MHIP) should ensure that appointments to a MHIP team take full account of the challenges of such a scheme by including, from the outset, a technical director who knows what design and planning expertise is required and how it can be procured.

The Government recognises this. In a report published to coincide with the March 2006 Budget⁴ it stated that it is working towards a number of objectives:

- To ensure projects are sufficiently developed and mature prior to release to the market;
- To ensure that authorities invest time and resources upfront so that there is certainty of affordability before procurement starts;
- The early indication of potential problems to enable issues to be considered in a timely and orderly manner;
- To ensure that only those projects which are value for money continue to proceed through to procurement;
- To reduce procurement timescales and costs;
- To improve the ability of departments to communicate with the PFI market;
- To capture the lessons to be learnt from projects in operation.

HM Treasury has clearly listened to the RIBA and is acting to improve the standard of design and procurement of future PFI projects. Poor design must be tackled head-on if we are to maximise the value of the UK's major investment in the nation's health and education. We are pleased that HM Treasury have acted so swiftly and decisively on the issues and proposals we identified. We hope we will continue to be able to work closely with HM Treasury to help develop these proposals through to a satisfactory delivery.

In terms of addressing design deficiencies in individual projects, the RIBA—working closely with the Commission for Architecture and the Built Environment—has developed a network of professional Client Design Advisors to help guide public sector clients through often highly complex procedures to achieve the best design outcomes.

³ *Contract Journal*, 8 March 2006.

⁴ *PFI: Strengthening Long Term Partnerships*—HM Treasury—March 2006.

 CONCLUSIONS

The Smart PFI processes—proposed by the RIBA and now picked up by the Government—facilitate a closer working relationship between the client and the designer. This is crucial at the early formative stages of the project to enable the parties to understand the options and how they relate to the clients’ and users’ needs. By facilitating better design outcomes, the long term benefits to the service provider and user can be significant, providing true long-term value for the development.

The RIBA believes that firmer design briefs and a stronger outline design will enable a far more accurate analysis of the true cost of each project, ending the spiralling expenses and poor understanding of risk founded in inaccurate projections.

 Supplementary memorandum submitted by the Department of Health

Question 75 (Mr Greg Clark): The exercise to revalidate planned PFI schemes to reaffirm the size, scope and timing of the NHS PFI programme

A document entitled “The NHS in England: the operating framework for 2006–07” was published on 26 January 2006 and circulated to all NHS bodies. It set out the agenda for the NHS for 2006–07. Paragraphs 4.14 to 4.17 notified trusts of the requirement for trusts to revalidate their investment plans and notified readers that going forward the NHS PFI programme would have an estimated value between £7–9 billion, reduced from £13 billion.

The revalidation of planned PFI schemes has been initiated in response to a number of different pressures. Firstly, the introduction of a series of important financial reforms into the management of the NHS such as payment by results and choice. These could have far reaching implications for the financial stability of some NHS organisations and it was felt that plans for PFI schemes needed to be checked in order to be sure that they could properly respond to the challenges represented by the financial mechanisms.

In addition, the publication of the White Paper “Our Health, Our Care, Our Say: a new direction for community services” signalled an important shift in emphasis away from the provision of care in the acute sector. Again this could have serious implications for the configuration of services envisaged in the plans for PFI schemes. Therefore, in consultation with HM Treasury, it was decided that every PFI scheme currently being planned with a capital value of over £75 million would be reviewed in order to ensure that both the plans and the financial position of the trust concerned were robust enough to withstand the pressures described above, and service provision in these new hospitals properly reflected latest thinking and they would be fit for purpose once built. It is our view that it is preferable to delay a scheme that is not fit for purpose in order to get it right rather than proceed in the knowledge it is wrongly specified.

Further guidance was published and circulated on 10 May 2006 in the form of a letter from the Acting Chief Executive of the NHS. This provided guidance on the purpose of the exercise which is to reaffirm the size, scope and timing of the NHS PFI programme.

It was hoped that the whole exercise could be concluded in six months following the appointment of a NHS project director in mid-March. The initial priority was to focus on the 3 schemes closest to financial close—Barts and The London, St. Helens and Birmingham—to ensure that these schemes were affordable before approved to proceed. Having completed this in early April, the review could then proceed for the remaining schemes.

In order to minimise cost, initial focus has been on the schemes that have formally begun the tender process. These are:

<i>Scheme</i>	<i>Capital Value pre-validation £m</i>
Barts and the London	1,000
St Helens & Knowsley Hospitals	338
University Hospital Birmingham	697
Tameside & Glossop Acute Services	91
Mid-Essex Hospital Services—Chelmsford	186
North Middlesex University Hospital	108
Mid Yorkshire Hospitals—Wakefield	280
Salford Royal Hospitals	190
Peterborough & Stamford Hospitals	360
University Hospitals of Leicester	550
University Hospital of North Staffordshire	411
Walsall Hospitals	100

<i>Scheme</i>	<i>Capital Value pre-validation £m</i>
North Bristol/South Gloucestershire PCTs*	400
Hillingdon Hospital*	338
South Devon	341
Essex Rivers**	167
Tees, Esk & Wear Valleys	78
Maidstone & Tunbridge Wells	428

*These schemes although not in the market were close to issuing their OJEU advertisement.

**Following their review the Board at Essex Rivers NHS Trust announced on Wednesday 14 June that it is withdrawing from their project.

Work has taken a little longer than hoped as the schemes are all large and complex and it necessarily takes time for the review team to fully understand the trusts' proposals in order to be able to interrogate and challenge the thinking behind the project.

It is anticipated that the reviews will be complete on about half of these schemes by the end of this month and the remainder by mid-August.

The team will then move on to review those schemes yet to engage with the market. As the majority of these trusts have yet to formulate proposals, it is anticipated these will be completed more quickly as discussions will focus on concepts and what can be afforded, rather than detailed designs. Schemes in this category are:

Royal National Orthopaedic Hospital
 Barnet & Chase Farm Hospitals
 North West London Hospitals—Northwick Park
 Aintree Hospitals
 Southampton University Hospitals
 Southend Hospital
 Taunton & Somerset
 Plymouth Hospitals
 Papworth Hospitals
 Sandwell & West Birmingham Hospitals
 East & North Hertfordshire/West Hertfordshire Hospitals
 Royal Liverpool & Broadgreen University Hospitals
 Plymouth Hospitals
 Royal Liverpool children's Hospital
 Mersey Care
 Leeds Teaching Hospitals
 Heatherwood & Wrexham Park Hospitals
 United Bristol Healthcare
 Whipps Cross University Hospital
 Royal Wolverhampton Hospitals

It is hoped that these will be completed within 3 months, giving a total programme time of 7 months.

The committee were also concerned about any cost of delay with this review, given that building cost inflation was currently running ahead of general inflation.

The department is acutely aware of the costs associated with delay, and is in contact with all the trusts with projects to ensure priority is given to those with programme pressures. For example, the trusts at North Bristol and Hillingdon have indicated they plan to issue their schemes to the market in the autumn. We have therefore included these in the initial batch of schemes already in the market and which will be completed by mid-August, thus allowing them to retain their current programmes.

We are not aware of any other trusts with plans to go to the market that would be jeopardised by the review's current timetable.

The review of schemes in the market may have resulted in original programmes not being met. To the best of our knowledge, none of these projects is being actually delayed by the process when their scheme already meets existing policies.

Question 79 (Mr Sadiq Khan): Paddington Health Campus' advisers experience of working on similar schemes (Relevant Experience of Advisers to 2000 Outline Business Case).

Newchurch were the management consultant advisers to West London Partnership Forum in preparation of the original outline Business Case approved in 2000.

They were supported by a technical team on planning and design.

GL Hearn were the lead town planning adviser who were responsible for the outline planning application which accompanied the OBC and was granted "Minded to Approve" status by Westminster Council in 2002.

SOM were the lead design adviser, an international firm of Architects, Engineers and Planners with experience in urban design and healthcare. They were supported by two other firms, Arup as engineering services advisers who have a long history of healthcare projects in the UK and overseas including USA and Davis Landon & Everest (now Davis Langdon) as quantity surveyors who are equally experienced in the UK healthcare market.

ARUP

The experience of Arup is detailed in their publication, Healthcare: Design planning and business management service.

DAVIS LANGDON

We aim to work with clients and their advisors as a team and recognise the multiplicity of skills that are required to successfully deliver a PFI/PPP scheme. In all our work we draw on the extensive project and client experience we have as one of the largest construction consultancy practices in the world.

Our PFI/PPP project and research experience is scheduled below:

Advice to the Private Sector		<i>Capital Value (£m)</i>
<i>Project</i>	<i>Nature</i>	
<i>In Service/Under Construction</i>		
The Royal Surrey County Hospital	Private Patients' Unit	20
Dartford & Gravesham Hospital	Hospital Rationalisation	94
St George's Healthcare NHS Trust—St George's Site	Hospital Rationalisation	48
Hastings & Rother NHS Trust	Hospital Rationalisation	10
PRIME	DSS Estate Rationalisation	350
University College London—Cruciform	University/Education	31
Bute Avenue, Cardiff	Road Infrastructure	120
North Ayrshire College, Kilwinning James Watt College	Further Education	8
Fire Fighting Training for the Royal Navy	Training Units (Portsmouth, Plymouth, Faslane)	20
University College London Hospitals NHS Trust—Gower Street Campus	Hospital Rationalisation	225
MoD Main Building Refurbishment—Whitehall	Government Accommodation	552
Hereford Hospitals NHS Trust—County Hospital	Hospital Rationalisation	65
King's Healthcare NHS Trust—Denmark Hill (King's College Hospital)	Hospital Rationalisation	75
East Sussex CC—Peacehaven School	Education	25
Treasury Building (GOGGS)	Government Accommodation	200
Swindon & Marlborough NHS Trust—Princess Margaret Hospital	Hospital Rationalisation	148
The Dudley Group of Hospitals NHS Trust	Hospital and Ambulatory Care	160
Carlisle Hospitals NHS Trust—Cumberland Infirmary	Hospital Rationalisation	75
Redbridge Healthcare NHS Trust—Mental Illness Beds	Hospital Rationalisation	10
Oxleas Hospital NHS Trust—Bexley Hospital	Hospital Rationalisation	15
Worcester Royal Infirmary NHS Trust—Three Hospitals	Hospital Rationalisation	100
Calderdale Healthcare NHS Trust—Halifax General Hospital	Hospital Rationalisation	96
West Lothian College	Education	20
Police Authority Divisional Headquarters—Derby	Police Headquarters	16
Ayrshire and Arran Community Health Trust—East Ayrshire	Hospital Rationalisation	9
Workington Police Station	Police Headquarters	5
<i>In Procurement (Short/Long Listing Status)</i>		
Mid Staffs General Hospital	Medical Records Centre	—
Canterbury College	Education	30
West Glasgow Hospitals	Hospital Rationalisation	120

Advice to the Private Sector		<i>Capital Value (£m)</i>
<i>Project</i>	<i>Nature</i>	
Wharfedale Hospital, Ilkeley	Acute Hospital	20
The Court Service: Exeter Court Group Accommodation		
Docklands Light Railway Extension	Rail Infrastructure	—
MOD Headquarters, Northwood	Government Accommodation	—
Ashford Borough Council—Stanhope Housing Estate	Housing Redevelopment	—
University Hospital Leicester	Hospital Rationalisation	450
Mid Essex Hospital Services NHS Trust—Staff Residential Accommodation	Hospital Accommodation	—
Borough of Telford & Wrekin—Hadley Learning and Community Village	Education	—
Oldham Metropolitan Borough Council—Library & Life-Long Learning Centre	Library	13
Anglian Water Group plc	Claim	—
Ealing Hammersmith & Fulham and Hounslow LIFT	Health Centres & GP Surgeries (various)	70
Lambeth, Southwark & Lewisham LIFT	Health Centres & GP Surgeries (various)	70
Broomfield Hospital	Hospital Rationalisation	140
Channel Tunnel Rail Link Section 1	Transport	—
North Notts LIFT	Primary Care Centres	15
Dudley South LIFT	Primary Care Centres	23
Manchester Schools	Education	30
Miles Platting Neighbourhood Housing	Housing	32
Barking & Dagenham, London Borough of—Secondary Schools	Education	40
Ravensbourne College Relocation Project	Education	
<i>Unsuccessful Bidder</i>		
Home Office Headquarters, London	Government Accommodation	130
Manchester Children's Hospitals NHS Trust	Hospital Rationalisation	400
Sir John Colfox School, Bridport	Secondary School	12
Norfolk Police Authority	Police Headquarters	20
Colchester Garrison	Defence	180
BHB Community Healthcare, Essex	Hospital Rationalisation	—
Good Hope Hospital, Birmingham	Hospital Rationalisation	3
Morrison Hospital, Swansea	Private Patients' Unit	—
The Brompton Hospital, London	Hospital Rationalisation	—
Bradford Royal Infirmary	Private Patients' Unit	10
Central Sheffield University Hospitals	Hospital Rationalisation	—
Northwich Park Hospital	Neonatal/Maternity Unit	12
North Wales Cancer Treatment Centre, Rhyl	Cancer Centre	—
Lister Hospital, Stevenage	Private Patients' Unit	—
Pimlico School, London	Replacement School	20
British High Commission, Lagos	Visa/Staff Accommodation	6
A1(M) Alconbury Link Road	Infrastructure	—
United Medical & Dental School, London	University/Education	120
SEECAT, Southend	College	20
Stonehenge Millennium Park	Visitors' Centre	90
NPL Teddington	Government Research	40
Chelsea Barracks	Defence	40
St Thomas More Catholic School, Willenhall, Birmingham	Education	11
GCHQ	Defence	200
Leeds Schools	Education	33
St Helens LIFT	Primary Care Centres	12
East Lancashire LIFT	Primary Care Centres	19
North Staffordshire LIFT	Primary Care Centres	8
MAST LIFT	Primary Care Centres	26
Sandwell	Housing	54
Plymouth Grove, Manchester	Housing	24
St Wilfrid's School, Birmingham	Education	10
Blackburn, Hyndburn & Ribble Valley	Hospital Rationalisation	70
Oxford Radcliffe Hospitals NHS Trust—Radcliffe Infirmary	Hospital Rationalisation	90

Advice to the Private Sector		<i>Capital Value (£m)</i>
<i>Project</i>	<i>Nature</i>	
North Staffordshire Hospitals NHS Trust—Hospital Buildings	Hospital Rationalisation	—
<i>In Service/Under Construction</i>		
Norfolk & Norwich University Hospital Trust—Hospital	New DGH	145
Wellhouse NHS Trust—Barnet Hospital	General Hospital	60
James Cook University Hospital—South Tees Hospitals NHS Trust	Hospital Rationalisation	122
Fulbourn Hospital, Cambridge	Development as Offices	10
Broadland Flood Alleviation	Environmental Agency Flood Alleviation	135
Pevensy Flood Alleviation	Environmental Agency Sea Defences	29
Bro Morgannwg NHS Trust—Baglan Hosp (Neath/Port Talbot)	Hospital Development	74
Norfolk & Norwich University Hospital NHS Trust	Residential Accommodation	7
MAFF Cambridge Accommodation	Office and Research Accommodation	20
University of Hertfordshire—Sports Facilities	Education/Sports Facilities	80
West Berkshire Priority Care Service NHS Trust—Fairmile	Healthcare	25
West Suffolk Hospital	Mental Health Facilities	3
LB of Hackney—Technology Learning Centre (Library & Museum)	Local Authority	25
Cardiff Community Healthcare NHS Trust—St David's Hospital	Hospital Site Rationalisation Infrastructure	17
Cleveland and Durham Police Firearms Training Facility	Training Facility	10
BBC Property Services	Estate Outsourcing	430
Havering Hospital	New DGH	200
Sandwell and West Birmingham Hospitals NHS Trust	Ambulatory Care Centre	25
Herts and Essex Hospital	Community Hospital	11
City Hospital Birmingham Ambulatory Care Centre	Healthcare	19
Edinburgh Schools PPP II	Education	190
Hinchingbrooke Hospital ACAD	Hospital Rationalisation	27
St Margaret's Hospital Epping	Community Hospital	9
Addenbrooke's Hospital Elective Care Centre	Health	43
<i>Contracts Let/In Procurement</i>		
St Thomas' Hospital, London	Women's & Children's Unit	120
Barts & The Royal London Hospital	Hospital Rationalisation	1,000
Health & Safety Executive, Sheffield	Laboratories	38
Ipswich Hospital	Planned Treatment & Continuing Care Centre Retail	1
IND Accommodation Centres, 4nr across the UK	Home Office	—
Powys Health Care NHS Trust	Community Hospitals	20
Royal Hull Hospitals NHS Trust	Hospital Redevelopment	25
National Audit Office	Consultancy/Project Reviews	—
Chase Farm Hospital	ACAD Unit	41
University Hospital Birmingham NHS Trust	Hospital Rationalisation	520
Edith Cavell Hospital, Peterborough	Hospital Rationalisation	250
Portsmouth Hospitals NHS Trust—Queen Alexandra Hospital	Hospital Rationalisation	100
Calderdale Borough Council—Schools	Education	30
Bristol City Council—Grouped Schools	Education	—
Coventry City Council	Housing	20
NHS Batching of Northern Acute PFI projects	Department of Health	485
Northamptonshire County Council—Schools	Education	100
Three Shires Batching of NHS PFI projects	Mental Health Community Hospital and Learning Disability	115
Central Manchester Hospital	Health	350
Hinchingbrook Hospital	Diagnostic Centre	
Norfolk Police Advisory Services	Police Headquarters	
London Borough of Merton—Five Schools	Education	40
Hull Oncology	Healthcare	

Advice to the Private Sector		<i>Capital Value (£m)</i>
<i>Project</i>	<i>Nature</i>	
Colchester General Hospital	Hospital Rationalisation	143
Market Harborough Community Hospital	Health	25
Mansfield Hospital	Modernisation of Acute Services	260
Advising Banks		
Bassetlaw Schools (Nottingham)	Education	131
Gartnavel Hospital	Health	18
North Ayrshire Schools	Education	84
Dundee Schools	Education	73
Unsuccessful Bidder		
Broomfield Hospital—Key Worker Accommodation (Moat HA)	Hospital Key Worker Accommodation	13
Bromley Hospitals NHS Trust—Provision & Operation of Key Worker Accommodation (Moat HA)	Hospital Key Worker Accommodation	5

Research into PFI and Related Topics

Research

PFI Hospitals (Overview & Cost Model)	— Building Magazine (1996)
Guidelines for Capital Procurement in the Higher Education Sector	— The Committee of Vice Chancellors and Principals
Risk Assessment in PFI	— CIRIA (1996/97)
Contractor Financing: WDA Development Programme	— Welsh Development Agency (1996)
An Audit Guide to the Management of Local Authority Capital Projects	— The Audit Commission (1995/96)
New Price Index Methodologies for Public Sector Housing Work	— DOE (1992)
Value for Money in Social Housing	— The Scottish Office (1995)
Price Trend Forecasting Model	— Highways Agency (1996)
Weighting of Building Environmental Impacts	— BRE (1992/93)
International Construction Price Comparison Study	— The Organisation for Economic Co-operation and Development (1987–)
A Stock Model of Sports Buildings In England	— Sports Council (1992)
Life Cycle Costing and the Sports Council	— Sports Council (1991)
The Value Management of Works Projects	— HM Treasury (1994)
Value Management in UK Practice	— CIRIA (1995)
A Guide to Construction Contract Insurance and Risk	— The Scottish Office (1994)
Guidelines for Quality in the Construction Process	— DWS (1996/97)
Benefit Trading in Construction: A Practical Guide	— CIRIA (1999)
The Role of Cost Saving and Innovation in PFI Projects	— Construction Industry Council (2000)
ProCure 21: Validation of Proposed FM Reference Test	— NHS Estates (2000)
PFI Cost Model	— Building Magazine (2001)
Capital Cost Implications of Consumerism on NHS Departmental Cost Allowances	— NHS Estates (2001/02)
<i>PFI Seminars Hosted/Co-Hosted By Davis Langdon</i>	
Public Private Partnerships, Dublin	— Office of Public Works (and others)
Public Private Partnerships, Dublin	— Anglo Irish Bank, Bank of Scotland, Ulster Bank, Bank of Ireland, Barclays Bank
Public Private Healthcare in Ireland, Dublin	— Davis Langdon/PKS
North Thames Region PFI Workshops	— NHS
North West, Scotland, Southern & London/Oxford Region Seminars	— Davis Langdon
Branch Lectures	— RICS
PFI, Prime Contracting & 'New' Methods for Government Procurement	— RICS (Owlion)
Financing PPP Facilities in the Leisure Industry	— Presentation to Sport England
Rail: PFI within the Sector	— RICS
Problem PFIs and the Performance Bond	— Davis Langdon

Davis Langdon are also Members of the RICS PFI Forum and Policy Group, the IPFA and represented on the CABE PFI Working Forum

Davis Langdon have extensive Design Build Finance Operate/Design Build Finance experience working on large international projects including:

- The Sovin Centre, Moscow
- Retail Projects in Poland & Hungary
- Seremban-PD Highway, Port Dickson, Kuala Lumpur
- KLIA Airport Terminal Buildings, Kuala Lumpur
- Forum Galleria Shopping Centre, Orchard Road, Singapore
- Pinehurst Golf and Country Club, Bangkok, Thailand
- Selyang Hospital, Kuala Lumpur
- KLCC LRT Underground Station, Kuala Lumpur
- Wellington Waste Water Treatment Plant, New Zealand
- Sports Campus Ireland, Dublin
- Budapest Arena, Hungary
- Estadio Municipal de Aveiro, Portugal
- Oman Joint Technical College, Oman
- Stadium Australia, Sydney

GL HEARN

GL Hearn was established in London in 1923 and was one of the first property consultancies to establish its own planning department in 1970. The firm now also has offices in five regional locations including Glasgow, Manchester and Belfast. Its London base was at London Bridge until 2003 when it moved to the West End.

We became involved in the Paddington Health Campus about 1998 when we won the commission to prepare a “Planning and Property” study through a competitive interview. Our presentation was made by two senior Directors, David Napier and David Beardmore, who have a total of over 55 years professional experience at that time. We subsequently undertook the work personally.

By then we had an established track record of major planning and property commissions from the NHS. While the majority of these were in the West Midlands and South West England we also worked on substantial health care projects in London. In 1998–2000 we were working on the redevelopment of Springfield Hospital Tooting.

As a practice we were actively working, or had recently done so, on a number of major infrastructure projects. We acted as the lead planning consultant for BAA at the Terminal Five Inquiry, including providing the expert witness covering all aspects of planning policy. We also were responsible for the acquisition of all of the land required for the London section of the Channel Tunnel Rail Link on behalf of Union Rail.

Our commercial activities in both planning and property fields are extensive. In London we were responsible for the development of the Hays Galleria at London Bridge while in Sheffield we were responsible for obtaining the permissions and acquiring the land for the Meadowhall Shopping Centre. We also gave commercial advice abroad for projects such as Granary Island, Gdansk in Poland.

We have advised public authorities throughout the UK on a variety of planning and property related issues. In 2001 we provided two of the English Heritage witnesses at the high profile Heron Tower Inquiry. We have also acted for public bodies in mainland Europe including French Regional Authorities in the Pas de Calais and in the area around Orleans. We have been involved, usually as lead consultants, in Regeneration Studies commissioned by public authorities in Cornwall, Devon, Bristol, Sunderland and Liverpool.

SKIDMORE, OWINGS & MERRILL

1. THE FIRM

Founded in 1936, Skidmore, Owings & Merrill (SOM) is a multi-disciplinary practice with experience in the design of projects of a wide variety of uses and range of sizes. We provide in house expertise in:

- Architecture
- Urban Design and Planning
- Structural Engineering
- Landscape Design
- Interior Design

SOM has major offices in North America, Europe and Asia. The firm has completed in excess of 10,000 commissions in over 50 countries throughout the world, and has received more than 800 national and international awards.

SOM has been active in Europe for more than 40 years. The London office of SOM was established as its European base in 1986, leading commissions for the award-winning Canary Wharf and Broadgate developments. It has a long history of executing large-scale Urban Design projects, starting with the original Canary Wharf Master Plan undertaken in the late 80s and the extension to Heron Quay in the mid 90s and continuing to the present day, with work at Leamouth Peninsula in London and Ebbsfleet in Kent.

Both the New York and San Francisco offices act as centres of excellence for healthcare projects. The following text refers to SOM's specific experience in the fields of Urban Design and Healthcare.

2. URBAN DESIGN

Urban Design Mission

- Restore and rebuild urban centres
- Make cities / communities more liveable
- Create vibrant urban environments
- Restore and conserve our natural environment
- Connect the project to the place
- Promote smart growth strategies and transport-oriented development
- Integrate best sustainable practices into every project
- Emphasise the public realm and urban infrastructure
- Promote social and economic diversity
- Ensure citizen-based participatory planning
- Respect the past and anticipate the future

A Commitment to Cities

SOM has undertaken some of the largest and most complex urban development projects in the world, focussing on cities as the places where the strongest forces for change are at work and where there is the greatest need to address issues of liveability, function and growth.

SOM has created long-range plans for whole cities, central city and waterfront districts, and urban neighbourhoods. At the same time it has created entire urban design concepts for new urban developments that have been built and have become homes and places of work. Recent work carried out by the London office includes:

- Leamouth Peninsula, London, UK
- Ebbsfleet City Centre, Kent, UK
- Bahrain National Planning Development Strategies
- Newport 2020 Master Plan, South Wales, UK
- Liverpool Regeneration Strategy, Liverpool, UK
- Elephant & Castle Master Plan, London, UK
- Bishopsgate Goods Yard, London, UK
- Pribinova Waterfront, Bratislava, Slovakia
- Broadgate Public Space Enhancements, London, UK

A Belief in the Power of Design

Our urban design practice assumes that the physical environment can be designed, that economic and political forces can be influenced by the design process, and that it is part of the public interest to stimulate, guide and influence private investment. Through urban design we collaborate with our clients to organise and balance the powerful pressure for growth and new development with the desire for appropriate conservation of key civic components and setting the appropriate physical character and liveability of the future environment.

Ensuring the Ease of Getting Around

The movement of people is central to the existence of the modern city. The best cities and neighbourhoods are walkable, offering high-quality pedestrian environments. We also believe public transport is vital to achieving an accessible city by reducing the functional and space demands of an auto dependent community. Maximising connections between all modes of transport must be integrated into all city planning efforts.

Creating a Strong Sense of Place

While there are forces that make cities look alike, we attempt to advance ideas that reinforce a city's unique culture and physical character in order to define its distinctive sense of place.

We believe that the best places have a distinctive look and a memorable quality. A strong sense of place is part of making cities liveable.

The Creation of Urban Value

A strong sense of place, the quality of open space, landscape and streetscape creates real estate value, making it possible that public and private interests can mutually support and enhance each other.

3. HEALTHCARE

Half-a-Century of Health Care Planning & Design

SOM's health and science portfolio spans 50 years and includes the planning and design of some of the most advanced research facilities currently underway. Every project brings teams of in-house and outside specialists together—healthcare and research strategic and facilities planning firms, consulting engineers, construction managers, and client groups—to achieve the highest response possible while maintaining budget and schedule. SOM's core strengths in planning, design, technical coordination, and management combined with the firm's healthcare and research planning expertise, allows for the optimal dialogue between knowledgeable experts in a collaborative effort.

Translational Research & the Campus of the Future

Having designed translational research facilities for a range of urban campus settings, SOM understands the complex issues involved in integrating clinical, research, educational and support uses in individual and multi-building solutions to create potent, interactive adjacencies that simultaneously respect the boundary between public and private. In addition, our experience with mixed-use urban projects provides the understanding of the synergies between the workplace, housing, retail, and civic uses that define the urban campus of the future.

In all settings—whether designing a high-rise translational research center for Mt. Sinai School of Medicine in New York or the Ohio State University James Cancer Center expansion—SOM draws upon its planning and technical expertise to carefully integrate new research buildings into the surrounding campus, adjacent neighbourhoods, and existing infrastructure. SOM's diverse experience in libraries, academic buildings, student housing, and public-private incubator developments further informs our approach to creating meaningful relationships between all elements of the research complex within the university and the broader university district, city, and region.

Change Management

Constant change is the most significant characteristic of the healthcare industry today. New medical technologies and practice patterns, rising patient expectations and increased competition are radically affecting the way in which health services are provided. Innovative ways of delivering care and organising the healthcare campus are being created in response to this dynamic. Our firm is a leader in the integration of new medical technologies into the overall functional framework of "the modern hospital." Our project team updates the knowledge base of both manufacturers and systems that affect safety and security, patient records and accounting, and staff communications, as well as major equipment such as MRI, Gamma Knife, or Linear Accelerator. From new wireless nurse call telemetry to iris recognition systems, our staff supports their projects with in-depth research into "state-of-the-art" processes, presenting innovative, advanced findings to their clients.

Healing Spaces

Our healthcare design supports a positive patient, staff, and visitor experience. Non-clinical in appearance yet highly functional space is achieved in many ways. The integration of natural lighting, creation of positive distractions such as gardens and water features, the choice of culturally appropriate fabrics and finishes, and integration of medical technology with casework, all provide an environment in which the process of care is enhanced.

Managing Design, Cost & Schedule

As a practice specialising in the planning and design of large and complex projects, SOM is recognised for our success at institutions such as Texas Medical Center and Harvard University where we worked with multiple institutions, departments, and interest groups to create solutions that meet the broadest range of priorities. Through decades of practice, we have honed our project-management processes and procedures, emphasising clear communication and documentation as the most essential component for keeping projects on schedule and within budget.

Multi-disciplinary Solutions

Regional collaboration is both a significant characteristic of the health and science industry today and a major impetus for urban development. Advances in technology, evolving practice patterns, and increased competition have come together to create one of the most challenging and exciting periods in the history of urban universities and the cities they call home. As a multidisciplinary practice founded on the premise of collaboration, SOM is uniquely positioned to offer the full spectrum of services necessary for realising the potential of this era. Our depth of expertise in urban and campus planning, architecture, interiors, and engineering, coupled with our experience in healthcare, research, and educational facilities, gives SOM the edge to lead, innovate, and advance the art of architecture for health and science.

Building Lasting Value

By emphasising quality, flexibility, and sustainability, SOM has earned international recognition and numerous awards for the long-term performance of its master plans and buildings. A pioneer in sustainable design, the firm has led advances in energy-efficient and environmentally responsive design. By designing enduring and well-crafted buildings that accommodate organisational and technological change over time, SOM creates lasting value for our clients and the communities we serve.

Question 86 (Mr Sadiq Khan): Can we have a note of the experts that were used and how much they cost.

Paddington Health Campus**INFORMATION ON USE AND COSTS OF ADVISERS TO THE PROJECT**

<i>Line</i>	<i>Topic</i>	<i>Company</i>	<i>Service</i>	<i>Appointed</i>	<i>Total expenditure</i>
1	legal	Berwin Leighton Paisner	PHC legal adviser	May 2002	£759,060
2	legal	Capsticks	One-off advice	May 2001	£4,250
3	Corporate finance	Pricewaterhouse Coopers	PHC corporate finance advisers	Oct 2002	£583,480
4	Corporate finance	Ernst & Young	Interim advice on risk and tariff	Jan 2001	£29,680
5	Healthcare planning	Office for Public Management	Interim training on PFI process	2001	£18,480
6	Healthcare planning	P Adams Consultancy	Consultancy support to Process Development Groups	2001	£21,500
7	Healthcare planning	Agenda	Review of planning assumptions	Nov 2002	£32,860
8	Healthcare planning	Sigma HB	Revision of OBC activity assumptions	April 2001	£99,190
9	Healthcare planning	Mike Hartfield	International benchmarking	Sep 2004	£8,210
10	Healthcare planning	IHG	Private Patients study	2001	£12,690
11	NHS finance	Mike Flaxman Associates	NHS Finance modelling	2000	£459,860
12	Healthcare planning	Secta	Healthcare advisers to PHC	Mar 2003	£128,990
13	Healthcare planning	Finnamores	WLPF appointment		£34,130

<i>Line</i>	<i>Topic</i>	<i>Company</i>	<i>Service</i>	<i>Appointed</i>	<i>Total expenditure</i>
14	Healthcare planning	Newchurch	OBC support		£318,890
15	Technical	BDP	Interim technical advice	June 2002	£93,850
16	Technical	Sheppard Robson	architectural adviser to PHC	Mar 2003	£112,160
17	Technical	Durrow Management	Planning advice		£10,410
18	Technical	Turner + Townsend	Project advice to Imperial College		£105,000
19	Technical	King Sturge	Due diligence report on the Point	Nov 2003	£35,270
20	Technical	DLE	Cost consultancy	2002/3	£508,740
21	Technical	Studio 4	Architectural adviser to PHC	Apr 2003	£154,290
22	Technical	IBS	Technical adviser to PHC	Apr 2003	£871,330
23	OBS	Virginia de Vere	Space planning	Oct 2001	£83,600
24	FM Support	Healthgain	FM consultancy	2001	£10,300
25	FM Support	DD Associates	Strategic equipment advice	2001	£2,900
26	FM Support	IBS	Interim FM adviser	May 2002	£44,380
27	FM Support	EC Harris	Interim Soft FM adviser	Feb 2003	£25,000
28	FM Support	EC Harris	Soft FM adviser	June 2003	£60,590
29	Decant	Love Jenkins	Decant costing	2000	£1,750
30	Decant	Studio 4	Architectural advice on decant and planning	Apr 2003	£279,440
31	Decant	TBA	QEQM condition survey	Jan 2001	£23,260
32	Decant	Hornagold and Hills	Project management and business case support	Oct 2002	£146,380
33	IM&T	Silicon	IM&T support to OBC		£15,850
34	IM&T	Saba/DQS	IM&T PHC advisers	2001	£105,760
35	IM&T	Health Systems		2003	£1,510
36	IM&T	Pagoda	Infrastructure advice	2002	£46,190
37	Property	Derek Horne	Planning Brief advice	Nov 2000	£9,920
38	Property	Insignia Richard Ellis	Property advice on Post Office site	2003	£24,360
39	Property	Weatheralls	Point Acquisition and PDCL land valuation	May 2003	£136,650
40	Property	District Valuer	Valuation of land deals	Aug 2003	£9,360
41	Property	Montagu Evans	Land sales valuation	Sep 2002	£122,760
42	Communications	Jonathan Street	Interim PR advise	Dec 2002	£18,730
43	Communications	Jonathan Street	PR support	Jun 2003	£8,600
44	Communications	Christows	Communications adviser to PHC	Aug 2003	£144,010
45	Communications	London Communications Agency	Communications adviser to PHC	Nov 2004	£49,490
46	PCO support	EC Harris	Set up electronic control office	Dec 2002	£78,920
47	Audit	Deloitte + Touche	External auditors to both Trusts	On-going appointment	£32,000
48	Audit	Parkhill Audit	Internal auditors to PHC	Jointly appointed by both Trusts	£38,930
49	Equipment	MTS	Estimate of PSC equipment cost	Nov 2002	£16,600
50	Equipment	UMG	Equipment adviser to PHC	Mar 2003	£77,540
51	Insurance	Willis	Insurance adviser to PHC	Oct 2003	7,680
52	Accommodation	Hunters	Staff accommodation strategy	2000	£24,710
53	Town Planning	Savell Bird & Axon	Transport planning	2000	£80,220
54	Town Planning	Gordon Ingram Associates	Daylighting and rights to light	2000	£35,780
55	Town Planning	SOM	Planning application	2000	£923,560
56	Town Planning	SOM	Post application support	July 2000	£114,350
57	Town Planning	GLHearn	Planning consultancy	1998	£217,340
58	Town Planning	Ove Arup	Environmental consultants	2000	£141,570
59	Town Planning	Terry Farrell & Partners	Masterplanning	July 2004	£181,700
60	Town Planning	TGA	Engineering investigation	2000	£5,030
61	Town Planning	Virtual Artworks	Visual assessment images	2001	£14,750
62	Town Planning	Museum of London Archaeology Service	Architectural heritage study	2002	£6,380
63	Other	various	Sundry items		£20,640

Question 92 (Mr Sadiq Khan): Could we also have a breakdown of the £14.9 million, the wasted costs.

Request from SHA for PHC costs (excluding carrying costs of £490k).

Expenditure by year for Paddington Health Campus Project & Forecast to 30 June 2005

PHC Spend by Year from 1999	WLPF	PHC	PHC	PHC	PHC	PHC	PHC from	PHC &
	1999–2000	2000–01	2001–02	2002–03	2003–04	2004–05	01–04–05 to 30–06–05	WLPF Total cost to 30–06–05
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Advisers	1,479	231	520	947	2,991	1,536	88	7,792
Pay	155	209	360	843	1,531	1,389	275	4,762
Accommodation & other Project costs	18	62	46	309	416	337	84	1,272
Total	1,652	502	926	2,099	4,938	3,262	447	13,827

NOTES:

1. Direct Costs from Partnerships UK (PUK) (not charged to budgets—but payable by Trusts on termination of Project) 282 380 409 0 1,071
2. Carrying costs are chargeable on PUK direct and indirect costs—total £390k 0
3. WLPF—West London Partnership Forum (hosted by former Kensington, Chelsea and Westminster Health Authority) to October 2000
4. PHC - Paddington Health Campus (St Mary's NHS Trust as paymaster) from November 2000 0
5. Delayed settlement costs of £100k (50–50 Trust split) 14,898

PHC Funding by Year from 1999	WLPF	PHC	PHC	PHC	PHC	PHC	PHC from	PHC &
	1999–2000	2000–01	2001–2	2002–3	2003–4	2004–5	01–04–05 to 30–06–05	WLPF Total funding to 30–06–05
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Funding—cash mgt for project (suplus)/deficit b/f	0	–246	256	82	–172	671	545	0
WLPF funding for outline planning application	–572	0	0	0	0	0	0	–572
SMH (60%) re 03–04 deficit & wind up	–326	0	0	326	0	–313	–45	–358
BH (40%) re deficit and wind up						–208	–30	–238
SMH–PUK unpaid 50%							–273	–273
RBH–PUK unpaid 50%							–273	–273
SMH share of IC wind up contribution							125	125
RBH share of IC wind up contribution							125	125
NWL SHA support for 03–04 deficit	0	0	0	0	0	–150	0	–150
Less Imperial College Contribution (5.08% of 50%)	0	0	0	0	–125	–58	0	–183
IC share of PUK—wind up costs	0	0	0	0	0	0	–250	–250
Less PUK Funding (payable on termination of Project)	0	0	0	–680	–2,469	–1,246	0	–4,395
PCT funding (NLLondon Secur PCTs—1% of SLA)—SMH	0	0	0	0	0	–1,257	–331	–1,588
PCT funding (NLLondon Secur PCTs—1% of SLA)—RBH						–156	–41	–197
Less RHA/SHA Funding (from 1.75% of OBC CAPEX)	–1,000	0	–1,100	–2,000	–1,500	0	0	–5,600
Total funding	–1,898	–246	–844	–2,272	–4,266	–2,717	–447	–13,827
(suplus)/deficit c-f	–246	256	82	–172	671	545	0	0

	<i>£000's</i>	
Total costs—funding including PUK direct, carrying costs and delayed settlement		14,898
Imperial conts @50% of 5.08%		– 183
Imperial PUK share & winding up		– 250
SMH–PUK share—excluding carrying costs	approx 50%	– 2,748
Less SMH share of IC cont to winding up	50%	125
Less SMH share of SHA support for PUK settlement	50%	1,000
SMH/PUK unpaid	50%	– 273
SMH deficit—wind up	60%	– 358
RBH/PUK share—excluding carrying costs	approx 50%	– 2,718
Less RBH share of IC cont to winding up	50%	125
Less RBH share of SHA support for PUK settlement	50%	1,000
RBH/PUK unpaid	50%	– 273
RBH deficit—wind up	40%	– 238
WLPF—contribution from W.London HA's		– 572
Sector PCT's—SMH SLAs		– 1,588
Sector PCTs—RBH SLAs		– 197
RHA–SHA		– 5,750
SHA assistance with PUK settlement (£1m assistance for each of SMH and RBH)		– 2,000
Surplus/deficit		0
Summary—Shares of PHC Costs	<i>£000's</i>	
Imperial	2.9%	– 433
SMH	15.1%	– 2,254
RBH	14.1%	– 2,104
Sector PCT's inc WLPF	15.8%	– 2,357
RHA–SHA	52.0%	– 7,750
		– 14,898

Note NAO report quotes £15 million (£14.9 million) which excludes PUK carrying costs and deferred settlement costs (£0.5 million)