

A Best Client Handbook for the Management, Briefing and Procurement of Capital Schemes

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BEST CLIENT HANDBOOK:

The Management, Briefing and Procurement of Capital Schemes

EXECUTIVE SUMMARY

- This document is a summary of 'The Best Practice Manual,' the objective of which is to provide guidance and practical advice in the planning, management and development of NHS Capital Projects.

- Government and Ministers recognise the importance of successful capital procurement as the foundation for modernisation within the NHS.

- They are committed to:

A major programme of capital investment in delivering the biggest new hospital building programme in the history of the NHS.

Improving the quality of healthcare environments by promoting and procuring better designed buildings.

"New Health facilities can be powerful symbols of a renewed commitment to public services".

"Good health facilities design has positive impacts on the patient environment and the individual patient – their state of mind, their prospects of recovery, their sense of well being"¹

- The NHS is committed to becoming a **"Best Client"**, facilitating improvements within the design, procurement and construction and so directly improving the quality of the patients' environment.

The full manual is available from www.nhsestates.co.uk

For the attention of:

Chairmen, Non-Executive Directors
Chief Executives, Medical & Nursing
Directors of health organisations
engaged in Capital Planning and
Development

The NHS Plan Capital Investment Objectives:

- 100 new hospitals built by 2010
- 20 Diagnostic and Treatment Centres developed by 2004
- Up to 3,000 family doctors' premises substantially refurbished or replaced by 2004.
- 500 new one-stop primary care centres by the year 2004.
- 25% of hospitals replaced or upgraded over the next 10 years

As a result of the NHS Plan:

- £7 billion of new capital investment through an extended role for PFI by 2010
- 40% of the total value of the NHS estate will be less than 15 years old by 2010
- By 2004 the NHS will have cleared at least a quarter of its £3.1 billion maintenance backlog accumulated through two decades of under-investment
- Up to £1 billion will be invested in primary care facilities

¹ Alan Milburn, Princes Conference "Building a Better Patient Environment – November 2001

Purpose and Status of this Document

Why has this document been produced?

NHS Estates has produced this document as an aid and source of good practice.

Who should read this document?

The document is intended for use by all NHS Managers involved with the planning and delivery of NHS capital investments, from Trust Chief Executives, Chairs and Non- Executive Directors, to Medical and Nursing Directors of health organisations.

The guide will assist consultants and contractors who may be engaged by NHS Trusts.

What does the document aim to achieve?

The aim is to improve processes, procedures, and to deliver consistent design quality standards in healthcare facilities. Guidance is offered based on best working practice gained from practical experience of major capital procurements.

What does the document do?

This document describes the processes that need to be followed and the information that needs to be prepared at each stage of the briefing, design and construction in order to:

- Prepare a clear brief.
- Communicate appropriate design expectations.
- Organise a sound evaluation process
- Manage the procurement process effectively and efficiently.

How is the document structured?

This document provides an overview of the more comprehensive Best Client Guide.

The overall document will be called The Best Client Guide with sections called Best Client Handbook and Best Practice Manual. The BC handbook will be subdivided to account for Doctor, Nursing, and Admin issues as well as PD guidance.

This document is split into two parts: Part 1 covers Best Client approaches and processes, Part 2 "Establishing the brief" provides a checklist for best practice briefing

Included in the guide are many lessons and examples of Best Practice, derived from previous experiences of PFI / PPP and Exchequer funded capital schemes: -

- Best Client Practice
- The Briefing and Design Process
- Approval Gateways
- Recent Influences on Briefing and Design
- The NHS Procurement Routes
- Risk and Value Management
- Construction and Change Control
- Evaluation
- Establishing the Brief
 - Project Management
 - Clinical Sign-off
 - Key Information to be Provided
 - Capital Planning
 - Hospital Policies
 - Output Specifications and Trust Construction Requirements
 - Equipment Procurement

Part 1:

1.01 Best Client Practice

Why Best Client?

The traditional procurement route of drawings and specification, invitation of tenders, and approval of lowest price has worked against the concept of continuous improvement. Each project has been treated in isolation, with performance and learning often limited as a consequence.

This arrangement has resulted in:

- A reinforcement of culture and behaviour by both client and contractor partners.

Resulting in:

- An “us and them” attitude, which may become adversarial.

Leading to:

- Wasteful practices.
- An end product that is not driven by the client.
- Delays due to conflict.

The ***Re-Thinking Construction Report (July 1998)*** included the concept of “Best Practice Clients” as one of its recommendations for improving the performance within the construction industry.

It called for substantial improvements in the way that the public sector procures construction, while still maintaining public accountability.

The report advocates a more integrated approach between all parties involved in the design, construction and operation of capital investments.

Best Client Attributes

To achieve the objectives of the “Governments Construction Industry Taskforce” and to improve the value to patients from capital investments, the NHS should embrace the following “Best Client” attributes:

- Best value solutions that take account of whole life cycle cost’s rather than the lowest price.

- Be an informed client.
 - Clear expectations of need and seeks new solutions. Integrated stakeholder, client and supplier relationships. Greater involvement of users in the design process.
 - Is solutions focused (e.g. focuses on value-added to end user, not just product). Less prescriptive approaches.
 - Committed to continuous improvement and end user focus.
 - Committed to open communication (i.e. has a collaborative mindset)
- Structures the relationship for reward and risk share linked to performance through a partnering arrangement
- Avoidance of conflict by use of risk management techniques
- Shares technology, processes and systems with partners
- Sets time aside for relationship building
- Pays on time
- Reduces red tape and bureaucracy

In developing an insight into the requirements of 'Best Client' ranges of competencies have been identified. These competencies are to be continuously reviewed and developed.

The adoption of these and other Best Client competencies should produce improvements in the quality of environments for healthcare facilities.

The Project Director (1.07) is an essential component for the successful delivery of these developments



BEST CLIENT – CONCLUSIONS

For the Best Client initiative to contribute to consistent improvements in performance, practical approaches need to be developed.

Trusts will need to consider how best they will:

- Support the training and development of project managers
- Implement sound project management processes
- Foster a culture that enables more effective partnering
- Encourage greater use of standardisation techniques and components.
- Help promote a common performance management system based on continuous improvement
- Effectively disseminate their own best practice learning and knowledge

1.02 Briefing and Capital Investment Approval Process

The NHS first issued the **Capital Investment Manual** in June 1994. Since then procurement decisions by the NHS have relied on using the structures and stages, which it sets out, and in particular the development and approval of **Outline Business Cases (OBC)** and **Full Business Cases (FBC)**. In December 1997 additional guidance was issued which required the production and approval of a **Strategic Outline (Business) Case (SOC)** as the first part of procurement process.

Detailed requirements of the SOC, OBC and FBC are set-out in the NHS Executive document "Public Private Partnerships in the NHS". The Private Finance Initiative section 1 & 2 and the Capital Investment Manual 1994.

Appendix 1.02a and 1.02b show the key approval stages for PFI and Partnering Schemes.

The Strategic Outline [Business] Case (SOC):

A SOC should comprise of six sections:

- Strategic Context
- Health Service Need
- Formulation of Options
- Affordability
- Timetable and Deliverability
- A Robust Estates Strategy

The proposal **MUST** demonstrate the health service need for a major capital investment, including detailing the service problems, which it is designed to overcome.

The Trust and their Commissioners need to demonstrate that the capital proposal:

- Is clearly linked to the Health Improvement Programmes (HImP's)
- Delivers the NHS Plan.
- Fits within the locally agreed strategic direction and is supported by Primary Care Trusts in the SOC.
- Has considered robust options and satisfactory project management proposals are in place.

All this information is required by the Capital Prioritisation Advisory Group to assess the scheme's national priority.

When the SOC has been approved, the Trust can proceed to develop the OBC.

The Outline Business Case (OBC):

Before preparing the O B C the Trust MUST formally appoint:

- The Project Director
- The Project Team,
- Clinical working groups

They must also establish levels of delegated authority

At this stage consideration should be given to the appointment of Technical Advisers.

Either

In accordance with EC requirements, in the case of PFI schemes

Or

In accordance with NHS ProCure 21 arrangements

Alternatively, a design team will need to be appointed in accordance with EC requirements in exchequer funded schemes.

The OBC should contain the summary of the Project Invitation Document (PI) and Project Execution Plan (PEP)

The OBC objective is to identify the preferred option that satisfies the requirements of the Trust and commissioners. It involves the development and evaluation of different options using recognised option appraisal techniques.

The OBC should demonstrate:

- ❑ Cost effectiveness
- ❑ Value for money
- ❑ Improvement in service quality
- ❑ Flexibility
- ❑ Robustness
- ❑ Financially viable
- ❑ Continuing support from the Primary Care Trusts

At this stage it is important that the Trust prepares a public sector comparator (PSC).

By this stage the Trust should have received outline planning permission for their proposals and have completed the output specification, design and construction requirements for PFI schemes.

When the Outline Business Case has been approved the Trust can then proceed to develop the F B C.

The Estates Strategy:

Recently cases have shown that where insufficient attention has been given to the Estate Strategy, the capital cost has been considerably under estimated in the SOC

This potentially leads to proposals being over-optimistic and constraints on time not being accounted for. Such issues are of major consequence for the development of the OBC

It is important that submissions should be realistic and deliverable. Capital costs need to be robust; it is not appropriate to assume that a capital cost can be set as a cap to establish an affordability envelope.

Public Sector Comparator

The PSC represents a risk-adjusted costing of the public sector's solution to the output specification, produced as part of the PFI process.

It is the benchmark for value for money and will be used to evaluate solutions. It may be challenged during the PFI bidding procurement process.

It should be designed and costed to a realistic level that if challenged could demonstrate that the Trusts output specification can be achieved.

In PFI schemes the memorandum of information, PITN, FITN and OJEC notice should be completed and the evaluation criteria agreed and approved by the Trust Board.

The Full Business Case (FBC)

The F B C needs to be developed and approved before the project can proceed to tender, or financial close. It should include:

- A Full review of the previously prepared business cases and the various approvals given.
- A Detailed specification of the functional contents of the proposed scheme.
- A Risk management strategy.
- Fully detailed project management arrangements.
- A Benefits realisation plan.
- A Plan for the evaluation of the project.
- Estate strategy and design proposals

There is a difference in the content and timing of approval depending on the process being used.

FBC for Exchequer Funded Partnering Schemes

Should be submitted and approved ahead of detailed design work and construction documentation being completed.

The Trust should complete this work, and then seek tenders, which should fit within FBC affordability limits.

FBC for PFI Schemes

The FBC is not approved until immediately before financial close is achieved.

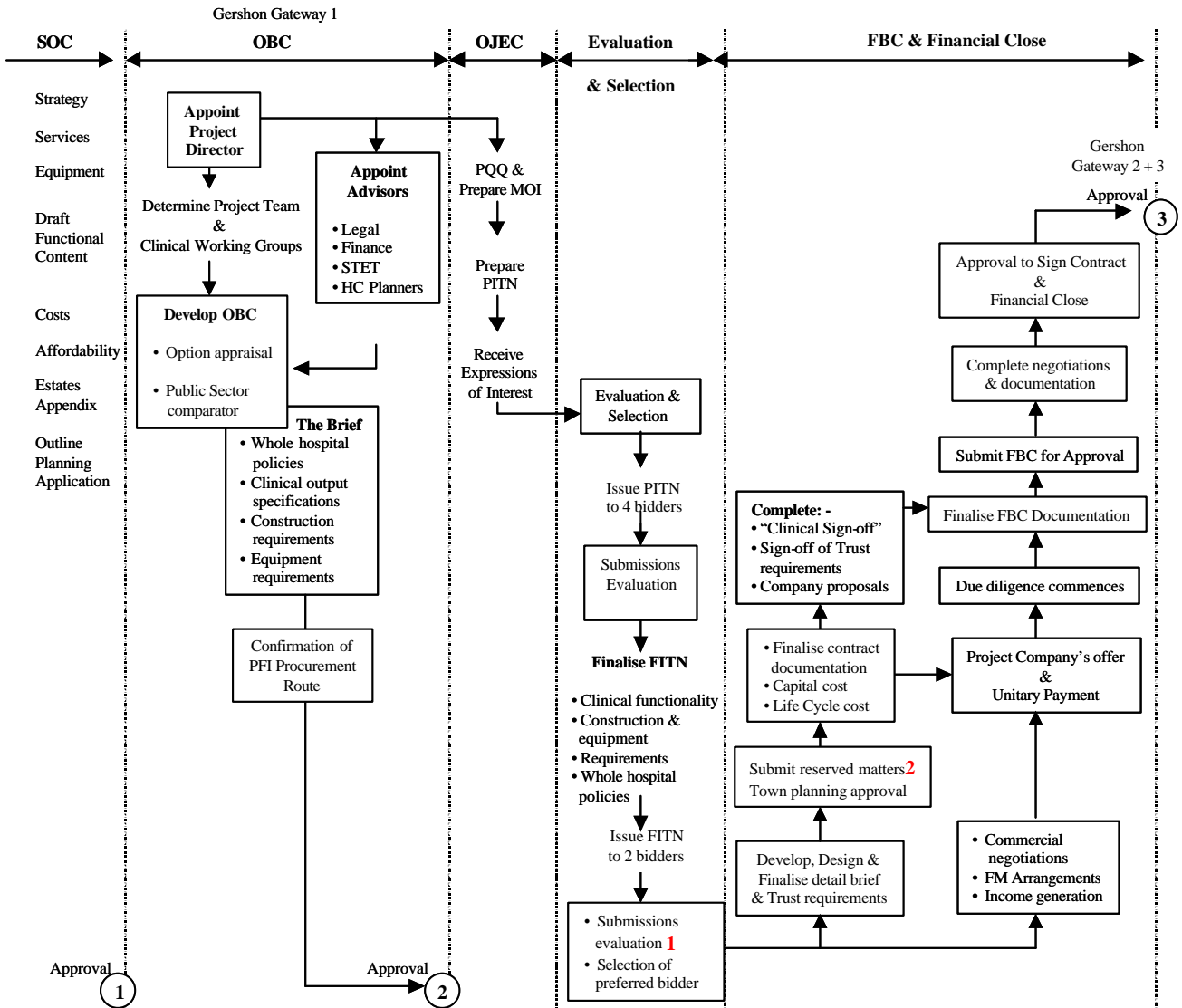
The consortia will have received town-planning approval / reserved matters for approval, and its contractor will have completed detailed design for major elements to enable a start on site immediately after financial close.

THE FBC should include a PSC.

Appendix 1.02a

This diagram applies to schemes over £60 million.

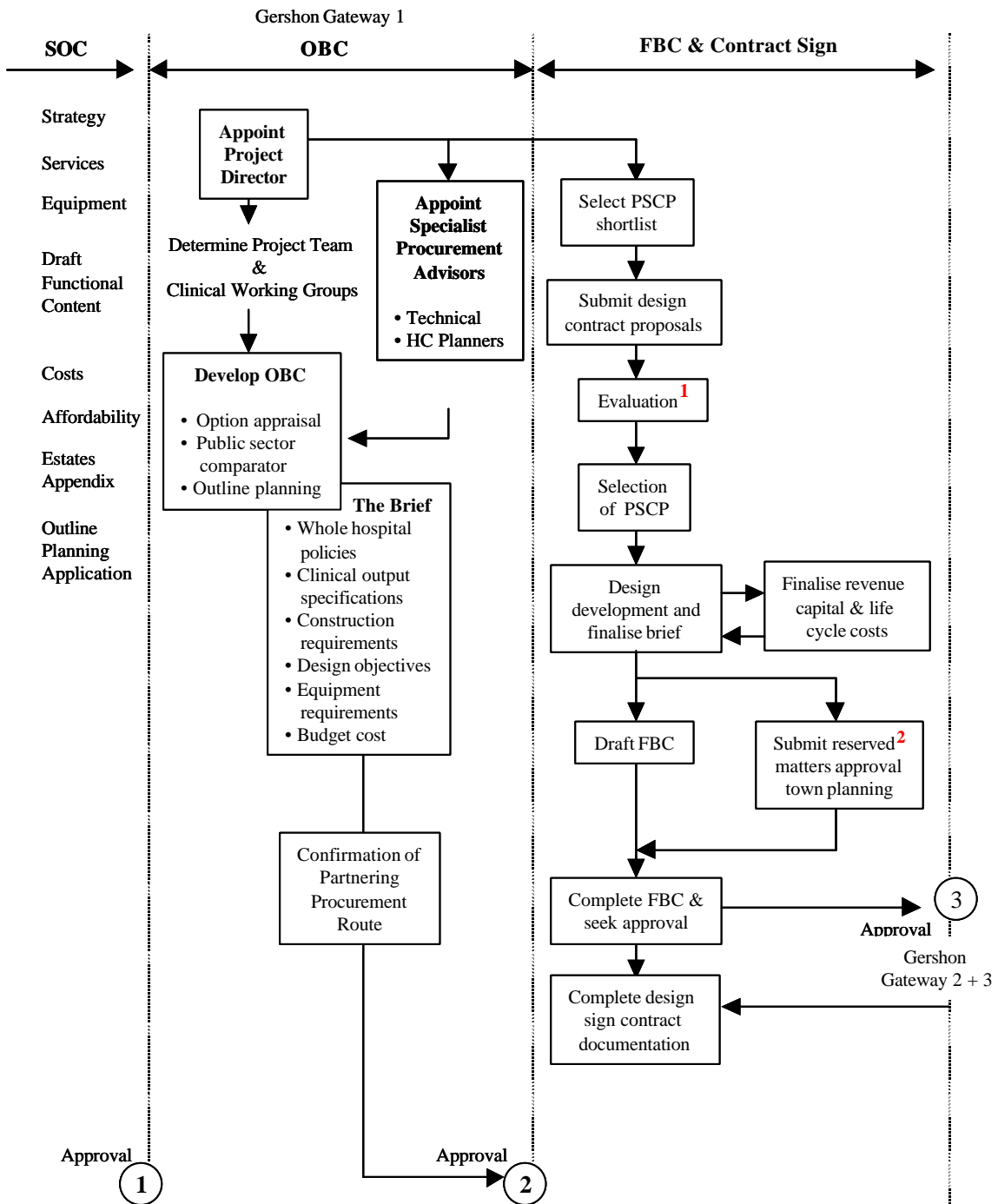
For schemes below £60 million an optional model is that the PITN stage is omitted and the FITN is issued to 3 bidders from which the preferred bidder is selected.



- 1: Proposed design evaluation by a national "expert" panel
- 2: Matters where the planning authority reserve their approval subject to more detailed information e.g highway / traffic study.

Appendix 1.02b

Key approval stages for Partnering Schemes to Contract



1: Proposed design evaluation by a national “expert” panel
2: Matters where the planning authority reserve their approval subject to more detailed information e.g highway / traffic study.

1.03 Recent Influences on Briefing and Design

The Prime Minister has instigated the drive to improve the quality of public buildings.

The NHS responded to this drive in a report "Better Public Buildings" published December 1999.

1. Centre for Healthcare Design

To maintain, develop and deliver the Department's extensive design programme, NHS Estates has established the "Centre for Healthcare Design". The Centre:

- Supports the NHS on design issues
- Manages the NHS design approval process
- Ensures the NHS plan objectives on the Patient Environment are reflected in design
- Commissions research and development
- Identifies and disseminates lessons and good practice

2. Recent Initiatives

- To raise awareness of the Government's priority of a high quality patient environment, several other initiatives have been undertaken: -
 - The Patient Environment Steering Group.
 - To raise the profile of the design quality and its impact on patient care.
 - The appointment of His Royal Highness the Prince of Wales as Design Champion for the NHS.
 - The creation of an NHS Estates led panel, including the Prince's Foundation, CABE and others to evaluate design proposals
 - Yvette Cooper as the Department of Health's Ministerial Design Champion – to be the figurehead of design programmes, share best practice amongst other government departments, inform the service of the design programme.
 - The Foresight Programme.
 - "Building a Better Patient Environment" - A one-day conference held at the Princes Foundation, late 2001. The conference aimed to raise the profile and impact of good design. Speakers included His Royal Highness the Price of Wales and Alan Millburn.

- NHS Estates' promotion of design through conferences and design symposiums. These conferences launch new initiatives such as:
 - The Building a Better Patient Environment Initiative.
 - Better Health Buildings.
 - The Achieving Excellence Design Evaluation Tool (AEDET).
 - NHS Design Portfolio Website and establishment of health demonstration projects.
 - An on-going relationship with Commission for Architecture and the Built Environment (CABE) has developed where CABE are able to assist Trusts in the development of their brief and review of submitted designs in partnership with the local planning authority and the PFI consortia.
 - NHS ProCure21

3. Key Issues for Trusts

Design quality should be a central part of a Trust's capital procurement strategy.

Consequently achieving design quality should not be viewed as purely spending more money on buildings.

'Good design is fundamental to value for money.'
(Chief Secretary to the Treasury, Feb 2001)

The greater focus on the quality and role of design is a matter for all capital investments from showcase through to simple refurbishment schemes.

Design concept and service strategies are intrinsically linked: without clear service strategies the building can not function, yet without appropriate building the clinical service can not be delivered in a suitable patient environment.

It is important for Trusts preparing Briefs and Designs to consider:

- The early involvement of designers
- Securing advice from appropriate technical advisors at an early stage
- The early integration of the concept of good design throughout all clinical and technical members
- Identification and sharing of best practices
- Innovative solutions, and challenge to design approaches

1.04 NHS Procurement Routes

An outline of Framework partnering and Private Finance routes for the procurement of capital schemes

Framework Partnering

NHS Estates has set up a pilot study to test the principles it has adopted for Framework Partnering. The pilot study is known as NHS ProCure21 and embraces Best Client, Design Quality and Benchmarking and Performance.

This initiative seeks to achieve greater efficiency and improvements in the procurement of new healthcare facilities through the sustained development of its client's functions to a standard that compares favourably with the best in the world.

The NHS will need to introduce several new sets of principles into the procurement arrangements. These new principles and procedures enable the development of long-term relationships and partnering arrangements.

To become a better-informed NHS client:

All parties must more effectively manage supply chains.

Many of the components, processes and procedures could be standardised. These include; briefing, design, selection of components and materials and construction methods.

A national partnering framework will be established comprised of **Principal Supply Chain Partners**.

Each Principle Supply Chain Partner will be different but is likely to include or have access to a team comprising: -

- A management contractor
- Financial advisors
- Financial funder
- Legal advisor
- Facilities Management advisor
- Mechanical engineering sub-contractor(s)
- Electrical subcontractor(s)
- Design services
- Facilities Management services

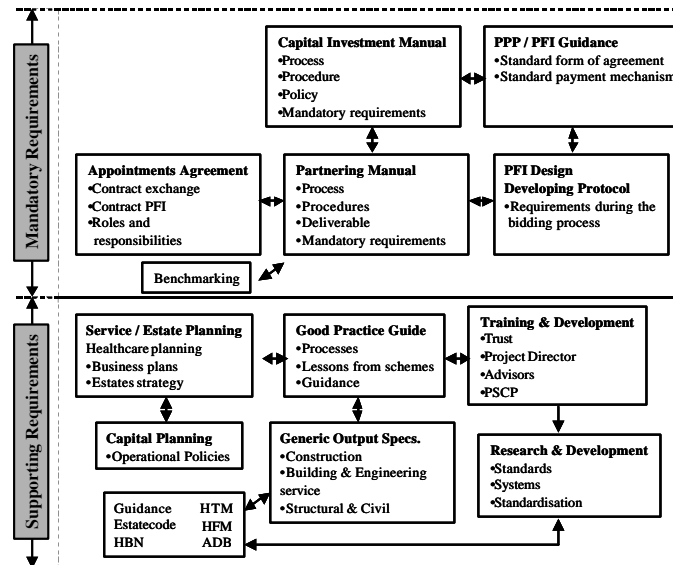
Trusts may also need to appoint Technical Advisors, who may include Architects, Engineers, Quality Surveyors, Legal Advisors, Valuation Advisors, Private Finance Initiatives Advisors, and / or a Capital Service Planner.

As partnering frameworks develop the roles of technical advisors will need to be reviewed. Trusts will probably always require an independent cost advisor.

PPP/ Private Finance Initiative

- PFI is one model of Public Private Partnership. It is not simply about capital investments, but about exploiting the full range of private sector management, commercial and creative skills.
- The resulting new healthcare buildings need to achieve the same standards of quality of design and construction as other procurement routes.

Diagram showing the inter-relationships of the NHS ProCure21 Documentation and Support Publications



- The Trust is required to sign off a design pre financial close (in PFI) and at details design in other procurement routes, to confirm that it can carry out its clinical functions in the hospital.
- It is for the private sector to ensure that the design enables the Trust to carry out its clinical functions.
- The Trust should ensure that it has established processes to restrict the need for changes to the design post financial close that results in delay and increased costs.

1.05 Controls Assurance and the use of Risk and Value Management

What is Controls Assurance?

A governance process, designed to provide evidence that the NHS organisations are doing their "reasonable best" to:

- Manage themselves
- Meet their objectives
- Protect patients, staff, the public and stakeholders against various specified risks.

It is a requirement of ALL Trusts to report directly to the NHS Executive on progress in implementing **controls assurance standards**.

By April 2003 ALL Trusts will be able to demonstrate substantive compliance against the controls assurance framework.

What does the Controls Assurance Framework Involve?

- A self- assessment against a framework of organisational standards, (subjected to audit.)
- An annual progress report is required by the organisations Board.

All contractors, tenderers and partnering organisations **MUST** be made aware of all Controls Assurance Systems and the risk and liability consequences of failing to uphold these standards.

What is the risk management standard?

This standard ensures that risks are managed at corporate and individual level by the effective involvement of people and functions.

This includes:

- Leadership,
- Developing commitment,
- Policy and strategy,
- Management processes,
- Evidence and complaint reporting and handling,
- Claims management,
- Review and improvement processes,

Organisational Standards The framework includes twenty-one organisational standards

1. Risk Management System.
2. Buildings, Land, Plant and Non-medical Equipment.
3. Catering and Food Safety & Hygiene.
4. Emergency Planning.
5. Environmental Management.
6. Fire Safety.
7. Health & Safety.
8. Human Resources.
9. Infection Control.
10. Information Management and Technology.
11. Medical Devices Management.
12. Medicines Management.
13. Professional and Product Liability.
14. Records Management.
15. Security Management.
16. Transport.
17. Waste Management.
18. Decontamination of Re-usable Medical Devices.
19. Financial Management.
20. Management of Purchasing and Supply.
21. Governance

A simple definition of risk is:

"The possibility of loss, injury, disadvantage or destruction"

Treasury Task Force Technical Note number 5 "How to Construct a Public Sector Comparator" provides clear guidance of risk evaluation techniques – "Preparing the PSC requires the public sector to undertake a full evaluation of the key commercial risks of a PFI contract."

1.06 Project Management of the Design Process

The Capital Investment Manual (CIM) provides a framework for the process of scheme development.

The Manual MUST be complied with.

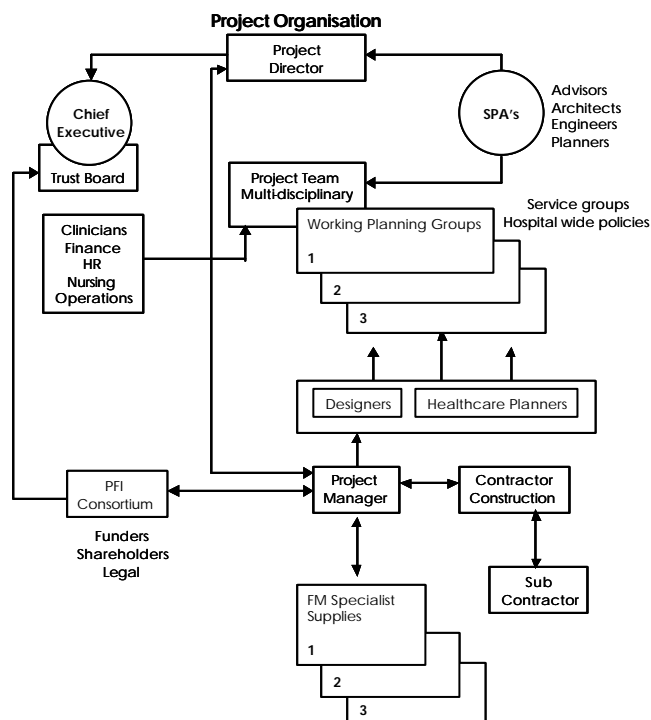
Procure21 requires Trusts to comply with the benchmarking performance review feedback process.

Trusts must show that Clinicians, Nursing staff and others have been consulted in the planning of the design. To begin with, these groups may find the complexity of the process, difficult to understand, time consuming and an extra burden.

It is the responsibility of the Project Director to ensure that all the users understand the processes. In order to ensure this a workshop may be used. This will not only facilitate understanding, but will emphasise the importance of achieving an agreed programme of sign-off dates.

Communication between all users and design team is essential throughout the process.

A way of enabling the briefing and design process is for the Project team to address much of the design development work before the clinical working groups are involved. Key clinical representation should be part of the Project Team thereby ensuring important clinical issues are not missed during development of the brief. The diagram below indicates a notional structure of how the various parties could be involved in developing the brief.



Managing the Project: -

- All forms of procurement are dependant on successful management of the projects.
- The role of Project Director with the relevant competencies is seen as a key function in enabling the NHS to become a best client.
- In response Professional training has now been developed in partnership with the Association of Project Managers and Lancaster University. Courses that meet the NHS project requirements are now available to perspective candidates.
- Project Directors can come from any background but need to exhibit the skills defined by the skills framework. These are a mix of leadership, performance, thinking and interpersonal skills.
- A register on project directors managing NHS schemes will be held centrally

Design and Clinical Sign-off at Each Stage of the Process

The Technical advisors MUST evaluate the design and advise the Trust as to its compliance with the construction output specifications and NHS Guidance. The clinical, nursing and management staff together with Health Planning consultants should review ALL documentation /data to ensure that the proposals meet or exceed the clinical requirements.

At each stage the drawings and other documentation must be signed off. It is suggested that the same process used following financial close for reviewable design data is applied throughout the **PFI** PITN / FITN and during negotiations with the preferred bidder up to the financial close. This process should be applied to **Partnering** and other procurement routes. This will:

- Ensure consistency
- Improve management process
- Provide a comprehensive and detail record and audit trail of the scope of the scheme
- Eliminate misinterpretation

It is for the Trust to confirm that the proposals enable it to carry out its clinical functions. Care must be taken to ensure the proposal includes:

- All of the functional content
- Adequate space standards are provided
- Support services spaces are satisfactory in provision, location and functional relationship for supporting delivery of clinical services the department.
- Achievement of the requirements of critical dimensions and ergonomic standards.
- Provision of appropriate equipment
- Achievement of environmental conditions described in the output terms

The principle underlying the process is to establish a clear methodology and management processes that ensures there are no ambiguities and misunderstandings as to what has been designed and agreed.

The Project Director must ensure that an audit trail is well established and that the Trust's Technical Advisers are fully briefed as to their responsibilities for this stage of the process.

Trusts are advised to see the PPP / PFI Design Development Protocol for more detail.

When the Trust signs the Project Agreement it is confirming that it has reviewed the Project Company's Proposals.

They should have ensured that the drawings and other documentation have been initialled by its Technical Advisors and Clinical groups during the design process.

Subject to any qualifications and / or comments notified by the Trust to Project Company in writing, the signing of the Project Agreement confirms that the proposals satisfy the Trust's requirements in respect of clinical functionality.

However this will also be subject to the level of detail in the Design Data that has been disclosed to the Trust by the Project Company.

It is acknowledged that in the PFI process design detail continues throughout the construction process. Thus meaning that there may be changes during the process of developing the detail that may impact upon clinical functionality.

Although this is not very different from normal procurement routes the transfer of risk to the private sector and the implications of a fixed construction price demands that there are very clear and strict controls over variations and approvals.

By applying these management and control systems to schemes procured through partnering, other procurement routes could well benefit from these strict control systems.

1.07 Construction Stage and Change Control Processes

Changes during the construction are inevitable. The implication of the changes are dictated by the scale, complexity or timing of the change. So, **“change = expense”** Thus the ability to keep to the scheme budget will be compromised by the extent of changes made during the process.

There are some basic established principles for the management of schemes during the construction stage that apply regardless of the procurement route. The application of the principles varies to reflect the transfer of risk in PFI.

Construction constraints and project procedures should be established before a contract is entered into. In a PFI scheme, the Trust requirements will have been drafted and included in the invitation to negotiate documentation.

Clear authority and accountability for instructions to vary the scheme is a pre-requisite to sound construction management.

The Project Director appointment should clarify the relationship between the Trust and its Project Board and the Project Director and Advisors to ensure that in the event of change, clear routes of accountability and nominated individuals with delegated power are agreed.

Instructions will vary in magnitude from ones relating to requesting an activity to stop for clinical reasons to giving approval to a variation.

The documentation of the management lines of authority should be included in the Trusts project procedures and be in the Private Finance Initiative agreement.

The Manual provides guidance and draft templates for the process.

The following outlines a number of points that need to be considered by the Project Director and Project Team

- Delegation of Authority
- Project Directory & Organisational Chart
- CDM Regulations
- Communications

- Requests for Information by either the PFI, Project Company or Trust
- Master Programme of Works
- Review and updating the programme
- Progress Photographs
- Permit to Work Procedure
- The Master Programme
- Pre-Site Meeting
- Project Meetings
- Reporting Systems
- Construction Safety
- Monitoring the quality and progress
- Public Relations
- Equipment
- The Carrying Out of all Tests and Sampling
- Engineering – Technical Commissioning
- Contract Clean
- Training of Trust Employees
- Pre Completion Commissioning and Completion
- Commissioning/Handover Meetings procedures
- Issue of Non Completion Certificate
- Post-Completion Commissioning - Rectification of Defects
- Snagging Register

1.08 Evaluation

Evaluation should be a continuous process that has key milestones during the design, construction and occupation phase.

The three main reasons for carrying out any evaluation are to:

1. Test the success of the project in meeting the brief and its objectives
2. Gather information for future projects
3. Help develop future policy and guidance

A good evaluation enables clients to differentiate between prospective organisations that have submitted their proposals in accordance with your requirements.

The basic principles of evaluation hold good irrespective of whether it is a major PFI or other capital investment or whether it is determining aspects of strategy or assessing the impact of environmental policy.

- Involve all of the stakeholders
- Develop a model that defines the problem or situation.
- Agree success criteria and the relative importance of each in relations to each other
- Benefits matrix.
- Agree a process method for scoring and recording proposals against the agreed evaluation model.
- Involve key stakeholders in the evaluation of proposals.
- Seek consensus in identifying the preferred options.

The whole purpose of investing in a structured and systematic approach is to make the decision making process easier.

Evaluation benefits all projects but must be conducted on all projects with a works cost in excess of £1 million **however it is recommended that the principles be applied to all other projects**. Ref: Learning Lessons from Post Project Evaluation (PPE) – <http://www.doh.gov.uk/pfi/goodpracticeguide.htm>

Within the process of producing a Full Business Case, plans must be made for monitoring the progress and completion of projects, and for evaluating the outcome following implementation.

The Evaluation Plan should be appended to the Full Business Case document.

Evaluation will be undertaken at key stages.

In the PFI process design and construction evaluation is one heading for evaluation at the selection of a shortlist of bidders (from 4 to 2) and at the selection of the preferred bidder.

NHS Estates will be carrying out an evaluation of schemes at the OBC and FBC approval stages using a number of criteria and the Department of Health's "Achieving Excellence Design Evaluation Toolkit"

The table below illustrates the evaluation framework for PFI schemes.

It is recommended that Trusts consider the use of the design evaluation toolkit for all capital procurement methods. The toolkit has been developed to improve the decisions about the quality of the design for healthcare buildings.

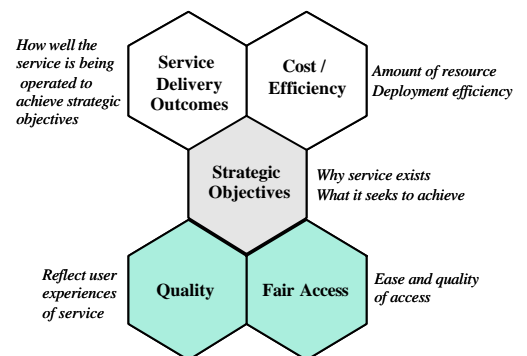
A Design and Construction	<ol style="list-style-type: none"> 1. Planning, functional content & design approach 2. Supporting information 3. Construction approach
B Services and Human Resources	<ol style="list-style-type: none"> 1. Management 2. Quality and monitoring 3. Operational 4. Service delivery 5. Approach to staff transfers 6. Experience of TUPE transfers and labour relations 7. Recruiting, retention and training 8. Pensions
C Legal	<ol style="list-style-type: none"> 1. Payment and pricing mechanisms 2. Key commercial customers 3. Risk allocation 4. Contractual matters 5. Key financial terms
D Finance	<ol style="list-style-type: none"> 1. Finance structure 2. Robustness of financial assumptions 3. Deliverability of funding 4. Acceptance of payment mechanism

* Weightings to be agreed by the Trust. It is essential to ensure appropriate professional advice is sought and that design quality has a high profile.

FACILITIES MANAGEMENT SERVICES

The intention of future policy (Value for Patients) is to replace the now redundant market-testing regime with a new policy of best value for support services.

Best value is a relatively new concept and one that has been in place within Local Authorities for a few years. Best value requires a significantly more qualitative approach than hitherto practices within the NHS.



Local Government Best Value – Five Dimensions of Performance

Basic elements include, identification and involvement of stakeholders (see best client section) performance assessment, output specification, evaluation and monitoring for continuous improvement.

Taken together these demands represent a real challenge to FM within the NHS and a shift in culture of both service providers and recipients.

NHS Estates are developing a national service specification framework (NSSF) for estates and facilities management

The objective is to identify a framework for consistent service delivery across the FM portfolio

The content of the framework will include:

- High-level policy and vision
- Patients' standards
- Output specifications
- Performance standards and their management
- Key inputs and processes

The anticipated programme is for completion during 2002, following consultation with stakeholders.

2.01 Establishing the Brief:

“The Brief is the Responsibility of the Client”

A brief should:

- Be fit for purpose
- Be efficiently and quickly produced
- Enable the Best Value for the future
- Engage the staff who will work in the new unit
- Where beneficial, allow innovation in quality, time and cost
- Be Clearly understandable
- Effectively communicate requirements to a wide ranging audience
- Be clear on the volume of patients to be treated, the patient flows, the patient management process and the nature of the tasks to be undertaken in the clinical areas

It should address the following areas:

- The scope of the service for example the nature of the services and the clinical specialties provided;
- Outline operational policies;
- Activity analysis, incorporating current levels and forecast levels (reconciled to the Strategic Outline Case / Outline Business Case);
- Essential clinical relationships;
- Desirable clinical relationships;
- Access statement detailing staff and visitor hours and any special access requirements;
- Essential room relationships;
- Desirable room relationships;
- Functional content.

A good brief should provide:

- A consumer focussed vision
- Clarity in requirements
- Comprehensive coverage of issues.
- Constancy of purpose
- Commitment of staff
- Concise documentation
- Conflict resolution processes
- Capable administration and communication

It is vital that users ensure that all the requirements of their department are documented. These requirements are susceptible to being glossed over and lost in the jungle of whole hospital issues and technical descriptions, so they must be on their guard against their omission.

The project team should ensure that the **output specification** 1) conforms to the overall brief and 2) that no significant issues are at variance with either the SOC or whole hospital policies.

The design team are particularly interested in the movement of people and objects throughout the building, the interaction of people and the need for services / equipment to be provided in a particular location to facilitate / enable the healthcare process to take place.

All the issues above and below, are addressed in the Best Practice Manual.

- How to write a brief
- Handling differences of opinion
- When to consider detailed content
- Practical considerations
- Where should meetings be held
- Confidentiality
- Sign-off: the implications
- Communication
- Involvement of all users: an inclusive approach

Guidance covered by the Best Practice Manual:

1: Schedules of Accommodation:

Introduces an explanation of the requirements and examples of operational policies.

2: Hospital wide issues

Many of these issues are covered in HBN 40 for common activity spaces. This guidance has already referred to the need to pay special attention to detailed ergonomic data and critical dimensions because of the large number of times that even minimum space standards are not achieved in developments.

3: The Overall Approach to Briefing

Considers the importance of addressing:
Hospital wide issues first
The Benefits of using standard components
The Need for the ability to deviate from standard
The limitations of being too prescriptive?
The advantages of Planning for flexibility

4: Clinical Groups:

The Trust should ensure that it has established appropriate clinical briefing groups, underpinned by an effective communications strategy. It should consider the following: -

A Clinical Policy Group to reconcile differences between groups (star chamber)
Membership of the clinical groups
The need to appoint Decision makers
Consultation in the Trust and buying into the Brief
When do the groups start?
What is the role of the clinical group?
How should the group approach its tasks?

2.02 Key Information to be Provided by Trusts

An outline of the information to be provided by Trusts to PFI Candidates as part of the Invitation to Negotiate.

The Clinical Brief:

The brief for each clinical and related support services should include the following information:

- Scope of service- i.e. the nature of the services, the principal clinical specialities provided etc.
- Whole Hospital Policies
- Outline operational policy for each department:
- Activity analysis Indicators: split into current and forecast service trends.
- Clinical relationships: differentiating between those that are essential, those that are desirable and those that are not acceptable.
- Work Patterns and Practices: Proposed working day, type of service,
- Occupancy and access statement: outlining operational processes, patient flow, process flow, staff and visitor Flow.
- Functional content, specifying the Trust's core requirements to deliver clinical services. This information should inform the design development of the Public Sector Comparator. In the case of exchequer funded schemes the Trust's may wish to be more prescriptive to ensure certainty of price.
- Trusts are required to prepare schedules of accommodation for the Public Sector Comparator at the Outline Business Case stage.
- Essential departmental and room relationships.
- Environmental and service requirements: transport, disabled access, daylight and views, light for clinical purposes, ventilation and extraction, cooling, noise attenuation.
- Any constraints in relation to patient flows particularly where a scheme might be linked into existing departments.
- Any constraints due to site use restrictions e.g joint Trust ownership of a shared site. More than one NHS Trust on a site with conflicting estate strategies.

Design Quality Statement:

Trusts are required to prepare a Design Quality Statement to establish a framework for the design, regardless of the scheme funding. *A number of NHS Estates publications on design and quality provide guidance for the Trusts in considering quality in health care buildings.*

Key briefing information to be provided by Trusts:

- Functional requirements
- Space standards
- People and material flows
- Responsiveness to change and growth
- Adaptability and flexibility, modularity, extendibility
- Technical functionality durability, cleanliness
- Ergonomic requirements
- Safety and security
- Access control
- Value for money and life cycle costs
- Environmental quality

Key Briefing Checklist: -

- Clinical brief
- Design quality statement
- Town planning statement
- Flexibility and adaptability
- Environmental impact
- Sustainability policy
- Trust construction requirements as output specifications

In line with Government policy to raise the design quality of buildings it procures, Trusts should therefore develop a robust Design Quality Statement should be developed following intensive discussion with clinicians and staff of the Trust. It should establish the parameters against which the Trust will evaluate the bidders proposals.

In addition, NHS Estates are working with the Prince's Foundation to pilot a vision for design quality on five NHS sites. Part of this initiative will include the implementation of the Department of Health – Achieving Excellence Design Evaluation Toolkit (AEDET)
Ref: www.nhs.estates.co.uk

Town Planning Constraints:

Emerging planning policies are likely to be more demanding, as a consequence of this Trusts need to make explicit commitment to government policies: such as promoting public transport, consultation with the local community etc.

The visual and environmental impact of major healthcare developments needs careful consideration in terms of the design so that they can be carefully integrated into the existing environment. The following are crucial to the acceptance of the design:

- The scale of the buildings,
- Height,
- Car parking,
- Use of materials, etc

Trusts are required to enter into early discussion with Planning Authorities prior to submitting an outline planning application. Specific planning requirements will require building into the brief and design / cost models of the PSC.

Planning application may be sought before or after the SOC is approved. The Trust will need to demonstrate that the Trust has robust capital costs. This is unlikely if planning application has not been approved. Local Planning Authority Department has not been consulted with regard to planning issues, which could have capital implications (e.g section 106 requirements)

The outline planning application should have received approval before the OBC is completed.

All relevant planning applications and associated details should be provided to PSCP's on its commission and PFI bidders at PITN stage, and attention drawn to any specific requirements or restrictions placed on the application. It is recommended that the Trust appoint a Town Planning Consultant for major schemes

Flexibility and Adaptability:

Trusts should give consideration to the requirements of future flexibility and adaptability to change. This is a highly complex area and may result in generalities. These will not be helpful in considering the design and future service requirements of the development.

It is anticipated that there will be significant changes in the utilisation of health care facilities brought about by changes in service models of care, developments in technology and clinical practices over the life of the building.

The ability of a development to cope and accommodate such changes will be largely determined by the flexibility of the initial design, locations of departments, the building structure, engineering and IT services, the design and use of materials.

The location of functions should be designed to facilitate future changes in capacity and function.

The use of easily re-located functions (stores, etc) a development control plan that is not restrictive and an engineering infrastructure that is readily updated and capable of increased capacity are all examples of building in some degree of future proofing.

Trusts need to balance their short-term needs with long-term objectives.

Sustainability:

Health facilities must be designed to incorporate the three facets of sustainable development – environmental, social and economic. The adverse impacts of noise, pollution, toxicity and emissions should be minimised and opportunities for reducing energy and waste should be taken, while water consumption should be maximised.

Attention to the sound management should extend beyond the capital project, to the maintenance and operation of the building.

Trusts should maximise the use of environmental management systems, with the NHS Environmental Assessment Tool (NEAT) will be used for the assessment of all sustainability issues in healthcare developments.

The output specification should include the following in a Project Procedures Document: -

- The provision of information from a contractor and design team.
- Testing and witnessing tests
- Quality plans and quality assurance
- Compliance with statutory and NHS specific requirements
- Commissioning engineering and building service pre-practical completion and post-practical completion
- Monitoring the performance of building and engineering services during the twelve months defects period

Construction requirements:

- Vision and philosophy of service.
- Design quality and vision statement.
- Project procedure and management.
- Construction and site constraints.
- Architectural output specification including landscaping, civil engineering and interior design.
- Engineering service output specification.
- Energy strategy.
- Generic environmental standard, services and requirements for rooms.
- Building and engineering performance parameters to be incorporated into the payment mechanism.

2.03 Hospital Policies

Sound and integrated hospital policies reflecting service requirements are the characteristics of a good brief

However often the policies do NOT reflect the service or the changing needs of the service.

Too often the policies have not reflected the service or their changing needs.

Therefore policies must be defined in enough detail to establish the **content and space requirements**. Consequently enabling production of costed preliminary building design proposals, capital, revenue and life cycle costs across the range of options to be analysed as part of the business case process.

Consultant medical staff, senior nurses, professionals allied to medicine, service managers and facilities managers should ALL have input into the policy development.

Those who are delivering the service should NOT be excluded from the development process.

The revenue consequences of operational policies should be evaluated before they are signed off and issued to capital planners and technical advisors.

Whole Hospital Policies

Factors to take into account:

- Strategic plan for the services to the community and catchments area.
- The relationship of the new development or works of adaptation to the site estate control plan
- The functional content of the development
- Any phasing requirements and service continuity
- The quality of service

The convenience to patients and quality of the environment should be key considerations and are NOT to be sacrificed to achieve short-term efficiency savings when rationalising buildings and services.

The following lists the key headings of an operational policy: -

- Scope of service
- Activity
- Functional content
- Operational principles
- Functional relationships
- Description of accommodation
- Supporting services
- Building and engineering services

Reference should be made to HBN 02

What should they include?

- Policies common to the whole hospital which will affect design considerations in individual departments
- Movement of traffic and people: the delivery of goods and the removal of waste from the site and buildings
- Policies common to the whole hospital which, will affect the facilities management of the new buildings, including security, maintenance cleaning, portering, catering, IT etc

Departmental policies:

Hospital Building Notes provide a useful source as a checklist, in the absence of a recognised national standard.

However relying on HBN's will mean that policies may not reflect current clinical practice or be sensitive to clinical developments.

The statement of policy for each department should include at least the following information:

- Philosophy of service
- The function of the department and its relationship to other departments.
- Utilisation
- Hours of operation
- Specific exclusions
- Relationships to Whole Hospital policies
- Specific design requirements
- Functional content

Design Briefing System:

This acts as an aid to the preparation of Whole Hospital and Departmental policies.

The DBS Notebook was arranged to provide a systematic approach to brief development and used the HBN as a checklist.

It is essential that service configuration decisions be translated into operational requirements that can be interpreted into designs that enable effective management and processes that do not constrict service delivery.

2.04 Equipment Procurement in Capital Schemes

Important lessons have been learned from the first wave PFI schemes, with experience showing that there have been a number of post contract variations and changes in capital and revenue cost due to lack of good definitions, appropriate schedules and output specifications for equipment.

A good practice process has been devised to ensure that there is a clear understanding as to what the Trust expectations are with regard to the supply, installation, maintenance and life cycle replacement of equipment.

The process will enable a realistic evaluation to be undertaken of the PFI candidates' proposals.

It is recommended that the equipment schedules are prepared in full consultation with the clinicians and clinical groups

The Trust will need to manage the production of Generic room data sheets, which set the standards and expectations of the Trust in both content, and finishes.

The way that the PFI candidates, or the contracted partner, are to respond with their proposals should be clearly specified. Care should be taken to ensure that the full range of requirements are included.

A list of equipment requiring output specifications should be completed and reviewed against the schedule of accommodation of the Principle Supply Chain.

Any assumptions should have been discussed with clinicians and clinical groups. The equipment schedules should be finalised and signed off when the brief for the Private Finance or Principle Supply Chain scheme is frozen.

The equipment schedules should also inform the Public Sector Comparator (PSC) design and capital costs.

The maintenance and / or replacement of furniture and equipment will need to be defined in lists for the service specification. On large schemes planned over a number of years great care must be taken to identify equipment likely to require replacing.

Adequate assessment of the risks associated with the likely future requirement of new equipment should be built into the public sector comparator.

Output Specifications should be developed to identify 'Medical Equipment Management', identifying issues such as: Key objectives, scope of medical equipment management service, compliance with general service standards, staff training, liaison, lifecycle management of equipment, service developments.

University Teaching and Research

Special consideration needs to be given to equipment in university and teaching hospitals and research accommodation.

Problems will need to be defined and resolved where the space is joint NHS / University.