DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

Warrington Health Authority
15 NOV 1989
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EL89(MB)/190

2 November 1989

Dear General Manager

GUIDANCE ON THE PREPARATION OF APPROVAL IN PRINCIPLE SUBMISSIONS

The accompanying guidance explains the Department's and Treasury's role in the Approval in Principle (AIP) process, and identifies some of the key points which need to be covered in any AIP submission, whether it comes to the DH or not. It should be read in conjunction with Capricode, which is being revised to take account of developments since 1986, including current thinking on the proposals in the White Paper, "Working for Patients".

As well as Capricode, "Option Appraisal - A Guide for the NHS" is relevant. As soon as we can, we shall be giving attention to rationalising all the available guidance to avoid unnecessary overlap.

The guidance attempts to take into account some of the changes and new opportunities arising out of the White Paper proposals - in particular, the separation of purchasing health authorities from provider units; the element of greater competition to satisfy user requirements that this will produce; the change to capitation funding of districts; and the higher profile which will attach to the viability of new schemes.

A number of issues still remain unresolved, however, and so the guide is inevitably of an interim nature. Meanwhile, new aspects will need to be interpreted flexibly to ensure they evolve in a practical way, at the same time preserving the underlying principle of optimum value for money in terms of both cost and quality.

Rather than wait for outstanding issues to be determined, the attached guidance is promulgated in the belief that health authorities will find it helpful now to have some pointers to refining and speeding up the approval process. We intend to produce a definitive guide by 1991. Meanwhile, a working group, with strong NHS participation, is to be set up to examine how the process can be improved.

If you have any queries, please get in touch with Doug Harris (G45 Richmond House, tel. 01-210-5640).

This letter will be cancelled on 31 December 1990.

Yours sincerely

Anthony Merifield

A J MERIFIELD

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NHS BUILDING - APPRAISAL TO APPROVAL IN PRINCIPLE (AIP)

Introduction

1 This guidance is interim and will be replaced by 1991, when the requirements of NHS Trusts will be clearer. Meanwhile, the guidance is aimed at managing health authorities.

2 The purpose of Stage 1 AIP procedures under Capricode has always been to ascertain and demonstrate the most cost beneficial way of meeting the requirements of a specified service need within a health authority's agreed strategy for health care. This underlying principle will not change. However, vital new elements have been added by the Government White Paper, "Working for Patients" - in particular, the move to a contract based system in which purchasing and provider roles will be separated; and the introduction of explicit capitation funding.

3 Capricode Stage 1 must be completed for all schemes, including "fast-track" (eg design and build or "turnkey" contracts) developments, and whether or not the AIP requires central approval.

The Department's Role

4 The Department of Health (DH) are responsible for giving approval in principle to certain schemes (see EL(MB)89/111). [The capital spending limits on individual schemes above which NHS Trusts would be required to seek Departmental approval have not yet been promulgated.]

5 The Department looks for assurance that individual investment proposals are soundly based and, in particular, that the health authorities have

a. justified the proposal in terms of costs (both capital and revenue) and benefits to patients (together with any other desirable non-service effects);

b. satisfied themselves that the chosen option represent the best value for money when compared with other feasible options;

c. assured themselves that the provider can afford the development in terms of capital resource assumptions, that income will match running costs and capital charges and that manpower requirements can be met;

d. proposed a solution compatible with local and national policies and strategies and directed to defined service need for the client groups and population to be served (while recognising that detailed evaluation associated with an option appraisal may suggest a change in local strategy); and

to reflect the proposals in "Working for Patients", that

e. where a scheme proposes continued provision of non-core services to residents of other HAs, the assumptions of future demand are reasonable in the light of past patterns of patient flows and future plans of significant users.

6 Regional Liaison (RL) are responsible for giving or withholding AIP on behalf of Ministers and the NHS Management Executive and for communicating all formal queries and decisions to authorities.

Treasury's Role

7 Larger schemes are submitted by the DH to Treasury for their approval (see EL(MB)89/111). Treasury's primary objective is to try to ensure value for money in public expenditure. To this end, they seek to:

a. promote a rigorous and systematic approach to investment decisions in the NHS; and

b. satisfy themselves that such an approach has been carried out.

8 Any proposal which involves unconventional financing (ie any means of obtaining the ownership/use of capital assets other than by direct purchase financed from allocations, receipts or donations) must be handled as described in EL(89)MB/142; and normally requires Treasury approval.

Region's Role

9 The Region's role is to ensure that the key points have been addressed (involving DH colleagues in the process), before forwarding an AIP submission to the DH. In particular, they will need to satisfy themselves that

a. health care needs and customer requirements have been clearly identified;

b. an adequate option appraisal has been carried out demonstrating best value for money; and

c. the service to be provided will be competitive in attracting patients and the accompanying resources to meet estimated running costs and capital charges.

KEY POINTS

Process

10 The main steps in the evolution of an AIP submission are:

i. identification, within a strategic setting, of a service development, cost savings or estate management requirement, which may need to be met through capital investment;

ii more detailed appraisal of the requirement, taking full account of the current and potential ability of existing available facilities, whether provided by the managing HA or other agencies, to meet service and other needs, leading to identification of possible options;

iii. appraisal of the options;

iv. formal AIP submission to DH if a capital development above

delegated limits proves the best solution, or any proposal which involves the use of unconventional finance;

v. DH scrutiny of the AIP submission involving Treasury and Ministers as appropriate.

Liaison

11 Experience has shown that DH involvement in discussions preceding the formal AIP submission can help speed consideration of submissions. It is useful, therefore, for DH and NHS staff to collaborate in preparing timetables for anticipated AIP submissions. A meeting, before detailed appraisal of a short list of options is undertaken, will give DH an early opportunity to understand the strategic context and service requirements against which options are being worked up; the problems with the status quo; and to feed in any points which may help in identifying and appraising options. The DH should also be given an opportunity to discuss the scope and depth of evaluation of options. The aim should be to achieve consensus on the approach to be adopted, although DH will have to reserve their position on the outcome of an AIP until the complete submission has been studied. AIPs are considered in DH by a team from the economic advisers, medical, nursing, estates, and finance divisions, led by RL.

The AIP Submission

12 The AIP submission is the description of a rational decision making process based on option appraisal. It will therefore need to make explicit how judgements and decisions have come to be made and to provide evidence to support arguments. Unsupported assertions are unacceptable. It should be clearly written and easy to follow, with any detailed working included in appendices rather than the main text.

13 The AIP submission will need to contain the following sections (Appendices I, II and III provide further detail):

I <u>Service Considerations</u>

- the managing HA should provide a description of the user population, identifying the main customer HAs and existing relevant accessible service provision (including facilities provided by other HAs, potential NHSTs and non-NHS sources);

- an estimate of the demand from the residents of the managing HA (with an explanation how the estimate was derived);

- where the proposed facility provides a service to other HAs, an explanation of the basis for the assumptions of demand (eg definite or provisional contracts, or agreement from the relevant Region(s), or forecasts on the basis of past trends - plus some evidence that referral patterns are likely to remain stable);

- a summary, provided by the managing HA, with input as necessary from other major customers, of the strategic requirements (building on the above information) for the services relevant to the proposed development. From this should flow a statement of service aims and

objectives against which the options can be assessed. Where the achievement of revenue savings or improved estate utilisation is a prime reason for the proposal, these issues should be addressed in much the same way, with the AIP also explicitly considering, where appropriate, service strategic aims and objectives relevant to the development.

- the problems with the status quo.

II <u>Option Appraisal</u>

- identification of a reasonable range of options, which should be discussed with DH colleagues before the detailed appraisal is carried out;

- preliminary assessment of individual options and the effects of any constraints upon them;

- short-listing of options;

- a comparison of the costs and benefits of the short-listed options;

- assessment of risks and uncertainties, including sensitivity testing;

- recommendation and a statement that, on present assumptions, the chosen option is feasible, its capital and running costs, and the manpower requirements, will be met.

III <u>The Chosen Scheme</u>

- a more detailed description of the chosen scheme appended to the main submission.

14 A separate summary pro forma, included at Annex I, should be completed to aid Departmental (and, where appropriate, Treasury) assessment of the AIP. (It also provides the Authority with a check list of the main points which should have been covered in the submission).

POST DH/TREASURY APPROVAL

Review of AIP

15 The managing HA must test that the criteria and assumptions made at Capricode Stage 1 for AIP purposes still hold good at Stage 2. Where material and significant changes occur the HA must review AIP in consultation with the Region and RL. RL will consult the remainder of the AIP team as appropriate. A decision to continue with the scheme, which must be justifiable in the light of changed circumstances, must be taken with DH and formally documented.

Lapse of AIP

16 Major changes in service policies, service priorities, functional content, selected design solution (eg a decision to depart from Nucleus), the DCP or

costs must be notified to the DH (RL) and may cause AIP to lapse, particularly where such changes undermine the character or objectives of a scheme. Additionally, Capricode provides [Annex 2A paragraph 8] that AIP must lapse if either annual revenue costs or total capital costs including fees and equipment increase (at constant prices) by more than 10%.

17 Where AIP lapses and a scheme is referred back to DH, it is for RL in consultation with the AIP team to discuss with the authority how to proceed and then to decide. Treasury would be consulted if their approval was required to the initial submission. Normally, a new option appraisal will be required where a major change in strategy, service priorities or national policies has occurred; or where viability is seriously affected through increased capital charges or running costs. In other circumstances, it will normally be sufficient to update the earlier option appraisal taking account of changed circumstances before making a fresh formal AIP submission to DH.

Reference Back at Tender Stage (STAGE 4)

18 Capricode paragraph 4.14 requires that significant escalation in cost (eg from an excess tender of more than 5%) may result in a scheme being referred back to the DH (RL). (The provisions of Capricode 4.15, which were enlarged upon in EL(88)MB107, allow for price increases resulting from local market conditions to be taken into account in reconciling tenders with the budget cost). In such circumstances Capricode gives DH, as the Authority which gave AIP, discretion to decide what action is appropriate. In extreme circumstances (say a very large cost escalation tending to undermine the basis on which AIP was given) DH may consider whether AIP should lapse. In other circumstances, where the escalation in costs is explained and justified, savings have been achieved and funding is secure, DH may give clearance for the HA to proceed subject to close monitoring. Where a scheme also required Treasury approval for AIP, Treasury should be consulted on the action to be taken.

Post Project Evaluation

19 Post project evaluation involves checking that costs and income were broadly as estimated and that claimed benefits were realised. For HA projects, such evaluation will fall to the Region in their monitoring role.

SERVICE CONSIDERATIONS

Description of the Client Population

1 This section will need to contain:

- details of the population served and projected changes;

- a brief summary of social and geographical characteristics;

- a map of the area, covering the population to be served, which indicates main communications, population centres, health care facilities and other relevant features;

- significant local factors, (including health problems) particularly any which could affect ease of access or service delivery.

Viability

2 Factors likely to affect the viability of a scheme will need to be examined, including

- a realistic assessment of how successful the scheme will be in attracting business in relation to quality and cost;

- other main health care facilities already available, relevant to the AIP, including details of number and type of beds, services provided (including teaching), and the condition of the stock assessed in accordance with current Departmental guidance;

- other ways (including non-NHS facilities) in which demand might be met;

- the foreseeable effect of any changes in funding of customer HAs.

Customer Requirements

3 The elements of customer requirements relevant to the AIP include:

- an assessment, which can be supported, demonstrating that the proposed provision is consistent with the service requirements of the managing HA and of other main users, which they are ready and able to afford;

- the type and quantity of services to be provided and any provision for medical teaching and research;

- the workload projected for each service;

- the broad way in which each service will meet the workload (in-patient, day cases, out-patients, community teams etc);

- the other services (eg x-ray, theatres as well as laboratory or catering) required with estimates of projected workload.

DH will expect to be satisfied that the services to be provided match the population to be served and projections of workload. Thus all the identified service requirements will need to be backed by a quantified assessment of workload with an indication of how the assessment was derived. Detailed workings should be annexed to the main submission.

4 The submission should summarise the facilities required and identify the main service objectives (including any revenue saving or estate utilisation objective) against which options can be measured. The objectives should be expressed in terms of requirements rather than solutions. For example, an objective ought not to be expressed in terms of "develop services on a single District General Hospital site" as that could be the solution (ie most cost beneficial option) to the particular requirement. The objectives should instead be defined in terms of the criteria for delivery of an acceptable standard of service and by reference to any financial, estate or manpower considerations.

5 Any constraints on the options should be identified and the reasons for them should be explicitly justified.

The Problem with the Status Quo

6 This section should clearly establish the case for change and why the AIP is being submitted. There should be an analysis by the purchasing HA(s) of current provision, explaining how far it falls short of service requirements, and identifying mismatches between the two. Where there are financial or estate reasons for investment, providers should set out the results of taking no action. They should include an assessment of the condition and potential of existing buildings. Perceived inadequacies should be demonstrated and not simply asserted as "uneconomic", "poor quality" "buildings at end of useful life" etc. Pre-AIP liaison may be particularly helpful here in enabling DH to understand in more detail the problems, objectives and constraints on any options and why there may need to be substantial capital investment. From this section a range of options for meeting the identified need should be developed.

OPTION APPRAISAL

APPENDIX II

Identification of Options

1 The options examined (though some may later be discarded) should include:

- a do nothing/do minimum option (defined as the best that can be done to meet the service requirement within existing facilities while incurring only essential capital expenditure, for maintenance or to meet statutory requirements - this forms the bench-mark against which other options can be compared);

- refurbishment, defined as maximum building repair and plant and equipment replacement short of major upgrading;

- upgrading/adaptation of existing stock;

- new build on existing site;

- (normally) a radical solution eg total rebuild of the hospital, phased if necessary, on a greenfield site;

- a non-capital solution (eg purchasing the service from elsewhere or contracting out the service).

The options should be feasible and viable; and should examine the possibility of a more radical reformation of the stock whereby revenue savings and land sales might negate the need for any additional capital requirement. For major developments the options should include alternative timescales for the total development, weighing the benefits of maximising any revenue or capital savings from early completion against any planning/programming advantage from a phased implementation. The submission should consider how any future development needs could be accommodated or met either on the same site or in other ways (eg a non-capital solution).

Appraisal of Individual Options

2 A guide to option appraisal was issued in May 1987 under cover of HN(87)18. Options are most helpfully appraised in two stages. First, a preliminary appraisal of all the options in order to identify a short list of those worthy of detailed consideration. There may be strong service, financial (based on broad brush costing), manpower or other arguments for dismissing options at an early stage. Rejection of an option on grounds of policy may not be sufficient, and any rejection on these grounds alone should be justified. However, it will frequently be easy to demonstrate briefly why an individual case should not be regarded as an exception to general policy. DH would expect:

- the do nothing/do minimum option to be fully evaluated (and not rejected at the preliminary stage) because of its value as a bench-mark;

- explicit statements on the reasons for excluding some and short-listing other options. Broad brush estimates of costs and benefits can be helpful in showing why some options have not been short-listed.

Again, pre-AIP liaison at this stage can help save time later if DH understand and accept the basis for the short-listing of the options.

Short-listed Options

3 The second stage in option appraisal is a more detailed analysis of the short-listed options. These should be linked to clear statements of functional content which match expected workloads. Different options may meet the workload in different ways and so have different functional contents. These should be specified. In all cases, attention should be paid to the level of activity and throughput compared with performance elsewhere. It is particularly important that, where new accommodation is proposed, the assessment of functional content takes account of accepted principles of good practice and any projected changes in workload and service delivery. It should not be over-influenced by the current levels of provision. Full account should be taken of the likely increases in throughput, eg on more day case provision and developments in community services. The Management Executive (ME) expect high performance in terms of efficiency based on maximising the utilisation of all new capital developments in meeting expected demand.

4 HAs and SGHs will be expected to have examined the viability of chosen options, ie that the running costs, capital charges and manpower requirements can be met.

5 Usually, individual schemes will be self-contained and the subject of separate AIP Submissions. Where a scheme, whether self-contained or not, implies commitment to future development on a site or is likely to have a major impact on the costs or benefits of other foreseeable projects, scheme options must be appraised and justified within the context of the overall service/site development before AIP can be given to the immediate scheme. In such cases it is important to consider the validity and viability of the full development, although the long term development intentions may have to be described in broad terms only.

Costs and Benefits

6 Costs. The capital and land costs of each option, including the opportunity cost of land already owned by the HA/SGH, should be identified, though not necessarily in equal detail, provided they are robust enough to identify inferior options. Different options are also likely to have different revenue costs which should be identified accordingly. It will become increasingly important to corroborate running cost estimates wherever possible. All costs should be discounted to give net present values (NPVs) and comparisons should be in equivalent annual costs. External costs, eg access costs to patients, should also be given where these differ significantly between options, so that an objective economic value can be assessed.

7 The submission should contain an explanation of the basis of the revenue cost estimates including details of the costing model used, the reasons for the differences in revenue costs, details of the source of any efficiency savings and their reliability. The analysis should start from the assumption that there will be different capital and running costs for different options; if they do not, the submission should explain why. ("Transfer of existing service" is not sufficient justification for using the same revenue costs for all options.) It is important, as far as possible, to corroborate any running

costs estimate by using more than one method (eg, a method based on existing departmental costs could support a method using specialty costs per case).

8 The importance of sound estimates for running costs is even greater than accurate capital costing, since they will be committed costs for the foreseeable future and will affect the purchaser's ability to meet demand. If the development assumes an increase or decrease in the services purchased from other providers (eg outside the managing HA) the associated costs or savings must be taken into account. Comments on the feasibility of an assumed increase, or the implications (eg for future viability of other facilities) of an assumed decrease will need to be sought from the other providers.

9 Any option which uses unconventional financing in any form should be compared with an equivalent option financed conventionally to demonstrate how best value for money is being achieved.

10 Benefits. Each option should be tested against the service objectives identified earlier in the submission. A full explanation of the benefits assessment methodology, including "scoring", should be given. The important points here are whether the weighting looks reasonable (the note on the scoring methodology should provide some explanation as to how these were derived), that the objectives remain consistent, and that minor objectives or attributes of the scheme do not unduly influence the final result. The last should mainly be used only to differentiate between options which are close to each other in either costs or benefits. An important component will be an assessment of the effects of each option on marketability of the services to be provided.

11 Comparison of the costs and benefits. The options should be ranked for their costs and benefits so that the most cost beneficial one emerges clearly. It will not necessarily be the cheapest option or the one with the most benefits. The important points are the combination of costs and benefits - how much has to be spent to get extra benefits and are they worthwhile? Marketability will be the main test. The analysis can most helpfully be presented in tabular form with first the costs and then the benefits compared.

Handling Risk

12 The following checklist of points to be addressed may help in the handling of risk:

- identify the factors in the appraisal that are most certain and those that are least certain;

- identify where uncertainty could be of greatest importance, and the potential implications of key uncertainties for costs and benefits;

- undertake sensitivity analysis and, where appropriate, calculate switching points (see para 14 below);

- consider whether scenarios, or other methods more sophisticated than sensitivity analysis, might be justified;

- make at least broad quantitative judgments about probabilities and ranges of potential variation of the important factors determining the outcome; and highlight cases where the probabilities of under- and over-

ANNEX I

APPROVAL IN PRINCIPLE SUBMISSION: SUMMARY SHEET

1 TITLE

2 LOCATION

3 SPONSORING AUTHORITY

4 TYPE OF DEVELOPMENT

5 PLANNED - START DATE
- COMPLETION DATE

6 ESTIMATED COSTS

WORKS COST..........................]
TOTAL CAPITAL COST..................] £MILLION*
REVENUE COST (PER ANNUM)...........]

7 CASH FLOW

PROCEEDS FROM LAND SALES...........]
PROCEEDS FROM SALE OF OTHER CAPITAL]
ASSETS.............................] £MILLION*
CAPITAL BORROWING REQUIREMENT (SGH)]
CAPITAL ALLOCATIONS................]

* indicate price base and year - cash or current.

8 IS THE SCHEME PART OF A LONGER TERM DEVELOPMENT WITH A TOTAL CAPITAL COST OF OVER £50 MILLION?

Y/N#

9 IF YES, HAS THE LONGER TERM DEVELOPMENT BEEN SUBJECT TO FULL APPRAISAL?

Y/N#
(If yes, state year and title)

10 GIVE THE FOLLOWING DETAILS## OF THE SCHEME:

- FUNCTION CONTENT
- DEVELOPMENT CONTROL PLAN
- FORECAST TIMETABLE FOR EACH STAGE

11 IS THE DEVELOPMENT BASED ON NUCLEUS DESIGN?

Y/N#
(If no, give reasons)

12 WHAT IS THE CURRENT PATTERN OF SERVICE PROVISION IN THE DISTRICT? (HEALTH AUTHORITY SCHEMES ONLY)

(Give summary of hospital facilities - beds, day places, out-patient departments - and relevant community care facilities).

13 WHAT ARE THE KEY OBJECTIVES## OF THE SCHEME? (HA SCHEMES ONLY)

(Give summary of deficiencies in service provision and/or efficiency which the scheme seeks to address.)

14 WHAT EFFECTS WILL THE SCHEME HAVE ON LOCAL SERVICE PROVISION? (HA SCHEMES ONLY)

15 HOW DOES THE SCHEME RELATE TO STRATEGIC AIMS/BUSINESS PLANS?

16 LIST ALL OPTIONS INCLUDED IN APPRAISAL, SHOWING:

- which rejected for full appraisal;
- which were "do nothing" or minimal option;
- which involve green field site development.

17 HOW WELL DO THESE OPTIONS MEET THE OBJECTIVES OF THE SCHEME?##

(Provide brief description for each.)

18 WHERE OTHER CUSTOMERS ARE INVOLVED,

- WHAT ARE THE CUSTOMER REQUIREMENTS?##
- HAVE MAIN CUSTOMER HAs ENDORSED THE DEVELOPMENT AS MEETING THEIR PLANNED NEEDS?

  Y/N#

- HAVE MAIN CUSTOMER HAs AGREED PROJECTED REVENUE AND CAPITAL CHARGES?

  Y/N#

19 WHAT WERE THE CAPITAL AND REVENUE COSTS, CASH FLOWS, DISCOUNTED CASH FLOWS AND BENEFIT SCORES (WHERE RELEVANT) OF THE APPRAISED OPTIONS?##

20 HOW (BRIEFLY) WERE RUNNING COSTS AND CAPITAL CHARGES ASSESSED?##

21 DID SENSITIVITY ANALYSIS FOR COSTS AND BENEFITS, ALLOWING FOR THE LIKELIHOOD OF CHANGES TO ASSUMPTIONS MADE, ALTER THE CHOICE OF PREFERRED OPTION?

Y/N#

22 DOES THE PREFERRED OPTION REDUCE THE COST OF SERVICE PROVISION? (HA SCHEMES ONLY)

Y/N#

(If yes, how?)

23 IS THE PREFERRED OPTION AFFORDABLE WITHIN CURRENT RESOURCE ASSUMPTIONS WITHOUT ADVERSELY AFFECTING OTHER PLANS AND PRIORITIES?

Y/N#

24 DO INCOME PROJECTIONS MATCH OR EXCEED ESTIMATED RUNNING COSTS AND CAPITAL CHARGES?

Y/N#

Delete as necessary.

Attach annex if necessary.