UNISON Northern

Options Appraisal for Prescriptions Pricing Division, NHS Business Services Authority

European Services Strategy Unit
(Continuing the work of the Centre for Public Services)

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Executive Summary

The Prescription Pricing Division of the NHS Business Services Authority is responsible for the processing and payment of prescriptions from GPs and 10,000 pharmacists. It provides an important financial, prescribing and drug information service to over 35,000 prescribers in England.

PPD processes 755m items on NHS prescriptions annually which have a direct bearing on the £8 billion NHS drugs bill. It also issues 4.4m Exemption Certificates, 1.1m Prepayment Certificates, 0.5m NHS Low Income Scheme claims annually and 21m European Health Insurance Cards.

PPD/KPMG proposal

In spring 2006, PPD engaged management consultants KPMG to examine options for the future provision of PPD services. A number of options were presented to the NHSBSA Board (see Part 2) which were later reduced to two options – an in-house optimised option and an outsource/offshore option.

The in-house optimised model was based on two operational centres and assumed 947 FTE job losses. The outsource/offshore model planned over 970 FTE job losses with 700 jobs offshored. None of the options deliver the required efficiency savings in the short term.

Shortcomings in the PPD/KPMG options appraisal

- The appraisal assumes that PPD is simply a transactional service which could be delivered from any location. The ICT component is understated and evidence of private sector delivery of public sector ICT projects which have resulted in delays, cost overruns and contract terminations (see Appendix 1) has not been taken into account. A more balanced view is required.
- Risk assessment is incomplete because it does not assess the risks of the offshoring option. Nor does it fully assess the differences in risks between the options. Risks have not been fully identified, costed and assessed. This fundamental omission invalidates the conclusions and recommendations of the options appraisal.
- The risk of the outsourcing/onshore option is 25% higher than the in-house option under the PPD/KPMG risk assessment excluding the offshore assessment. Our assessment indicates the outsource/offshore option has a 70% greater risk than the in-house option.
- Furthermore, the appraisal claims that outsourcing “has a low risk profile in terms of service continuity”, yet no evidence is supplied to support this assertion.
- The full range of transaction costs associated with the outsourcing/offshoring option have not been identified and are probably under-stated in the financial model. Proposed changes to NHS redundancy and pension arrangements will significantly increase transition costs of the outsource/offshore option.
- The value for money assessment is very limited in scope.
- It does not include an assessment of optimism bias to take account of any over optimistic assumptions and forecasts and make any necessary adjustments to the projected costs, benefits and timescales. Optimism bias is evident in four ways:
    - Firstly, the PPD/KPMG assume there is a ‘perfect contract’ in which a private contractor will deliver all of the PPD’s requirements. They do not take account

of contract problems, variations and failures and hence additional costs which are a common feature of virtually all contracts.

- Secondly, they believe and recommend that market forces should be allowed to dictate how and where PPD operations are carried out. We believe this is fundamentally the wrong approach to achieve PPD objectives of quality, accuracy and security and protect the public interest.
- Thirdly, the appraisal adopts an overly negative perspective about the capacity and risks associated with the in-house option.
- Fourthly, it adopts an overly optimistic perspective about the performance of private contractors in outsourced IT and related services.

- The focus is almost exclusively on efficiency savings with little consideration of the wider NHS issues.
- Patient confidentiality, security and fraud are not fully considered.
- The report fails to fully examine the employment impact of the options, in particular the offshoring of processing operations will substantially increase the job losses but this is not quantified nor assessed.
- Social impact is considered only in relation to redundancies. It ignores the wider community impact, assumes that job losses will have no long-term impact on employment conditions in the North East, North West and Yorkshire and Humberside. The wider public costs are ignored.
- Most stakeholders have not been consulted, hence there is no certainty that their interests have been taken into account.
- The Business Case is inadequate – the incomplete risk assessment (failure to assess the risks of offshoring), the incomplete value for money assessment, the failure to identify the all potential transaction costs, means that the Business Case is incomplete. It is certainly not robust

The UNISON report:

- Develops a more comprehensive evaluation matrix using 30 criteria organised under the following headings – quality, continuity and accuracy; flexibility to cope with future policy and social change; capability; finance; contribution to the NHS whole system; corporate framework; and quality of employment. The in-house option had 37%, 57% and 6% respectively in the high, medium and low categories compared to 10%, 53% and 37% in the same categories for the outsource/offshore option. This means the in-house option has a substantial advantage over the outsource/offshore option.
- Assesses the direct and indirect employment impact of the options. The optimised in-house option is based on 947 FTE in PPD which will have a knock-on impact in local/regional economies equivalent to a further 235 job losses (total of 1,182 job losses). The outsource/offshore option is based on 970 PFT PPD job losses plus 700 offshored which will have a knock-on impact equivalent to 415 jobs in the local and regional economies (total of 2,085 job losses).
- Assesses the risks of offshoring and reassesses the risks taking into account evidence of optimism bias.
- Carries out a value for money assessment which shows that the in-house option has substantial advantages on viability, desirability and achievability grounds.
- Takes account of transaction and public sector costs. The in-house option will result in wider one-off public costs of £1.05m compared to £1.86m for the

outsource/offshore option. The offshoring of 700 jobs will result in mean a loss of government income of £19.22m after taking into account increased corporation and VAT income. The economic impact of redundancy payments will depend on location, age profile, length of service, re-employment rates and spending/saving ratios.

- Summarises recent and current PPD performance which is relevant to options appraisal.
- Summarises some of the problems experienced with private sector provision of public sector ICT and related services projects, recent insourcing trends and ICT surveys.

Recommendations

UNISON strongly recommends that:

- The in-house option should be selected as the way forward for PPD.
- Review, and if necessary strengthen, project management capability to ensure CIP meets its targets.
- The PPD should explore with Counter Fraud and Security Management Service (CFSMS) the potential for extending current data mining services and current CFSMS investment plans to further develop the PPD information systems to benefit all NHS stakeholders.
- The PPD should explore with The Information Centre for Health and Social Care opportunities for further development of the PPD information services and potential for use of the service infrastructure to deliver added value information services.
- The PPD, with the BSA, NHS and DH, should make a full assessment of the value of the information services and delivery infrastructure to the NHS. This would involve understanding the value of the PPD to costs and quality practices within primary care prescribing and to enhance a flexible and responsive approach to policy initiatives to the DH. It would place PPD costs within a full economic and social understanding of the value of the PPD in the NHS system.
- If a procurement process is commenced then an in-house bid should be prepared to ensure genuine value for money is obtained.
- If a procurement process is commenced then bidders should be required to include options for both secondment and TUPE Plus staff transfer employment models.

UNISON believes that the PPD/KPMG recommendation to proceed to procurement with an ‘open market’ approach is poor public management practice. This approach is wrong because:

- It has a very high risk of not meeting PPD requirements.
- Where public sector bodies have commenced procurement without establishing clear requirements and contract terms there have been problems and this approach runs against national procurement best practice.
- Initial advantages at the market sounding stage are often eroded as practical realities become apparent during later bidding and preferred bidder negotiations.
- An offshoring component gives licence to a very wide range of options with the focus being entirely on cost cutting and a narrow efficiency agenda.

- It makes the procurement process much more costly because a larger input from management consultants will be needed to evaluate the different options and bids, which will be more complex and difficult to verify. Furthermore, the procurement process is likely to take longer thus consuming more management time and potentially delaying the commencement of savings.
- Offshoring relies solely on exploiting differences in pay and conditions between Britain and developing countries.

Part 1
Introduction and context

Overview

The Prescription Pricing Division of the NHS Business Services Authority is responsible for the processing and payment of prescriptions from GPs and 10,000 pharmacists. It provides an important financial, prescribing and drug information service to over 35,000 prescribers in England.

PPD processes 755m items on NHS prescriptions annually which have a direct bearing on the £8 billion NHS drugs bill. It also issues 4.4m Exemption Certificates, 1.1m Prepayment Certificates, 0.5m NHS Low Income Scheme claims annually and 21m European Health Insurance Cards plus a wide range of health and social care data. Not only does PPD have control over patient information but it also holds personal, financial and medical information in order to carry out these other services, some of which are means tested. Security and accuracy are therefore paramount.

PPD services

The range of services provided by PPD is summarised in Table 1.

Table 1: **Summary of PPD services**

Service	Principal stakeholder
Payment Services – processing over two million prescription items for payment every working day.	10,000 community **pharmacy contractors** are paid directly, 4,400 **dispensing doctor** payments are calculated for payment by **PCT**s
Information Services – analysing each item to form the basis of our prescribing information services.	**PCT**s receive a range of prescribing and financial information. National information services support **other NHS bodies**.
Regulatory Services – providing regulatory and administrative support to the Department of Health to enable it to manage a range of pharmaceutical services.	Services which support **prescribers** and **dispensers** and which enable the **Department of Health** to implement policy effectively and holistically
Patient Services – administering exemption or assistance with health costs for those who need it. Receiving applications and distributing European Health Insurance Cards to those entitled to these throughout the UK.	Over five million **NHS patients** receive Help With Health Costs. Fifteen million UK citizens have received an EHIC since September 2005.
Managed and Hosted Services – underpinning our own direct services and those of other NHS organisations.	Supporting **national bodies** working across **health and social care** with Finance and HR services.

Source: PPA Annual Report 2005/06.

PPA's financial services were transferred to NHS Shared Business Services in April 2006 and Human Resources were centralised within NHBSA.

PPD Centres

The PPD operates from several centres in the North and Midlands employing about 2,800 staff. There are 12 centres, including the PPD and NHSBSA headquarters based in Newcastle, plus 3 warehousing and storage depots. The plan in late 2005 was to have three processing centres each employing between 200 – 250 staff:

North West – a new building in Bolton which is ready and available - closure of Preston, Manchester, Liverpool and Bolton offices.

North East – Cuthbert House, Newcastle and Durham which is planned to close.

Central – new building in Rotherham which will have to be built - closure of Sheffield, Wakefield and West Bromwich centres.

At present there are only two centres available with the third requiring development and construction. The options appraisal assumes a two-centre operation for the in-house option.

Options appraisal for future of PPD

In spring 2006, PPD engaged management consultants KPMG to examine options for the future provision of PPD services. A number of options were presented to the NHSBSA Board (see Part 2) which were later reduced to two options – an in-house optimised option and an outsource/offshore option. A decision on the options is expected to be made quickly so a procurement process could be commenced quickly if the outsourcing option is selected.

NHS Business Services Authority

The Department of Health has 38 Arms Length Bodies (ALBs) employing 22,000 staff with a combined annual budget of £4.8bn. It plans to reduce the number to 20 by 2007/08, saving £0.5bn and cutting staff by 25%. They include the NHS Purchasing and Supply Agency (PASA), NHS Direct, NHS Logistics Authority (outsourced to DHL in September 2006), NHS Business Services Authority, and NHS Blood and Transplant. Democratic accountability is a marginal concern in the review and reconfiguration proposals (Department of Health, 2004).

NHS Business Services Authority: The Business Services Authority, based in Newcastle, took over five arms length bodies from April 2006:

1. *Counter Fraud and Security Management Service Division*
2. *Dental Practice Division*
3. *Pensions Division*
    - The NHS Pension Scheme
    - The NHS Injury Benefits Scheme in England and Wales
    - The NHS Bursary Scheme for England
4. *Prescription Pricing Division*
    - Renumeration and reimbursement of dispensing contractors in England
    - Provision of Financial, Prescribing and Drug information
    - Help With Health Costs
    - European Health Insurance Card
5. *NHS Logistics*

The NHSBSA is the main processing facility and centre of excellence for payment, reimbursement, remuneration and reconciliation for NHS patients, employees and affiliated parties. The NHSBSA has to make a major contribution to reduce ALB expenditure by £500m and reduce staffing by 25% by 2008.

The NHSBSA is a commissioning organisation “rather than a service provider” and aims "to be the first choice for the Department of Health and the NHS in commissioning, procuring and performance managing all appropriate non-clinical NHS-related business

and service contracts. These service contracts will ensure best value for money as set out in relevant international standards." (NHSBSA web site).

NHS Logistics was outsourced to DHL in autumn 2006.

Efficiency savings

BSA has a target of £37m efficiency savings by 2007/08 of which £20m will be contributed by the CIP. The NHSBSA Budget for 2006/07 to 2008/09 has a baseline allocation which "was around £11m less than the total sums allocated to the individual authorities in 2005/06" with no funding for inflation or volume growth.

The Capacity Improvement Programme has a target to achieve £20m savings annually. However, the BSA has imposed new financial targets on the PPD to save an additional £5.6m in 2008/09 and £9m per annum from 2009/10.

Capacity Improvement Programme

The CIP Business Case examined the possibility of outsourcing and recommended this option should be considered at a later date after CIP implementation rather than now. It discussed the advantages and disadvantages of each option. It concluded:

> *"The anticipated model for the Business Service Authority is based on outsourcing processes and services. It is the PPA's contention that this is best achieved once efficiency savings have been driven out of the system by technological innovation, especially where proof of concept has already been demonstrated and in the light of the significant IT resource deployed that has already moved the programme to an advanced stage.*
>
> *…..There is nothing within the CIP process that prevents outsourcing the operation of the system at a future date. Indeed it lends itself well to the process, as it relies on clearly defined roles for staff that can be easily set out in a contract capacity."* (PPA, 2005)

The CIP Business Plan identified annual cost savings rising to £34.2m in 2009/10 based on a three centre option.

Electronic Transmission of Prescriptions

Electronic Transmission of Prescriptions is being developed by NHS Connecting for Health – by March 2006, 1,034 GP sites and 148 community pharmacies were ready to switch on and 296 GPs and 11 community pharmacies sites were using the EPS system (NAO, 2006). The volume of electronic prescriptions is growing – by the end of March 2006 a cumulative total of 726,843 prescriptions had been issued electronically.

The progressive implementation of ETP could make a significant impact on helping PPD achieve the efficiency savings, although implementation is the responsibility of Connecting for Health (CfH) and its contractors.

Currently about 15,000 or 18,000 of 25,000 pharmacy outlets are fully ready to use ETP with smart cards issued. About 39,000 GPs have smartcards. This involves the physical installation of a reader and connection to the NHS Spine. Release 1 of ETP does not link to the PPD but does link the GP to the spine and to the Pharmacy. The CfH website reports that ETP will be "fully operational across England by the end of 2007".

Release 2 which will directly make claims for payment from the PPD is due to go live in March 2007, Release 2 only requires a software upgrade which for most of the pharmacy systems suppliers is now achieved down the line (Boots, co-op, Sainbury's, Pharmacy Plus on this model, Unichem moving to it). Boots is already asking customers if they want to make use of this service. Currently about 90,000 prescriptions per day are issued through ETP (October 2006).

The rollout of ETP is gathering pace, the first million ETP prescriptions took two years, the latest million took three weeks. Recently a change to the terms was made that means that patients will need to opt out of ETP rather than opt in. The restriction on the roll out of ETP is likely therefore to be that Connecting for Health and the Minister want to be sure that this is a safe system that meets patient needs and pays pharmacists correctly. The intention that a number of PCTs will trial ETP through 2007. At the end of 2007 there is no reason not to assume a massive jump in the use of ETP, it is not inconceivable that ETP will cover 80% of prescriptions by the end of 2008 (controlled drugs and community nurse prescribing are unlikely to be included by then).

"The prime objective of the implementation is to ensure that the service is fully operational across England by the end of 2007"

"Once a majority of users are able to operate the transitional service, the need to use paper prescriptions will considerably reduce and the default position will become the issue of an electronically generated and signed prescription against which drugs etc can be dispensed. In such cases a paper prescription, hand signed by the prescriber, will not be issued unless there are specific reasons to issue a paper prescription rather than an electronic one. This will complete the implementation of the service."

http://www.connectingforhealth.nhs.uk/eps/implementation/(accessed 08/10/06)

NHS context

NHS Drugs bill

The annual NHS drugs bill is £8 billion in England. The PPD processes over two million prescription items daily, determining reimbursement and remuneration levels through to payment. "The PPD also provide assurance that effective use is made of NHS resources" (para 8.2.1, PPD/KPMG report). PPD information services have access to prescription information for the whole population and "have developed systems to enable these data sources to be analysed through its expertise in data mining and manipulation" (para 8.2.2). PPD provides a range of financial reports "which enable the NHS to identify where it is investing its resources, to manage actual spend on drugs and to provide information for future investment decisions" (ibid).

The National Audit Office plans to examine the annual NHS drugs bill in 2006/07. The study will "consider the prescribing practices of and information available to, GPs and how variations in practice that can lead to inefficiencies can be addressed in order to generate financial savings" (NAO, 2005). The NAO also intends to investigate the Health and Social Care Information Centre and the relationship with Dr Foster.

Public sector IT projects and the NHS IT programme

The current problems with the NHS National Programme for IT (NPfIT) are part of the context of the PPD options appraisal. This programme has experienced very significant cost increases – up from £5bn to £12.4bn, long delays, service failures, missed targets, and the termination of contracts and withdrawal of one major contractor (see Appendix 1).

More than transactional services

PPD is often referred to being 'just' a transactional service. However, this is not the case as it includes IT development.

- IT development is a key part of the current and future work of the PPD until the use of ETP reaches 100%. If PPD is outsourced, a private contractor will have to take over development and implementation of CIP or alternatively develop another programme. Thus it is important to draw on the track record of failed and poor performing ICT. Over twenty public sector ICT contracts have been

terminated and/or have suffered from significant cost overruns and long delays. There are different degrees of 'failure' ranging from contract termination to delays and spiralling costs which make the original Business Case worthless. Although ICT projects were excluded from PFI from July 2003, the problems have continued in a wide range of other projects including partnership and traditional outsourcing contracts. In addition, four strategic service-delivery partnerships have been terminated and nine local authorities have opted to carry out business transformation in-house rather than outsource. See Appendix 1 for further details (also see NAO, 2006 and Bacon and Pugh, 2006).

- Some of the other public sector IT projects are claimed to be 'just' transactional services, which on paper appear straightforward, but in practice are not as virtually all the major IT contractors have discovered. Whilst some public sector IT contracts are successful, many are not.
- Many transactional services are a mixture of income collection and payment systems but PPD is heavily focused on payments to pharmacists and using this data for health information analysis.
- Outsourced revenue and benefits contracts in local government, also claimed to be 'just' transactional services, have experienced many contract terminations and poor quality of service.

More than a back office service

The PPD carries out other functions such as information analysis, administers the scheme under which people on a low income can get help with health costs, and administers the European Health Insurance Card scheme. PPD also produces a Drug Tariff and maintains a Primary Care drug dictionary which sets out what can be prescribed, what it costs and what the NHS can be charged.

It maintains integrity and integration of prescription processing, payment and information interrogation for the NHS, in particular patients, GPs and pharmacists.

Organisational change

Proposals for organisational change in the NHS and health services should not be regarded as 'fixed in stone' for the purposes of the options appraisal. For example, the possible transfer of health information analysis from PPD to a new Health Information Centre may or may not happen, and if it does, there is no certainty that it will succeed or continue. The public sector, particularly the NHS, has a long history of almost constant organisational change and there is no indication that this is about to slow. There is no 'right' solution yet organisational change often takes precedence over public management and process changes.

Language

It is also important that options appraisal and risk assessment is free from jargon to ensure a common understanding of the key issues and criteria at all levels. This report therefore attempts to use plain English. For example, reference is made to a 'delivery organisation' in the PPD/KPMG report when in practice this will be a private contractor and outsourcing is often described as a 'partnership' when in fact it is a client-contractor relationship with a contract.

Objectives of this report

Our goal in this paper is to identify the problems with outsourcing for the managers in the PPD who are actively considering it. Our considered approach looks at more than just the cost and takes into account the needs of the PPD/NHS, the skills of the workforce, knowledge of the business and quality of output.

We hope we will provoke a thoughtful discussion among managers about the issues we have highlighted.

The objectives include re-assessing the evaluation criteria and the risk matrix which form the basis of the PPD/KPMG recommendations. We also seek to maximise the implementation of CIP in the interests of staff, improve the overall effectiveness of the PPD and develop the case for the retention of the PPD in the public sector.

Methodology

This study began as an analysis of the CIP to examine ways in which it could be developed whilst minimising the negative impact in staff and closure of centres in the North and Midlands. It included an analysis of the Prescription Pricing Authority's corporate plans and policies. It covered analysis of the PPA Business Plan 2005/06, Strategy 2004/09, Annual Report 2004/05 and other corporate documents and government strategy for NHSBSA and PPD in particular. There was also a concern that once CIP was implemented then PPD might be outsourced or privatised.

However, it soon became evident that the agenda had rapidly changed to the possibility of outsourcing and offshoring of most of PPD's operations now. PPD had engaged KPMG to assist with an options appraisal and set a programme for PPD, NHSBSA and Ministerial decisions on the options.

This report has been researched and written by the ESSU with the close involvement of UNISON convenors from the PPD operational centres and the PPD Joint Consultative Committee.

Part 2
The Sourcing Options

Introduction

This section briefly notes the identification of options which ranged from retaining in-house provision to outsourcing and offshoring.

- Options devised by KPMG
- Savings claims
- Offshoring and global sourcing

Options presented by KPMG

The initial identification of options made by KPMG ranged from in-house to offshoring:

1) In-house: Continue with CIP implementation. Date refresh means that savings targets are not to original timescale.

2) **Managed Service:** PPD retains ownership and responsibility for the people, assets and service delivery. Private sector supplier provides consulting expertise, additional IT and BPR expertise and access to low cost people resources to replace turnover and deal with growth in volume.

3) **Joint Venture – legal entity:** Public-private partnership and staff and possibly assets transfer to JVC. New entity may seek new business opportunities.

4) **Shared Service Centre:** Third party provider supplies service from own operating centre. Transfer of staff depends upon locations.

5) **Third Party provision:** Supplier provides services from UK, potentially from PPD facilities.

6) **Third Party Offshore:** Supplier provides service from offshore service centre. 'Transfer offshore as fast as possible'.

7) **Third Party On shore/Offshore Mix:** Supplier accepts that percentage of service provided on shore. Phasing and percentage negotiated.

The options were reduced to two for the appraisal:

1. In-house Optimised with reduction to 1 delivery centre plus disaster centre.
2. Outsource Optimised by Offshoring the following services
    - Prescription processing
    - Low Income Scheme
    - European Health Insurance Card
    - Prepayment Certificates
    - Maternity Exemption certificates
    - Medical Exemption certificates
    - Tax Credit Exemption

Savings claims

Savings claims are regularly overstated. No evidence was provided to justify these claims either in terms of any research evidence base or to verify that all the transaction and public costs had been taken into account to ensure that the figures were reasonably accurate. These figures were presented to the NHSBSA Board in July 2006 (see Table 2). We are confident that even bigger savings could be achieved following a global sourcing operation which identified a developing country with a basic infrastructure but where terms and conditions of the workforce could be reduced, relatively, to marginal cost. But of course this is not the issue despite the rather simplistic KPMG approach.

Table 2: **Claimed savings from sourcing options**

Option	Potential Savings (in addition to CIP but excluding transaction costs)
In-house	"less than ALB targets"
Managed Service	10%
Joint Venture Company	20% - 30%
Shared Service Centre	30%
Third Party provision	20% - 30%
Third Party Offshore	40% - 60%
Third Party On shore/Offshore mix	30% - 50%

Source: NHSBSA Board Presentation by KPMG, 25 July 2006.

The options appraisal report has reduced the 50% - 60% savings from offshoring to 40% because of increased management costs which confirms that they were inaccurate in the first place and should not have been presented to the NHSBSA.

Transaction costs

The PPD/KPMG report claimed savings are net of the transaction costs which will be considerable in any form of outsourcing. This further undermines the credibility of the savings figures. It also raises questions about the motives of presenting such questionable figures at the beginning of an options appraisal process. Only a limited amount of information appears to have been presented to the NHSBSA Board thus giving the 'savings' figures centre stage when in fact they are only one of many issues which the PPD, NHSBSA and Department of Health have to take into account.

There are basically three types of transaction costs - transitional costs incurred in project planning and the procurement process including transition and redundancy costs; permanent costs such as client and contract management; and periodic costs of reviewing provision, performance and organisational change.

Comments on in-house transaction costs: A £1m allowance has been included in the financial model for one off "external support for programme delivery" ie consultants fees.

Comments on outsource onshore transaction costs: "Transition costs comprising of external support for the procurement and supplier costs associated with executing the transaction" of £2.5m are included in the financial model.

Comments on outsource/offshore transaction costs: It is interesting to note that no similar consultancy costs or transition costs are included in the offshore option. This must be an oversight because the transition costs are likely to be significant in offshoring. The contractor would price for their costs in the tender but are unlikely to fund the PPD's transition costs as well. On this basis the transaction costs in this option are significantly under-estimated

General comments

The PPD/KPMG transaction costs only include redundancy and relocation. Nothing else.

- Redundancy is based on the current NHS scheme but this is likely to be changed to a more generous one soon to comply with Employment Equality (Age) Regulations. This will affect both options but the offshoring option more significantly because of the larger job losses. The PPD/KPMG report notes that "transition costs for all options would be significantly higher" but does not admit that the additional 725 redundancies in the offshore option will make this option significantly more costly than the in-house option.
- Pension charges are not included in the financial model.
- Procurement and contract management costs may be underestimated based on past experience of outsourcing. There will be additional costs of contract monitoring and problem solving which do not appear to have been estimated and taken into account.

Part 3

Options appraisal criteria and assessment

Introduction

This part of the report focuses on the evaluation criteria and assessment of options. It is divided into four parts:

- The rationale for the evaluation criteria
- The Evaluation Matrix and assessment of options
- Sustainable development and community well being impact
- Transaction and public costs

Rationale for the Evaluation Criteria

The Evaluation Matrix is organised in seven sections to provide a clear framework.

- Quality, continuity and accuracy
- Flexibility to cope with future policy and social change
- Capability
- Finance
- Contribution to the NHS whole system
- Corporate framework
- Quality of employment

The first part of this chapter establishes the rationale for the main headings and the criteria included under each heading. The Project Objectives established by the PPD Working Group, outlined on pages 8 – 10 of the PP/KPMG options appraisal report, also provide the rationale for the evaluation criteria.

Quality, continuity and accuracy: Confidentiality and security of patient information was one of six key issues raised generally and specifically for prescriptions by a wide range of consultees in the preparation of the National Audit Office report on the NHS national IT programme (NAO, 2006). Ability to meet targets in the Prescription Pricing Division Business Plan 2006-07 (NHSBSA, 2006), meet requirements of the NHS BSA Directions 2006 (Secretary of State for Health, 2006), and to obtain an optimal balance between cost, quality and flexibility (NAO, 2006).

Flexibility to cope with future policy and social change: The White Papers *Choosing Health: Making healthier choices easier* (DH, 2004*) and Our health, our care, our say: a new direction for community services* (DH, 2006) together with the Green Paper, *Independence, Well-being and Choice* (DH, 2005*)*, have indicated that fundamental changes are required in health services. It is therefore essential that central services such as the PPD retain a high degree of flexibility to adapt to change and new requirements for information and data analysis.

Ability to operate within a rigorous change control mechanism to meet changing needs of the NHS and prevent suppliers charging excessive prices for changes was one of the lessons learnt from the National Audit Office investigation of the NHS national IT

programme (NAO, 2006) and is also evident from the experience of strategic service-delivery partnerships in local government (Centre for Public Services, 2005).

Capability: The government has launched a Capability Review programme which is intended to increase the capability of the Civil Service in leadership, strategy and delivery. Each review is carried out by the Prime Minister's Delivery Unit with a team of external reviewers. Four departments have been reviewed and a further five are under way. "Capability Reviews mark a watershed in the history of British public administration" stated Tony Blair in the foreword to the first review (Cabinet Office, 2006). The reviews focus on setting priorities and managing performance, improving delivery, responding to citizens, businesses and communities and building skills, capacity and capability to meet the demands of the future.

Finance: Various guidance documents provide the basis for the financial criteria, for example the Arms Length Body Review (DH, 2004), Value for Money assessment guidance (HM Treasury, 2004), evaluation frameworks designed for PPP projects but relevant to large scale outsourcing (National Audit Office, 2006) and various guidance document from the Office of Government Commerce.

Contribution to the NHS whole system: The White Paper Choosing Health: Making healthier choices easier included a commitment to establish a corporate citizenship programme (Department of Health, 2004) and was followed by a toolkit and case studies (Sustainable Development Commission and NHS).

> "*Procurement can play a part in the government's health inequality, community cohesion, social inclusion and regeneration agendas by having consideration for where the economic benefit of purchases will be received, and the impact of purchases on the labour market. By considering the social impacts of procurement, there is potential for the NHS to involve communities in supplying goods and services, and improve their health outcomes.* (NHS Purchasing and Supply Agency, www.pasa.nhs.uk/sustainabledevelopment accessed September 2006).
>
> *"A responsible organisation does three things:*
>
> *1. It recognizes that its activities have a wider impact on the society in which it operates;*
>
> *2. In response; it takes account of the economic, social, environmental and human rights impact of its activities across the world; and*
>
> *3. It seeks to achieve benefits by working in partnership with other groups and organisations." [Business and Society, CSR Report, 2002]*
>
> *For business, Corporate Social Responsibility is about recognising the interests of all stakeholders, not just shareholders. The European Commission defines CSR as the "voluntary social and environmental practices of business, linked to their core activities, which go beyond companies' existing legal obligations". For the Agency, and for government as a whole, it is about linking all of our activities with the goal of achieving a better quality of life. CSR includes integrating issues such as accountability, human rights, corporate governance codes, workplace ethics and stakeholder consultation and management into everyday business practices."*

The Department of Health is committed to sustainable development – see the NHS Plan (DH, 2000) and (www.dh.gov.uk/PolicyAndGuidance accessed September 2006). KPMG is also committed to corporate social responsibility (www.kpmg.co.uk).

Improving responsiveness to stakeholders/customers is one of the principles developed for the Arms Length Board sector (Department of Health, 2004).

The Department of Health is also committed to 'information prescriptions', 'social

prescribing' and a range of different prescription schemes such as exercise-on-prescription, 'well-being prescriptions' by PCTs to give easier access to services, facilities and activities. The *Independence, Well-being and Choice* consultation indicated that people want different services more closely integrated to meet their needs, with better information.

> *"A better-integrated workforce – designed around the needs of people who use services and supported by common education frameworks, information systems, career frameworks and rewards – can deliver more personalised care, more effectively"* (DH, 2006).

Integration of NHS IT systems was discussed in detail in the National Audit Office report on the national NHS IT programme (NAO, 2006).

Corporate framework: Alignment required to the Prescription Pricing Division Business Plan 2006-2007 (NHSBSA, 2006), the Business Case for the Capacity Improvement Programme Implementation (Prescription Pricing Authority, 2005), the NHS Business Services Authority Directions 2006, Schedule 4 (Secretary of State for Health, 2006).

Quality of employment: The overview in the PPD Business Plan 2006/07 has a concise statement on the importance of the quality of employment. The PPD will achieve its mission by five key actions including:

> *"fostering an ethos of customer service, where clients use the NHSBSA based on its reputation as a natural provider of business services for the NHS, and a reputation as an employer/contractor where people matter in which values of integrity, decency and development prevail." (*NHSBSA Prescription Pricing Division, Business Plan 2006/07).

The need for more managers to engage with frontline staff (often as a surrogate for stakeholder interests) to improve the design of public services is emphasised by the Capability Reviews (Cabinet Office, 2006). Engaging frontline staff in the Best Value process has also been recommended by the Improvement & Development Agency and the Employers Organisation in local government (IDeA, 2001). The NHS Knowledge and Skills Framework was designed for the implementation of Agenda for Change and covers the knowledge and skills needed, staff development and pay progression (Department of Health, 2004).

The Evaluation Matrix and assessment of options

Rating system

A three-part assessment has been used.

- High – Very good basis for achieving the criteria.
- Medium – Used where some aspects may be positive but other elements are more doubtful.
- Low – where existing practice or track record indicates that this objective may not be achieved to the desired level.

Changes from KPMG model

The Matrix differs in several respects from the PPD/KPMG model.

Firstly, it is more comprehensive and aligned to the needs of the PPD.

Secondly, some of the assessments in the PP/KPMG version have been changed. For example, the scoring of the 'ability to maintain service levels and quality of service' was scored high for the outsourcing option. This has been changed to a 'medium' rating because the private sector will have responsibility for more than providing transactional services (in which the private sector does not have a 100% record as KPMG seems to

imply) and will be required to takeover the provision of new ICT systems. This raises questions, in the light of private provision of public sector ICT projects, whether service quality will be maintained consistently.

Thirdly, some the scope criteria have been changed. For example, the 'ability to facilitate exploitation of new opportunities' has been directed to more internally generated opportunities such as the proactive use of health information rather than a commercial perspective of taking on additional services and functions for other organisations. The record of organic growth of regional business centres in strategic service-delivery partnerships is very limited. Furthermore, 'success' should be judged solely by the quality and degree to which PPD services can delivered over a 7-year contract, together with internal innovation, rather than making value judgements over the possible commercial success of a private contractor who has yet to process a prescription.

PPD must first ensure that it delivers its core functions, as detailed in the NHS BSA Directions 2006 order, in a period of significant ICT and health policy changes, before it contemplates providing non-core activities. However, we believe there is scope to enhance the health and social care information services.

Impact of outsourcing

The risk assessment examines the different types of risks which could arise in the in-house and outsource/offshore options. The rating of the outsourcing model will be reduced if an offshoring component is added.

Table 3: **Options Appraisal Evaluation Matrix**

Evaluation criteria	In-house	R	Outsourcing	R
Quality, continuity and accuracy				
Ability to maintain service level, quality of service and Accuracy (Working Group 'absolute' objective)	Good track record on quality and accuracy	H	Transfer to contractor and IT development means that quality may not be maintained.	M
Ability to deliver the required benefits within the required timescale (but Working Group state that short-term savings should not be secured at expense of longer-term value for money)	Potentially not achieve level of savings but will achieve non-financial benefits	L	Better ICT systems may be achieved but savings may be exaggerated with higher contract and transactional costs.	M
Ability to maintain service continuity during transition and contract period (Working Group 'absolute' objective)	No transition of staff/assets. CIP and rationalisation of processing centres will require skills.	M	Transfer of service to private sector could lead to major transition problems. Plus private sector rationalisation could provoke staff opposition	L
Ability to achieve continuous service improvement and innovation	Good record of continuous improvement and cost reduction.	M	Experience of enhancing transactional element but question mark over ICT/CIP	M
Ability to be responsive to customers (BSA and ALB objective)	Integrated provision more likely to achieve higher level of responsiveness	H	Highly dependent on specification and contract management so it is priced for.	M
Confidentiality and security of patient information	Good record of maintaining confidentiality & security	H	Good but possible offshoring of parts or all of services bring security into question	M
Ability to minimise fraud and work closely with security management	Good record of minimising fraud and security cooperation could be further developed	M	Assume contract requirements would include close cooperation	M
Flexibility to cope with future policy and social change				
Adapt to future health policy and business change	Has track record of adopting to change in the NHS.	M	More likely to be reactive and within contract boundaries.	L

Ability of the option to cope with changes in service volumes and delivery channels	Has shown capacity to cope with change although rapid changes likely to cause problem	M	Any substantial changes almost certain to incur contract variations and additional costs	M
Ability to facilitate exploitation of new opportunities	PPD has track record of developing initiatives.	M	Can be expected to initiate and innovate internally.	M
Capability				
Retention of key skills and knowledge	Most skills and knowledge retained by PPD.	H	Substantial loss of skills to contractor. Need to acquire contract management skills.	M
Level of management capability and commitment required to manage the change	Need to improve project management skills but some proven capacity.	M	Poor private sector record of managing IT based contracts but some transaction processing management capacity.	M
Level of management capability and attention required to manage the ongoing delivery of services	Continuity of current provision and management input	M	New skills required to manage contract.	M
Finance				
Affordability	Predicted reduction in costs from CIP application makes option affordable.	M	Predicted reduction in costs from CIP application makes option affordable.	M
Total cost during the life of the programme	Less predictable and could be affected by slippage in CIP programme	M	Theoretically costs are more predictable with a 7 year contract but this could change if there are problems and cost variations.	H
Financial benefits	Programme of cost reductions from CIP should reduce unit costs	M	Outsourcing/offshoring may produce larger cost savings but questions over level of savings	H
Value for money considerations		H		M
Transparency of costs including range of transaction costs	Costs more predictable.	M	Transaction costs (permanent client, transitional and periodic costs) identified and can be considerable plus contract variation costs. KPMG appear to estimate only supplier costs.	L
Minimise knock-on public sector costs to government	Phased programme of change and centralization will minimize costs borne by other public sector bodies.	M	Assume faster closure of existing centres and outsourcing resulting in job loses and slower re-employment.	L
Contribution to the NHS whole system				
Integration with NHS IT systems	Direct control over integration with other IT systems	M	Less direct control with additional resources needed to ensure integration.	L
Ability to meet NHS stakeholder needs and contribute to health strategies	Accommodated different needs and linked to whole system ideology	M	Defined by contract requirements.	L
Ability to implement NHS sustainable development policies	Mainstreaming of five components of sustainable development more likely within PPD	H	Global sourcing trends leading to changes in production and supply changes and lower commitment to SD	M
Ability to implement NHS Corporate Social Responsibility: Social, Environmental, Local economy and community well being	Many policies and practices in place and direct management supervision	M	Private sector patchy record. Difficult to verify.	L

Corporate framework				
Alignment to the PPD/BSA business strategy	Runs counter to BSA outsourcing strategy	L	Aligned with BSA business strategy.	H
Degree of fit with PPD culture	Close fit to PPD culture	H	Limited experience of managing outsourcing	L
Accountability and governance of service delivery	Internal governance maintained with scope for new arrangements	M	Requires contract governance arrangements but more indirect	L
Quality of employment				
Provision for training and workforce development	Good track record	H	Assume selected contractor would have proven record.	M
Maintaining public sector pensions for staff	Staff remain in public sector pension scheme.	H	Many private sector firms reluctant to join public sector pension schemes.	L
Equality and diversity policies	Policy framework in place.	H	Variation in private sector practice and between policy and practice.	M
Staff and trade union involvement	Industrial relations framework and consultation in place.	H	Private sector practice not so comprehensive and weak consultation.	L

Summary of scores/ratings

The in-house option had 37%, 57% and 6% respectively in the high, medium and low categories compared to 10%, 53% and 37% in the same categories for the outsource/offshore option – see Table 4. This means the in-house option has a substantial advantage over the outsource/offshore option. The in-house option scored a higher rating in all sections compared to the outsource/offshore option. The in-house had 94% of the assessments in the high and medium scoring whereas the outsource/offshore option had only 63% in these categories.

Table 4: **Summary of options appraisal**

Main criteria	In-house			Outsourcing		
	High	Medium	Low	High	Medium	Low
Quality, continuity and accuracy	3	3	1	-	6	1
Flexibility to cope with future policy and social change	-	3	-	-	2	1
Capability	1	2	-	-	3	-
Finance	1	5	-	2	2	2
Contribution to NHS whole system	1	3	-	-	1	3
Corporate framework	1	1	1	1	-	2
Quality of employment	4	-	-	-	2	2
Total	**11**	**17**	**2**	**3**	**16**	**11**
%	**37%**	**57%**	**6%**	**10%**	**53%**	**37%**

Sustainable development and community well being impact

Employment impact

The PPD employed 2,764 (2,119.2 FTE) permanent full and part-time staff at 28 February 2006. Employment in current PPD operating centres varies: Manchester 150 (est.), Liverpool 150 (est.), Bolton 205 FTE (267 jobs), Preston 100 (est.), West Bromwich 150 (est.), Sheffield 221, Wakefield 170, Durham 240 and Newcastle 1,086 jobs.

The options appraisal is based on a reduction of 800 FTE (1,043 staff or jobs). The in-house optimise option includes a further 147 FTE (192 staff or jobs) by increasing ICR from 45% to 50%, increasing the roll-out of CIP and further efficiency savings, giving a total potential job loss of 1,235.

The outsource and outsource/offshore options increase job losses to 1,670 (800 FTE plus 170 FTE plus offshoring 700 FTE).

Knock-on effect on private sector employment

The loss of public sector jobs will have a knock on effect on employment in local services unless the lost jobs are immediately replaced by other public or private sector growth, which is highly unlikely in the current economic conditions.

Given the level of wages of the staff in the PPD centres, a multiplier of 1.25 has been used to assess the knock-on effect on local retail and service sector (EOC, 1995).

Table 5: **Projected job losses (FTE)**

Option	Core reduction in PPD/KPMG option	Jobs offshored	Additional job losses in local economy	Total job losses
In-house optimised	947		235	1,182
Outsource/offshore	970	700	415	2,085

Source: PPD/KPMG Options Appraisal, 2006 and ESSU calculations.

Additional jobs will be lost in the local and regional supply chain, particularly with the offshore option. This option will result in ICT equipment/services and support services being resourced locally.

Inconsistencies

- Although the financial model has an estimate of contract management and monitoring costs this does not appear to be reflected in the staffing structure. The number of PPD corporate staff is reduced from 13 to 9 after outsourcing with one left in operations and the administrative staff reduced from 57 to 4.
- No allowance is made for additional contract management staff in the offshore option.
- No indication of which services will/should be retained onshore and which would be offshored. This is further evidence of the approach of not specifying PPD requirements but allowing the market to dictate.
- This is a full outsourcing model leaving a shell organisation based in Newcastle.

Conclusions of options appraisal

The in-house option had 37%, 57% and 6% ratings respectively in the high, medium and low categories compared to 10%, 53% and 37% in the same categories for the outsource/offshore option. This means the in-house option has a substantial advantage over the outsource/offshore option.

The optimised in-house option is based on 947 FTE in PPD which will have a knock-on impact in local/regional economies equivalent to a further 235 job losses (total of 1,182 FTE job losses). The outsource/offshore option is based on 970 FTE PPD job losses plus 700 offshored which will have a knock-on impact equivalent to 415 jobs in the local and regional economies (total of 2,085 FTE job losses).

Part 4
Value for Money assessment

Introduction

The section of the report contains a value for money assessment of the two options. It also identifies the wider public sector costs which will be incurred.

The VfM framework

The Treasury has published guidance on both qualitative and quantitative assessment of value for money (HM Treasury 2004a and 2004b).

Table 6: **Value for Money Qualitative Assessment of the options**

Value for Money Qualitative Assessment		
	In-house option	**Outsource/offshore option**
VIABILITY		
Programme level objectives and outputs	Best placed to meet the project objectives outlined in p8-10 of PPD/KPMG report, particularly absolute objective of maintaining existing quality and continuity of service, but also flexibility, continuous improvement, benefits of CIP, employment and long-term value for money.	Although "achievement of cost saving targets is the primary driver behind the project". All options fail to meet savings target. Evidence (Part 7 and Appendix 1) indicates objectives and outputs are unlikely to be met in full.
Operational flexibility	This option maximizes operational flexibility allowing a best in class approach to external sourcing and responding to ETP implementation and other initiatives. Responsiveness to peaks and troughs more limited but unlikely in core business.	More restricted flexibility in a 7-year contract. Possibly more flexibility to respond to peaks and troughs but this will incur contract variation costs.
Equity, efficiency and accountability	Maximises equity in terms of treatment of staff in a downsizing situation. Retains NHSBSA accountability.	Offshoring means loss of jobs in Britain plus further loss through knock-on effect on local economy and cuts in supply chain. Indirect accountability in contract culture.
Overall viability	**Option has key advantages in meeting objectives, flexibility, equity and accountability.**	**Only possible advantage is efficiency savings but risks challenge viability.**
DESIRABILITY		
Risk management	Option will minimise operational risks. Savings target will not be met by any option.	Higher risks to quality, accuracy, security and continuity of service delivery in outsourcing and offshoring. Risk is 25% higher for onshore outsourcing and significantly higher risk for offshoring
Innovation	PPD designed CIP with focus on implementation.	Either CIP implementation or new software developed by private sector.
Service provision	More likely to maintain current high level of accuracy, quality and security of service to stakeholders. Strategic reasons to retain in-house.	Transfer of provision could cause problems during/after transition.

	Service improvements can be obtained with in-house option.	
Incentive and monitoring	Monitoring arrangements continue. CIP project management may be strengthened to improve implementation.	Monitoring offshore more complex and costly.
Lifecycle costs and residual value	n/a	n/a
Overall desirability	**Quality, continuity and other benefits outweigh any doubts about efficiency savings.**	**Substantially higher risks not only to efficiency savings but also to quality, continuity and security.**
ACHIEVABILITY		
Transaction costs and client capacity	Option avoids contract transaction costs. Retains and increases client capability.	Considerable procurement costs (£1m plus) and other transaction costs not quantified. Increased client capacity needed to manage contract.
Competition	N/a	Contract competition exists but PPD must set clear requirements and terms. Evidence whether private sector will deliver is mixed.
Overall achievability	**Efficiency savings can be achieved via combination of CIP and ETP implementation.**	**Outsource/offshore option possible but major questions whether it can meet other objectives.**

Source: Framework from Value for Money Assessment Guidance, HM Treasury, 2004.

Value for Money Quantitative Assessment

The framework for the quantitative assessment of the options is based on the HM Treasury guidance (HM Treasury, 2004).

Public sector costs and benefits

The PPD/KPMG options appraisal dismisses the inclusion of social costs because they assume that all staff will obtain new employment immediately. But outsourcing usually has a considerable knock-on impact on the local economy. For example, the ESSU social and economic audits undertaken for major city councils, the Equal Opportunities Commission, the Department of Health and Social Services Northern Ireland in addition to public sector employment studies for the North West Regional Assembly and the Department of Health and regional bodies in the East of England. In addition, the Green Book specifies that social costs should be taken into account in options appraisal (HM Treasury, 2004).

The types of social costs which arise vary depending on the type of project, its scope and location. With regard to the PPD project the following impacts need to be taken into account:

- The loss of jobs and the extent to which staff are reemployed.
- The related social costs of unemployment such as child care, caring responsibilities
- The cost of closing the PPD centres including termination of leases, security costs, rent forgone etc.
- Changes in the supply chain and any knock on effect on employment.
- Potential environmental effect of empty buildings if new tenants/uses not immediately found.

A number of public sector costs and benefits are associated with these impacts which include:

- Changes in the level of benefits payable by DWP, housing benefit and council tax benefits as a result of direct and indirect employment change.
- Changes in personal income tax payments and employer/employee National Insurance contributions.
- Cost of government financed job training.
- Changes in private sector companies Corporation Tax and VAT payments in relation to outsourced contracts.
- Changes in Corporation Tax and VAT as a consequence of offshoring.

The Options Appraisal report claims that:

> *"…..the social impact of the options has been considered (in accordance with Treasury Green Book guidance). As all the options leave the services essentially unchanged, the principal social impact would be the possibility of redundancies creating long-term unemployment. We have made the assumption that, given the current state of the UK economy, and the location of the workforce, this is unlikely to happen, and therefore no explicit allowance has been made in the appraisal*." (PPD/KPMG, 2006)

A fuller explanation of the public sector costs is set out in Appendix 4. This has assessed the one-off costs and benefits of each option including the cost of unemployment and related benefits, changes in corporation tax, VAT, income tax and employee/employer National Insurance contributions. The figures are summarised in Table 10.

The in-house option is estimated to incur an additional one off public cost of £1.05m resulting from the wider public costs of temporary unemployment. These costs will be borne primarily by the Department of Work and Pensions.

The outsource/offshore option incurs one-off costs associated with unemployment of £1.86m. The effect of offshoring 700 FTE will result in the loss of income tax and national Insurance Contributions of £0.15m and £0.18m per annum giving a total cost of £19.81m over the 7 year contract period. This option gains from Corporation Tax and VAT payments of £1.05m and £1.40m respectively. This income would be substantially greater at £9.45m over the contract period if no operations were offshored.

Redundancy payments will also have an impact on the local economy, to some extent mitigating the economic impact of job losses. However, the precise impact in each location will depend on the age profile, length of service and re-employment rates which will determine what proportion of redundancy payments are spent in the local economy, invested in savings, property or spent on travel overseas.

Table 7: **Summary of public sector costs and benefits**

Option/item	Short-term public costs & benefits (£m)	Continuing public costs/benefits per annum (£m)	Total over the 7 year contract period
In-house option			
Cost of temporary unemployment including Job Seekers Allowance, housing benefit and council tax benefit (additional £0.12m if local economy job losses taken into account)	-0.57	N/a	-0.57
Loss of Income Tax	-0.18	N/a	-0.18
Loss of Employee & Employer National Insurance contributions	-0.30	N/a	-0.30
Total	**-1.05**	N/a	**-1.05**
Outsource/offshore option			
Cost of temporary unemployment including Job Seekers Allowance, housing benefit and council tax benefit	-1.01	N/a	-1.01
Loss of Income Tax – loss based on 700 FTE offshored	-0.31	-1.25	-9.06
Loss of Employee and Employer National Insurance contributions – loss based on 700 FTE offshored	-0.54	-1.58	-11.60
Corporation Tax (+ £0.6m per annum if onshore)	N/a	+0.15	+1.05
VAT (+ £0.75 per annum if onshore)	N/a	+0.18	+1.40
Total	**-1.86**	**-2.50**	**-19.22**

Source: Appendix 2

If the public costs of the job losses in the local economy occurring as a direct result of PPD changes in staffing levels are taken into account, the additional cost for the in-house option will be a one-off cost of £263,000 (Job Seekers Allowance, loss of income tax and National Insurance contributions) and £464,000 for the outsource/offshore option.

Table 8: **Value for Money Quantitative Assessment of options**

Value for Money Quantitative Assessment		
	In-house	**Outsource**
Lifecycle costs	Not applicable	Not applicable
Transaction costs	Many transaction costs would be avoided in this option and could be used instead to improve capability to meet targets - amendments to financial model required.	Procurement and transaction costs potentially under-estimated – adjustments required to financial model.
Third party income	Possible but disregard given only 7-year contract and priority focus on PPD service delivery.	Possible but disregard given only 7-year contract and priority focus on PPD service delivery.
Flexibility	Taken into account in Options Appraisal evaluation criteria	Taken into account in Options Appraisal evaluation criteria
Indirect VfM factors Externalities	Taken into account in Options Appraisal evaluation criteria	Taken into account in Options Appraisal evaluation criteria
Non-market impacts	Taken into account in Options Appraisal evaluation criteria	Taken into account in Options Appraisal evaluation criteria
Tax and public costs and benefits	One-off social costs of £1.05m (see Table 10)	Loss of public sector income of £19.22m over 7 years if offshored. Potential income of £9.45m over 7 years if outsourced in Britain (see Table 10)

Source: HM Treasury, 2004.

Optimism bias

Options appraisal requires making judgements based on evidence and experience. There is a tendency for appraisals to be overly optimistic about the achievement of targets, costs and benefits and the wider impact of policies and projects. This tendency is frequently evident in both public and private sector options. However, in the PPD options appraisal the evidence of optimum bias is evident in the outsource/offshore model.

There is an evidence base to assess optimum bias in capital projects but there is significantly less evidence for outsourcing projects (HM Treasury, 2004).

Optimum bias in evident in:

PPD project definition – assumption that PPD is a transactional service but this ignores the IT development component of either developing and implementing CIP and the data analysis and information service which are core PPD activities.

Contractor capabilities – the ability of private contractors to deliver the project objectives is overstated. Evidence of IT and outsourcing contracts which have resulted in delays, cost overruns and contract terminations is ignored. A more balanced view is required.

Project impact – the options appraisal does not fully assess the impact of options on the PPDs contribution and role in the wider NHS system, nor does it assess the wider social and economic costs thus leading to an understatement of the impact of options.

Financial – there are number of areas where optimism bias is evident. The options appraisal did not examine the costs likely to be borne by other public sector bodies and the government and underestimates transactional costs.

External political influence – the security and political issues associated with the proposal to offshore PPD functions have not been fully taken into account. Ethical concerns of offshoring.

Inadequacy of the Business Case – the incomplete risk assessment (failure to assess the risks of offshoring), the incomplete value for money assessment, the failure to identify the potential transaction costs, means that the Business Case is incomplete.

Part 5
Risk assessment

Introduction

The PPD/KPMG options appraisal is fundamentally flawed because it assess risk only for the in-house, optimised and outsource, on-shore options. “We have taken the on-shore variant as being representative of the various outsourcing alternatives” (para 5.2, page 25). But the risks associated with offshoring are different and significantly greater than an outsource/onshore option.

This section examines:

- Offshoring and global sourcing
- Employment Risk Matrix
- Risk Matrix

Offshoring and global sourcing

The PPD/KPMG evaluation did not assess the additional risks of offshoring. It presented the risks only in relation to an outsourcing option which were compared to those of the in-house optimisation model. Yet the PPD/KPMG report recommends an outsource/offshore model.

It is therefore essential that the risks of offshoring are included in the options appraisal.

The risks of offshoring, in addition to those of outsourcing, are substantial:

- concern over patient confidentiality and security.
- quality of service.
- loss of continuity of service during and after transition as a new workforce is employed.
- loss of business knowledge from the workforce.
- viability of providers.
- hidden costs.
- contractual disputes and difficulties and increased costs of contract management.
- loss of organisational competencies.
- fraud monitoring is more complex.
- difficulty in ensuring compliance with NHS corporate policies.
- difficulty of establishing high levels of dialogue with service users as a result of cultural difference and skills.
- the risk of stakeholder backlash.

Additional costs of offshoring

The case for offshoring is usually centred on a comparison of wage rates between Britain and India or China but this is simplistic and masks the full costs. In addition to the costs of procurement, the cost of transition which could include training, investment in software/hardware and testing systems; the cost of making some staff redundant in

Britain; the cultural cost – differences in productivity, staff turnover and language difficulties; and the cost managing an offshore contract including invoicing and auditing should be taken into account (CIO.com).

Employment Risk Matrix

Outsourcing via a transfer of staff effectively means that the NHSBSA is transferring a series of risks to their existing staff. TUPE transfers and the Best Value Code of Practice on Workforce Matters do not provide any guarantees. Pensions are not covered by TUPE. There is considerable change occurring in the pensions sector with private sector employers replacing final salary with money purchase schemes and a growing number of under-funded pension schemes.

There are basically three employment models:

1) In-house or secondment in which staff remain employed by the NHSBSA.
2) Transfer to a new employer under the TUPE regulations
3) A 'choice' model promoted by some private contractors which is a mix of secondment and transfer.

The European Services Strategy Unit has devised an Employment Risk Matrix which assesses the degree of changes in four categories of risk:

- Risk of changes to terms and conditions of service.
- Pensions arrangements (not covered by TUPE regulations).
- Risk of changes to staff consultation and representation.
- Risk of problems with secondment agreement.

The Employment Risk Matrix shows that 100% of the risks for the secondment model are in the none/low risk category compared to only 20% in the transfer model and 16% in the 'choice' model – see Table 9. The transfer model has 40% of the risk for employees in both the high and medium risk categories.

Table 9: **Summary of Employment risk**

Risk level	In-house/Secondment		Transfer		'Choice'	
	Number	%	Number	%	Number	%
None	9	36	3	12	0	0
Low	16	64	2	8	4	16
Medium	-	-	10	40	17	68
High	-	-	10	40	4	16
Total	25	100	25	100	25	100

European Services Strategy Unit, 2006.

The overall effect of the 'choice' model will depend on the proportion of staff that second and transfer and how this changes over the length of a contract. Private contractors expect the proportion of secondments to reduce considerably or to zero as the contract proceeds. This would mean that the in later part of a contract the risk profile in the 'choice' model would change and become similar to the transfer risk profile.

Risk matrix

The risk assessment below combines a risk analysis of outsourcing onshore and offshore. It uses the risk rating system was used by PPD/KPMG - see Table 10.

Table 10: **Risk rating used in the risk assessment**

Likelihood			Consequence		
5	Almost certain	Event likely to occur on a regular basis	5	Catastrophic	Service interrupted for several months
4	Likely	> 30% chance of occurrence in any given year	4	Critical	Service disruption for 1 month / adverse publicity/ remediation costs >£5m
3	Moderate	Event has occurred in similar projects, approx 30% chance of occurrence during time horizon of sourcing	3	Significant	Service problems (e.g. late payment of less than 1 month) / remediation costs £2m-£5m
2	Unlikely	Event has occurred in similar projects, approx 10% chance of occurrence during time horizon of sourcing	2	Moderate	Service problems experienced do not impact external stakeholders. Management attention required / Remediation costs <£2m
1	Rare	Event has not occurred on a similar project to our knowledge	1	Low	Problems experienced, no impact on external stakeholders / no remediation costs

Source: KPMG, 2006.

A 'significant' consequence of in the high end of the £2m - £5m range or a 'critical' consequence of over £5m would virtually eliminate the savings for 2008/09 and would account for over 50% of planned savings in future years.

Basis of risk assessment

The risk assessment in Table 13 is based on the two options. Whereas the PPD/KPMG report only assesses the risks associated with the outsource/onshore option, this report assesses the risk of the offshoring option.

The Risk Matrix combines the analysis of risks associated with the two options with a risk rating obtained by multiplying the Likelihood and Impact scores. It is based on the risk assessment of the two options in the PPD/KPMG report but the assessment and scores have been adjusted to take account of offshoring.

The first number is the likelihood and the second number is the impact score in Table 11. This is a summary of the Matrix from the full report submitted by UNISON to the PPD.

Table 11: **Risk Assessment Matrix**

Risks	In-house option	R	Outsourcing option	R
1. Quality of services delivered is not maintained at the required levels	The in-house organisation has a track record of delivering a high quality service. There is no reason to assume that this would change.	1 x 3 = 3	Even with comprehensive contract significant service impacts and remediation costs may occur if the service provided encounters long term difficulty in meeting service levels.	3 x 3 = 9
2. Contractor is unable or unwilling to continue services due to bankruptcy or other event	The likelihood is of an in-house delivery organisation being unable or unwilling to continue service is considered to be very low.	1 x 3 = 3	Contractor could "walk away" from the contract, for example because it becomes unprofitable, or contractor fails due to bankruptcy.	2 x 5 = 10
3. Preferred option is not politically acceptable	In-house delivery of services is very unlikely to be considered politically unacceptable.	1 x 4 = 4	At present, outsourcing may be politically acceptable provided that it can be justified on value-for-money grounds But could be critical if the current position changed.	2 x 4 = 8
4. The political agenda changes	Unlikely during transition as not an election year, and no known	2 x 3 =	Opposition to offshoring could be significant. Evidence of	3 x 3 =

	agenda to change this.	6	growing opposition by service users. UNISON is committed to opposing any transfer of jobs overseas.	9
5. Contractor fails to deliver the solution	Given the scale of the change required, the likelihood of failure to deliver in house is considered to be moderate due to past failures, for example, delays to CIP programme.	3 x 4 = 12	Moderate for onshore but more significant risk if offshore.	3 x 4 = 12
6. The cost savings of the programme are not realised	There is a strong likelihood of not delivering the savings in house.	4 x 3 = 12	This is a risk because there is a possibility that: a). procurement does not result in effective bids and b). supplier cannot deliver on promises.	3 x 4 = 12
7. Business continuity is not maintained during the transition	The likelihood of business continuity being interrupted by factors such as staff losses, problems with handing over developments is low under an in-house option because the majority of these factors are under direct management control.	1 x 3 = 3	The likelihood of business continuity being interrupted by factors such as staff losses, problems with handing over developments is higher than for the in-house option due to the involvement of a third party.	2 x 3 = 6
8. Business requirements not defined or expressed accurately and clearly	Due to the fact that business requirements documents do not form part of a formal commercial arrangement, there is a moderate likelihood that some requirements are tacit or inaccurate.	2 x 3 = 6	Relies heavily on specification and contract documentation and contract management. This is a complex task that has not been undertaken before by PPD.	3 x 4 = 12
9. Reputation of the BSA is adversely impacted by activities of the contractor	Under the in-house option, the NHSBSA has a greater degree of control over the activities of the service delivery organisation and its staff, and this risk is unlikely to occur.	1 x 3 = 3	This could be due, for example, to a supplier paying low wage rates to staff working on another client, resulting in “guilt by association”, bad press etc.	2 x 3 = 6
10. CIP is delayed and /or the planned CIP benefits fail to be realised	PPD management have expressed 80% confidence in delivery of CIP according to the existing plan.	3 x 3 = 9	The risks associated with CIP delivery are increased by introducing a third party into the equation.	4 x 4 = 16
11. Poorly managed contract with contractor	The likelihood is assessed as Unlikely because there is a track record of managing existing delivery, however, the impact of a failure to manage delivery could be significant.	2 x 3 = 6	There is an increased risk in using a third party, particularly one based primarily based offshore.	3 x 3 = 9
12. Staff support is lost or not achieved	The risk under the in-house option relates to lack of motivation and staff turnover if significant redundancies are required.	2 x 3 = 6	This is more likely in an outsource scenario because it introduces significant additional change over and above CIP.	3 x 3 = 9
13. Key business knowledge is lost in the long term	Unlikely on the basis that required posts are not being transferred, however, there is some risk that a programme of voluntary redundancy may result in some unanticipated skills leakage..	2 x 3 = 6	It is more difficult to retain and rebuild knowledge if large sections of the organisation have been outsourced.	3 x 4 = 12
14. Ability to exit the selected option may be limited/PPD may be locked into an unfavourable contract or inappropriate solution	This is not an issue under the in-house option as PPD can simply decide to change the model at a later date.	1 x1 = 1	There is a risk of being locked into an unfavourable / unsuitable solution.	2 x 4 = 8
15. Unanticipated	There is a risk from	2 x	There is a risk that	2 x

business changes invalidate key assumptions	unanticipated events (e.g. a sudden and massive increase in volume resulting from a policy change). This is considered unlikely.	3 = 6	unanticipated events (e.g. a sudden and massive increase in volume resulting from a policy change). This is considered unlikely, however, if it did occur, the impact could potentially be critical if it resulted in major contract change control (e.g. if volume bands were breached or major functional changes were required).	4 = 8
Total risk rating		**86**		**146**

The risk analysis in the PPD/KPMG report concludes that the in-house option has a total score of 103.50 compared with the outsource/onshore score of 129. In other words, the outsource/onshore option has 25% higher risk than the in-house option.

However, when the risks of offshoring are taken into account and the likelihood of some of the criteria occurring with the in-house option have been reduced the risk rating of the in-house option is 86 compared to 146 for the outsource/offshore option ie the latter has a 70% higher level of risk.

Conclusion

The Prescription Pricing Division's Business Plan 2006/07 refers to the NHSBSA mission of providing best-in-class services and the delivery of efficiencies which can be re-invested in frontline patient care.

> *"where there is a tangible business case for doing so, taking maximum benefit from the appropriate extension and/or introduction of private sector providers by adopting a NHSBSA business model of commissioning, procuring and performance managing the delivery of its relevant services, whilst retaining overall accountability for performance to its key clients and users;"*

The options appraisal and risk assessment shows conclusively that there is not a business case for outsourcing PPD functions.

Part 6
PPD Performance

Introduction

The PPD has a strong record in quality performance and meeting targets. This section summarises this track record and other achievements.

PPD performance track record

PPD performance must be considered in the context of the constant increase in the volume of prescriptions and additional responsibilities and functions:

- Growth in the number of prescriptions issued of 6% per annum.
- New responsibilities for pre-payment, medical and maternity exemptions for prescription charges (October 2003), Tax Credit Exemptions (April 2003), Help with Health Costs (April 2004) and the European Health Insurance Card (September 2004).
- The impact of government legislation, plans and inquiries such as the Health and Social Care Act 2002, Shipman Inquiry 2003, Lyons Review 2004, Gershon Review 2004 and the DH Arms Length Bodies Review 2004.

Cost improvements

PPA/PPD has achieved substantial reductions in unit costs:

- In February 2006 the Board heard that the cost of processing prescriptions improved by over 7% on the previous year with a cumulative cost of £38.96 per thousand prescriptions.
- The processing cost per 1,000 prescriptions was £53.95 in 2005/06, a 2% improvement on the previous year (Reported to PPA Board, March 2006).
- A 40% cost reduction had been achieved over the previous five years – prior to 2001 staff costs were about £69 per thousand prescriptions.
- In April 2006 the chief executive informed the NHSBSA Board that all of the PPD's KPIs and business objectives had been met or exceeded. In May 2006 the chief executive reported that all targets continued to be met in PPD.

EHIC project award

The EHIC won the Government to Citizen category in the BT Government Computing Awards 2006, from over 150 other projects. The DH Head of Information Services recommended EHIC to the Cabinet Office as one of two successful IT projects which help the public. The National Audit Office is using EHIC as an example of a successful government IT initiative.

ISO accreditation

The PPD has been awarded the International Quality Accreditation of ISO 9002.

Table 12 summarises PPA/PPD performance between 2002/03 and 2005/06 using the main volume performance measures. It shows that 26 of the 28 targets were exceeded in this period. Only two were not and in one case (to assess 97% of LIS claims accurately – cumulative yearly target) the target was met the following year. In the second case (to assess 97% of certificate applications accurately) information for the following year's performance is not currently available.

Table 12: **Summary of PPD performance 2002/03 to 2005/06**

Volume Performance Measures	2002/03	2003/04	2004/05	2005/06
Accuracy to be at least 99.8% net	99.89	99.94	99.96	99.91**
Achieve 99.7% accuracy in amendments to the Drug Tariff (monitored quarterly) Discontinued.	99.76	-	-	-
To assess 93% of claims accurately (cumulative yearly target) - 97% of LIS claims accurately from 2004/05	95.51 -	95.61 -	- 95.4	- 97.5*
Clear 98% of all complete claims within 15 working days of receipt - 99% from 2004/05	99.63	99.93	99.94	99.9*
Clear 97.5% of resubmitted claims within 5 working days - 99% from 2004/05	99.91	99.99	99.9	100
Clear 97.5% of miscellaneous items within 5 working days - 99% from 2004/05	99.9	99.56	99.66	99.4*
Certificate applications are processed and dispatched within 21 working days (from 03/04) - 99% of certificate applications within 5 working days from 2004/05	n/a	100.00	99.94	100*
Assess 95% of certificate applications accurately - 97% from 2004/05	n/a -	97.07 -	95.02	

PPA Performance Reports, PPA Annual Reports 2002/03, 2003/04/ 2004/05 and 2005/06, Handover Report on the Activities of the Prescription Pricing Authority 2005/06, 2006. * 11 month period. ** 10 month period.

Part 7
Insourcing trend gathers pace

Introduction

This section examines the recent trend towards insourcing service delivery in both the public and private sectors. It focuses on:

- Private sector insourcing examples
- Local authorities which have insourced very large ICT projects instead of outsourcing to a Strategic Service-delivery Partnership with the private sector.
- A summary of recent ICT sector surveys

Private sector insourcing

Sainsbury's Supermarkets

Completed insourcing of 470 ICT staff in May 2006 from Accenture. The £1.7bn contract with Accenture was terminated in October 2005 with five years remaining. A Sainsbury company statement stated: "Sainsbury's will take an exceptional item of circa £65m as a result of the termination. As a result of future cost savings, the exit costs are expected to pay back in less than two years" (reported in Computer Weekly, 9 May 2006). The decision to insource followed an operational review which found that the company could improve logistics and other operations if it regained direct control of its IT systems and staff.

JP Morgan (US bank)

The bank terminated a £2.8bn seven-year contract with IBM resulting in 4,000 staff returning to the company. The change came as a result of the merger with Bank One. The original contract was with Pinnacle Alliance, an outsourcing consortium comprising CSC, Accenture, AT&T Solutions and Bell Atlantic which was hailed as the largest outsourcing deal of its kind in 1996. It included data centres, desktops, networks and some corporate applications in the US and Europe. (Computer Weekly, 24 September 2004)

Prudential

Prudential terminated a five-year contract with Capgemini in 2005 following a benchmarking exercise to determine the level of service and value for money. Prudential had retained originally twenty percent of the datacentre work in-house. It decided to create a datacentre to insource the management of its mid-range systems and 90 staff returned to Prudential.

Richard Punt, head of strategy practice at consultant Deloitte, says more firms are considering their sourcing options. *'Many companies are realising they should not have done deals in the first place, and we will see companies insourcing IT on a regular basis,'* he said (Computing, 7 July 2005).

Centrica terminates Accenture contract

Centrica has moved its £400m transformation programme in-house from Accenture following delays. Launched in 2002, the programme was designed to consolidate separate gas and electricity accounts into one billing system but only a third had been transferred by spring 2006. *'We have transitioned the programme migration and support*

operations in-house, having developed the internal expertise,' said a Centrica spokeswoman (Computing, 4 May 2006).

Powergen terminates Indian call centres

In June 2006 Powergen announced that in future it will operate call centres solely in the UK following customer complaints of call centres based in India. *"…we believe that we can best achieve industry-leading customer service by operating solely in the UK"* stated Powergen's managing director Nick Horler (Channel Register, 16 June 2006). 450 jobs will be created by late 2006 (Personnel Today, 16 June 2006).

Spirit Group

After the group acquired Scottish and Newcastle Retail in November 2003 it decided to use the retail IT system to replace their own mainframe system and to insource at the same time. The head of IT concluded that:

- *"Having an in-house team ensures that high-quality, targeted development work can happen quickly.*
- *It allows the group to introduce customer offers quickly through fast analysis of trading patterns.*
- *It makes it possible to address the continual demands of flexible system enhancements more speedily and more cheaply." Jane Kimberlin, IT manager, Spirit Group* (Computer Weekly, 23 May 2006).

Cable and Wireless

Cable and Wireless terminated a £1.8 billion ten-year IT infrastructure and customer billing systems contract with IBM some five years early in 2003 and returned to in-house provision (Computing, 12 May 2005).

Selfridges

Decided not to renew a contract for data centre services with Capgemini in 2005 and instead brought the work in-house (Computing, 12 May 2005).

Britannia

The building society has decided to bring payroll and HR in-house from ICS. It will now use a SAP system to provide a three-year change programme to provide self-service HR for 4,500 employees. The HR manager was quoted as saying: *"We wanted to be able to develop applications quickly and have close control over them, as we have so many plans in this area. Our existing outsourcing arrangements were too static and did not give us the functionality we needed"* (Personnel Today, 1 June 2006).

RMC

RMC UK's cement division, part of one of the world's largest building materials and concrete suppliers, announced that it was bringing its multi-million pound logistics operation in-house from November 2004. Outsourced to TNT since 2000, the operation employed 380 staff. *"Going in-house will enable us to achieve better control, react more quickly and effectively in the marketplace, and also make cost savings,"* stated RMC's cement division's supply chain director Clive Oakley, (The Manufacturer, August 2005).

Public sector insourcing

In-house alternative to Strategic Service-Delivery Partnerships

Twenty-two Strategic Service-delivery Partnerships (SSPs) have been negotiated since 2000 of which three have been terminated by local authorities and another is being substantially reduced in scope with many services reverting to in-house provision. A further nine local authorities considered the SSP option, and in some cases reached the

preferred bidder stage in the procurement process, before deciding to adopt an in-house approach (see Table 13).

Table 13: **Local authorities which adopted in-house option instead of an SSP**

Local authorities which retained in-house provision	
Kent County Council	Terminated preferred bidder negotiations with HBS Business Services. Established in-house improvement strategy.
Northamptonshire County Council	Withdrew during procurement process from joint partnership with Milton Keynes Council.
Newcastle City Council	Awarded £200m to in-house service and rejected rival BT bid on grounds of value for money and quality of service improvements.
Barnsley MBC	Decided not to proceed with BT bid in May 2003 because first three year payments could not be guaranteed. Risk of frontline services being cut to meet contractually-binding investment requirements.
Salford City Council	Decided against SSP approach for corporate services and did not commence procurement.
Walsall MBC	£650m project requiring transfer of 1,500 staff to Fujitsu Services abandoned in January 2006 at the preferred bidder stage. Planned to create 750 new jobs. Council said "strong service improvements" achieved by the local authority in the past few years, felt that "it is now better placed to meet the needs of local people without the joint venture."
Wakefield MBC	Decided not to pursue a SSP after research of Liverpool, Newcastle and Middlesbrough. The former Chief Executive from Middlesbrough joined Wakefield and made the case that the market had moved on and that Middlesbrough was able to secure a 'golden deal' at the time but given Wakefield's healthy financial reserves a mixed economy approach would be more effective.
Dacorum District Council	Withdrew from preferred bidder negotiations.
Isle of Wight Council	Decided to adopt an internal strategic transformational approach drawing on private expertise instead of outsourcing to a strategic partner.

Source: European Services Strategy Unit, 2006.

SSP failures

The failed SSP contracts are summarised in Table 14.

Table 14: **Failed SSP partnerships**

Failed Strategic Service-Delivery partnerships in local government	
Bedfordshire County Council	Terminated £265m contract with HBS Business Services in 2005 after failure to achieve key deliverables and poor performance.
West Berkshire Council	Terminated £168m contract with Amey Group in 2005.
Redcar & Cleveland Council	Following a 'strategic review of services' HR and Payroll, Finance and Accounting, ICT, Public Access and Business support will be brought back in-house by September 2006 after only 3 years of the 10 year contract.
London Borough of Southwark	Education Services £100m contract with WS Atkins terminated because of poor performance.

Source: European Services Strategy Unit, 2006

Network Rail

Railtrack originally split the rail network into 20 maintenance contract areas which were awarded to seven firms – Amey, Carillion Rail, First Engineering, Balfour Beatty, Amec, Jarvis and Serco. In October 2003 Network Rail made a strategic decision to terminate

all contracts and to return all maintenance work in-house following the earlier agreement to takeover Amey's Reading contract in January 2003 (Network Rail, 2003). By July 2004 some 16,000 maintenance staff, over 5,000 road vehicles, 600 depots and a network of 11 training centres had been transferred to create a single rail maintenance operation. Network Rail achieved significant improvements in performance with the new in-house operation, for example reducing delays in Thames Valley, Wessex and East Midlands by 21%, 20% and 22% respectively (Network Rail, 2004).

The insourcing of maintenance and the subsequent restructuring has resulted in a reduction of more than 1,000 indirect staff, managers and supervisors, and has delivered cost savings of around £100 million per annum.

> *"We came to the conclusion this was a flawed concept," says David Carrier, Network Rail's head of competence and training management, describing maintenance of the 21,000 miles of track as a 'key enabler' of effective running of the railway, in much the same way as clean hospitals are critical to the NHS. To outsource such an enabler to a "third party who doesn't share your core business proposition" just didn't make sense*. (our emphasis, Training magazine, Personnel Today, 1 February, 2005).

Recent ICT surveys

A number of recent surveys and statements substantiate the case for insourcing:

- IT analysts Gartner report that four out of five outsourcing contracts are renegotiated over the duration of the contract (Computing).
- Some 64% of firms have already brought an outsourced service back in-house according to Deloitte (Computing).
- Another survey of 188 firms by Gartner in 2006 revealed that 24% were considering bringing outsourced services back in-house (Computing, 20 April 2006).
- A survey of over 300 organisations by PA Consulting (including IT service providers and legal advisers) found that over half *"struggled to realise the expected benefits from IT outsourcing"* (IT Week, 23 May 2006).
- An outsourcing survey by Deloitte in 2005 revealed that cost savings were the main reason why 70% of organisations outsourced IT and business processes. However, it found that 44% failed to save any money. Nearly half those surveyed cited hidden costs as the most common problem (Insourcing – why is it happening? FSN, 17 July 2006).
- *"In fact, 17% to 19% of all outsourcing contracts (change suppliers)"* Robert Morgan, Morgan Chambers, outsourcing consultancy (Computer Weekly, 24 September 2004).
- The problems with outsourcing are *"caused by the immaturity of the organisation's sourcing practices rather than being the fault of the service provider. Organisations learn too late that managing external services requires vastly different competencies than managing the same, internally provided services"* (Linda Cohen, Vice President, Gartner quoted in Computer Weekly, 9 November 2005).
- A survey of ICT managers reported that 56% claimed that outsourced IT work was inferior to in-house provision and 11% stated that outsourcing led to a setback in the firm's production (Software Development Magazine, January 2004).

Security breaches

HSBC: £233,000 stolen from UK customers at offshore data processing centre in Bangalore, India (IT Week, 28 June 2006.

Citibank: attempt by three workers to steal $350,000 from accounts (vnunet.com 13 September 2005)

India: In June 2005 a call centre worker was arrested after selling the account details of 1,000 customers of a UK bank to an undercover reported from The Sun. accounts (vnunet.com 13 September 2005)

Terrorist attack: Firms using Indian IT centres were advised to upgrade their security following a suspected terrorist attack on the Indian Institute of Science in Banagalore in December 2005. One person was killed and four people were injured in what was thought to be an attack on the centre of Western companies IT interests in India.

Advantages of insourcing

Benefits to PPD and NHSBSA

- Directly link investment to achievements and needs. In other words tie investment to the PPD's specific needs as and when it is required rather than a pre-determined programme of work.
- Choose best in class - the PPD will be able to acquire the best available hardware, software, training and business process re-engineering advice. This will enable the PPD to select the right partner for each issue or project, rather than being restricted to the input of one organisation.
- Take advantage of technological change, new software products.
- Build internal capacity, retain and attract new staff as the PPD will be developing and implementing projects rather than simply operating as a client monitoring the activities of a private contractor. It needs to retain and increase the PPD's 'intellectual capital'.
- Maximising choice and flexibility - the in-house bid avoids the constraints of relying on a single contractor for the next decade.
- Better value for money: Several public sector organisations have demonstrated that they can harness savings from business process reengineering more effectively than the private sector.
- Allows the continued development and enhancement of a public service ethos in the planning, design and delivery of PPD services.
- There will be no requirement to negotiate with a legally separate third party in order to implement PPD and NHSBSA policies.
- Maintenance of direct democratic accountability and a higher degree of transparency in the delivery of the service.
- Maintaining and building trust – an insourcing or public-public collaboration option is better placed to enhance service user trust in PPD services and to meet community preferences.
- Increases capacity and intellectual knowledge through skills transfer.
- Draw on best practice from public and private sectors.
- Reduced risk because of procuring 'best in class' rather than reliance on one contractor.

- Flexibility to set targets and priorities.
- Support for sustainable development and supply chain policies.

Financial benefits

- Link investment to affordability and timed to meet the resources of the NHSBSA.
- The same investment at lower cost: The ability to fund the necessary investment without the overheads and restrictions of third-party processes is a key advantage.
- Investment can be financed through a variety of means including savings from service improvements, prudential borrowing, leasing, and new government projects likely to be launched over the next decade.
- Better to exploit external sources of finance instead of being committed to regular large payments to a contractor.
- Avoids high procurement and transaction costs

Employment benefits

- Fewer job losses will be incurred with an in-house option compared to outsourcing.
- There is likely to be greater cooperation of staff and trade unions.

Part 8
Why PPD must retain in-house service provision

Introduction

The case for retaining in-house service delivery in PPD is substantive. This has been set out under the following headings:

- Quality and accuracy
- Capacity and intellectual capital
- Customer responsiveness
- Cost effectiveness
- Protecting the public interest
- Contribution to the NHS whole system
- Corporate policies
- Control and accountability
- Quality employment

Quality and accuracy

High level of accuracy

A high level of accuracy is vitally important for customers with minimum expenditure on verification and monitoring. The in-house PPD service has consistently met targets as detailed in Part 6.

Continuity and security

Continuity of service and knowledge of local requirements and conditions are important parts of service delivery. In-house provision provides longer-term security of provision.

Quality

Properly resourced in-house services can provide a higher standard of service, and are more responsive and flexible to changing needs and circumstances.

Coordination of services and functions

Service delivery, social inclusion, community well-being strategies, regeneration, and economic development increasingly require a multidisciplinary, coordinated approach. This requires integrated teams, the pooling of skills, experience and resources between directorates and organisations in networks, partnerships, alliances and coalitions with the public sector playing a central role. It requires joined-up government, not quasi joined-up contracts. The objective is to achieve the vertical and horizontal integration of a democratically accountable and complex range of services.

Continuous service improvement

Recent research has demonstrated that improved performance and productivity requires five key elements – engaging and motivating staff, meeting service users needs, promoting creativity and innovation, keeping stakeholders involved and informed, and increasing shareholder value (improving community well being in public services) – being

managed and coordinated. Contracts fragment service delivery, replicating the very 'silos' which modernisation is supposed to be eliminating.

Integration of strategic policy and service delivery

Identifying, assessing and prioritising social needs, as well as planning and allocating resources and operational management, are integral to the quality of service. Close working between client and contractor is essential to improve services and ensure that they address social needs.

Enhancing a public service ethos and values

In-house service delivery enables a public body to retain and enhance a public service ethos.

Innovation

The Capacity Improvement Programme (CIP) is a good example of public sector innovation. Development is designed to specifically meet user needs and PPD objectives.

Flexibility

The PPD desires flexibility, which is the capacity to increase and decrease scale of production rapidly. This is not easy to reconcile with a "lean" and low cost operation unless the private company has multiple clients across whom they can balance demand. But that, in turn makes it less likely that they can function as a dedicated captive unit for the PPD that is highly responsive to the unique requirements of the PPD.

Capacity and intellectual capital

Public sector intellectual capital

It is essential that public bodies retain ownership and control of the public sector's intellectual capital – the knowledge and information about the infrastructure, geography, and rationale of services and how they work. Once the private sector gains ownership of this intellectual capital it is then in a position to recharge public bodies to gain access to this knowledge.

Enhancing public sector capacity and skills

It is also essential that public bodies retain the capacity to critically examine the potential impact of government, EU and business policies from a public service and local economy perspective.

Private sector ability overstated

The ability and capacity of the private sector to deliver quality public services is frequently overstated. This is starkly evident in private sector delivery of public sector IT and related services contracts - see Appendix 1. In contrast, the public sector's knowledge of the complexity of services and the needs of stakeholders is often understated.

Customer responsiveness

In-house provision helps to retain skills and experience which enables the authority to respond to changing demands and circumstances and to emergencies.

Cost effectiveness

Value for money

A full cost comparison, which takes account of all client and commissioning costs, contract management, the cost of variation orders over the length of the contract (for

additional work or changes to the contract) and other costs borne by the public sector, plus comparable employment costs, will usually demonstrate that in-house services can provide services at lower or equal cost. Budget holders often claim a 'saving', but this is usually absorbed by transaction costs borne by other departments or parts of the public sector.

Efficiency and effectiveness

At its best, public provision is equal to, or more, efficient and effective than private or voluntary sector provision. Efficiency is a means to an end, it is not an end itself and must therefore always be discussed in connection with effectiveness.

Economies of scale

An integrated service is usually less expensive than one where services and functions are divided between organisations and contracts.

Avoidance of transaction costs

In-house provision avoids all the transaction costs incurred in the procurement and contracting process, which are additional to the cost of the service. They include the cost of advertising, consultants and legal and technical advisers, market soundings, preparation of contract documentation, evaluation of bids and contract management, which usually adds between 3% and 5% to the service budget.

Cost transparency

The true cost of in-house services can be more readily assessed than those of private or voluntary providers, who use commercial confidentiality to avoid disclosure. The full costs are usually obscured by the frequent use of the contract variation order system.

Protecting the public interest

Minimising fraud and corruption

Procurement and commissioning (the contracting system) can lead to 'collusion' between client officers and private firms who place the needs of the procurement system over social and community needs. The greater the involvement of private firms in the delivery of public services, the more likely there will be corruption and collusion, particularly as contracts get larger and longer-term.

Contribution to the NHS whole system perspective

Integration with NHS IT systems

Integrate and ensure required level of compatibility with IT systems being developed by the NHS national programme.

Ability to meet NHS stakeholder needs and contribute to health strategies

The in-house service has demonstrated that it can meet the needs of pharmacists, doctors and others by providing good quality and accurate payment service, by continually improving the quality of health information available to a wide range of stakeholders, and providing the NHS with regular drug expenditure data which can be used to control expenditure.

Ability to implement NHS sustainable development policies

The achievement of sustainability objectives requires the vertical and horizontal integration of local and regional economic development policies and their implementation. This includes maximising the direct and indirect benefits from building and consolidating local and regional production and supply chains and minimising negative impacts on the environment. The alignment of strategic

policy and implementation can only be fully achieved by direct provision. In-house providers are more committed to creating and maintaining local and regional supply chains which support the local economy.

Ability to implement NHS Corporate Social Responsibility: Social, Environmental, Local economy and community well being

In-house services have a better track record in preventing environmental damage and in taking initiatives to safeguard and enhance natural resources.

Improving public health

The health and safety record at work and in the community are central concerns of in-house services which operate to minimise pollution, improve standards of hygiene and cleanliness, control diseases, and improve community well-being.

Corporate policies

Implementation of corporate policies and priorities

Policies on sustainable development, employment, social justice and community well-being are more effectively implemented directly through in-house services. The private sector's 'corporate social responsibility' falls well short of this and is more often in name only.

Ownership of assets

It should be the rule, not the exception, that public assets such as land, buildings, vehicles and equipment be retained within the public sector (unless there are compelling reasons based on community well-being criteria, or as a part of a strategy to secure the longer term future of public services, for their sale to the private or voluntary sector at full market value).

Eliminating service inequalities

In-house provision is more committed to improving access, participation in the planning and design of services, and to taking mitigating action to eliminate or reduce adverse impact.

Control and accountability

Control and accountability of service delivery

Outsourcing imposes contractual relations between a public body and a private contractor, thus reducing democratic control and accountability. This is further reduced when services are offshored, usually to Asia and Eastern Europe.

Participation of staff and stakeholders

In-house service delivery provides the best circumstances by which stakeholders can be engaged to influence service delivery and longer term improvement. This is most effective when there is direct dialogue between the provider and stakeholders. Outsourcing makes this more complex with at least three participants (client, contractor and stakeholders) and often more if consultants are used to mediate between client and contractor interests.

Quality employment

Quality service/employment relationship

The quality of service is best achieved when the quality of employment is also a key objective combining terms and conditions of service and pension scheme together with staff and trade union involvement in the planning and design of services, and an effective industrial relations framework. In-house services are less likely to use a high level of

agency and temporary staff. A two-tier workforce is also much less likely to develop. The Treasury's value for money guidance states that "VfM should not be achieved at the expense of workers' terms and conditions" (HM Treasury, 2004, para 1.6).

Training and workforce development

The vast bulk of training in core public services such as education, health and housing is provided by local and central government, the NHS and other public bodies. The level and quality of training and provision for staff education and learning is usually significantly better than that provided by private contractors.

Staff and trade union involvement

The public sector has a much better record than private contractors for continuing and sustainable involvement of frontline staff and trade unions in the planning, design and operation of service delivery.

Industrial relations framework

Comprehensive structures between employers and staff and trade unions in the public sector for policy making, employment, health and safety, and grievance procedures provide a framework for service improvements and a qualitative working environment.

Trade union representation and organisation

Trade unions have an important role in working with management in workforce development

Family friendly policies

Public sector employers, whilst often not fully embracing the full scope of family friendly policies, have a much better track record of implementation than the private sector, which often pay lip service unless it is in their economic interest to do otherwise.

Promoting equalities and diversity

The commitment to, and implementation of, equality and diversity policies is more substantive in the public sector than with private contractors and consultants.

Part 9
Recommendations

UNISON strongly recommends that:

- The in-house option should be selected as the way forward for PPD.
- Review, and if necessary strengthen, project management capability to ensure CIP meets its targets.
- The PPD should explore with CFSMS the potential for extending current data mining services and current CFSMS investment plans to further develop the PPD information systems to benefit all NHS stakeholders.
- The PPD should explore with The Information Centre for health and social care opportunities for further development of the PPD information services and potential for use of the service infrastructure to deliver added value information services.
- The PPD, with the BSA, NHS and DH, should make a full assessment of the value of the information services and delivery infrastructure to the NHS. This would involve understanding the value of the PPD to costs and quality practices within primary care prescribing and to enhance a flexible and responsive approach to policy initiatives to the DH. It would place PPD costs within a full economic and social understanding of the value of the PPD in the NHS system.
- If a procurement process is commenced then an in-house bid should be prepared to ensure genuine value for money is obtained.
- If a procurement process is commenced then bidders should be required to include options for both secondment and TUPE Plus staff transfer employment models.

Procurement process

UNISON believes that the PPD/KPMG recommendation to proceed to procurement with an open market approach is poor public management practice. There is a very high risk that it could fail to meet PPD requirements. This approach would mean that the NHSBSA would rely on market forces and private contractors to shape and determine the future provision of PPD services. We believe that starting from a position of ‘what can the market do for PPD’ is fundamentally the wrong approach. If procurement is necessary, which we don’t believe it is, then it should be based on ‘whether suitably experienced and resourced private contractors can assist PPD meet its objectives in service delivery’.

The relative size and scope of a potential PPD contract means that the PPD and NHSBSA should be requesting private firms to bid on their terms having clearly worked out the parameters and requirements.

There is a danger that the PPD and KPMG make a false assumption that the private sector fully understands the scope of PPD requirements and can ‘slot’ these into their existing contracts and service centres. Evidence from strategic service delivery partnerships in local government indicates that the private sector often under-estimates the scope and nature of public service delivery.

PPD is not simply a traditional transactional services contract – it includes IT development and implementation of systems specifically designed to meet the high standards of PPD services.

The PPD/KPMG approach is wrong because:

- It has a very high risk of not meeting PPD requirements.
- Where public sector bodies have commenced procurement without establishing clear requirements and contract terms there have been problems and this approach runs against national procurement best practice.
- Initial advantages at the market sounding stage are often eroded as practical realities become apparent during later bidding and preferred bidder negotiations.
- An offshoring component gives licence to a very wide range of options with the focus being entirely on cost cutting and a narrow efficiency agenda.
- It makes the procurement process much more costly because a larger input from management consultants will be needed to evaluate the different options and bids, which will be more complex and difficult to verify. Furthermore, the procurement process is likely to take longer thus consuming more management time and potentially delaying the commencement of savings.
- Offshoring relies solely on exploiting differences in pay and conditions between Britain and developing countries.

Appendix 1

Private sector problems in delivery of public sector IT projects

This is a summary of problems encountered in private sector delivery of public sector ICT and related services projects. It is based on large outsourcing and PFI contracts but excludes strategic partnership and medium/small contracts.

Table 15: **Private sector problems in the delivery of public sector IT projects**

Government department or agency	Value of contract £m	Contractor	Contract terminations, problems cost increases and delays
Department of Work and Pensions	141	IBM, Seibel and Curam	Benefits Processing Replacement Programme to streamline benefits processing cancelled August 2006 after 3 years but never put into use despite being based on commercial off-the-shelf products
Department of Constitutional Affairs	146	Fujitsu	Libra information system now over three times original cost at £487m (August 2006) and long delays since 1998, Renegotiated in 2000
Child Support Agency	427	EDS	New IT system 'performed no better than its predecessor' (2006), systemic problems, over 40 internal audit reviews, CSA spent £91m on external advice, soaring costs. Viability and security of national system questioned – other countries developing local/regional systems.
NHS	5,000	BT, Accenture, Fujitsu, Computer Science Corporation EDS, I-soft, Cable & Wireless,	Spiralling costs – now £12.4 billion; 110 major incidents affected hospitals in last four months (Sept 2006); Accenture walked away from two of five major contracts in Sept 2006, with losses of about £240m; Main software supplier (IDX) sacked by BT and Fujitsu; CSC sacks digital imaging company Commedica; EDS email contract terminated, BT paid £159m extra for broadband.
Passport Agency	120	Siemens	Long delays and failures in 1999 cost Agency £13m. Online passport failure in 2006
Inland Revenue	1,033	EDS	Cost increased 135% in six years 1994-2000
Immigration and Nationality	100	Siemens	Soaring costs and delays. Home Office cancelled final phase and had to employ 600 additional staff to deal with backlog
National Savings	635	Siemens	Delays and did not reduce staff numbers in line with original plan
National Insurance	N/a	Accenture	£53m additional cost, thousands of underpayment of pensions and delays. Renegotiation of contract.
Court Service	25	EDS	Cost increases of 328% and delays

Lord Chancellors Department and Court Service	130	Liberata	£50m cost increase and delays in ARAMIS resource accounting project
Ministry of Defence	2,570	BAE Systems	Renegotiated submarine contract in 2003 increasing cost by £1bn – delays and failure of computer aided design
Department for the Environment, Food and Rural Affairs	34	Accenture	Cost increase to £54m (59%) and dispute over delays of Single Payment Scheme to farmers by Rural Payments Agency (2006)
Department for Transport			MOT Computerisation contract renegotiated in April and July 2005 – increased support by contractor and greater control over performance by VOSA.
Cabinet Office	83	ITNET	Data centre and hosting management service – terminated 2004 after just £5m expenditure.
Department for Education and Skills	269	Capita	Individual learning Account project started 2000, closed November 2001 after major security/fraud issues and £70m overspend.
Northern Ireland Civil Service	3.3	McDonnell Douglas Information Systems	After 9 years of problems and delays caused by deficiencies in software and contractual issues was terminated in May 2001. Unrealised savings were £6.1m
Department of Social Security and Post Office Counters	1,000	ICL	Benefit Payment Card cancelled after delays and technical problems and contractor's demand for increased prices (2000).
Cabinet Office	6.7	Compaq	Consultancy and IT asset purchases for Government Gateway terminated in 2000.
Department for Trade and Industry	0.75	n/a	Personnel records system contract terminated 1999.

Sources:

NHS patient records project 'not holed below the water line', Financial Times 29 September 2006; Major Incidents hit NHS national systems, Computer Weekly 19 September 2006; Was NAO report truly independent? Computer Weekly 19 September 2006; DWP shelves £140m benefits processing system, Computer Weekly 8 and 12 September, 2006; Bacon, R. and Pugh, J. (2006) Information Technology in the NHS: What Next? House of Commons, London; Child Support Agency – Implementation of the Child Support Reforms, HC 1174, Session 2007/06, June 2006; National Audit Office, Department of Health: National Programme for IT in the NHS, HC 1173, Session 2005/06, June 2006, London: Unanswered Questions on NHS IT, Computer Weekly, 26 June 2006; ZDNet News 15 March 2006 (BAE Systems); Cabinet Office IT Failures, Written Answers, 5 October 2005, Column 2772W and 2 February 2006 Column 667W; Department of Trade and Industry IT Projects, Written Answers 10 October 2005, Column 25W; Department of Work and Pensions (2005) Child Support reforms: The Views and Experiences of CSA Staff and New Clients, Research report No 232, A. Atkinson and S. McKay, University of Bristol; House of Commons Works and Pensions Committee, The Performance of the Child Support Agency, Vol 1, Second Report 2004/05, HC 44-1, January 2004; UK Computing Research Committee, Questions on NHS IT System, September 2004; National Audit Office (2003) PPP in Practice: National Savings and Investments' deal with Siemens Business Services, four years on, HC 626, May; National Audit Office (2002) Individual Learning Accounts, HC 1235, October; House of Commons Education and Skills Select Committee, Individual Learning Accounts, Third Report, May 2002; Justice Forum (2002) Privatising Justice: The impact of the Private Finance Initiative in the Criminal Justice System, Centre for Public Services; National Audit Office (2000) The Cancellation of the Benefits Payment Card Project; Northern Ireland Audit Office (2004) Civil Service Human Resource Management System: Cancellation of the Payroll Project; National Audit Office (1999) United Kingdom Passport Agency: The passport delays of summer 1999, HC 812, October;

Appendix 2
Calculation of the public costs of the outsource/offshore option

The loss of jobs through CIP and outsourcing/offshoring will result in staff redundancies and create unemployment. To what extent this creates long-term unemployment is questionable. Redundancies will take place in four regions – North East, North West, Yorkshire and Humber and West Midlands - with higher than average levels of unemployment, vacancies and Incapacity Benefit.

The Claimant Count (claimants as a percentage of the estimated total workforce) was 2.9% in the North East compared to 2.6% in the West Midlands, 2.3% in both the North West and Yorkshire and Humber in contrast to 2.2% for the UK (Spring Quarter 2005, Regional Trends 2006 Edition).

In July 2006 the UK unemployment rate had increased to 5.5%, a 0.8% increase in a year. The number of unemployed people increased by 280,000 over the year bringing the total to 1.70m. The average number of job vacancies in the three months to August 2006 was 608,800, a decrease of 7,400 over the year.

There are currently 2.7m people in the UK claiming Incapacity Benefit and the government has launched Pathways to Work programme to reduce this total by one million over the next ten years. The ratio of claimants as a percentage of the working population in the North East and North West are twice those in London and the south east. The IB claimant rate in Liverpool is 15% and Manchester is 13%. There are 945,000 claimants in the 25-44 age group in the four regions. The figures are important because they will have some impact on the rate at which redundant PPD staff can be re-employed. Only Yorkshire and Humberside created more jobs in the 1997-2005 period than the target reduction in IB numbers set for the 2005-15 period.

Assumptions in re-employment rates of PPD staff made redundant:

- 40% of staff obtain immediate re-employment
- 30% after 3 months
- 25% after 6 months
- 5% after 9 months

The weekly cost of Job Seekers Allowance is £57.45 from April 2006. Unemployed people can also claim income support (lone parents), housing benefit (average weekly payment £65.00 – Feb 06, National Statistics, 2006), council tax benefit (average weekly payment £13.00 – Feb 06, National Statistics, 2006). Assume that 25% of claimants also receive housing benefit and council tax benefit and 10% claimed an average income support of an average £50 for 15 weeks, then the additional cost will be £574,865 based on 947 FTE job losses and £1,013,755 based on 1,670 FTE job losses in the offshore option.

Corporation Tax

The financial model projects total outsourcing costs of £58.4m (reflecting transition costs) in 2009 and then £27.4m in 2010 reducing to £25.3m by 2015. The private sector is likely to seek a 10% profit margin. In the case of outsourcing in Britain the government could expect to receive income from corporation tax on profits. If the work is offshored than it is likely that the company will be liable for corporate taxation in the host country with no corporation tax payable in Britain.

The current corporation tax rate is 30% but there are differences between taxable and accounting profit, timing differences between taxable and accounting profit, and differences between accounting profit and cash flows which mean that the actual tax rate paid will be less than 30%. For the purposes of this study a 20% rate has been assumed with 75% of the operation and profits related to the offshore operation. Income from corporation tax, assuming both the contract and the company is profitable and based in Britain, the government could expect corporation tax proceeds of about £600,000 per annum (based on an average contract value of £30m over 7 years, 10% profit level and net 20% tax rate). This income would reduce to £150,000 per annum if the work were offshored.

VAT payments

If the work is outsourced in Britain, the government will gain the annual VAT payment of £1m because the service will be delivered by the private sector in place of the public sector which has VAT payments refunded.

The offshoring of PPD operations will result in a loss of VAT on non-staff costs since they are almost certain to be resourced locally. The financial model shows outsourced non-staff costs of £6,389,000 in 2009 rising to £7,864,000 in 2015. Assuming 90% of non-staff costs are subject to VAT at 17.5% and 75% of the costs are related to offshore operations, then VAT income will be £755,000 in 2009 rising to £930,000 by 2015. However, offshoring will reduce this gain by 75% to £180,000 per annum in 2009 rising to £232,500 in 2015.

Loss of Income tax

For the purposes of this analysis 10% of the 800 FTE are assumed to be in the mid point of Pay Band 1 with an average salary of £12,317, 80% in the mid point of Pay Band 2 with an average salary of £13,642, and 10% in the midpoint of Pay band 5 with an average salary of £21,984.

It is assumed that 40% of FTE are re-employed immediately with 30% being unemployed for 13 weeks, 25% for 26 weeks and 5% for 39 weeks. The calculations were based on a personal allowance of £5,035 for 2006/07, the first £2150 @ 10% tax rate and the remainder @ 22% tax rate. The loss of Income Tax related to unemployment for the insourcing option will be a one-off £178,550. The loss of Income Tax for the offshore option would be a one short-term cost of £314,865.

The annual loss of income tax as a result of permanently offshoring 700 FTE would be £1,253,000 based on the tax and pay assumptions above.

Loss of National Insurance Contributions

Employee and employer National Insurance contributions were calculated on the salaries noted above using a combined contribution of 15.75% of wages. The lost NI contributions relating to a period of unemployment based on the assumptions made above will be £305,000. This will rise to £538,000 for the offshore option based on 1,670 FTE job losses. The annual loss of NI contributions as a result of offshoring 700 FTE will be £1,582,000 per annum.

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