Opportunities for nurses in a private finance initiative

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The private finance initiative is part of the government’s building procurement policy, incorporating both public and private sectors. This article outlines the part nurses can play, as a clinical adviser, within a PFI project team and within particular aspects of the PFI process.

Nurses’ roles in healthcare have changed over the decades, as is demonstrated by the plethora of career opportunities such as nurse consultant posts and nurses becoming GPs’ business partners. Indeed, nurses are setting up their own private companies to provide NHS services (O’Dowd, 2006). Common themes throughout these roles include clinical entrepreneurialism, change leadership and healthcare modernisation.

However, nurses may be overlooking career opportunities within non-clinical settings. One example of this is within private finance initiative (PFI) schemes, the government’s building procurement policy, which incorporates both public and private sectors.

The concept of PFI is that, following a brief from an NHS trust, a facility is designed, developed and built within a set budget financed by a private sector consortium (Gittoes and Trim, 2005). Once built, the NHS trust rents the building and repays the finance over an agreed number of years (Wilson and Ridgway, 2006) with the consortium retaining a maintenance management responsibility.

The scheme usually has an NHS trust project team comprising design and clinical planning, construction, human resource and finance elements. This paper aims to describe the role nurses can play as a clinical adviser (CA) within a PFI project team.

Clinical output specifications

Output specifications describe how each service should work (Gittoes and Trim, 2005) and are the basis for design. The documents usually have a number of subsections (Table 1) and underpin the whole design, build, finance and operational stages.

While they can be written by any individual, output specifications should be developed on a departmental basis by clinicians who work in and understand the service. It is important to have input from services such as infection control and microbiology (Wilson and Ridgway, 2006).

The CA has an important role in developing output specifications, ensuring the correct format, language and content are used. Skills for this include:

- Facilitation – ensure the right people contribute;
- Guidance – help them to provide relevant material;
- Leadership;
- Knowledge of the PFI process.

Accuracy and attention to detail are vital as the private consortium uses the outcome specification to cost the project with regard to equipment, quality of materials and size of rooms, as well as to employ architects who use it to develop an initial design. It is also a negotiation tool for the trust during design reviews and can be used by the CA if there are any disputes about clinical requirements.

For example, the percentage of rooms to have ceiling-mounted hoists should be documented precisely as an increase may increase costs while a reduction would decrease them. Architectural drawings may not show suction within a bedhead service but, if this was documented in the output specification, the private consortium could not contest its inclusion and it would be provided within the project price rather than at an additional cost.

The CA’s role may be more important in developing some sections of the output specification than others. For example, the wording in ‘future clinical service development’ should allow for a flexible, adaptable and future-proofed departmental design to enable service development and change in practice.

Design development and review

The design review process (Table 2, p34) begins with a whole-site plan and ends with the detail of each room. Each stage of the review concludes with clinicians and the trust’s project clinical team agreeing the designs. This is called sign-off.

The list in Table 2 is not exhaustive and once the main hospital design has been agreed, the trust reviews other information such as the walls of each room, equipment and samples of materials such as the finishes for reception desks, flooring and wall buffers, to name but a few.
The CA’s role in the design review usually commences when the 1:500 scale drawings need developing. The aim at this stage is to agree departmental locations (adjacencies) within the build, for example that critical care is located adjacent to theatres, or podiatry with diabetes.

During development of the output specifications the CA may conduct a piece of work with clinicians or departments to find out who they work most closely with. This will help them establish which departments should be adjacent to each other horizontally (on the same floor) and vertically (on different floors), and whether this is essential or desirable.

This information is collated and analysed, resulting in a hospital plan showing all the departments in the building. The CA uses operational knowledge, understanding of models of care and clinical experience to develop this and assist in achieving a clinically functional design. This must meet the needs of clinical and non-clinical disciplines so the CA must be able to consult with all staff groups.

1:200 design reviews
Once the overall building design is agreed, architects develop departmental layouts by interpreting the output specifications. These designs are issued to the NHS trust and reviewed by appropriate clinicians. As Wilson and Ridgway (2006) identified, if trust staff are not involved at this stage it may result in an environment they had not wished for because architects may not always appreciate clinical essentials such as infection control.

The CA leads this review process, encouraging teamwork between the private consortium and clinicians to achieve room layouts that reflect not only the output specification but also clinical functionality. For example, an A&E department plan may include a staff base in sight of the most commonly used cubicles to aid observation. It may also be close to the resuscitation bay to enable communication and working between the two areas. In addition a corridor could be positioned next to the A&E reception area to provide rapid escape for the reception team if the need arose due to agitated or aggressive attendees.

This review process is completed in an agreed programme with stringent time constraints and it is the CA’s responsibility to ensure the programme achieves departmental sign-off. The 1:200 stage is dynamic because the design development process is not complete.

To ensure completion, some of the CA’s responsibilities/skills include:
- Knowledge: architects will use health building notes and other Department of Health guidance to design a department. Wilson and Ridgway (2006) give requirements such as the number of single and four-bed rooms within an acute build and the amount of clear space around beds to enable

### REFERENCES


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(2006)

Wilson, A.P.R., Ridgway, G.L.
Reducing hospital-acquired infection
by design: the new University for Flexibility.


REFERENCES


The clinicians will rely on the CA to interpret any of their requirements that the private consortium has not understood to ensure their understanding of the Disability Discrimination Act, facilities and mortuary services. The CA must understand and be able to reference the relevant department’s health building notes guidance and other documentation to be able to support and discuss the tabled designs. Furthermore an understanding of the Disability Discrimination Act, both the 1995 and 2005 documents, is essential.

Organisation: the CA must ensure review group members are prepared and understand how to interpret drawings so they can review functionality. The CA must also ensure all relevant parties are invited, which often includes coordinating with external advisers.

Facilitation: the CA must keep meetings to time and order, frequently negotiating with clinicians about their requests for change, and ensuring these are reasonable and within the scope of the project. The CA also monitors, reviews and makes decisions on any matter arising, particularly if it has cost implications, for example requests for more rooms.

Documentation: the CA is responsible for providing accurate notes from meetings and must use the agreed formal process to request information from the private consortium. Accuracy is vital as these documents are subsequently referred to and are part of the audit process.

Follow-up: the CA must make certain that all issues or actions are complete before subsequent meetings.

1:50 design reviews

The CA has a key role at the 1:50 stage review where each room is reviewed for content, position and clinical functionality. The purpose is to ensure equipment is in the right place and conducive to clinical functionality. For example, in an A&E cubicle, handbasins are placed at the entrance to encourage people to wash their hands before entering and leaving the cubicle. Overall, the room is reviewed to ensure the design can accommodate the department’s model of care.

When reviewing such rooms, the CA’s familiarity with the output specification, health building notes and other guidance is vital to ensure all aspects are included in the design. If any function/request in the output specification is no longer required, this may provide a cost saving or negotiating tool for cost-neutral additions. To achieve sign-off of clinical design at 1:50, the following skills are important:

Communication;

Negotiating;

Political awareness;

Managing conflict;

Being receptive to new information and understanding it.

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Important skills

The ability to communicate in a variety of situations and environments with different groups with varying knowledge of a PFI project is vital for the CA. For example, the CA may be required to communicate contentious decisions to review groups that, while meeting with the project’s scope, are potentially contradictory to that department’s wishes or vision of the new hospital.

In addition the CA frequently attends conferences, meetings and study days for both clinical and non-clinical staff as well as patient groups to update them on and discuss the project. This requires the ability to highlight the aspects of the project with particular relevance to the specific group. For example, non-clinical groups may be interested in facilities for administration assistants or porters, whereas patient groups would be interested in issues such as outpatient facilities and car parking. Modes of communication include both written and verbal and accuracy is essential as it is used for audit purposes.

Negotiating with the private consortium to offset costs, for example by removing one item to facilitate the addition of another, is an important role during design reviews. For example, the removal of a wall, function or piece of equipment could be offset against an additional cost for including an item of equipment or service function that may not have been included in the output specification. Reallocation of resources to achieve maximum value relies on the CA having good negotiating skills and a good relationship with the private consortium.

The clinicians will rely on the CA to interpret any of their requirements that the private consortium has not understood to ensure their

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<th>TABLE 2. DESIGN REVIEW PROCESS</th>
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department is clinically functional. Developing a good professional relationship with the private consortium as well as the clinicians provides a sound and conducive environment in which these negotiations can occur.

PFI projects tend to create considerable discussion as demonstrated in the press over the past few months regarding schemes in Birmingham and London. For example, Brady (2006) described how PFI schemes were undergoing review following a request from the health secretary.

The CA needs a basic understanding of the wider picture relating to PFI projects but, more importantly, should have political prowess to ensure different groups receive appropriate information at the right times to prevent unnecessary concern about either PFI strategy or local project decisions that may lead to emotive responses. Empathy, understanding and sensitivity are qualities and skills the CA needs to use on a regular basis.

Designing a new healthcare facility does, on occasion, create conflicts of interest between the private consortium, the trust project team and clinicians. In review meetings the CA will be required to facilitate emotive and heated discussions, ensuring the meeting remains ordered and on track. As Wilson and Ridgway (2006) noted, the overall financial viability of a project will at some stage affect the services to be provided. In their case, they reported controversy over the number of single beds and the distance between beds.

The CA will be required to facilitate departmental meetings of which they may have little or no previous experience. For example, a CA could facilitate the clinical laboratories or mortuary 1:200 and 1:50 design reviews. This is an exciting opportunity to gain insight into and understanding of departments to which they may not otherwise have had access.

In addition there is an abundance of new information that guides designers to ensure that facilities are suitable. Understanding this information will help the CA to assess whether the architects have designed rooms appropriately.

The CA may also need to visit other new hospitals to gain first-hand insight into equipment and designs. This is particularly useful with regard to equipping the new hospital.

Other skills that can be developed while working on a PFI project are summarised in Table 3.

### Conclusion

Developments in the nursing profession have led to many new career opportunities for nurses. While most of these – such as nurse consultant and nurse practitioner roles – have had a clinical focus, others have a less clinical focus and may offer other career opportunities. One such role is that of clinical adviser (CA) in a PFI scheme. Although the role does not involve dealing with patients directly on a day-to-day basis, patients are always in the forefront of the CA’s mind to ensure the completed new facility meets their needs.

The CA is essential to the successful completion of the clinical design review process within a PFI project. A range of skills is necessary in order to achieve this, including facilitation, negotiation and communication.

This article has aimed to give an overview of the review process and provide an insight into the CA’s role, including skills that are either essential or useful to ensure the success of the PFI scheme.

The CA role is diverse and interesting and provides the postholder with a sense of ownership of their new facility and an opportunity to be involved with the development of a new healthcare facility that has the patient as its focus.

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<th>TABLE 3. SUMMARY OF SKILLS</th>
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<td><strong>Flexibility in working</strong></td>
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<td><strong>Interpretation skills</strong></td>
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<tr>
<td><strong>Innovative in design, seeing a solution</strong></td>
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<td><strong>Managing change</strong></td>
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<td><strong>Logical and reliable</strong></td>
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<td><strong>Networking skills</strong></td>
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Another example is strategic positioning of power and data sockets at the bedhead in a room to allow clinicians to use electronic patient data software systems such as electronic imaging facilities or medication prescribing systems.