

**Department of Health : innovation in the NHS : Local Improvement Finance
Trusts / report by the Comptroller and Auditor General.**

Contributors

Great Britain. National Audit Office.

Publication/Creation

London : Stationery Office, 2005.

Persistent URL

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Innovation in the NHS:

Local Improvement Finance Trusts

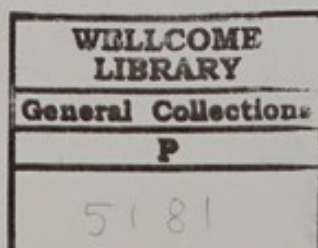
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REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 28 Session 2005-2006 | 19 May 2005

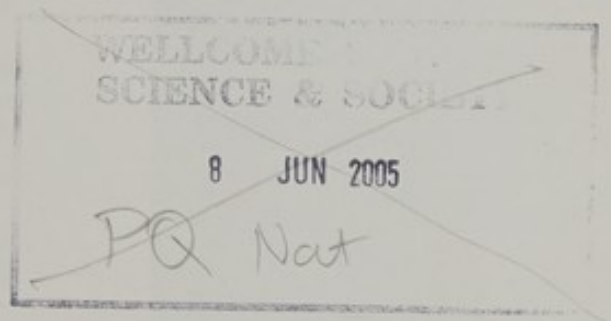
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22501372662



DEPARTMENT OF HEALTH
Innovation in the NHS:
Local Improvement Finance Trusts



LONDON: The Stationery Office
£9.25

Ordered by the
House of Commons
to be printed on 17 May 2005

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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn
Comptroller and Auditor General
National Audit Office

15 April 2005

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SUMMARY



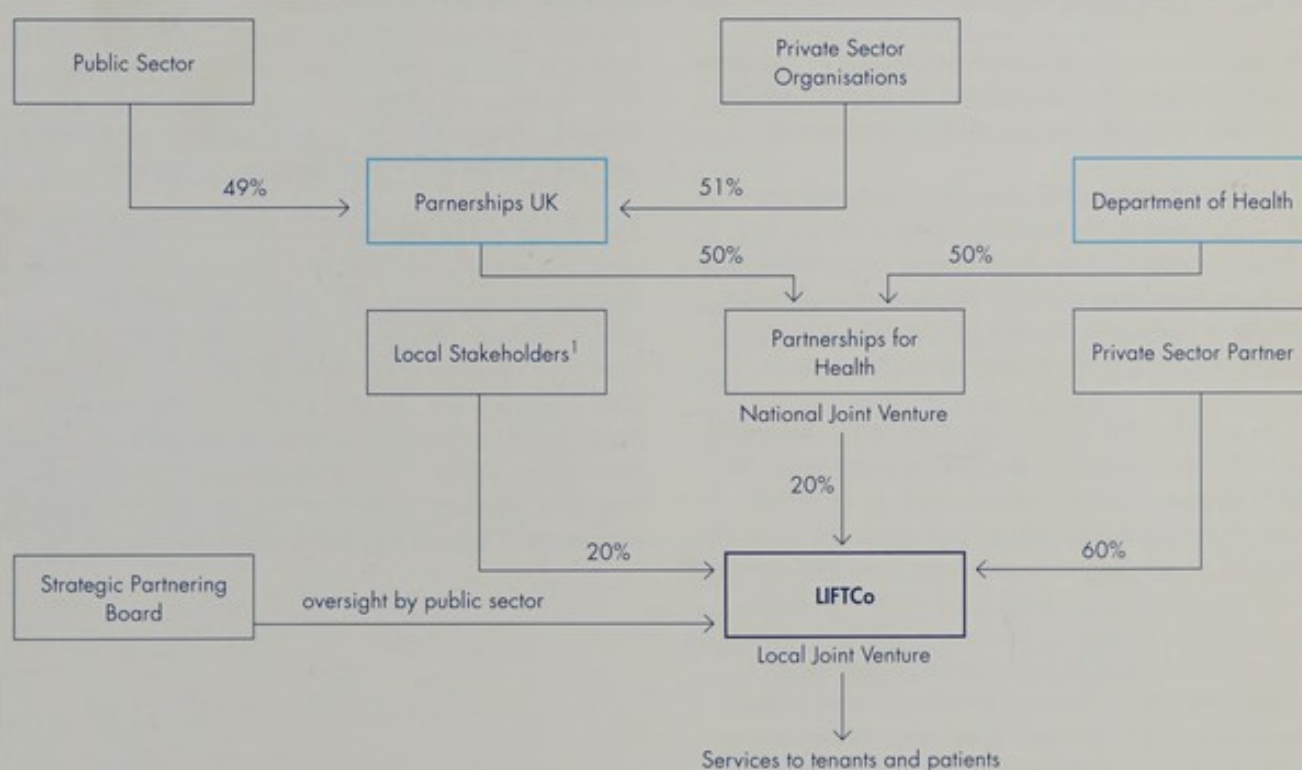
1 Although 90 per cent of patient contact with the National Health Service (NHS) is for primary care services - the care received upon first contact with the healthcare system - investment in primary care historically has been inadequate and piecemeal. Most public sector health investment has been channelled into hospitals. As a result the quality of primary care buildings is often poor. To address these issues, the Department of Health (the Department) announced in 2000 a major new initiative, - the establishment of NHS Local Improvement Finance Trusts (LIFT) to develop primary and social care services¹ and facilities in England.

2 LIFT is innovative in that it is based on long term joint ventures at national and local level. The national joint venture, Partnerships for Health, is between the Department and Partnerships UK.² The local joint venture company (the LIFTCo) is owned by representatives of the local health economy, Partnerships for Health and a private sector

partner (Figure 1). As individual primary care developments tend to be small scale - averaging around £5 million - LIFT takes a "batched" approach and promotes a standardised procurement process. Project priorities are determined in the context of a local strategic plan, developed by a Strategic Partnering Board, comprising representatives of stakeholders from the local health economy.

3 This structure fits with Government policy to use the private sector where feasible to increase healthcare investment. The structure also has strategic advantages over other forms of procurement. It allows long term investment projects to be prioritised according to local needs and developed using private sector expertise. In addition it means local and national priorities can be sustained at the operational level. The new approach cannot, of course, guarantee success, which will be dependent on the effectiveness of the local partnering arrangements.

1 Structure of a LIFT Public Private Partnership



Source: National Audit Office

NOTE

1 Primary Care Trusts, Local Authorities, General Practitioners who wish to take a shareholding.

1 Social care is the professional provision of care, support and welfare for dependent or vulnerable groups or individuals.

2 Partnerships UK, is itself a joint venture between HM Treasury, Scottish ministers and the Private Sector, HM Treasury having a substantial minority shareholding. Partnerships UK work exclusively for the public sector to improve delivery of Public Private Partnerships.

4 42 local schemes across England had been approved by the Department by August 2002, with a total capital value (for initial buildings) of £711 million. A further nine schemes were announced in November 2004. Initial schemes were focused around deprived inner city areas, where health needs are greatest and prevailing conditions are poorest. The Department made start up funding of £195 million available, with the aim of leveraging in a total of up to £1 billion of private investment between 2000 and 2010. This investment in primary care is unprecedented in the history of the NHS.

5 At the local level, LIFT is led by Primary Care Trusts which set up a project board to:

- Develop a Strategic Service Development Plan – defining local health needs and prioritising development of services and premises. This enables a focus on better service delivery and outcomes and not just new premises;
- Attract interest from potential private sector bidders and carry out a competitive procurement process for a sample of projects; and
- Negotiate terms with a preferred bidder for the initial batch of projects and establish the basis for which projects over the next 20 years are undertaken.

6 Unlike PFI deals, LIFT deals are based on the local LIFTCo owning the premises which it builds and refurbishes. Income comes from leasing space to Primary Care Trusts, healthcare professionals (including General Practitioners (GPs), pharmacists and dentists) and other interested social care or voluntary sector tenants.

7 As at early 2005, LIFT is still at an early stage. Most LIFTCos are operational but few buildings are open. The initial buildings commissioned are likely to be only a fraction of the developments planned under the initiative. Most of the developments to date have been well received by local stakeholders, although some proposals have provoked local opposition. Similar procurement models are already being used in other sectors – notably in secondary education. There is therefore a lot of interest in the set-up of LIFT, its ongoing value for money and its accountability arrangements.

8 This report examines whether LIFT will support improved primary and social care services that meet local needs while providing value for money. It focuses on the lessons learned and best practice recommendations of benefit to future LIFT schemes and similar procurement models. Evidence at the local level comes largely from case study material from the first six schemes completed: East London and the City, Barnsley, Sandwell, East Lancashire, Barking and Havering and Ashton, Leigh and Wigan.

9 We conclude that it looks as if LIFT will work – at national level LIFT is an attractive way of securing improvements in primary and social care. The local LIFT schemes we have examined appear to be effective and offer value for money. Local management frameworks need to be strengthened.

The National LIFT programme

10 LIFT will bring improvements in GPs' premises, support co-location of healthcare professionals and help forge links between primary and social care. Indirectly, it may help resolve GP recruitment and retention problems, help shift services away from secondary care³, assist in achieving good chronic disease management⁴ and enhance "Patient Choice" – giving patients more choice over how, when and where they receive treatment.

11 It may not be the best procurement method for all areas, but overall does offer advantages over the alternatives. Procurement in primary care prior to LIFT included central funding, third party developments (where a private contractor develops premises on behalf of GPs or Primary Care Trusts) and PFI. The LIFT areas we visited had often experienced problems in developing new premises through these routes. Primary Care Trusts particularly welcomed a long term approach under local strategic direction together with national support and standardised documentation.

3 Health care provided by specialists or facilities on referral from a primary care professional, requiring more specialist knowledge or skills than can be provided through primary care.

4 Chronic diseases are those that at present can only be controlled and not cured. They include diabetes, asthma, arthritis, heart failure, obstructive pulmonary disease, dementia and a range of neurological conditions.

12 The processes for selecting LIFT areas, facilitating the set-up of LIFTCos and allocating start up funding were all basically well managed. Inevitably when establishing a new initiative and aiming for quick results there were some management problems. The local use of enabling funds was not monitored routinely by the Department, and some schemes did not utilise this funding in a timely manner. Although LIFT is still a quicker route than PFI, the timetable of 12 months for establishing the LIFTCo and completing negotiations for initial developments was too ambitious. Ashton, Leigh and Wigan were the quickest to complete in 13 months. Partnerships for Health thought it unproductive to monitor advisory fee expenditure strictly by LIFT areas given LIFT was new with no established comparators. Local project teams were responsible for monitoring, but the spend for each LIFT area was not reviewed centrally until December 2003, when Partnerships for Health identified that some schemes were not taking advantage of reduced rates because of a lack of local oversight of the total time billed by advisors.

13 Second and third wave LIFT schemes were rolled out before the first wave schemes had completed negotiations. Although common problems were generally resolved centrally, some project teams had to spend time resolving issues as they arose, because they did not have the chance fully to learn the lessons from the first schemes. Nevertheless, Partnerships for Health and the Department did disseminate emerging lessons to schemes through several channels, for example conferences. There are plans to develop the dissemination of lessons further at a national level to allow LIFT schemes, non-LIFT areas and those using similar procurement models to benefit. The Department recognises that LIFT is not the only means of securing improvements in primary care. No formal framework to evaluate LIFT exists, however, including the important issue of how it compares in practice to experience using alternative procurement routes.

The local LIFT models

14 With initial support from Partnerships for Health, strategic planning within local health economies has improved and the process has developed to be more inclusive of a wide range of local stakeholders. LIFTCos have developed plans tailored to local circumstances and are continuing to progress these to improve their effectiveness. Most LIFTCos are also now demonstrating that they have the capacity to think innovatively and are building strong local partnerships with key stakeholders. Inevitably in some cases not all stakeholders have been supportive of proposals. The Primary Care Trusts faced some inherent constraints in kick-starting LIFT's development. As newly established organisations operating against a backdrop of change in Primary Care, it is not surprising there were difficulties in co-ordinating all the different elements that were needed to complete the deals effectively and on a timely basis.

15 LIFT itself appears to be an effective and flexible procurement mechanism, capable of providing value for money. The process for selection of private sector partners has produced good initial results with robust competition from at least three credible shortlisted bidders in all LIFT areas. Business cases to develop initial schemes and to establish the joint ventures are now robust.

16 The financing structure and terms for LIFT are broadly similar to those achieved in PFI deals, even though LIFT deals are smaller and have novel features. The ratio of debt to equity (gearing) of the schemes examined was in the range 89 to 95 per cent, with PFI typically 90 per cent. Returns to the private sector also appear comparable. The blended equity Internal Rate of Return⁵ of LIFT projects in our case studies, ranges from 14.3 to 15.9 per cent. These are not out of line with the 12.5 to 15 per cent seen on similarly sized PFI projects. The deals have been designed to offer clear long term benefits to both the public and private sector participants (see Figure 12). Requirements for benchmarking and market testing, aimed at protecting future value for money, have also been built into the contracts.

⁵ Blended equity IRR includes subordinated debt – debt which ranks below other loans with regard to claims on assets or earnings, also known as mezzanine debt – a debt instrument which combines the features of debt and equity, and equity and equates to the rate of interest that balances the present value of cash outflows from a project with the discounted cash inflow of the investment.

Outcomes and Prospects

17 In general the first LIFT developments to be completed were those less challenging ones that could be achieved quickly. Later projects are more likely to address LIFT's long term aims, such as involving Local Authority services to be able to offer patients integrated health and social care. Despite problems in getting started, local outcomes are encouraging and future prospects for LIFT look good, providing performance measurement and accountability frameworks are strengthened.

18 Local areas, guided by Partnerships for Health and the Department, should strengthen their monitoring and evaluation frameworks. The Department in turn would benefit as this would improve its understanding of how LIFT is contributing to the modernisation of the primary care estate and integration of healthcare provision in the areas of greatest need would improve.

19 The accountability arrangements also need to be strengthened. The accountability of the LIFTCo to the Strategic Partnering Board is well defined. At present, however, there is no one organisation to oversee the performance of the Strategic Partnering Board, a body established locally in each LIFT area to commission services. Overall oversight of the Strategic Partnering Board and promulgation of guidelines to help minimise tensions which may arise where public sector employees are fulfilling several roles in the LIFT structure would reinforce the accountability arrangements. Additionally as the Strategic Partnering Board represents multiple clients, it needs to be clear to the LIFTCo at the outset of a project who the customer is. For example, where a single Primary Care Trust is driving a project, the LIFTCo may deal directly with them as the client on a day to day basis. But where joined-up delivery from multiple clients is required, the Strategic Partnering Board will need to ensure an effective negotiations framework is adopted.

20 As a result of their experience to date Partnerships for Health have announced some changes for the planned fourth wave of nine LIFT schemes. The most notable change is an extension of the timetable to 15 months to reflect the fact that the 12 month timetable has proved too ambitious and trying to meet it can be counterproductive.





RECOMMENDATIONS

There are a number of recommendations aimed at improving the outcomes of future LIFT schemes and similar procurement models.

Planning a new initiative

1 A systematic approach to evaluating advisory firms and the quality of contributions from individual advisors should be established. This would help achieve good quality advice and value for money. Partnerships for Health undertook informal assessments of the effectiveness of both advisory firms and their employees, and generally concluded that the quality of advice received was good.

2 Realistic timetables for negotiating deals and making services available need to be agreed, following benchmarking where possible. It is important that timetables are kept under review as an initiative develops. Early deals are likely to take longer to complete as they lead the way and establish precedents for the later ones. Unrealistic timetables can lead to inadequate initial preparatory work, leading to delay later.

3 It is important that effective reviews of Strategic Service Development Plans for LIFT schemes are undertaken regularly, in accordance with Partnerships for Health guidance. Primary Care Trusts are responsible for the initial plan. Once the LIFTCo is established, the Strategic Partnering Board takes ownership of the plan and needs to lead on its annual review if LIFT is to meet its, wider, longer term objectives. It is important to consult with all relevant local stakeholders and determine how LIFT will contribute to issues such as premises design, organisational development, regeneration and financing whilst ensuring good strategic fit with other local initiatives in related areas – for example,

in secondary, acute and social care, or in regeneration. The plan should also anticipate potential change in the long term and assess the impact that LIFT will have on the local area as a whole - not just development sites.

4 The benefits seen from using a single strategic planning document, such as the Strategic Service Development Plan, suggest the Department should also encourage similar integrated strategic planning more widely across the NHS to support other healthcare investment and development initiatives.

Implementing a new initiative

5 Processes should be developed so that best practice in encouraging innovative ways to speed up project completion is disseminated effectively to local stakeholders. Delays and periods of “dead time” are common to all forms of procurement and need to be well managed. Some LIFT schemes for example, experienced delays in obtaining Strategic Health Authority approval for their business case. Local teams would benefit from meeting regularly with a representative from the Strategic Health Authority to discuss emerging issues. All parties should aim to synchronise finalisation of the business case with a Strategic Health Authority Board meeting to speed up the process.

6 To realise the full benefits of initiatives like LIFT, the local team responsible for implementation needs to be resourced adequately. We found for an average sized scheme that a core of three to four people was sufficient prior to financial close, although this needed to be increased at critical periods in the procurement. An experienced team leader, with excellent knowledge of at least one key aspect of LIFT (for example, the local health economy or

experience in project finance) is important. Where local areas find it hard to employ a suitable individual to lead the process it is useful to consider alternative ways of recruiting somebody with the requisite skills and experience, for example through secondment or external project management support.

7 Buy-in from stakeholders is crucial. Guidance about the initiative aimed specifically at key groups of stakeholders (in the case of LIFT; clinicians, Local Authorities, Primary Care Trust senior management and secondary and acute care colleagues) should be developed and disseminated. Where there are specific issues arising which affect a particular class of stakeholder, there may be a case for national forums to help disseminate best practice. For example, the Department set up a network of local champions to help GPs understand LIFT. Local teams should seek to engage groups of key stakeholders early on and involve them in decision making, such as selection of the private sector partner. Appropriate channels, particularly more formalised local networking, need to be developed to disseminate lessons learned to participants in a timely manner.

Evaluating a new initiative

8 It is good practice to establish pathfinder schemes for a new initiative to ensure that lessons are learned in advance of its full implementation – this was not possible for LIFT as second and third wave schemes were rolled out, following a policy decision, before the first wave schemes had completed negotiations. In these circumstances, it is important that the public sector develop an alternative framework to identify good and bad practice, any common difficulties and how to resolve them as they arise during implementation. The Department and Partnerships for Health did disseminate lessons and plan to develop their framework further. This framework could be a useful starting point for similar procurement models.

9 The Department should establish a framework with which it can establish and evaluate the impact of LIFT. There are two essential components; firstly the Department should develop clear guidance about the nature and timing of Post Project Evaluation for LIFT schemes, allowing for a rigorous evaluation of implementation best practice and initial value for money. Secondly, the Department could usefully develop a basket of measures reflecting national priorities, allowing the Department to monitor the impact of LIFT over time. Working closely with the Department, LIFTCos could then track health outcomes and regeneration achievements. Local measures could be defined by LIFTCos and prioritised on the basis of the Strategic Service Development Plan. Together,

these components will enable reasoned comparison of LIFT to alternative procurement models. Where developing similar initiatives it is important that Departments establish these frameworks prior to financial close.

Overseeing a new initiative

10 Additional guidance should be developed by Partnerships for Health to help LIFTCo Boards manage potential conflicts of interest when senior individuals such as Chief Executives or Finance Directors from a Primary Care Trust are also appointed as a public sector director to the LIFTCo Board. Where an individual has such a dual role as Board member of the customer (Primary Care Trust) and supplier (LIFTCo) it is not prudent to rely solely on individual integrity to manage potential conflicts of interest. Partnerships for Health understandably want to secure suitably skilled candidates for the role of public sector director, and believe the benefits of appointing a senior, knowledgeable individual from the Primary Care Trust outweigh the potential difficulties that might ensue.

11 In the light of experience it now seems that the accountability framework of LIFT could usefully be strengthened. For example, members of the Strategic Partnering Board are all accountable to their parent organisations, but there is no one organisation holding the Board to account. It would be beneficial for the Department to establish principles and develop guidance defining responsibility for local oversight of the Strategic Partnering Board. The framework could also provide guidance encouraging Strategic Partnering Boards to define for each project who will act as the customer of the LIFTCo.

Learning from a new initiative

12 It is important that other Government departments developing similar procurement models learn and apply the lessons from LIFT. The Department for Education and Skills has launched its Building Schools for the Future initiative, a £25 billion programme to renew or rebuild England's entire secondary school estate. The models for Building Schools for the Future and LIFT were both developed by Partnerships UK and have elements in common. Many lessons have already been learned by Partnerships for Schools, the national body responsible for implementing the programme, but there is a risk that the full range of lessons learned from LIFT around set-up, resources, evaluation and governance are not adopted. Lessons learned and best practice should be transferred bilaterally between Partnerships for Health and Partnerships for Schools as both programmes develop and there are already mechanisms in place to achieve this.

PART ONE

The National LIFT Programme

This section of the report finds that LIFT has the potential to deliver against the Department's objectives for primary and social care development. LIFT is well designed, offers advantages over other forms of procurement and the implementation of the initiative has been generally well managed. The Department needs to establish a learning framework to ensure spread of best practice and to facilitate comparison of LIFT with other procurement routes for primary care.



LIFT has the potential to support improvements in primary and social care

1.1 The Department's vision for the development of primary care services is set out in the 2000 NHS Plan. LIFT was established to address directly some of the objectives highlighted in the Plan, including premises improvement, increased co-location of healthcare professionals and recruitment and retention of GPs. As the Department's priorities have evolved to cover, for example, improvements in chronic disease management, so have the expectations of LIFT.

1.2 As a result of years of under investment in primary care services, the condition, functionality and age of many GPs' surgeries is unsuitable for delivery of modern primary care (**Figure 2**). Premises are often not purpose built; data collected in 1996 shows that almost half were based in either adapted residential buildings or converted shops. Access to these buildings for patients is often

inadequate and buildings frequently fail to comply with Disability Discrimination Act (1995) requirements.⁶ Many premises were built over 30 years ago before standards on size were set, and lack of space inhibits development of services. LIFT will re-house GPs in new, purpose built and more spacious surgeries and where appropriate, redevelop existing premises to meet modern standards.

1.3 There is a national shortage of GPs. The NHS Plan 2000 set a target to recruit an extra 2000 GPs by the end of 2004. Some GPs have been put off practicing because of the poor quality of the premises available and restrictive and long term leases. Under LIFT, GPs can be bought out of existing premises and offered flexible leases within a LIFT building. In addition GPs can take shares in the LIFTCo equivalent to the value of the freehold on their existing premises, effectively swapping an interest in one property for an investment in a portfolio of properties and services, which may be traded if a secondary market develops. These new developments may encourage existing GPs to stay in the profession and will provide more choices for newly qualified GPs.

2 The condition of the Primary Estate is inadequate

Percentage of Practices ¹				
Below required size ²	In cramped conditions	<10 years old	10-30 years old	>30 years old
81%	15%	15%	32%	53%

Source: Department of Health Investment Strategy (2000)

NOTES

1 This analysis excludes those practices reimbursed under the cost rent scheme, whereby GPs own the premises and are reimbursed rent reflecting the cost of the premises. These practices represent approximately thirty percent of the total primary estate but are generally of newer build.

2 Required size is set out in the premises schedule of Statement of Fees and Allowances.

⁶ The Disability Discrimination Act 1995 aims to end the discrimination faced by disabled people. The final rights of access came into force in October 2004, with service providers, including GPs, having to making permanent physical adjustments to their premises where non-compliant with the law.

1.4 LIFT encourages the co-location of health and social care professionals in one building together with a more integrated approach to Primary Care. This would typically involve GPs working alongside nurses, pharmacists, dentists, therapists, opticians, midwives and social care staff. Co-location aids referral between primary care professionals and strengthens links between primary and social care services. Integration of services will benefit patients who need to draw on wider community services, particularly in deprived areas where the overlap between users of primary and social care services is greatest. Mental health teams, children's and elder person's welfare teams, advisory services and other community based initiatives can become involved in local LIFTs.

1.5 LIFT will also help meet changing priorities, such as making a wide range of services which currently are performed largely in a secondary care setting, for example minor surgery and scanning, available through primary care. LIFT is also well placed to assist in meeting the Government's chronic disease management agenda. Chronic disease accounts for 80 per cent of GP consultations and if well managed will minimise the need for admissions to secondary care, freeing up resources. The establishment of specialist chronic disease clinics within many LIFT buildings will offer patients co-ordinated care through multidisciplinary teams. Furthermore, the range of care provided through LIFT can help address "Patient Choice" issues. Giving patients a choice about how, when and where they receive treatment is currently a secondary care priority area. Patient choice in primary care is expected also to become a priority.

LIFT usually offers advantages over alternative mechanisms of procurement

1.6 Funding for small scale redevelopment and refurbishment of primary care premises may still be available from traditional public capital investment. But the scale of investment and resources needed to redevelop substantial portions of the primary care estate required an innovative approach. LIFT offers many advantages to the local health economy while its structure fits with Government policy to use private sector investment where feasible to increase investment in healthcare. LIFT schemes are a partnership – the private sector provides a large proportion of the overall funding and have expertise in, for example, property development and project management. Furthermore because LIFT transfers property development and management risk to the private sector, the partnership enables public sector healthcare professionals to focus on delivery of a good quality service. For example, unlike a conventional lease, the lease agreement in LIFT was designed so that the LIFTCo, as landlord, takes responsibility for repair, maintenance and insurance of the premises.

1.7 Conventionally, improvements to premises may also be procured as third party developments - where GPs or Primary Care Trusts engage a private sector contractor to redevelop premises on their behalf and then lease the premises back from the contractor. LIFT may be less appealing to GPs attracted to third party development; they do not retain their capital asset and tend to lose overall control of the development. In some cases GPs take out private loans to fund improvements and keep control of the development. The development process in these cases can, however, be a burden on the GP practice particularly in the early stages of site selection and agreement of terms. Third party developments generally do not have the advantages of LIFT. In particular ad hoc GP developments may not fit with local strategic priorities, can lack input from Primary Care Trusts and may not encourage co-location of healthcare professionals.

1.8 More recently, PFI has also been used as a route to develop larger premises. Most primary care developments are, however, relatively small scale – at an average development cost of around £5 million.⁷ They are unsuited to PFI because of high transaction costs (current Treasury guidance suggests PFI should not be used for projects under £20 million). LIFT is designed as a batched approach to investment in a portfolio of properties to make smaller projects viable. The common approach and delivery through a national programme is a key advantage of the LIFT model. Primary Care Trusts and GPs do not need to develop contract documentation for new schemes as is the case using alternative procurement routes.

1.9 One further key advantage of LIFT is that it can also deliver quickly. Ashton, Leigh and Wigan LIFT completed negotiations on a bundle of projects in 13 months, compared to the very varied and unpredictable lead times which alternative routes for primary care development have taken to provide just one building.

In some areas of the country LIFT may not be a suitable procurement mechanism and there may be viable alternatives

1.10 Although the need for LIFT is assessed against a number of criteria, the population served by a LIFT is important because it is an indicator that a steady supply of schemes will be forthcoming, making the local LIFTCo viable over the 20 year period of the partnership. The population served by a LIFT scheme ranges from 1 million people within the Manchester, Salford and Trafford area to only 196,000 in Oxford. The Department believe LIFT areas generally need a population of between 300,000 and 500,000 people. Similarly, the level of capital investment through LIFT also needs to be sufficient to attract private sector investment. We found that the Department judged one very deprived area unsuited to LIFT because it had only a combined value of schemes totalling £2 million. To date, the average development cost of completing just one tranche of schemes is around £14 million. Local areas which do not have the critical mass to support a LIFT can consider alternative routes or may consider joining a neighbouring LIFT scheme.

Sites were sensibly chosen

1.11 The Department has rolled out 42 LIFT schemes in three waves of six, 12 and 24, with a further nine schemes announced in November 2004. The first six schemes⁸ launched in February 2001 are all inner city areas, selected by the Department from Health Action Zones on the sensible assumption that these areas have the most urgent need for improvement. Applications from local health economies were invited for areas wishing to get LIFT status within waves two (February 2002) and three (August 2002) and assessed by the Department against a series of weighted criteria. The criteria were developed beyond the need for LIFT in the locality and the current condition of the primary care estate, to encompass ability for efficient delivery, project management arrangements and stakeholder support. Expansion of the criteria for inclusion in waves two and three was reasonable as it increased the chance that schemes could complete their first projects efficiently and to timetable.

1.12 The Department's selection exercise identified that there were deprived areas in need of LIFT, but which were not suitable for selection because they ranked low on ability to deliver. Primary Care Trusts were given detailed feedback from the Department on their weaknesses and were encouraged to consider how they could strengthen their application for later waves. Eight schemes rejected from wave two reapplied and were accepted in wave three⁹, and the Department encouraged Primary Care Trusts which were still not in LIFT to consider applying for the fourth wave of schemes.

⁷ The development cost represents total capital cost including fees and interest.

⁸ The first wave schemes were East London and the City, Manchester, Salford and Trafford, Newcastle and North Tyneside, Sandwell, Barnsley and Camden and Islington. However, only three of these schemes were amongst the first six to complete and feature as case studies in this report. Some schemes in the second and third waves completed before the other first wave schemes.

⁹ Doncaster, Gedling, Tees Valley, Leeds, Wolverhampton, Colchester and Tendring, Ealing, Hammersmith and Hounslow, and Bromley, Bexley and Greenwich.

3 Location of NHS LIFT schemes in England

NHS LIFT Schemes - January 2005

1st Wave Scheme

Newcastle and North Tyneside
Manchester, Salford and Trafford
Barnsley
Sandwell
Camden and Islington
East London and the City

2nd Wave Scheme

East Lancashire
Bradford
Hull
Liverpool and Sefton
North Staffordshire
Leicester
Birmingham and Solihull
Coventry
Redbridge and Waltham Forest
Barking and Havering
Medway
Cornwall and Isles of Scilly

3rd Wave Scheme

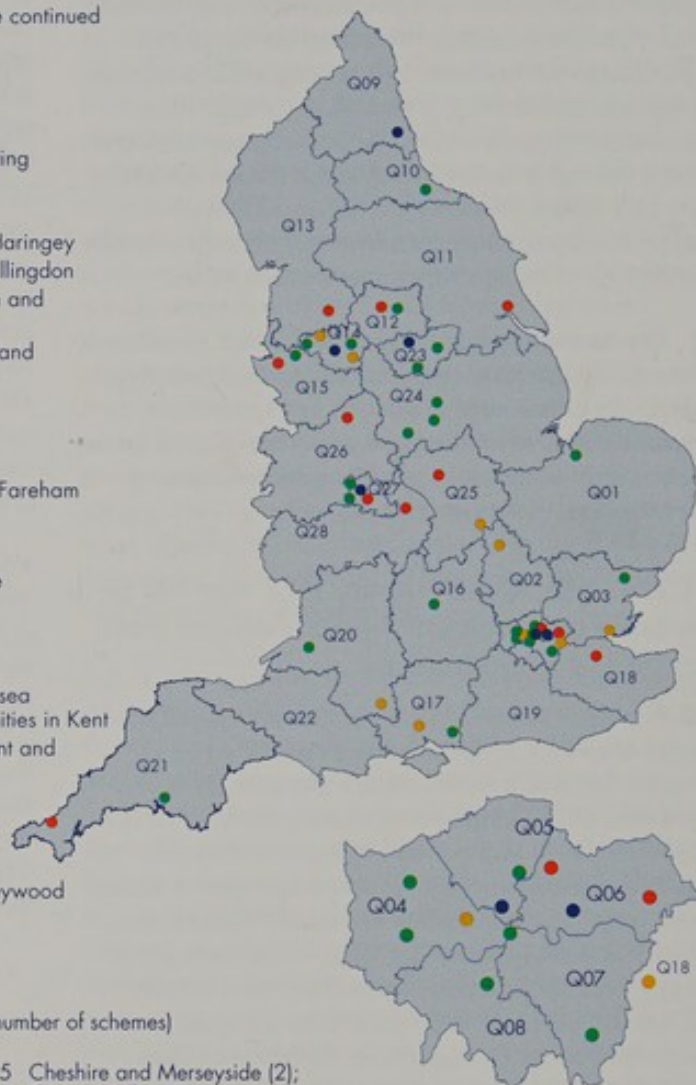
Tees Valley
Leeds
St Helens, Knowsley and
Warrington
Ashton, Leigh and Wigan
Oldham
Doncaster
Sheffield
North Notts (Ashfield)
Greater Nottingham (Gedling)

3rd Wave Scheme continued

Southern Derbyshire
Norfolk
Wolverhampton
Dudley South
Colchester and Tendring
Oxford
Bristol
Barnet, Enfield and Haringey
Brent, Harrow and Hillingdon
Ealing, Hammersmith and
Hounslow
Lambeth, Southwark and
Lewisham
South West London
Bromley, Bexley
and Greenwich
East Hampshire and Fareham
and Gosport
Plymouth

4th Wave Scheme

Bury and Tameside
South Midlands
South East Midlands
Kensington and Chelsea
Sustainable Communities in Kent
Southend, Castle Point and
Rochford
Wiltshire
South West
Hampshire
Rochdale, Bolton, Heywood
and Middleton



Produced by DH from maps provided by Ordnance Survey

Key to Strategic Health Authorities (Number in brackets denotes number of schemes)

Q01 Norfolk, Suffolk and Cambridgeshire (1);

Q02 Bedfordshire and Hertfordshire (1);

Q03 Essex (2);

Q04 North West London (3);

Q05 North Central London (2);

Q06 North East London (3);

Q07 South East London (2);

Q08 South West London (1);

Q09 Northumberland, Tyne and Wear (1);

Q10 County Durham and Tees Valley (1);

Q11 North and East Yorkshire and North Lincolnshire (1);

Q12 West Yorkshire (2);

Q13 Cumbria and Lancashire (1);

Q14 Greater Manchester (5);

Q15 Cheshire and Merseyside (2);

Q16 Thames Valley (1);

Q17 Hampshire and Isle of Wight (2);

Q18 Kent and Medway (2);

Q19 Surrey and Sussex (0);

Q20 Avon, Gloucestershire and Wiltshire (2);

Q21 South West Peninsula (2);

Q22 Dorset and Somerset (0);

Q23 South Yorkshire (3);

Q24 Trent (3);

Q25 Leicestershire, Northamptonshire and Rutland (2);

Q26 Shropshire and Staffordshire (1);

Q27 Birmingham and the Black Country (4);

Q28 West Midlands South (1).

Source: Department of Health

The implementation was well managed

1.13 Partnerships for Health, in consultation with the Department and Partnerships UK, worked closely with the 42 local project boards. Each was assigned a facilitator from Partnerships for Health to aid in setting up the LIFTCo. We surveyed project directors across the 42 schemes and identified that 88 per cent of respondents rated the facilitators as a moderately or highly useful resource. There has been no central assessment of the performance of these individuals although Partnerships for Health obtained informal feedback from local LIFT project directors. Regular liaison between senior management from Partnerships for Health and each project board ensured that local problems were identified and resolved. In particular Partnerships for Health's Chief Executive met with project teams once negotiations were well advanced to ensure that all key issues were finalised in advance of closing deals on the initial sample.

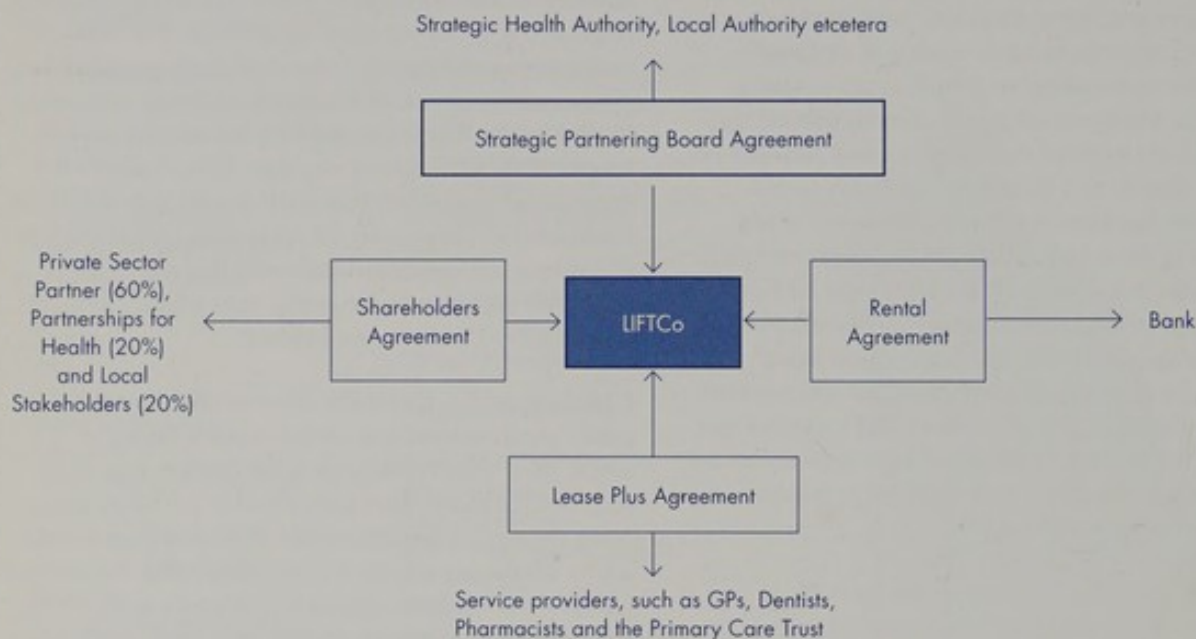
1.14 In recognition that LIFT was a new form of procurement, Partnerships for Health ensured that both the public and private sectors had opportunities to learn about the initiative. Sources of information for prospective participants in LIFT included conferences, a dedicated website and individual meetings with senior Partnerships for Health representatives. We surveyed all shortlisted bidders across the 42 LIFT schemes and 93 per cent of respondents felt that prior to bidding for LIFT they were able to develop their knowledge of the initiative adequately through these sources. 64 per cent of respondents also believed that the market for investment in primary care prior to LIFT was undeveloped and that Partnerships for Health were crucial in stimulating their interest. Partnerships for Health were supported in developing LIFT by external organisations with an interest in a particular aspect of the initiative. 4Ps, for example, part of the Local Government Association, advised Local Authorities on their involvement in LIFT. Additionally, the Commission for Architecture and the Built Environment (CABE) assisted a small number of schemes through their Enabling Programme (Appendix 3). CABE will also assist schemes in the planned fourth wave.

1.15 Partnerships for Health were supported by KPMG and Bevan Ashford, who were appointed as central advisors for the first wave on financial and legal matters respectively, following open competition. The advisory teams were instrumental in developing the standardised procurement process and supporting documentation and in advising the first wave of LIFT schemes. The market for providing local advice was then opened out for the second and third waves to test the competitiveness of the initial advice. The process for appointing advisory teams was robust, and advisory teams who had represented the public sector were prevented from advising first and second wave private sector bidders.

1.16 Partnerships for Health allowed advisors to the public sector on first and second wave schemes to advise third wave bidders. As some bidders have won schemes across the three waves and as all waves were being developed simultaneously, they would be able to advise third wave private sector bidders what returns and concessions had been agreed in a range of earlier deals. Partnerships for Health think that such information was readily available and, in any case, they valued transfer of ideas between the public and private sectors. We agree that these arguments have some force, particularly in a mature market. LIFT was, however, still a new initiative when the third wave was announced in August 2002.

1.17 Partnerships for Health developed a suite of guidance notes and standardised contract documentation (**Figure 4 overleaf**) for all schemes, using their experience of PFI as a starting point. The time spent on developing the standard contracts was longer than anticipated at the outset, and several versions were issued before finalised documents were agreed. The standard documentation was often amended following local negotiations. Nevertheless, its existence resulted in time and money savings in setting up LIFTCos and getting projects underway. We questioned whether there were benefits in extending standardisation beyond these traditional parameters. Partnerships for Health are understandably reluctant to impose standard buildings on diverse local areas, but recognise there may be additional untapped benefits in using standard modular designs for rooms within the LIFT building. We note there may also be potential to standardise the interior configuration of buildings with a view to enhancing the "patient journey". One area visited analysed the usage of different primary care services and had designed the flow of rooms in their building to reflect this research.

4 Primary standard agreements between LIFT participants



Source: National Audit Office

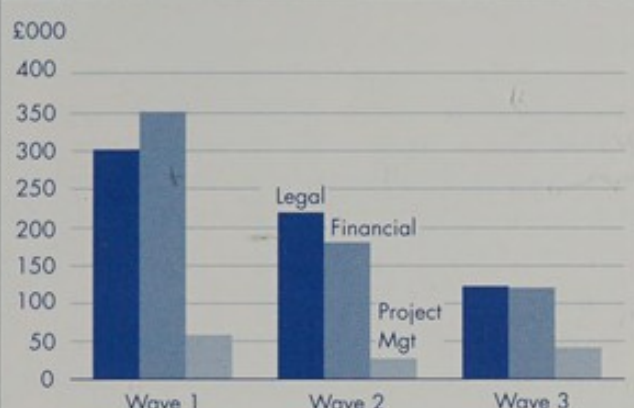
Advisory costs have decreased as learning curves have been overcome

1.18 Our survey of project directors showed that the overall usefulness of advice provided to local schemes from Partnerships for Health, financial advisors and legal advisors was moderately or highly rated by 88 per cent, 98 per cent and 98 per cent of respondents respectively. Key concerns about the advice supplied, identified by our case study areas, were that there was little continuity in the individuals allocated to schemes, obtaining a decision was often a slow process and the level of fees paid were greater than expected. These problems were due in part to LIFT being a new programme that was expanded more quickly than expected initially. Partnerships for Health therefore deployed first wave advisors on subsequent schemes to spread existing knowledge. Difficult issues encountered by individual schemes were resolved at a national level to ensure a correct precedent was set.

1.19 Although LIFT was a new initiative with no comparators, Partnerships for Health set initial local budgets for financial and legal advice and an overall budget for central advisory costs. The local budgets were revised and became more accurate for each subsequent wave of LIFT schemes. Public sector advisory costs reached £17.5 million in September 2004, which represents 4 per cent of total capital expenditure on LIFT. This appears reasonable in comparison to average advisory costs of around 4 per cent of the capital value of projects in NHS PFI deals, particularly as LIFT schemes have much smaller capital values than most PFI schemes and advisory costs within the LIFT lifecycle are front loaded – the bulk of advisory costs being incurred prior to completion of negotiations to establish the joint venture.¹⁰ Although the public sector found the initial costs involved in setting up LIFT expensive, costs reduce in the longer term as learning curves for both the advisors and the public sector are overcome with time. This is already borne out by the reduction of advisory costs per scheme for each successive wave shown in **Figure 5**.

¹⁰ The Committee of Public Accounts – 19th report 2002-03 “The PFI contract for the redevelopment of West Middlesex University Hospital HC 155 2002-03” gives costs varying between 1 and 8 per cent of the capital value of NHS PFI projects with the average being 3.7 per cent. These costs were broadly consistent with costs which the Ministry of Defence told the National Audit Office they expected to incur on major projects.

5 Advisor's costs fell across waves as standard documentation was developed



Source: National Audit Office analysis of Partnerships for Health advisory costs report

1.20 Partnerships for Health undertook regular monitoring against overall budgets, but detailed monitoring of spend for each scheme was carried out locally. Overall review of local advisory costs started in December 2003, largely because Partnerships for Health noticed that local schemes were not always taking advantage of reduced rates which they had negotiated centrally with advisors – to be triggered once an agreed volume of work had been billed. Although Partnerships for Health undertook some informal analysis of the cost effectiveness of advisory firms and their employees, there is no formal process for capturing feedback from the local project teams or a systematic approach to assessment.

Some stakeholders were confused about pump priming funds

1.21 The Department made available £195 million to assist in kick-starting the LIFT initiative of which £177 million has been allocated to date. These enabling funds were intended to cover capital expenditure such as purchase and preparation of a site, buy-out of GPs and provision of temporary accommodation. There was, however, some flexibility for Primary Care Trusts to use the funds to cover revenue costs (for example advisory fees and project management) provided this did not exceed 3 per cent of the total enabling funds received by each project team.

1.22 The Department issued enabling funds guidance in November 2002. This states that enabling funds are not automatically refundable but there may be circumstances in which the Department would be keen to reclaim funding to enable it to be recycled into further LIFT developments. A third of project directors remained unsure about how enabling funds would work in practice, resulting in local variation of usage. No subsequent guidance has been issued by the Department. Monitoring of how funds have been used locally was not routinely undertaken – in some cases allocated funding was untouched for significant periods without being subject to central review. As at January 2005 no funds have been paid back to the Department. This has prompted a review of the efficiency of how funds are used and recycled.

LIFT has yet to contribute significantly to targets for investment in primary care

1.23 The 2000 NHS Plan expected LIFT to make a significant contribution against the following targets for investment in primary care services:

- Up to £1 billion invested in primary care facilities to 2010;
- Up to 3,000 family doctor's premises substantially refurbished or replaced by 2004; and
- 500 one-stop primary care centres by 2004.

The number of LIFT premises anticipated by the end of 2004 was not specifically defined. Progress of LIFT has been slower than the Department initially expected and although 31 out of the 42 schemes completed negotiations by the end of 2004, only 4 buildings were actually open to patients. The Department has, however, delivered a large part of the 2004 targets through mechanisms other than LIFT. The future contribution of LIFT to improving the primary care estate is expected to be significant with approximately 50 new buildings opening in 2005. Partnerships for Health expect all 42 LIFT schemes to have reached financial close on initial schemes by summer 2005. The new 2004 NHS Improvement Plan expects that 50 per cent of the population will be served by LIFT buildings by 2008.

Evaluation processes could usefully be improved

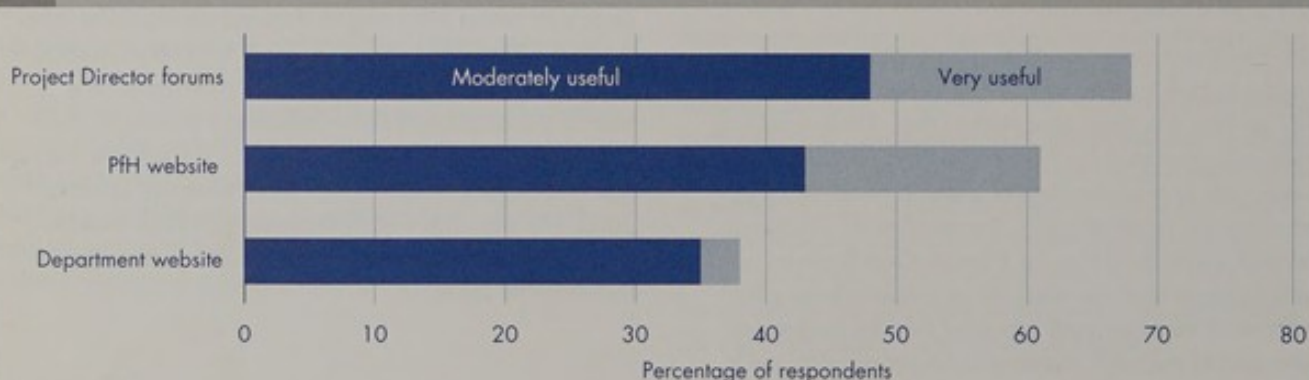
1.24 The Department's early thinking was that the six first wave projects, launched in February 2001, would act as pathfinders. A policy decision to speed up LIFT and enhance the contribution to NHS Plan targets precluded using the first wave schemes as genuine pathfinders. Instead the second and third waves of schemes were initiated in February and August 2002, before any first wave schemes established their LIFTCo. Although Partnerships for Health took steps to disseminate lessons as they were learned, inevitably common problems were replicated and some schemes had to resolve issues as they arose because they had not had a chance to learn from the first schemes. For example, several schemes wrestled with the legal issues around whether the Primary Care Trusts would have to take the headlease on a building and sub-let to tenants or whether each tenant would take a direct lease. Ultimately, this was resolved – Primary Care Trusts have found it simpler to take headleases.

1.25 Sharing of best practice and learning of lessons happened at a national level. Partnerships for Health and the Department disseminated emerging lessons to schemes through a variety of initiatives, including conferences, websites and project director forums. We surveyed project directors across the 42 initial schemes and found that they thought generally that these resources had been useful (see Figure 6). Local networking was also useful between schemes in the same region or with the same private sector partner.

1.26 There is clearly scope for the Department and Partnerships for Health to improve the learning framework if best practice is to be further disseminated, into the fourth wave and into non-LIFT areas who wish to use the model independently. Partnerships for Health intend to expand their procurement support and investor role in LIFT into organisational development. They recognise the need to develop expertise, which they do not currently have, to do this. Early developments include a series of workshops for participants in LIFT.¹¹ Partnerships for Health have also established a discussion forum on their website to allow exchange of experience across the country.

1.27 It is important that the Department evaluates LIFT in comparison to other available procurement routes. The Department encourages local areas to consider LIFT as a procurement route, but recognises that LIFT is not the only way of securing improvement in primary care, and is still committed to provide central funding for new premises and small scale redevelopment. Formal and ongoing analysis of the advantages and disadvantages of LIFT in comparison to other procurement mechanisms needs to be undertaken to enable local areas to decide which route to take. A framework, perhaps in the form of a decision tree, to help local areas understand the different routes and sources of funding for improvement would also be useful.

6 The majority of Project Directors found available information useful



Source: National Audit Office survey of Project Directors

¹¹ Non executives of LIFTCos, Chairs of Strategic Partnering Boards and service delivery planners.



PART TWO

The local LIFT models

This section of the report looks at the local models and draws on examples from case studies of the first six LIFT schemes to complete their initial projects. The procurement process was effective although some schemes were delayed in achieving financial close because of constraints on the Primary Care Trusts. We found that even though value for money of a LIFT project is hard to quantify, the LIFT model facilitates the achievement of value for money, initial deals look robust and there are arrangements in place to test value for money on a periodic basis.



LIFT schemes are developing effective strategies

2.1 Primary Care Trusts selected to develop a LIFT scheme are required to produce a Strategic Service Development Plan. The plan is a 5-10 year strategy for the area and its population – it identifies the service requirements and related facilities to be addressed. The plan is based to some extent on existing information and in the longer term is intended to provide a single and ready strategic planning tool for primary care. The Department now encourages all Primary Care Trusts to produce this document. We found that Strategic Service Delivery Plans are also now being used effectively in non LIFT areas.

2.2 Analysis of the initial Strategic Service Development Plans from our six case study LIFT areas found that they largely covered the Department's requirements although there were some gaps around the organisational set-up of the LIFTCo – descriptions of the structural framework of the LIFT were brief, perhaps understandably given the infancy of the joint ventures. We compared the model to the Office of Government Commerce "Successful Delivery Toolkit" which describes best practice for production of a robust strategy - it was broadly consistent in terms of purpose and suggested content.

2.3 Our survey of project directors indicated that Primary Care Trusts found the process of producing their plans complex and time consuming. This was understandable given the volume of work for individuals involved in setting up LIFT. Strategic Partnering Boards who are responsible for updating the plans following closure on the first tranche of schemes, now intend to work on improving the quality of the documents and to ensure they are updated annually.

Most LIFTCos are building strong local partnerships

2.4 Primary Care Trusts consult with organisations that strategically manage or deliver local primary or social care services to ensure wherever possible, endorsement of their Strategic Service Development Plan. Stakeholder support for LIFT has on the whole been encouraging. The structure of LIFT is designed to foster a spirit of partnership with stakeholders working together to achieve mutual goals, but of course the success of the partnership is dependent on local circumstances and personalities. We found in some case study LIFT areas that local stakeholders become further engaged in the scheme as LIFT develops - for example, stakeholders have provided assistance in selecting the private sector partner and attended user group meetings. There are, however, some areas where proposals have generated local opposition or where groups of stakeholders felt that LIFT did not fulfil their aspirations.

2.5 Local Authority input is a key feature of LIFT as they undertake many health related functions, and can get involved at a number of levels; as shareholders in the LIFTCo, as strategic partners, or simply as tenants of the premises. Whatever route Local Authorities choose to follow, their involvement is most effective when harnessed early. This has not always proved possible. Local Authorities tend to have different decision making processes and finance regulations to Primary Care Trusts. Several council representatives in our case study areas felt there were constraints preventing full involvement in LIFT.

Several Local Authorities were concerned about becoming shareholders in LIFT because the standard contract gives LIFTCo the exclusive right to provide all new facilities or services commissioned by NHS participants. Barnsley Metropolitan Borough Council wanted to build on a long standing relationship with the Primary Care Trust and become full shareholders in the LIFT scheme but wanted to define explicitly the level of exclusivity for Local Authority participants granted in the Strategic Partnering Agreement. Therefore to resolve this difficulty they instructed lawyers to amend the wording of the Strategic Partnering Agreement to clarify the exact level of exclusivity to which they were prepared to commit. The Council decided to just grant LIFTCo exclusivity to develop children's services.

LIFT teams have been innovative in their approach to managing difficulties

2.6 We found several instances of local project teams developing innovative solutions to difficulties that arose. There were common periods of "dead time" in the procurement process which some areas managed effectively. One such example is Ashton, Leigh and Wigan where, when completion of negotiations was imminent, but had not been completely resolved, the private sector partner agreed with the public sector team that they would risk starting initial construction work early to better allow them to meet their proposed completion date. Another common delay was in obtaining Strategic Health Authority approval for business cases. Schemes which engaged the Strategic Health Authority in the process early on and co-ordinated their timetable with that of the Strategic Health Authority Board reduced the time taken to obtain approval.

LIFT is an effective and flexible procurement mechanism

2.7 Partnerships for Health developed a detailed procurement route for establishing local LIFT joint ventures. LIFT schemes were given a framework for developing their proposals, selecting their private sector partners, seeking approval to establish the LIFT and negotiating with stakeholders to reach completion on the first tranche of projects.

Procurement processes were effective

2.8 Our survey of 35 shortlisted bidders across the 42 schemes identified strong interest in bidding from the private sector, with in excess of 30 expressions of interest for many LIFT areas. A variety of players were involved – often large companies with experience of PFI, but also third party developers of primary care premises and regional contractors. Involvement from regional companies is encouraging. They are often very well placed to deliver positive outcomes – they know the local area and its issues and are visible to the public sector participants and the wider community. Through sub contracting of their supply chain they can also expand capacity to other regional companies. A majority of LIFT schemes found it was possible to select three good candidates at the shortlist stage. All LIFT schemes managed to maintain competition between at least two bidders until selection of preferred bidder.

2.9 Local selection processes followed an established national model. Short listed bidders developed detailed plans for a sample of first tranche schemes and presented their proposals at open meetings at which wider stakeholders had chance to comment and feed in their requirements. Although evaluation criteria were developed centrally, LIFT project boards gave their own weighting to these in line with local needs. This resulted in some local variation in the final evaluation process. Most areas set up separate committees to evaluate the key components of the bids.¹²

Business cases for establishing LIFTCos are improving

2.10 Initial LIFT business cases set out proposals for first tranche projects and for establishing the local joint venture. Guidance on the content and evidence required for business cases was issued by the Department in June 2003 after they became concerned about the mixed quality of the draft business cases being produced by early schemes. When guidance was issued, it required Strategic Health Authorities to assess evidence which had not been generally collated at that stage, for example on risk management strategies and Information Technology proposals which took time to produce. Business cases produced following the issue of the guidance are generally of good quality and demonstrate that schemes have considered:

¹² Typically LIFTCos set up separate committees for legal, financial, technical and partnering evaluation.

- proposed value for money;
- affordability for local health economy;
- compliance with standard NHS LIFT contractual terms;
- fit with the Strategic Health Authorities' strategic objectives;
- service modernisation;
- reform and efficiency; and
- integration of the service models into the wider context.

2.11 For second tranche schemes, Partnerships for Health have developed a formal project approval process. Using the Strategic Service Development Plan, the Strategic Partnering Board is expected to:

- issue new project proposals for development by LIFTCo;
- grant stage one approval to proposals which meet requirements;
- define detailed service requirements and affordability criteria;
- review detailed proposals developed by LIFTCo; and
- grant stage two approval where proposals meet the criteria.

The process ensures that the public sector agrees an upfront affordability cap, sets out its minimum requirements and builds in agreements about how abortive costs are met should a project be abandoned. Primary Care Trusts can link this process into their existing procedures to ensure they obtain necessary Strategic Health Authority approvals for business cases. Given the continuing role that the Strategic Health Authority will continue to play in approving projects, however, we were concerned that in two of our case study areas a representative from the Strategic Health Authority had not been invited to attend Strategic Partnering Board meetings. Local areas may face future difficulties and delays getting proposals agreed if they do not maintain a close working relationship with their Strategic Health Authority.

Constraints on some Primary Care Trusts delayed some schemes

2.12 A shortage of suitable sites and appropriately skilled public sector staff led to delays in some cases. Schemes found it difficult to identify and purchase appropriate sites for construction of LIFT buildings. Land outside the primary care estate was found to be scarce (especially in London) and expensive. Suitably skilled public sector workers to implement LIFT were scarce. We found several examples where project directors were solely responsible for their local LIFT and operated on a day to day basis without a support team. Some of these individuals had additional non-LIFT work responsibilities. Where Primary Care Trust Chief Executives have shown a high degree of buy-in to the process and have been closely involved in local decision making, the process of completing negotiations has run generally more smoothly.

2.13 In our survey of project directors, 56 per cent of respondents indicated that they did not have sufficient resources to complete the drive towards financial close efficiently. Our case studies showed that where Primary Care Trusts allowed for closer involvement of senior management and key finance staff around the critical period just before financial close, negotiations were completed more quickly and non-LIFT Primary Care Trust activities remained adequately resourced. Where Primary Care Trust Chief Executives have shown a high degree of buy-in to the process and have been closely involved in local decision making, the process of completing negotiations has run generally more smoothly.

2.14 Negotiations with local clinicians, for example GPs, pharmacists, dentists and opticians, have tended to take longer than expected. Buy-in was sometimes patchy and in some cases attracting established GPs whose premises were not up to standard into the LIFT buildings proved more difficult than expected. Many GPs are very independent with established working patterns and did not find LIFT with its emphasis on co-location appealing. Representatives from the National Pharmaceutical Association, the British Dental Association and Local Authorities told us they had concerns over rental costs. There is a common perception from these groups of prospective tenants that the higher cost of LIFT, compared to current rent payments, outweighs the benefits of new, purpose built premises. The Department worked hard to address this through creation of GP champions for local areas and by hosting forums for GPs to understand the issues. Take up rates from other healthcare professionals have been variable and, occasionally, the Primary Care Trust has agreed to subsidise the rents to meet their wider health agenda. Generally pharmacists were interested in LIFT, while dentists and opticians were not.

2.15 In the absence of any experience of the demands presented by LIFT, Primary Care Trusts were often too optimistic about the number of projects that could be undertaken in the first tranche. East London LIFT, the first scheme to reach financial close, originally aimed to close on seven sites but scaled back to three sites, closing on just one site in May 2003. Partnerships for Health quickly grasped that closing on a manageable number of schemes was a key lesson for other areas to learn if they were to deliver to timetable and in October 2003 advised project teams that they should aim to complete their first tranche on a bundle of around three schemes. This practice had already been adopted by our other case study areas.

2.16 None of our case study LIFTCos negotiated the period from selection of Preferred Bidder to financial close in the three month timetable set by Partnerships for Health. It took Barnsley 11 and Sandwell eight months to complete this phase of procurement (Figure 7).

2.17 A key contributor to delays in some cases was difficult and time consuming negotiations with preferred bidders. In most cases delays were caused by the public sector changing project requirements. We are also aware that some private sector partners did not manage their involvement adequately. For example, one private sector partner was involved in several of the 42 local areas and found its resources too stretched to drive forward all its

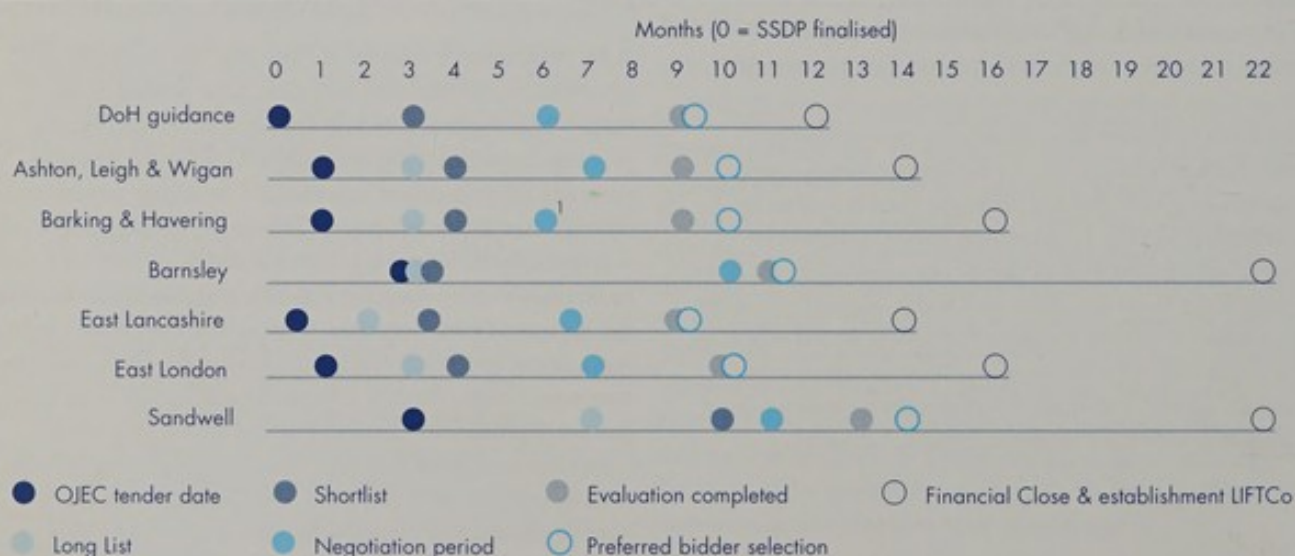
LIFT schemes. Project teams also experienced difficulties in managing the multiplicity of stakeholders in the lead up to financial close. They are required to consult with the preferred bidder, the Department and Partnerships for Health; they must also negotiate with other public sector organisations and prospective tenants.

2.18 Clear guidance about the role and level of involvement of stakeholders in the LIFT process is also important. The role of Strategic Health Authorities was only clearly defined in June 2003. The initial lack of guidance meant approval to the business case from some Strategic Health Authorities within our case study areas was delayed.

The LIFT model facilitates the achievement of value for money

2.19 The value for money of a LIFT project needs to be judged on the basis of whole life costs (taking operation, life cycle, replacement and maintenance costs into account as well as construction costs) and how well it meets objectives, including local health priorities, delivery to time and budget, the quality of the building in structural and functional terms and flexibility of use over time.

7 None of the LIFT schemes were able to meet the Department's timetable



Source: Department of Health and individual LIFT schemes

NOTE

¹ Estimated date.

2.20 Appraising value for money is not, therefore, straightforward or easy. The main advantages of LIFT over other forms of procurement are:

- i projects are prioritised and developed in light of local strategic priorities; and
- ii private sector expertise is brought in and frees up the public sector to concentrate on core health activity.

This should lead to better health outcomes – which may be very difficult to quantify. A judgement needs to be made on the value of unquantifiable health outcomes. Whole life costs over the length of the partnership are inevitably uncertain. The cheapest option may not, therefore, be the option that offers best value for money.

2.21 In practice value for money has largely been demonstrated by there being a competitive procurement and review of (i) proposed rental costs by the District Valuer¹³ and (ii) the funding terms. Any adverse changes between selection of preferred bidder and completion of negotiations are also scrutinised carefully. A series of measures and checks have also been built into the procurement process to try to secure longer term value for money. The affordability of the lease plus charges has also been an important issue and has driven the initial financial structures. As debt is cheaper than equity, the public sector has sought to keep equity to around 10 per cent of the financing.

Barking and Havering selected Primaria as their private sector partner, even though they were ranked second out of three shortlisted bidders on the basis of their cost proposals. The higher lease payment was still affordable, but Primaria were chosen because of the strength and depth of their partnering ethos, their fit with local contracting authorities, a robust design approach, full legal compliance, excellent facilities management and a strong long term vision for the local health and social care economy and local regeneration.

2.22 To make schemes more affordable, LIFTCos may generate third party income which in the longer term can be used to plug funding gaps and reduce the rent levels paid by other tenants. For example, cafes, vending machines, internet training facilities and complementary therapists occupying space within the building are treated as forms of third party income. Pharmacy, however, is likely to be the most significant source of third party income. Unlike other primary care providers such as GPs and dentists who receive some automatic reimbursement for the rent paid to practice from primary care premises, it is at the discretion of the Primary Care Trust as to whether pharmacy is treated as a primary care provider. More often, pharmacy is treated as a business, which as such will pay full rent to occupy space in a LIFT building. The model is flexible enough to allow third parties to take short term leases as the LIFTCo can underwrite the risk of not filling the rental space to protect other shareholders. LIFTCos have forecast the level of third party income likely to be generated within their financial models to reflect the initial interest from third parties in taking space in the buildings.

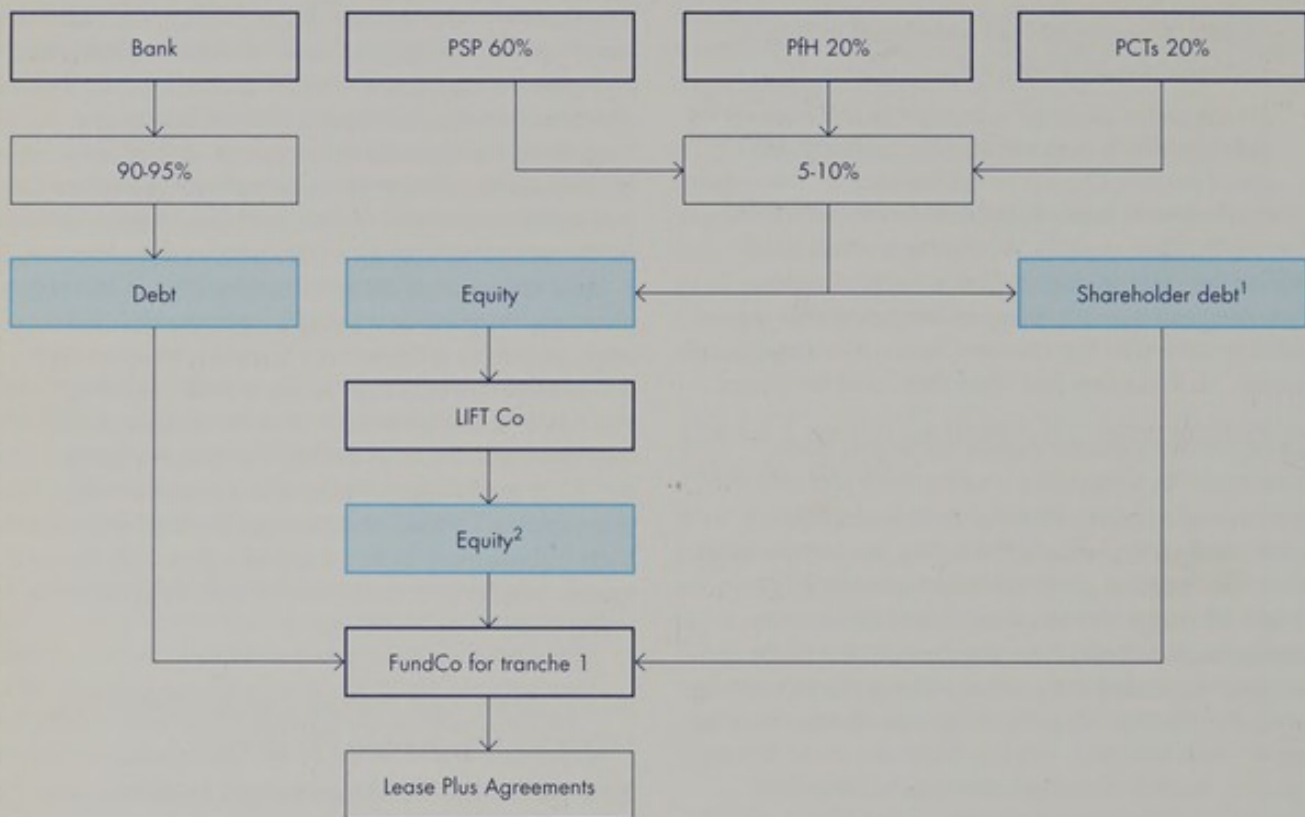
Initial deals look robust and are similar in financial structure to PFI deals

2.23 The funding structure of the LIFT model has been designed to allow relatively small capital schemes to be financed in batches, termed tranches. This allows the LIFTCo to take advantage of the economies of scale available in the capital markets. The bulk of the financing is provided through debt, with the Private Sector Partner, the Primary Care Trusts and Partnerships for Health contributing the equity, which includes some shareholder debt.

2.24 The financial models prepared by the LIFTCo and the reasonableness of its charges were examined closely by the public sector's financial advisors and the lenders. The key drivers of costs are the terms of the senior debt, the upfront costs and the return required by investors. Sensitivity analysis was carried out to show that the LIFT businesses are robust and can cope, in all but the most drastic circumstances, with variations in revenue, cost and the Retail Price Index, which is used to inflate the lease plus charge.

¹³ The District Valuer is a local representative of the Valuation Office Agency, an executive agency of the Inland Revenue, with responsibility for assessing the value of public sector property and giving sign off to the level of rent paid by the public sector to occupy space in a building.

8 The funding structure of LIFT is heavily geared



Source: Sandwell LIFTCo business case

NOTES

1 Shareholder debt is classed as a form of equity (although it has no attached voting rights), and is used in addition to a small amount of cash equity because it allows cash to be freed up in the business once the LIFTCo is operational.

2 The LIFTCo owns nominal equity in each FundCo.

2.25 The most prevalent alternative to LIFT is third party development. Direct comparison between the financing terms is not possible because of the difference in structure – whole life costs are not measured in third party developments. Moreover the financial structure and terms of third party developments vary greatly from one development to another. It is more meaningful to make comparison with similarly sized PFI projects.

2.26 For all but one project, we found that the ratio of debt to equity (gearing) and debt terms were similar to PFI. The principal differences are that in the LIFT model the residual value of the buildings after 25 years¹⁴ can be used to repay part of the loan and that security is provided for the lender through a charge over the property. Under

a PFI structure the loan would be repaid before the end of the contract and security is provided to the lender through measures which:

- i allow them to take over the contract if the contractor fails to fulfil its obligations; and
- ii entitle them to compensation if the contract is terminated early.

2.27 Reduced repayments to the lender during the lease term compared to a PFI structure should result in more efficient use of cash flows within the LIFTCo. An increase in the perceived risk to the lender may, however, have an impact on the terms available. The costs of the debt in the early LIFT deals examined are similar to that of a typical PFI (Figure 9).

¹⁴ Although the Strategic Partnering Agreement is for a period of 20 years, the lease on a LIFT building is usually over a 25 year period.

9 Terms of senior debt look similar to PFI

	Lender	Gearing (senior debt as percentage of equity)	Interest margin percentage above LIBOR	Interest margin percentage above benchmark Gilt yield
Barking & Havering	GPFC	95	-	1.7
Barnsley	Barclays	89.5	0.95-1.11	-
East Lancashire	RBS	90	1.05-1.15	-
East London	Bayerische Landesbank	90	1.15-1.25	-
Sandwell	HBOS	93	1.00-1.05	-
Ashton, Leigh & Wigan	RBS	88.9	1.05-1.15	-
PFI Health centre 1	Not known	89.7	0.90-0.95	-
PFI Health centre 2	Not known	90.6	0.90-1.15	-

Source: National Audit Office derived from financial models for LIFT and similarly sized PFI health projects

2.28 Barking and Havering LIFTCo elected to use gilt based financing rather than bank financing; gilts are government bonds. Gilt backed financing is difficult to compare to bank financing which is based on LIBOR (the London interbank offered rate), the most commonly used benchmark for interest rates. While gilt financing is competitive, the rate is only one factor determining price – margins charged and the initial cost of financing can be higher. Barking and Havering's use of gilt backed financing has had no significant impact on the cost of their deal compared to others examined.

2.29 Upfront costs for land, construction and advisory fees represent a larger proportion of the total cost of smaller LIFT projects than typical PFI deals. Inevitably fixed costs are more significant for smaller projects and combined with the newness of the LIFT initiative, this has meant that the first projects cost more than future ones are expected to. Some upfront costs not specific to any one project can be deferred to later tranches of projects to help smooth the costs over time. The long term guarantee of work from LIFT has also encouraged the private sector partner to seek lower initial returns than would otherwise have been the case.

2.30 The private sector expects a return on its investment relative to the perceived risk of the project. The blended equity Internal Rate of Return¹⁵ of LIFT projects in our case studies, varies between 14.3 and 15.9 per cent (**Figure 10 overleaf**). This is above the initial business planning assumption by Partnerships for Health in 2001 of 13 per cent, but is not out of line with the 12.5 to 15 per cent seen on PFI projects. Across all LIFT schemes which had finalised negotiations by the end of 2004 the range is between 12.4 and 16.2 per cent – with an average rate of 15.1 per cent. These returns, however, incorporate the residual values of the LIFT buildings which are uncertain and vary substantially across schemes – from 12 to 131 per cent of the initial construction and land costs. These differences cannot readily be explained by market variations between areas, and are more likely to be attributable to inconsistencies in the assumptions made by the District Valuers (footnote 13). Owing to these variations the actual return on the residual values is likely to be different to that assumed. There is a sharing mechanism reflecting the equity split for any eventual surplus over the residual value modelled.

¹⁵ Blended IRR includes hybrid debt and equity and equates to the rate of interest that balances the present value of cash outflows from a project with the discounted cash inflow of the investment.

10 Internal Rates of Return of LIFT are similar to PFI, but depend on the residual value of properties

Our case studies areas are anonymous to protect commercial sensitivities

	IRR percentages excluding residual value	IRR percentages including residual value	Residual value £ million	Residual value as percentage of land and construction costs
LIFT case study 1	14.4	15.9	9.4	67.7
LIFT case study 2	10.6	14.3	13.5	131.0
LIFT case study 3	14.0	15.1	8.3	38.9
LIFT case study 4	Not available	15.0	3.6	12.6
LIFT case study 5	12.2	14.6	10.0	96.4
LIFT case study 6	13.4	14.9	8.8	48.1
Health PFI 1	N/A	15.8	N/A	N/A
Health PFI 2	N/A	14.5	N/A	N/A

Source: National Audit Office derived from LIFT financial models and similarly sized PFI projects

Value for money arrangements are tested periodically

2.31 The Strategic Partnering Agreement clearly describes the long term responsibilities of the different partners involved in LIFT. It covers all key areas of the LIFT Public Private Partnership, including:

- premises and services;
- property issues;
- financial issues;
- procurement and evaluation of long term value for money; and
- remedies, defaults and termination issues.

The Strategic Partnering Agreement is a good generic model for individual schemes to develop a tailored local framework for agreeing standards and acting on poor performance.

2.32 The first business cases are required to demonstrate initial value for money by describing the processes followed which support the economic case for LIFT. Given the newness of the initiative and the importance of strategic factors that are not easily quantifiable, conclusions about the likely longer term value for money of LIFT are likely to be judgemental in nature. Some of the Strategic Health Authority representatives in our case study areas were anxious that initial business cases did not sufficiently explore the risks of LIFT and that it was hard to have complete assurance about value for money for an untried initiative. Continued scrutiny of business cases by Strategic Health Authorities is therefore useful.

2.33 Although the LIFT contract grants exclusivity rights to the LIFTCo, protection of longer term value for money for the public sector is built into the contract. If LIFTCo cannot demonstrate through either benchmarking or market testing that value for money criteria have been satisfied, the participants have the right to go elsewhere for the services required. For a period of up to five years from the initial financial close, new projects can be priced by benchmarking the costs against the original competition. Evidence of improving performance through long term relationships and subsequent tranches will enhance any demonstration of value for money. Alternatively, and after five years, value for money is demonstrated through market testing. LIFTCo will be required to demonstrate that its supply chain remains good value through comparison to current cost trends, both locally and nationally, with reference to other market testing exercises and LIFT projects. Parties within the Strategic Partnering Agreement will agree market testing tender information and evaluation criteria.

2.34 The flexibility of the LIFT model is also an important long term factor in value for money. The financial structure of LIFT is sensibly designed to be flexible to changes over the length of the partnership. LIFTCo is not tied into the funder of initial schemes and the structure allows for financing for each tranche of schemes through separate FundCos if this gives better value for money (see figure 8). Nevertheless, there is an expectation that the LIFT model can evolve from a PFI based structure to look more like

that of a traditional property business. If the LIFT estate is treated as a portfolio of properties, cash can be freed up, providing the LIFTCo with opportunities to grow the business. The LIFT model also allows for new equity to be added – for example, once a local scheme becomes established, Local Authorities or even individual GPs may wish to take a shareholding in the LIFTCo.

2.35 As LIFT partnerships run for 20 years, the contracts were designed to offer long term incentives to both the public and private sectors as shown in **Figure 11**. These incentives are well balanced, reflecting the inputs of the different partners and should encourage good performance from both sides within their respective areas of responsibility.

11 LIFT offers incentives for both public and private sector participants

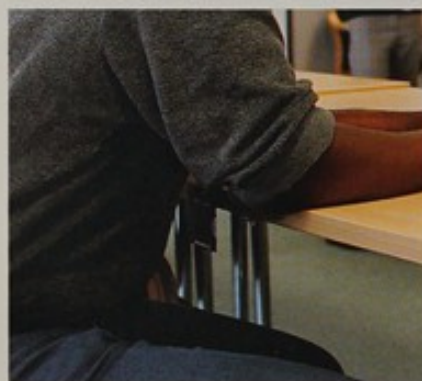
Public Sector		Private Sector	
Incentive	Benefits	Incentive	Benefits
Common approach to procurement	<ul style="list-style-type: none"> Reduced complexity in negotiations Reduced procurement costs over many projects Ensures more productive use of time 	Strategic framework for bringing development opportunities to the private sector	<ul style="list-style-type: none"> Reduced complexity of negotiating terms Reduced risk of cancellation of projects Contract exclusive to all primary care developments in local health economy Reduced risks and costs inherent in new projects
Local stakeholders have a shareholding	<ul style="list-style-type: none"> Public sector can direct investment in line with local priorities GPs reduce risk of investment through shareholding in portfolio of properties Public sector can reinvest its share of profits in local health economy 	Opportunities to increase income	<ul style="list-style-type: none"> Increased profitability from LIFT schemes Improved relationships for private sector with local organisations and businesses
Fit for purpose facilities provided	<ul style="list-style-type: none"> Good quality buildings Improved working environment Fully serviced premises provided 	Opportunity to influence local health and estates strategies	New ideas and suggestions will deliver better outcomes and may increase returns
Flexible structure	<ul style="list-style-type: none"> LIFT model can respond to long term requirements of public sector Shares can be sold/re-distributed 	Low risk investment	<ul style="list-style-type: none"> Returns to private sector are reasonable Government backed cash represents increased security
Improved primary care estate	<ul style="list-style-type: none"> Can extend and co-locate care services Can help meet primary care targets Can secure buy-in from tenants 	Facilitates introduction to non NHS clients	Contact with suppliers of facilities outside the NHS may open up commercial opportunities outside of LIFT

Source: National Audit Office

PART THREE

Local outcomes and future prospects

This section of the report looks at the local outcomes in our case study areas. We found more widely that first tranche projects are largely concerned with re-housing GPs, but there are encouraging signs of longer term thinking, and the long term future of the initiative looks positive. The frameworks for performance measurement and accountability need to be strengthened. Partnerships for Health have announced other changes for a fourth wave of schemes.



The first projects combine quick wins with some longer term thinking

3.1 Most first tranche LIFT projects have concentrated on re-providing existing primary care services in modern premises. Quick wins were needed to meet pressing local needs. For example, in April 2001 prior to starting LIFT, Sandwell found 80 instances across 39 of their 87 premises where it was considered either technically unfeasible or uneconomic to achieve compliance with modern statutory standards, particularly the requirements of the Disability Discrimination Act 1995. Sandwell's first LIFT projects were therefore focused strongly on replacing some of the worst existing premises to make an immediate impact on the local modernisation agenda.

3.2 While the most pressing need has been to accommodate GPs, some projects are incorporating wider primary care services. The Church Road scheme in East London is a flagship one stop centre. Complementary services include a pharmacy, a dental suite, radiology, psychology and transfer of cardiology outpatients from the acute sector.¹⁶ Firm commitment to some services from stakeholders has, however, not been obtained as at April 2005. Future developments in East London could also incorporate key worker housing and an opportunity for Sure Start¹⁷, another national initiative implemented locally, to run advice sessions for young parents.

3.3 It is difficult when entering into a 20 year partnership for local health economies to predict changing shifts in service provision and the population's needs over the longer term reliably. Flexibility and adaptability, although desirable, come at an additional cost. Some first tranche projects have nevertheless been designed to allow for changing use in the future. In the Church Road project, the radiography suite, for example, can easily be adapted for alternative use in the future.

Some future projects will address LIFT's wider aims

3.4 Now that many first tranche projects where it was crucial to re-provide primary care premises quickly have been dealt with, future projects should contribute towards LIFT's overarching aim of developing new ways to provide primary care services. For example, East Lancashire LIFT has a diverse demographic mix over its three Primary Care Trusts of ethnic, rural and urban populations. A model has been developed where specialist "hub" services are located to best serve a particular population's needs, for example, the population of West Accrington is young and transient and therefore children's and sexual health services will be located in this "hub". More generalist and local "spoke" services, for example GPs, will however be retained within the LIFT area, reflecting the needs of rural communities who may find it hard to access centralised services.

¹⁶ Acute care is provided, normally in a hospital setting, to those whose illnesses are short term or episodic.

¹⁷ Sure Start is the Government's Programme to deliver the best start in life for every child by bringing together early education, childcare, health and family support.

3.5 After a cautious start, some LIFT schemes are now actively engaging wider stakeholders to build in service provision beyond that traditionally associated with primary care. For example, Newcastle and North Tyneside where the Local Authority were instrumental in broadening the range of services provided through LIFTCo. Many of the Council's social inclusion developments, designed to ensure better access to services, work, leisure and housing opportunities, may now be supplied through LIFT. The Council's joint service partner agencies also extend the range of services available to users. There are also encouraging signs across a number of LIFT areas where plans to involve voluntary projects are taking shape. These may be health related but are also likely to offer leisure, IT and art based activities to local communities. For example, two areas we visited had invited their local Age Concern¹⁸ group to run services from a LIFT building.

3.6 Flexibility to respond to future changes is not just focused on infrastructure. LIFT schemes are encouraged to consider whether they are sensitive to future demographic trends. The planned expansion of the Thames Gateway¹⁹ which covers both East London and Barking and Havering LIFT areas, aims to deliver sustainable growth and has major economic and housing potential. The Mayor's London Plan forecasts significant population growth in the Thames Gateway, but the likely population profile and associated health issues are unknown. In London, an NHS Healthy Urban Development Unit has been established, which reporting through the North East London Strategic Health Authority, will promote sustainable communities by assisting Primary Care Trusts and others, including LIFT schemes, to engage fully and effectively with urban planning and development processes.

3.7 LIFT areas are beginning to think about how they can link into local regeneration initiatives. The Barking and Havering LIFT scheme has included a Strategic Health Authority Regeneration Director on their Strategic Partnering Board to help them understand how LIFT can contribute to local regeneration. Initial ideas have focused on using LIFT to offer affordable housing and training opportunities to the community and to contribute to re-design of the local transport infrastructure. Local employment in LIFT areas may also benefit. Our East Lancashire and Ashton, Leigh and Wigan case examples are both areas that have suffered from a decline in their traditional industries. As LIFT contracts become established, there may be new opportunities to offer secure and long term employment to these areas.

Evaluation and performance measurement arrangements are not consistent

3.8 An important aspect of the LIFT programme is the extent to which the implementation of each wave of the programme is evaluated providing for opportunity to spread best practice. Of our case study areas, only Sandwell has developed a post project evaluation plan basing it on generic guidance from the Department; *Learning Lessons from Post Project Evaluation (January 2002)*. Although both Partnerships for Health and the Department recognise the importance of evaluation there is no clear guidance recommending either its nature or timing. Detailed guidance is important given the scale and speed of LIFT implementation – it will enable a consistent approach. There is also a risk, that without clear guidance, and given operational priorities, evaluation activity is curtailed.

3.9 The Strategic Partnering Agreement²⁰ confirms that each LIFTCo will monitor the performance of the maintenance and partnering services demonstrating improvement through a series of Key Performance Indicators. Many of our case study areas were developing long term business plans, but there is no consistent approach to developing performance indicators. Apart from Sandwell who had developed a wide range of performance indicators, references in the business plans to performance measures were unspecific. There was little evidence that LIFTCos had gripped the approach to measuring and setting targets for the delivery of services once operational. Partnerships for Health and the Department would benefit greatly from the ability to produce a periodic picture of how LIFT is performing as a whole - consistency of approach is needed for this picture to be meaningful.

3.10 Over the longer term it is important that the local health economy is able to show that expected wider benefits of the LIFT programme have indeed contributed, as expected, to health and regeneration outcomes. In turn this will form an important element of the evidence base through which Partnerships for Health and the Department show longer term service improvements and value for money from LIFT. The Sandwell post project evaluation plan sensibly incorporates a benefits realisation plan, outlining how they intend to measure the wider benefits of the LIFTCo. The Department has significant experience in post project evaluation, but to

18 Age Concern is a UK charity which supports people over 50. They provide essential services such as day care and information. They also campaign on issues such as age discrimination and pensions and work to influence Government policy about older people.

19 The Thames Gateway is a national regeneration priority area comprising a population of 1.6 million and an area of land approximately 40 miles long and 20 miles wide, extending from the Isle of Dogs in London, to Southend in Essex, and to the Isle of Sheppey in Kent.

20 Schedule 17 (section 2): Strategic Partnering Agreement.

assess the impact of LIFT needs to develop performance measures reflecting national priorities and policy. LIFTCos would benefit greatly from working with the Department to evaluate local outcomes - especially given that the monitoring of wider outcomes is a complex area. While we recognise that it may not be possible to establish direct linkage between LIFTCo activity and health outcomes, nonetheless, interim or proxy measures related to key local health concerns or deprivation issues could be developed. For example, a LIFT area that reports a high prevalence of lung cancer in its Strategic Service Development Plan would want its LIFT scheme to help deliver a reduction in lung cancer and could define an indicative measure such as the number of smoking cessation clinics held in LIFTCo buildings.

The accountability framework in LIFTCos needs strengthening

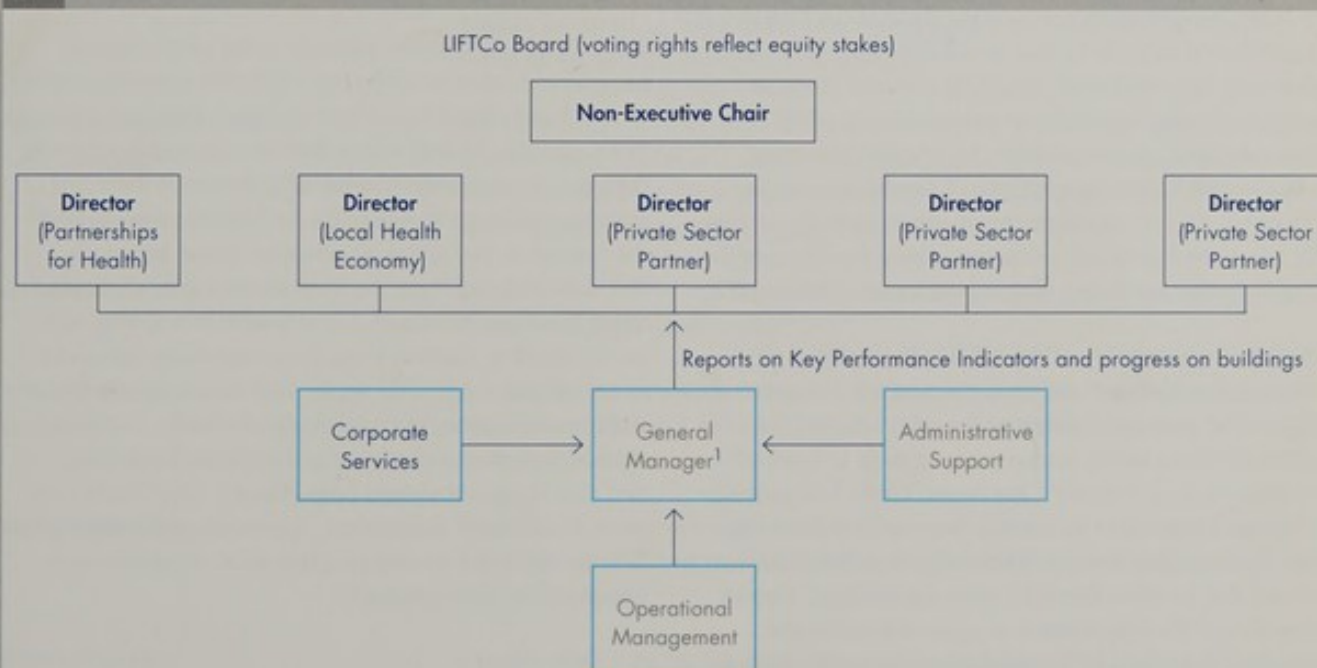
3.11 Two bodies with oversight functions, the LIFTCo board and the Strategic Partnering Board, have been established within local LIFT schemes. The roles of the boards are clearly defined by Partnerships for Health and there is a distinct separation of duties. The Strategic

Partnering Board, comprising representatives from the local health economy, commission services and buildings to be delivered by the LIFTCo. The structure of the LIFTCo board comprises one non-executive chair and five directors; three of whom are from the private sector partner, one from the public sector and one from Partnerships for Health (Figure 12).

3.12 Partnerships for Health consider that the small and local nature of LIFT creates inherent difficulties for Board appointments. They believe that the benefit of securing the optimal candidate for a position outweighs the risk of conflicts of interest arising. As a consequence they did not issue explicit guidance about the likely background of candidates, but instead defined the attributes of individuals filling board positions on LIFTCo and on the Strategic Partnering Board. This has resulted in different local interpretations about who should be appointed public sector director of LIFTCo.

3.13 As a result, four of our six case study areas appointed Primary Care Trust Chief Executives or Finance Directors to act as public sector directors on LIFTCo. There is potential for a conflict of interest where these individuals have responsibilities to two organisations with different

12 Structure of the LIFTCo



Source: National Audit Office

NOTE

¹ The LIFTCo General Manager/Chief Executive may be from a public or private sector background, they also serve as the link between the LIFTCo and the Strategic Partnering Board.

priorities – for example, if the LIFTCo was in financial difficulties, as a LIFTCo director a Primary Care Trust employee might have conflicting pressures between helping the LIFTCo and protecting the interests of the Primary Care Trust. Other LIFTCos did take steps to avoid these tensions – East London LIFT has appointed the chairman of a local hospital, to fill the role and in East Lancashire the public sector director will be rotated between Primary Care Trusts within the LIFT. To safeguard properly against tensions arising, however, there need to be clearer boundaries in place and Partnerships for Health could consider whether LIFT schemes would benefit from further guidance to help them manage those tensions that cannot be avoided. For example, the public sector director, in the role as a LIFTCo Board Member, has a fiduciary duty to act in the interests of the LIFTCo and not for the Primary Care Trust as a client or shareholder. These directors should, when in a difficult position in respect of their prime duty to the LIFTCo, refer matters back to the Primary Care Trust for a decision.

3.14 Recruitment of non executives to chair the LIFTCo and Strategic Partnering Board has also presented difficulties for the local LIFT areas. Understandably most LIFT schemes only gave these appointments their full attention having reached the milestone of financial close and filling these posts has since been slow – as at January 2005 one of our case study areas is yet to appoint a LIFTCo Chair. Partnerships for Health consider that the independent chairs are central to the functioning of the boards and that nominees should be selected because they have the requisite skills to exert proper control and safeguard public sector interests. In practice, however, this has meant that independence of candidates can be overlooked. Of the appointments made to date in our case study areas we found two instances where the Chair of the Strategic Partnering Board was a local stakeholder in LIFT.

3.15 The accountability of the LIFTCo to the Strategic Partnering Board is well defined. It is unclear, however, to whom the Strategic Partnering Board is responsible beyond members being accountable to their individual organisations (e.g. Primary Care Trusts, Local Authorities). We have not been able to identify how or by whom the performance of the Strategic Partnering Board will be assessed and whether there are roles for Strategic Health Authorities or the Department in a general oversight framework. Additionally because the Strategic Partnering Board represents multiple clients, the LIFTCo's customer

for each individual project is never defined. The important issue is that the Strategic Partnering Board makes it clear who the client is for the LIFTCo and monitors the relationship between the LIFTCo and the client. On an operational basis, where a project is driven by a single Primary Care Trust, it may be easier for the LIFTCo to deal directly with the Primary Care Trust as the customer. But, where a joined up delivery is required, the Strategic Partnering Board needs to act effectively as the customer of the LIFTCo.

Changes will be announced for a fourth wave of LIFT schemes

3.16 A fourth wave of nine new schemes was announced in November 2004.²¹ Partnerships for Health, in recognition of the lessons learned from the initial three waves, have instigated a number of changes to the set-up process, which they expect fourth wave schemes to follow. In terms of service issues, more Local Authority involvement is encouraged from the outset and it will be possible to procure soft facilities maintenance, which up to now has not been included in the LIFT contract. LIFTCos will be encouraged to expand the range of services provided and there will be increased emphasis in evaluating bidders on long term benefits to the public sector, building design and wider regeneration linkages.

3.17 There will also be changes to the procurement programme. Most notably, the 12 month timetable, which LIFT schemes have found hard to meet, has been extended to 15 months. Project teams will be required formally to deliver a manageable number of schemes in their first tranche. Although Partnerships for Health promulgated this advice to the initial 42 schemes it was not made mandatory. In addition the level of resources dedicated to LIFT will be increased. Local health economies will be expected to commit project management resources to set-up and the private sector will have to prove it has sufficient resources to close deals efficiently. Furthermore, central expertise and advice and improved technical and due diligence should help Primary Care Trusts with more timely land acquisition. Approvals processes will also be tightened to enable schemes to complete their negotiations more smoothly.

21. Bury, Tameside and Glossop, Sustainable Communities in Kent, Rochdale, Bolton and Heywood and Middleton, South East Midlands, South East Essex, South Midlands, Kensington and Chelsea, Wiltshire, South West Hampshire.

GLOSSARY

Enabling Funds	Funds from the Department of Health to launch NHS LIFT, allocated to the lead Primary Care Trusts in localities where LIFT is pursued. Project teams are required to apply for Enabling Funds during the preparation of the Strategic Service Development Plan and prior to procurement. Primary Care Trusts are required to return Enabling Funds following successful completion of their first tranche of schemes, but may apply to recycle them.
Facilitator	Partnerships for Health provides at least one facilitator per LIFT scheme to provide advice and assist with implementation, of the standard documentation and the achievement of Financial Close.
Financial Close	Completion of negotiations leading to formal establishment of the LIFTCo.
FundCos	A shell company within the LIFT financing structure holding the debt funding for each individual tranche of LIFT projects.
Lease Plus Agreement	Developed by Partnerships for Health to govern occupation of LIFT premises, this standard document is similar to a conventional lease, but responsibility for maintenance, repair and insurance of premises rests with the LIFTCo throughout the term. It is intended to be used substantially un-amended, with minor amendments to customise it to reflect particulars of individual schemes.
Local Health Economy	The NHS organisations, including GPs, voluntary and independent sector bodies involved in commissioning, development and provision of health services for particular population groups.
Local Improvement Finance Trust Company	(LIFTCo) Local Joint Venture Company limited by shares held by private sector partner, local health and social care stakeholder, and Partnerships for Health and governed by a 20 year partnership agreement to deliver investment and services in local primary care facilities.
NHS Plan	Initiated in 2000 by the Department of Health, this is a ten-year strategy for investment and reform in the NHS.
Partnerships for Health	A National Joint Venture formed by Partnerships UK and the Department of Health to implement NHS LIFT. Partnerships for Health also invest 20% equity in each LIFTCo.
Partnerships UK	Established by the Treasury as a successor to the Treasury taskforce, Partnerships UK is itself a PPP and works in partnership with the Public Sector to develop PPP projects.
Project Director	Usually employed by the lead Primary Care Trust involved in the LIFT scheme, the Project Director manages the procurement process and set-up of LIFTCo.

Primary Care Trust	There are 302 Primary Care Trusts in England, established in 2002. They are local organisations, receiving 75 per cent of the NHS budget, with responsibility for managing local primary care services – the care provided when you first have a health problem.
Private Sector Partner	In most cases a consortium of private sector entities which invest the major shareholding of 60 per cent in, and deliver services to, the LIFT Co.
Private Finance Initiative	A policy introduced by the Government in 1992 to harness private sector management and expertise in the delivery of public services, while reducing the impact of public borrowing.
Residual Value	The expected value of an asset at the end of a specified period.
Shareholders Agreement	Standard document developed by Partnerships for Health establishing the shareholding agreement between Partnerships for Health, the LIFTCo, the Private Sector Partner, the Primary Care trust and other public sector shareholders.
Strategic Health Authority	England is split into 28 Strategic Health Authorities. These organisations were set up in 2002 to develop plans for improving health services in their local area and to make sure their local NHS organisations are performing well. Each Strategic Health Authority is responsible for several Primary Care Trusts in its area.
Strategic Partnering Agreement	Standard document developed by Partnerships for Health, this 20-year agreement establishes the long-term strategic partnering between LIFTCo and the participants (Primary Care Trusts, NHS Trust and Local Authority) relating to the delivery of improved health and care services in the area. Management of the partnership requires the establishment of a Strategic Partnering Board.
Strategic Partnering Board	Established by the stakeholders in a local health and social care community, the Board is responsible for monitoring the performance and identifying the future direction of the LIFTCo.
Strategic Service Development Plan	Each Strategic Partnering Board is responsible for the annual review and approval of this document which forms the basis of the LIFT strategy for primary and community based health services.
Third Party Development	Development of new premises undertaken by a private contractor on behalf of a Primary Care Trust or GPs.
Tranche	A bundle of several projects commissioned and built by the LIFTCo within one financing package.
Whole Life Costs	The costs incurred over the lifetime of an asset taking into consideration initial capital costs and future costs including operational, maintenance and disposal costs.

APPENDIX 1

Methodology

1 We used a variety of methods to undertake our examination, from qualitative approaches such as document review to the quantitative analysis of the financial models, aimed collectively at ensuring logical rigour and technical robustness in the final report. **Figure 13** shows the different methods we used by study phase.

Explanatory Notes

Note 1 – The Issue Analysis/Dinner Party approach (IADP™)

2 The Issue Analysis /Dinner party approach (IADP™) is a methodological framework developed by the NAO as a means to deliver audit reports that are focused, logically rigorous and built on consensus. It helps structure an audit programme around which to base evidence collection and

analysis (the aim of the issue analysis) and organise the resultant report in a clear and logical way (the aim of the Dinner Party™).

3 Issue analysis produces a series of yes/no questions terminating in audit tasks which indicate what hypothesis the auditor should seek to test and what method of data collection and/or analysis he or she should use. The high level questions that we based this audit around are in **Figure 14**.

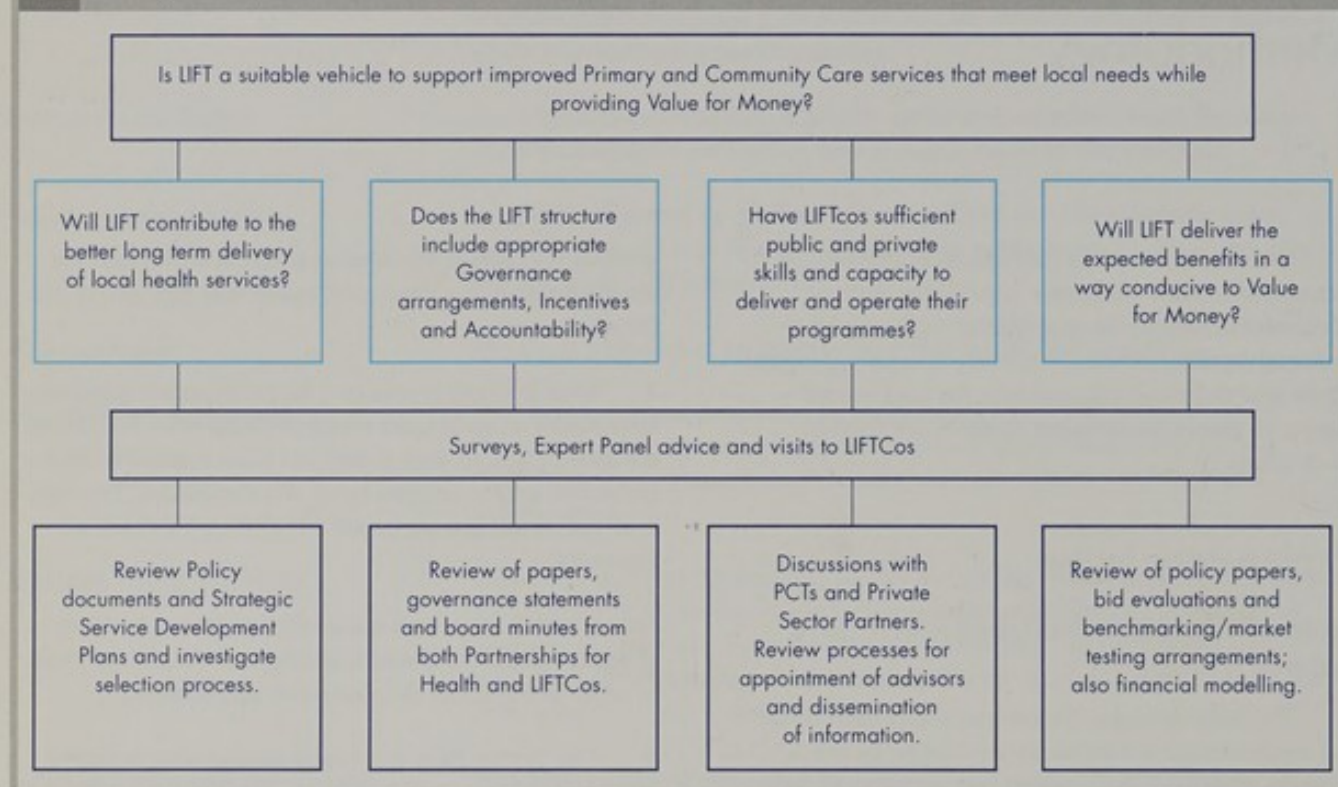
For each of the top level questions, we set a subsidiary group of questions, linked logically to the main question, in order to direct our detailed work and analysis.

4 The Dinner Party™ is based around what happens at a real dinner party, when you typically have only a short period of time to hold a fellow guest's attention. The Dinner Party™ meeting takes place after data collection

13 Methods used to undertake our examination

Method	Study phase			
	Issue identification	Audit programme	Evidence collection and analysis	Report drafting
Issue analysis (see note 1)	✓	✓		
Brainstorming	✓			
Internet research	✓		✓	
Document review	✓		✓	
Stakeholder Interviews	✓		✓	
Surveys (see note 2)			✓	
Statistical/financial analysis (see note 3)			✓	
Consultation with expert panel (see note 4)	✓	✓	✓	✓
Case study analysis (see note 5)			✓	
Dinner Party™				✓

14 The high level questions that we based this audit around



and analysis is complete and the aim is to produce crisp, interesting report conclusions that can each be stated in 10-15 seconds, and to build up more levels of detail on that basis. In this case, the high level conclusions which resulted from the Dinner PartyTM process were:

- The National LIFT Programme appears an attractive way of securing improvements in Primary and Community Care
- The local LIFT models appear to be an effective mechanism clearly demonstrating Value for Money; however, local management frameworks could be strengthened.

Note 2 – Surveys

5 Questionnaires were developed and submitted to three interest groups to gain an understanding of their views about LIFT and involvement in the procurement process. The surveyed target groups and response rates are as follows:

- | | |
|---|------------|
| ■ LIFT Project Directors
(across 42 LIFT areas) | 95% return |
| ■ Shortlisted Bidders
(across 42 LIFT areas) | 66% return |
| ■ Local Pharmaceutical
Committees (for case study areas) | 67% return |

The methodology and results of our surveys were discussed with the Department and Partnerships for Health.

Note 3 – Financial Analysis

6 Operis, the Business Engineering firm reviewed the financial models, sensitivities and financing terms of each of our case study LIFTCos. Operis provided clarification of the key information contained in the models and associated sensitivities. Their work also provided insights for interpreting the robustness of each of the models. We were also assisted in our financial analysis by Arshad Mahmood, an MSc student at Cranfield University.

Note 4 – NAO Expert Panel

7 The Expert Panel consisted of a range of experts external to the National Audit Office, plus one Director from an NAO department specialising in Health. The panel was invited to comment on issue identification and the structure and draft of the report, thereby providing assurance of quality. External members of the Expert Panel were:

- Sylvia Wyatt, Project Manager, NHS Confederation
- Dr K Arswani, Fellow of the Royal College of General Practitioners
- Claire Jones, Assistant Head of NHS Service Development, National Pharmaceutical Association
- John Morris, Dental Practitioner
- Matthew Symes, Matthew Symes Project Management Ltd
- Rob Hann, Director, Legal and Joint Services, 4Ps
- Steve Spoerry, Project Director, Tees Valley and South Durham NHS LIFT
- Mairi Johnson, Enabling Advisor, Commission for Architecture and the Built Environment
- Colin McLeod, Chief Executive, Middlesbrough Primary Care Trust

Note 5 – Case Studies

8 The first six LIFTCos to achieve Financial Close were examined as case studies. We selected the first six because at the time of starting our fieldwork they had been through the full procurement process and were well placed to identify best practice and lessons learned. The case study LIFTCos were:

- | | |
|----------------------------|----------|
| ■ East London and the City | (Wave 1) |
| ■ Barnsley | (Wave 1) |
| ■ Sandwell | (Wave 1) |
| ■ East Lancashire | (Wave 2) |
| ■ Barking and Havering | (Wave 2) |
| ■ Ashton, Leigh and Wigan | (Wave 3) |

Research for the case studies included document review, interviews with stakeholders and visits to proposed sites.

APPENDIX 2

Case Studies: Key Facts

Pale blue areas indicate PCTs in LIFT scheme

East Lancashire

Second wave
PSP: Eric Wright Group

LIFT Co established:
17 Sep 03

Capital value	£21.2m
PCTs	3
Schemes	3
Population	501,000

Barnsley

First wave
PSP: Community Solutions for Primary Care

LIFT Co established:
30 Jan 04

Capital value	£10.3m
PCTs	1
Schemes	3
Population	225,000

Ashton, Leigh & Wigan

Third wave
PSP: Eric Wright Group

LIFT Co established:
09 Feb 04

Capital value	£15.5m
PCTs	3
Schemes	3
Population	310,000

Barking & Havering

Second wave
PSP: Primaria

LIFT Co established:
04 Dec 03

Capital value	£14.8m
PCTs	2
Schemes	3
Population	398,000

Sandwell

First wave
PSP: Excellcare

LIFT Co established:
15 Jan 04

Capital value	£8.8m
PCTs	3
Schemes	3
Population	295,000

East London & City

First wave
PSP: Global Solutions Ltd/
Babcock & Brown

LIFT Co established:
29 May 03

Capital value	£5.5m
PCTs	3
Schemes	1
Population	666,000

Source: Department of Health

APPENDIX 3

Attributes of a well designed building

1 The Commission for Architecture and the Built Environment has had a range of involvement with the Primary Care Trusts that are forming LIFTCos, including through their Enabling Programme and their Design Review Programme.

2 CABC have devised a list of ten points that they consider to be the attributes of a well-designed LIFT building. These attributes are listed below:

Good urban design, allowing the building to contribute positively to the urban environment and providing a clear, easy approach that is integrated with public transport.

Good public open space, with pedestrians prioritised over cars so that the building is not dominated by parking requirements. Cafes and other services that benefit from outside space should be situated to enhance the integration of the building into the surrounding area. Landscaping should be used to enhance the external environment. Public open space is particularly important where there are aspirations to use the new health facility to kick-start regeneration of the surrounding area.

A clear plan, with a natural progression from public to treatment rooms. Ideally, visitors should be able to see their destination from their starting point.

Generous amounts of natural light and ventilation, contributing to good and energy efficient environmental conditions throughout. As well as providing a comfortable and therapeutic environment, this assists with the human scale of the elevations, provides views and aids wayfinding within.

Capacity to adapt to future changes in the healthcare service by sizing rooms generously and laying them out thoughtfully. Many new primary healthcare buildings will be housing people and organisations that have not shared accommodation before - it is CABC's view that space should be viewed as a resource, not a territory, allowing patterns of use to evolve over time.

A single reception point. This makes for a clear expression of the entrance on the outside, an early welcome once inside and assists in orientation when travelling around the building. Security and privacy issues can be resolved in the detailed design of the reception area.

Circulation and waiting areas that are places in their own right. The sizing of the clinical spaces of primary healthcare buildings are likely to be determined by Health Building Notes; therefore the journey to the treatment room and the waiting areas are the main opportunities for designers to creatively enhance the basic facilities. Waiting areas are often integrated into the circulation and care should be taken that both areas benefit from this relationship.

Robust and attractive materials, finishes and furnishing. Structure and detail should all correspond to a clear approach to design and there will also be on-going benefit for whole life costs as maintenance and replacement is reduced.

Adequate and effectively planned storage.

A layout that encourages community use out of hours. Ground floor space will always be in high demand, particularly from GP practices. In the interests of contributing to a healthy lifestyle, encouraging initiatives such as nurseries or art groups to use some of the easily accessible space would be beneficial.

REPORTS BY THE COMPTROLLER AND AUDITOR GENERAL, SESSION 2005-2006

The Comptroller and Auditor General has to date, in Session 2005-2006, presented to the House of Commons the following reports under Section 9 of the National Audit Act, 1983. The reports are listed by subject category.

		Publication date
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National Health Service		
Innovation in the NHS: Local Improvement Finances Trusts	HC 28	19 May 2005

Printed in the UK for the Stationery Office Limited
on behalf of the Controller of her Majesty's Stationery Office
179194 05/05 7333



Layout and production by
NAO Information Centre
DG Ref: 4253VE

Printed on Consort Renew Satin containing 50% recycled fibre

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